



Working for Mental Health

## **Mental Health Coordinating Council**

**Report to the  
Network of Alcohol and Other Drug Agencies (NADA)**

**Reviewing Implementation of the  
Mental Health Drug and Alcohol Change Management Project  
2008-2009**

# **NO WRONG DOOR**

**May 2010**



# Acknowledgements

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The “*No Wrong Door: Mental Health Drug and Alcohol Change Management Project*” is being conducted by the Network of Alcohol and other Drug Agencies (NADA) in partnership with the Mental Health Coordinating Council (MHCC) with funding provided by the NSW Health Mental Health Drug and Alcohol Office (MHDAO). The project was managed by Heidi Becker, Project Manager NADA in collaboration with Tina Smith, Senior Policy Officer/Workforce Development - MHCC. The development of the *No Wrong Door* approaches and resources – along with the learning to date from the project - has involved the input, support and collaboration of many people. NADA and MHCC would like to thank the following individuals and organisations for their invaluable participation in developing and implementing the project:

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- Kedesh Rehabilitation Services
- Lifeline Mid-North Coast
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- NEAMI
- NSW Consumer Advisory Group (CAG)
- Richmond Fellowship of NSW
- Schizophrenia Fellowship of NSW
- South Sydney Youth Services
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The “*No Wrong Door*” AOD learning and assessment materials have been developed by the Network of Alcohol and other Drugs Agencies (NADA) in partnership with the Mental Health Coordinating Council (MHCC). The final project resources include all learning and assessment materials for the following courses:

Foundations of Alcohol and Other Drugs: Working Within the Mental Health Context

CHCAOD402A Work effectively in the alcohol and other drugs sector

Assessing and Addressing the Needs of Mental Health Consumers Who Use Alcohol and Other Drugs

CHCMH408A Provide interventions to meet to needs of consumers with MH & AOD issues

CHCAOD408A Assess the needs of clients with AOD issues

CHCCS403B Provide brief interventions,

CHCAOD411A Provide brief interventions for people with AOD issues

These resources and this report on the implementation stage of the project are jointly owned by NADA and MHCC. Reproduction of the resources is permissible for the purpose of education and service development and delivery with the permission of either NADA or MHCC.

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# 1. Executive Summary

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From March 2008 the Mental Health Coordinating Council (MHCC) worked in partnership with the Network of Alcohol and Other Drug agencies (NADA) and the University of Wollongong Illawarra Institute of Mental Health (iiMH) to develop, implement and evaluate the “No Wrong Door: Mental Health Drug & Alcohol Change Management Project” (hereafter referred to as “No Wrong Door”/NWD). Project planning and course development/piloting occurred March 2008-09 (Phase 1). NADA funded MHCC to implement the project April to December 2009 (Phase 2). Project evaluation will continue through December 2010 (Phase 3). This report focuses on the implementation phase of the project.

“No Wrong Door” was designed to improve responses to consumers of the NSW community managed mental health sector who also have drug and alcohol issues. The specific aims of the “No Wrong Door” project are to develop and deliver a training resource that would:

1. Elicit staff attitudes, confidence levels and skill sets in working with clients who present with alcohol and other drugs (AOD) issues in the mental health sector and facilitate attitudinal change and an increase in staff confidence and skills in working with this client group.
2. Improve management and agency capacity to support clients within mental health agencies with alcohol and other drug issues.

The project was planned to offer organisational change management approaches to workforce learning and development for up to 20 Mental Health Workers at each of six course locations across NSW throughout 2009 to: facilitate workforce development in responding to co-existing problems; increase the knowledge, skills and confidence of Mental Health Workers and workplaces in responding to substance use problems; and, ensure robust evaluation of the project to maximise learning outcomes for all stakeholders.

Project implementation has delivered six courses (ie, three metropolitan and three regional/rural to 125 individual participants from 20 organisations and 40 programs across NSW. The first four courses delivered by MHCC involved 24 hours of trainer and participant contact over 6 days (3 full days and two half days). A final revised course involved 30 hours of trainer and participant contact over 4 full days thus increasing teaching hours and decreasing overall time out of role for participants.

Modification of the training content and process was based on trainer, participant and workplace feedback from the first four courses and also necessitated by revision of the Community Services Training Package (ie, to ensure sustainability of the project beyond 2009). The revised “No Wrong Door” courses are aligned with the following five units of competence from the Certificate IV in Alcohol and Other Drugs Work for participants wanting to pursue national skill recognition qualifications through the MHCC’s registered training organisation – the Learning and Development Unit:

## Foundations of Alcohol and Other Drugs: Working Within the Mental Health Context

CHCAOD402A            Work effectively in the alcohol and other drugs sector

## Assessing and Addressing the Needs of Mental Health Consumers Who Use Alcohol and Other Drugs

CHCMH408A            Provide interventions to meet to needs of consumers with MH & AOD issues

CHCAOD408A            Assess the needs of clients with AOD issues

CHCCS403B            Provide brief interventions,

CHCAOD411A            Provide brief interventions for people with AOD issues

As at 31 May 2010:

- 100 of 125 (80%) of course participants had enrolled with LDU to complete assessments;
- 52 of those (52%) had successfully completed assessments; and,
- 38 of those (38%) had used the NWD/AOD pathway toward achieving their Certificate IV in Mental Health.

The project also contributed to the development of further coexisting problems coursework that has been aligned with the new Diploma in Community Services (Mental Health and/or Alcohol and Other Drugs Work) thus allowing greater professional development opportunities for workers from either sector.

