The Catchment Beacon Project

July 2014 to December 2016

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1. Executive Summary

The Catchment Beacon Project (CBP) involved the application of an implementation framework used for promoting family inclusion within service sectors to a cross sector service catchment structure. Over an 18-month period, The Bouverie Centre worked together with clinical mental health, Mental Health Community Support (MHCS) and AOD services located within a rural (Goulburn Valley) and a metropolitan (Melbourne South West) catchment to implement a family inclusive practice model.

Ten out of a possible fourteen agencies across the two catchments were engaged in the project. This is a positive result given the major reforms occurring across the three sectors at the time and the fact that the participating catchments did not initiate involvement in the project but instead were selected by DHHS and The Bouverie Centre.

A novel process that brought together service users, their families and practitioners from each catchment was used to identify issues in service delivery and to inform the selection of a family inclusive practice model. Single Session Family Consultation (SSFC) was the practice model chosen by all services across the two catchments. SSFC, a brief model of family engagement, was the stated preference over other family-based approaches which had stronger evidence bases but tended to be more complex and longer in duration.

One hundred and fifty-four practitioners from clinical mental health, AOD and mental health community support services were trained in SSFC across seven rounds of a two-day training program. Ninety-six were from the Goulburn Valley catchment. Other components of the implementation approach included catchment-based management steering groups, the identification, training and support of practice champions within agencies, and the use of catchment practice enquiry groups (PEGs) facilitated by Family Practice Consultants from The Bouverie Centre. In total, The Bouverie Centre's project team met with the services on 40 different occasions - at champion briefings, steering group and PEG meetings, onsite consultations and opening and closing forums.

A pre and post family inclusive practice survey, training evaluations, and a log tracking the use of SSFC were used to evaluate the quality of services delivered by The Bouverie Centre as well as the impact of the initiative on practitioners. In addition, both agency managers and practice champions were interviewed individually and in focus groups to explore their experiences of participating in the project and the extent to which CBP facilitated interagency collaboration.

The training and implementation support provided resulted in 273 family consultation sessions (or family meetings) and 102 consultations with individual family members across the two catchments. In addition, over 780 invitations to participate in SFFC sessions were made to consumers and family members. The ratio of client and family SSFC sessions to client invitations was 55% which is broadly in keeping with uptake ratios found in previous Beacon projects. Consistent with the numbers participating in training, the number of families participating in a SSFC session was higher in the Goulburn Valley catchment than in the Melbourne South West.

In addition to changes to the services delivered to families, the findings revealed further shifts at the practitioner level. Practitioners' confidence in practicing in a family sensitive manner and in holding formal meetings with families rose over the 6 – 9-month period. There was also evidence of increased provision of family meetings by practitioners.

It was clear from both the focus groups and interviews with agency managers and practice champions that both cohorts valued meeting together with colleagues from different agencies as it gave them the opportunity to engage in shared problem solving and mutual support. These groups were also seen as helping to maintain project momentum, as was the involvement of an external agent, The Bouverie Centre.

Agencies used a range of strategies to implement SSFC including incorporating the framework into formal meeting processes and performance standards, and instituting decision-making supports and reminders. Barriers to the uptake of SSFC were identified as operating at the level of service users, their families, practitioners, the work setting and in the wider context. Changes to organisational processes, and SSFC's congruence with an agency's directions were seen by some as factors that could help sustain the use of the framework, whereas staff turnover was identified as a constraint to sustainability.

Managers observed that practitioners' skills in working with families increased corresponding with their service's involvement in the project, as did their positivity towards families and the number of family members attending the service. CBP was seen as having the potential to promote consistency in practice across services, foster shared expectations and facilitate information sharing. However, not all managers were of the view that the project led to increased collaboration. The absence of co-ordinated service provision within the catchments suggests that the project's potential for promoting greater inter-agency co-ordination in the provision of care was not fully realised.

In summary the project was successful in increasing the use of a family-based model of intervention within the two catchments and in building practitioner and service capability to be inclusive of families. The network of family inclusive practitioners provided valuable input during the project but was not sustained after its conclusion. The aims related to creating a shared vision around family inclusion, better co-ordination and the development of referral pathways between services within each catchment were not achieved. This suggests that the catchment was a viable platform from which to mount practice change activities but that additional resources and time may be needed to achieve a cross sector vision, cooperation and service delivery. Finally, the CBP has provided valuable knowledge about implementation in a catchment context and has added to existing knowledge about implementation of family inclusive practices and the acceptability of the SSFC model more generally. This knowledge has been disseminated in state-wide forums and publications.

Key learning

1. The CBP demonstrated that service users, families and practitioners can be constructively engaged in identifying gaps and other issues in service delivery and in informing decisions about how services can be improved. This process needs further development to address issues such as how service user and family involvement can be sustained over the course of an implementation project.

2. Consistent with other Beacon projects, data collection in CBP was both critical for its success and difficult to achieve. Obtaining accurate data is relevant not only for measuring the impact of implementation projects but also for influencing uptake of new practices. Creating quick, easy and efficient methods for practitioners (and, as relevant, services users and families) to record their activities and making use of existing service data remain major imperatives in future implementation projects.

3. Catchments can provide a useful platform for implementation endeavours. CBP produced evidence of significant and meaningful change in practice across a range of agencies both in terms of increased inclusion of families and in changes in practitioner attitudes and behaviour. While the rural catchment had higher levels of participation in training and higher rates of uptake than the metropolitan catchment, evidence of practice change was evident in both settings. The outcomes in terms of the uptake of a new practice are also broadly similar with projects where individual services have been the focus of implementation support. Delivering training and implementation support at a catchment level is therefore viable and has advantages. For example, smaller agencies that might otherwise not have a critical mass of staff or sufficient resources to access training and support in their own right would be able to participate in catchment-based training and implementation activities.

4. Within the context of CBP, agencies demonstrated that they were able to work together to problem solve and offer each other support in relation to implementing a common practice model. It seems likely that bringing practitioners and managers from different agencies together to work on joint projects can improve relationships and may ultimately lead to co-operation and co-ordination in the delivery of services. However, such benefits may take years rather than months to be realised. It also seems likely that achieving the level of interagency co-ordination and collaboration required to benefit service users and families requires additional measures. These include funding bodies making service co-ordination and collaboration a direct and measurable requirement and the provision of additional resources.

2. Project background

In 2014, The Bouverie Centre was funded by The Department of Health and Human Services (DHSS) to deliver a Beacon implementation project within the context of the then newly formed service catchments. The plan for a Catchment Beacon Project (CBP) was devised during a time in which significant state government reforms to the alcohol and other drug (AOD), mental health community support (MHCS) and clinical mental health sectors in Victoria were unfolding (New directions for alcohol and drug treatment services, 2013; Reforming community support services for people with mental illness, 2013; The Mental Health Act, 2014).

In addition to reforms unique to each sector, there were commonalities across sectors, chiefly the shift to more family-inclusive and recovery-oriented practice and the implementation of formalised place-based measures to encourage discrete agencies to work together in a structured and planned manner. The latter reform initiative aimed to improve service coordination at a catchment level, with AOD and clinical mental health services and MHCSS within each catchment to potentially operate under a single plan tailored to respond to the specific needs of their communities (Victoria's Alcohol and Drug Workforce Development Framework 2012 – 2022; Victoria's Specialist Mental Health Workforce Development Framework 2014 – 2024). The development of catchment structures aimed to promote better coordination, planning and delivery of services across MHCS, AOD and adult clinical mental health services.

Since 2008, The Bouverie Centre has embarked on several 'Beacon' projects with Victorian AOD and mental health services. The aim of these Beacon projects is reflected in The Bouverie Centre's document, *From Individual to Families: A Client–Centred Framework for Involving Families (2015)*:

> '… to help adult oriented organisations translate research evidence into practice and build on what they are already doing to involve families and children in client treatment and care.' p3

More specifically, Beacon projects aim to achieve meaningful and measurable change in the family inclusiveness of these services. These multi-site projects are characterised by the use of a range of change strategies informed by implementation science (Damschroder, et al, 2009), extended engagement with services (two years), and the intention to build and share knowledge about the implementation of family-based approaches.

The CBP represented the application of an implementation approach developed through the Beacon projects to a new service delivery environment created via the establishment of the new catchments. In contrast to the previous Beacon projects in which isolated services and/or programs were the focus of change efforts, all providers of mental health and AOD services operating within the one catchment became the unit of attention. The CBP was identified as a potential mechanism for strengthening service delivery coordination within catchments, requiring local mental health and AOD services in these regions to work together to address the specific issue of improving responsiveness to the families of clients accessing their services.

In CBP, The Bouverie Centre was contracted to work with clinical mental health, AOD and MHCS services within two newly defined catchments (including one rural catchment) over a two-year period to develop and implement a plan for better responding to the needs of families at the catchment level.

The project involved presenting each catchment with a range of relevant family-based practice models from which to choose from that could be implemented through a tailored support package.

The project had the following aims:

- increasing the effective use of family-based models of intervention within the two catchments
- building practitioners' skill and confidence to work with families and assisting services to create contexts that support family inclusive practices (FIPs)
- facilitating the development of a shared vision for the provision of family inclusive services within each catchment
- assisting AOD, MHCS and clinical mental health services within each catchment to better coordinate the supports offered to families including the creation of referral pathways
- fostering a network of family inclusive practice leaders within catchments
- capturing and sharing the knowledge gained and lessons learned to inform future workforce development initiatives

The following report describes the key activities undertaken over the two-and-a-half-year period and presents outcomes and key learning.

2.1 CBP: A catchment approach to workforce development

As described, the CBP was proposed as a new application of an existing approach developed by The Bouverie Centre to build adult mental health and alcohol and drug services' capacity to constructively include families in care – The Beacon Strategy. Detailed accounts of the strategy including the rationale, activities and outcomes are provided in Beacon project reports previously submitted to the department regarding the AOD (2008-2011) and the mental health (2010-2013) sectors. However, for the sake of convenience, a brief overview of the approach is provided forthwith.

