COLLABORATIVE APPROACHES TO OPERATIONALISING IMPLEMENTATION STUDIES: LESSONS FROM THE GROG APP IN PRIMARY CARE

Chaired by:

Prof Scott Wilson
Prof Kate Conigrave

CHAIRS: SCOTT WILSON & KATE CONIGRAVE

ABORIGINAL DRUG AND ALCOHOL COUNCIL SA / NSW HEALTH, USYD

Acknowledgements

We have no interests to declare in the work we are talking about

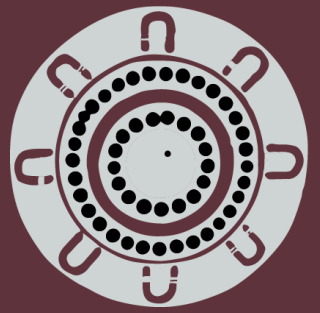
1. Why Grog App in primary care?

2. Designing for dignity

3. Collaborating with community

4. Implementing Grog App in primary care

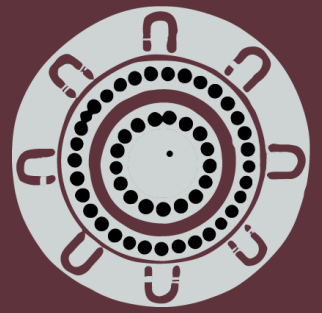
Adapting the Grog App to ask about drinking & deliver tailored brief intervention in Aboriginal and Torres Strait Islander primary care



Centre for Alcohol Policy and Research
Priority Populations

Where does this story start?


INALA
INDIGENOUS
HEALTH
SERVICE

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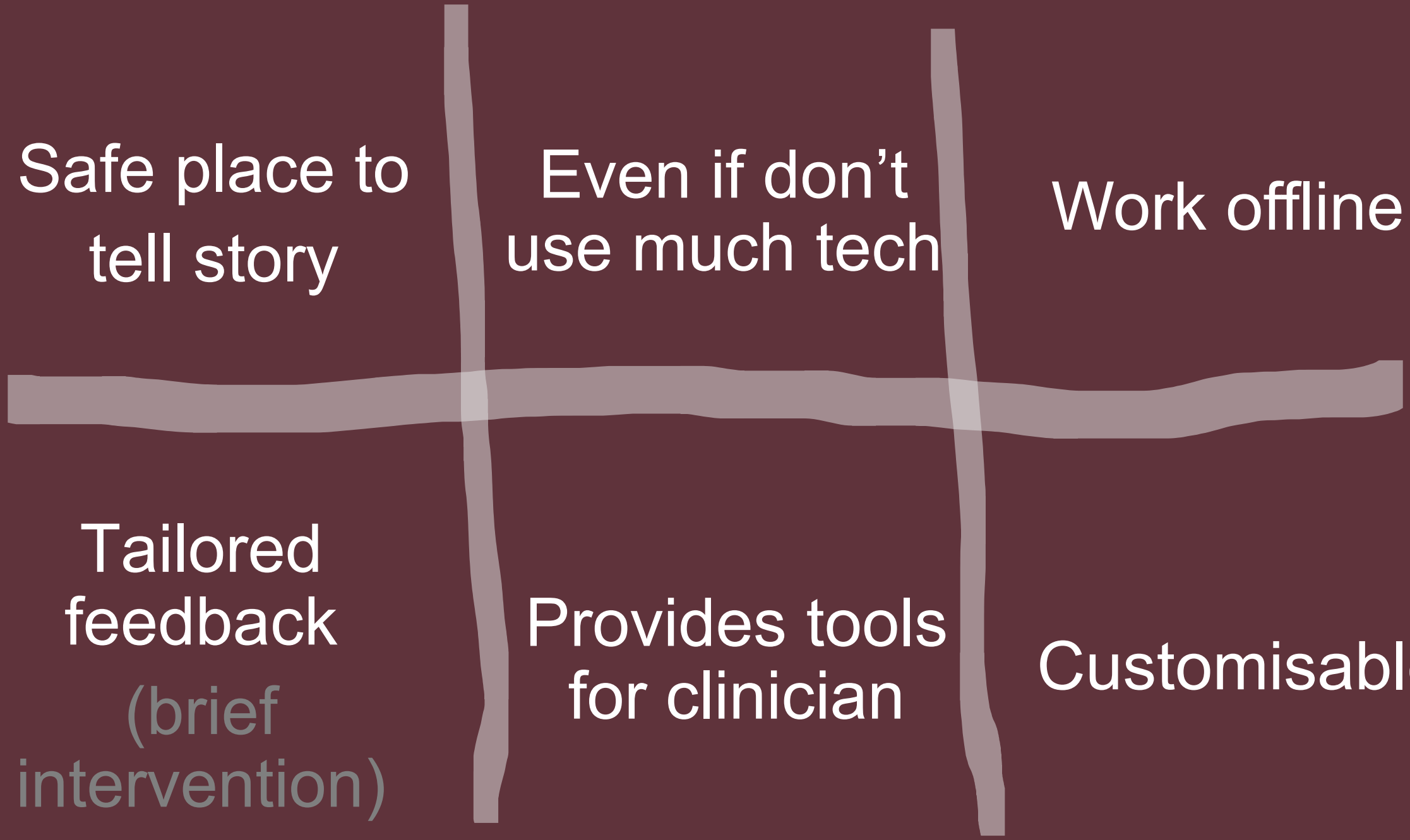
Priority Populations

It is hard to ask about drinking


stigma/shame
‘regular’ drinking
? what is a standard drink
non-standard containers
sharing drinks
? understanding time frames

GROG CHECK


Safe place to tell story
Even if don't use much tech
Work offline
Tailored feedback (brief intervention)
Provides tools for clinician
Customisable

For each person

Screening items

For clinician

Screening results

Brief intervention

Cheat sheet

27:00

English - Female

Volume

Help

Have you had any grog at all in the last 12 months? (since the AFL/ NRL football grand final last year)

Yes

No

Replay

Pause

Back

Next

Reflections on what Grog Check offers clinicians?

