The Western Australia Model for Violence Prevention Pilot Evaluation

Trends and Process Evaluation Report 2 - Executive Summary

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Contents

1. EXECUTIVE SUMMARY

1.1 Introduction

- The WA Mental Health Commission (hereafter "the Commission") partnered with the East Metropolitan Health Service (EMHS)* to implement a four-year pilot, the Western Australian Model for Violence Prevention (WA MVP) Pilot. The WA MVP Pilot aims to address alcohol-related violence and injuries, reduce emergency department (ED) presentations at Royal Perth Hospital (RPH),** and improve community safety.
- Verian is conducting a process, outcome, and economic evaluation of the WA MVP Pilot. The process evaluation aims to provide insights into the WA MVP Pilot's implementation, including what worked or didn't, and why. It also tracks trends in long-term outcomes. The trends and process evaluation is conducted every six months and provides early indicators of change and helps guide timely adjustments.
- This report is the second trends and process evaluation report (hereafter "Report 2"). It comprises two parts: 1) a longitudinal process evaluation and 2) a trends analysis of long-term outcomes.

*Note: * EMHS comprises an extensive hospital and health service network which includes RPH, St John of God Midland Public Hospital, Byford Health Hub, Armadale Health Service, Bentley Health Service, and Kalamunda Hospital. Source: https://emhs.health.wa.gov.au/Hospitals-and-Services/Hospitals.*
*** RPH is located in Perth and has one of the busiest EDs in Australia and the second biggest trauma workload in the country. Source: https://royalperthhospital.health.wa.gov.au/About-Us.*

1.2 Longitudinal process evaluation

Key evaluation questions (KEQ)

The longitudinal process evaluation aims to address the following KEQs:

- **KEQ 1.** Across key activities and outputs of the WA MVP Pilot implementation, what worked well and what didn't – and why?
- **KEQ 2.** How do different stakeholders understand, experience, and support the WA MVP Pilot?

Data

- The longitudinal process evaluation utilises data from an online survey of stakeholders conducted every six months, capturing their opinions on nine implementation elements of the WA MVP Pilot. Respondents may be the same or different between survey waves. Therefore, changes in implementation over time could be due to different samples rather than shifts in the opinions of the same individuals.
- Report 2 uses data from the second wave of the stakeholder survey undertaken between 5 August 2024 to 19 August 2024. A total of 30 usable responses* were obtained from government frontline staff** (n=27) and government back-office staff** (n=3).
- Given the limited sample size of government back-office survey respondents (hereafter "respondents"), comparative analysis between different stakeholder groups (KEQ 2) was not meaningful. Subsequently, this report does not report findings against KEQ 2. Responses from government back-office staff have been combined with those of the government frontline staff and analysed in aggregate to answer KEQ 1.

*Note: * The survey had a total of 41 respondents. However, 11 only answered the screener questions. These respondents were excluded from the analysis, leaving a final sample size of 30 observations for the analysis.*
*** Government frontline staff are defined in the evaluation as those with a role that primarily involve direct interaction with the public, such as public health nurses and police officers. Government back-office staff are defined as those with a role that mainly involve administrative tasks, policy development, finance, human resources, and other support functions.*

1.2 Longitudinal process evaluation (cont'd)

Key findings

KEQ 1. Across key activities and outputs of the WA MVP Pilot implementation, what worked well and what didn't – and why?

Overall, a higher percentage of respondents were familiar with most surveyed aspects of the WA MVP Pilot compared to March 2024. The information/education about the WA MVP Pilot achieved higher reach, with more respondents finding it practical, informative, and clearly delivered. Better ratings were also observed in perceived feasibility, leadership, and collaboration. Additionally, there was a reduction in the time spent on the WA MVP Pilot, and self-efficacy among respondents increased. However, while a greater proportion of nurse respondents said that patient data collection was easy, the time required to collect data per patient increased, and more respondents reported unintended consequences.*

1. Familiarity: Compared to March 2024, respondents' familiarity with the WA MVP Pilot increased. In August 2024, a higher percentage of respondents reported being informed of the WA MVP Pilot's purpose (+10 percentage points, hereafter "pp", to 100%), measurable outcomes (+12 pp to 97%), implementation processes (+25 pp to 100%), timeline (+20 pp to 93%), and the stakeholders involved (+15 pp to 87%). The proportion of respondents who felt informed about their role in the WA MVP Pilot remained high and unchanged at 90%. Most respondents did not specify additional information they wanted to know about the WA MVP Pilot; only a few expressed interest in learning more about its outcomes (n=2), implementation plan (n=1), and strategy development method (n=1).

2. Information/Education: Compared to March 2024, a higher percentage of respondents recalled receiving information/education about the WA MVP Pilot (+10 pp to 97%) and found it to be practical (+7 pp to 72%), informative (+10 pp to 72%), clearly delivered (+6 pp to 59%), and of an appropriate length (+3 pp to 41%). Among those who did not find information/education to be of an appropriate length, the majority (69%, n=11) preferred it to be shorter. Some respondents suggested that regular reminders (n=1) and follow-up education (n=1) would further enhance the quality of information/education provided.