Project evaluation is continuing throughout 2010 in partnership with the University of Wollongong – Illawarra Institute for Mental Health. Project evaluation involves a pre and post-training methodology making use of:

#### Qualitative Measures

- Session and Course Surveys;
- Implementation Experiences Survey;

#### Quantitative Measures

- Dual Diagnosis Capability in Mental Health Teams Scale;
- Co-morbidity Problems Perception Questionnaire; and,
- Evidence Based Practices Attitudes Scale.

Project evaluation to date indicates:

- Positive uptake of AOD training opportunities by both community mental health workers and workplaces (as indicated by both participation and assessment completions)
- Significant improvements in training participants' attitudes, knowledge and confidence in their capacity to work with people who have co-existing substance use and mental health problems
- Improved attitudes to adopting evidence based practices were also found, particularly in terms of the facilitation of growth oriented attitudes

Twelve key recommendations arising from the project to date presented for consideration as the evaluation component of the project continues to progress.

The "No Wrong Door" project is utilizing a multilayered, systemic approach to increasing individual, organizational and sector capacity and MHCC is pleased to have been given the opportunity to coordinate the implementation phase of the project.

As the peak body for community managed mental health organizations in NSW the MHCC is well positioned to progress recommendations arising from the project as these are more fully identified and prioritized.

## 2. Project Background

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Research into co-existing mental health and substance use problems in Australia acknowledges the prevalence of people living with both issues. Demands on drug and alcohol and mental health services to respond to this client group are increasing and service delivery outcomes associated with this particular client group are generally poor. Developing staff and organizational capacity to better respond to this client group in community-based drug and alcohol and mental health organizations has been identified as a beneficial way to respond to this issue.

From March 2008 the Mental Health Coordinating Council (MHCC) worked in partnership with the Network of Alcohol and Other Drug agencies (NADA) and the University of Wollongong Illawarra Institute of Mental Health (iiMH) to develop, implement and evaluate the “No Wrong Door: Mental Health Drug & Alcohol Change Management Project” (hereafter referred to as “No Wrong Door”/NWD). Development and piloting of the project resource material occurred between April 2008 and March 2009. NADA funded the MHCC to employ a Project Officer for the NWD project implementation in the non-government community managed mental health sector from April 2008.

This “No Wrong Door” Report focuses on the implementation phase of this project (ie, Phase 2). An earlier report was prepared for NADA in March 2009 by Project Consultant, Jenny Melrose – JEMECO Psychology, describing the early stages of project development (Stage 1)<sup>1</sup>. It is anticipated that a further final report will be developed in 2011 by MHCC when project evaluation has been completed although it is noted that this deliverable is outside of the scope of funding provided by the NSW Health Mental Health and Drug and Alcohol Office (MHDAO).

### Project Aim

“No Wrong Door” was designed to improve responses to consumers of the NSW community managed mental health sector who also have drug and alcohol issues. The specific aims of the “No Wrong Door” project are to develop and deliver a training resource that would:

1. Elicit staff attitudes, confidence levels and skill sets in working with clients who present with alcohol and other drugs (AOD) issues in the mental health NGO sector and facilitate attitudinal change and an increase in staff confidence and skills in working with this client group.
2. Improve management and agency capacity to support clients within mental health agencies with alcohol and other drug issues.

The “No Wrong Door” project was planned to offer organisational change management approaches to learning and development for up to 20 Mental Health Workers at each of seven locations across NSW throughout 2009 to:

- facilitate workforce development in responding to co-existing mental health and substance use problems;
- increase the knowledge, skills and confidence of Mental Health Workers and workplaces in responding to substance use problems; and,
- ensure robust evaluation of the project to maximise learning outcomes for all stakeholders.

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<sup>1</sup> While this report references and summarizes Phase 1 project development activity readers are referred to this earlier document for full details.

## Funding and Sector Context

Funding for the “No Wrong Door” Project was provided by the NSW Health MHDAO. In June 2006, the NSW Government committed \$939 million over five years to deliver improved mental health services. This funding was under the banner of “A New Direction in Mental Health”. It has long been acknowledged that a large proportion of clients accessing mental health services also experience drug and alcohol problems. For this reason \$17.6 million of this funding was allocated over a five year period for “Better Integration of Mental Health Services and Drug and alcohol Services”.

The “new directions” funding was complimentary to additional Commonwealth funds provided under the “COAG National Action Plan for Mental Health 2006-2011”. This included the \$73.9M “Improved Services Initiative” - a national project to build the capacity of non government drug and alcohol organisations to effectively identify and treat coexisting substance use and mental health problems. The Department of Health and Ageing (DoHA) funded 26 NSW drug and alcohol organizations to explore and increase their capacity to respond to people with coexisting problems.

Other NSW Health policy and related activities of note that have shaped service delivery directions and the context in which the “No Wrong Door” project was planned and implemented include:

- Proposal for MHCC & NADA Mental Health Drug and Alcohol Research Networks Project (2010-2012, outcome pending)
- MHCC & NADA Mental Health and Drug and Alcohol Research Grants Program (2007-2010);
- NSW Health “Comorbidity Framework for Action” (2008); and,
- NSW Health “NSW Clinical Guidelines for the Care of Persons With Comorbid Mental Illness and Substance Abuse Disorders in Acute Care Settings” (2009).

The later document is of particular relevance in that it provides specific guidance to non-acute mental health services - including community managed organizations (CMOs) - with regard to best practice in identifying and responding to people with both mental health and substance use problems. This included discussion of role delineation for mental health and alcohol and other drug (AOD) workers and services with recommendations for routine use of screening and assessment practice and tools in service delivery.