- Very short screen (< 5 mins)
- Modified visual AUDIT-C: but no maths or understanding about standard drinks needed
- ‘Don’t want to miss anyone’: everyone asked about dependence (ICD-11)

Reflections: What Grog Check offers clinicians?

- Are you worried about your drinking?
  - Raise a flag (not too high!) – to help clinicians open the door to talk with people about their drinking

- Grog Check results: into patient software

- Clinician ‘cheat sheet’: make it easier to consider next steps

Reflections: What Grog Check offers clinicians?

Centre for Alcohol Policy and Research

Priority Populations

www.gathering.edu.au

Designing for Dignity

Co-creating culturally safe digital health tools about drinking with Aboriginal and Torres Strait Islander communities

Presenters: Jim Cook, Lydia Gu, Darren Phung
ICT TechLab & University of Sydney

The Challenge: Asking About Alcohol Respectfully

Conversations about alcohol use in Aboriginal and Torres Strait Islander primary care settings are deeply sensitive. Historical trauma, fear of discrimination, and experiences of judgment create significant barriers to open dialogue.

Patient barriers include:

- Past experiences of discrimination in healthcare
- Fear of child removal or legal consequences
- Shame and stigma around disclosing drinking

Clinician challenges include:

- Time constraints in busy clinical settings
- Limited culturally-informed screening tools
- Difficulty building trust quickly
- Balancing sensitivity with clinical needs

Our challenge was to help design technology to support *both* patients and clinicians — not just collect data, but facilitate healing conversations.

The Framework: Designing for Dignity

Developed at TechLab, this framework transforms dignity from an abstract value into concrete, measurable design principles that guide every decision.

Accessibility

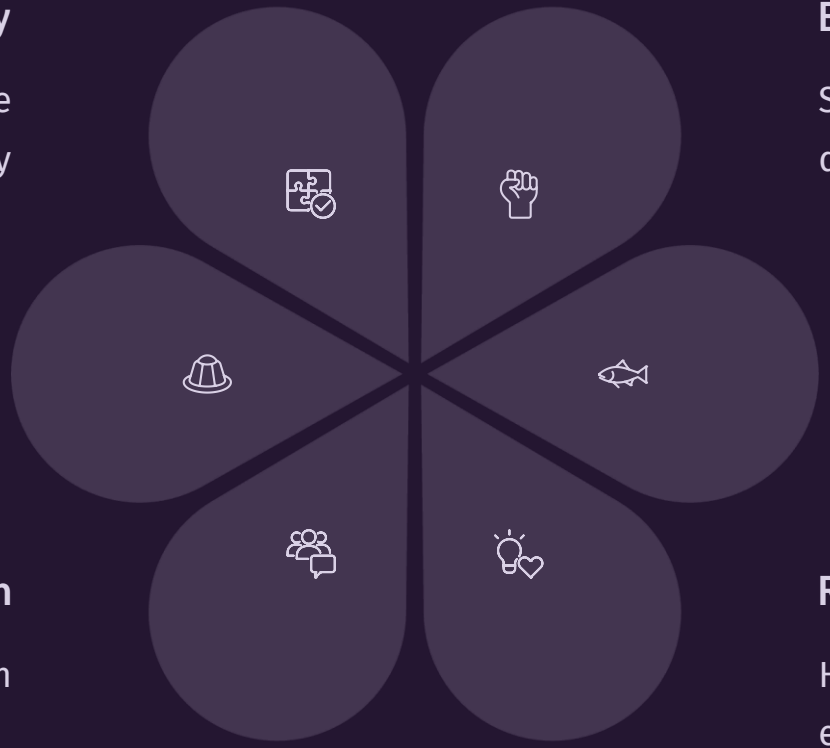
Universal design ensuring everyone can use the technology effectively

Transparency

Clear communication about data use and system purpose

Collaboration

Co-designing with communities, not for them



Empowerment

Supporting user autonomy and informed decision-making

Usability

Intuitive interfaces that reduce cognitive load and frustration

Respect

Honouring cultural values and individual experiences

This is human-centered design elevated to **dignity-centered design** — where every pillar acts as a checkpoint, ensuring technology respects and serves the people who use it.

Applying the Framework in Practice

Co-Design

Community voices shape initial concepts and priorities

Prototype

Early sketches and wireframes tested with stakeholders

Feedback

Aboriginal health workers and clinicians guide refinements

Build

Technical development informed by cultural insights

Validation

Community members ensure the app feels right and belongs

Throughout this iterative process, we treated technical accessibility and cultural safety as equal priorities. Every stage involved genuine partnership — Aboriginal health workers, community members, and clinicians weren't consulted, they were co-creators.