The Bouverie Centre's Beacon strategy is an implementation framework designed to assist adult-oriented organisations to improve the quality and range of services offered to families in the context of client centred care. The Beacon strategy draws on The Bouverie Centre's considerable experience in delivering workforce development programs and is informed by a growing evidence base regarding what promotes the uptake of family interventions. Whilst iteratively adjusted and refined to suit a given service system, the core components of the strategy include:

- a strong emphasis on achieving meaningful and measurable changes in practice and monitoring progress towards this end goal
- facilitating change in different levels of a service system – that is, going beyond targeting the knowledge, routines or attitudes of individual

practitioners to focus on the characteristics of the client group, organisational processes, policies and regulations, leadership, and external variables such as the broader political and economic context
- the use of a suite of tools to promote change (for example, identifying and engaging management sponsors to help drive implementation; provision of ongoing practice support to facilitate skill acquisition; mentoring identified practice champions to guide local implementation; and regular audits to monitor the progress and impact of the project)
- working collaboratively with participating sites over a sustained period to promote local ownership and sustain change
- creating regular opportunities for project participants to discuss their experiences of implementing change, exchange insights, and support each other as they refine and generate new knowledge
- processes for capturing learning from each project to build knowledge in relation to implementing family-based approaches, sharing this learning with the sector and using it to inform subsequent Beacon projects

In addition to producing similar outcomes for families and services as those achieved in previous Beacon projects (i.e., a positive shift in the attitudes, beliefs and responses to families within participating sites; greater practitioner confidence and an increase in the provision of services for families of clients) it was anticipated that adaptation of the centre's existing strategy to a catchment-based setting would deliver further benefits. These benefits included improving the connections between services and people within each catchment, the establishment of referral protocols, increased cross agency awareness and information sharing, and where appropriate, joint service delivery. By fostering commitment to a common cause, bringing together management sponsors from different agencies to collectively address the issue of improving services to families in their catchment, and providing cross-sector training and follow-up consultation support to practitioners, the CBP was viewed as a potential vehicle for strengthening existing and emerging relationships between catchment services.

The next section of the report explores the extent to which the various components of the CBP program were delivered as specified in the original project plan. Overall, it describes the types and quantities of outputs delivered, the beneficiaries of these services, the practical problems encountered, and the ways such problems were resolved.

3. CBP in action: Activities and outputs Phase 1: Engagement and planning

3.1.1 The Bouverie Centre's project team

The core project team comprised:

- Dr Brendan O'Hanlon, project manager and facilitator of the South West Melbourne Catchment Steering Group
- Sarah Jones, project officer and facilitator of the Melbourne South West Catchment Practice Enquiry Group (Melb SW PEG)
- Naomi Rottem, project officer and facilitator of the Goulburn Valley Catchment Steering Group
- Hanna Jewell, project officer and the Goulburn Valley Catchment Practice Enquiry Group (GV PEG)
- Michelle Wills, project coordinator and evaluation officer
- Dr John Bamberg, research officer

All members of the team aside from the research officer and project coordinator delivered training. The team met at least once a month during the project term, firstly to develop an understanding of the key stakeholders and the service delivery context; and after this, to pool and analyse information gathered from participating services, to monitor and refine strategies for facilitating the implementation of the project and to problem solve as required.

3.1.2 Selection of pilot catchment areas

The original CBP plan specified that an expression of interest process would be conducted in June 2014 to select suitable candidates, with successful Catchment Beacon sites notified in July 2014. It was apparent at the commencement of the project that many AOD and MHCS services were still struggling to navigate the recent changes to the system, including consortium arrangements within the AOD sector. Given this degree of 'turbulence', and the fact that only two catchments could ultimately take part in the project it was decided that the two catchments would be directly selected.

DHHS, together with The Bouverie Centre, selected two catchments based on the following criteria:

- Service providers within the catchment had working relationships
- Services showed interest in implementing family inclusive practice
- Services displayed a willingness and capacity to commit resources to the project
- Services in the catchment had not recently participated in one of the DHHS funded projects conducted by The Bouverie Centre
- One of the catchments was classified as non-metropolitan

In April 2015, eight months later than originally scheduled, one regional and one metropolitan catchment were chosen as sites for Catchment Beacon:

- South West Melbourne Catchment

    - Odyssey House-UnitingCare ReGen consortium; Western Integrated Drug and Alcohol Network - approved providers for AOD functions
    - Neami; cohealth - approved providers for MHCSS function
    - Werribee Mercy Health (ADMH) - funded provider for clinical mental health
- Goulburn Valley Catchment
    - Australian Community Support Organisation (ACSO); Primary Care Connect consortium; Goulburn Valley Alcohol and Drug Service consortium - funded providers for AOD functions
    - ACSO; Mental Illness Fellowship Victoria - funded providers for MHCSS function
    - Goulburn Valley Health - approved provider for clinical mental health

3.1.3 Service engagement and the development of catchment plans

Following the selection of the catchments, senior management representatives from each of the lead agencies listed in Table 1 were identified and emailed information about the initiative (see Appendix 1). Several follow up phone calls and emails were made in the ensuing weeks to recruit project sponsors from amongst management at each service and to arrange a suitable date in which to assemble the representatives together for an initial meeting. Many of the members of both steering groups continued to provide project governance until the CBP officially concluded at the end of 2016.

Table 1: Services invited to participate in the CBP

Service	Catchment	Participated
ACSO	GV	Y
Goulburn Valley Alcohol and Other Drugs Service	GV	Y
Goulburn Valley Mental Health Service	GV	Y
Mental Illness Fellowship	GV	Y
Nexus Primary Health#	GV	Y
Primary Care Connect	GV	Y
Rumbalara Aboriginal Cooperative^	GV	N
cohealth (AOD)	Melb SW	Y
cohealth (MHCSS)	Melb SW	Y
Isis PC*	Melb SW	N
Neami	Melb SW	Y
Odyssey House - Re Gen	Melb SW	Y
Werribee Mercy	Melb SW	Y
Western Health*	Melb SW	N

Nexus Primary Health staff only participated in training

^ Several attempts to engage Rumbalara in the project were ultimately unsuccessful.

* The Bouverie Centre learned that Isis PC, and not their consortium partner and lead Western Health, was responsible for delivering AOD services within the Melbourne South West region (along with the Odyssey House-UnitingCare ReGen consortium). Despite numerous invitations to be involved in the project, Isis PC did not participate.

The aim of early steering group meetings was to increase participants' understanding of Catchment Beacon and their roles, and to map existing family involvement in services delivered in each catchment. This process included identifying existing data sets that might provide initial information about families, their needs and contact with services as well as potentially capture any changes resulting from CBP. Whilst some progress was made in the first two meetings towards identifying a) areas of unmet need for families and clients, and b) data collection processes and opportunities for improvement, richer details emerged during the consultation forums held in Shepparton and Werribee.

3.1.4 Opening forums

The design of the opening forums was informed by learning from previous Beacon projects that engagement of services needs to occur beyond the level of management. Managers of the participating services were involved in recruiting practitioners, service users and family members to attend a half day consultation forum. Table 2 shows that a total of 26 practitioners and 33 people with lived experience (i.e., consumers of the service and family members of service users) attended the two events.

In a process informed by concepts from Experience-based Design (Bate & Robert, 2007), participants were divided into small groups – one made up of practitioners, another consisting of individual service users, and a third comprising family members/carers (Appendix 2). Group members were invited to share their experiences of family inclusion in services at various points in the 'journey of care' and to make recommendations for how this experience could be improved. A representative from each group then reported these experiences and recommendations back to the larger group - see Appendices 3 & 4 for a summary of the key themes.

Following lunch, The Bouverie Centre facilitators presented information (which included video demonstrations) about four different family interventions – Single Session Family Consultation (SSFC), Multiple Family Groups (MFG), Let's Talk About Children (Let's Talk) and Behavioural Family Therapy (BFT) (see Appendix 5 for a description of each approach).

Shortly after this, participants were divided into service-based groupings comprising people with lived experience and practitioners. These groups were then asked to consider which of the family interventions presented would be most useful in their service, having heard about experiences of care. (See Appendices 3 & 4 for a summary of responses.)

Most of the groups reached a consensus about a preferred family intervention.

Table 2: Opening forums

Date	**Catchment**	**Venue and time**	**No. of attendees**	
			Staff	Persons with lived experience (i.e., clients or family members)
14/09/2015	Goulburn Valley	Parklake Hotel, Shepparton. 10am - 2pm.	13	12
7/10/2015	Melbourne South West	Werribee Racing Club, Werribee. 10am - 2pm.	13	21

The information generated during both events was compiled and disseminated to the respective steering groups ahead of their next meetings. In the two meetings that followed, steering group members, together with the facilitators from The Bouverie Centre, used the findings to decide which family intervention would be implemented by services in each catchment and who would be trained in the approach. Interestingly, despite active consideration of the other models, SSFC was chosen as the preferred intervention by all services across both catchments.

3.1.5 Appointment of practice champions

Each service was encouraged by The Bouverie Centre to appoint two practice champions - motivated and enthusiastic practitioners who would be expected to support their colleagues to acquire new skills and knowledge in family inclusive work

and encourage them to put their learning into practice. These practice champions were also required to attend Practice Enquiry Group (PEG) meetings. [PEGs are an adaptation of communities of practice (Wenger, 2010), drawing together staff members leading change 'on the ground' to reflect on and improve their own clinical work, as well as to share challenges and strategies for implementing new practices.] Champions received mentoring and support from an experienced family therapist during PEG meetings.

3.1.6 Agreed implementation plans

Due to the complexity involved in implementing practice change, facilitators also recommended each service convene its own internal working group to team up with practice champions for the purposes of mobilising interest in applying the SSFC approach, communicating expectations about the use of SSFC, and exploring and addressing barriers to putting the approach into practice. These internal working groups also attended to the selection of practitioners and programs for training, scheduling issues and arrangements for follow up support.

Mutually agreed upon implementation plans were scheduled to go into effect from December 2015 through to December 2016 – see summary in Table 3.

