

The Implementation of Single Session Work in Community Health

September 2008

THE BOUVERIE CENTRE
VICTORIA'S FAMILY INSTITUTE
LA TROBE UNIVERSITY



Prepared for
**Primary Health Branch, Rural & Regional
Health & Aged Care Services Division,
The Department of Human Services**

Prepared by

Shane Weir,
(Project Team Leader)

Michelle Wills,
(Project & Research Officer)

Jeff Young,
(Project Manager)

and

**Associate Professor
Amaryll Perlesz**
(Research Advisor)

**THE BOUVERIE CENTRE
VICTORIA'S FAMILY INSTITUTE
LA TROBE UNIVERSITY**

Acknowledgements

We wish to acknowledge the support provided by the Department of Human Services, Rural & Regional Health & Aged Care Division, in particular the Director of Primary Health, Janet Laverick and for the support provided throughout the project by Sue Hughes, Senior Project Officer, Primary Health.

We would like to thank the Community Health sector's openness to this research and for what they have taught us during the Single Session Work (SSW) consultations. Particular thanks must go to all the people who participated in the research and gave information so willingly and specifically, to those CEOs and managers that courageously volunteered their organisations for scrutiny.

To SSW clinical champions, Lou Hewitt and Jacinta Horan-Smith, for generously sharing their expertise with the field.

Direct contributors

Pam Rycroft as another founding member of The Bouverie Centre SSW training team from whom we have received much needed professional and personal support. Pam has contributed much to the knowledge contained in this study.

Thanks also to Brendan O'Hanlon for assisting us with his knowledge of the implementation literature, Dr. Kerry Proctor for providing guidance, Hannah Moon for her help with the telephone survey, Sylvie Meltzer for transcribing the in-depth interviews, Ian Williams for his expertise in web survey design and Carmel Hobbs and Christine Neil for assisting with the formatting of this document.

Thank you

We are grateful for the support and stimulation provided by Dr. Colin Riess, and the community services and administrative teams at Bouverie.

Table of contents

List of figures	1
List of tables	2
1. Executive summary	3
1.1 Background.....	3
1.2 Key findings.....	5
1.2.1 The level of SSW implementation.....	5
1.2.2 The impact of SSW on service delivery	6
1.2.3 Factors impacting on the adoption of SSW.....	6
1.2.4 Counsellor and organisational factors influencing SSW implementation.....	7
2 Introduction	8
3 Background to the research project	9
4. Literature review	12
4.1 What is Single Session Work (SSW)?.....	12
4.2 International SSW research	12
4.3 Australian SSW research.....	14
4.4 The implementation of service innovation	18
5 Method	25
5.1 A pre and post SSW implementation questionnaire (See Appendix B & C)	26
5.2 In-depth interviews with representatives from six Community Health Services	27
5.3 A web survey for counsellors (see Appendix F)	30
5.4 A telephone survey of all Community Health Services to determine the level of SSW implementation	32
5.5 Interview with The Bouverie Centre SSW trainers	32
6. Findings	33
6.1 The pre and post SSW implementation questionnaire	33
6.2 The web survey for counsellors.....	34
6.2.1 Demographic characteristics of the 116 people who responded to the survey	35
6.2.2 Counsellor attitudes and practices that are compatible with SSW	38
6.2.3 Other factors that may influence SSW implementation.....	40
6.2.4 Service impact.....	43
6.2.5 Respondents who <i>had</i> implemented SSW (n=101) vs. those who <i>had not</i> (n=15).....	45

6.2.6	A comparison between SSW as an organisation wide approach to service delivery and implementation at the discretion of individual counsellors.....	47
6.2.7	Comparisons between the four principal organisations that participated in the in-depth interviews.....	49
6.3	Telephone survey to determine level of implementation across the sector.....	51
7.	Discussion	54
7.1	Implementation factors for SSW in Community Health	54
7.1.1	Relative advantage.....	55
7.1.2	Compatibility.....	57
7.1.3	Complexity.....	62
7.1.4	Trialabilty	64
7.1.5	Observability	68
7.1.6	Re-invention.....	70
7.1.7	Organisation adaptability	72
7.1.8	Risk.....	74
7.1.9	Training and support.....	75
7.1.10	Incentive and regulation	78
7.2	The Bouverie Centre trainers' experience.....	81
8	Conclusion.....	85
9.	References	89
10.	Appendices	92
A.	Letter inviting participation in the SSW Implementation Research.....	93
B.	Pre SSW implementation questionnaire	95
C.	Post SSW implementation questionnaire.....	101
D.	Participant information and consent form	107
E.	FAQs for SSW web survey for counsellors	109
F.	SSW web survey for counsellors	111

List of figures

Figure 1: Community health counselling state wide contact data:2002-3, 2003-4, 2004-5 ..9	
Figure 2: Gender of respondents	35
Figure 3: Respondents practising in rural, regional & metropolitan Victoria	35
Figure 4: Years of experience in CHS counselling	36
Figure 5: Respondents who had undertaken SSW training	36
Figure 6: Respondents who had looked at the implementation parcel.....	37
Figure 7: Application of SSW in respondents' workplaces.....	37
Figure 8: Level of SSW implementation across Victorian CHS from survey	53
Figure 9: Influences that affect implementation	54

List of tables

Table 1: SSW training and implementation timeline.....	11
Table 2: SSW implementation research timeline.....	25
Table 3: Significant differences between organisation application and individual counsellor application of SSW	48
Table 4: Significant differences between the four principal organisations that participated in the in-depth interviews.....	50
Table 5: Level of SSW implementation in Victorian Community Health Services as at April, 2008	51

1. Executive summary

1.1 Background

In 2004 the Department of Human Services, Victoria (DHS) sponsored training in Single Session Work (SSW) for Community Health (CH) counsellors across Victoria. This training, provided by The Bouverie Centre, was offered to the field as a result of the DHS review of community health counselling and casework services conducted by John Pead, which found that 50% of the 35,000 community health counselling clients attended only 1-2 sessions (Department of Human Services, Victoria 2002). For example in 2004-5 over 42% of clients attended for only one session and over 64% attended for either one or two sessions (see Figure 1, section 3). The SSW training also complemented some of the key areas for development in the sector including demand management, effective practice and quality improvement.

The rationale for implementing Single Session Work is based on three empirical findings:

1. The modal number of sessions in a large number of counselling services internationally and across many service types is one (session).
2. It is difficult to predict which client will attend for one session and which client will attend for ongoing sessions.
3. The majority (75%-85%)¹, of counselling clients only attending for one or two sessions, who are often viewed as drop-outs or a service failure, report being satisfied with the service they receive.

If accepted, these findings encourage counsellors to adopt SSW principles, in particular, make the most of the first, and sometimes only, session for all clients.

This report documents the key findings about how SSW was successfully implemented into a high number of Community Health Services (CHSs). Traditionally, training to CH counsellors has been offered as a one-off enterprise without resources and support for further sector implementation. The current research documents what is required to implement effective workforce development and makes recommendations for sustaining the high level of change that has been achieved.

¹ See Talmon's research in section 4.2.

Since 2004 The Bouverie Centre has trained over 400 CH counsellors in SSW. DHS also funded The Bouverie Centre to provide over 70 consultations to CHSs interested in incorporating SSW as a service delivery option (Whittle & Young, 2006). The Bouverie Centre was also funded to offer free catch-up SSW training to CH counsellors. In response to the increasing need for broader service support for the implementation of SSW, The Bouverie Centre produced a SSW implementation parcel and to date, has distributed approximately 468 to counsellors and managers in community health counselling services across Victoria.

DHS approved funding for this research project in response to the sector's positive reception to SSW training and the high level of SSW implementation in services. Funding was provided to understand and document SSW implementation in the community health sector.

The research aimed to investigate and record:

- The level of implementation.
- The impact of SSW on service delivery.
- Factors impacting on the adoption of SSW.
- Counsellor and organisational factors influencing SSW implementation.

Five types of data collection procedures were used for the research:

1. A pre and post SSW implementation questionnaire.
2. In-depth interviews with representatives from six CHSs.
3. A web survey for counsellors.
4. A telephone survey of all CHSs to determine the level of SSW implementation.
5. An interview with The Bouverie Centre SSW trainers.

1.2 Key findings

1.2.1 The level of SSW implementation

The level of implementation was remarkable given that the literature cites a large variability in workforce uptake with between 11% and 65% of treatment in the health sector based on evidence-based practises (Buchan, 2004).

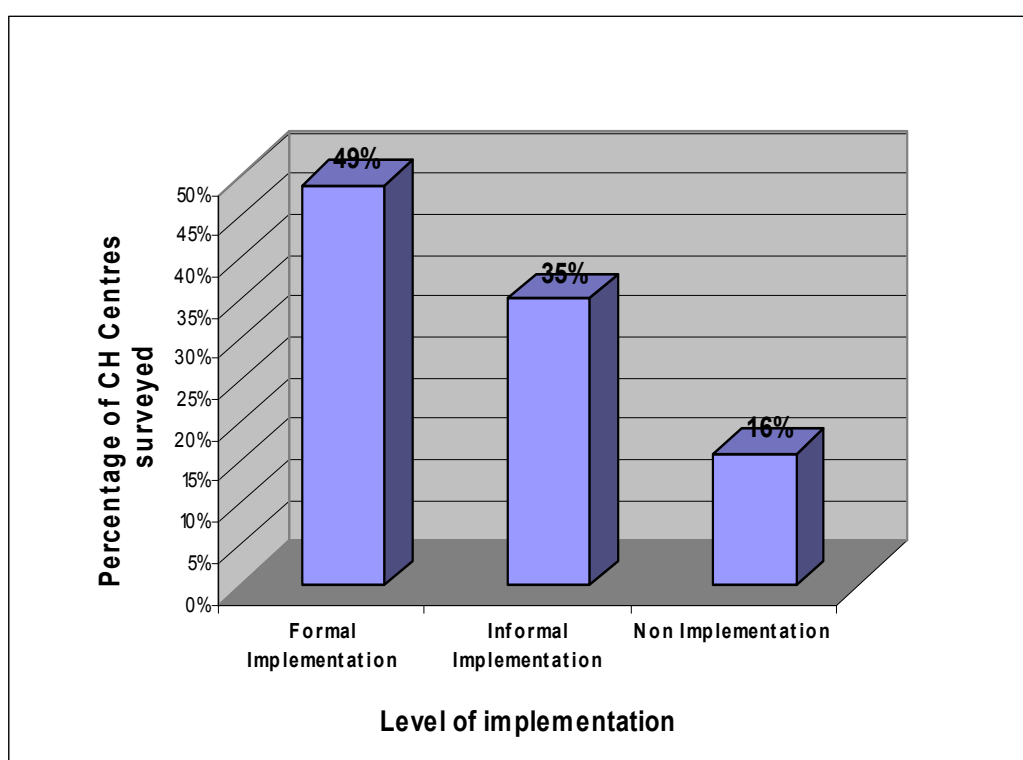


Figure 8 Level of SSW implementation across Victorian CHS from survey (section 6.3).

- Forty-eight (84%) out of a total of 57 organisations that responded to the Telephone Survey had implemented SSW in some form with 28 organisations (49%) implementing SSW as part of a formal service response (section 6.3).
- Of counsellors who responded to the Web Survey, 101 out of 116 respondents (approximately 33% of the total workforce) stated that they used some of the principles and practices of SSW in their work after receiving SSW training (section 6.2.1).

1.2.2 The impact of SSW on service delivery

- SSW is a noteworthy form of service delivery because the most common number of sessions that clients attend in community health counselling is one. (see Figure 1, section 3 and section 6.1).
- Organisations that implemented SSW reported a reduction in counselling waiting times for clients between one and 47 weeks (sections 6.1 and 7.1.1).
- Most organisations that successfully implemented SSW also experienced a boost in staff morale by coming together as a team to apply and review SSW (section 7.1.10).

1.2.3 Factors impacting on the adoption of SSW

- SSW is more likely to be implemented by individual counsellors or as a formal organisational response to service delivery, if training is combined with informative support materials and ongoing availability of organisational consultations (section 7.1.9).
- Counsellors who participated in SSW training were more likely to implement SSW practices and principles than those counsellors who had not attended training (section 6.2.5).
- The organisations that adopted SSW viewed the approach as augmenting existing quality assurance measures (section 7.1.8).
- By funding the SSW training, DHS provided a recommended solution to some of the issues facing community health counselling services, such as demand management, that most managers are compelled to seriously consider (section 7.1.10).
- The implementation of SSW was aided by the influence of:
 1. respected internal counsellors;
 2. other organisations that had implemented SSW and;
 3. consultations with recognised SSW experts (section 7.1.5).
- The presentation of SSW in training as flexible and recursive in order to engage with various stakeholder groups and meet the changing needs of the sector over time (section 7.2).

1.2.4 Counsellor and organisational factors influencing SSW implementation

Counsellor factors

- A large proportion (up to 80%) of practitioners agreed that SSW was compatible with their core counselling beliefs and practices especially regarding the compatibility of SSW with the social model of health, and a client centred, and strengths based approach (section 6.2.2).
- The majority of practitioners who had implemented SSW experienced their supervisors as supportive and reported a reasonable climate of co-operation in their workplace (section 6.2.3).
- Counsellors who experienced the organisational implementation of SSW, as compared to counsellors who implemented SSW at their individual discretion, were more likely to agree that:
 1. SSW was effective in reducing waiting lists and promptly responding to clients.
 2. They were also significantly more likely to report structures at work that assisted with the administration, evaluation and support of SSW (section 6.2.6).
- Counsellors were more likely to successfully adopt SSW when their practice values were aligned closely with SSW (section 7.1.2).

Organisational factors

- Those services that implemented SSW invested resources into adapting the accompanying SSW paperwork to suit the agency context (section 7.1.3).
- The use of a regular review or an evaluation process assisted the adaptation of SSW to the specific service delivery context (sections 7.1.4 & 7.1.6).
- Organisations that implemented SSW were more likely to be headed by leaders who inspired staff, were passionate about the provision of client services and gave clear direction (section 7.1.4).
- Providing specialist external supervision assisted counsellors to maintain confidence in applying SSW particularly where their line manager did not have qualifications or expertise in counselling (section 7.1.9).
- The offer of ongoing external consultation to services by The Bouverie Centre staff provided an opportunity for counsellors and managers to adapt SSW practices with guidance from recognised experts (section 7.1.9).

2 Introduction

This study explores the implementation of Single Session Work (SSW)² in counselling and support services within CHSs in Victoria. The aim of this study was to investigate the factors that have contributed to the successful implementation of SSW or contributed to the rejection of SSW. This study has four principle areas of focus:

1. Recording the level of SSW implementation in CHSs.
2. The impact of SSW on service delivery in community health counselling services.
3. Factors impacting on the adoption³ of SSW.
4. Counsellor and organisational factors influencing SSW implementation.

This report is divided into a number of sections. The first will explain the background to DHS sponsored SSW training in Victoria that led to the current research. This is followed by a short explanation of SSW and summary of the international and Australian SSW literature. An examination of the literature on the implementation of evidence-based practice or service innovation⁴ then provides the foundation for the SSW implementation research. An explanation of the methods used for data collection and analysis is followed by the findings. The implementation factors discussed in the discussion section are assembled under the main categories discerned from the literature. The report finishes with a conclusion and references.

² The phrases Single Session Work and Single Session Therapy are used to describe the same type of Single Session practice and framework. Originally the framework was called SST by Moshe Talmon and The Bouverie Centre uses the phrase SSW to acknowledge that the same framework can be used by different professional groups in a variety of practice settings.

³ For the purposes of this report the words adoption and implementation are used interchangeably.

⁴ SSW has an international research base and is considered an innovation that can improve current practice.

3 Background to the research project

In 2004 the Department of Human Services (DHS) sponsored training in SSW for Community Health (CH) counsellors across Victoria. This training, provided by The Bouverie Centre, was offered to the field as a result of the DHS review of community health counselling and casework services conducted by John Pead, and the resulting public consultation (Department of Human Services, Victoria 2002). The Pead Review identified that over 50% of clients attended for one or two sessions and posed the question: 'How can we improve counselling services by extending the number of sessions that clients attend?' During the consultation process Dr. Colin Riess and Jeff Young (The Bouverie Centre) highlighted that this statistic is a common finding internationally and difficult to change. They suggested making the most of the first two sessions (by utilising a SSW framework) as a more effective way of improving the quality of counselling. SSW training was eventually offered to the sector which also complemented some of the key areas for development in the sector including demand management, effective practice and quality improvement. Below is a graph collected by DHS outlining the state-wide contact data for community health counselling services. In 2004-5 over 42% of clients attended for only one session and over 64% attended for either one or two sessions.

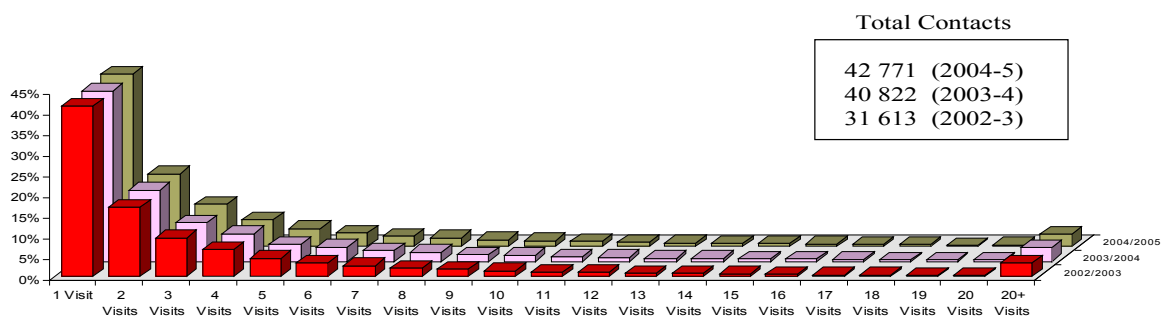


Figure 1: Community health counselling state wide contact data:2002-3, 2003-4, 2004-5

Since 2004, The Bouverie Centre has trained over 400 CH counsellors in SSW. DHS also funded The Bouverie Centre to provide over 70 consultations to CHSs interested in incorporating SSW as a service delivery option (Whittle & Young, 2006). The Bouverie Centre was also funded to offer free catch-up SSW training to CH counsellors.

In response to the increasing need for broader service support for the implementation of SSW, The Bouverie Centre produced a SSW implementation parcel and to date, has distributed approximately 468 to counsellors and managers in community health counselling services across Victoria.

The implementation parcel included:

- A DVD with a role-play of SSW.
- A downloadable CD with examples of paperwork associated with SSW.
- Lift-out flow charts explaining the SSW process for counsellors and intake workers as well as an evaluation procedure.
- Explanations of various applications of SSW for both counsellors and managers.

Traditionally, training to CH counsellors has been approved as a one-off enterprise without resources for further sector consultation. DHS approved funding for this research project in response to the sector's positive reception to SSW training and the unique support provided for SSW implementation. Funding was provided to understand and document SSW implementation in the community health sector. The research looked at:

- Quantifying the level of implementation.
- Documenting successful implementation practices.
- Attempting to understand the factors that promoted or inhibited implementation.
- Investigating the impact of implementation.

The research also provided an avenue for some agencies to reconsider implementation as a result of being presented with interim findings through the DHS funded organisational consultations and direct assistance to design an implementation plan, for example, the participation of Service 2 (described in section 5.2) in the research.

Table 1: SSW training and implementation timeline

Date	
June 2004 - July 2005	<ol style="list-style-type: none">1. Letters from DHS to community health Chief Executive Officers (CEOs) announcing the SSW training initiative.2. Briefings with community health managers outlining SSW.3. State-wide SSW training to 269 CH counsellors.
June 2005 - July 2006	<ol style="list-style-type: none">4. "Catch-up" SSW training provided to 121 CH counsellors.5. SSW implementation forums and in-services to 49 CHSs.6. Consultation on SSW provided to 11 CHSs undertaking DHS funded Counselling Client Pathways Framework projects.7. SSW implementation and information packs developed for intake workers, counsellors and managers. Four hundred and sixty eight distributed to CHSs across Victoria.8. SSW implementation research project approved and begun in March, 2006.9. DHS-sponsored launch of the implementation parcels and research project that influenced Service 2 manager to re-consider SSW implementation.10. Email and telephone support provided to CHSs.
June 2006 - July 2007	<ol style="list-style-type: none">11. Catch-up SSW training provided to 40 counsellors.12. 50 SSW implementation and information packs distributed.13. SSW implementation in-services to 19 CHSs.14. Email and telephone support provided to CHSs.15. SSW counsellor web survey conducted.
June 2007 - July 2008	<ol style="list-style-type: none">16. Ongoing "catch-up" SSW training provided to CH counsellors.17. SSW implementation consultations provided to CHSs on a continuing basis.18. Email and telephone support to CHSs.

4. Literature review

4.1 What is Single Session Work (SSW)?

Single Session Work is based on three empirical findings:

1. The modal number of sessions in a large number of counselling services internationally and across many service types is one.
2. It is difficult to predict which client will attend for one session and which client will attend for ongoing sessions.
3. The majority (75%-85%)⁵, of counselling clients only attending for one or two sessions, who are often viewed as drop-outs or a service failure, report being satisfied with the service they receive.

If accepted, these findings encourage counsellors to make the most of the first, and sometimes only, session for all clients.

The SSW process usually involves one longer than normal face-to-face session, and a pre-session questionnaire combined with follow-up phone contact to determine whether the client wants or requires further sessions. A post-questionnaire can be included to measure client outcomes from the session. It is not a 'one-off' therapy but rather a structured first session which attempts to maximise the client's first therapeutic encounter, understanding that it may be the only appointment the client chooses to attend, while entertaining the possibility of ongoing work. Single Session Work has historically been known as Single Session Therapy (SST). The Bouverie Centre has substituted the word 'work' for 'therapy' because of the broad range of counsellors and organisations currently using this approach in a variety of health and welfare settings.

4.2 International SSW research

The phenomenon of single sessions has existed in therapeutic practice since the foundation of psychotherapeutic work in modern society. One of the earliest documented single sessions in psychotherapy was Sigmund Freud (Breuer and Freud, 1944) who wrote of a successful single therapeutic intervention with a woman called Katharina in the Austrian Alps. Other accounts of single session interventions included Grotjahn's account of 'curing' a

⁵ See Talmon's research in section 4.2.

forty-five year old depressed physician (reported by Alexander and French, 1946 in Talmon, 1990). Although Grotjahn's work was not received positively in the psychoanalytic community a few psychotherapists have continued to discover the positive effects of a single therapeutic encounter for a significant proportion of people seeking psychotherapy (for example, Malan, 1975; Kaffman, 1995). These studies found that a large percentage of clients who attended for one session had a significant decrease in their symptoms (51% for Malan) and an increase in their sense of well-being. Moreover, clients maintained the change after follow-up periods from two to seven years. In some studies (Littlepage, 1976; Silverman & Beech, 1979) there was no difference in the usefulness attributed to therapy between clients attending one session and those attending for a prescribed number of sessions. However it appears difficult to determine who will benefit from one session and who will benefit from longer term work.

Despite the evidence produced in studies asserting that a single session can be useful for a significant proportion of people seeking psychotherapy, the psychotherapeutic community's predominant view of clients who attend for only one session, is negative. Generally, clients who attend for one session are deemed to be 'drop outs' and are almost universally described by counsellors as possessing personal attributes that decrease the likelihood of therapeutic success. Talmon (1990) asserts that a once-only session with a client is assumed by counsellors as a failure to create a working rapport between client and therapist, despite growing evidence that the majority of clients (75%) who only attend one session are satisfied with that encounter. This does not mean that the client would not benefit from further work. It merely indicates that clients will discontinue counselling after getting 'enough' of what they want or need at any given time.