In late 2009, the DOHA also released “Guidelines on the Management of Co-occurring Alcohol and Other Drug and Mental Health Conditions in Alcohol and Other Drug Treatment Settings” (ie, “National Comorbidity Guidelines”). However, these were specific to the alcohol and other drugs sector only.

## Project Planning

In planning the project MHCC initially put forward the view that community managed mental health services needed workforce development in a higher level skill set that related to complex responses to people with both mental health and substance use problems. This view was informed by the 2006 Training Needs Analysis demonstrating a diverse workforce with about 70% of workers having industry relevant qualifications and the 2008 Member Survey responses indicating that essential AOD organisational policies and worker competencies were in place for many organisations (see Attachment 1). However, this initial position was not supported.

Throughout March, April and May 2008 consultation with consumers, carers and MHCC member organizations was undertaken by NADA and MHCC to determine resource package content. This consultation process identified that community managed mental health workers and services need basic drug and alcohol training to increase skills in screening, assessment, and brief intervention as a necessary platform upon which higher level competencies might later be developed for better identifying and responding to the needs of people affected by both mental health and substance use problems.

“No Wrong Door” training approaches were initially modeled from a similar project NADA is undertaking in partnership with Kedesh Rehabilitation Services (KRS) – the Mental Illness and Substance Use (MISU) Capacity Building Project (NADA & KRS, 2008). A Literature Review conducted for the MISU Capacity Building Project identified numerous workforce learning and development strategies necessary to increase:

- Role adequacy (ie, workers’ beliefs that they have the ability to do the job);
- Role legitimacy (ie, workers’ beliefs that the role they tasks they do are a legitimate part of their job role and they have a legitimate right to be involved in the work);
- Role support; (ie, Workers’ beliefs that they will be supported by the organization they work for to do the tasks required) and,
- Transfer of learning (ie, better understanding the organizational mechanisms through which training transfers to service delivery and professional practice).

This work also formed the basis for developing a Literature Review underpinning NWD (Melrose, 2008) and the above strategies were also considered in developing the initial training materials and approaches as follows:

1. Worker role adequacy

- training components on attitudes and beliefs about working with people who use substances were included to stress the importance of a therapeutic alliance
- training components on rates of co-existing mental health and substance use problems were included
- training components on assessment, referral, brief interventions and relapse prevention were included.

2. Worker role legitimacy;

- a pre-prepared meeting agenda item relating to the training was provided to supervisors for use within team meetings concrete resources were provided for use with clients
- following the training program participants will have the opportunity to be assessed for four units of competency within the Certificate IV Mental Health (non-clinical)
- concrete resources will be provided for use with clients
- an emphasis was placed on the fact that many of the existing techniques being utilized to support clients with mental health issues are effective strategies for addressing substance use issues

3. Worker role support; and,

- all levels of staff including supervisors, managers and service delivery workers were included in the training
- a review of current policies, procedures and other documentation pertaining to working with clients with co-existing mental health and substance use problems occurred before the training commenced and feedback was provided including suggestions of improvements to better service these clients
- ensuring that facilitators have a good relationship with both staff and managers as well as an understanding of the difficulties that the organisation faces working with this client group.

#### 4. Transfer of learning.

- learning tasks were developed for participants to work through between modules to provide practice opportunities and/or in skill recognition assessment tasks
- buy-in by each level of the organisation receiving the training was achieved before training commenced
- the training was spread out over a few months to allow for practice between and after modules.

These strategies are briefly reviewed here as it is generally agreed that training increases role adequacy but rarely leads to individual practice or service delivery change without the other domains being addressed. For these reasons, opportunities for exploration and consideration of all the above areas was built into project planning, implementation and evaluation.

## Project Piloting

The Phase 1 pilot of the training component of the project was coordinated by NADA and MHCC at Aftercare in Penrith between December 2008 and March 2009<sup>2</sup>. This involved 24 hours of training including breaks delivered in 5 sessions over 3 months (ie, essentially three full and two half days).

Session 1	Module 1 – Overview of AOD (6.5 hours)
Session 2	Module 2 – Assessment and referral (5.5 hours)
Session 3	Module 3 – Brief Interventions (5.5 hours)
Session 4	Module 4 – Relapse Prevention (3.5 hours)
Session 5	Module 5 – Self Care and Review (3.5 hours)

There was also a 2 hour pre-training engagement session and optional post-training booster session. This totaled 24 hours of trainer contact with course participants on six separate days. Training materials were minimally modified on the basis of the piloting experience and participant feedback and then handed over to MHCC to coordinate roll-out of the training to a further five sites.

## MHCC Roll-out

The same training materials and approach were subsequently used for four additional courses (ie, NEAMI, Wagga, Aftercare – Stanmore & Tamworth). A revised training materials and approach was used with a fifth course (ie, Port Macquarie) and an intended sixth course was renegotiated. This redirection in the project was requested by MHCC and agreed to by NADA in July 2009.

The project variation was requested to increase the sustainability of the project beyond 2009. The project learning and assessment materials were reconfigured against feedback and experience of delivery at the first four sites and to align with the unit requirements of the new 2008 Community Services Training Package (the materials were originally aligned with the 2002 package). The reconfigured materials were then piloted at one additional organization/location before being made available to the sector from 2010 onwards through the MHCC who is also a registered training organization (RTO, ie, the Learning and Development Unit). This approach will deliver a more sustainable training resource for the community services sector that can articulate toward both Certificate IV and the new Diploma level qualifications in MH and/or AOD work. This also required MHCC to extend their scope of registration with the NSW Vocational Education and Training Advisory board (VETAB) to include the Certificate IV in Alcohol and Other Drugs (AOD) and Diploma in Community Services Practice (Mental Health and/or AOD).