Table 3: Implementation activities and time allocations

Staff involved	Implementation activity	Time allocation
Practitioners	Training in practice model (Single Session Family Consultation - SSFC)	2 days
	Participation in supervision	To be negotiated with service. Possibly 1 hr per month
	Involvement in an evaluation process	.25 hrs per month (Feb 2016 - Nov 2016)
Project champions	Project briefing	3 hrs
	SSFC training	2 days
	Practice enquiry group (PEG) meetings	1.5 hrs per month (Feb 2016 - Nov 2016)
	Live supervision sessions with families at The Bouverie Centre or in own workplace	If deemed necessary and feasible, 3 hrs per session (max 5 sessions)
	Internal implementation group meetings	To be determined by individual services
	Assess and monitor results	.5 hrs per month (Feb 2016 - Nov 2016)
	Supervision for colleagues	To be negotiated with service. Possibly 1 hr per month
Management sponsors	Catchment steering group meetings	1.5 hrs per month in planning phase. As needs basis during implementation phase
	Internal implementation group meetings	To be determined by individual services
	Individualised technical assistance from Bouverie consultants	Consultation as needed

3.2 Phase 2: Implementation of project strategy

3.2.1 Engaging and supporting practice champions

All services participating in CBP nominated at least one practitioner to act as their service's champion. Champions were brought together in their catchment groupings prior to the delivery of SSFC training (see Table 4) to be briefed about the broad aims of the project, the family-based model of intervention chosen (SSFC), the implementation framework that would be used to support its adoption, and their role in the process. In addition to establishing rapport and reinforcing the importance of their participation in the project, these sessions were designed to

prompt practice champions to begin thinking about potential impediments to implementation and how to mitigate such obstacles.

Tables 5 through to 8 show that practice champions from each catchment continued to meet in the nine months following training. The Bouverie Centre facilitated five PEG meetings in Shepparton and South West Metropolitan Melbourne from March to June 2016. Dwindling attendance at both the PEG and steering group meetings prompted a merging of steering and PEG groups. A further seven Catchment Beacon project meetings were held in the two catchments.

Typically, PEG / CBP project meetings opened with a review of data collected using the mechanism described in Section 4 to help champions and sponsors monitor the uptake of the SSFC in their service. This led to discussions about what each site had been doing to promote the adoption of the newly introduced practice and any further action that may be required to advance implementation efforts. Feedback received from practitioners about the clinical work conducted also featured on the agenda, as did information and events Bouverie wanted to highlight.

Interestingly, while the option of a live consultation session was made available to the participating services in both catchments, this offering was not taken up. Logistical challenges related to scheduling sessions with multiple practitioners and family members may have been a contributing factor. The potential for practitioners, who often feel vulnerable about their skills in working with families, to feel exposed may have also been a disincentive.

Table 4: Champions briefings

Date	**Catchment**	**Venue and time**	**No. of attendees**
9/12/2015	Melbourne South West	The Bouverie Centre, Brunswick. 12:30pm - 3:30pm	8
14/12/2015	Goulburn Valley	Primary Care Connect, Shepparton. 11:00am - 2:00pm	10

Table 5: Melbourne South West catchment PEG meetings

Date	**Venue and Time**	**No. of meeting attendees**
23/03/2016	Saltwater Clinic, Footscray. 9:30am – 11:00am	6
21/04/2016	Anglicare, Werribee. 9:30am - 11:00am	6
25/05/2016	Mercy Public Hospital Inc, Community Care Units. 9:30am - 11:00am	6
30/06/2016	Neami, Yarraville. 9:30am - 11:00am	CANCELLED. Insufficient numbers
PEG AND STEERING GROUP MEETINGS WERE COMBINED FOLLOWING CANCELLATION OF JUNE MEETING		

Table 6: Goulburn Valley catchment PEG meetings

Date	Venue and time	No. of meeting attendees
7/03/2016	PCC, Shepparton. 11:00am - 12:30pm	8
9/05/2016	PCC, Shepparton. 11:00am - 12:30pm	5
6/06/2016	PCC, Shepparton. 11:00am - 12:30pm	CANCELLED. Insufficient numbers
PEG AND STEERING GROUP MEETINGS COMBINED		

Table 7: Melbourne South West catchment combined steering and practice enquiry group meetings

Date	Venue and time	No. of meeting attendees
17/08/2016	Neami, Yarraville. 2:00pm - 3:30pm	13
28/09/2016	Mercy Public Hospital Inc, Community Care Units. 9:30am - 11:00am	13
27/10/2016	Neami, Yarraville. 2:00pm - 3:30pm	10

Table 8: Goulburn Valley catchment combined steering and practice enquiry group meetings

Date	Venue and time	No. of meeting attendees
11/07/2016	PCC, Shepparton. 11:00am - 1:00pm	11
1/08/2016	PCC, Shepparton. 11:00am - 1:00pm	8
12/09/2016	PCC, Shepparton. 11:00am - 1:00pm	8
15/11/2016	Quest, Shepparton. 11:00am - 1:00pm	13

3.2.2 Upskilling practitioners in family inclusive practice

Whilst insufficient on its own, high quality training is necessary to achieve practice change. During this phase of the project, 155 mental health and AOD practitioners from 13 different services were trained in the SSFC model. A total of seven two-day workshops were delivered in the South West Metropolitan and Goulburn Valley regions - see Tables 9 & 10.

After a few months of trialling the SSFC approach, practitioners trained in the model during Feb – April 2015 were given the opportunity to learn further techniques and skills to enable them to effectively manage conflict or difference expressed by family members during sessions. Table 11 shows that a total of 27 practitioners

responded to the invitation to attend a one-day "Managing Conflict in a Family Meeting" booster session.

Table 9: Single Session Family Consultation (SSFC) training workshops

Date	Venue and time	No. of attendees
Feb 2 – 3, 2016	The Bouverie Centre, Brunswick. 9:30am - 4:30pm	20
Feb 17 – 18, 2016	Parklake Hotel, Shepparaton. 9:30am - 4:30pm	22
March 2 – 3, 2016	Learning Precinct Building, Werribee Mercy Hospital. 9:30am - 4:30pm	23
March 15 - 16, 2016	Seymour Racing Club, Seymour. 9:30am - 4:30pm	26
April 12 & 19, 2016	St Paul's African House, Shepparton. 9:30am - 4:30pm	24
Sept 13 – 14, 2016	The Bouverie Centre, Brunswick. 9:30am - 4:30pm	15
Feb 14 – 15, 2017	Quest, Shepparton. 9:30am - 4:30pm*	24
Total		**154**

Table 10: SSFC training participants by service

Service	Catchment	No. of attendees
ACSO	GV	9
cohealth (AOD)	Melb SW	2
cohealth (MHCSS)	Melb SW	21
Goulburn Valley Mental Health Service (includes CYMHS, Adult, Aged)	GV	30
Goulburn Valley AOD Service	GV	8
Mental Illness Fellowship (Wellways)	GV	35
Neami	Melb SW	11
Nexus Primary Health	GV	4
Odyssey consortia	Melb SW	8
Primary Care Connect	GV	8
Werribee Mercy AMHS	Melb SW	16
Other	GV	2
Total		**154**

Table 11: Managing difference and conflict in a family meeting (Booster training workshops)

Date	Catchment	Venue and time	No. of attendees
06/07/2016	Melbourne South West	The Bouverie Centre, Brunswick. 9:30am - 4:30pm	10
25/07/2016	Goulburn Valley	St Paul's African House, Shepparton. 9:30am - 4:30pm	17

3.2.3 Engaging management

As mentioned in Section 3.1.3, in Phase 1 of the project each service nominated a manager with the capacity to authorise and facilitate organisational change to act as a Catchment Beacon sponsor. Tables 12 and 13 show that The Bouverie Centre met with local management sponsors on eight occasions (June to Nov 2015) to conduct a stock take of existing family inclusive service provision as previously described and to create a detailed plan for how the needs of families in the catchment could be improved through participation in the project.

Management sponsors continued to meet during the implementation phase, with The Bouverie Centre facilitating a further six steering group meetings, and seven combined PEG and steering group meetings (see Tables 7 & 8), in which sponsors were engaged in the process of monitoring implementation progress and identifying further supports that might improve implementation success.

Table 12: Melbourne South West catchment steering group meetings

Date	Venue and Time	No. of meeting attendees
09/06/2015	Civic Centre, Werribee. 10am – 11:30am.	7
08/07/2015	Neami, Yarraville. 10am – 11:30am.	6
28/10/2015	Neami, Yarraville. 2pm – 3:30pm.	9
16/12/2015	Neami, Yarraville. 2pm – 3:30pm.	6
09/03/2016	Neami, Yarraville. 2pm – 3:30pm.	6
26/04/2016	Neami, Yarraville. 1:30pm – 2:30pm.	4
8/06/2016	Neami, Yarraville. 2pm – 3:00pm.	3
FOLLOWING THIS DATE PEG AND STEERING GROUP MEETINGS COMBINED – SEE ENTRIES IN TABLE 7		

Table13: Goulburn Valley catchment steering group meetings

Date	Venue and time	No. of meeting attendees
11/05/2015	Primary Care Connect (PCC), Shepparton. 11am -12:30pm	11
15/06/2015	PCC, Shepparton. 11am -12:30pm	9
20/07/2015	PCC, Shepparton. 11am -12:30pm	5
12/10/2015	PCC, Shepparton. 11am -12:30pm	8
23/11/2015	PCC, Shepparton. 11am -12:30pm	7
15/02/2016	PCC, Shepparton. 11am -12:30pm	9
2/05/2016	PCC, Shepparton. 11am -12:30pm	8
FOLLOWING THIS DATE PEG AND STEERING GROUP MEETINGS COMBINED – SEE ENTRIES IN TABLE 8		

3.2.4 Tertiary consultations

Despite being clear that the use of SSFC by practitioners would be heavily influenced by the attention given to reducing implementation barriers and to creating the conditions necessary for the practice to thrive, management sponsors and champions did not readily take up our multiple offers of service development / tertiary consultations. Table 14 summarises the nine offsite consultations that were delivered during Catchment Beacon. Most of these sessions were booked in by The Bouverie Centre's consultants when a specific issue was identified by a service participant as proving a barrier to implementation or in response to a specific need.

Table 14: Tertiary consultations with individual services

Date	Service	Time	No. attended meeting
14/08/2015	Mercy Mental Health Service	10:30am –11:30am	3
17/08/2015	Neami Yarraville	2:00pm – 3:00pm	3
10/09/2015	Odyssey House	3:00pm – 4:00pm	2
18/11/2015	Goulburn Valley AMHS	12:00pm – 1:30pm	4
15/02/2016	Rumbalara Aboriginal Cooperative	1:30pm – 2:30pm	2
15/06/2016	Neami National	10:30am – 11:15am	>5
1/08/2016	ACSO	1:30pm – 2:30pm	>9
2/08/2016	cohealth (MHCSS)	10:30am – 11:30am	18
12/09/2016	Goulburn Valley Alcohol and Other Drugs Service	1:00pm – 1:30pm	4

3.2.5 Communicating with project participants

In addition to face to face meetings and phone calls, throughout this phase of the project and the preceding one, the project team maintained regular email contact with management sponsors and practice champions sending meeting reminders, minutes, resources, news of potential opportunities for participants and requests for data.