Co-Design in Action

Community members guided every aspect of the app's development, from tone and language to visual design and interaction patterns.

Key co-design outcomes:

- Rewording screening questions to be conversational rather than clinical
- Eliminating judgmental language that could trigger shame
- Choosing approachable colors and icons over medical imagery
- Designing for privacy to reduce disclosure anxiety
- Building trust through transparency about data use

This slower, more deliberate process built genuine trust and produced a tool that *feels like it belongs* to the community it serves — not imposed from outside.

How the Grog App Embeds Dignity

Each design decision translates dignity principles into concrete features that respect users throughout their experience.

Plain Language

Neutral wording that avoids clinical jargon and judgement

Private Self-Reporting

Allows people to respond as they want to, before discussion

Clear Purpose

Intro screens explain why data are collected and how they're used

Accessible Design

Larger text, intuitive navigation, and progress indicators support all users

These features aren't cosmetic — they're structural expressions of respect that support both patient dignity and clinical effectiveness.

Next Steps: From Design to Implementation

Design Complete

Co-design framework applied through iterative community partnership

1

Validation Study

Testing app accuracy and user experience in controlled settings

2

Implementation Study

Pilot integration into urban Aboriginal and Torres Strait Islander primary care

3

Clinical Integration

Sustainable deployment supporting ongoing community health

4

Our validation study will ensure the Grog App is not only inclusive by design but also clinically effective and sustainable in real-world practice.

This phased approach ensures we maintain the dignity-centered values that guided development while meeting rigorous clinical standards.

Inclusive design is not just about usability — it's about dignity.

When we embed dignity in every design decision, we build trust, strengthen care, and support healing. Technology becomes more than functional — it becomes relational, creating space for conversations that honor the whole person.

Design with Community

Co-creation ensures tools belong to those they serve

Centre Dignity

Make respect measurable through concrete design principles

Iterate with Care

Slower, deliberate processes build trust and better outcomes

Thank you. I'll now hand over to the next presenters, who'll share how this approach came to life within community and clinical settings.

Doing alcohol research in primary care in a way that works for community

Claudette 'Sissy' Tyson and Bena Brown

Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care

Acknowledgement of Country

Metro South Health | Queensland Government

Positioning ourselves

- White, with Nordic, Irish and English ancestors
- My family are settler-colonists
- Born on the lands of the Motu and Koitabu people
- Live on Jagera and Turrbul land, work on Yuggera land
- My parents born and raised on Kamilaroi Country (northwestern NSW)
- Middle class and privileged
- Finished high school, university and PhD

- Proud, strong Aboriginal woman
- Kuku Yalanji tribe, Far North Queensland
- Grew up in Inala and Acacia Ridge
- Inala (suburb in southwest Brisbane) is my Community
- I am the eldest of 3, have 5 children, and 10 grandkids
- My mother was one of 17 children, a twin – one of 5 sets
- Helped raise my younger siblings, cousins

The Inala Aboriginal and Torres Strait Islander Community

- Traditional lands of the Yuggera people
- Current population of Inala = 15, 273 (ABS, 2021)
- 2.9% population growth over 5 years
- 6.6% identify as Aboriginal and/or Torres Strait Islander (increased by 1.1% over 5 years)
- A number of Community Controlled organisations
- Named by the Surveyor-General in 1952
- Housing Commission purchased land to cater for housing need after WWII
- Home to mob from many locations
- High level of pride in and connection to Inala by mob

‘Inala’ – ‘resting place’ in Bundjalung language, Yugumbir dialect

The Health Service:

Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care

- Opened in 1995
- Early research in the 1990s found only a small number of Aboriginal and Torres Strait Islander people attended the mainstream health clinic.

Why?

- Unwelcoming environment that Indigenous people could identify with
- Lack of Indigenous staff
- Staff perceived as unfriendly
- Inflexibility regarding time
- Intolerance of Indigenous children's behaviour

MJA 2009; 190: 604–606

The Health Service:

Southern Queensland Centre of Excellence in Aboriginal and Torres Strait Islander Primary Health Care

Implementation of strategies to address access to the service:

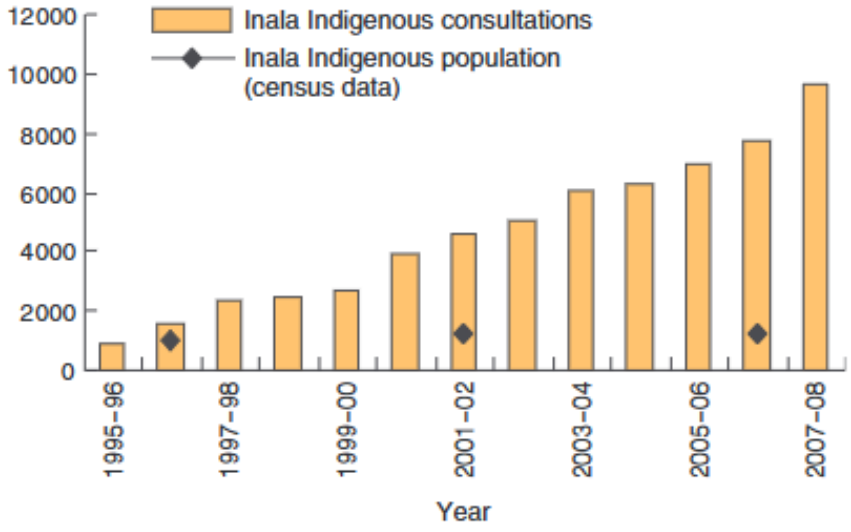
1. Increase Aboriginal and/or Torres Strait Islander workforce
2. Create an environment that is culturally welcoming
3. Ensure all staff have cultural awareness training
4. Build connections and relationships with local Community and services
5. Promote intersectoral collaboration