*Note: * Interpretation of these trends should be approached with caution due to the limited survey sample size and potential variations in respondent composition across survey waves.*

1.2 Longitudinal process evaluation (cont'd)

Key findings

3. Perceived feasibility: Compared to March 2024, a significantly higher percentage of respondents (+33 pp to 79%) believed that achieving the purpose of the WA MVP Pilot was likely. Some respondents suggested that increased stakeholder engagement (n=5) and improved data entry system (n=3) could further enhance its feasibility. The data entry system should not display branching questions about alcohol use when nurses indicate that a presentation is not alcohol-related*.

4. Leadership: A higher percentage of respondents agreed that leadership was excellent or very good in communication (+8 pp to 92%), implementation support (+8 pp to 81%), and responsiveness to feedback (+21 pp to 88%). Factors that facilitated positive feedback about leadership included open communication, approachability, and being informative and helpful (n=3). However, a delay in implementation raised concerns among some respondents (n=2), as they were anticipating the start of strategy implementation.

5. Collaboration: Compared to March 2024, a higher percentage of respondents (+9 pp to 95%) felt working with others on the WA MVP Pilot was collaborative. Among those who provided additional information on their collaboration experience, positive experiences were attributed to networking opportunities (n=1) and participation in meetings (n=1). However, one respondent suggested that more active contributions from each stakeholder agency would enhance collaboration.

6. Time spent on the WA MVP Pilot: The average proportion of respondents' working time spent on the WA MVP Pilot over the past six months decreased by 7 pp to 14% in August 2024. Similarly, over the past four weeks, the average number of hours spent on the WA MVP Pilot dropped by 18%, down to 18 hours in August 2024. This could be due to the larger proportion of nurse respondents in the August 2024 survey.

*Note: * When nurses select "no" to the question "Is the reason for your attendance related to your alcohol use or someone else's?", the system displays follow-up questions about alcohol use such as "where did you obtain most of your alcohol from" (see triage questions in Annex 6.1).*

1.2 Longitudinal process evaluation (cont'd)

Key findings

7. Self-efficacy: The percentage of respondents who felt that their actions in the WA MVP Pilot were effective increased by 13 pp to 70%. Some respondents provided additional information on the support they needed to be more effective, including a better data entry system at triage (n=2), increased stakeholder engagement (n=2), and improved data on pre-hospital situations (n=1).

8. Patient data collection: The percentage of respondents who found data collection easy increased by 7 pp to 64%. The same barriers to patient data collection identified in March 2024 were observed, including patient unwillingness or inability to provide information (n=2), time constraints (n=1), and psychological barriers (n=1). While two nurse respondents believed that little could be done to improve the quality and quantity of data collected from intoxicated presentations, others (n=3) offered suggestions, including a better data entry system (n=1), encouraging other ED staff who interacted with patients to assist with data collection (n=1), and conducting in-depth interviews with patients (n=1).

9. Unintended consequences: The percentage of respondents reporting unintended consequences increased by 8 pp to 24%. The unintended consequences included "abuse" to nurses by patients (n=3), a potential displacement effect where patients seek new stores or methods to obtain alcohol or present to different healthcare facilities (n=1), and a deviation from the original intentions of the WA MVP Pilot (n=1).

1.3 Trends analysis of long-term outcomes

Key findings

The WA MVP Pilot commenced in July 2022. To identify trends of intended long-term outcomes, we analysed administrative data.* While the WA MVP Pilot has multiple intended long-term outcomes, Report 2 includes data relating to one outcome: alcohol-related ambulance callouts, covering the period from 2018/2019 (financial year) to 2022/2023, as well as the first nine months of 2023/2024 (i.e., July 2023 to March 2024). The findings against this outcome with gender and age** subgroup analysis are presented below.

- Between 2018/2019 and 2022/2023, monthly alcohol-related ambulance callouts in the EMHS increased by 9.3%. This upward trend continued during the first nine months of 2023/2024.
- Alcohol-related ambulance callouts were 1.6 times higher for males than for females in EMHS, with this gender difference remaining stable over time.
- The trend in monthly alcohol-related ambulance callouts varied by age group. Callouts showed an increasing trend for individuals aged above 24 (+17.9% during 2018/2019-2022/2023), while a decreasing trend was observed for those under 18 (-29.8%). For those aged 18-24, callouts temporarily increased following the COVID-19 pandemic but later levelled off. Callouts for individuals aged 16-17 remained relatively stable over the period.

*Note: * Administrative data refer to alcohol-related health and criminal data provided by the WA Mental Health Commission and the WA Police Force for the purpose of the WA MVP Pilot evaluation. These data are different from the patient data collected by nurses at RPH ED at triage, which is used to identify hotspots for alcohol-related harm and community violence or injury.*
*** Comparisons between age groupings are not included due to differences in age grouping size.*