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<sup>2</sup> Note that this was not fully inclusive of learner assessment or project evaluation which continued beyond March 2009.

## Summary of Differences Between “No Wrong Door” and MISU Capacity Building Project

Some significant differences in approach from the MISU Capacity Building Project agreed to early in planning the “No Wrong Door” project included:

- Course roll-out to a variety of diverse service types and locations to maximize project learning (see Section 3 – Course Roll-out);
- Project evaluation methodology strengthened to capture information beyond short-term change in worker attitudes and confidence and to also include measures of transfer of training to practice and organizational performance/change over time (see Section 4 - Evaluation); and,
- The MISU project had more mental health topic areas available as options for potential substitution whereas No Wrong Door had few options for content variation and was thus more amenable to alignment with recognized units of competence from the Community Services Training Package (CSTP)
- The alignment of the “No Wrong Door” training resource with recognized units of competence from the Community Services Training Package as a critical workforce development strategy (see Section 5 - Skills Recognition);
- Acknowledgement of the possible need to adjust learning and assessment materials to ensure currency against the CSTP Review that was underway at the same time that the “No Wrong Door” project was being planned and implemented (see Section 6 – Resource Modification)
- The understanding that this was also an opportunity for MHCC – as the peak body for NGO community mental health services – as well as our members, consumers, carers, MHDAO and NADA to learn about and make recommendations regarding community managed mental health service infrastructure and capacity building needs in this important area of sector development (Section 7 – Discussion and Recommendations).

### 3. Course Rollout

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MHCC negotiated course locations and participation with member organizations and other interested parties throughout 2009 (ie, call for Expressions of Interest in our weekly “FYI” electronic newsletter and quarterly “View From the Peak” newsletter, project information on the MHCC website, forum & conference announcements, word of mouth, direct approaches to organizations and communities, etc). Several organizations/communities expressed interest in participating and then withdrew due to capacity barriers (eg, over-extended education and training commitments, unanticipated sector change including significant change to mental health employment services).

MHCC’s intent was to identify a robust cross section of service types, organizational sizes and geographic locations in order to maximize learning outcomes for all stakeholders, however, no claims are made regarding sector representativeness of participants.

Throughout 2009, MHCC coordinated the roll-out of five courses and more detailed information about each course follows:

1. NEAMI
2. Wagga
3. Aftercare – Stanmore
4. Tamworth
5. Port Macquarie

A visual summary of the timeline for the training roll-out is provided in Table 1 below. The staggered approach to roll-out was necessary to ensure that the project resources were sufficient to address the demands of the large volume of training delivery and to be available to provide support to both course participants and their workplace supervisors. The late commencement of some courses was a result of sudden withdrawals by some organizations and uncertainty for some non-metropolitan communities about having sufficient numbers to justify courses proceeding.

**Table 1: Summary of 2009 “No Wrong Door” Post-Pilot Training Roll-out**

	May	Jun	July	Aug	Sept	Oct	Nov
NEAMI							
Wagga							
Aftercare – Stanmore							
Tamworth							
Port Macquarie							

## Details of Course Roll-out

In summary, the “No Wrong Door” training – including the original pilot course at Aftercare Penrith – involved a representative cross-section of the NGO community mental health sector including:

- Three metropolitan (Sydney) and three non-metropolitan (Wagga, Tamworth & Port Macquarie) communities
- A diverse mixture of service types: accommodation support; education & employment; family & carer support; helpline & counseling; leisure & recreation; self-help & peer support; and prevention and promotion
- 125 individual participants
- 20 organizational participants
- 40 programs

More detail on each of the five courses whose roll-out was coordinated by MHCC is provided below.

### 1. NEAMI (Sydney)

This is a single organization course for Housing and Accommodation Support Initiative (HASI) accommodation support service staff that operate across NSW<sup>3</sup>. Course participants were direct care Residential Support Worker staff from NEAMI’s inner-Sydney Darlinghurst office and also included Senior Practice Leaders from NSW other teams.

- 23 participants from 8 service delivery locations
- Location – Rex Center (City of Sydney), Kings Cross
- Trainer – Alison Bell (contractor)
- Pre-training meeting – 12/5
- Training - 26/5, 9/6, 23/6, 14/7 (with the two half-day Sessions 4 & 5 combined at the request of the workplace)

### 2. Wagga

As with all non-metropolitan locations, this is a multiagency course involving 24 staff from: the Schizophrenia Fellowship of NSW (SFNSW – Sunflower House, Resource & Recovery Services Program, Personal Helpers and Mentors Service/PHAMS programs (ie, centre-based, community integration & Carer Assist respite support staff); the Richmond Fellowship of NSW (RFNSW - HASI accommodation support); Centacare PHAMS – Wagga, Griffith & Albury; and, St. Lukes Mental Health Service (PHAMS) - Albury.

- 24 participants from 5 organizations and 7 service delivery locations
- Location – Wagga RSL Club
- Trainer – Maria Walsh (MHCC Learning and Development Unit/LDU)
- Pre-training meeting 15/7
- Training - 29/7, 19/8, 2 & 16 & 30/9

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<sup>3</sup> Only the NSW operations of organizations are summarized in this report although it is acknowledged that several organizations are also providing services in other States.