Talmon (1990, 1993), was the first psychotherapist to thoroughly investigate the 'single session' phenomenon in psychotherapy. After a review of 100,000 outpatient contacts at the Kaiser Permanente Medical Centre psychiatry department he found that the modal length of therapy for clients of all clinicians was one session. He found that 30% of the 100,000 clients reviewed, from his service, elected to come for one session in a one year period. This led Talmon to evaluate 200 of his own clients who had attended for one session. Seventy eight per cent reported feeling 'better' or 'much better'. A 'blind' follow-up evaluation with a random sample of clients from the centre elicited similar findings with only 10% of clients reporting that they did not like the therapist or the outcome of the session. Challenged by the evidence, Talmon enlisted the support of several colleagues to structure

therapy sessions in a way that could take advantage of the possibility that some clients may find substantial benefit in attending therapy only once while still being open to further sessions as determined by the client. As shown by Bloom's (2001) meta-analysis of 40 papers evaluating SST, there is emerging evidence that approximately 71-88% of clients who attend for one session report improvements in their wellbeing and are satisfied with the session. However, more research is needed to better understand and empirically support such claims, because the studies to date have tended to be small clinical samples with no standardised outcome measures, and no randomised control trials with control groups. Bloom's meta-analysis does not include a recent, well controlled evaluation of SST conducted by Dr. Ruth Perkins (2006) from Victoria, Australia.

4.3 Australian SSW research

Inspired by Talmon's investigation several Australian practitioners conducted single session work studies. Price's (1994) article was the first in Australia to describe a purposeful therapeutic structure that attempted to capitalise on the possibility that one structured therapy session may be sufficient for some families. The family therapy team at Dalmar Child and Family Care in New South Wales decided to offer families on their waiting list a single session with the prospect of returning to the waiting list if more therapy was deemed to be necessary. Single sessions were conducted on dedicated 'open days' where all counselling staff participated in single session therapy with invited clients. A follow-up evaluation generated findings similar to those of Talmon (1990) and other international studies; 78% of families found the session helpful and 45% chose to attend only one session. The Dalmar example is also significant because it was one of the first attempts to use single session work as an effective demand management tool.

Boyhan (1996) states that the traditional response to over-demand for therapeutic services has been to place clients on waiting lists. She questions the ethics of leaving clients unattended for prolonged periods of time on a waiting list whilst abuse or difficult problems could still be occurring. Boyhan also questioned the effects on counsellors who have no structured ways to manage over-demand. Boyhan researched the first 50 families seen for Single Session Therapy (SST) at The Bouverie (family therapy) Centre and compared the results with Dalmar Child and Family Care, Child and Adolescent Mental Health Services in the Australian Capital Territory (ACT), and Moshe Talmon's original study. She concluded

that the SST approach assisted the reduction of counselling waiting times for clients and contributed to high client satisfaction rates. In the study, 36 families were available for follow up and review of the SST process. Fifty three per cent of the families decided they only needed to be seen once and a further 8% chose to be seen for a second session only. After the Single Session, 25% of families opted to return to the waiting list to wait for further sessions and 14% started ongoing therapy after being prioritised by the counsellor. Clients were followed up both at 7 days and 2 months post session.

Despite the variation in service context, Boyhan's results were remarkably similar to those of Dalmar Child and Family Care, ACT Child and Adolescent Mental Health Service, and Moshe Talmon on the percentage of clients attending for one session (53%), clients' perception of improvement post session (78%), and clients' ratings of session helpfulness as equal to or above 7.5 on a 10 point scale (81%). Boyhan found that seeing clients promptly, as closely as possible to the initial referral for counselling, had a positive impact on perceived helpfulness. A thematic analysis from structured questionnaires given to the families at follow-up reinforced the high degree of satisfaction with the SST service. Families mentioned the timeliness of the response and that their situation would have deteriorated if they had not been seen quickly. A relatively small number of families identified some negative aspects to the session. It is not clear from Boyhan's study whether these factors are a result of SST or general factors attributable to all forms of therapy. These included the difference in problem definition between client and therapist as well as one client's construct of surface versus in-depth therapy that contributed to negative ratings of the session. Boyhan also found that families who found the first session less helpful were more likely to seek out further counselling contrary to the belief that a less satisfactory first session may result in clients dropping-out of therapy.

Boyhan's work was developed further by Young and Rycroft (1997) who outlined the clinical guidelines for SSW and conceptualised SSW as a service delivery framework. They contend that SSW is not a model of therapy but a set of counsellor attitudes which influence the delivery of all counselling models by enacting the following beliefs: one contact can be therapeutic; clients are more receptive to change when they first seek help; clients and counsellors need to share the responsibility for decisions about the therapy; and the therapist does not need to take a central role in the client's life.

Campbell (1999) acknowledges the possibility for SST as an effective and efficient way of providing therapeutic interventions for clients in high demand public health settings. He is critical of previous Australian research (Boyhan, 1996; Price, 1994) for relying on survey style self reports from clients with no specific pre and post measures and no control groups to compare results with clients who had received a single session. Campbell (1999) advanced the research into SST by introducing pre and post outcome measures for clients. In his study on single session interventions clients were offered SST following a telephone interview which excluded clients presenting with high risk issues such as psychosis, suicidality and ongoing abuse. Clients assigned to SST were asked to complete three questionnaires before the session: the Problem Evaluation Summary (PES), the Self-Report Family Inventory, and the Family Pride Inventory. At a six week follow-up telephone call clients were again asked to complete the PES. Thirty three clients completed the pre and post measures with the mean problem rating prior to the session being 12.48 and the post session mean being 8.21. Clients experienced significant overall benefit from SST in relation to a perceived decrease in effect of the problem and an increase in their ability to cope with the problem. While the majority of the 27 families followed up showed an increase in pride, the 15 families classified with a high-pride rating on the Family Pride Inventory showed a significant decrease in problem ratings which were greater than the 21 low-pride ratings.

The most rigorous study to date has been Perkins' (2006) recent clinical trial of SSW with 258 families over a 14 month period in a Victorian Child and Adolescent Mental Health Service. On referral, families were randomly assigned to a treatment group who received a single session within 2 weeks or a control group who were 'wait listed' for 6 weeks. Questionnaires were administered to both groups at intake, and to the treatment group both after the SST and after 1 month post treatment. The control group completed the second set of questions prior to treatment after 6 weeks. Clients presented with a variety of diagnostic categories and only those who presented with immediate risk of self harm were excluded from the study. Measures to assess outcome included standardised and multi-dimensional outcome measures and pre and post rating scales which included the Devereux Scales of Mental Disorders (DSMD) to measure the change in client psychopathology between the treatment and control groups, the Health of the Nation Outcome Scales for Children and Adolescents (HoNOSCA) to determine changes in the global functioning of the treatment group and the Client Satisfaction Questionnaire-8 for parents of the treatment group. Perkins' research produced findings similar to previous Australian and international studies. Of the clients assigned to the single session group,

50% elected to have a single session and one follow-up session only. Client satisfaction after the single session was 95% immediately after the session and 88% at the 4-week follow-up. Importantly, both groups showed a marked reduction in the frequency of the presenting problem with the single session treatment group exhibiting a significantly greater improvement (71%) than the control group on the outcome measures completed by clients, parents and teachers. An improvement in severity of the problem was recorded in 74% of SSW clients. Parental reports on their child's psychopathology in the treatment group all showed improvement clinically and statistically on the DSMD. Along with those who preceded her, Perkins' research has helped support the efficacy of SSW in a variety of clinical settings.

More research into the effectiveness of single session work for client outcome is still warranted to investigate the claims of Talmon (1990, 1993) and Young and Rycroft (1997) that: all forms of therapeutic technique can fit a SSW approach; that the severity of diagnosis does not indicate whether a client will find SSW helpful or not; and that it is possible to use single session work in a broad variety of counselling contexts. In line with Hubble, Duncan and Miller's (1999) investigations about the effectiveness of therapy relying on the client's belief about change some informal evaluation data gathered by community health counselling services suggests that it is the client's belief and perception of the therapy that determines the success of SSW. This emerging idea would need further investigation to confirm the validity of the claim. Whilst clinical research into SSW is growing steadily there has been no research looking at the implementation of SSW into a host agency⁶. Understanding the components that contribute to the successful implementation of SSW in counselling services is important for three reasons:

- 1) SSW training will not translate into effective practice unless it is incorporated into the continuum of client services within the trainee's host agency.
- 2) SSW clinical practice needs to be imbedded into agency processes in order to provide a transparent and ethical service with clear client-informed consent and an equitable system for managing demand.
- 3) As a DHS sponsored training initiative it is important to determine which components are necessary to translate training individual counsellors in SSW into agency adoption.

⁶ The terms agency and organisation are used interchangeably in this report.

4.4 The implementation of service innovation

"Given the preponderance of evidence from a variety of sources, implementation appears to be a crucial component of moving science to service with fidelity and good outcomes for children, families, and adults."

(Fixsen, Naoom, Blase, Friedman, and Wallace, p.68, 2005.)

Until recently research has centred on evidence-based practice techniques to guide practitioners in the most effective ways to provide treatment to consumers of health and welfare services. What has become increasingly apparent in the last decade is that despite a strong evidence base, innovative practices that have the demonstrated ability to improve the outcomes for clients have failed to be adopted by practitioners and organisations alike (Fixsen, Naoom, Blase, Friedman, and Wallace, 2005). The failure to successfully implement new initiatives to improve practice is a widespread phenomenon across a variety of human service organisations. Torrey, Drake, Dixon, Burns, Flynn, Rush, Clark, and Klatzker (2001) and Bond, Becker, Drake, Rapp, Meisler, Lehman (2001) lament that, notwithstanding the empirical research, certain pharmacological, psychosocial and supported employment interventions are not widely offered in routine mental health practice settings in the USA. Despite the distribution and proliferation of practice guidelines, Lomas, Anderson, and Domnick-Pierre (1989) assert that guidelines alone are not enough to change the practices of clinicians. According to research into patient treatment in the United States and the Netherlands health care systems (Grol & Grimshaw, 2003), patient outcomes could be significantly improved if the knowledge gained from research was effectively implemented. Moreover, 30%-40% of patients do not receive treatments of proven effectiveness. As a result of the startling research findings, regarding the under utilisation of evidence informing clinical practice, researchers have turned their attention toward understanding the domains which make it more likely for innovation and evidence-based practice to be adopted in human service organisations. Evidence-based practice now needs to be applied to the implementation of innovation itself (Grimshaw & Eccles, 2004).

Examples from the medical and health care sector on the implementation of evidence-based and innovative practices are well represented in the literature. By contrast there is a dearth of published studies into the implementation of counselling interventions across the health

and welfare sector. One study by Hitt, Robbins, Galbraith, and Todd (2006) evaluated whether the introduction of a counselling based protocol improved the achievement of HIV prevention counselling goals in four prevention counselling programmes in Texas. The four organisations selected to participate in the study represented a diverse range of structures, client groups and counselling, referral and testing settings. Staff received five days of training and participating organisations received documents relating to counselling protocols, tools and quality assurance procedures. The project also investigated factors that aided or impeded the implementation of the counselling protocols.

Hitt et al. (2006) found that most counsellors reported the tools designed to assist the counselling process were useful, particularly, a prompt book and session documentation forms. Some counsellors expressed concern that the implementation of the protocol would inhibit their ability to use effective counselling skills. Reports from client exit interviews alleviated workers' concerns. Only one organisation implemented the recommended quality assurance procedures and both supervisors and counsellors mentioned the additional time and paperwork required as significant barriers. Qualitative interviews with counsellors revealed that the role played by managers and supervisors was crucial in the successful implementation of the protocol. Supervisors who prioritised other work role demands were less likely to provide the necessary support with quality assurance. The study also found that counselling training and protocols that were too rigid in design inhibited the ability of individual counsellors to flexibly adapt the interventions to match their individual style. Although the study provided evidence that counselling services can successfully implement new protocols and initiatives no follow-up data was collected to ascertain how organisations performed after the implementation period. More research is required to ascertain if and how counselling protocols can be embedded into organisational culture and maintained over many years. Some of the potential barriers to implementation reported by Hitt et al. (2006) were similar to those found in a survey of physicians from the Netherlands on implementing guidelines for diabetes care cited in Grol and Wensing (2004). The most popular reasons for not implementing the guidelines included heavy workloads (81%), no financial compensation for changing practices (57%), and overly rigid guidelines (56%). Furthermore, half of those surveyed did not like activities imposed upon them.

The adoption of innovation by health and welfare practitioners and organisations is often confounded by the complexity and multitude of variables that affect successful implementation. Rogers (1995) identifies six elements that determine if a new practice will

be adopted: relative advantage, compatibility, complexity, trialability, observability and reinvention. **Relative advantage** is the perception by all stakeholders that the innovation is better than the practice that it superseded. The perceptions of what is deemed 'better' by various stakeholders may vary. Clinicians may be more interested in whether the innovation improves their ability to work efficiently and effectively while maintaining clinical control whereas organisations may be more interested in improving efficiencies as well as client outcomes. **Compatibility** is measured by the extent to which new practices fit with the values, experiences and the current needs of practitioners and service providers. A new initiative is more or less likely to be adopted depending on the **complexity** of the procedure. If the practice is perceived as simple to understand and simple to adopt by clinicians and managers it has more chance of success. **Trialability** is the extent to which the innovation can be tested and modified. Rogers (1995) states that this provides clinicians with the added evidence gained through testing the practice in their own context and the ability to adapt the procedure to fit the local treatment environment. **Observability** is described as the innovation being adopted by respected colleagues and demonstrated by organisations across the sector. Where new techniques are adopted in a visible manner across the sector, services may perceive a disadvantage in not adopting the innovation. **Reinvention** is the process whereby the adopters can modify the innovation to suit the particular service context. Rogers also suggests that the adoption of innovation is more likely where there are multiple channels of communication and information dissemination including face-to-face consultations between clinicians with similar professional background.

Further contributing to Roger's (1995) work Greenhalgh, Robert, MacFarlane, Bate, and Kyriakidou (2004) conducted an exhaustive literature review on the diffusion of innovations in service organisations from over 1,000 sources. These authors add five more key attributes that influence the adoption of innovation. These include fuzzy boundaries, risk, task issues, knowledge required to use the innovation and augmentation/support. Fuzzy boundaries refer to the interaction between the fundamental elements of the innovative practice and the organisational systems ('soft periphery') required for implementation. The **adaptability** of the organisational systems to the key elements of the innovative practice is important to successful implementation. When the amount of **risk** or uncertainty is balanced by the potential benefits for an organisation it is more likely evidence-based practice will be operationalised. If the new practice is **relevant**, feasible and user-friendly it is more likely to be adopted. If the knowledge required to perform the procedure is easy to **replicate** and transfer to different contexts it has a better chance of acceptance. Task

relevance and ease of replication are two concepts that are very similar to Roger's (1995) generalised concepts of relative advantage, compatibility and complexity. Relevance is part of understanding the need for the service to incorporate the innovation especially where a problem can be solved through implementation of the new initiative. Ease of replication is also linked closely to the ability of the innovation to aid adoption by reducing complexity. Finally, to be effective and to ensure uptake it is important for all new clinical practices to be accompanied by a variety of **training and support** options.

In their literature review of 1,054 sources of implementation research Fixsen et al. (2005) note that there are similar key implementation components that have a significant and generalised application across a broad range of service areas. This meta-study corroborates the findings of earlier studies, such as Davis and Taylor-Vaisy (1997), whose findings argue that using information dissemination and workforce training by itself seldom leads to implementation. Effective implementation requires a longer term multi-level approach. They suggest that, although hard to quantify, organisational factors and system influences play a major role in successful implementation.

There is a large body of information in the literature which identifies an extensive list of components that influence the adoption of innovative practices. Fixsen et al. (2005) suggest that studying the interaction of these components over time would help identify what combination of factors at each stage of the implementation process would aid successful adoption. Henderson, Davies, and Willet (2006) identified eight common themes to implementation using a thematic analysis of open ended evaluation questionnaires submitted by twelve implementation project officers in primary health settings. The study is based on the evaluation of 13 projects funded by the National Institute of Clinical Studies to increase the use of clinical evidence to improve patient care in Australian hospitals. Findings, although limited to the perspective of project leaders, were consistent with previous studies and identified leadership support, key stakeholder involvement, practice changes, communication, resources, staff education, outcome evaluation and consumer involvement as common focal points in the adoption of evidence-based practices.

Some researchers have concentrated on understanding the failure to adopt innovative practice across a generalised group of professionals. They tend to utilise psychological theories or attempt to understand practitioner and organisational attitudes. Aarons (2004) identified four distinct domains that influence the implementation of research-based

practices by mental health practitioners. He surveyed 322 mental health practitioners and 51 program managers from 51 public sector agencies providing mental health services to children, adolescents and their families in California. Aarons found that practitioners are more likely to comply with an organisational requirement to implement a new clinical practice if: it has intuitive appeal; there is openness to change; and the new practice is deemed to be necessary. Aarons' survey also compared the scores of interns with general staff; the level of practitioner education attainment and the professional discipline of practitioners. He concluded that interns were more likely than regular staff to be positive toward adopting new clinical practices as well as practitioners with higher levels of educational attainment. There was no difference in the attitude toward adoption of evidence-based practice between professional disciplines.

Michie, Johnston, Abraham, Lawton, Parker, and Walker (2005) convened a group of experts in psychology and health related fields from the United Kingdom to develop a comprehensive set of behaviour change domains that would influence healthcare professionals' acceptance and ability to implement evidence-based practice. They identified twelve domains as follows: knowledge; skills; identity; beliefs about capabilities; beliefs about consequences; motivations; memory and decision-making processes; environmental context; social influences; emotion; behaviour regulation; and the nature of behaviours. Michie et al. (2005) contend that the implementation of evidence-based practice depends on human behaviour and that any potential practice change can be enhanced by understanding the underlying psychological processes that are at play with individual and groups of professionals. They suggest that by using their twelve domains it is possible to identify and select behaviour change techniques to improve the adoption of innovation.

While Michie and his colleagues have assisted in expanding on an important component to the successful adoption of evidence-based practice, it is only one of a number of domains that require close attention for any successful implementation programme. By concentrating on the fine detail of individual psychological factors that inhibit change, organisations may create a complicated and unworkable approach that hinders the ability to provide a systemic approach to workplace change. This is particularly the case when considering factors that are not directly related to the psychological realm such as legal and resource issues. Some proponents of change over-estimate the importance of concentrating on the psychological aspects of clinicians as the most important domain, and in the process neglect other areas such as the quality of the organisation's leadership, resources and tools for implementation.

In Aarons' (2004) study he also interviewed the program managers about organisational characteristics such as culture, flexibility and policies. Practitioners working in less bureaucratic environments were more likely to be open to new practices and comply with organisational requirements. Practitioners working in organisations with policies that were clearly linked to the adoption of new practices scored more positively on attitudes toward implementing new practices. While it is clear from Aarons' study that worker attitude is important, it is only one factor in a complex amalgam of service provision.

While focusing on one area may yield more specific understanding on implementing innovation, generally the literature regards the implementation process as a "messy and complex task," where success is a function of evidence, context and facilitation (Kitson, Harvey, and McCormack, 1998). In their theoretical paper designed to stimulate debate, Kitson and colleagues define evidence as a combination of being derived from credible research, clinical experience with broad practitioner acceptance and patient acceptance or input. While credible research is required to support clinical effectiveness it must be accepted by practitioners and patients for successful implementation to occur. These authors define context as the organisational environment in which culture, leadership and administrative monitoring functions are combined. It is the combination of an organisation's strategy for promoting change and quality improvement, along with clear role responsibility and team work overlaid with systematic review processes that promote implementation. Lastly, facilitation is described as the type of support provided by external experts to assist people to change their attitudes, skills, and way of working. Kitson et al. (1998) distinguish the role of external facilitators as more far reaching than that of opinion leaders, while acknowledging the important contribution of the latter. For instance, Locock, Dopson, Chambers, and Gabbay (2001) have documented the positive influence an opinion leader may have in changing clinician behaviour. Opinion leaders work within organisations and benefit from the respect of the majority of their colleagues. They generally influence their peers through what Locock et al. (2001) identify as trying to explain the innovation, creating a favourable climate for change and adapting the innovation to suit the agency context. Often opinion leaders play a role in the initial endorsement of the evidence-based practice in a way that is acceptable to colleagues. However, facilitators work across professional and organisational boundaries with the aim of assisting the cohesiveness of the group charged with implementation.

Kitson et al. (1998) identified three variables in order for facilitators to effectively influence practitioners in the implementation process: facilitator characteristics, role and style. Personal characteristics of credibility and supportiveness enhance the process when combined with the clarity of the facilitator's role and a flexible style that is sensitive to a variety of interests.

Canadian health academics Davis and Taylor-Vaisey (1997) maintain that incentives and regulations are also important catalysts to influence individual practitioners and organisations to adopt evidence-based practice. These may include a mix of direct reward-based initiatives to more complex guidelines linked to funding and service agreements.

In summary, the adoption of innovative or evidence-based practice is based on the interaction of a number of key elements that operate within the domains of the individual practitioner, service user, organisation, wider system and perceived usefulness for clients. While there are a number of factors that play a key role in determining the successful adoption of evidence-based or innovative practices, no single study has accurately predicted the relative influence each factor plays in the implementation process or the significance one factor has over another. That is, if the style of leadership provided in an organisation is more influential in the adoption of evidence-based practices than the type of training and support offered to practitioners and organisations.

The literature reviewed in this report is predominantly from Europe, the United States of America and Australia. While a variety of work settings are analysed, such as mental health, education and counselling, the majority of studies into effective implementation of evidence-based practice are centred on health practitioners and medical services. Most of the papers reviewing the literature into the implementation of evidence-based practice narrowed their scope to publications in English. Despite the generalised assertions made in the literature about the universal applicability of core factors for successful implementation it is untested and unclear whether the factors identified in this report are bound by cultural and other contextual factors. It is beyond the scope of this report to comprehensively review the variability of culture and work place context within the literature on implementation of evidence-based practice.

What is clear from the literature is that organisational representatives charged with improving the use of evidence-based practice in a variety of clinical settings require knowledge about the factors that influence successful implementation as well as knowledge about the proposed evidence-based practice.

5 Method

The following section describes the process and various means that data were collected for this study.

Table 2: SSW implementation research timeline

Date	
November 05	The Bouverie Centre receives funding to investigate SSW implementation in Community Health Counselling Services.
February 06	The Bouverie Centre receives ethics approval.
March 06	The Bouverie Centre informs Community Health Service CEOs and invites their organisations to take part in the research (See Appendix A).
May 06	CHSs chosen for in-depth interviews. In-depth interviews are conducted with the first organisation.
July 06	Pre-SSW implementation questionnaires sent to consenting CHSs (See Appendix B). In-depth interviews are conducted with a second organisation.
October 06	In-depth interviews are conducted with a third organisation.
December 06	An in-depth interview is conducted with the senior manager of the third organisation.
January 07	In-depth interviews are conducted with a fourth organisation. An in-depth interview is conducted with representatives from two CHSs acknowledged by The Bouverie Centre for having established SSW implementation before 2005.
February 07	Post-SSW implementation questionnaires collected (See Appendix C).
May 07	Web survey for counsellors conducted (See Appendix F).
February 08	Telephone survey of all CHSs to determine the level of SSW implementation across the sector.
March 08	Interview with The Bouverie Centre SSW trainers.

Five types of data collection procedures were used for the research:

1. A pre and post SSW implementation questionnaire.
2. In-depth interviews with representatives from six CHSs.
3. A web survey for counsellors.
4. A telephone survey of all CHSs to determine the level of SSW implementation.
5. An interview with The Bouverie Centre SSW trainers.