MJA 2009; 190: 604–606

Improving Indigenous patients' access to mainstream health services: the Inala experience

Noel E Hayman, Nola E White and Geoffrey K Spurling

2 Improved access to the Inala Indigenous Health Sevice, 1995–96 to 2007–08 financial years



SOUTHERN QUEENSLAND CENTRE OF EXCELLENCE

Health Research – the Inala Way

Our Research Governance Model: Inala Community Jury for Health Research

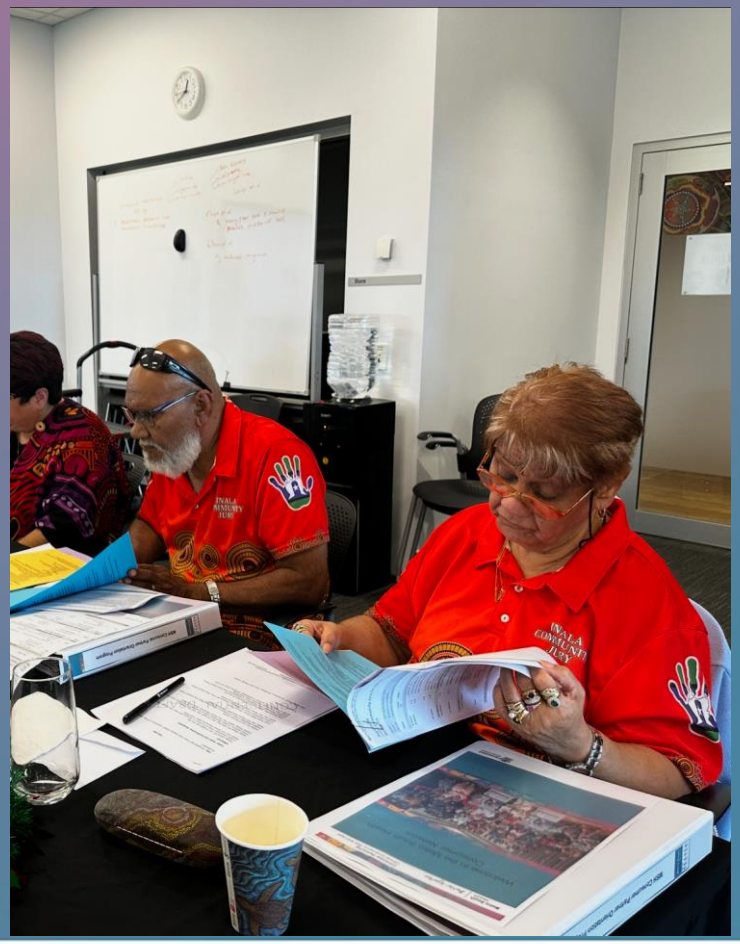
- Inala Community Jury for Health Research, established 2010
- 14 Aboriginal and/or Torres Strait Islander people from the Inala Community
- Members are either clients of the service, or represent Community Controlled organisations in the area
- Jury ensures research is ethically sound, culturally safe, locally relevant and benefits the Community

- Jury members decide how business is done
- Researchers present proposal face-to-face
- Jury interrogates methods, resources, capacity building, and impact on Community/health service

"It puts a human face on the researched" – A qualitative evaluation of an Indigenous health research governance model

Chelsea Bond,[1] Wendy Foley,[2] Deborah Askew[2,3]

Australian and New Zealand Journal of Public Health



Monitoring and maintaining a relationship with the Inala Community Jury for Health Research

- Researchers are expected to maintain their relationship and connection to Community Jury throughout the life of the research

- Researchers are required to provide:

    - Regular progress updates to Community Jury
    - Final update at project completion
    - Create a Community report for dissemination to the Inala Community
    - Seek approval following data analysis of results to present or publish the data
    - Community Jury to review manuscript prior to submission for publication

Grog App team engagement with our Community and health service

April 2016

First visit to Community Jury

Submission for Inala Community Jury for Aboriginal & Torres Strait Islander Health Research

Title of Project: "Making it easier for Indigenous primary care services to reduce the harms from alcohol"

Researchers: Kate Conigrave, Paul Haber, Noel Hayman, Kylie Lee, Rowena Ivers, Tim Dobbins, Dennis Gray, David Johnson, Scott Wilson

Institutions: Sydney and Curtin Universities; Royal Prince Alfred Hospital; Illawarra Aboriginal Medical Service (NSW), Aboriginal Drug & Alcohol Council SA

April 2018

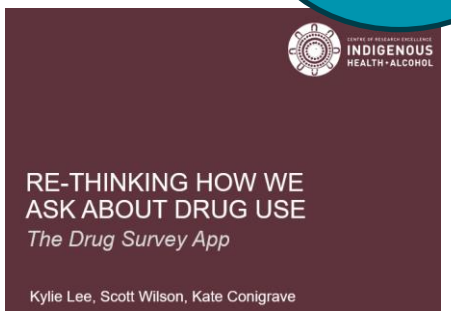
Report final update to CJ about Grog App