Plans for a newsletter and online forum were placed on hold until after the delivery of the first round of basic training. The primary purpose of such mechanisms was to maintain connection with the workforce post training and support them to put their newly acquired skills and knowledge into use as soon as possible. The first post-training update was sent to SSFC-trained practitioners in late March 2016, in which respondents were asked to indicate the types of content they would find helpful in future communications and in what form. Less than 10 people responded directly to this request. However, subsequent follow up with champions confirmed a preference for brief e-news updates via email featuring advice and tips, resources such as templates and video clips, and a Q & A section. There was no enthusiasm for an online forum, with practitioners describing the existing face to face structures as sufficient.

Two electronic news updates were published in July and September 2016, reaching an audience of approximately 121 readers. Each issue can be viewed by clicking on the following links or copying and pasting each URL into an Internet browser's address bar:

http://bouverie.i-events.info/link/id/zzzz57760e70b0c34790P/page.html

http://bouverie.i-events.info/link/id/zzzz57d0a75bcf41c433P/page.html

3.2.6 Closing forums

Two forums held in December 2016 to mark the formal conclusion of the project were devoted to providing feedback in relation to implementation, showcasing catchment services' achievements and sharing learning gained through the experience. Forty-four staff and people with lived experience joined project team members from The Bouverie Centre at the ½ day events. The forums included a presentation from special guest Dr Peter McKenzie on the use of SSFC when working with clients with complex needs. See Appendix 6 for an example of the forum program.

Table15: Closing forums

Date	Catchment	Venue and time	No. of attendees	
			Staff	Persons with lived experience (i.e., clients or family members)
1/12/2016	Melbourne South West	Encore Events Centre, Hoppers Crossing.10am – 2pm	25	4
14/12/2016	Goulburn Valley	Quest, Shepparton. 10am – 2pm	14	1

4. Evaluation of Catchment Beacon

The previous section of this report summarised how The Bouverie Centre went about the process of working with AOD and mental health services (clinical and MHCS) within two catchments to improve the responses to the needs of families within the two regions. This next segment presents feedback provided by project participants about the quality of the services The Bouverie Centre delivered and components of the CBP strategy as well as considers the short-term impact of the initiative on participants. It begins with an introduction to the methods used to evaluate different aspects of CBP and follows with a summary of the findings pertaining to each data source, including a description of how the data was analysed.

4.1 Evaluation methodology

Six quantitative and qualitative measures were used to capture managers and practitioners experience of Catchment Beacon – see Table 17. A summary of the key domains evaluated, the types of data collected to inform our assessment (indicators) and the data source is summarised in Table 16.

The original evaluation plan proposed prior to commencement of Catchment Beacon was scaled back, partly because of delays in site selection and because it became apparent that many services were feeling overwhelmed by the volume and scale of sector changes taking place. For instance, we had intended to measure service users and families' experience of the SSFC intervention. We later decided against this given the time required to obtain ethics approval from the multiple human research ethics committees. This narrow timeframe for measurement would have resulted in a very small sample size. Instead, we confined our focus to the volume of family involvement in care post training and to the impact on practitioner knowledge and confidence.

4.2 Domains and evaluation methods

Table 16: Target areas of evaluation and evaluation methods

Key domain	Indicator	Data collection tools/data source
Impact of Catchment Beacon on practitioner behaviour	Uptake post training, i.e.: 1. Number of clients engaged in a discussion about SSFC by those trained in the model 2. Number of clients whose families were invited to participate in SSFC by those trained in the model 3. Number of consultation sessions conducted with clients and their families by those trained in the model 4. Number of single session consultations conducted with a solitary family member	Entries in SSFC Log completed by champions in consultation with practitioners
	Comparison of the number of family meetings conducted at baseline and at the end of the project	Self-report questionnaire completed pre and post by training participants
	Practitioners' responses to families and efforts to include families in service delivery	Key informant interviews at end of project
	Level of information sharing, joint planning & co-delivery of services with practitioners employed in other catchment services	Key informant interviews/focus groups at end of project
Impact of Catchment Beacon on practitioner knowledge and confidence	Confidence in relation to family inclusive practice at baseline and at the end of the project	Self-report questionnaire completed pre and post by training participants
	Level of cross-agency awareness and nature of attitudes towards practitioners in other services	Key informant interviews/focus groups at end of project
Impact of Catchment Beacon on organisational and system environments	Internal policies, procedures or structures instituted to support the uptake of SSFC or family inclusive practice more broadly	Key informant interviews at end of project
	Functional structures, protocols or policies instituted to improve the connections with other services	Key informant interviews at end of project
Influences on services' responsiveness to Catchment Beacon	Factors that facilitated the adoption of SSFC and/or created barriers to practice change	Key informant interviews/focus groups at end of project
Interagency collaboration	Informal linkages between services in catchment (joint preparation of resources; referral protocols; establishment of forums to build relationships and facilitate info sharing between services) and formalised coordination linkages (joint planning; formalised protocols/agreements for collaboration; setting of joint goals and	Key informant interviews/focus groups at end of project

	mutual responsibility for their achievement)	
Quality of facilitation	Quality, usefulness, and relevance of technical assistance provided by Bouverie to build workforce capacity	Key informant interviews/focus groups at end of project Training evaluations

4.3 Evaluation measures

Table 17: Evaluation measures

Data collection tool	Date of administration	Participants
Family inclusive practice self-assessment survey	Pre-Survey: Beginning of basic training Post Survey: November 2016	Practitioners who attended the Feb, March, April 2016 SSFC workshops
Training evaluation	End of basic training	Practitioners who attended the Feb, March, April 2016 SSFC workshops
SSFC log	March – September, 2016	Practice champions in consultation with practitioners trained in the model
Focus groups	Melb SW: October 27, 2016 GV: November 15, 2016	Management sponsors
Focus groups	Melb SW: October 27, 2016 GV: November 15, 2016	Practice champions
Individual telephone interviews	October 22 – 24, 2016	Management sponsors

5. Findings

5.1 SSFC training evaluations

One hundred and seven participants at the February, March and April 2016 SSFC workshops completed a one-page evaluation at the end of the training (See Appendix 7). This one-page form designed to gauge response to training, asked participants to rate the calibre of the workshop on a 1 to 5 scale, where 1 equals "Unsatisfactory" and 5 equals "Excellent", as well as requested qualitative feedback about the training experience, including, but not limited to, what participants found most valuable for their learning and their suggestions for improvement.

Analysis of both quantitative and qualitative data gathered from the surveys suggests basic training was well received.

5.1.1 Quantitative feedback

Inspection of Table 18 reveals that participants' ratings of the workshop were on average high to excellent (M=4.22, N=107). A one way between-groups ANOVA revealed a significant effect for training workshop ($F(4, 102)= 8.53$, $p<.001$). Post hoc analyses using the Bonferroni criterion for significance indicated that, on average, the March 15 -16 cohort held a more favourable view of the training (M=4.69, SD=0.47) than did the March 2 – 3 (M=3.82; SD=0.72) and the April 12 & 19 (M=3.84, SD=0.50) groups.

Table 18: Frequencies of responses, means and standard deviations by workshop

SSFC Workshop	1	2	3	4	5	M	SD	n
Feb 3 – 4			3	7	8	4.28	0.75	18
Feb 17 -18			1	11	9	4.38	0.59	21
Mar 2 -3			8	11	4	3.82	0.72	23
Mar 15 -16				8	18	4.69	0.47	26
Apr 12 & 19			4	14	1	3.84	0.50	19
Total			**16**	**51**	**40**	**4.22**	**0.69**	**107**

5.1.2 Qualitative feedback

As part of evaluation, practitioners were asked to list the three most valuable things they learned during the workshop. A thematic analysis conducted on the 254 responses written indicated there was some variability in how the question was interpreted by participants, with some choosing to comment more generally about the most beneficial aspects of the training, rather than what they learned. The top 10 most frequently cited categories are presented in Table 19. The results strongly suggest participants found the meeting structure particularly helpful for their work with families, as well as techniques for keeping the session focused.

Table 19: Most valuable things learned – frequencies

Element	n
A structure / framework SSFC brings to sessions	52
Activities initiated by The Bouverie Centre to promote learning (e.g., role plays, group discussions)	23
SSW skills for keeping the session on track (e.g., checking in; respectful interrupting; time checks)	20
A process for negotiating a shared and workable agenda for a family meeting	16
How best to set up / convene family meetings	14
The value of a family inclusive/sensitive orientation	12
The overall model and its features	12
Skills for guiding an effective group process (e.g., eliciting and acknowledging contributions from all members)	11
How to introduce clients and families to the idea of SSFC	10
Practical skills and techniques (types not specified)	9

Participants were also asked to specify how they would revise or redesign the training if they were given the chance. A number of respondents left this section of the evaluation form blank or wrote 'nil' or 'N/A' followed by a positive comment *('Nothing. Good balance of video, formal instruction and role play').* Others made suggestions for improvement, which are grouped below in categories – see Table 20.

The ideas proposed largely centred on changing the structure of the course or the setting. With respect to how the material was organised, there were calls for condensing the training (n=13) into a maximum of 1.5 days and for spreading the two sessions across two different weeks. Comments about the methods used to facilitate learning were mixed with some requesting fewer role plays and more discussion, and others calling for more of these experiential exercises.

Table 20: Suggestions for improvements – frequencies

Suggestions	n
Changes to the structure, length and pacing of the multi-day workshop (e.g., changes to time allocated to each activity; ordering of activities; or days on which training was held)	22
Changes to the types and volume of different learning activities	21
Alternate venue / caterer	10
Requests for additional content and coaching	4
Miscellaneous	3

5.2 Pre and post family inclusive practice self-assessment survey

An 11-item paper-based self-report questionnaire was first administered to participants during the first day of the February, March and April 2016 SSFC

workshops (Time 1) and again to the same participants in November 2016 (Time 2) via Survey Monkey (See Appendix 8). The survey, a purpose-built instrument, sought to investigate the impact of participation in CBP on practitioners' confidence and practice in relation to family inclusive care.

Fifty-one practitioners completed *both* the pre and post questionnaires across the five training groups, a response rate of 44.34%. Table 21 presents a description of the sample. Of the 64 practitioners that did not go on to complete the follow up survey, 19 had vacated their positions by the time of the second questionnaire administration and at least 3 were on leave.