5.1 A pre and post SSW implementation questionnaire (See Appendix B & C)

All 89 CHSs in Victoria, identified as receiving DHS funding to provide counselling services, were sent correspondence inviting them to participate in the collection and collation of counselling service data as part of a pre and post SSW implementation questionnaire. The researchers followed up initial letters explaining the research project, with telephone calls to every service inviting them to take part and requesting the name of an appropriate contact person. During the initial telephone contact the researchers confirmed the service had received SSW implementation parcels and repeated the explanation about the research project. The contact person from 48 organisations verbally agreed to participate in the study. The 48 organisations were sent written information outlining the scope of the study and written consent forms to be signed by the CEO (see Appendix D).

Of the 48 organisations that verbally agreed to participate 10 did not return a signed consent form despite numerous telephone and email reminders. Upon receipt of the signed consent form the designated contact person was sent a copy of the pre-questionnaire with a deadline of approximately three weeks. Respondents filling in the questionnaire were asked to collect and collate agency counselling data for the period prior to implementing SSW and where appropriate, six months afterwards to assess whether there was an appreciable difference in waiting list management and number of sessions attended after the introduction of SSW. The survey also required respondents to document what steps, if any, had been taken to implement single session work in their agency.

Thirty-one organisations completed pre-questionnaires after numerous reminders. Of the 31 organisations that completed the pre-questionnaire four decided against implementing SSW. Twenty-seven organisations stated that they had implemented SSW or planned to

implement SSW. These organisations were contacted approximately six months after completing the pre-questionnaire or sooner if they had implemented SSW for longer than six months. Seventeen organisations returned the post-questionnaire after repeated attempts to remind respondents by telephone and email.

5.2 In-depth interviews with representatives from six Community Health Services

Through a process of purposeful sampling seven community health counselling services were invited to participate in a series of semi-structured in-depth interviews about the experience of implementing SSW. Four organisations were chosen for a series of in-depth group interviews with staff, and managers, and individual interviews with the CEO or Senior Manager. Three further organisations were identified as having counselling services that had implemented SSW for three years or more. These organisations were invited to send a counselling team leader or manager to attend one group interview. Two of the three organisations sent a representative. Both agencies are recognised as leaders in the area of providing SSW as part of counselling services in Victoria. Information about the study was forwarded to the selected organisations and consent to participate was requested from each CEO; as required from the La Trobe University Human Ethics Committee (See Appendix D). Most interviews varied from 90 to 120 minutes in duration with one individual interview lasting 45 minutes. All interviews were digitally recorded, and partially transcribed by the researcher, with emphasis in partial transcription placed on any information provided by participants that could shed light on implementation of SSW (12 interviews were fully transcribed). All identifying information was removed from transcribed, in-depth interview data prior to being reviewed by other members of the research team. Each interview was analysed prior to the next interview, with the analysis informing the content of questions asked in subsequent interviews. Relevant parts of verbatim transcripts were inductively, thematically coded and the possible meanings and theoretical and practice implications of selected data were discussed by research team members, with findings reported below.

Four CHSs were selected to provide the widest range of service types based on one or more of the following criteria:

- Based in rural or regional Victoria.
- Based in metropolitan Melbourne.
- Fully implemented SSW.
- Difficulty implementing or not implementing SSW.

Three further CHSs were selected to participate in one joint interview based on the following criteria:

- Implementation of SSW had taken place before the current DHS initiative.
- Advanced practice in SSW implementation.

Organisational profiles

Services involved in a series of in-depth interviews:

Service 1:

An organisation with less than 150 staff located in the metropolitan fringe of Melbourne. This organisation was chosen based on a reputation of having successfully implemented SSW. This centre has multiple sites and dedicated intake workers. Counselling staff are not part of a recognised counselling team.

The interviews were conducted in the following order:

- An interview with the recognised Senior Clinician, within counselling services, who took primary responsibility for leading the implementation process.
- An interview with the CEO.
- A group interview with seven members of staff including representatives from intake, counselling and nursing⁷.

Service 2:

A large organisation located in Victoria. This organisation approached the researchers to be involved with the study because they had not previously implemented SSW and were interested to investigate the possibilities of introducing SSW in the future. As a result of participating in this study Service 2 decided to trial SSW implementation. The counselling staff are located at multiple sites and do not have a centralised service or dedicated intake staff. Counselling staff are not part of a recognised counselling team. The in-depth interviews were conducted prior to a trial of SSW and attempted changes to service delivery.

⁷ Workers who participated in the interview are referred to as counsellors in the discussion section due to the use of SSW as a multi-disciplinary counselling modality.

The interviews were conducted in the following order:

- A group interview with five members of staff representing counselling.
- A group interview with six managers.

After the initial interviews this organisation decided to trial the implementation of SSW and after a review process decided that SSW could be used at the discretion of individual counsellors. To date the majority of counsellors do not use SSW although substantial changes are being undertaken in service delivery.

Service 3:

An organisation with a large counselling team working in multiple sites located in Melbourne. This region is characterised by a diverse client group situated over multiple local government areas. There was a broad range of counsellor opinion to SSW and SSW implementation. Counsellors are part of site based teams.

The interviews were conducted in the following order:

- A group interview with four managers.
- A group interview with six members of staff representing intake and counselling.
- An interview with the Senior Manager.

Service 4:

A small organisation with fewer than 100 employees located in Victoria. SSW has been fully implemented by the staff with some variability in confidence toward using the approach.

The interviews were conducted in the following order:

- An interview with the CEO.
- An interview with the Manager.
- A group interview with two members of the counselling team.

Services advanced in SSW implementation⁸:

Counselling co-ordinators from three organisations identified as advanced in SSW implementation were invited to participate in a group interview. A representative from one service was unable to attend.

Service 5:

An organisation located in outer metropolitan Melbourne with multiple sites that had implemented SSW for more than four years. Counselling staff form part of an identified team and operate across several sites.

Service 6:

A large organisation with more than 200 staff located in metropolitan Melbourne. Counselling staff are part of site-based multi-disciplinary teams. SSW had been implemented as part of counselling services for more than three years.

5.3 A web survey for counsellors (see Appendix F)

A 98 item survey was specifically constructed for the purpose of this study. The survey was designed as a web-based survey to maximise the reach to counsellors across Victoria and increase research efficiencies with a time limit for the survey and the collation of data. The purpose of the survey was to augment data collected through the other research procedures and to specifically:

- Investigate how and if counsellors were implementing SSW in their work place.
- Canvass individual counsellor attitudes toward SSW.
- Understand individual counsellors' perceptions that may have enhanced or impeded the implementation of SSW work in their organisation.
- Understand the perceived impact of SSW implementation on individual counsellors and their workplace.

⁸ Due to the limitations of this study Services 5 & 6 were invited to participate in one joint interview. These services implemented SSW several years before the current training and implementation project. Emphasis on the analysis of interview data has been concentrated on the four services that participated in the current implementation and training project.

Items for the survey were formulated through reference to the interim thematic data collected from the in-depth interviews, factors identified in the literature on implementation, principles gleaned from the literature on SSW and the Burnout Scale from Hudnall Stamm's Professional Quality of Life Scale (2005). A hard-copy version of the survey was trialled with six counsellors who had experience with SSW, counselling and a community health background. As a result of the trial, modifications to some of the wording of the survey were made. An IT consultant was employed to convert the survey to a web-based format and several trials were conducted with ten participants. As a result of the on-line trial a 'Frequently Asked Questions' (FAQ) document was created (see Appendix E).

On May 3rd, 2007 participation of the web survey was actively solicited via email correspondence and telephone contact with counselling team leaders and managers. Managers of counselling services were notified via email about the survey and asked permission to allow their staff to complete the survey. They were also encouraged to forward an advertising flyer and FAQ document to members of their counselling team. The web questionnaire was advertised as active from May 7th to June 8th, 2007. A reminder that the survey would close was sent three weeks prior to the intended closure. On June 8th the researchers made the decision to extend the survey period due to an inadequate response rate. A concerted recruitment campaign was conducted including email reminders to all counselling managers and to participants who had previously completed SSW training. The survey was closed on 29th June, 2007 after an acceptable number of responses had been obtained and no further responses were logged after a number of days.

Counsellors from organisations that had participated in the in-depth interviews were asked to complete a paper-based version of the web survey that would identify their organisation. Managers of counselling services were sent coded copies of the survey and were asked to forward these to staff and allow them the time to complete the survey. The researchers requested that managers remind staff to complete and return the survey before the closure date.

5.4 A telephone survey of all Community Health Services to determine the level of SSW implementation

From January 2008 until April 2008, 89 CHSs identified in 2005-06 by DHS as receiving funding to provide Community Health Counselling were contacted and asked whether: they had implemented SSW, if counselling staff used elements of SSW or if they did not use SSW in the service. The researchers contacted the manager, team leader or a designated contact person in community health counselling services and asked them to specify whether the counselling service had either:

1. Formally implemented SSW – the service.
2. Informally implemented SSW – individual counsellors use SSW or the principles of SSW identified in the training to conduct SSW at his or her own clinical discretion.
3. Not implemented SSW – the service has decided not to encourage the implementation of SSW. The reasons were not explored.
4. Was not applicable to the service – these services do not currently provide counselling services.

5.5 Interview with The Bouverie Centre SSW trainers

In March 2008 the principal researcher (Shane Weir) conducted an interview with Jeff Young and Pam Rycroft, two of the main trainers and workers involved in the SSW project funded by DHS. The primary aim of the interview was to understand their strategy and experience of delivering SSW training and implementation advice to the community health sector.

6. Findings

6.1 The pre and post SSW implementation questionnaire

Seventeen CHSs completed and returned the pre and post implementation questionnaire. The majority of counsellors from all seventeen CHSs had completed The Bouverie Centre SSW training. Twelve organisations had decided to implement SSW as an organisation while five agencies encouraged SSW at the individual discretion of counsellors.

Waiting list reduction

Eight organisations reported a significant reduction in waiting times for clients after the introduction of SSW and four organisations reported a slight reduction in waiting times. Two organisations reported difficulty in providing reliable information due to problems in implementing SSW or other work-based factors. The information provided by three organisations was unclear or did not correspond to the questions provided. Reported reductions in client waiting times due to SSW implementation ranged from one week to 47 weeks.

Number of sessions

Scant information was provided on the difference in average and modal number of sessions per client, as well as the number of sessions conducted over 12 sessions per client. Commonly, information was not provided or reported as an estimate based on anecdotal information. Three services provided comprehensive data that confirmed an overall reduction in the average number of sessions and a reduction in the number of sessions conducted for clients above 12 sessions. Most organisations reported no change to the modal number of sessions conducted with the most common figure reported being 1 or 2. The modal number of sessions per client is consistent with the DHS data and the international research into SSW.

Untrustworthy data

A large proportion of the data provided was confusing. The majority of respondents commented about the anecdotal nature of the data provided or that the current organisational data collection systems did not routinely collect the information required for the questionnaire. Several agencies commented about the inaccurate quality of the information that they provided.

Useful aspects of participating in the questionnaire for some organisations

When followed up through the telephone survey the 17 organisations that completed the questionnaire continue to provide SSW in some form. Some of these organisations conducted comprehensive surveys and audits of their counselling services. Significant time and resources were employed by these organisations to investigate their current counselling processes. This effort in itself potentially provided a useful impetus for team leaders to engage counsellors about increasing the effectiveness of counselling services.

6.2 The web survey for counsellors

One hundred and sixteen counsellors of 310 counsellors involved in the provision of counselling in community health centres across Victoria completed the survey. Proportionally, the respondents represent approximately 37% of the current workforce. Seventy-three respondents indicated that their agency had a waiting list for casework/counselling. One hundred and one respondents reported they had implemented at least some principles and practice of SSW in their work with clients while 15 counsellors had not applied any SSW principles and practices at all.

6.2.1 Demographic characteristics of the 116 people who responded to the survey

98 respondents were female; 15 were male and 3 did not respond to this question.

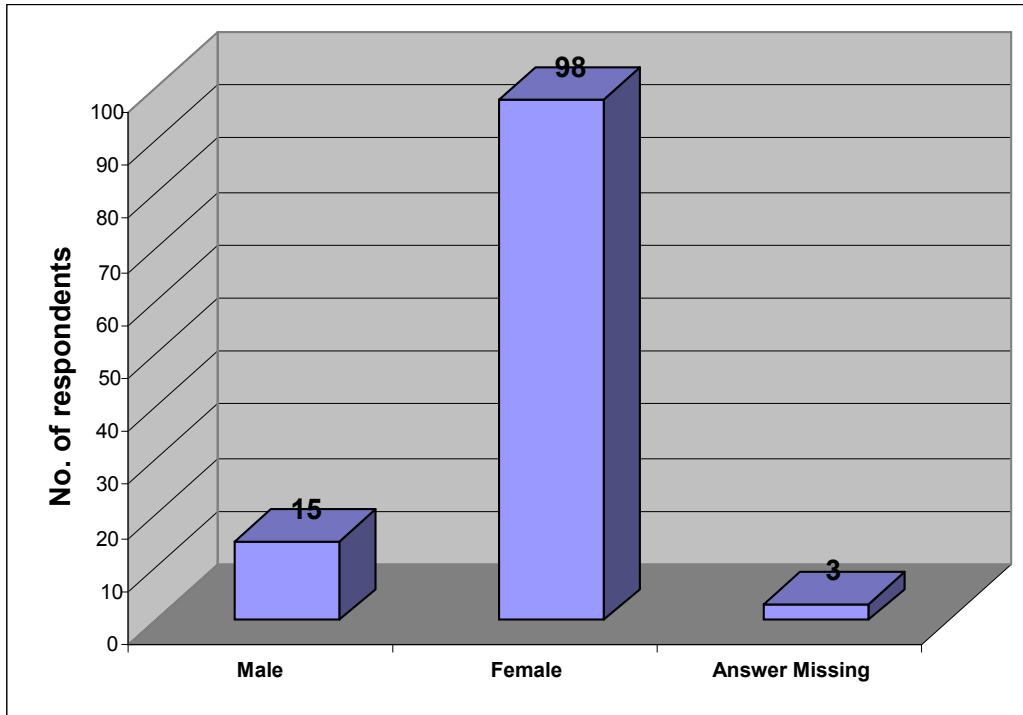


Figure 2: Gender of respondents

Half practised in a rural/regional Victoria – the other half in a metropolitan region.

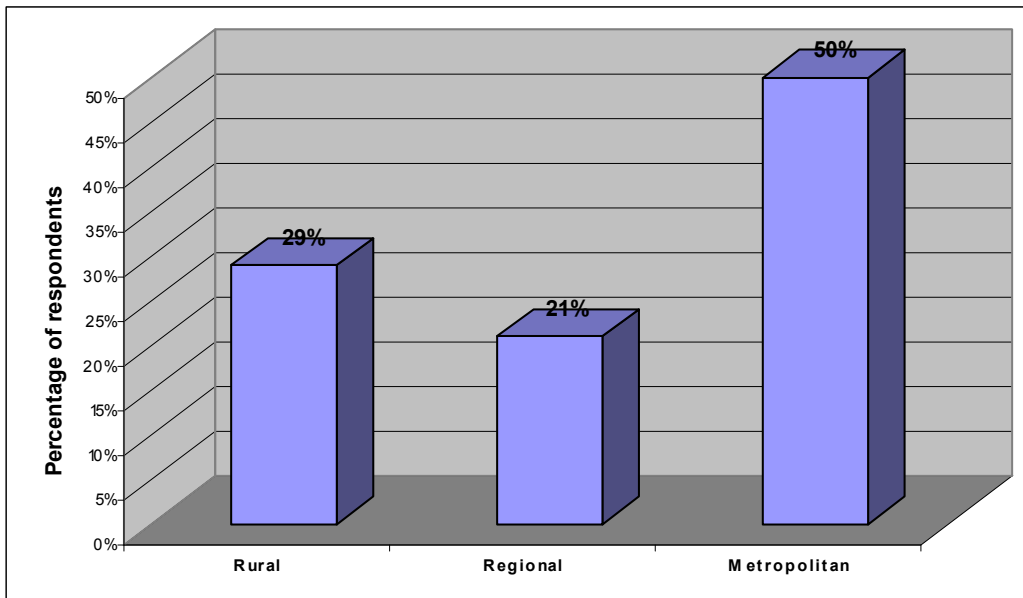


Figure 3: Respondents practising in rural, regional & metropolitan Victoria

Respondents' years of community health counselling experience ranged from less than 6 months to over 20 years, with the majority reporting between 3-10 yrs of experience equating to 66.4%.

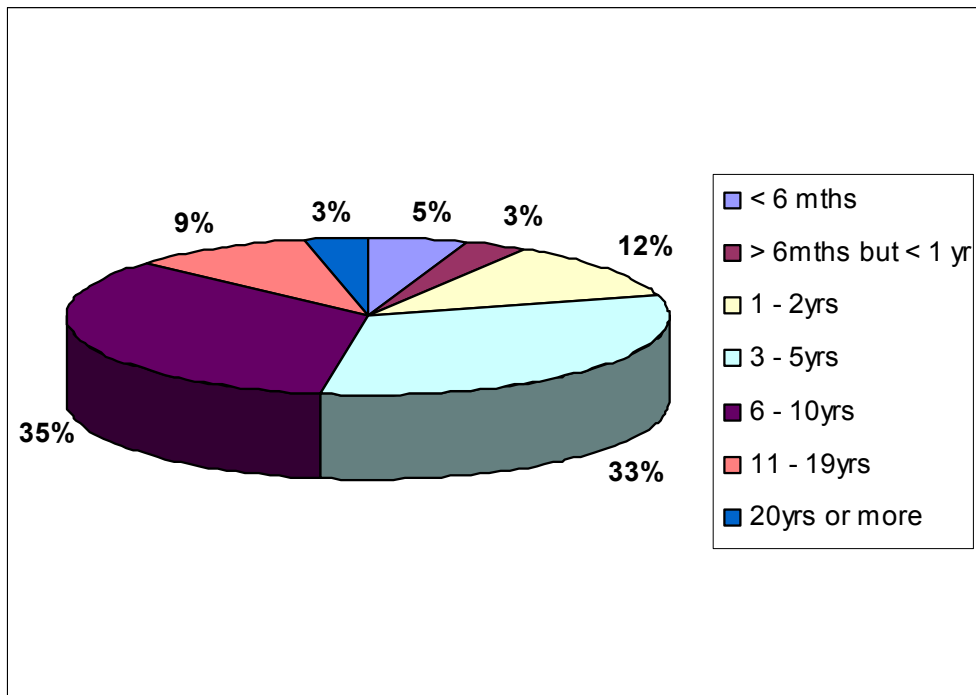


Figure 4: Years of experience in CHS counselling

Ninety-eight respondents had undertaken pre-service or in-service SSW training – 91 of the 98 at The Bouverie Centre.

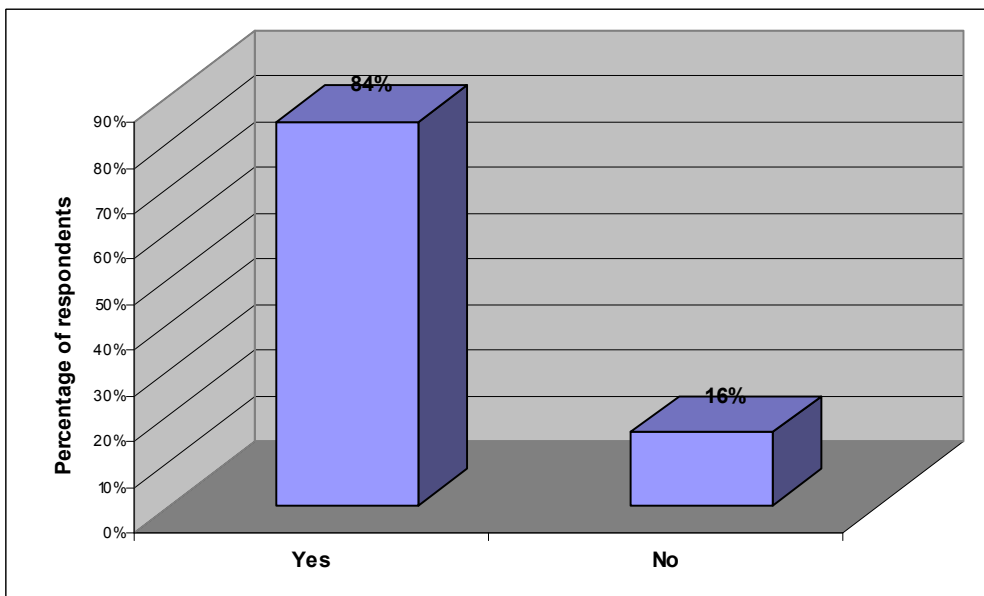


Figure 5: Respondents who had undertaken SSW training

Ninety respondents had viewed the SSW implementation parcel.

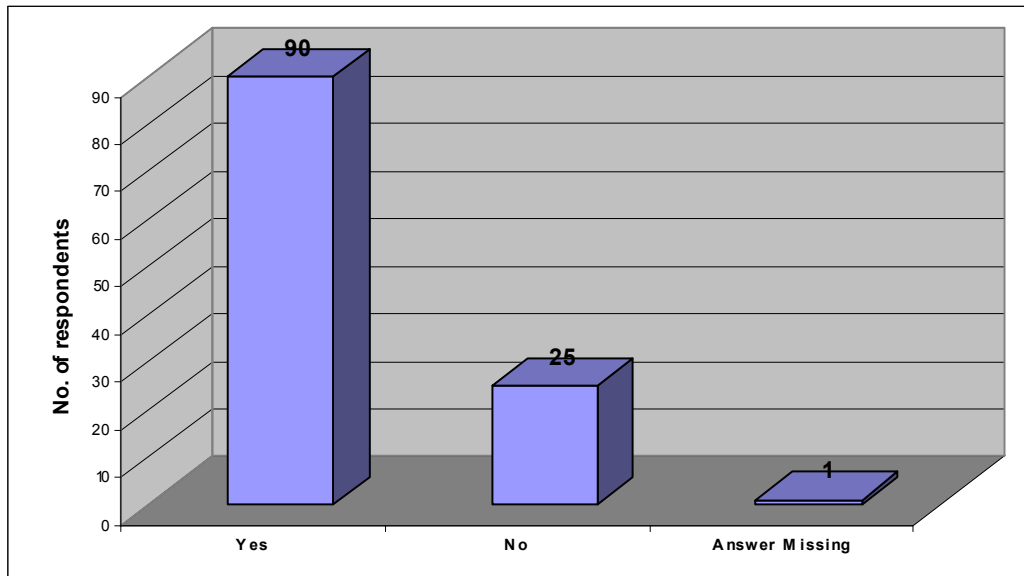


Figure 6: Respondents who had looked at the implementation parcel

Fifty-five respondents indicated SSW had been applied as an organisation wide approach to service delivery in their agency while 53 described application of the practice of SSW as at the discretion of individual counsellors.