3. Aftercare – Stanmore

This is a single organization course for HASI, PHAMS and NSW Boarding House Reform Active Linking Initiative (ALI) staff that provide services in the Sydney metropolitan area

- 21 participants from 6 service delivery locations
- Location – Aftercare Lillyfield
- Trainer – Alison Bell (contractor)
- Pre-training meeting 29/7
- Training 12 & 26/8, 9 & 30/9, 14/10 (with the two half-day Sessions 4 & 5 combined at the request of the workplace)

4. Tamworth

This is a multi-organization course including: Billabong Clubhouse; Psychiatric Rehabilitation Association (PRA); Lifeline Tamworth; Peel Valley Training and Employment; Sunnyfield; Department of Housing; NSW Health Area Mental Health Service staff (hospital-based, community rehabilitation & Aboriginal liaison); and, the Aboriginal Medical Service.

- 19 participants from 8 organizations and 10 service delivery locations
- Location – Tamworth Golf Club
- Trainer – Maria Walsh (MHCC LDU)
- Pre-training meeting - 5/8
- Training - 12 & 26/8, 9 & 24/9, 7/10

5. Port Macquarie

This is a multi-organization course including: Centacare (Disability Employment Network), Lifeline Mid-North Coast (help-line & counseling service), Willing and Able Foundation & Dads in Distress (peer support).

- 21 participants from 4 organizations and 4 service delivery locations
- Location – Centacare
- Trainer – Alison Bell (contractor)
- Pre-training meeting – nil (although aspects of this were included in pre-evaluation meeting on 12/10)
- Training 2, 3, 23 & 24/11

## Demographics of Course Participants

All course participants were asked to complete a demographics survey and 77 of these were completed for the courses coordinated by MHCC as follows:

- 25 males (32.5%) and 52 females (67.5%)
- ages ranging from 22 to 63 years (average age was 39 years)
- highest education level ranging from School Certificate (11%), Higher School Certificate (8%), TAFE certificate or diploma (34%), undergraduate degree (39%) and postgraduate degree (5%)
- length of time working in the mental health sector ranging from just started to 32 years (average of 4 years)
- length of time working in the health and community services sector ranging from just started to 32 years (average 8 years)
- weekly hours of employment ranged from 4 to 40 (average 33 hours)
- percentage of clients who are considered to have both mental health and AOD issues ranging from 1% to 100% (average 49%)
- 28 people (36%) noted having participated in some form of past AOD training.

## Course Attendance

The attendance of course participants across training sessions is summarized in Table 2. There were about 25 participants in each course with about 20 of these attending each of the training sessions. The high level of participation and attendance for all courses and sessions indicates a high level of interest in by both community managed mental health services and individual Mental Health Workers in learning skills to work more effectively with people with substance use issues. An exception to this trend was attendance at the pre-training engagement session (about 15 participants per session). This is likely indicative of the reluctance of both workers and workplaces to take time away from direct service that is not essential.

**Table 2: Summary of Course Attendance**

	Pre Training Meeting	1	2	3	4	5	Total Participants
Aftercare – Penrith (Pilot)	13	17	14	15	13	15	17
NEAMI	17	23	16	16	18		23
Wagga	18	19	17	17	18	13	24
Aftercare – Stanmore	18	17	17	17	15		21
Tamworth	12	14	17	15	12	18	19
Port Macquarie	n/a	19/18	18/19	n/a	n/a	n/a	21
Average Per Activity	15.6	21.8	20	20	19	19.75	24.8
Total Participants							125

## **Coordination & Promotion of Course Roll-out**

MHCC, NADA and the iIMH met at least quarterly during the course roll-out to discuss progress and future plans. Challenges in establishing viable courses were discussed and mutually agreed strategies for the project proceeding were identified. The course roll-out also coincided with three conference presentations on the “No Wrong Door” project:

- Aftercare Penrith presentation at the MHCC/NADA “Outside In” Conference, May 2009 – regarding experience of pilot course.
- MHCC presentation at the Creating Synergies Conference VI: Creative Ways Forward in AOD & Mental Health University of Wollongong, 1-3 July 2009, “No Wrong Door: The Mental Health Drug and Alcohol Change Management Project” - regarding project planning, implementation and preliminary evaluation data.
- Riverina Division of GPs – Wagga – “Merging Minds: Mental Health Drug and Alcohol” Conference, 18 May 2010.

MHCC & iIMH have also been accepted to present a paper on the No Wrong Door project at the 2010 THEMHS Conference to be held in Sydney in September.

Detailed information about the project evaluation methodology (Section 4) and skills recognition context (Section 5) of the project are provided next. A summary of learning to date – Section 6 Discussion and Recommendations – is also provided with this Stage 2 implementation report. The learning and recommendations arising from the “No Wrong Door” project are anticipated to continue as results from the evaluation and skills recognition components of the project will not be completed until the end of 2010

# 4. Evaluation

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## Overview

The evaluation component of the project was developed and is being implemented in partnership with the University of Wollongong – Illawarra Institute for Mental Health (iiMH) and is summarised in Table 3. This section describes the evaluation tools selected, the methodology for their use and presents preliminary data evaluation as at 11 May. Data collection will not be completed until the end of 2010 and a timetable for this to occur is provided in Table 4.

