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Innovation:

Program Design & Development

Presenter:
Tony Johannsen

Acknowledgement

Family Life, and all the individuals who make up our organisation respectfully acknowledge the Traditional Owners of the country on which we live and work. We especially acknowledge the Wurundjeri people on whose lands we meet, as well as the Boon Wurrung /Bunurong people, and other peoples of the Kulin nation on whose ancestral lands Family Life provides services to the community.

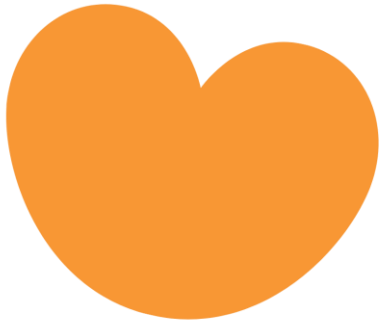
We pay our respect to elders past and present, and acknowledge their living culture and centuries of custodianship of these lands, which were never ceded. We acknowledge that the lands on which we stand always was and always will be aboriginal land.

Who Am I ?

- My name is Tony Johannsen
- I began my career working as a forensic AOD clinician before training as a MBCP facilitator.
- I designed and implemented The U-Turn program, Talk4Change, Support4Change, Home in Focus & MBCP intensive workshops
- I currently work at Family Life – Executive Manager of Clinical Practice & Quality.
- I have always favoured an Existential Psychotherapeutic lens in my clinical work.
- I also run a private practice (Psychotherapy, Clinical Supervision & Mentoring).

Terms of Reference

- Define 'Innovation'
- Define 'Continuous Improvement'
- What is the difference?



Why do we need to Innovate?

- Improve client outcomes
- Make better use of our finite funding $$$
- Legislative changes & increased acuity thresholds – Child Protection, Courts, Area Mental Health Services, Corrections...etc...
- Changes in Public Opinion & Societal Paradigm Shifts – often linked watershed moments (Luke Batty & Jill Meagher murders)
- Advances in Diagnostic criteria – Neurodiversity & Gender Dysphoria
- Shifts in Ideology, Academia & Evidence (1985 The introduction of Harm Reduction via Australia's first National Drug Strategy – 2018 Medically Supervised Injecting Room (MSIR) - 2024 Jess Hill & Michael Salter: Rethinking Primary Prevention)
- Tenders

Essential Ingredients for Program Innovation?

- *See previous slide*
- Continuous Improvement is not Service Innovation – Assimilation Vs Accommodation
- Gaps in service delivery – PHNs won't fund existing Department services – find the gap
- Solve Government's Problems – make your employers look good
- Strong Thematic Narrative & Case Studies – data alone won’t sell an idea
- Relationships, Conversations, Networks, Allies, Conferences, Coffee...etc...(Hustle)
- Strong appetite for Risk & the Unknown
- Redirected widgets to test a 'conceptual design' (can contradict a funding pitch tho)
- Funding !

Conceptual Design – Tips

- What is the problem are you trying to solve?
- How will this benefit your funders, clients and community?
- What makes your idea better than the current status quo?
- What interventions and why?
- What knowledge and interventions from other fields could be applied to this field?
- Treatment sequencing is fundamental to a good design
- Develop a 'Theory of Change' (formal or informal) - or at least a consistent narrative
- Targeted interventions for a targeted cohort – don't overreach, or underestimate complexity
- Targeted interventions are only as good as your targeted referral pathways

Evaluation – Tips

- If you don’t Evaluate it – it didn’t happen (when $$$ is scarce - Internal will suffice)
- Evaluation design is as important as Program design
- Build eval $$$ into your pitch – University evals are expensive
- Remember ethics – approval can be difficult for ambitious research designs
- Clean data is king – label & file everything accurately – ensure consent is approved by ethics & watertight
- Any data can tell a story – it is up to you to tell a good one !
- Choose your psychometrics carefully – honor your clients' time, not your own curiosity
- Most evaluations will not determine if your program 'works' - Narrative is everything
- Demographic data tells its own story; not just 'what' you are doing, but 'who' are you doing it with?
- Conceptual study designs add significant value to the field

Congratulations !