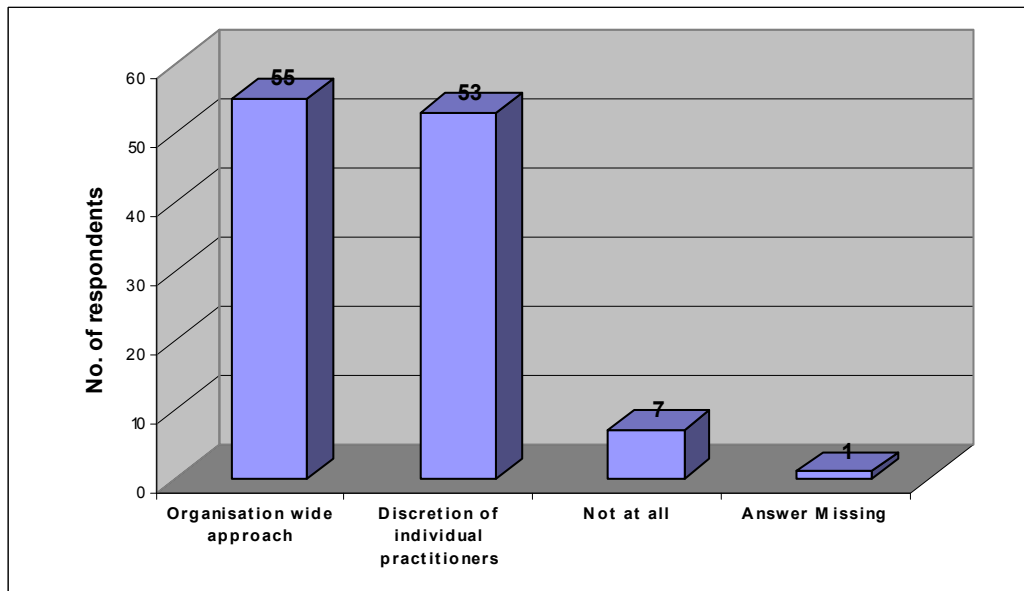


Figure 7: Application of SSW in respondents' workplaces

6.2.2 Counsellor attitudes and practices that are compatible with SSW⁹

"Implementation rests in the hands of staff providing services. Therefore, innovations that fit with intended adopters' values, norms and perceived needs are more readily taken up. Compatibility with organisational or professional norms, values and ways of working is an additional determinant of successful assimilation."
(Greenhalgh, et al., 2004 p.596)

The statements included in this section of the web survey were concepts taught in the SSW training. Core principles to the approach include:

- providing clear information about the process to clients,
- planning the session according to the time available,
- viewing each session as complete in itself,
- clarifying goals with the client,
- prioritising issues with the client,
- 'checking in' with the client to make sure the conversation is 'on track',
- making use of reciprocal feedback and directness with clients,
- trusting that the client is the main architect of change,
- being transparent with the client about what the counsellor may be thinking,
- the counsellor's use of expertise rather than being the expert.

The majority of counsellors supported a client-centred, strength-based approach that was needs based and goal focused. They valued reciprocity in giving and receiving feedback between clients and counsellors. These counsellors also acknowledged that counselling was only a small part of their clients' lives. They also reported reasonable compatibility between their own values and a SSW approach. The majority of survey responses suggest that counsellors share similar beliefs, for example, about the role of the counsellor and the client in the process of client change in particular: "...the power is in the client; therapy is about helping clients to help themselves and about respecting clients' assessments of their own needs." While these values are not the sole domain of SSW they represent some of the core principles underlying the approach.

⁹ Statements reported on in sections 7.2.2 to 7.2.7 were rated by respondents on a 1 (strongly disagree/not at all) to 5 (strongly agree/to a large extent) scale. Those ranking a statement ≥ 4 were considered to be endorsing its content.

Client-centred, strength-based approach

A majority of respondents (over 80%), concurred with the statement that: Clients are experts in reporting what kind of and how much change is important for them at any particular time. Many of those who had implemented SSW principles and practices in their work indicated that they were more likely than not to:

- Always ask and explore what a client wants from each session. (77%)
- Shift their agenda to meet a client's concerns. (67%)
- Be more overt and collaborative with clients when deciding how much therapeutic contact is required. (73%)
- Not only focus on a client's problems, but acknowledge a client's strengths and abilities to cope. (78%)
- Create opportunities for clients to try things themselves before assuming they need ongoing professional help. (66%)

Factors outside formal counselling have a significant effect on client change

There was strong support for the notion that; life, not therapy, is the great teacher.

- 84% agreed that: The process of change starts before the first session and will continue long after counselling ends.

Client prioritised and goal focused

Many of those indicating that they had implemented SSW principles and practices reported they were trying to make the most of each therapeutic encounter, by:

- Having a greater sense of urgency to clarify what needs to be achieved during each contact. (63%)
- Checking in from time to time during every session to track whether their work is on target. (67%)

Reciprocity in openness and feedback

Almost two-thirds of those who claimed to have applied SSW principles and practices in their work stated that they encourage feedback about the quality of service received from their clients and moreover, used this input to shape their work. The majority of respondents agreed with the following statements.

- I always obtain feedback from clients about the service they have received. (62%)
- I always elicit what clients will take away from the therapeutic contact. (60%)
- I incorporate direct client feedback in my work. (64%)

Many of those indicating that they had implemented SSW principles and practices also value openness with clients. Sixty-nine per cent of respondents agreed that SSW had influenced them to be more direct and honest with clients.

Compatibility with counsellor, client and organisation values or need

There was a general consensus about the compatibility of SSW with individual values and organisational and professional norms, as well as the broader service system.

- 71% of people rated their individual theoretical orientation or values relating to service provision as **not** at odds with the SSW approach.
- 63% of respondents agreed with the statement that: SSW fits well with the core values of my organisation.
- 80% rated SSW as: Compatible with a social model of health, providing counselling which is driven by and empowering to clients.

The results further suggest that few respondents perceived SSW as incompatible with service users' needs. The majority of respondents **disagreed** with the following statements:

- SSW reflects the interests of administrators rather than representing the key needs and concerns of clients. (60%)
- SSW is not useful in my agency due to client demographic and/or presentation. (79%)
- SSW is unnecessary in my agency due to lack of demand. (78%)

6.2.3 Other factors that may influence SSW implementation

"Research has repeatedly shown that staff members who have high levels of emotional exhaustion and depersonalisation are less likely to be aware of or implement innovative approaches to human services. Moreover, they are less interested in learning new treatment approaches."

(Corrigan, Leigh, McCracken, Blaser, and Barr, 2001, p.1,600)

Despite the compatibility of SSW with organisational values (as reported above), counsellors who implemented SSW seemed to obtain greater support from their immediate supervisor rather than through well structured organisational processes and guidelines. Even though most counsellors did not think change was managed well in their organisation they were open to attempting new initiatives, such as SSW.

Counsellor stress not a factor

The web survey findings seem to suggest that most counsellors who responded to the survey were not experiencing burnout. The majority of counsellors ***disagreed*** with the following statements:

- Because of my work as a helper, I feel exhausted. (60%)
- I feel overwhelmed by the amount of work or the size of the case/workload I have to deal with. (59%)
- I feel "bogged down" by the system. (62%)

Nonetheless, approximately 40% rated themselves as moderately to significantly overwhelmed, yet had still implemented SSW principles and practice in their work.

Organisational support often lacking

Different organisations possess a diverse range of internal characteristics and are impacted by external influences that will affect the adoption of innovative practices. Often the decision by individual practitioners to implement innovation is dependent on decisions made by others and the type of support provided by their organisation (Greenhalgh et al., 2004). Rogers (1995) and Fixsen et al. (2005) note the importance of communication within services, a clear rationale for the proposed change to service delivery, the influence of practitioner leaders, and the provision of various support mechanisms including professional development and guidelines.

Fewer than half of survey respondents indicating that they had implemented SSW did so with the explicit support of their respective agencies.

- There are written guidelines and/or policy documents outlining this organisation's commitment to SSW and expectation of staff. (32%)
- A key staff member/task force was appointed with the responsibility to oversee/champion the implementation of SSW in our agency. (48%)
- This organisation provides some form of supervision/professional development about the SSW process. (53%)
- An evaluation process has been established in my workplace to gain feedback from clients about the SSW process. (45%)

Supportive supervisors

Hart and Cooper (2001) contend that where leaders display supportive behaviours and exhibit a respectful interpersonal style, practitioners are more likely to make an extra effort to implement new practices. There was evidence to suggest that supportive leadership from immediate supervisors was a common experience of survey respondents, with the majority of respondents agreeing with the following statements:

- My immediate supervisor is supportive towards me. (86%)
- My immediate supervisor communicates well with employees. (73%)

Practitioner inclusion in the decision making and operational processes of implementation is seen as an indicator for successful adoption in Greenhalgh et al. (2004). The results show that the majority of counsellors had some role to play in the SSW implementation process with 67% agreeing to the statement below.

- Counsellors were involved in deciding how SSW ideas were applied and implemented in this agency.

A climate of cooperation and counsellors willing to attempt new initiatives

Generally, the survey indicated that there were no major impediments to implementation posed by a negatively perceived workplace culture.

Hart (1999) also highlighted the influence that a 'positive organisational climate' can have on individual practitioner performance. The majority of respondents ***disagreed*** with the following statement:

- There is a lack of cooperation and collaboration between staff in this organisation. (66%)

Similarly, only 19% of respondents ***agreed*** with the statement below:

- There is a negative emotional tone in this workplace.

While many survey respondents indicated change management processes in their workplace were not optimal, 37% of people ***agreed*** with the following statement:

- Change is managed well in my workplace.

The majority perceived their colleagues as not averse to trying new things and ***disagreed*** with the statement below:

- Staff members in my organisation are unwilling to try new things. (71%)

6.2.4 Service impact

"Even when some value incongruence exists, implementation theory suggests that positive experiences with an innovation, defined as improved organisational performance, can reduce the span of value gaps and change organisational values to be consistent with those of the innovation or program...."

(Miller & Shinn, 2005, p.173)

There was moderate support from counsellors to a range of improvements that SSW made to service provision, particularly with regard to seeing clients sooner. Respondents highlighted some problems associated with the introduction of SSW including a lack of resources dedicated to SSW introduction, staff turnover, some tension created between management and counsellors, and disagreement between counsellors about some counselling practices. Conversely, counsellors also indicated that the implementation of SSW led to a sense of team building, a positive example of change within the service, and an evaluation system that highlighted the value of this for clients.

Improvement in some aspects of service delivery

SSW was rated by respondents as modestly contributing to:

- A higher quality of service provision in this agency. (44%)
- High client satisfaction. (39%)
- Providing a productive service to clients who attend only irregularly. (59%)

There was moderate support for the timeliness of the approach, with respondents indicating that the introduction of SSW had:

- Allowed clients to meet with a counsellor at the initial time of their concern and/or crisis. (66%)
- Assisted 'at risk' clients still required to wait for ongoing counselling to develop protective behaviours in the interim. (45%)

Some implementation problems encountered by counsellors

Around 40-60% of those who reported implementing SSW principles & practices in their work agreed that there were drawbacks in the SSW approach including those listed below. When applying a SSW approach the following respondents **agreed** with the statement listed.

- Heightened counsellor stress because SSW requires intensive output and the development of a new way of working. (51%)
- Increased pressure on counsellors to provide one brilliant session. (59%)
- Led to disagreement about counselling practices and conflict in staff relations. (65%)
- Led to tension between management and counselling staff. (65%)
- The paperwork and other documentation required for SSW takes time away from the more pressing needs of my service and its clients. (45%)
- Required counsellors to be more resourceful and flexible in utilising whatever is likely to be helpful to particular client(s) at the particular time. (52%)

Only a moderate number of respondents **agreed** that SSW allows more time to spend with clients who require longer term treatments.

- Freed up my time for work with longer term clients. (44%)

Other factors that hindered and helped implementation

Respondents were asked to list any other factors they could think of which may have helped or hindered SSW being incorporated as part of clinical service delivery at their workplace.

Themes developed from the participants' open ended responses are as follows:

Hindered:

- Lack of time and resources dedicated to training and implementation (e.g., "No training or time being allocated to individual counsellors to set up SSW or slight modification"; "time to get SSW up and running in organisation"; "busy caseload as a sole rural counsellor, insufficient time to reflect, study, review practice"; "lack of staffing").
- Low demand for counselling services (e.g., "hindered - not a high waiting period for clients in my service").
- Staff turnover and organisational restructure (e.g., "New staff appointed after old staff had done the training and some had left. Big changes in the organisation meant that focus was elsewhere"; "at the time of implementing single session the counselling team was restructured"; "org. going through lots of change").

Helped:

- Management support, advocacy of implementation process (e.g., “An active leader to implement SSW into the processes of service has helped SSW succeed in our CHS”).
- Opportunities for co work.
- Useful evaluation / feedback structures (e.g., “workers have seen benefits for clients”; “having a system of tracking and evaluating client pathways from the outset of SSW”).

6.2.5 Respondents who *had* implemented SSW (n=101) vs. those who *had not* (n=15)

It is difficult to draw significant conclusions when comparing respondents who implemented SSW with those who did not implement SSW. The sample size of the non-implementers is very small and comprised only 13% of overall survey respondents. Statistically significant differences¹⁰ were found between the samples in the areas of training completion, individual and organisational values compatibility, and organisational support mechanisms.

Respondents who did not implement SSW also indicated that training was not offered to them, staff turnover impeded implementation, their professional orientation did not fit with SSW, and client presentations were not appropriate for an SSW approach.

Training completion

Results from a Chi square test suggests that those counsellors who participated in SSW training were more likely to implement SSW practices and principles than those counsellors who had not attended training.

- Ninety-one (90.1%) of the 101 counsellors ***who had*** implemented SSW principles and practices in their work had undertaken SSW training.
- Seven (46.7%) of the 15 counsellors ***who had not*** implemented SSW principles and practices in their work had also completed SSW training.

Training in SSW was found to be a statistically significant factor in influencing counsellor implementation of SSW principles and practices. Although due to the small sample size of non-implementers the significance of this finding is potentially unreliable. Although training in SSW did play an important part in the implementation process it is clear that other factors also contributed to implementation of SSW, as indicated in the implementation literature.

¹⁰ Statistical Package for the Social Sciences (SPSS) was used to support this analysis, and an alpha level of .05 was used for all significance testing.

Values compatibility and organisational supports

There were statistically significant differences in the mean scores between counsellors who had implemented SSW compared to those who had not implemented SSW with regard to their values, and perceptions of organisational support. A series of t-tests revealed those who had implemented SSW were more likely to agree with the following statements in comparison to those counsellors who had not implemented SSW.

- SSW is compatible with a social model of health, providing counselling which is driven by and empowering to clients.
- There are written guidelines and/or policy documents outlining this organisation's commitment to SSW and expectation of staff.
- Caseloads between SSW and ongoing work are balanced in my workplace.
- This organisation provides some form of supervision/professional development about the SSW process.
- SSW fits well with the core values of my organisation.

Impediments for non-implementers

Other differences that almost reached statistical significance where **SSW implementers** more likely to **disagree** with the following statements:

- SSW is not useful in my agency due to client demographic and/or presentation.
- SSW training was not offered to me either internally or externally.

Respondents who **had not** implemented SSW were asked to list three main factors that had contributed to their not taking up SSW. Themes developed from the participants' open-ended responses are as follows:

- Training (lack of access to training; insufficient time/money to invest in training).
- Professional preference (e.g., "Prefer to work with clients without constraint"; "doesn't sit well with my theoretical orientations").
- Working with clients or clinical presentations that counsellors believe are not suitable for SSW (e.g., "Clients with complex personalities, particularly affect regulation and attachment, have not tolerated the process well; "Work primarily with children & families...engagement with kids requires time"; "Clients' survey told us they don't want SSW").
- Staff turnover.

6.2.6 A comparison between SSW as an organisation wide approach to service delivery and implementation at the discretion of individual counsellors

There were statistically significant differences between some of the responses from counsellors involved in the organisational implementation of SSW compared to counsellors who chose to implement SSW on an individual basis. A series of ANOVAS¹¹ was used to compare counsellors applying SSW as part of an organisational wide approach with those applying SSW at their individual discretion.

General value and benefit of the approach

It was more likely for counsellors who experienced organisational implementation of SSW to agree with the compatibility of the core values of the approach and the organisation and to accept it as an effective way of reducing waiting lists. They also were more likely to strongly agree that SSW provided an opportunity to respond promptly to clients.

Attitude toward change and cooperation

There was also a significant difference between organisational and individual implementers about staff attitudes to change and cooperation. Organisational implementers were much more likely to agree that there was a willingness by their colleagues to try new things and that there was adequate cooperation between colleagues.

Organisational support for SSW

Predictably, counsellors were more likely to enjoy structures to assist with the administration, evaluation and support of SSW in organisations that decided to implement SSW.

¹¹ A statistical technique which compares the variability of responses within each group to the differences between groups.

Table 3: Significant differences between organisation application and individual counsellor application of SSW

The aforementioned statements were rated by respondents on a 1 (strongly disagree/not at all) to 5 (strongly agree/to a large extent) scale. <i>Only the survey items where we observed statistically significant differences in the means of the two groups are reported below.</i>		Applied as organisation wide approach to service delivery (n=55)	Applied at discretion of individual counsellors (n=53)
Questionnaire Item	Significance = $p < .05$	Mean	Mean
<i>General value and benefit of the approach</i>			
25. SSW fits well with the core values of my organisation.		4.02	3.48
2. Reduced waiting list?		3.55	2.96
4. Allowed clients to meet with a counsellor at the initial time of their concern and/or crisis?		4.00	3.44
<i>Attitude toward change and cooperation</i>			
21. Staff members in my organisation are unwilling to try new things.		1.87	2.34
8. There is a lack of cooperation and collaboration between staff in this organisation.		1.96	2.64
20. Had a positive effect on staff morale?		3.24	2.54
<i>Organisational support for SSW</i>			
4. An evaluation process has been established in my workplace to gain feedback from clients about the SSW process.		3.83	2.23
6. There are written guidelines and/or policy documents outlining this organisation's commitment to SSW and expectation of staff.		3.44	1.87
9. Extra administration time was provided in my agency to assist counsellors to become more familiar with SSW processes.		3.13	2.19
11. A key staff member/task force was appointed with the responsibility to oversee/champion the implementation of SSW in our agency.		3.62	2.40
16. Caseloads between SSW and ongoing work are balanced in my workplace.		3.71	3.12
20. This organisation provides some form of supervision/professional development about the SSW process.		3.78	2.83
22. An effective evaluation process has been established in my workplace to gain feedback from counsellors about the SSW process.		3.27	2.26

6.2.7 Comparisons between the four principal organisations that participated in the in-depth interviews

The Web Survey (paper version) highlighted some significant differences between the organisations that took part in the in-depth interviews. A series of ANOVAS was used to compare each of the case study organisations. Only items where there were statistically significant differences in the means between two or more groups are reported below.

General benefit of the approach or influence on practice

Service 2 (non-implementing organisation) varied significantly with Service 4 regarding the importance of managing 'at risk' clients on the waiting list. This was due to concerns of staff from Service 4 to manage potentially 'at risk' clients on the waiting list, while counsellors from Service 2 were not consistently required to keep client waiting lists (See section 7).

Interestingly, the clinical practices of Service 3 staff featured as, on average, being influenced by SSW consistently lower than Service 2. This is understandable considering some Service 3 counsellors were sceptical about the benefit of SSW. For example, this was clearly evidenced by Service 3 counsellors giving a significantly less favourable response to; 'Even a brief encounter can be therapeutic' as compared to counsellors from Service 2.

While there may be large variability in counsellors within an organisation finding SSW appealing this is not a barrier in itself to organisational implementation.

Organisational compatibility and effective processes

Service 1 stands out as an organisation that clearly articulated its values to staff and evaluated the process effectively (See section 7). Part of what may have contributed to some counsellors from Service 3 having an unfavourable attitude to SSW was their perception of an inadequate consultation process involving them in SSW implementation as evidenced in question 22 below.

Organisational climate affecting implementation

The culture experienced by counsellors in Service 1 as compared to Service 2 was clearly judged by the survey respondents as more conducive to a co-operative and beneficial organisational environment for counsellors. Counsellors that are supported and stimulated in their work roles without feeling under too much pressure are more likely to co-operate with SSW implementation.

The significant comparisons between Services 3 and 1 potentially reflect a number of variables that are difficult to isolate such as Service 3 possessing a larger and more complex organisational structure and larger staff complement where there is likely to be more variability in attitude.

Table 4: Significant differences between the four principal organisations that participated in the in-depth interviews

The aforementioned statements were rated by respondents on a 1 (strongly disagree/not at all) to 5 (strongly agree/to a large extent) scale. Questionnaire Item from Web Survey Significance = $p < .05$	Service 3 (n=7)	Service 1 (n=6)	Service 4 (n=2)	Service 2 (n=5)	Which groups significantly differed from one another
<i>General benefit of the approach or influence on practice</i>					
1. Even a brief encounter can be therapeutic	3.57	4.50	5.00	4.80	S3 & S2
2. Not only focus on a client's problems, but acknowledge a client's strengths and abilities to cope	3.14	4.83	3.50	4.25	S3 & S1
3. Be more direct and honest with clients?	2.43	4.33	4.00	3.75	S3 & S1
8. Combine services for a client in one session, such as assessment functions with therapeutic intervention?	3.00	4.67	4.50	4.25	S3 & S1
9. Assisted 'at risk' clients still required to wait for ongoing counselling to develop protective behaviours in the interim?	3.00	4.00	5.00	1.67	S4 & S2
13. Incorporate direct client feedback in my work?	2.29	4.67	4.50	3.50	S3 & S1
12. Be more active or structured in client follow-up?	2.71	4.67	3.50	3.50	S3 & S1
9. Shift my agenda to meet a client's concerns?	2.67	4.5	5.00	3.25	S3 & S1
5. Always obtain feedback from clients about the service they have received?	2.86	4.67	5.00	3.75	S3 & S1
2. Workers in this organisation are sceptical of SSW	3.33	1.17	1.50	2.80	S3 & S1

Organisational compatibility and effective processes						
25.	SSW fits well with the core values of my organisation.	3.29	4.83	5.00	2.80	S3 & S1; S1 & S2; S4 & S2
14.	Contributed to a higher quality of service provision in this agency?	3.14	4.83	3.50	2.67	S3 & S1; S1 & S2
22.	An effective evaluation process has been established in my workplace to gain feedback from workers about the SSW process	1.86	4.33	4.00	2.60	S3 & S1
Organisational climate affecting implementation						
8.	There is a lack of cooperation and collaboration between staff in this organisation.	2.29	1.33	2.50	3.80	S1 & S2
23.	There is a negative emotional tone in this workplace.	1.43	0.67	1.00	3.00	S1 & S2
24.	I feel "bogged down" by the system	1.86	1.67	2.00	3.80	S1 & S2
20.	Had a positive effect on staff morale?	2.57	4.33	3.00	2.00	S1 & S2

6.3 Telephone survey to determine level of implementation across the sector

A telephone and email survey was conducted to determine how many counsellors utilise SSW principles in their work and how many organisations have formally implemented SSW. Eighty-nine CHSs that were identified in 2005-06 by DHS as receiving funding to provide Community Health Counselling were contacted for the purpose of the survey from information provided by DHS. Forty-eight out of the 64 CHSs (75%) that responded to the survey use SSW in some form.

Table 5: Level of SSW implementation in Victorian Community Health Services as at April, 2008

Formal Implementation	Informal Implementation	No Implementation	Total	No Counsellors Not recorded in total
28	20	9	57	7

Formal implementation by the organisation

Twenty-eight agencies (49%) reported that SSW had been implemented as an organisation-wide approach. For the majority of services this meant offering SSW consistently during intake. On several occasions it was offered at the counsellor's discretion. As reported by some team leaders, a number of counsellors noted that the SSW framework was most relevant in rural areas where the "community wants it". They explained that although clients in metropolitan areas mostly request ongoing counselling, you often "only get one shot" at helping rural clients so SSW is a good way of targeting their needs in the first instance. Half of the agencies who had formally implemented SSW are from rural or regional Victoria.

Informal implementation by individual counsellors

Twenty agencies (35%) reported that their individual counsellors used various principles of SSW with their clients, although no organisation-wide SSW system or policy had been implemented. A number of these described strong intentions to formally implement a SSW framework in the near future, including training staff where required. In some cases formal implementation was not seen as necessary as the agency only had one counsellor. Some stated that they did not have the infrastructure to formally implement the framework. For example, a number of the agencies surveyed had no intake worker and multiple sites were seen as a barrier to implementation.

Many agencies were waiting for staff turnover or other organisational changes to be complete before embarking on further SSW implementation. Seventy-five per cent of agencies informally implementing SSW were from rural or regional Victoria.