Title of Project: Grog Survey App

Researchers: Kate Conigrave, Kylie Lee, Robin Room, Tanya Chikritzhs, Noel Hayman, Dennis Gray, Scott Wilson, Ted Wilkes, Sarah Callinan

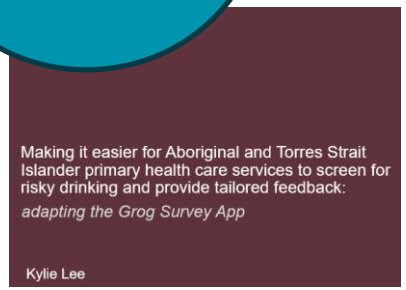
Feb 2021

Drug App



June 2023

Update Grog App and Drug App



August 2024

Update Grog App and Drug App (+ education re: MRFF and NHMRC projects)

Nov 2025

Update Grog App and Drug App


How many people were you drinking grog with?
(Drag how many people were in your drinking circle)
5 people

Conclusions and next steps

- Feedback from Community and health service supporting the build of the Grog App in primary care
- Validation study in 2026
- Grog App implementation into SQCoE clinic
- Technology connection between app and clinic software
- App to support clients to discuss grog with their health care team
- App to support health care team to provide better care to mob

Do research with us not on us

Implementing the Grog App into an urban primary care service for and with Aboriginal and Torres Strait Islander peoples

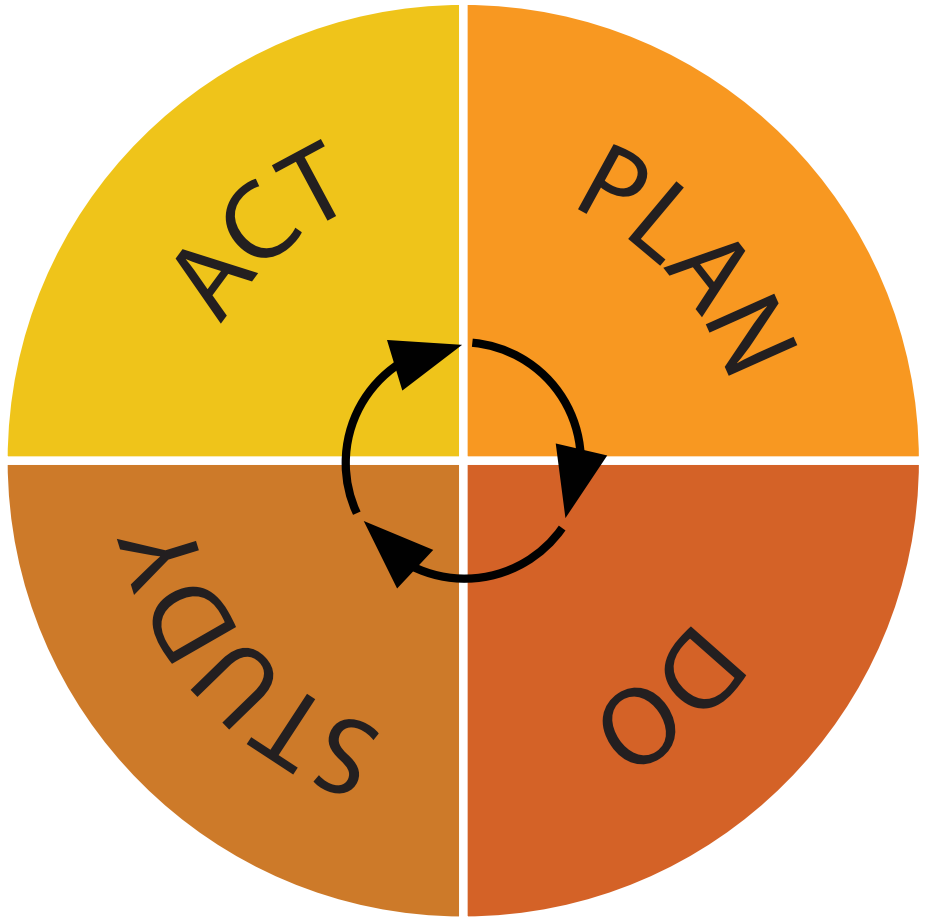
Monika Dzidowska, Nikki Percival

Study design considerations

- 12 months to implement GrogCheck in a clinically meaningful way
- Want to:
  - Tailor to local context
  - Ensure relevance to the site - clinic and community
  - Inala is an innovative centre - own research and practice improvement processes

Continuous Quality Improvement

- Systematic data-guided activities to identify problems and achieve improvement
- Designing with local conditions in mind
- Iterative development and testing



(Reubenstein et al 2014)

QIS strengths and limitations

Strengths	Limitations
Inside job	Limited generalisability
Fast and flexible	Lessons not well documented or shared
Relatively cost effective	Can overlook issues of equity
Complex, dynamic environment	

Implementation science

- Focused on developing generalizable knowledge about how to implement an evidence-based intervention or practice
- Considers factors that influence implementation
    - Chooses implementation / behavior change strategies to address these
- Evaluates how the evidence-based intervention or practice needs to be adapted across different settings