Pre and post evaluation data were analysed using SPSS for Windows. Paired-samples t-tests were conducted on the responses given at Time 1 and Time 2 to explore change in average ratings over time. A series of mixed design ANOVAs was then used to examine whether differences in average scores were influenced by the variables gender, service type (AOD, MHCSS, Clinical MH), catchment region, amount of previous family-oriented training, and years of experience as a helping professional. Appendix 9 presents full summaries from each analysis in tabular form. For ease of access, the overall pre and post mean ratings are re-presented in Table 22. Instances where the changes in scores where not equivalent across groups are reported in text.

Overall, Table 22 shows that the practitioners surveyed made gains in a number of areas over the 6 – 9-month period. Prior to undertaking the training, respondents on average rated confidence in their ability to respond to others in a family sensitive manner as 2.84 out of 5. By the conclusion of CBP, the overall mean rating of family sensitive practice confidence had risen to 3.98. This increase was statistically significant ($t(50)= -8.65$, $p<.001$). Further analyses revealed a statistically significant interaction between self-reported confidence in working in a family sensitive manner and catchment [Wilks' Lambda=.88, $F(1,49)=6.87$, $p = .01$] and between family sensitive practice self-efficacy and amount of previous family sensitive/inclusive training [Pillai's Trace=.30, $F(1,49)=21.32$, $p < .001$]. That is, there was a significant difference in the average baseline scores of respondents who had received 'none' to 'a little' previous training in family inclusive or sensitive practice ($M= 2.45$) versus respondents who had undertaken more education in this area ($M=3.56$). Both groups' average confidence ratings had increased and equalled out by the conclusion of the project (Less training, $M=3.97$; More training, $M=4.00$). With respect to differences across the two catchments, the mean increase in family sensitive practice confidence was significantly higher in the Goulburn Valley catchment (Pre $M= 2.81$; Post $M= 4.26$) than in the Melbourne South West region (Pre $M=2.88$; Post $M = 3.67$).

There was also a statistically significant difference, on average, across the two time points in practitioners' self-reported confidence to run an effective family meeting – an increase of 1.12 ($t(50)= -7.73$, $p<.001$). Once again, there were significant interactions between the within subjects factor (time) and the variables 'catchment' [Wilks' Lambda=.79, $F(1,49)=12.75$, $p = .001$], 'previous family sensitive/inclusive training' [Wilks' Lambda=.89, $F(1,49)=5.82$, $p <.05$], and 'years of experience' [Wilks' Lambda=.86, $F(1,48)=7.74$, $p < .01$]. Respondents in the GV region experienced a

greater boost in their family meeting efficacy (Pre M=2.44; Post M=4.00) in comparison to their Melb SW colleagues (Pre M=2.58; Post M=3.21). Furthermore, the 'none' to 'a little' previous training group's average confidence ratings at Time 1 (M= 2.18) differed significantly from the 'some' to 'a lot' group (M= 3.11) but this disparity in scores was no longer significant by Time 2 (Less training, M=3.55; More training, M= 3.78). Likewise, respondents with less than 5 years of experience as a helping professional in their sector had significantly lower family meeting confidence scores at baseline (M=2.20) than respondents with a 5 year plus history in the sector (M=2.76). However, the gap between the two groups had closed by the conclusion of the project (Less experience, M=3.72; More experience, M=3.52).

With respect to the impact of Catchment Beacon on practitioners' work practice, respondents were asked to indicate what proportion of their caseload involved having contact with a client's family – 'none of my clients', 'some', 'almost half', 'most' and 'all of my clients'. Analyses performed on the responses from practitioners with a direct service role did not reveal a statistically significant difference in the mean ratings given at Time 1(M=2.81) versus those reported in Time 2 (M=2.58) ($t(42)=1.40$, $p = .17$). Thus, the number of client families direct service providers had contact with did not appear to vary over time.

We did observe a statistically significant difference in the ratio of formal family meetings convened per day worked in a fortnight across the two time periods, albeit modest ($t(35)=-2.23$, $p < .05$). (NB: Analysis was confined to the responses given by practitioners with a caseload who had worked at least one day in both time periods – $n = 36$). In the fortnight prior to participating in CBP, respondents conducted an average of 0.04 structured sessions with clients and families per day worked. This figure rose to 0.11 sessions per day worked in the fortnight prior to completing the post survey.

Table 21: Description of pre-post survey respondents (N=51)

		N	Percent.
Gender			
	Female	39	76.5
	Male	12	23.5
Type of service			
	AOD	12	23.5
	Clinical MH	10	19.6
	MHCSS	26	51.0
	Other	3	5.9
Main client group (Multiple Responses)			
	Individual adults	40	
	Aged persons	3	
	Youth and children	9	
	Couples	2	
	Families	6	
	Aboriginal or Torres Strait Islander peoples	2	
	Culturally and Linguistically Diverse peoples	5	
	Other	3	
Service setting (Multiple Responses)			
	Community based, non-residential	42	
	Hospital inpatient service	3	
	Residential program	4	
Location of service			
	GV	27	52.9
	Melb SW	24	47.1
Previous family inclusive/sensitive training			
	'None' to 'A little'	33	64.7
	'Some' to 'A lot'	18	35.3
Involved in direct service provision			
	Yes	43	84.3
	No	8	15.7
Years of experience as helping professional			
	0 to 5 years	25	50.0
	6 years and over	25	50.0

Table 22: Mean ratings of family inclusive practice efficacy and family contact

	Prior to participation in CBP (M)	After participation in CBP (M)	Difference in average scores	n
Confidence in family sensitive practice	2.84	3.98	1.14	51
Family meeting self-efficacy	2.51	3.63	1.12	51
Proportion of caseload that involves family contact	2.81	2.58	-0.23	43
No. of family meetings held per day worked	0.04	0.11	0.07	36

5.3 SSFC log

Practitioners trained in the SSFC model with a clinical caseload were informed verbally on the first day of training that they would be expected to make a record of their SSFC activities and report these statistics to their service's practice champion each month. Specifically, they were asked to record the number of:

1. clients they had engaged in a discussion about SSFC
2. clients whose families/supportive others they had invited to participate in SSFC
3. consultation sessions they had conducted with clients and their families
4. single session consultations they had conducted with one family member

This request was reinforced in a paper-based *Practitioner SSFC Log* distributed to participants – see Appendix 10.

Practice champions were asked to collect this data from all SSFC-trained practitioners at their service, collate it, and submit monthly summaries at each PEG meeting.

Despite our collective best efforts, the data submitted was of variable quality – both across services and from month to month. For example, some champions were only able to collect information from a subset of SSFC-trained practitioners in their service; some submitted figures which included SSFC activities performed by staff yet to receive training in the model; and some missed months. A high workload caused by staff shortages/turnover and the transition to a new building were some the reasons cited for the inability to turn in monthly summary data.

While there are gaps in the data set and it is impossible to calculate the average number of SSFC related activities performed by each practitioner trained in the model, the information provided offers an indication of the uptake of different components of the SSFC model.

We were able to surmise from the data that across both catchments at least 273 family meetings were delivered using the SSFC framework, and a further 102 sessions minimum were conducted for single family members using the same structure. Equally important, an estimated 494 invitations were issued to clients to take part in

an SSFC session, and 286 to families. Table 23 further hints at variation between the services, with ACSO, cohealth (MHCSS), GVADS, and GV Health MH Services appearing to extend more SSFC offers to clients per practitioner than their counterparts. Inspection of Table 23 would also seem to indicate GV Health MH Service, GVADS and Werribee Mercy MH Services ran more SSFCs per trained practitioner in comparison to the other services; and ACSO and GVADS ran more sessions with single family members. Overall the ratio of client and family SSFC sessions to client invitations was 55%, with the two clinical mental health services reporting that virtually all their invitations to client had resulted in a SSFC session. However, these figures are only indicative given the variable reporting rates.

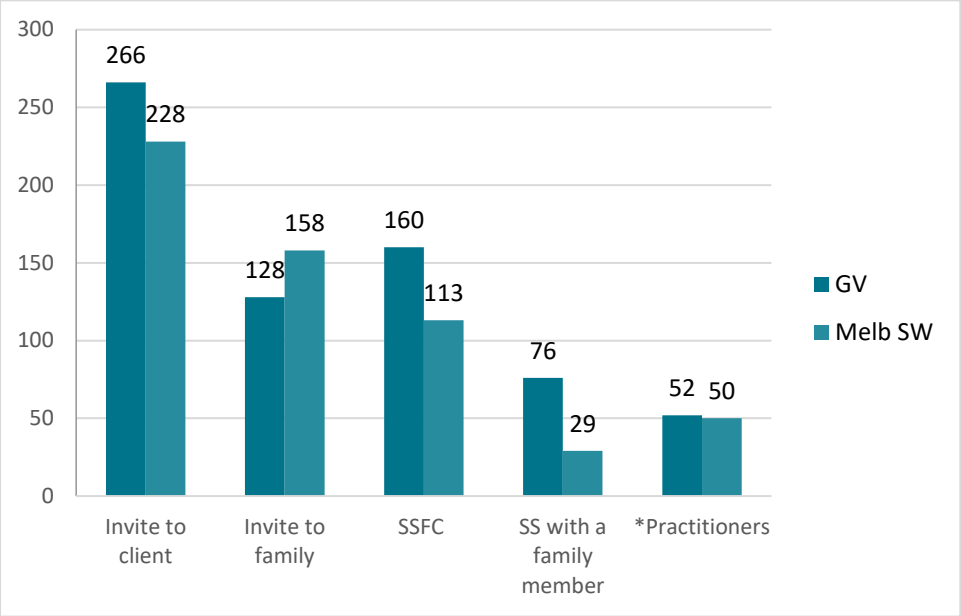
Graph 1 shows that practitioners in the Melbourne South West catchment reported facilitating a total of 113 SSFC sessions, in comparison to the 160 recorded as being convened by practitioners in the Goulburn Valley catchment.