No implementation

Nine agencies (16%) reported that they had not implemented SSW at all. Five of the nine stated that the sole reason for this was that they did not have a waiting list to manage. Other reasons included lack of training in SSW, the feeling that more sessions were always required anyway, or that another system was already working well. Fifty-five per cent of these services are from metropolitan Melbourne.

No counsellors

Seven agencies stated that SSW was not applicable to their service as no counselling services were currently offered. All of these services are located in rural areas.

Of the agencies that reported using SSW as standard practice, very few described the decision as a response to high case loads. They were more likely to apply it as a means of maximising productivity or responding to a client’s personal preferences. This is in contrast to the frequent responses from agencies that do not plan to implement SSW because they “have plenty of staff” or have no waiting list.

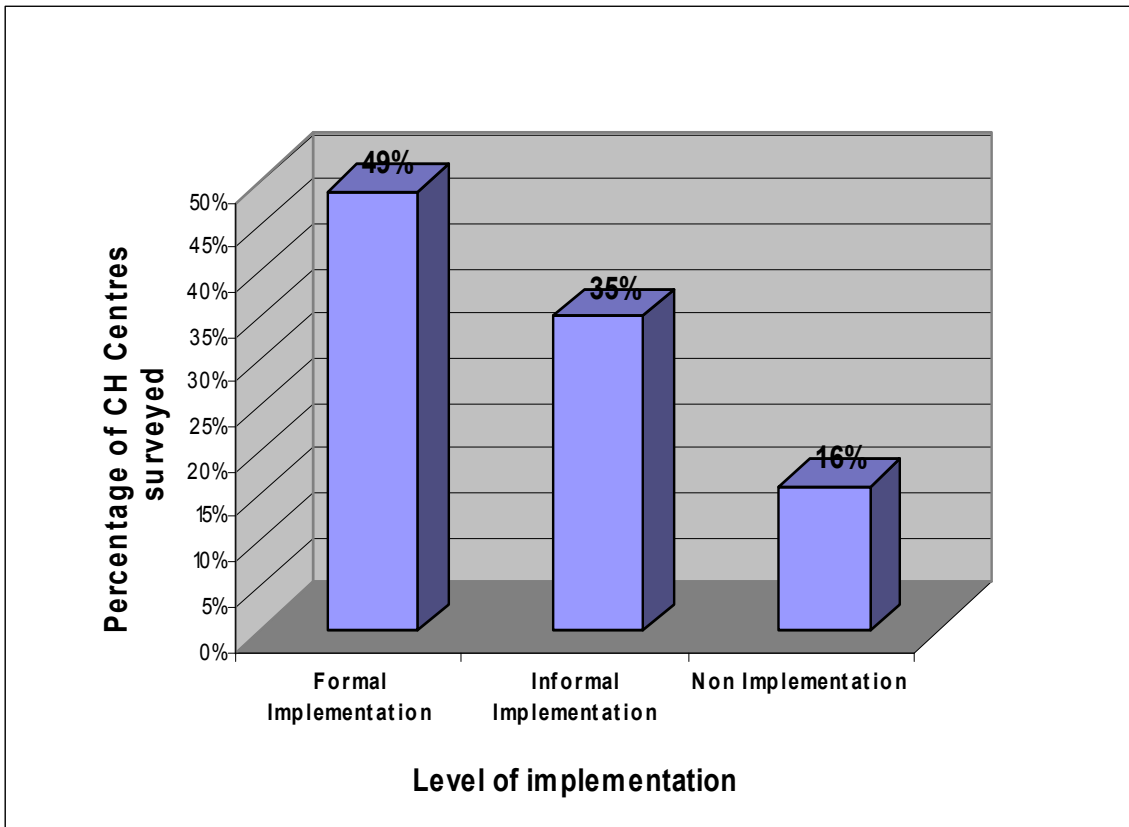


Figure 8: Level of SSW implementation across Victorian CHS from survey

7. Discussion

7.1 Implementation factors for SSW in Community Health

After the collation, analysis and triangulation of the data collected from the pre and post questionnaires, in-depth interviews, telephone survey, the web survey for counsellors and reviewing the literature on the implementation of evidence-based practice, ten overarching factors have been selected to explain the data collected from the SSW Implementation in Community Health Study. The factors we have identified in the literature, specifically from the work of Rogers (1995), Greenhalgh (2004) and Davis and Taylor-Vaisey (1997), comprehensively match the themes that emerged from our own data analysis. These factors are: relative advantage; compatibility; complexity; trialability; observability; re-invention; organisation adaptability; risk; training and support; and incentive and regulation. These factors interact at a number of levels within a service system as shown in the table below.

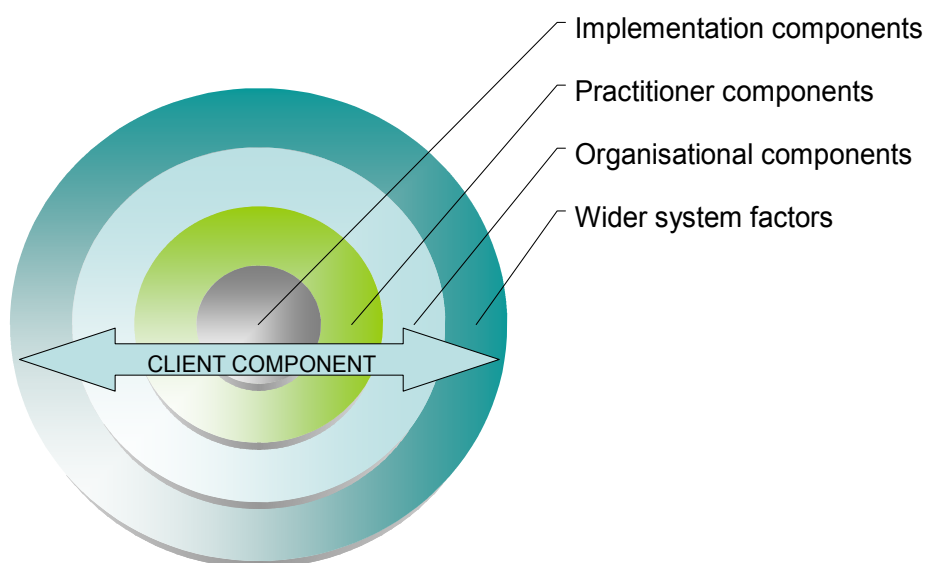


Figure 9: Influences that affect implementation

7.1.1 Relative advantage

(The perception by all stakeholders that the new practice is 'better' or that there is an identified problem that can be solved by the new practice.)

Demand management

Single session work was introduced to the community health sector during a time when demand management was identified as a priority by DHS. Some organisations were already investigating ways to provide effective and efficient services to clients and support staff with the increased pressure associated with managing large waiting lists. CHSs statewide contact data supplied by the Primary Health branch of DHS showed evidence that over 60% of people requesting counselling and case work services attended for a maximum of two sessions (see Figure 1). SSW provided a means to effectively assist a large percentage of clients relatively quickly. Findings from the current study support this, with 66% of respondents to the web survey agreeing that it provided a timely response for clients to initially deal with their concerns and a further 45% confirming SSW as a useful method of assisting some clients in the interim while waiting for ongoing counselling.

Waiting lists

"... there is a bit about single session dropping the number of clients on your waiting list...that's a bonus to us and a bonus to the client. It's a bonus to management and that reduces the sort of burnout feeling of all that pressure constantly on you, because it's suddenly lifted." (Counsellor, Service 1)

All of those interviewed from Services 1, 3, and 4 identified large waiting lists as a serious burden to providing quality services. CEOs and managers from the three services also mentioned that the front end management of services for clients needed improvement with large waiting lists for counselling services at all sites. This was also echoed by the majority of counsellors interviewed. All intake workers represented in the interviews from the three services expressed concern about counselling waiting times for clients. Interviewees from Service 4 confirmed that SSW provided a valuable framework for ensuring that vulnerable clients received prompt and appropriate services after experiencing an incident with a client waiting for counselling. The CEO, Manager and counsellors all spoke of the significant stress that staff experienced due to the lack of an adequate demand management framework.

“Our concern was that people were on the waiting list and they weren’t being provided a service! Management were a bit concerned that we were closing the books, they were telling GP’s, everyone that we weren’t available no one liked that at all.” (Counsellor, Service 4)

Prior to the introduction of SSW Service 1 clients experienced a two-month wait for counselling services and the service had periodically closed the waiting list due to the high demand on limited resources. The CEO was concerned to provide a priority access system for clients and the Senior Clinician stated that the current model of service delivery was no longer meeting the needs of the service. Although there was a priority system in place at Service 3 there were substantial waiting times for clients at all sites with the maximum time being 22 weeks at one site. The Senior Manager of the service was concerned to maximise limited resources due to the extensive demand placed on the service by the continued population growth. Service 5 was worried that no adequate follow-up assessment was conducted with clients on the waiting list while staff in Service 6 were concerned about the large numbers of people waiting and the substantial amount of time spent on indirect service delivery to manage the waiting list.

Managers from Service 2 did not state that the demand on counselling services was a motivation to implement SSW. Counsellors at one site expressed concern about the high demand for counselling services, being over six months for one counsellor and two months for another counsellor. The usual service response was to refer clients elsewhere rather than carry a waiting list. Managers and counsellors stated that there were no uniform guidelines for waiting list management or resource allocation. Out of the nine agencies contacted from the Telephone Survey that stated they did not implement SSW in any form, six reported that they did not have to manage a waiting list.

Positive perception of new practice

Results from the Web Survey also provided evidence that those counsellors in favour of SSW believe it contributes to quality service provision. Generally, those services interviewed who have successfully implemented SSW view it as an effective way of utilising scarce resources. Most services had or were developing priority access systems for clients and SSW is viewed as compatible with those systems. There was also a strong belief that SSW contributed to a higher quality of service provision among those counsellors from the three services that had successfully implemented SSW as compared to Service 2. Services 1, 3, 4,

5 and 6 had also received positive feedback from clients about the introduction of SSW (see Trialability below). Of the agencies in the Telephone Survey that reported using SSW as a standard practice, very few described the decision as a response to high case loads. They were more likely to apply it as a means of maximising productivity or responding to clients' personal preferences. Some individual counsellors who were interviewed stated that SSW provided a useful framework to add to their counselling repertoire. This was particularly emphasised by counsellors where clients irregularly attend counselling. One service from the Telephone Survey indicated that they were currently using a system that worked well and did not deem it necessary to introduce SSW.

Summary

There is no doubt that a significant factor influencing the implementation of SSW is the Relative Advantage perceived in changing a current service delivery problem by all levels of the service system. All the organisations that participated in the In-depth Interviews had identified demand management as a major problem affecting service delivery. Generally, SSW was perceived as a means to improving individual and organisational service delivery to clients. SSW implementation was unsuccessful where individual counsellors and managers either had not identified an agreed-upon problem in service delivery or did not agree that SSW provided an appropriate solution.

7.1.2 Compatibility

(The new practice fits with the values of clients, practitioners and the organisation. It also suits the current needs or culture of the organisation.)

Counsellor values

"Values wise, it's about empowerment, it's about working in partnership with people, it's the social model of health which is good." (Counsellor, Service 4)

One of the factors contributing to the adoption or rejection of SSW mentioned by counsellors in the Web Survey and by the various stake holder groups interviewed in the In-depth Interviews was the match between professional and service values with the principles of SSW. Of those counsellors who completed the Web Survey 71% agreed that SSW fitted with their practice values and 80% agreed that SSW is compatible with a social model of

health, upon which community health is based. Those counsellors who had implemented SSW overwhelmingly identified beliefs and practices in their counselling approach that were compatible with the principles of SSW.

There was unanimous agreement with counsellors that SSW fitted with their practice values as well as those of the organisation in two of the four organisations from the In-depth Interviews. In Service 3 there was a recognition from all the groups interviewed that a minority of individual counsellors found it challenging to integrate SSW principles with their theoretical orientation. This was evidenced in the Web Survey by Service 3 having a significantly less positive response to questions related to professional compatibility with the values of SSW as compared to Service 1. Counsellor responses from Service 3 even differed on occasion from those counsellors where there was no formal organisational SSW implementation, including Service 2 (see Table 4). Strong leadership combined with SSW compatibility with the majority of counsellors' values assisted implementation in Service 3. Compatible values most regularly mentioned by all stakeholder groups from the In-depth Interviews included being client focused, that SSW is respectful and emphasises client empowerment and that clients can have control in a self determining process. Counsellors who expressed some discomfort in the values of SSW highlighted a preference for long-term work as the most successful way to provide good outcomes for clients. It is difficult to determine if these counsellors did not understand or accept that SSW is not a brief model of therapy, in particular, that it does not prohibit long term work when chosen by clients.

Organisational values

Sixty-three per cent of respondents from the Web Survey agreed that SSW fitted with the core values of their organisation. Out of the three services participating in the In-depth Interviews that had implemented SSW, there was a broad agreement among managers at all levels and the identified clinical leaders or 'SSW clinical champions',¹² that SSW was highly compatible with the desired model of service delivery for the organisation. All three organisations that had successfully implemented SSW were in the process of, or had completed work on, articulating the mission and values of their organisation. Counsellors interviewed from the three organisations clearly articulated the values also mentioned by the Managers and CEOs. Counsellors from Service 1 all exhibited a thorough understanding of the organisation's service values. Counsellors from Service 1 and 4 showed a very strong

¹² A SSW clinical champion is a practitioner who has the respect of her colleagues and provides specific clinical leadership to assist the uptake of SSW.

agreement with organisational values and SSW compatibility as compared with Service 2 which had not implemented SSW.

"As a leader I need to inspire, to bring people together with a common purpose vision." (CEO Service 1)

It is interesting to note that both CEOs from Service 1 and 4 had committed resources to changing the existing organisational structures and to sharing a future service delivery vision with staff. Service 3 had also embarked on the formulation of shared organisation and service values, although some counsellors interviewed expressed confusion about the communication of the process. Service 3 is a substantially larger organisation than Service 1 and 4. Counsellor perception of the fit between SSW and organisational values varied the most in Service 3 which may have reflected uneven organisational communication processes.

"I think the implementation of single session (at Service 3) for me, has really emphasised the limitation of our structure in a whole lot of ways, in terms of a shared culture, shared values, shared work practices and ability to engage with that in a meaningful way, just because of the sheer numbers of staff that we as coordinators are responsible for." (Manager, Service 3)

Managers and counsellors in Service 2 agreed that there was no consensus on service values. While some individual counsellors expressed similarities in their values with SSW, there was general disagreement about the values that should underpin service delivery across the organisation and the use and allocation of resources. Managers acknowledged that no common service vision had been developed.

"So we disagree on who we should see, we disagree over things about how we should see them, about what's most valuable in terms of how we use our, our resources." (Counsellor, Service 2)

Client values

The literature on SSW contends that SSW values are compatible with the service expectations of clients. There is a broad range of values that are attributed as compatible including the timeliness of the response, purposefulness of the therapeutic structure and the client focused nature of the approach. All the services involved in the In-depth Interviews who had implemented SSW had conducted client satisfaction surveys (see Trialability below). While the satisfaction surveys did not specifically ask questions about the compatibility of SSW with client values all services reported an overwhelmingly positive response from clients who responded to the SSW satisfaction questionnaires. While it is difficult to differentiate the impact of SSW from the positive effect of counselling, 80% of clients from Service 1 and 73% of clients from Service 4 stated that they clearly understood the SSW process. Ninety two per cent of clients who responded to the questionnaire from Service 1 and 100% from Service 4 found SSW useful.

Current needs and culture of change

In-depth Interviews with representatives from all organisational levels in Service 1, 3 and 4 described the offer of SSW training, by DHS and The Bouverie Centre, as a timely response with the possibility of catering to current service difficulties. In **all** of the Services interviewed cultural change and customer service were on the agenda of CEOs and managers. The various levels of leadership in all organisations acknowledged the need for change in some forms of service delivery or in the attitude of some counsellors. Interviews with representatives from Service 5 and 6 highlighted that the identified need to change service delivery also required a substantial change in counsellor attitude, knowledge and energy. The CEOs and Managers in Service 1, 3 and 4 all commented that the change associated with SSW was often a frustratingly slow process that required firm and fair active management.

SSW was used as a positive example of change in Service 1. Counsellors had experienced a sustained level of organisational change over several years that had occasionally been 'painful'. SSW implementation in Service 1 was viewed by all the stakeholders who were interviewed as an example of a positive experience of service change. Counsellors from Service 4 commented that the SSW implementation process had not been "over-managed." Their perception fits with the management views of Service 4 that change needs to be democratic with time allocated to investigating the barriers to implementation. Counsellors from all three services who implemented SSW reported that ultimately they were clear on

the expectations of implementing SSW. Management from Services 1 and 4 highlighted the need to “bring staff along” with any proposed change in line with some of the literature on successful implementation (Locock et al., 2001). After an initial SSW implementation task group was disbanded in Service 3, senior management took a more directive approach to the implementation of SSW with some counsellors feeling they had been forced to use SSW. The Managers and Senior Manager thought that facilitating the uptake of SSW had assisted the management group to unify and find a sense of purpose. While the management group in Service 3 was clear that SSW would be implemented they also expressed an understanding of the different reactions people have to change in the work place. The successful adoption of SSW in Service 3 runs contrary to the idea that ‘democratic change’ is always necessary when implementing evidence-based practices. Other variables are also important.

“I chose to do it really slowly because I needed all the counsellors to be on board and I knew that they would be fairly resistant and I wanted them to understand it and I didn’t want them to feel like they were being forced. Although I am aware that they probably feel that they have been forced. I wanted them to want to do this and to have all the time they needed to understand it and to go, “yeah, this will work for us.” I wanted them all to be trained and to talk about it and to be absolutely involved in how we would make this work, but at the same time I said we are going to do this.”

(Senior manager, Service 3)

Service 2 did not have a positive culture associated with organisational change. Some counsellors viewed the possible implementation of SSW as serving the interests of meeting organisational targets rather than those of clients. Counsellors from the service disagreed strongly that change was managed well in their organisation and a large percentage agreed that there is a lack of collaboration and co-operation between staff and the organisation. Both these findings were significant in comparison to Service 1.

“Facilitation and leadership have been disjointed and there hasn’t been a collective opportunity to create a vision and service plan.”

(Manager, Service 2)

Managers from Service 2 spoke about their time being consumed with day to day operational matters which left no time for strategic planning. Interviewees from the manager and staff groups spoke about the lack of action that had resulted from past service reviews. There was acknowledgement that there was a void in co-ordinated service direction that had led to a sense that individual counsellors usually “worked as private practitioners” and could make their own choices about SSW. Hence managers had not conveyed the service values or clinical reasons for implementing SSW.

Summary

Counsellors are more likely to successfully adopt SSW when their practice values were aligned closely with SSW. Organisations that articulated clear service values coupled with a culture that highlighted a need to change or critique current service delivery were more likely to successfully implement SSW. While a ‘democratic’ change process was seen to ease SSW uptake by counsellors in several organisations, it was not an essential ingredient to implementation. Management directives in the context of a clear service vision seemed to promote implementation in one service where some counsellors disputed the validity of SSW.

7.1.3 Complexity

(The new practice is simple to understand.)

“...it’s very practical, it’s concrete you can hold it in your hand. It’s in the context where there is so much change and so much of it is blabber... . Whereas this (SSW) is something that is tangible and you can see the change and you can see the value,... it’s kind of a shining light amongst it all.” (Counsellor, Service 1)

Understanding the approach

A potential hurdle to the implementation of SSW is the lack of clarity or understanding of the principles and core ingredients of the approach. In Services 1, 3 and 4 the CEO, managers and counsellors exhibited a thorough knowledge of SSW. Counsellors and managers who were interviewed were able to clearly articulate the fundamental principles of SSW and explain how SSW fitted within the service framework. The CEO from Service 1 took a personal interest in understanding SSW as an approach. Although the CEO was supportive to SSW after reading the SSW Training Manual she was unclear how SSW could

be incorporated into the current intake system for all counselling clients. The CEO completed the SSW training provided by The Bouverie Centre so she could fully appreciate the potential application of SSW in her organisation.

"I could see the logic of it (SSW), but it helped me feel passionate about it by doing it and believing in it, there's a leap of faith and a logic to the belief in some ways." (CEO, Service 1)

Conversely, in Service 2, where SSW was not implemented, counsellors and managers did not articulate a clear understanding of SSW principles or its intended application. Some managers and counsellors also expressed assumptions about SSW's lack of suitability for some clients that is not sustained in the research and is addressed in SSW training programmes. One manager talked about her negative preconceptions that SSW couldn't engage clients and be helpful in one session. Another manager described SSW as brief therapy that would not work with clients presenting with complex problems. Other managers were unaware of the approach until one interested staff member and an interested manager had explained the approach.

SSW paperwork

A number of counsellors and managers were perturbed by the amount, style or intention for using the supporting paperwork that accompanied the implementation of SSW. This paperwork included a pre and post counselling client questionnaire, a SSW client summary sheet for case notes, a SSW follow-up phone call sheet and a SSW client evaluation form. Other forms included letters that could be sent to clients and referrers explaining the SSW process. Some counsellors experienced the paperwork being an extra burden on already demanding administrative workloads. Others thought that the pre and post questionnaires were unsuitable for their service context. There was also some uncertainty expressed about the usefulness of the pre and post questionnaires coupled with the client satisfaction survey. Whilst the pre counselling client questionnaire was the only paperwork deemed necessary by The Bouverie Centre to maintain the fidelity of SSW this had not been clearly communicated to the sector. Issues relating to SSW paperwork demanded an amount of dedicated consideration by the three Services that participated in the In-depth Interviews. Rather than viewing the various SSW support paperwork provided by The Bouverie Centre as an impediment to implementation, Services 1, 3 and 4 decided to adapt, discard or adopt various examples of the paperwork that suited the service context.

Forty-five per cent of counsellors who had reported implementing SSW from the Web Survey agreed that, "the paperwork and other documentation required for SSW takes time away from the more pressing needs of my service and its clients." The average response from counsellors in Services 3 and 2 agreed with the above statement and contrasted dramatically with the average response of counsellors from Service 1 and 4 who did not agree that the SSW paperwork detracted from service delivery. Counsellors from Services 1, 3 and 4 did adapt the paperwork to suit their needs.

Summary

SSW was viewed by the majority of counsellors as relatively easy to understand. Implementation was assisted by a large proportion of counsellors expressing commonality between their current counselling practices and some elements of SSW. Some counsellors commented that they were already practising within the principles of SSW or that SSW was a "re-branding" of their existing counselling practices. Those services who implemented SSW invested resources into adapting the accompanying SSW paperwork to suit the agency context. A number of counsellors and managers from the non-implementing service did not demonstrate a thorough understanding of SSW. This was the result of counsellors and managers not possessing detailed information about SSW rather than the complexity of the approach per se. Personnel in organisations that received detailed information about SSW and implementation strategies as a complement to the SSW training were more likely to understand the potential application and principles of SSW.

7.1.4 Trialability

(The new practice can be easily evaluated in multiple contexts.)

A SSW Resource Pack was developed by The Bouverie Centre with funding provided by DHS. The Resource Pack contained: a SSW clinical example from intake to the follow-up phone call; a downloadable CD with all the supporting paperwork; three flow-charts that could be attached to the wall that outlined a SSW intake procedure, the SSW process and a SSW evaluation process; a booklet with an explanation of SSW, the possible applications of SSW in a variety of contexts and advice on how to trial and evaluate SSW; and some examples of potential client satisfaction and counsellor questionnaires.

Evaluating the process

In the three organisations that successfully implemented SSW, the CEO or a manager had dedicated time to individually research SSW. The interest and ability to show leadership toward trialling SSW was an outstanding feature of these three organisations. The Senior Clinician and clinical advocate of the approach in Service 1 provided a presentation to the CEO that convinced her that the approach was worthwhile trialling for twelve months.