IS Strengths and limitations

Strengths

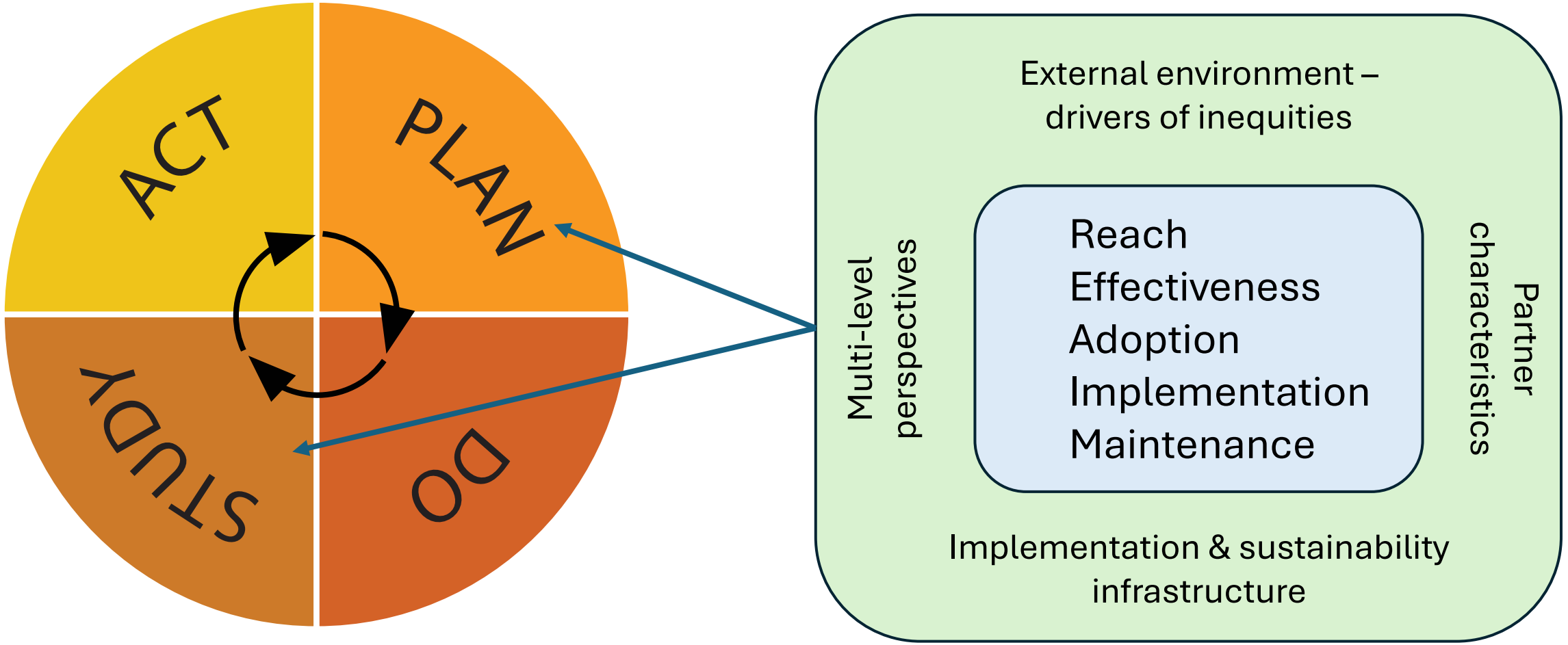
Uses conceptual frameworks (e.g. PRISM/REAIM):

- Address implementation at multiple organizational levels
- Ensure key contexts are not missed
- Comprehensive, pragmatic planning and evaluation for greatest possible impact

IS Strengths and limitations

Strengths	Limitations
Uses conceptual frameworks (e.g. PRISM/REAIM): • Address implementation at multiple organizational levels • Ensure key contexts are not missed • Comprehensive, planning and evaluation for greatest possible impact	Slower than QIS
	Often not enough contextual evidence
	Iterative tests of change not common • Pressure to get it right the first time • Hard to address all key contextual factors
	Frameworks a challenge for non-academics
	Few implementation scientists in healthcare