The evaluation strategy includes pre and post training use of the following individual and organizational quantitative measures as well as qualitative surveys at the end of each training day and course and a qualitative Implementation Experiences Survey (IES) following each course:

- The Dual Diagnosis Capability in Mental Health Teams (DDCMHT) Scale
- The Co-morbidity Problems Perceptions Questionnaire (CMPPQ)
- The Evidence Based Practice Attitudes Scale (EBPAS)

All measures were completed by the course participant with the exception of the DDCMHT. The DDCMHT is used to evaluate organizational change and the CMPPQ and EBPAS are used to evaluate changes in worker attitudes and confidence.

All data collected from individual course participants was anonymous and/or de-identified.

**Table 3: Summary of “No Wrong Door” Project Evaluation Methodology**

	<b>Pre pre-training</b>	<b>Pre-training</b> Beginning of first Training Session	<b>Post-training</b> End of last Training Session	<b>Post post-training</b>
<b>Qualitative Measures</b>				
Session Survey	End of each training session			
Course Survey			X	
IES Survey				X 6 months
<b>Quantitative Measures</b>				
DDCMHT	X			X 12 months
CMPPQ	X	X	X	X 6 months
EBPAS	X	X	X	X 6 months

**Table 4: Timetable for 2010 Post-Training Data Collection**

	Feb	Mar	Apr	May	Jun	July	Aug	Sep	Oct	Nov	Dec
Aftercare - Penrith			DDCMHT								
NEAMI	CMPPQ EBPAS EIS						DDCMHT				
Wagga			CMPPQ EBPAS EIS						DDCMHT		
Aftercare – Stanmore				CMPPQ EBPAS EIS						DDCMHT	
Tamworth				CMPPQ EBPAS EIS						DDCMHT	
Port Macquarie					CMPPQ EBPAS EIS						DDCMHT

## Session and Course Surveys

A copy of the Session and Course Survey was included in the Phase 1 report. It asks course participants to rank and/or provide subjective comments about the quality of training materials and processes. Table 5 quantifies the number of surveys collected from individual course participants for all courses including the pilot. There were 450 surveys collected in total with between 63 and 97 evaluations collected for each session/course. Responses for the five courses coordinated by MHCC are provided in Attachments 2 & 3. In summary, the course content was extremely well valued with the vast majority of course participants scoring both content and process highly.

**Table 5: Summary of Numbers of Session/Course Survey Evaluation Measures Collected From Individual Course Participants**

	Session					Overall Course
	1	2	3	4	5	
Aftercare – Penrith (Pilot)	16	12	13	13	13	13
NEAMI	17	14	15	9	12	14
Wagga	18	18	17	16	13	13
Aftercare – Stanmore	17	17	11	14	13	n/a
Tamworth	14	14	15	11	17	17
Port Macquarie	15	n/a	n/a	n/a	n/a	19
Total	97	75	71	63	68	76

Frequently occurring positive comments about the course included:

- Greater awareness of and less judgmental about client experience of substance use
- Knowledge and experience of trainers & classroom interactivity greatly appreciated
- Learning about/reviewing different substances and their effects
- Positive changes in attitudes/values and increases in confidence noted
- Appreciated copies of structured screening & assessment tools
- Liked relapse prevention, brief interventions, harm reduction and motivational interviewing information
- Liked opportunities for practice of skills
- Course content was very practical and relevant in content

Most participants indicated that they would recommend the training to others and were also interested in seeking further AOD training themselves.

Frequently occurring constructive comments about the course included:

- Too much content for length of time allocated
- Frustration at low level of assumed knowledge
- More information on behavioural impacts (especially as this relates to people with mental illness)
- More practice with screening and assessment tools
- Wanted more demonstration of skills
- Want to develop further skills in motivational interviewing (and applying stages of change theory)
- Too many handouts
- Variable comments about self care content
- Concern about number of training days and gaps between training days
- Difficulty completing tasks between sessions

This feedback contributed to directions for subsequent modification of the learning and assessment materials.

## **Pre/Post Training Evaluation Measure Collection**

The numbers of CMPPQ, EBPAS and/or EIS collected as at 15 March and the timeline for collection of the remaining measures is summarized in Table 6.

**Table 6: Summary of Numbers of Pre/Post Training Evaluation Measures Collected From Individual Course Participants**

	Pre Pre	Pre	Post	Post Post
Aftercare – Penrith (Pilot)	n/a	12	15	10
NEAMI	18	17	15	February 2010
Wagga	18	23	13	April 2010
Aftercare – Stanmore	18	18	13	May 2010
Tamworth	18	18	17	May 2010
Port Macquarie	6	18	17	June 2010
Total	78	106	90	TBA

## Implementation Experiences Survey (IES)

A copy of the IES Survey is provided as Attachment 4. This individual participant qualitative self-report measure was developed by the project to explore opportunities and barriers in transfer of training to service delivery. Course participants are also asked to provide any reflections on the nine workforce development pathways identified by MHCC in their 2009 “Mental Health Recovery Philosophy to Practice: Workforce Development Guide” publication as they relate to transfer of training to practice. Reporting on the results of this measure will await the Phase 3 Evaluation Report as the IES Survey has so far only been completed at the pilot site.

## The Dual Diagnosis Capability in Mental Health Teams (DDCMHT) Scale

### An Important Note on Selection of this Measure

The DDCMHT was selected as the use of a complimentary measure – the Dual Diagnosis Capability in Addictions Treatment (DDCAT) - has been required for drug and alcohol NGO community services funded under the COAG National Action Plan for Mental Health (2006-11) “Improving Services” initiative. Use of complimentary tools may allow for later cross-sectoral data comparisons.

The Comorbidity Program Audit and Self Survey (COMPASS) is a similar measure that was considered. While this is being extensively used in Victoria it appears better suited to reflection on individual rather than organizational practice.