Table 23: March – Sept 2016 SSFC activities recorded by service (frequencies)

Service	**n Invite to client**	**n Invite to family**	**n SSFC with client and family**	**n SSFC with a single family member**	**n Practitioners ***
ACSO	34	0	0	5	1
GVADS	53	17	35	51	8
GV Health MH Services	75	84	72	0	13
Mental Illness Fellowship	64	26	43	14	22
PCC	40	1	10	3	8
cohealth (AOD)	2	6	1	0	3
cohealth (MHCSS)	111	70	34	26	16
Neami	28	14	5	0	10
Odyssey consortia	20	0	13	0	7
Werribee Mercy MH Services	67	68	60	3	14
Total	**494**	**286**	**273**	**102**	**102**

* Number of practitioners with a client load trained in model still employed by the service at the end of project

Graph 1 March – Sept 2016 SSFC activities recorded by region (frequencies)



* Number of practitioners with a client load trained in model still employed by the service at the end of project

5.4 Management and the CBP process - focus group data

Three management sponsors from the Melbourne South West catchment and five sponsors from the Goulburn Valley catchment participated in end of project focus groups convened directly before their respective final project meetings. Over the course of 30 minutes, group members in both sessions were asked a series of questions (see Appendix 12) designed primarily to explore their views on the merits of CBP as a strategy for promoting collaboration and service coordination. Both focus groups were audio recorded, transcribed and analysed thematically to interpret the key themes as they pertained to the following categories:

- A catchment-based approach to workforce development
- The steering group process
- Value of an external change agent's input

The themes that emerged from the data are common to both the metropolitan and non-metropolitan catchments unless otherwise specified.

A catchment-based approach to workforce development

Potential for promoting consistency across services

Participants indicated that one of the strengths of a catchment-based approach is its potential for creating consistency in service delivery and a joint understanding of family work across services.

> *"I think it's good to have consistency between services who are delivering similar services."*

"It creates that sort of shared understanding of – of approaches and that sort of thing."

Fosters shared expectations

Another advantage of bringing services together as part of a joint workforce development initiative identified by participants is that it enables providers to be on the same wavelength.

> *"Well, everyone's on the same page, so yeah, if we've got an agreement, or there's an understanding that we're going to suggest it or recommend, then the people that we're working collaboratively with are aware of that, so it doesn't come as a shock … So, everyone's on the same page and aware of what the expectations are."*

Facilitates information transfer

Participants further suggested that collaborative approaches like CBP serve to build relationships between service providers which leads to improvements in information and knowledge transfer across agencies.

> *"From that level, if you've got a face to a name, or you've got a question about another service, or the entry into that service or what that looks like, it's a lot easier to pick the phone up and ring that person and say, "What is the process for this?" or, "Do you have this particular program?"*

Impact depends on context

One participant's response indicated that the benefits of a catchment-wide approach for promoting collaboration may be more limited for areas in which services are already connected.

> *"The amount of collaboration we would have between our services for example remain fairly constant, irrespective of that. Yeah, and in terms of – like I didn't sense that there was an increase in collaboration with clinical services that came out of this process either."*

Shared service delivery requires a deliberate investment of time and resources

There was some indication that joint clinical work and networking outside of functional structures set up by purveyors (e.g., project groups) needs strong leadership.

> *"… perhaps as agencies perhaps we could've been more proactive in linking in with each other. I don't know … but there wasn't a lot of that kind of networking and doing some shared practice even with the clinical service, even though we talked about it and maybe that's something for the future that we can actually begin to do that now."*

> *"…it was good to come together … it was a nice way to reorient and hear a bit about what the challenges were from the other services … but what we didn't do is that next step of actually collaborating I guess directly outside those services"*

The steering group process

Mechanism for problem solving

Participants reported that participating in the steering group helped generate ideas for solving problems and addressing challenges encountered when implementing practice change.

> *"I think that was fantastic really. Because there's common challenges and then there's different ones that you can learn from as well and I think it's useful to kind of normalise the challenges that people are experiencing… how can I do this better and what's worked for other people in different settings and – and maybe even, I think different organisational approaches to the implementation as well."*

Tool for maintaining momentum

Participants were clear that regular steering group meetings also functioned to keep change efforts on a busy service's agenda.

> *"My sort of recollection of the year was that we would have quite a lot of momentum around the single sessions when we would have one of these meetings or the champions would get together, it sort of renewed the focus and elevated it above the other competing priorities of which there are many, so and we would sort of then refocus and elevate that in people's minds and three or four weeks later other things have come up and so it was useful to have people going off and kind of rearranging themselves to the – to the process I guess. It stimulated that momentum through the year."*

External change agent's input

Sustained support kept the project on track

Participants described their ongoing relationship with Bouverie during the initiative overall as very valuable. They explained that the project team's prompt and friendly support helped fuel motivation to make the program a success.

> *"I thought we had a close relationship with the Bouverie folks who came up and who we had access to over the phone in between times, and we get to see the face every so often. I always got the feeling that Bouverie was intent and involved and really wanted it to work, and I thought it was a good thing for us. And it kept us going even when we're having our low times and trying to work out how we're going to do this. So, no, I thought Bouverie was good."*

5.5 Practice champions focus group data

Four practice champions from the Melbourne South West catchment and three champions from the Goulburn Valley catchment participated in end of project focus groups convened directly after their respective final project meetings. Over the course of 30 minutes, group members in both sessions responded to a series of questions largely focused on their experiences as practice champions. (The full list of questions is presented in Appendix 13). Both focus groups were audio recorded, transcribed and analysed thematically to interpret the key themes as they pertained to the following categories:

- Practice enquiry group meetings
- The experience of being a practice champion
- Sustainability of changes post Bouverie's involvement
- External change agent's input

The themes that emerged from the data are common to both the metropolitan and non-metropolitan catchments unless otherwise specified.

Practice enquiry group (PEG) meetings

Tool for maintaining momentum

Like their management sponsor counterparts, embedding SSFC in their service was just one of many work responsibilities occupying practice champions' time; thus, regular PEG meetings helped to keep the initiative on the radar as well as serving an accountability function.

> *"I think it's a positive thing because it keeps you – especially starting the problem – it keeps the momentum going and it keeps you, "Oh, who hasn't done their training yet?" It jolts your memory, though to get into your busy day today at work, and those things, you don't have time to think about those things. So, I think that's been a really positive thing we need."*

> *"I definitely think having this group and having it facilitated formally has made all the difference, because I really don't think it would have happened otherwise."*

> *"It pushed us to all come together, encouraged us, it gave us deadlines and goals and accountability, exactly."*

Mechanism for exchanging ideas and obtaining support

Participants stated that coming together as practice champions also provided an opportunity to learn from their peers and to enlist assistance to solve the challenges they experienced in implementing the project.

> *"I guess getting to hear about the ways that other practice champions were approaching things – this person had some really good ideas about the ways that they were keeping it on their agenda in their team meetings and how they were sort of rolling it out at their organisation and team and I did find that really useful because, we're all creative in different was so it was things that we hadn't thought of …"*

> *"I found it really helpful in a couple of ways; one was around strengthening ties between staff members from other services but also just having the opportunity to kind of, troubleshoot some of the challenges that I was encountering in terms of feeling – how to enlist a bit more support from the team, being able to discuss that with…….Sarah and getting her support around that and her advice relating to Practice Champ roles that she has had and how she kind of worked within those roles was really helpful for me."*

Rural challenges

Despite describing group meetings as worthwhile, practice champions working in a rural setting spoke about the 'tyranny of distance' and the inconvenience of having to set aside large chunks of time to attend meetings.

> *"My only one would be time, just because it's an hour to get here, an hour to get back. But, that's fine; that was part of working in Seymour."*

> *"It is a big time commitment. It's basically half a day out of our week, but I think the advantages outweigh that time commitment, in the long run."*

The experience of being a practice champion

Participants indicated that whilst it had its rewards, the role of practice champion brought with it challenges.

Challenge 1: Data collection

Participants commented that compiling data about their service's application of the model was an onerous task as many SSFC-trained staff did not record their activities. This potentially led to an underreporting of the extent of the work done.

> *"Adding it to things that we're already doing instead of creating more ways of recording. But, still having the data being accurately recorded has been a problem, because staff are doing it, they're just not remembering, or identifying that they've actually done it."*

Challenge 2: Variable uptake and enthusiasm for the new practice

Participants spoke about the frustration they experienced when continued efforts to encourage colleagues to put the new approach into practice did not yield results, and sometimes even elicited irritation.

> *"I was enjoying the role of Practice Champ, I think I started to feel a little bit like the broken record, putting it out there in team meetings week after week but not really feeling hugely supported by the team in terms of offering it to consumers and families so it was probably a little bit of frustration there for me at times that there was this great intervention that we could offer to people but it wasn't being utilised as much as it could be."*

Challenge 3: Recruitment of families

Recruitment of clients and families to the program presented difficulties for some workers.

> *"I don't have the client numbers at the moment and the service is a bit segregated and people don't really work together and as a bit of an idea with the AOD team that their clients are estranged from their family so they're not really thinking in the family sort off frame of mind so I guess that's what has been most difficult for me."*

Opportunity 1: Satisfaction of helping to shift practice

One participant described helping to facilitate the change process as professionally rewarding and satisfying.

> *"I ended up being the only person, but I've actually really enjoyed it. It's helped me do*

something different, and something to focus on, and I guess, change our service, the way we think, I guess."

Opportunity 2: Enhancement of current practice

Another participant identified SSFC as an intervention which enhanced the existing family inclusive work being done at their service.

> *"Because it was something that was aligning with our – what we're already doing, it created that structure for everyone to feel like they can see the reason for doing it."*

Sustainability of changes post Bouverie's involvement

There were mixed thoughts across both catchments as to whether the change program would continue post Bouverie's involvement. A few factors were identified as possible influences on the sustainability of changes.

Facilitative administration

Some participants were of the view that internal policies and procedures that had been instituted by their service would facilitate the continued use of SSFC beyond the official end of the project.

> *"I think because it's kept momentum going for so long now, it's embedded, just because it's on agenda items and meetings. It's on reports, so it's a constant reminder that it's there."*

Level of congruence with values and work practice

Another participant's response indicates that the perceived fit between the practice model (SSFC) and a host service's values and practices may influence whether it is embedded in the long term.

> *"I think that the family meetings will definitely continue, because that means a reasonable focus and we certainly always encourage family meetings."*

Staff turnover

There was some concern about the continuity of the program should key staff members resign and leave a service.