How will we do it at Inala



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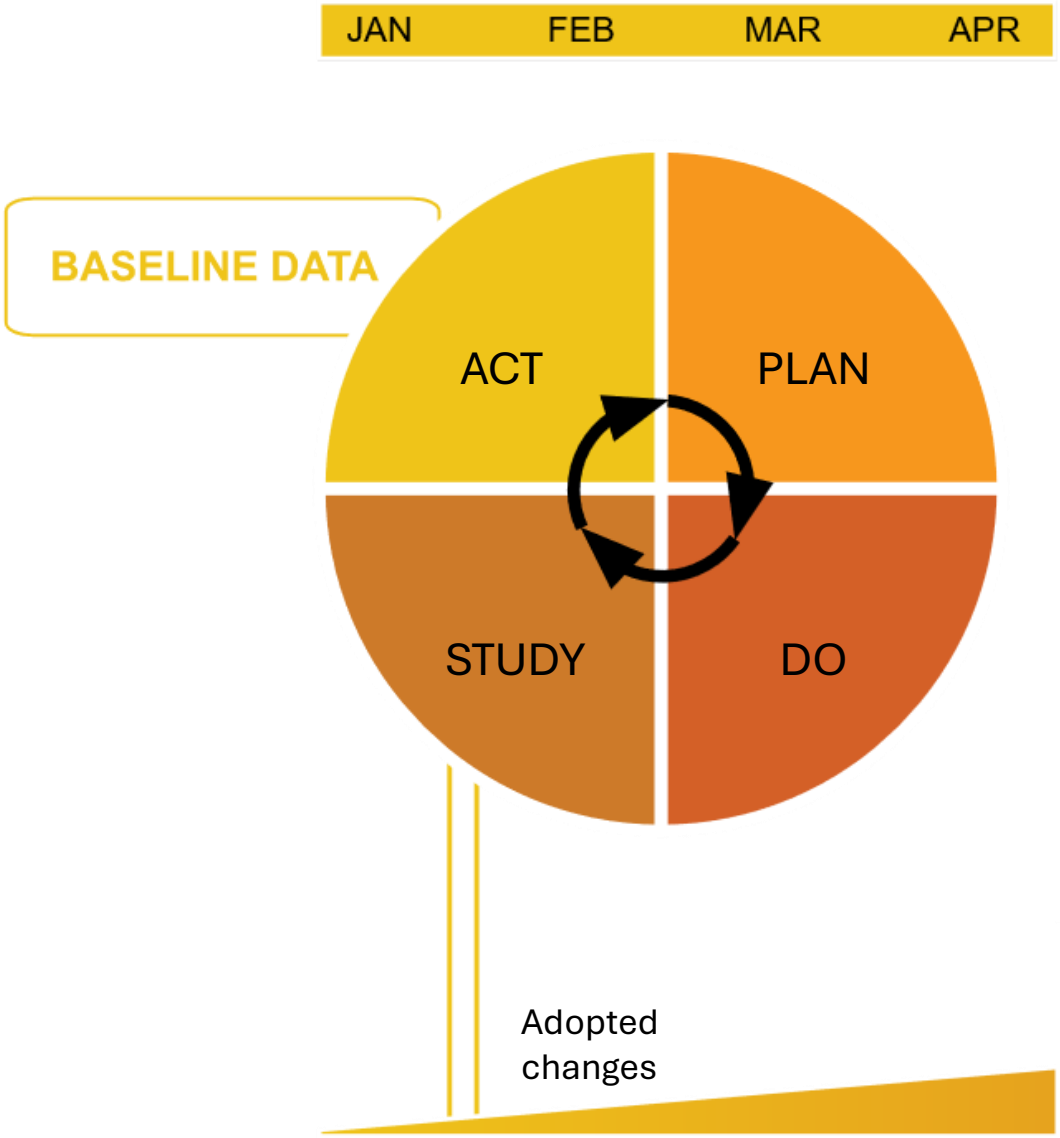