This measure was modified from the Dual Diagnosis in Mental Health Treatment scale (Gotham et al). A copy of the modified tool is provided as Attachment 5. The modifications made were primarily to use language that better reflected the context of recovery-oriented service provision within the community managed mental health sector (ie, clinical terminology was replaced with recovery-oriented language).

Item s1B and 1D relating to US funding structures was also altered to better reflect the Australian service delivery context and scale scoring adjusted accordingly.

The DDCMHT is an integrated mental health and substance use service delivery fidelity scale. It essentially consists of 35 items reflecting evidence-based practice in integrated mental health and drug and alcohol work across seven broad organizational domains as follows:

1. Program Structure - General organizational factors that foster or inhibit the development of integrated mental health and substance use services.
2. Program Milieu - Culture of a program and whether the staff and physical environment of the program are receptive and welcoming to people with both mental health and substance use problems.
3. Assessment - Whether specific activities achieve specific benchmarks for mental health and substance use assessment.
4. Service Delivery - Whether specific activities achieve specific benchmarks for mental health and substance use assessment.
5. Continuity of Care - Long term service delivery issues and external supportive care issues commonly associated with persons who have both mental health and substance use issues.
6. Staffing - Staffing patterns and operations that support assessment and service delivery.
7. Training - Appropriateness of training and supports that facilitate the capacity of staff to help people with both mental health and substance use problems.

#### Administration

The DDCMHT is ideally administered annually through: site visits; file audits; desk based reviews of policy, procedure, paperwork, etc; and, client, frontline worker and manager focus groups. An instruction sheet was developed by MHCC to assist organizations with preparing for the DDCMHT pre-training administration activity and this is included as Attachment 6. For, multiagency (ie, non-metropolitan) sites this measure was administered with one identified lead agency only.

#### Scoring

Organizations are scored for each of the domains as being either a mental health only service (MHOS), dual diagnosis capable (DDC) service or dual diagnosis enhanced (DDE) service. The measure can be used as a more formalized basis for conducting integrated mental health and substance use service development and/or service training needs analysis at an organizational level as well as for tracking practice change over time.

#### Results

Table 7 summarizes results from the pre-training administration of the DDCMHT at the six project sites. In summary, prior to commencement of the “No Wrong Door” project the NSW community managed mental health sector appears to be not operating as a MHOS but is not yet DDC or DDE. Services are routinely assessing for and welcoming of people with substance use issues but not sufficiently equipped to effectively respond to these issues. Assessment does not make use of formalized tools (ie, mostly interview based with variable documentation of results).

**Table 7: DDCMHT Pre-training Administration Scores**

Domain	Organization Result						
	1	2	3	4	5	6	Average
Program Structure	1.33	2	2	1.67	2.67	2.67	2.06
Program Milieu	3	2	2	1.67	3.5	2.5	2.45
Assessment	2	2.71	2.14	2.71	2.57	2.29	2.40
Service Delivery	1.9	2	1.9	2.3	2.2	1.6	1.98
Continuity of Care	1.6	1	1	1	1	2	1.27
Staffing	1.8	2	1.2	1.6	1.6	2	1.70
Training	1.5	1.5	1.5	1.5	1	2.5	1.58
Average	1.87	2.02	1.82	2.24	2.18	2.26	

Areas where organizations are performing well (scored 3 or above):

- Expectation of people with AOD issues (Item 2A)
- Access to AOD supervision/consultation (Item 5C)
- Program acceptance based on existing AOD issue and severity (Items 4E & F)

Areas where organizations could most improve performance include (scored 1):

- Funded to deliver MHS only (Item 1)
- No routine AOD screening/assessment (Items 3A & B)
- AOD medications not used (Items 4E)
- Variable continuity of care (Item 5)
- Staff need AOD skills training (Items 5 & 6)

DDCMHT post-training administration will use the same approach as with pre-training administration. This will allow change to be measured both for individual organizations that participated to contribute to their quality improvement activities as well as the combined result allowing community managed mental health sector observations to be factored into the Phase 3 Evaluation Report.

# The Co-morbidity Problems Perceptions Questionnaire (CMPPQ)

The CMPPQ is a 33 item questionnaire that explores the attitudes of staff toward people with co-existing mental health and substance use problems. The CMPPQ subscales relate to:

1. Role adequacy
2. Role support
3. Work satisfaction
4. Self efficacy/esteem
5. Role legitimacy

The CMPPQ is used as research tells us that positive and helpful staff attitudes are critical to the acquisition of knowledge and application of effective skills in working with people with both mental health and substance use issues. This tool is also used by the NADA MISU Capacity Building Project and may allow for cross-sectoral comparisons.

## Results

Table 8 summarizes the combined CMPPQ score for all sites. The results indicate that participants (n=57) reported significant improvements in their knowledge, attitudes and confidence in regards to working with people with co-occurring substance abuse and mental health problems (note that lower scores indicate higher confidence, etc). Furthermore, when these gains (CMPPQ total scale scores) are compared to the control group data (i.e. services/workers who had not received the training), it is clearly evident that the gains for the trainees can not be explained as merely a consequence of time and usual practices. Specifically, tracking changes in the CMPPQ scores for the control group (n=48) indicates that the scores did not vary in a significant manner [time 1 mean 65.64 (14.30) compared to time 2 mean 69.66 (12.23),  $t=-2.05$ ,  $p = .05$ ]. In fact a non-significant negative trend was observed, suggesting that attitudes and confidence tended to decline over time without specific training.