All three services (1, 3 and 4) conducted some form of SSW trial. Evidence collected from the SSW trial was identified as an essential factor in the successful implementation of SSW in all three organisations. While there was considerable variation between organisations in the structure of the trial and the type of data collected, all reported positive feedback from clients, intake workers and counsellors. The most comprehensive SSW trial and evaluation process was conducted by Service 1.

Service 1 formed a group responsible for the trial implementation of SSW. Meetings were held with key clinical staff and intake workers to discuss the logistics of offering SSW. Management agreed that co-therapy would be used during the initial use of SSW and that The Bouverie Centre would be invited to provide some facilitated supervision sessions while establishing SSW. The implementation team devised a SSW service delivery format and decided on a time frame for the trial. Documentation to be used and the process of evaluation were agreed upon. Forms were assessed and adapted to meet the needs of Service 1. SSW was initially trialled with a set number of clients and then reviewed by the counselling and intake staff. A staff member from The Bouverie Centre attended the meeting to assist with any outstanding questions the counsellors had about SSW. Changes were made to the process as a result of the meeting and SSW was trialled for a further six months. A representative from The Bouverie Centre was then invited to a further meeting to consult with the group about several questions that had arisen as a result of the trial period. The SSW documentation was reviewed and changes were made after consultation with counsellors and a consumer reference group.

After six months Service 1 found that: the waiting list had reduced dramatically, client feedback was overwhelmingly positive, intake workers were pleased with more timely interventions for clients, counsellors were generally pleased with the way SSW was received by clients and counsellors enjoyed the opportunity for co-therapy especially across professional disciplines. After 12 months data was collected from SSW client satisfaction

surveys which found that of the 95 people who were offered SSW 92% found the session to be useful. Fifty-two per cent of clients attended for one session. Counsellors were also surveyed and asked about the benefits and barriers of utilising SSW as part of service provision. The feedback from the counsellor survey was reported as generally positive and a series of meetings was convened to respond to any difficulties that were highlighted.

Service 3 and 4 also carried out similar trials and collected data from client evaluations. The positive responses from clients reinforced the usefulness of the approach for most counsellors in these services. The information collected from evaluations in Service 3 had only been reported to counsellors in general terms and had not been used as a direct means of positively reinforcing the current SSW work practice or as a means to refine the current SSW work practice. In response to receiving feedback about the client evaluations from one manager, a counsellor in Service 3 commented:

"(It was) Just (reported) general(ly) that the feedback has been good. We don't know what that is? We don't know whether other things need to be (changed)."

In response to the Web Survey, counsellors from Service 1 and 4 agreed that an effective evaluation process had been put in place while the majority of counsellors from Service 3 disagreed. It is unclear if counsellors from Service 3 were critical of the evaluation process or were responding to a lack of detailed information dissemination from management.

Learning culture driven by leadership

"I do feel passionate about what we are doing... what is possible and the potential...there are no boundaries, we can do anything if we decide to. It is important for staff to get fired up like that too. I think that's what leadership is about. I think you have to inspire people to lead them."
(CEO, Service 1)

In Services 1 and 4 the CEOs were described by counsellors as "inspirational" and "visionary." The CEOs ability to provide a learning culture in their organisations seems to have played a part in counsellors being prepared to take part in a SSW trial. In Service 1 counsellors mentioned that the CEO had paid for community development training for the organisation to change counsellor approaches to health promotion. Counsellors who were

interviewed stated that the CEO articulated a clear vision for service delivery in the agency and that most staff embraced that vision. There was acknowledgement from all the people interviewed from Service 1 that some workers left the service during a time when the CEO's vision was being implemented. These workers either did not share the CEO's vision or found the change unpalatable.

Interviewees in all participating organisations expressed two potentially contradictory positions: that people need a long time to change and that eventually people need to "jump in and give it a go." The two organisations that had CEOs described favourably by counsellors were also described as, leaders who were supportive and facilitative while being prepared to make hard decisions.

"I've seen enough organisations go down the tubes or create big difficulties by management not making strong decisions when it's required and I will do that. I hopefully do that with as much compassion as I can." (CEO, Service 4)

The Manager from Service 4 attributed the SSW implementation process as contributing to a key learning in her management of change. She reflected that she understands that her role is, "now not to placate people who are challenged by service changes but to support them through the process of change."

Counsellors from Service 3 also described a directive from management to start a full implementation of SSW even though some counsellors disagreed with elements of the approach. There was some residual discord expressed by a few counsellors about being directed to implement SSW with what they thought was inadequate consultation. The Senior Manager of the service decided that although there had been significant turnover of staff 18 months was an adequate timeframe for the trial.

Summary

The use of a cyclic review or an evaluation process was initiated by three organisations that successfully implemented SSW. Problems were identified and adaptations were made to service processes or SSW practices via this process. Usually the trial process was governed by the formation of a SSW implementation working group. Some counsellors were impressed by the trial structure put in place by their organisation while others did not

believe there was enough consultation. Some counsellors expressed their initial scepticism about the SSW process and were convinced about the usefulness of the process only after receiving compelling positive client feedback. Organisations that implemented SSW were more likely to possess leaders who inspired staff, were passionate about the provision of client services and gave clear direction.

7.1.5 Observability

(The new practice is adopted by respected colleagues and demonstrated by organisations.)

"Trust your champion. Support them, if you've got one you're lucky."

(CEO, Service 1)

Clinical champions

While the leadership provided by the managers in the organisations studied has proven to be an important factor in the adoption of SSW, so has the involvement of a clinical champion or what Kitson et al. (1998) calls an opinion leader. In all three organisations that successfully implemented SSW, 'clinical champions' played an influential role in service adaptation, clinical influence and support to colleagues. In Service 1 the clinical champion was instrumental in the adoption of SSW by the organisation. This Senior Clinician was identified by her colleagues and manager as a team leader in everyway except by name.

In Service 1, the 'clinical champion' (Mary) enjoyed a close working relationship with the CEO and the respect of her colleagues. Staff and the CEO agreed that Mary was the instigator for adopting SSW. She motivated her colleagues and led a presentation to the management team and CEO about trialling the implementation of SSW. Mary had worked in Service 1 for nine years, and had showed support for the two organisational restructures she had experienced while acknowledging the difficulty of the change process for some of her colleagues.

"She (Mary) has got a lot of defacto authority and that's her seniority and her level of qualification, her sheer competence,...she breaks new ground and she involves other people." (CEO, Service 1)

By the time she was touting SSW, Mary was recognised as the most credentialed, experienced and long serving counsellor on staff. Service 4 recruited a counsellor with experience in the implementation of SSW. While this counsellor did not enjoy any formal hierarchical status, management and colleagues acknowledged that she played a significant role in the adoption of SSW. In Service 3, an intake worker and counsellor (Fran) also took on 'champion' status due to her passion for the approach and previous training she had completed. While Fran had a large amount of input at the site where she worked, she did not have much influence at the other Service 3 sites. Although Fran is not a team leader, she is a longstanding member of staff and her site is recognised as the most successful adopter of SSW in her organisation.

External influences

All three organisations consulted with other organisations recognised for the successful implementation and use of SSW as well as respected colleagues in the field. The function of consulting external agencies and counsellors performed two purposes. Firstly, it confirmed that SSW was an approach that worked well in a similar service context. Secondly, the potential challenges that could be encountered were discussed with people who had no vested interest in the ongoing implementation of SSW. Service 1 and 3 invited a Bouverie Centre staff member recognised for their expertise in SSW to consult with counsellors and managers on a number of occasions. Service 4 utilised the experience of an external supervisor who had training and clinical experience with the approach.

Service 1 was subsequently identified as a lead agency in the implementation of SSW and representatives reported being contacted by a number of interested agencies. The Senior Clinician highlighted that the publicity associated with implementing a perceived innovation proved to be a positive reinforcer for the SSW implementation process.

A positive external influence for adoption by counsellors in Service 3 was their attendance at a SSW workshop facilitated by Moshe Talmon, the original international proponent of the approach. Talmon's influence assisted these counsellors adapt and accept the approach in a way that was different from the initial training from The Bouverie Centre. Comments from the counsellors suggested that they embraced the developmental nature of SSW and were able to find a way to critique the earlier training while accepting current SSW practices.

Although at the time of this study Service 2 had not implemented SSW, managers and some counsellors became interested in trialling the approach. A manager attended a SSW practice forum hosted by DHS and was interested in the idea that a number of CHSs were effectively using SSW. After circulating some information about SSW a staff member contacted the manager keen to trial the approach. The Service 2 manager also interviewed representatives from another community health service who had successfully implemented SSW. These external influences led to Service 2 trialling SSW and engaging in the current research.

"A senior clinician from another service said a whole lot of positive things, she challenged some of the myths that I and others in the service held, around the accessibility of this model for people who perhaps aren't verbally that articulate or are illiterate." (Manager, Service 2)

Summary

All 'clinical champions' enjoyed the trust and clinical confidence of management. Furthermore, they were bestowed with the clinical respect of their colleagues. All displayed qualities that recognised their informal leadership of certain clinical aspects of the service by their respective agencies, particularly regarding SSW. The managers and CEO of the four primary services participating in the In-depth Interviews consulted and were influenced by other organisations that had experience in the implementation of SSW. All four services benefited from the consultative support of a Bouverie Centre SSW expert. In some way all four organisations were interested in SSW because of the appeal the approach had generated in the sector, either as a lead agency or as something that was worth trying.

7.1.6 Re-invention

(The new practice can be modified to suit individual contexts.)

"Knowledge isn't fixed, it's developmental, so it never entered my head that we wouldn't fiddle with it because you're always trying to improve... ." (Service 6, Team Leader)

Adapting administrative material

The organisations that successfully implemented SSW showed evidence of an ability to be flexible and have confidence to alter the processes of SSW to fit the service context. In those agencies that successfully implemented SSW all counsellors and managers interviewed were clear on the central principles of the approach while being prepared to alter the application of SSW to suit the agency specific context and requirements. The sound knowledge of SSW coupled with a process of evaluation, adaptability of the implementing organisations and consulting a Bouverie Centre specialist all combined to allow managers and counsellors to change the approach as they deemed necessary. Managers and counsellors described their actions in modifying and solving difficulties related to the application of SSW as they went along. The most common modification was the decision to change the paperwork and administrative procedures associated with SSW suggested by The Bouverie Centre. In Service 1, intake workers changed some of the letters sent to clients which helped them “own” the process. Services 3, 4, 5 and 6 all changed the paperwork to suit the needs of the individual organisation.

Flexibility applying SSW

“When you first implement it (SSW), you are very rigid,...but as time goes on your practice modifies, you become a bit more laid back...” (Counsellor, Service 3)

Counsellors in Service 3 also stated that they did not follow a “regimented process” and were pragmatic about applying SSW depending on the client presentation. Mary from Service 1 talked of identifying the transferable skills that could be utilised in SSW which assisted counsellors stay true to their own practice orientation while being faithful to the core concepts of SSW.

A counsellor from Service 4 commented;

“You take it (SSW) and then you use it in a way that works so... you’re not doing it the right or wrong way.”

Services 1, 5 and 6 also gave examples of applying the principles of SSW creatively in other areas of service delivery. Service 1 had involved allied health staff in using a SSW

framework to assist clients who presented intermittently over long periods with chronic problems. Services 5 and 6 had adapted the approach with multi-disciplinary paediatric teams as an initial assessment and intervention framework.

Summary

Organisations that successfully implemented SSW adapted the approach to suit the specific needs of the service. Modifications were principally made to aspects of the paperwork while maintaining faithfulness to the core principles of SSW. Some organisations developed SSW to provide services not initially envisaged in the original training.

7.1.7 Organisation adaptability

(The organisation can adapt procedures to meet the core components of the new practice.)

"I love working with people and trying to get the best out of people. For me, that includes setting up really good systems to support them so that they can then produce the best service to our client group." (CEO, Service 4)

Procedures and guidelines

All managers and 'clinical champions' involved in the study emphasised the importance of clear procedures for their respective counselling teams as an important step to maintaining accountable and consistent SSW service delivery. Interviewees from Services 1, 5 and 6 explained that the implementation of SSW coincided with a review of the general guidelines governing counselling practices. The guidelines governing SSW had to fit with the overall service guidelines from the initial client intake until the client exited the service. The CEO from Service 1 stated that her organisation had to be very purposeful, in terms of their service delivery, and couldn't afford "to have any loose procedures." Mary reported that it helped Service 1 administratively that the SSW fitted with the other processes and guidelines that were being developed for the agency. This was coupled with Mary working closely with her colleagues to ensure their adherence to the SSW process. Counsellors from Service 4 appreciated that while they were given a certain degree of professional independence, "codified systems" helped make them accountable and provide clarity about service delivery. Service 4 counsellors acknowledged that there were clear guidelines outlining the agency expectation about SSW.

Most notably the Senior Manager of Service 3 insisted that there was adherence to service guidelines incorporating SSW even though some of these were perceived as unpopular and impractical. This was motivated by her desire to provide consistent, accountable and equitable services across all of the organisation's service delivery sites. The Senior Manager and managers acknowledged that strict procedures had been put in place to increase counsellor adherence to providing regular SSW as part of their regular work component. It is notable that Service 3 counsellors in the Web Survey generally agreed that the SSW paperwork detracted from service delivery, in stark contrast to other counsellors who had adopted SSW. Management's demand for strict adherence to some administrative parameters linked to SSW in Service 3 may have added to some counsellor dissatisfaction with the implementation.

Each of the organisations that had implemented SSW mentioned the need to adapt current administrative systems and work practices to accommodate SSW. A common challenge was deciding on how many Single Session counsellors should provide based on their effective full time hours and the concern that caseloads may increase if clients opted for more sessions. Another difficulty that had to be overcome for Service 3 was the amount of direct counselling time wasted if clients cancelled a Single Session appointment. The "sticking point" for counsellors in Service 3, as described by the Senior Manager, was how many SSW sessions a counsellor could be reasonably expected to achieve in a week rather than the benefit of providing SSW.

Service 2 did not have general uniform processes for the counsellors across various sites and identified that issue as a key priority. Managers acknowledged that staff had not had clear guidance about counselling and casework services and as a result provided services in accordance with their passion, interest and skill.

Summary

In organisations with a large or complex staffing component, the provision of clear guidelines aids implementation by increasing counsellor accountability. Even in smaller organisations clear guidelines and procedures assist with the consistent delivery of SSW, especially when individual counsellors vary in their theoretical orientation to counselling.

7.1.8 Risk

(The benefit of the new practice outweighs the potential risks.)

"It (the adoption of SSW) is not driven by cost effectiveness but by risk to the organisation and clients.... So let's find new ways to do things better... . I can afford to lose a bit of money or a bit of time, I can't afford damage to the structure or the fabric of the organisation or clients."

(CEO, Service 1)

Accountability

Most of the people interviewed from the three organisations that successfully adopted SSW viewed the approach as fitting with their own concept of accountability. It is unclear from the interviews what the concept of accountability means for each stakeholder group. However a sense was conveyed that counsellors and managers wanted counselling work with clients to be clearly articulated and measured against some organisational requirement or standard. Most managers mentioned that SSW fitted well with quality assurance processes and that the application of SSW assisted the achievement of those quality processes. Service 4 had experienced a significant client incident and was conscious of improving screening and waiting list management processes. Counsellor responses from Service 1 and 4 strongly reflected the notion that SSW had also assisted them in the management of at-risk clients still required to wait for ongoing services. The Senior Manager from Service 3 acknowledged that there had been "a history of very free and easy structure(s)" and that SSW provided one of several opportunities to introduce some structure and accountability across all the sites offering counselling services.

Culture of experimentation

In Service 1, the counselling service was empowered to try SSW due to the "established culture of experimentation," as described by one counsellor. The Senior Clinician also described a culture where trying new things was encouraged. The CEO articulated a clear philosophy of supporting staff to try out new initiatives and to learn from mistakes without fear of reprisals from management.

'I think we all have to try things out. Even if we are not taking risks and you make a mistake, you learn from the mistake and you move on.' (CEO, Service 1)

Summary

The organisations that adopted SSW viewed the approach as not only outweighing any potential risk to clients or the organisation, but augmenting existing quality assurance measures. A culture that embraces cautious experimentation seemed to position the service to take advantage of the potential benefits offered by SSW.

7.1.9 Training and support

(Effective training and ongoing support is provided by consultants.)

External training, support and consults

Counsellors interviewed from Services 1, 3 and 4 that implemented SSW had all completed the DHS funded training provided by The Bouverie Centre. Only one counsellor from Service 2 had completed the same training, although another counsellor had attended training over six years ago. Counsellors from Services 5 and 6 had also been trained before the implementation of SSW. The CEO from Service 1 had also attended the training in order to fully acquaint herself with the core concepts and implications of adopting the approach. Each of the people interviewed from these agencies exhibited a clear understanding of SSW and managers had read some or all of the materials provided by The Bouverie Centre: that is, the training workbook, implementation parcel and/or viewed the DVD. Most counsellors agreed that the training had provided a "solid foundation" for understanding SSW. There was broad agreement that the training and support materials were very helpful and that the evidence presented about the approach was credible. The Senior Clinician from Service 1 "did not trust the research" at first and carried out her own investigation to determine the validity of the approach. She contacted trusted colleagues from various services familiar with SSW and to her surprise they confirmed that 30% of clients presented for one session.

Managers found the implementation parcel useful, especially in Service 3 where there was a large management team with no specialist training in social work or psychology. A number of managers from Service 2 who had not implemented SSW exhibited a limited or misguided knowledge of SSW and had not had direct access to the training support materials. This resulted in one manager viewing SSW as a particular therapeutic approach rather than as a service delivery framework. This manager assumed that the issues some clients presented with were of a complex or chronic nature unsuited to "short-term" work. Aside from the misconception that SSW is a brief therapy, these beliefs are at odds with the research and the experience of Service 1. Counsellors from Service 2 said that the SSW training was just

another professional development opportunity and some counsellors were unaware that it was being offered or that it was offered at no cost as a DHS sponsored state-wide initiative. There was an acknowledgment from managers that the training was not co-ordinated and supported. Conversely, the other three organisations either encouraged or mandated as many counsellors as possible to attend the training. In Service 1 nurses and intake workers were trained, as well as intake workers from Service 3. As a result of the Service 1 initiative to involve intake workers early in the training cycle, The Bouverie Centre recommended that other organisations considering formally implementing SSW also encourage intake workers to attend the training.

Services 1 and 3 had benefited from the post training consultations that were offered by The Bouverie Centre as part of DHS funding. Service 1 was provided with the consults gratis by The Bouverie Centre because ongoing consults to support SSW implementation had not been negotiated with DHS to provide free consults at that time. It was through the consultation process with Service 1 that The Bouverie Centre was able to make recommendations to DHS for ongoing SSW consultations and to open up the training for intake workers. A range of those people interviewed commented that the external consultations provided by The Bouverie Centre had been useful and had helped the further refinement of the implementation process. Of the organisations contacted through the Telephone Survey 75% with counselling positions had attended a SSW consultation with The Bouverie Centre and 84% implemented SSW formally or informally. Only 9% of organisations that formally implemented SSW **did not** attend consultations. Thirty per cent of organisations that informally implemented SSW **did not** attend consultations. Whereas, five out of nine organisations that attended consultations decided not to implement SSW at all. The post training consultation process clearly assisted the majority of organisations in the uptake of SSW.

Internal support and resource allocation

"I'll find the time and resources and whatever it takes to explore it."

(CEO, Service 1)

All five organisations utilising SSW had dedicated extra resources to the process. The managers and CEOs expressed the need to support staff through a variety of initiatives. Service 1 allocated time for a SSW working party to meet and discuss issues relating to implementation. The CEO also periodically attended these meetings to listen to any concerns and then fed back her perspective on timeframes and resource allocation for SSW implementation. Service 3 also formed a working group to consider SSW implementation. This group was disbanded after what management perceived as a lack of progress into strategies for the roll-out of SSW. The Senior Manager of Service 3 periodically met with counsellors to review the SSW implementation process. Service 4 also provided time for counsellors to meet and discuss the implementation process. There was recognition from the managers of Services 1, 3 and 4 that some medium term adjustment to counsellor targets was necessary while staff attended extra meetings or paired up to support each other with the SSW process. Services 4 and 5 also had allocated extra resources to the initial implementation process with Service 6 forming a staff working group.

Supervision

"I think staff need clinical supervision no matter what background or discipline they're from. As a manager who has to oversee a lot of disciplines, you can provide management but you can't do everything. You can't provide the clinical feedback when it's not your clinical area." (Senior manager, Service 3)

All the agencies interviewed had identified the need for competent clinical supervision with a supervisor who is well versed in SSW. Service 3 specifically contracted a counsellor who had a sound knowledge of SSW to provide clinical supervision. Service 4 had a contracted clinical supervisor who had suggested using a SSW approach independently of the DHS training offer. Service 1 received ongoing group supervision by a consultant from The Bouverie Centre.

Summary

The majority of counsellors and support staff must be trained to ensure confident and consistent SSW service provision. When training is combined with informative support materials and organisational consultations it is more likely for SSW to be implemented by individual counsellors or as formal organisational response to service delivery. All interviewees emphasised the importance of clear communication between all staff and meetings dedicated to SSW implementation as essential. All the implementing organisations from CEO to counsellors described a process of active management where counsellors were asked to report on the progress of SSW implementation. Providing specialist supervision assisted counsellors to maintain confidence in applying SSW particularly where their line manager did not have qualifications or expertise in counselling.

7.1.10 Incentive and regulation

(Adoption of the new practice comes with inducements and/or is specified by a governing authority.)

This study found that there were two types of incentive for implementing SSW. One type acknowledged by the literature is characterised by an external authority (such as a funding body) as influencing implementation. We have called this type of incentive the Extrinsic Value. The other type is not commonly acknowledged in the literature as an incentive because it is often a by-product of the implementation process. We have called this type of incentive the Intrinsic Value, that is, the incentives generated through starting to adopt SSW while not directly attributable to benefits in service delivery. Intrinsic values are generated from within a team or agency while extrinsic values are generated from outside of the team or organisation.

If timing was a critical component for SSW uptake by the organisations interviewed in this study then this was in large part due to a DHS review of counselling services and demand management strategies across the sector.

"There was a fair bit of information coming through about the Single Session model and I think the Department (DHS) were deliberately pushing it as an alternative to long waiting lists." (Counsellor, Service 4)

Extrinsic value

It is clear that DHS recommending and sponsoring the SSW training played a major role in the uptake of SSW in the case study organisations. The Bouverie Centre had provided SSW training through its continuing education programme for ten years before the state-wide training was offered to the community health sector. Only three CHSs had formally implemented SSW during that period: two of those organisations were Services 5 and 6. Managers from Services 1, 3 and 4 mentioned that it was a rare opportunity to be able to take advantage of free training for a section of the workforce. The managers from Service 3 remarked that it is important to take notice of what DHS recommends. Managers from Service 2 who did not initially consider implementing SSW expressed a need for clear guidelines regarding counselling services from DHS to inform their client service direction. One manager (with a social work background) from this service had influenced the agency to revisit the uptake of SSW after attending a DHS sponsored forum on the issue.

Some of the managers interviewed considered some counsellors as fiercely independent, who guard their professional status and prize their specialist knowledge. It was more difficult for managers who did not have a background in counselling or where the organisation did not have clearly articulated service values to determine the legitimacy of some critiques about SSW by counsellors. A manager from Service 3 thought the DHS sponsored SSW initiative fitted well as a catalyst to stimulate peer discussion and inform service change.

"We thought that this was a useful initiative from the department and ... there would be a jury of peers and lots of peer discussion that could inform and influence individual (counsellor) views." (Manager, Service 3)

It is difficult to determine how obligated the managers of organisations felt in relation to DHS recommending the training. It is reasonable to surmise that the influence from DHS prompted all the managers interviewed to seriously consider SSW implementation. Initially (2004–2005), The Bouverie Centre SSW training feedback forms contained a proportion of comments from counsellors suggesting that it was solely a push for bureaucratic efficiency. In the last eighteen months SSW training feedback forms have had very few comments suggesting it is an attempt by DHS to manipulate the type of clients and the length of time clients are engaged by a service.