> *"We're not sure really at this stage, it has been a bit of an ongoing conversation within our internal steering group, obviously it's – there's quite a number of us in the team that have been trained now to resource and it's another tool that we can use and another intervention that we can offer to consumers and I think we will be wanting to continue with that but I wonder more long-term with turn-over of staff and things like that, I think the short answer is we don't know."*

> *"Another big issue has been staff turnover for us. I think you'll see the stats this month and every second box says resigned. So, I think across the board, trying to keep people will be a problem. And then we had two champions to begin with and well, she's gone."*

External change agent's input

Availability and quality of support

Participants spoke warmly about the support they received from The Bouverie Centre, in particular about the team's responsiveness and availability.

> *"Certainly from Sarah in terms of the practice enquiry groups but even just having another staff member there if I needed to email and ask for a resource to present something to the team, it was – that support was there, almost immediately and with a lot of warmth and generosity I found that the support and that – Bouverie a real advantage."*

> *"I think you guys have answered every question you've been ever, ever emailed. Even yesterday I phoned someone and asked them, "What are these nice people working there?" How do you get a job there?"*

> *"An email has never been not replied to, and you know how it feels when you're trying to get an answer from someone and they just forget about you – or it feels like they're forgetting about it. You never feel forgotten with Bouverie."*

5.6 Management and service level impact - individual interviews

This section of the report presents the findings from nine structured telephone interviews conducted individually with management sponsors from AOD and MH services over a three-day period. In comparison to the focus group which tapped into services' experiences of working in collaboration with one another, the individual interviews were designed to elicit managers' thoughts about their respective individual services' participation in the project – see Appendix 14 for a copy of the interview protocol. All nine interviews were audio recorded, transcribed and analysed thematically to interpret the key themes as they pertained to each of the following:

- The impact of participating in CBP
- Strategies services used to introduce and embed SSFC
- Barriers encountered
- What made practitioners who implemented SSFC successful
- SSFC after The Bouverie Centre

The impact of participating in CBP

Improved confidence and skills

Several interviewee respondents commented that staff's confidence and skills in working with families had improved because of taking part in various CBP-related activities.

> *"Maybe their confidence probably the main thing, so feeling more confident in inviting family members into sessions and also more confident in viewing with tricky family issues such as dealing with conflicting sessions."*

> *"The champion from our service absolutely, she really benefited immensely from it and I think that her skills developed substantially and her interest in the family session improved."*

Stronger connections with other services

Interviewees also indicated that CBP had enhanced relations with other participating services within their catchment.

> *"It's also been good to have those connections with other services as well and see what other services are doing and also probably improved relationships with other services as well."*

Change in the approach to families

Practitioners' orientation towards families and the nature of the work undertaken in this area reportedly shifted because of involvement in the initiative. Some respondents described increased efforts to engage and work alongside families; others talked about the work being tighter.

> *'There's been a real shift in mentality around how we think about working with families and a cultural change I suppose. So sort of taking that next step from being family inclusive and providing information to families to actually sort of actively working with them and moving towards that more collaborative approach."*

Increased family attendance

Some interviewees spoke about observing an increase in the number of families visiting their service since participating in CBP.

> *"We've been noticing lately that we have a lot more family members accompany our clients when they come in for their assessments because we've talked to them, we've explained to them the process, we've told them that that is an option that we offered, even to the family member as the session, not only for the client, so we do have a lot of family members actually attending the assessment sessions now as well."*

No appreciable differences

Some respondents stated that little had changed within their service since commencing CBP. They had difficulty isolating whether this was a function of current organisational circumstances or characteristics of the initiative itself.

> *"We had a lot of management change; we had some long-term sick leave, if you like, from other managers, so we had interim managers in other programs that weren't really aware or on board with what we were doing. So, I'd say, no, it hasn't had the impact that we would have expected, and the model didn't really suit. But I don't know that it didn't suit because it's not a good model, or it didn't fit because of the timing in our organisation."*

Strategies services used to introduce and embed SSFC

Whilst some services struggled to put much in place beyond releasing staff for training, interviewees made specific mention of having utilised the following methods to encourage the use of SSFC and its sustainability.

Incorporating SSFC into formal planning and performance standards

According to interview respondents, some services had articulated a commitment to the sustainability of family inclusive practice in formal plans and in position descriptions.

> *"So, from a systems point of view, I've definitely added (it) to the position descriptions. People are expected to work with families."*

"It has been included in our strategic plan, so it's something that we do every year."

"It's been put into planning for the future on the catchment-based plan and that's in two streams. One is around workforce development and one is about responding to families."

Decision support systems and reminders

Written prompts and verbal reminders issued via existing meeting structures were further utilised by some to support uptake.

"One of our practice leaders, developed a series of prompt cards, I guess, and placed them in different locations. So, in our staff vehicles, for example, and in different folders, just so that people when they were flicking through things, or jumping in the car to do outreach, would have them in mind."

"It's on the agenda for our ongoing team meetings so I think we just continue to monitor it and implement it on our ongoing basis here."

Multi-pronged approach

It was clear that some services had employed the full range of measures – e.g., training; opinion leaders; internal working groups; administrative interventions; and monitoring – to promote implementation success.

"We went with the strategies that were suggested from Bouverie, so looking at facilitating training; identifying champions in each program area; developing the internal implementation group meetings; encouraging the champions to go to the practice enquiry groups that were monthly."

Barriers encountered

The top three barriers to the provision of SSFC cited by each management sponsor roughly fell into four categories – barriers at the level of the practitioner; workplace barriers; barriers at the level of families and clients; and barriers in the external setting.

Barriers at the level of the practitioner

Interview respondents indicated that workers who demonstrated less openness to change and/or who perceived SSFC as a big departure from business as usual were harder to persuade to trial the approach. Additionally, it was difficult to keep SSFC on the agenda as practitioners were juggling competing priorities.

"It's changing the ways of practice of people that have been in the industry quite a while, and quite often they're more resistant to change."

"That level of confidence just in terms of family work, I think people see it as a very different thing to what we typically do individually with consumers and I think that feeds into a lack of confidence around engaging families more broadly."

"Keeping the momentum over a long-term project as well, because you have times where there was a lot going on and lots of motivation and then within a few weeks people would just forget and you'd have to sort of bring them back on track and do it that way."

Workplace barriers

Elements of the work environment identified as barriers to implementation of SSFC by interviewees included employee turnover and hours of operation.

> *"It is easier to have phone access during the day, but most of the family members who are working are not able to access our services during the daytime and we offer late night services only one day a week, so that has been a little bit of a barrier."*

> *"I guess probably changing the staff, because we initially had two champions and one left a month or so after the project commenced. So probably that, the transition of staff in and out of services."*

Barriers at the level of the client and family

According to interview respondents, troubled relationships with family and friends / social isolation, crisis presentations and a lack of practical and emotional resources on a family's part – i.e. too busy, demographics (live too far away) – contributed to difficulties with recruiting interest in family sessions.

> *"I think that our clients, because of what they have been through, they don't always want the family to be involved. There's a lot of hurt, anger, resentment, guilt, shame and that has been a barrier, trying to get them actually get them to see that family involvement can be a positive thing in the recovery."*

> *"I suppose the family members that you need to meet with in regards to the identified consumers' needs, may not necessarily all be geographically located in the one area, so some of that stuff may have had to have been done over the phone."*

> *"I would say that the majority of people that we are working with at any given point in terms of the level of complexity within their own lives that they're dealing with and the level of crisis that they are often enduring over long periods of time, it's difficult to – I mean, I use the word sell, I guess – it's difficult to sell at single family sessions with the kind of prep work and the kind of time line that it worked to …"*

Barriers in the outer setting

Interviewees observed that the CBP was launched towards the end of a significant period of upheaval. Participating services were tired. As time progressed, there were other improvement initiatives introduced by various bodies that drew further energy away from the project.

> *"I think when this started too we were still in a lot of turmoil because the AOD reform had only sort of just kicked in and we had a lot of staff that were feeling a bit tired and a bit jaded."*

> *"The difficulty or the challenge of trying to maintain a focus on any one thing for an extended period of time. So, like I was saying before, at different times during the year we would have different projects and timelines that would come through from any number of sources and that would necessarily shift the focus from things like the Beacon project."*

What made practitioners who implemented SSFC successful

Years of experience as a practitioner

Interviewees noted that unlike new recruits who were still coming to terms with the basics of their role, practitioners who more readily put the model into practice commenced the project with a solid skills base.

> *"It's definitely people that have probably been in this industry a little bit longer. I think the newer staff struggle to implement it purely because they had so many other things that they needed to sort of get down pat first."*

Belief in the value of change and the confidence to trial a new approach

According to interview respondents, another common characteristic of practitioners who had been successful in their efforts to apply SSFC was an enthusiasm for working with families and a willingness to try something new.

> *"I really think it is that passion and that belief in wanting to work with families but also having the confidence to do so, confidence is a really big one as well. And I also think being open to trying new things and open to challenging themselves."*

> *"Feeling like they have the skills and the knowledge as well, but also knowing that there's other team members that they too can use for that peer support as well."*

An understanding of the importance of family work

Interviewees also made a positive link between an appreciation of what the model could potentially offer family and clients and the extent to which SSFC was embraced.

> *"I think it's getting it, you know, getting the fact that family focused work, or family inclusive work is actually beneficial ... understand the theory behind it and how it's effective and how it's useful and how is successful and why."*

SSFC after The Bouverie Centre

Many management sponsors interviewed appeared interested in retaining at least some elements of the approach at their service. Some spoke about what they thought needed to happen to continue to support the practice. There was some doubt though as to whether there was sufficient momentum behind the change effort to ensure its long-term future post the withdrawal of The Bouverie Centre's ongoing support.

> *"We would try our best to make sure that we do family work, ongoing family work and as I was mentioning, it is our service intention to have more family involvement."*

> *"All of our workers now currently have been trained in the single session work, but I would like to see that become a part of any new workers that come there, give them the opportunity so that we do have it as part of our sort of standard core competency."*

> *"I think it will be difficult to keep up momentum."*

5.7 Additional observations by The Bouverie Centre's facilitators

- In the Goulburn Valley Catchment, services worked together to create a simple waiting room sign promoting the inclusion of families in care. Although the output was modest, the process of developing the advertisement created useful conversations within services around family involvement.
- Catchment Beacon was referenced in the GV AOD regional services plan.
- Chris Nunn, catchment planner, with assistance from GV AMHS intends to bring management sponsors and champions together annually to continue to collect and analyse data in relation to SSFC.
- In Melbourne South West, Neami and cohealth MHCSS held a joint Christmas party reflecting a strengthening of their relationship because of their involvement in Catchment Beacon.
- Enthusiastic and motivated champions were important in determining the extent of uptake at specific sites.
- Staff turnover, particularly involving the loss of project champions, was disruptive to the process of implementation at some of the project sites.
- Team leaders and middle managers with existing knowledge and expertise in introducing practice change, quickly and effectively developed a plan for how to introduce SSFC within their service.