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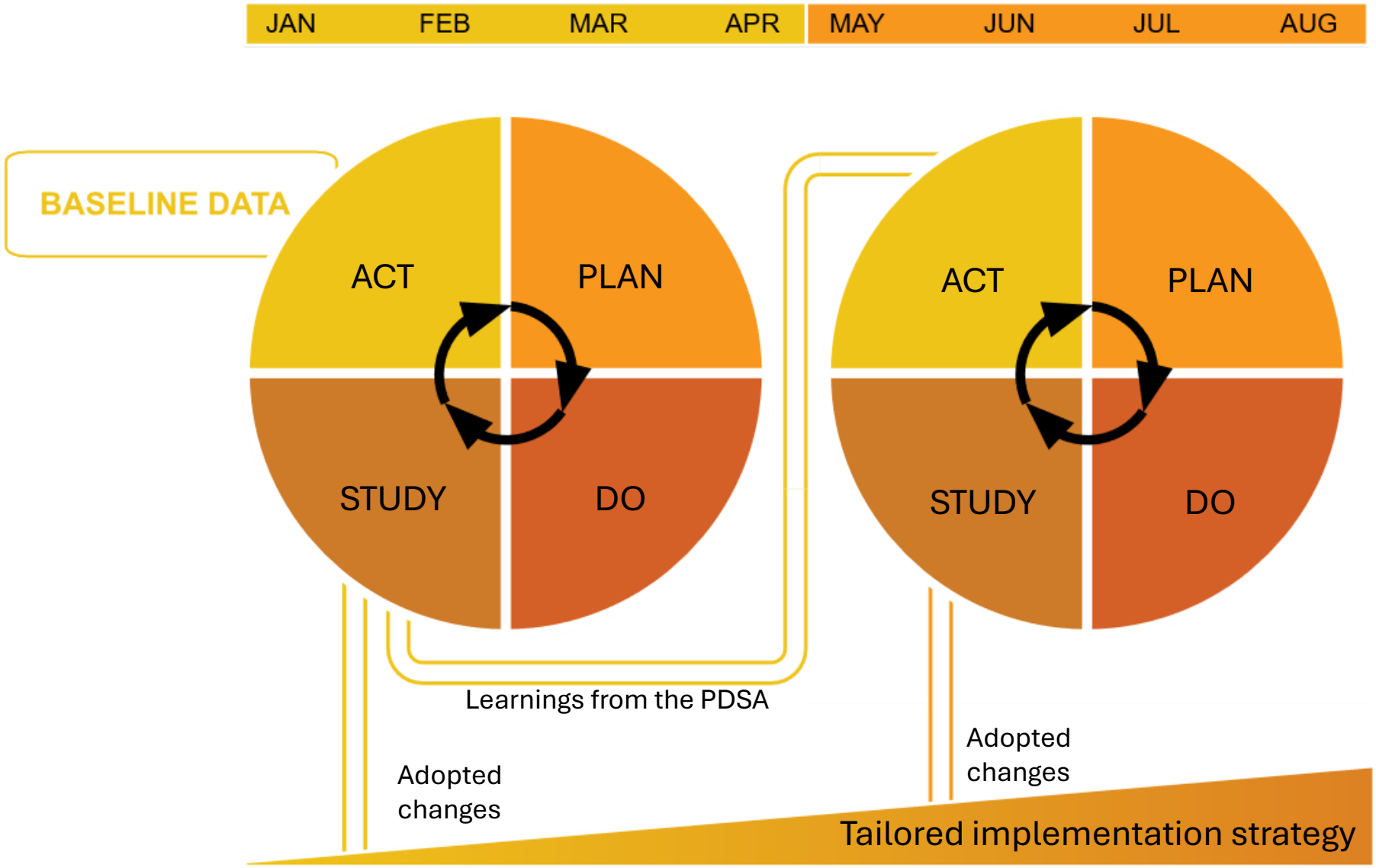
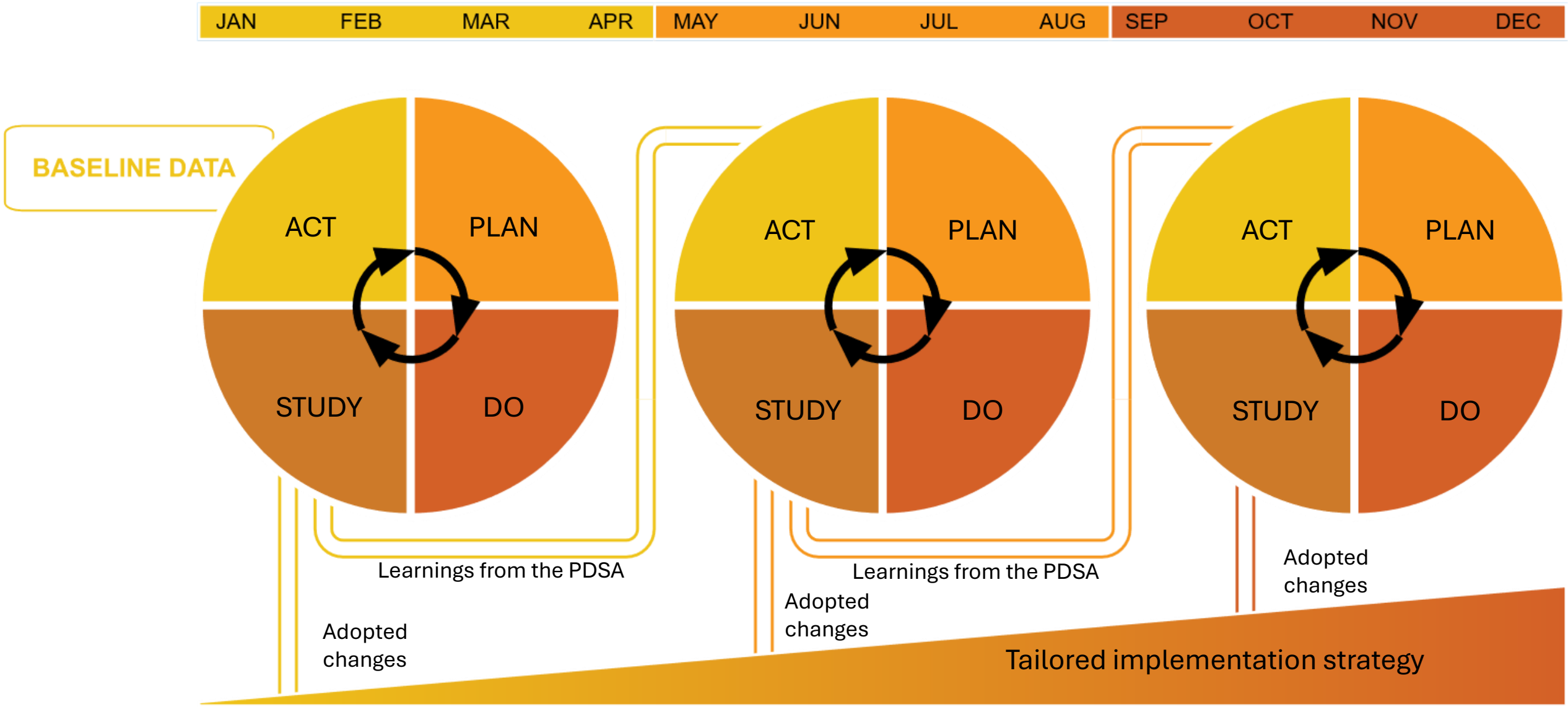


How will we do it at Inala



Conclusion

- The integration of QIR and IR ensures that:
  - Research that is culturally safe, locally relevant, benefits the Community
  - Project yields a meaningful result tailored to local needs
  - The capacity to further improve or adapt implementation will remain beyond project end
  - We can do all this quickly **together**

GROG CHECK

Questions?