Intrinsic value

There were often other benefits attributed to the adoption of SSW that were not directly attributable to a DHS or internal organisational inducement or decree. Some of the positive factors outlined through this study were attributable to the process of implementing SSW. There was a positive impact for some staff and managers by engaging in certain practices associated with change, particularly where the adoption of SSW was successful.

Status

As discussed previously there were clear benefits across all tiers within the organisations that implemented SSW. Aside from solving a defined problem in service delivery all representatives interviewed from organisations that had successfully implemented SSW felt a sense of achievement in accomplishing a change to service delivery whether at the coal face, as an intake worker or counsellor, or as a manager. In Service 1 the Senior Clinician of the SSW process presented the service delivery change to the Senior Management Group. There was a sense conveyed from those who had successfully adopted the approach that they had gained in status within the organisation as a result of their efforts.

Staff morale

"It had the effect of bringing the counsellors together (they were in different teams) ... it actually worked as a bonding exercise." (CEO, Service 1)

One of the most advantageous and unanticipated positive outcomes of implementing SSW in some organisations was the boost to team morale. Some counsellors from Services 1, 5 and 6 practised co-therapy while performing SSW. SSW co-therapy was utilised in some services as an ongoing form of service delivery or in other organisations as a part of the initial implementation process. SSW co-therapy was reported as having a major benefit in terms of team building. Co-work was also viewed as advantageous for many clients seen in Service 1. Representatives from Services 1 and 5 commented that it gave counsellors the opportunity to work together using a framework that was flexible enough to accommodate various counselling techniques and approaches.

Summary

The timing of SSW training coincided with a number of DHS initiatives designed to articulate standards for community health counselling as well as improving client pathways and demand management. By DHS funding the SSW training it provided an opportunity for most agencies to inform the majority of staff about the approach. It also sent a message that DHS was providing a recommended solution to some of the issues facing community health counselling services that most managers were compelled to seriously consider. Services that successfully implemented SSW often experienced a sense of positive regard by others within their organisation and sometimes from colleagues external to their organisation. Most organisations that successfully implemented SSW also experienced a boost in staff morale by coming together as a team to apply and review SSW.

7.2 The Bouverie Centre trainers' experience

The SSW trainers interviewed thought that the community health sector was somewhat receptive to SSW training due to the positive reputation of The Bouverie Centre. The trainers actively attempted to "practice what they preached" by making themselves available for email and telephone contact after the training in line with a SSW philosophy. Fundamentally they thought that SSW was a 'good product' that fitted with the service values of many community health agencies and the practice philosophy of many counsellors. There are five categories outlined below that broadly summarise what the trainers identified as key factors that influenced the training and implementation project.

Recruitment

Staff involved in the SSW training and implementation project were recruited on the basis of their extensive clinical knowledge of SSW, experience implementing SSW at The Bouverie Centre and in a large community health service. The manager and two of the counsellors had previously worked in CHSs. As a result of their combined experience with SSW and other state-wide projects they understood that to be successful, training must be accompanied by service development. As a result the project was designed to be appealing and target different stakeholder groups including managers, counsellors and clients.

Work with stakeholder groups

The trainers used their systemic view to acknowledge the different needs and motivations of stakeholder groups while attempting to create workable alliances between the groups. The

trainers were concerned that they maintained their passion and integrity regarding the clinical advantages of SSW while not being viewed by CH counsellors as the 'arm' of government.

To this end The Bouverie Centre SSW project manager actively worked with DHS to ensure that the training was not compulsory. The trainers were transparent with training participants and provided the same implementation information to managers and counsellors. The individual trainers also made a conscious attempt not to 'sell' the approach and encouraged counsellors to make their own judgements while encouraging open mindedness and experimentation. They were also encouraged to think about how they could elicit feedback from clients and evaluate the process before deciding on a course of implementation.

The trainers also enjoyed a positive relationship with key DHS representatives. This relationship enabled feedback and information loops between DHS, The Bouverie Centre and the community health sector that was productive and responsive to sector opinions. For example, counsellors employed in CHSs as counsellors under different funding streams were allowed to attend the SSW training at the request of CHSs.

Common values

The trainers believed that the values of The Bouverie Centre and the community health sector were compatible. In particular, both shared common beliefs about the importance of the social model of health with the client as central in the decision making about their own treatment. SSW provided a framework that fitted with the community health values of respecting difference and the trainers emphasised respect for all therapeutic approaches by outlining Asay and Lambert's (2003) common factors to therapy and defining SSW as a service delivery model rather than a model of therapy. This had the effect of offering the possibility for the bridging of difference between therapeutic orientations rather than prescribing a particular therapeutic approach. The trainers used the DHS client contact data (see Figure 1) to highlight the SSW research and to reinforce that every client represented in the contact data should be provided with the best possible service.

Relevance of training

The SSW training was delivered at the same time as the DHS review into counselling services and an emphasis on demand management. SSW provided an acceptable solution which was compatible with the values of the majority of organisations and counsellors. A number of strategies were used to make the training and subsequent implementation as relevant as possible. Some counsellors who attended the DHS funded training had previously attended SSW training and were encouraged to speak about their experience using the approach. Using the workshop evaluation forms as a guide, the training was redeveloped during the project to adapt to the changing needs of the participants. Trainers observed that over time participants were less sceptical about the approach and wanted more practical activities during workshops to learn how to apply SSW.

The advent of the SSW implementation research gave The Bouverie Centre access to community health counselling contact data compiled by DHS (see figure 1, section 3). The Bouverie trainers used the data to reinforce the research, finding that the most common number of sessions attended by clients is one. This highlighted the aim of the SSW training to assist counsellors to provide a better service rather than recommending a reduction in sessions for clients.

Strategy to assist the scope of implementation

The initial round of training was received favourably by the field and served as a consciousness-raising activity for the sector. The Bouverie Centre provided some consultations free of charge to several organisations interested in formally implementing SSW. The Bouverie Centre learned about SSW implementation through the example of these early consults including the involvement of intake workers in the process. These early consultations generated SSW 'demonstration organisations' in the field and highlighted local expertise that had the effect of The Bouverie Centre not being seen as the sole guardians of SSW.

As a result of the initial training and consultation initiative the trainers designed a further training and implementation strategy that was funded by DHS. This was based on the understanding that the community health sector prides itself on respecting diversity and therefore a number of different implementation options were provided to suit the diversity of the sector. Multiple opportunities were provided to continue to engage the sector and maintain the momentum of SSW implementation. Further training, ongoing consultations and the launch of the SSW Implementation Parcel kept SSW visible and accessible to the

sector through meaningful activity. Funding by DHS provided the ongoing opportunity for counsellors to trial the approach especially if they had not had an opportunity during the initial training phase.

Summary

Trainers had credibility with the sector due to their extensive experience in the clinical application of SSW and previous employment in CHSs. Various stakeholder groups were engaged while the trainers acknowledged that the groups sometimes held different motivations for implementing SSW. The common values between The Bouverie Centre and the community health sector were thought to contribute to a similar understanding of the therapeutic application of SSW as a framework for service delivery rather than a therapeutic model. The SSW training was altered during the project to adapt to the changing needs of training participants. A strategy was formed to provide multiple opportunities for the workforce to be actively engaged in opportunities for SSW implementation over an extended period of time.

8 Conclusion

DHS, and particularly the staff in the Primary Health Branch, Rural & Regional Health & Aged Care Services Division, must be congratulated for having the foresight to fund a comprehensive training program coupled with an ongoing implementation strategy that led to the remarkable implementation levels of Single Session Work. The SSW training and implementation project is the culmination of a comprehensive review of community health counselling services by DHS, coupled with the combination of a unique administrative climate and visionary personnel willing to fund a new approach to workforce development in the sector. This research was funded in an attempt to understand and evaluate the new approach initiated by DHS to funding sector wide workforce development. The Bouverie Centre training and research team have benefited from key personnel at DHS also taking a 'leap of faith' in trusting our judgement to deliver the SSW project, especially when project deliverables were uncertain due to the vagaries of offering a flexible and responsive implementation support service. This was, in part, due to robust relationships established between staff from The Bouverie Centre and DHS that established an air of trustworthiness.

Originally this research project was viewed as a relatively small enterprise that would document the promising implementation of SSW in community health counselling. When we started the research at The Bouverie Centre we thought that the sector had received the initial SSW training positively and had started to incorporate SSW into general service provision. The significance of the degree of receptivity to the implementation of SSW has only become apparent when compared to the low uptake rates of evidence-based and innovative practices reported in the literature across the health and welfare sector more generally. The uptake was particularly significant considering the complexity of the variables involved in initiating a change to counselling practices and the jealously guarded diversity across most CHSs. Perhaps there is an element of luck associated with the remarkable enthusiastic uptake of SSW by the sector: after all, 'timing is everything,' and this project came when the mood (the DHS review of counselling services) and evidence for change (particularly regarding demand management) was high. The current research helped understand and document what factors are required to successfully implement SSW in Victorian community health counselling services. These factors will inform implementation of SSW in other services and other innovations in community health. In short, a deliberate,

thoughtful approach coupled with a concerted plan of action by all stakeholder groups is required.

Specifically the research shows that key factors in the successful implementation of SSW in community health counselling include:

Relevance

- SSW is an extremely relevant approach to service delivery because the most common number of sessions that clients attend in community health counselling is one.
- By funding the SSW training, DHS provided a recommended solution to some of the issues facing community health counselling services, such as demand management, that most managers were compelled to seriously consider.

Compatibility

- A large proportion (up to 80%) of counsellors agreed that SSW was compatible with their core counselling beliefs and practices especially regarding the compatibility of SSW with the social model of health, and a client centred, strengths based approach.
- The organisations that adopted SSW viewed the approach as augmenting other existing service tasks such as quality assurance measures and service improvement.

Outcomes

- Organisations that implemented SSW reported a reduction in counselling waiting times for clients of between one and 47 weeks.
- Most organisations that successfully implemented SSW also experienced a boost in staff morale by coming together as a team to apply and review SSW.

Adaptation

- Those Services that implemented SSW invested resources into adapting the accompanying SSW paperwork to suit the agency context.
- The use of a regular review or an evaluation process by implementing organisations assisted the adaptation of SSW to the specific service delivery context.

Leadership

- Organisations that implemented SSW were more likely to possess leaders who inspired staff, were passionate about the provision of client services and gave clear direction.
- Respected counsellors within services or 'clinical champions' of the approach also influenced the uptake of SSW.

Training and support

- Providing flexible and recursive training that engaged various stakeholder groups to meet the changing needs of the sector over time, including 'catch-up' training to induct new team members.
- Providing specialist external supervision assisted counsellors to maintain confidence in applying SSW particularly where their line manager did not have qualifications or expertise in counselling.
- The offer of ongoing external consultations to services by The Bouverie Centre staff provided an opportunity for counsellors and managers to adapt SSW practices with guidance from recognised experts.

Perhaps the most significant factor to the successful implementation of SSW was the openness of CH counsellors and their managers to engaging with SSW ideas. The overwhelming majority of CHSs were the willing recipients of training and actively adapted the ideas conveyed by The Bouverie Centre trainers to fit with their agency context and beliefs about prudent client service provision, particularly the central role of the client in determining the nature and duration of treatment. Although managers and counsellors were willing to participate in various aspects of this research project the low return rate for the pre and post implementation questionnaire and the untrustworthiness of some of the data was disappointing. This highlights the need for the sector to continue to work with DHS to collect the most relevant service data that is fed back to counsellors in a way that can meaningfully affect client service provision.

A spirit of co-operation also exists in the community health sector that assisted the implementation process. Organisations that had already adopted SSW generously shared the experience and consulted with other organisations. Counsellors and managers, from SSW implementing CHSs, who consulted to other agencies gained a sense of acknowledgment that further reinforced the value of SSW in their own agency.

Those CHSs and individual counsellors that have successfully implemented SSW can be justifiably proud of the achievement given the constraints to implement new initiatives. It will be a challenge to maintain the long term use of SSW as an element of service delivery with the high rate of management and counsellor turnover in most CHSs. This will require a similar degree of dedication and planning as shown in the initial implementation. This research emphasises the need for any future workforce development strategies to incorporate a comprehensive, ongoing training and support approach that engages collaboratively with all service stakeholders. We hope that the experience gained from the participation in this project and the information from this report will assist the field to understand the elements necessary for the successful implementation of other practices. While there are specific variables involved in this project the implementation knowledge gained from this example can be transferred to future service development initiatives within community health and other health and welfare service sectors.

9. References

- Aarons, G. (2004). "Mental Health Provider Attitudes Toward Adoption of Evidence Based Practice: The Evidence-Based Practice Attitude Scale (EBPAS)." Mental Health Services Research **6**(2): 61-73.
- Asay, T., & Lambert, M. (2003) The Empirical Case for the Common Factors in Therapy. In M. Hubble, B. Duncan, & S. Miller. (Eds.) The Heart and Soul of Change. Washington, DC., American Psychological Association.
- Bloom, B. (2001). "Focused single session psychotherapy: A review of the clinical and research literature." Brief Treatment and Crisis Intervention **1**(1): 75-86.
- Bond, G., Becker, D., Drake, R., Rapp, C., Meisler, N., Lehman, A., & Others (2001). "Implementing supported employment as an evidence-based practice." Psychiatric Services **52**(3): 313-322.
- Boyhan, P. (1996). "Clients' Perceptions Of Single Session Consultations As An Option Waiting For Family Therapy." Australian and New Zealand Journal of Family Therapy **17**(2): 85-96.
- Breuer, J., & Freud, S. (1944). Studies in Hysteria. The Complete Psychological Works of Sigmund Freud. In J. Strachey. London, Hogarth Press. **2**.
- Buchan, H. (2004). "Gaps between best evidence and practice: causes for concern." The Medical Journal of Australia **180**(6): s48-s49.
- Campbell, A. (1999). "Single session interventions: An example of clinical research in practice." Australian and New Zealand Journal of Family Therapy **20**(4): 183-194.
- Corrigan, P., Leigh, S., McCracken, S., Blaser, B., & Barr, M. (2001). "Strategies for Disseminating Evidence-Based Practices to Staff Who Treat People With Serious Mental Illness." Psychiatric Services **52**(12): 1598-1606.
- Davis, D., & Taylor-Vaisey, A. (1997). "Translating guidelines into practice." Canadian Medical Association **157**(4): 408-416.
- Department of Human Services (Victoria). (2002). Review of counselling services in community health: discussion paper. Primary and Community Health Branch, Rural and Regional Health and Aged Services Division, Melbourne.
- Fixsen, D., Naoom, S., Blase, K., Friedman, R. & Wallace, F. (2005). Implementation Research: A Synthesis of the Literature. University of South Florida, Louis de la Parte Florida Mental Health Institute. Tampa, The National Implementation Research Network.
- Gotham, H. (2006). "Advancing the Implementation of Evidence-Based Practices Into Clinical Practice: How Do We Get There From Here?" Professional Psychology: Research and Practice **37**(6): 606-613.

- Greenhalgh, T., Robert, G., MacFarlane, F., Bate, P. & Kyriakidou, O. (2004). "Diffusion of Innovations in Service Organisations: Systematic Review and Recommendations." The Milbank Quarterly **82**(4): 581-629.
- Grimshaw, J., & Eccles, M. (2004). "Is evidence-based implementation of evidence-based care possible?" The Medical Journal of Australia **180**(6): S50-S51.
- Grol, R., & Grimshaw, J. (2003). "From best evidence to best practice: effective implementation of change." Lancet **362**: 1225-1230.
- Grol, R., & Wensing, M. (2004). "What drives change? Barriers to and incentives for achieving evidence-based practice." The Medical Journal of Australia **180**(6): S57-S60.
- Hart, P. (1999). "Predicting Employee Life Satisfaction: A Coherent Model of Personality, Work and nonwork Experiences, and Domain Satisfactions." Journal of Applied Psychology **84**(4): 564-584.
- Hart, P., & Cooper, C. (2001). Occupational Stress: Toward a More Integrated Framework. In N. Anderson, D. Ones, H. Sinangil, & C. Viswesvaran. (Eds.) Handbook of Industrial, Work and Organisational Psychology. London, Sage.
- Henderson, A., Davies, J. & Willet, M. (2006). "The experience of Australian project leaders in encouraging practitioners to adopt research evidence in their clinical practice." Australian Health Review **30**(4): 474-484.
- Hitt, J., Robbins, A., Galbraith, J. & Todd et al. (2006). "Adaptation and Implementation of an Evidence-Based Prevention Counseling Intervention in Texas." Aids Education and Prevention **18**: 108-119.
- Hubble, M., Duncan, B., & Miller, S. (2003). Directing Attention to What Works. In M. Hubble, B. Duncan, & S. Miller. (Eds.) The Heart and Soul of Change. Washington, DC., American Psychological Association.
- Hudnall Stamm, B. (2005). The Professional Quality of Life Scale: Compassion Satisfaction, Burnout and Compassion Fatigue / Secondary Trauma Scales. Idaho, Sidran Press.
- Kaffman, M. (1995). "Brief Therapy in the Israeli Kibbutz." Contemporary Family Therapy, **17**(4): 449-468.
- Kitson, A., Harvey, G. & McCormack, B. (1998). "Enabling the implementation of evidence based practice: a conceptual framework." Quality in Health Care **7**: 149-158.
- Littlepage, G. (1976). "The Problem Of Early Outpatient Terminations From Community Health Centres: A Problem For Whom?" Journal of Community Psychology **4**: 164-167.
- Locock, L., Dopson, S., Chambers, D. & Gabbay, J. (2001). "Understanding the role of opinion leaders in improving clinical effectiveness." Social Science & Medicine **53**: 745-757.
- Lomas, J., Anderson, G., & Domnick-Pierre, K. (1989). "Do practice guidelines guide practice? The effect of a consensus statement on the practice of physicians." Journal of Medicine **321**: 1306-1311.

Malan, D., Heath, E., Bascal, H., & Balfour, H. (1975). "Psychodynamic changes in untreated neurotic patients, II. Apparently genuine improvements." Archives of General Psychiatry, **32**: 110-126.

Michie, S., Johnston, M., Abraham, C., Lawton, R., Parker, D. & Walker, A. (2005). "Making psychological theory useful for implementing evidence based practice: a consensus approach." Qual Saf Health Care **14**: 26-33.

Miller, R., & Shinn, M. (2005). "Learning from communities: overcoming difficulties in dissemination of prevention and promotion efforts." American Journal of Community Psychology **35**(3): 169-184.

Perkins, R. (2006). "The effectiveness of one session of therapy using a single-session therapy approach for children and adolescents with mental health problems." Psychology and Psychotherapy: Theory, Research and Practice **79**: 215-227.

Price, C. (1994). "Open days: Making family therapy accessible in working class suburbs." Australian and New Zealand Journal of Family Therapy **15**(4): 191-196.

Rogers, E. (1995). Diffusion of Innovations. New York, Free Press.

Rosenbaum, R., Hoyt, M., F., & Talmon, M. (1990). The challenge of single-session therapies: Creating pivotal moments. Handbook of Brief Psychotherapies. R. A. Wells and V. J. Gianetti. New York, Plenum Press: 165-189.

Silverman, W. B., R. (1979). "Are Dropouts, Dropouts?" Journal of Community Psychology **7**: 236-242.

Talmon, M. (1990). Single Session Therapy: Maximising the Effect of the First (and often only) Therapeutic Encounter. San Francisco, Jossey-Bass.

Talmon, M. (1993). Single-Session Solutions: A Guide to Practical, Effective, and Affordable Therapy. New York, Addison-Wesley Publishing Company.

Torrey, W., Drake, R., Dixon, L., Burns, B., Flynn, L., Rush, A., Clark, R. & Klatzker, D. (2001). "Implementing Evidence-Based Practices for Persons With Severe Mental Illnesses." Psychiatric Services **52**(1).

Whittle, T., & Young, J. (2006). Single Session Implementation in Community Health. The Bouverie Centre, Unpublished.

Young, J., & Rycroft, P. (1997). "Single-Session Therapy: Capturing the Moment." Psychotherapy in Australia **4**(1): 18-23.

10. Appendices

- A. Letter inviting participation in the SSW Implementation Research
- B. Pre SSW implementation questionnaire
- C. Post SSW implementation questionnaire
- D. Participant information and consent form
- E. FAQs for SSW web survey for counsellors
- F. SSW web survey for counsellors

A. Letter inviting participation in the SSW Implementation Research

50 Flemington Street
Flemington 3031

16 March, 2006

To: CEOs, Managers, Directors of Victorian Community Health Services
Re: Single Session Work Evaluation in Community Health Counselling Teams

The Bouverie Centre has received funding from the Department of Human Services to document the implementation process and impact of single session work in community health counselling services across Victoria. This represents a unique opportunity for community health services in conjunction with The Bouverie Centre to investigate the usefulness of single session work as it has been interpreted and used by a variety of community health services across the state.

We would like to invite your organisation and particularly your counselling team to contribute to the data we intend to collect. Through the collation of various data we intend to compile a profile of:

- How single session work has impacted on service delivery,
- How individual agencies have applied the ideas,
- What has been effective or ineffective,
- Why some agencies have decided against implementation.

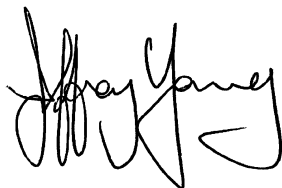
All the data gathered from your agency will be encoded and unidentified for the purposes of the research and any subsequent findings.

If you decide to proceed as a participating agency, Shane Weir (project officer) or Michelle Wills (research assistant) will contact you and send you information on the data we would like you to collect as well as questions relating specifically to your service.

In order for your agency to participate, we require that an authorised office bearer from your organisation signs the attached consent form. We ask that you also include the name, position, and contact details of the staff member or members you would like us to engage with for the course of the project. All future correspondence from us requesting information will then go to this person or persons.

We look forward to forging even closer links with your service and other community health services through this exciting initiative. If you have any further queries about the Single Session Work research please contact Shane Weir on 93769844 or email s.weir@latrobe.edu.au.

Yours sincerely,



Jeff Young (Project Manager)

B. Pre SSW implementation questionnaire

50 Flemington St.
Flemington 3031.

23 July 2006

Dear Colleague,

Request for Single Session Data

Thank you for consenting to participate in this DHS sponsored state-wide initiative to research the implementation of single session work (SSW) on service delivery in community health counselling services. We have prepared a short electronic survey that canvasses the experiences of agencies involved in the provision of counselling in the community health area. This survey requires the collection and collation of agency data during the period **prior to implementing SSW**. Some of the information we are requesting includes data that you routinely report to funding bodies. We appreciate, however, that some figures may not be readily accessible, and wish to thank you in advance for your efforts to procure them.

Your answers will remain **confidential** and care will be taken to safeguard the **anonymity** of your agency. All data received will be **de-identified**. Classifications will only be made by region and possibly by counselling team configuration i.e. service context and resources.

Could you complete the survey electronically and return it to the email address listed below by **Monday 21st August, 2006**? Feel free to attach any other information you believe is relevant or gives a background to your agency and service context.

You will be asked to complete a short follow up survey in **6 months** time. This will allow a comparison of your agency's experiences pre and post trialling or implementing SSW. **Note:** Contributions made by **all** agencies (including those **who have not decided to implement single session work** for whatever reason) will play a valuable role in building a rich profile of professional practice in community health counselling services state-wide.

A researcher will contact you periodically to discuss any questions you may have regarding the research. Should you have any further queries or concerns please do not hesitate to contact us at any time – Shane Weir, phone 93769844 or email s.weir@latrobe.edu.au or Michelle Wills m.wills@latrobe.edu.au.

On behalf of the research team thank you for your co-operation in this project.