- You have created a beautiful program & managed to get it funded !
- Now what?

Pilots – Tips

- **PILOTS ARE NOT FUN** – they are stressful & meaningful
- Be realistic with timelines – Pilots take A LOT longer to implement that you may think
- Strong appetite for Risk & the Unknown
- Don't overcook it – Be prepared to build the plane as you fly it
- Be flexible – your pitch is not your program – allow your clients to shape content – adapt to the environment - pivot early or perish
- Socialise internally asap – internal resistance is a thing - change is hard
- Referral pathways are as important as funding – shore them up
- No-one cares as much as you – **YOU** are the senior clinician, group facilitator, supervisor, captain, coach, cheer squad, data collector, researcher, interviewer, promoter...etc...

Any Questions or Reflections so far ?

Case Study – The U-Turn Program

The Problems I was trying to solve:

- Low to medium risk men responding to FVIVOs where AOD was a contributing factor quickly escalating to the Criminal Justice system
- Growing pressure on MBCP waitlists
- No current AOD treatment for men using FV
- Men with multiple protective factors and no prior convictions mixing with recidivist offenders of FV in MBCPs
- The idiocy of a 'one-size-fits-all' paradigm for men using FV - No 'risk-needs-responsivity'
- 20 weeks is too long for higher functioning men

Case Study – The U-Turn Program

Why Innovation and not Continuous Improvement?

- The AOD sector had no FV informed interventions at the time
- MBCPs refused to add MH & AOD content to programs (by and large)
- A MBCP facilitator and an AOD clinician
- U-Turn kept a gendered lens and added MH & emotional literacy, psycho-ed, emotional regulation and AOD interventions – shorter in length – content pitched higher
- Most MBCPs were not sequenced, and few were manualised (U-Turn was both)
- U-Turn explicitly draws on knowledge from multiple disciplines and fields
- Targeted intervention for a targeted cohort (MBCPs were not at the time)

Case Study – The U-Turn Program

The benefit for Government:

- Less men escalating to the Criminal Justice system on FV charges ($$$ savings)
- Addressing FV in the context of AOD – DH-AOD had no FV interventions at the time
- Novel response to FV post Royal Commission

Allies & Partners (consult, partners & curious conversations):

- Magistrate Goldsbrough, MCV, FSV, DH(AOD), VicPol, VAADA, Monash Uni, AOD sector

Strategic Omissions:

- NTV & The Family Violence Sector

Case Study – The U-Turn Program

Adapting to the Environment:

- The Royal Commission into FV was about to be released
- Unprecedented funding into FV
- I had upskilled and was facilitating MBCPs whilst working as an AOD clinician
- I was establishing myself in the AOD & FV sectors – no-one spoke both languages, but I could translate
- I emersed myself in anything and everything that would help establish my legitimacy – never underestimate the personal/professional work you need to invest
- I was meeting the right people (Magistrate Goldsbrough & Anna Keato)
- TaskForce was very supportive

Case Study – The U-Turn Program

Building the plane as we flew:

- Program structure – 3 x orientation sessions, 12 x U-Turn sessions (15x sessions in total)
- When the first program commenced, I had only manualised approx 10-sessions of a 15-session program !
- I re-concuptualised 'orientation' to 'group readiness' to ensure greater completion rates
- We ran 4 x pilots across 2 years – COVID hit year 2 !

Case Study – The U-Turn Program

The Future:

- U-Turn is its 6th year – now in Frankston, Moorabbin & Regional Vic
- Talk4Change & Support4Change @ Family Life are heavily informed by my U-Turn experience
- I now conceptualise eval design, targeted cohorts and referrals pathways in conjunction with program design
- I competently engage with researchers
- We are rolling out Home in Focus @ Family Life as we speak

Final Questions & Reflections?

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https://www.familylife.com.au/