6. Discussion

The Catchment Beacon Project involved the application of an existing implementation approach – the Beacon strategy – to the context of the then, newly formed MHCS and AOD catchments. The Bouverie Centre engaged with mental health (both clinical and MHCS) and AOD services within the Melbourne South West and Goulburn Valley catchments. The findings of the evaluation are discussed in terms of the stated aims of the project, followed by consideration of the limitations of the project evaluation.

6.1 Increase the use of family-based practice models

In total, 154 practitioners from 10 different agencies were trained in seven two-day programs. In addition to training, the project team engaged with services across the two catchments on 40 different occasions through champion briefings, steering group and PEG meetings, onsite consultations and opening and closing forums. Although activity was spread across different agencies in the two catchments, this nonetheless represents a high level of implementation support and a substantial commitment of resources by the participating agencies who also undertook a range of 'in-house' activities required to introduce and support the use of SSFC.

While the scale of activity associated with the project was significant, a key consideration in terms of the 'value' of CBP was the extent to which training translated into practice change. Despite the difficulties in capturing accurate information about the use of SSFC by practitioners, analysis of the available data provides some evidence of practice change. At least 273 family meetings were delivered using the SSFC framework and a further 102 sessions were conducted for single family members using the same structure. An estimated 494 invitations were issued to clients to take part in an SSFC session, and 286 to families. The ratio of client and family SSFC sessions to client invitations was broadly consistent with implementation outcomes in previous SSFC projects. Consistent with the differential uptake of training by the two catchments, more SSFC sessions were conducted in the Goulburn Valley catchment compared to Melbourne South West.

A more stringent evaluation of the implementation of a new family-based model would weigh the number of families reached against the level of implementation support activity. It would also consider the extent to which service users and family members benefited from SSFC and any unintended negative consequences. That said, the findings suggest that several families who may not have otherwise received a service did so as a result of CBP which is significant.

Another significant aspect of the use of family-based practice models was the universal preference for the implementation of SSFC. At one level this speaks to the appeal of a brief and accessible practice model that can be used by practitioners with differing skill levels. Practitioners, consumers and carers expressed the view that SSFC could be more easily implemented in services than the other available interventions. SSFC was viewed as a means of improving family engagement and as a logical first step to improving the overall service response to families. On the other hand, it is concerning that the evidence-based interventions, such as Behavioural

Family Therapy and the Multiple Family Group, were not chosen by any of the services. This appeared to reflect concerns about the intensity and duration of these interventions, although Let's Talk, a brief, parent focused intervention was not selected either. As proposed by some of the participants, establishing SSFC might constitute a first step in family engagement and that with time there will be interest in implementing more intensive, change oriented interventions.

6.2 Build practitioners' skill and confidence and service capacity

Results from the pre and post survey indicated that practitioners experienced a boost in their confidence and capacity to practice in a family sensitive manner and to hold formal meetings with families which was retained up to six months post training. Given that post training gains in confidence often evaporate rapidly, these findings are particularly heartening. Analysis of the survey data also suggested that the benefits of SSFC training extended beyond the services delivered to families in formal meetings, influencing practitioners' general sensitivity towards families as well. There was also a modest increase in the number of family sessions conducted per day.

These findings were consistent managers' impressions. Managers noted increases in practitioners' positivity towards families and in their skills when working with this group, as well as greater attendance at the service by family members in the individual interviews. When reflecting on the key issue of sustainability, appreciation was expressed for the changes that had been made to several organisational processes such as meetings and reporting. The congruence of SSFC with the service values was considered something that would improve the assimilation of SSFC within services while staff turnover was seen as a threat to this occurring.

6.3 Develop a shared vision for family inclusive services

Although the project did not achieve the stated aim of developing a shared vison for family inclusive services within each catchment, most of services within the two catchments were uniform in their high level of commitment to the implementation of family inclusive practice. Of the 14 services invited to participate, one service sent staff to training only, and a further three did not participate in the project at any level despite repeated invitations. The remaining ten were fully engaged. This level of engagement can be viewed overall as a positive outcome especially given the significant changes occurring across the mental health and AOD sectors and that the catchments did not self-select to become implementation sites, but rather were designated by DHHS and The Bouverie Centre.

The degree of participation in training, as indicted by attendance figures, was highest for MHCSs, followed by clinical mental health and AOD services. Considering that clinical mental health services have a significantly larger workforce than MHCS and AOD services this finding was somewhat surprising. Such a disparity in uptake may have reflected the MHCS sector's readiness for improving their responsiveness to families. It may also simply be that MHCS services found it easier to release direct care staff for training than clinical mental health services. At a pragmatic level, the

free training and support which would no longer be available after transition to the NDIS may have proven a strong incentive too. Given the relatively recent introduction of the concept of family inclusion in AOD services, and the comparatively small size of the sector, the rates of AOD workers' participation in the training were encouraging.

The Goulburn Valley Catchment had stronger representation in training than Melbourne South West, accounting for 62% of all participants. This was in part due to a single Goulburn Valley MHCS sending 35 of its staff to training. In the Goulburn Valley, clinical service boundaries aligned with the catchments meaning that all programs within the clinical service were in scope for participation. By contrast, the clinical and catchments boundaries in Melbourne South West did not align. This meant that a somewhat arbitrary line was drawn within the clinical services in Melbourne South West. Some programs were eligible to participate in the CBP and others not, contributing to a level of participation from this service that was nearly half that of its' rural counterpart.

Another promising step towards articulating a shared vision for the project aside from the widespread uptake of training was the attempts made to involve service users and family members in the planning phase. One of the most notable features of the CBP was the trialling of a novel process in which consumers, family members and practitioners were brought together in an opening forum to identify issues and gaps in relation to how services responded to families. They then worked together to formulate preferences in terms of the practice model that would be chosen for implementation in each service. While there were limitations to this process, most notably a failure to ensure continuing representation from consumers and carers in other aspects of the project, it showed potential as a method of service engagement in implementation and practice change initiatives. The engagement of service users and family members in the process of introducing new practices may lead to changes that better respond to their needs. It may also mean that services are held more accountable in following through with implementing the chosen new practice. This application of experience-based design warrants further trialling and refinement as well as consideration regarding how it aligns conceptually with current ideas around co-production.

6.4 Better coordination of the supports offered to families

The focus groups and individual interviews conducted with service managers and practice champions shed light on the project aim relating to service co-ordination and referral of families. The steering group and the PEG process was helpful in both shared problem solving around implementation and maintaining project momentum. This points to the potential for cross sector collaboration to support and enhance implementation. The role of The Bouverie Centre in keeping the project on track was also acknowledged.

A catchment-based approach to workforce development was viewed as having the potential to promote consistency across services, foster shared expectations and facilitate information sharing. However not all managers believed that the current CBP had led to increased collaboration. There was a view expressed that

improvements in this area required a deliberate investment of time and resources. The absence of evidence of substantial co-operation or co-ordination of service provision supports the view that the project's potential to improve relationships between services was not fully realised. It is likely however that a direct focus on service co-ordination would have drawn attention away from achieving other priorities, namely practice change within the participating services.

6.5 Develop a network of family inclusive practice leaders within catchments

CBP aimed to support practice champions to become an enduring network of practitioners committed to advancing family inclusive practice in each catchment post our involvement in the project. The extent to which family inclusive practice leaders were developed during the CBP is addressed in the project's focus on identifying and supporting project champions.

In CBP, practice champions appreciated the opportunity to help shift the service towards greater family inclusion and to enhance existing work with families. They also found some aspects of the role difficult, such as data collection, the variable uptake and enthusiasm for SSFC from their colleagues, and the recruitment of families in a context where practitioners did not always hold families in mind. These reflections indicate that being a champion can at times place the person occupying the role in a difficult position with their colleagues. It also points to the importance of support from external implementation agents and by managers within their teams. Practice champions certainly valued the responsive support they received from The Bouverie Centre through the practice consultants and the project co-ordinator.

While practice champions were both appreciative of and challenged by their role, it is not possible to determine whether they have continued in their roles. Consistent with the observations about participation in steering groups, champions did work well and productively together in the PEGs, however there was no clear indication that the network would continue after the CBP concluded.

6.6 Share knowledge gained from the project

The CBP has generated useful knowledge which has been disseminated both within and outside of the project. Importantly, the CBP tested the viability of the catchment structure as a platform for practice change endeavours. The project also served as an endorsement of implementation approaches adopted in previous Beacon projects as additional services were provided to families and there were changes in practitioner attitudes and behaviours towards families.

The CBP added to existing knowledge from previous Beacon projects in important ways including the use of novel stakeholder engagement process and greater appreciation of the experiences of appointed practice champions. In addition, the evaluation highlighted how managers and champions worked to influence their organisations and the significant challenges they faced in achieving practice change. For example, barriers to implementation were identified across practitioners

(resistance to change, confidence and loss of momentum), the workplace (operating hours and staff turnover) and client and family (conflict, family not living locally and complex circumstances) and wider context (turmoil from AOD reform and multiple projects and other initiatives).

As part of the formal closure process, services and service users and families were invited to catchment-based forums where participating services reported on their progress in implementing SSFC in their organisations. In addition, The Bouverie Centre shared the data gathered to date. The CBP was selected as an example of workforce innovation and was presented at a state-wide Workforce Innovation Day in 2017 hosted by DHHS. The findings have also been shared in a range of other forums describing the implementation work of The Bouverie Centre.

6.7 Limitations

As well as the limitations already noted about the project processes (for example sustaining service user and family participation), there were also limitations associated with the evaluation. Firstly, the evaluation did not include a direct measure of families' experience of SSFC or a measure of impact. In addition, it was not possible to obtain baseline data from agencies about their existing level of family contact or family meetings. Obtaining data remained a continuing challenge as the project progressed, leading to gaps in the information collected. This limits to some extent the confidence that can be placed in the findings related to uptake and practice change. However, most of the quantitative findings were consistent with the perceptions of managers and champions as expressed in qualitative interviews. Finding effective and efficient means for collecting data remains a continuing challenge in implementation projects like the CBP.

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