Yours sincerely,

Jeff Young (Project manager)

Section One

Please answer the following questions. Your responses will help provide background information about your agency and service context. Remember, your agency will not be identified by your responses in the research findings. Results will be presented across the various DHS regions and counselling team configurations.

1. Name of your agency:

2. What DHS region does your agency fall into: (Please highlight the appropriate box)

- | | | | |
|-----------------------|--------------------------|----------------------|--------------------------|
| Barwon-South Western | <input type="checkbox"/> | Eastern Metropolitan | <input type="checkbox"/> |
| Gippsland | <input type="checkbox"/> | Grampians | <input type="checkbox"/> |
| Hume | <input type="checkbox"/> | Loddon Mallee | <input type="checkbox"/> |
| Northern Metropolitan | <input type="checkbox"/> | Southern Region | <input type="checkbox"/> |
| Western Metropolitan | <input type="checkbox"/> | | |

3. Number of counselling staff employed by your agency:

4. Number of counselling hours per fortnight (eft):

5. Number of sites where counselling is provided:

6. Your Agency's System of Intake: (Please highlight the appropriate box)

- Centralised and specific workers
 - Rostered duty system
 - Other, please describe:
-
-

7. How many staff members in your agency have received SSW training?

8. Has your agency decided to implement single session work (SSW)? (Please highlight the appropriate box)

Yes, or in the process of deciding.

No, **Please go to Question 12.**

9. How have, or will, the principles and practice of SSW be/been applied in your workplace? (Please highlight the appropriate box)

As an organisational approach to service delivery.

At the discretion of individual practitioners.

10. Are single session appointments used, or will they be used, as an initial intake point for all clients who meet the criteria for your service or are/will they be elective? (Please highlight the appropriate box).

SSW are/will be used as an initial intake point for all clients.

SSW appointments are/will be elective.

11. Who determines, or who will determine, which clients are allocated a single session appointment? (Please highlight the appropriate box/es).

Client.

Intake Worker.

Individual Practitioner.

(Please skip to Section Two after completing this question.)

12. Why has your agency decided against using a SSW approach? (Please highlight the appropriate box/es).

- Opposed due to our theoretical orientation or our values regarding service provision.
- Unnecessary due to lack of demand.
- Some staff are opposed.
- Insufficient resources.
- Lack of training.
- Lack of confidence/competence in ability to implement SSW.
- Not useful due to client demographic and/or presentation.
- Other, please describe:

Section Two

The following section of the questionnaire asks a number of questions regarding the session attendance and waiting list at your agency. If your agency has already implemented SSW or is in the process of doing so, please answer the next five questions based on your agency's experience prior to introducing SSW.

1. What was/is the average no. of sessions attended by clients for counselling?

2. What was/is the most common (modal) no. of sessions clients would attend for counselling?

3. What percentage of clients attended/attend for more than 12 sessions?

4. How many people were/are waiting for counselling?

5. What was/is the waiting time for counselling?

Thankyou for completing this survey

C. Post SSW implementation questionnaire

50 Flemington St.
Flemington 3031.

3 August 2007

Dear Colleagues

Statewide research into the impact Single Session Work in Community Health:

Thank you for collecting/collating the agency data we requested for the period **prior to** your agency's trial or implementation Single Session Work (SSW). We appreciate your time, effort, and commitment to the research. Your contributions will play a valuable role in building a rich profile of professional practice in community health counselling services state-wide.

To help us compare your agency's experiences pre and post trialling or implementing SSW, we have prepared a short follow up survey. **Note:** the information you previously provided is summarised for your perusal at the beginning. Please review it and confirm whether it is recorded accurately.

The remainder of the survey requires the collection and collation of agency data **now after** implementing SSW. Some of the information we are requesting includes data that you routinely report to funding bodies. We appreciate, however, that some figures may not be readily accessible, and wish to thank you in advance for your efforts to procure them.

Your answers will remain **confidential** and care will be taken to safeguard the **anonymity** of your agency. All data received will be **de-identified**. Classifications will only be made by region and possibly by counselling team configuration i.e. service context and resources.

Please complete the survey and return to Michelle Wills via email (see below address) or fax (03 9376 9890) by **Monday August 27, 2007**. Feel free to attach any other information you believe is relevant or gives a background to your agency and service context.

Should you have any further queries or concerns please do not hesitate to contact us at any time – Shane Weir, phone 93769844 or email s.weir@latrobe.edu.au or Michelle Wills m.wills@latrobe.edu.au.

On behalf of the research team thank you again for your co-operation in this project.

Yours sincerely,

Jeff Young (Project manager)

Section One

The following table lists the background information you provided about your agency and service context. Please read over and confirm or correct as required. Remember, your agency **will not** be identified by your responses in the research findings.

Background Information	Answers you provided	<input type="checkbox"/> If correct
Name of your agency:		
DHS region:		
Number of counselling staff employed by your agency:		
Number of counselling hours per fortnight (eft):		
Number of sites where counselling is provided:		
Your Agency's System of Intake: a) Centralised and specific workers, b) Rostered duty system or c) Other.		
Number of staff members in your agency that have received SSW training:		
The principles and practice of SSW have been applied in your workplace as: a). As an organisational approach to service delivery or b). At the discretion of individual practitioners		
Single session appointments are used as: a). An initial intake point for all clients who meet the criteria for your service or b). They are elective		

Background Information	Answers you provided	<input type="checkbox"/> If correct
a) The Client and/or b)The Intake Worker and/or c) The Individual Practitioner determines which clients are allocated a single session appointment.		

Section Two

The following table lists the information you provided based on your agency's experience prior to introducing SSW. Please read over and confirm or correct as required.

Background Information	Answers you provided	<input type="checkbox"/> If correct
The average no. of sessions attended by clients for counselling at your service:		
The most common (modal) number of sessions clients attended for counselling:		
The percentage of clients who attended for more than 12 sessions:		
Number of people waiting for counselling:		
Waiting time for counselling:		

D. Participant information and consent form

The Bouverie Centre has received funding from the Department of Human Services to document the implementation process and impact of single session work in community health counselling services across Victoria.

The aim of the study is:

To investigate the impact of Single Session Work in Community Health Services specifically where it has been implemented or has been attempted in counselling services.

To participate:

All community health services across Victoria may participate in the research if they have or are going to attempt to implement single session work or if, for any reason the service has decided not to implement single session work.

What will it involve?

Involvement in the study will require your organisation to provide a range of data, information and documents that will establish what steps have been taken to implement single session work and how it has impacted on service provision within counselling services.

Storage and Confidentiality:

Every effort will be made to protect the anonymity and confidentiality of participants. All information collected during this research will be kept confidential and only the researchers will have access to the information and know the identity of participating organisations. Individuals will not be named in the reporting of the research and all identifying information about you will be removed. Participating organisations will only be named with the approval of the CEO and only in connection to any collaborative presentations at conferences etc. All completed questionnaires will be kept in a locked cabinet with any computer files being password protected. After the final research report the original data will be kept in a special secure facility at La Trobe University and destroyed after a period of 5 years.

What if I change my mind about participating?

Participation in the study is voluntary and any individual or organisation is free to withdraw at any time for any reason. If you withdraw, your contribution to the study will also be withdrawn unless you give written permission for the inclusion of the material.

Research findings:

You will be provided with a copy of the final report. The research findings may be presented at conferences or published in journals. Care will be taken to ensure that no individuals will be identified and that the organisation cannot be identified in any presentation of the material without the approval of the CEO.

Data collected from this study may be retained and used in future studies to further research Single Session Work. This may include a possible follow-up study. Organisations will be notified and consent obtained before any extra study is undertaken.

Research Investigators:

Jeff Young - Project Manager. The Bouverie Centre, 50 Flemington Street, Flemington 3031.
Telephone – 93769844, email: j.young@latrobe.edu.au

Shane Weir – Project Officer. The Bouverie Centre, 50 Flemington Street, Flemington 3031.
Telephone – 93769844, email: s.weir@latrobe.edu.au

Michelle Wills – Research Assistant. The Bouverie Centre, 50 Flemington Street, Flemington 3031.
Telephone – 93769844, email: m.wills@latrobe.edu.au

Any questions?

If you have any further questions about this research please contact Shane Weir at The Bouverie Centre, 50 Flemington Street, Flemington 3031 ph. 9376 9844 or email s.weir@latrobe.edu.au

If you have any complaints or queries that Shane is unable to answer please contact Jeff Young at The Bouverie Centre or the Ethics Liaison Officer, Human Ethics Committee, La Trobe University HEC (ph: 9479 1443, or email: m.junge@latrobe.edu.au).

I..... have read the participant information details and any questions I have asked have been answered to my satisfaction. I agree for, the organisation I represent, to participate in the study above knowing that I may withdraw this consent at anytime. I agree that information collected from the study may be presented at conferences or published in journals on condition that the organisation is not identified in the material without my consent.

I would like future correspondence from The Bouverie Centre to be directed to the staff member named here:

(Name).....(Position).....

(Phone).....

(Email).....

I sign this document as the delegated authority for the above mentioned organisation.
Signature of Chief Executive Officer (on behalf of organisation):

Date:

I will adhere to all conditions set out in this document.

Signature of researcher:

Date:

E. FAQs for SSW web survey for counsellors



Worker Feedback on The Single Session Process

Web Based Single Session Work (SSW) in Community Health Questionnaire FAQ's (Frequently Asked Questions)

Q: What will The Bouverie Centre do with my information?

A: Only the researchers will have access to raw survey data captured through the electronic survey system. Individuals will **not** be named in the reporting of the research and all identifying information will be removed.

Q: What is Single Session Work (SSW)?

A: *SSW, single session work, single session therapy and single session* are interchangeable terms. They all describe a service delivery system that results from accepting that approximately fifty per cent of clients attend only once or twice. The service delivered is characterised by treating each contact as if it may be the last, while laying the foundation for ongoing work if required.

Q: What type of information will be provided by the Single Session Work (SSW) in Community Health Questionnaire?

A: Information provided by individual clinicians/counsellors will help build a profile of:

- How single session work has impacted on service delivery;
- How individual workers have applied SSW ideas;
- What has been effective or ineffective;
- Why some workers have decided against implementation; and
- Factors that support implementation and sustainability of a SSW approach.

Q: What are the advantages to workers completing The Bouverie Centre's Single Session Work (SSW) in Community Health Questionnaire?

A: The questionnaire will provide individual workers with an opportunity to reflect on their practice and review their client service delivery as well as help illuminate what kinds of support community health counselling services may require to implement and sustain a SSW approach.

Q: When does the survey period commence?

A: The questionnaire will be active from May 7 to June 8 2007.

Q: How do I access the questionnaire?

A: Simply type www.bouverie.org.au/s257 into your web browser and follow the prompts.

Q: If I get interrupted, can I exit the questionnaire and return to it at a later stage?

A: The questionnaire is designed to be completed in a single sitting and should take around 20 minutes to finish. Workers are advised to respond to each question with the first answer that comes to mind and not to deliberate for too long. If a user exits the questionnaire or loses connection to the server before clicking on the submit button at the end of the survey, his/her responses will **not** be recorded. **Note:** if the survey is left idle for more than 20 minutes, the session will automatically timeout and any unsaved responses will be lost.

Q: What if I want to change what I have said?

A: Respondents are able to click on the “previous” button and browse through/amend their responses prior to submitting their answers at the end of the survey.

Q: My Community Health Service has not formally incorporated Single Session Work into its counselling program, can I still complete the questionnaire?

A: Yes, contributions made by **all** workers (including those who have not decided to implement single session work for whatever reason) will play a valuable role in profiling how single session work has been interpreted and used by a variety of community health services across the state.

Q: How will I know if The Bouverie Centre receives my information?

A: You will receive a confirmation message when you submit your information.

Q: When will I know the results of this questionnaire?

A: Once the results have been compiled, the key findings will be disseminated with the approval of DHS to all Community Health Services.

Q: Who should be contacted if there are questions not covered in this FAQ?

A: If you have any additional queries about this survey please contact Shane Weir or Michelle Wills at The Bouverie Centre, 50 Flemington Street, Flemington 3031 ph. 9376 9844 or email s.weir@latrobe.edu.au or m.wills@latrobe.edu.au.

F. SSW web survey for counsellors

50 Flemington St.
Flemington 3031.

12 March 2007

Dear Colleague,

Request for Worker Feedback on Single Session Process

The Bouverie Centre has received funding from the Department of Human Services to document the implementation process and impact of single session work (SSW) in community health counselling services across Victoria.

As part of the research, we have prepared a questionnaire canvassing the experiences of workers involved in the provision of counselling in the community health area. It asks respondents to reflect on what steps have been taken to implement single session work within their agency and how it has impacted on service provision.

Consent to participate in the research will be implied from completion of the survey. Participation is entirely **voluntary** and **anonymous**. All responses will be treated with the strictest of confidence.

The survey should take around 20 minutes to complete and **must be finished in one sitting**. Please respond to each question with the first answer that comes to mind (do not deliberate for too long). There are **no** right or wrong answers. Just give the answer that is most accurate for you.

Contributions made by **all** respondents - **including** counselling staff employed at agencies **who have decided against applying this approach** for whatever reason - will play a valuable role in building a rich profile of professional practice in community health counselling services state-wide.

On behalf of the research team, thank you in advance for taking the time to complete this questionnaire. If you have any queries or concerns please do not hesitate to contact us at any time – Shane Weir, phone 93769844 or email s.weir@latrobe.edu.au or Michelle Wills, m.wills@latrobe.edu.au.

Yours sincerely,

Jeff Young (Project manager)

Section One

Please answer the following questions by selecting the appropriate response. Your answers will help provide us with information about your specific service context. Remember, your responses will remain completely confidential.

1. What is your gender?

Male

Female

2. How much Community Health counselling experience do you have?

Less than 6 months

Greater than 6 months but less than 1 year

1 to 2 years

3 to 5 years

6 to 10 years

11 to 19 years

20 years or more

3. What is your professional background? (Check any that apply)

- Family Therapist
 - Social Worker
 - Psychiatrist
 - Psychiatric Nurse
 - Occupational Therapist
 - Psychologist
 - Welfare Worker
 - Other, please describe:
-

4. Which category best describes your main counselling role?

- Generalist
 - Family
 - Youth
 - Children
 - Alcohol and other drugs
 - Gambling
 - Other, please describe:
 -
-

5. Who are the main client groups you work with? (Check any that apply)

- Individual adults
 - Individual adolescents
 - Children
 - Couples
 - Families
 - Other, please describe:
-

6. What are the main types of client issues that you provide specialised counselling for? (Check any that apply)

- Anxiety
 - Depression
 - Alcohol and other drugs
 - Domestic/family violence
 - Family/Relationship issues
 - Grief
 - Personality disorders/Serious mental illness
 - Problem gambling
 - Sexual abuse
 - Stress and adjustment disorders
 - Other, please describe:
-

7. Which area does your agency operate in?

- Rural
- Regional
- Metropolitan

8. Do you work alone or as part of a counselling team? Branch to Section Two if option 2 is **NOT** selected.

- Alone
- Part of a counselling team
- Part of a multidisciplinary team

9. How many people are part of your counselling team?

Section Two

The following questions focus on the implementation of Single Session Work (SSW) in your organisation. Please select the appropriate response.

- 1. Have you undertaken any Single Session Work (SSW) training? (Please select the appropriate response).**

Yes

No **Branch to Question 6 if this option selected**

- 2. ****MANDATORY ****Was your SSW training provided by an internal or external source? (Check any that apply) **Branch to Question 4 if option 2 is NOT selected.****

I received SSW training from a staff member within my agency

I received SSW training from The Bouverie Centre

I received SSW training from an external organisation other than The Bouverie Centre

- 3. When did you receive SSW training from The Bouverie Centre?**

Less than 6 months ago

Greater than 6 months but less than 1 year ago

1 to 2 years ago

3 to 5 years ago

6 to 10 years ago

11 to 19 years ago

20 years or more ago

9. How long have you been using SSW principles and practice as part of your approach to service delivery?

- Less than 1 month
- 1 to 5 months
- Greater than 6 months but less than 1 year
- 1 to 2 years
- 3 to 5 years
- 6 years or more

10. How has the practice of SSW been applied in your workplace? (Please select the description that best fits your workplace).

- As an organisation-wide approach to service delivery
- At the discretion of individual practitioners
- Not at all Branch to Section Three if this option selected

11. Are single session appointments used as an initial intake point for clients who meet the criteria for your service? (Check any that apply)

- Yes, (all new clients to our service attend a Single Session appointment initially) Branch to Section Three if this option selected.
- Yes, (some new clients to our service attend a Single Session appointment initially)
- No, (new clients to our service do not attend a Single Session appointment initially)

12. Who determines which clients are allocated a single session appointment? (Check any that apply)

- Client
- Intake worker
- Counselling intake meetings
- Individual practitioner
- Other, please state _____

Section Three

The statements below describe how people might think or feel about counselling. Using the following scale, please select the response which best describes the extent to which you agree or disagree with each statement:

1 **2** **3** **4** **5**
Strongly **Strongly**
Disagree **Agree**

	Strongly Disagree		Strongly Agree		
1. Even a brief encounter can be therapeutic.	1	2	3	4	5
2. SSW reflects the interests of administrators rather than representing the key needs and concerns of clients.	1	2	3	4	5
3. For about half of the clients who attend counselling, significant change can happen in 1 or 2 sessions.	1	2	3	4	5
4. Counselling is built upon the therapeutic relationship which always takes more than 1 or 2 sessions to develop.	1	2	3	4	5
5. The paperwork and other documentation required for SSW takes time away from the more pressing needs of my service and its clients.	1	2	3	4	5
6. The process of change starts before the first session and will continue long after counselling ends.	1	2	3	4	5
7. Clients are experts in reporting what kind of and how much change is important for them at any particular time.	1	2	3	4	5
8. Big problems need a long time in counselling.	1	2	3	4	5
9. Clients are often most ready to change when they first seek help.	1	2	3	4	5
10. SSW is compatible with a social model of health, providing counselling which is driven by and empowering to clients.	1	2	3	4	5

	Strongly Disagree			Strongly Agree	
13. My immediate supervisor is supportive towards me.	1	2	3	4	5
14. I do not feel experienced or confident enough to help clients in a single session.	1	2	3	4	5
15. I feel overwhelmed by the amount of work or the size of the case/workload I have to deal with.	1	2	3	4	5
16. Caseloads between SSW and ongoing work are balanced in my workplace.	1	2	3	4	5
17. SSW training was not offered to me either internally or externally.	1	2	3	4	5
18. My immediate supervisor communicates well with employees.	1	2	3	4	5
19. Workers were involved in deciding how SSW ideas were applied/implemented in this agency.	1	2	3	4	5
20. This organisation provides some form of supervision/professional development about the SSW process.	1	2	3	4	5
21. Staff members in my organisation are unwilling to try new things.	1	2	3	4	5
22. An effective evaluation process has been established in my workplace to gain feedback from workers about the SSW process.	1	2	3	4	5
23. There is a negative emotional tone in this workplace.	1	2	3	4	5
24. I feel "bogged down" by the system.	1	2	3	4	5
25. SSW fits well with the core values of my organisation.	1	2	3	4	5

26. Are there any other factors which may have helped or hindered SSW being incorporated as part of clinical service delivery at your workplace? If so, what are they?

27. Please list any types of clients or clinical presentations that you believe are not suitable for SSW.

===== After completing Section Four=====

Respondents who select no when answering Question 8 of Section Two (Have you implemented the principles and practice of SSW in your work with clients?) now need to be presented with the following:

28. Please list the three main factors that have contributed to you not taking up SSW.

1. _____
2. _____
3. _____

Following this, they are to skip to Section Six q25.

Respondents who select the “yes” option to Question 8 of Section Two, need to be linked to Sections Five and Six.

Section Five

Single Session Work (SSW) training may have changed the way in which you think about and practice your work. Using the scale below, please select the response which best describes the extent to which you adopt the following practices:

1 **2** **3** **4** **5**
Not at **To a large**
all **extent**

	Not at all					Large Extent				
1. Have a greater sense of urgency to clarify what needs to be achieved during each contact?	1	2	3	4	5					
2. Not only focus on a client's problems, but acknowledge a client's strengths and abilities to cope?	1	2	3	4	5					
3. Be more direct and honest with clients?	1	2	3	4	5					
4. Always ask and explore what a client/s wants from each session?	1	2	3	4	5					
5. Always obtain feedback from clients about the service they have received?	1	2	3	4	5					
6. Always elicit what clients will take away from the therapeutic contact?	1	2	3	4	5					
7. Be more overt and collaborative with clients when deciding how much therapeutic contact is required?	1	2	3	4	5					
8. Combine services for a client in one session, such as assessment functions with therapeutic intervention?	1	2	3	4	5					
9. Shift my agenda to meet a client's concerns?	1	2	3	4	5					
10. Check in from time to time during <u>every</u> session to track whether my work is on target?	1	2	3	4	5					
11. Create opportunities for clients to try things themselves before assuming they need ongoing professional help?	1	2	3	4	5					

	Not at all			Large Extent	
12. Be more active or structured in client follow-up?	1	2	3	4	5
13. Incorporate direct client feedback in my work?	1	2	3	4	5

14. Are there any other ways in which SSW training has changed the way you think about and practice your work? If so, what are they?

Section Six

The following questions focus on the service implications of introducing Single Session Work (SSW). Your responses will help us to monitor and map changes in counselling services resulting from SSW.

1. Does your agency have a waiting list for counselling/casework?

Yes

No **Branch to Question 3 if this option selected**

2. To what extent has applying a SSW approach reduced the overall counselling waiting list at your agency?

1
Not at
all

2

3

4

5

To a large
extent

Using the above scale, please indicate the extent to which applying a SSW approach has:

	Not at all		Large Extent		
3. Been useful in providing a productive service to clients who attend only irregularly?	1	2	3	4	5
4. Allowed clients to meet with a counsellor at the initial time of their concern and/or crisis?	1	2	3	4	5
5. Provided a useful way to understand better what clients want and need?	1	2	3	4	5
6. Provided an effective way to receive immediate feedback about my work from clients and/or colleagues?	1	2	3	4	5
7. Heightened practitioner stress because SSW requires intensive output and the development of a new way of working?	1	2	3	4	5

8. Been useful in engaging clients who wouldn't otherwise attend (e.g., people who are suspicious of counselling)?	1	2	3	4	5
9. Assisted 'at risk' clients still required to wait for ongoing counselling to develop protective behaviours in the interim?	1	2	3	4	5
10. Freed up my time for work with longer term clients.	1	2	3	4	5
11. Required workers to be more resourceful and flexible in utilising whatever is likely to be helpful to particular client(s) at the particular time?	1	2	3	4	5
12. Decreased practitioner stress as a result of being able to intervene quickly?	1	2	3	4	5
13. Led to greater focus and helped avoid "therapeutic drift" in my longer term work?	1	2	3	4	5
14. Contributed to a higher quality of service provision in this agency?	1	2	3	4	5
15. Increased pressure on counsellors to provide one brilliant session?	1	2	3	4	5
16. Produced reluctance within my workplace to instigate long term counselling?	1	2	3	4	5
17. Led to disagreement about counselling practices and conflict in staff relations?	1	2	3	4	5
18. Encouraged counselling staff to talk about their work with each other?	1	2	3	4	5
19. Increased opportunities for counselling staff to work together and support one another?	1	2	3	4	5
20. Had a positive effect on staff morale?	1	2	3	4	5
21. Led to tension between management and counselling staff?	1	2	3	4	5
22. Contributed to high client satisfaction?	1	2	3	4	5

23. Are there any other service implications due to the introduction of SSW in your workplace? If so, what are they?

24. What will help your organisation sustain SSW?

25. Is there anything we have missed which you think is important in understanding the impact of SSW in community health services? If so, please use the comments box below to tell us what it is.

Thank you for taking the time to complete this questionnaire.