**Table 8: Summary of Combined CMPPQ Scores**

	Pre-training Mean (std. dev)	Post-training Mean (std. dev.)	t-value	Significance p-value
Role Adequacy	20.66(6.91)	18.89(7.11)	7.11	.00**
Role Support	10.75(3.04)	8.40(3.49)	4.41	.00**
Work Satisfaction	14.36(2.64)	12.75(3.42)	2.98	.00**
Task Self Efficacy	9.67(4.12)	8.32(3.93)	2.49	.02*
Role Legitimacy	9.14(2.42)	6.08(3.22)	5.67	.00**
CMPPQ Total	71.58(11.81)	54.48(15.59)	7.42	.00**

\* - Significant at 0.05, \*\* - Significant at 0.01

Further analysis of these results is pending completion of data collection.

## The Evidence Based Practice Attitudes Scale (EBPAS)

The EBPAS is a 15 item questionnaire used to explore staff attitudes towards adoption of evidence based practice (EBP). Four dimensions of attitudes towards the adoption of EBP are considered:

1. Intuitive *Appeal* of EBP;
2. Likelihood of adopting EBP given *Requirements* to do so;
3. *Openness* to new practice; and,
4. Perceived *Divergence* with usual practice with research based/academically developed interventions.

The EBPAS is used as it gathers information to better tailor EBP implementation efforts within workplaces and this is thought to facilitate transfer of training to service delivery practice.

### Results

Table 9 summarizes the combined EBPAS score for all sites. The results indicate that participants (n=57) reported significant improvements overall in their attitudes regarding adopting evidence based practices. More specifically the results suggest that participants improved their attitudes in positive ways (ie, approached positive gains, became more growth oriented) as indicated by significant improvements in “appeal” and “openness”. The “appeal” subscale assesses the extent to which the participant endorses that s/he would adopt an EBP if it were intuitively appealing, could be used correctly, or was being used by colleagues who were happy with it. The “openness” subscale assesses the extent to which the participant endorses that s/he is generally open to trying new interventions and would be willing to try or use more structured or manualised interventions.

Interestingly there were no notable changes in how participants rated the “requirements” and “divergence” subscales. The “requirements” subscale assesses the extent to which the participant endorses that s/he would adopt an EBP if it were required by their service or supervisor, whereas the “divergence” subscale assesses the extent to which the participant endorses that s/he perceives EBPs as not clinically useful and less important than clinical experience. Taken together the differences in the subscale results suggest that attitudinal change related to readiness to adopt evidence based practice is more likely to occur if trainers/supervisors explore growth oriented opportunities in line with EBPs rather than simply tell staff what to do, which might be perceived as undermining their clinical experience.

Furthermore, when these gains (EBPAS total scale scores) are compared to the control group data (i.e. services/workers who had not received the training), it is clearly evident that the gains for the trainees can not be explained as merely a consequence of time and usual practices. Specifically, tracking changes in the EBPAS scores for the control group (n=47) indicates that the scores did not vary in a significant manner [time 1 mean 45.32 (9.34) compared to time 2 mean 43.37 (9.34),  $t = 1.17$ ,  $p = .25$ ).

Further analysis of these results is pending completion of data collection.

**Table 9: Summary of Combined EBPAS Scores**

	Pre-training Mean (std. dev)	Post-training Mean (std. dev.)	t-value	Significance p-value
Appeal	12.08(2.43)	12.96(2.44)	-2.45	.02*
Requirements	8.43(2.76)	8.55(3.20)	-.23	.82
Openness	12.26(2.47)	12.99(2.50)	-2.20	.03*
Divergence	10.62(3.55)	10.98(2.84)	-.78	.44
EBPAS Total	41.96(8.56)	44.97(7.67)	-.3.25	.00**

\* - Significant at 0.05, \*\* - Significant at 0.01

## Summary of Evaluation Results to Date

The results to date indicate that there were significant improvements in training participants' attitudes, knowledge and confidence in their capacity to work with people who have co-existing substance use and mental health problems. Improved attitudes to adopting evidence based practices were also found, particularly in terms of the facilitation of growth oriented attitudes. These improvements cannot be explained as merely a function of time and usual practices.

An additional, important and specific aspect of project evaluation relates to the formal recognition under the Australian Qualifications Framework of AOD skills acquired by individual course participants choosing to pursue qualifications as an outcome of the project and this is discussed next.

# 5. Skills Recognition

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## Qualifications Alignment

It was agreed that the “No Wrong Door” training materials would be aligned with nationally recognized units of competence from the 2002 Community Services Training Package (CSTP/CHC02). MHCC’s recent and extensive work in the area of community mental health workforce development has informed us that where professional development opportunities can be aligned with opportunities for achieving formal qualifications then this should be pursued.

While the “No Wrong Door” project is not necessarily about individual participants achieving formal qualifications the pilot was used to further explore approaches for aligning it with the following four units of competence for those wishing to pursue qualifications outside of the project (eg, Certificate IV in Mental Health and/or AOD):

1. CHCAOD2C Orientation to AOD work;
2. CHCAOD8C Assess the needs of clients who have AOD issues;
3. CHCCS403A Provide brief interventions; and,
4. CHCMH8A Provide interventions to meet the needs of consumers with MH and AOD issues.

Paradigm Consulting Network/Gillian Bonser contracted with NADA and worked with MHCC to develop four course assessments for participants wanting to achieve the above qualifications/units of competence. The assessment tasks were also aligned with the within and between class action learning training tasks to minimize student workloads and the MHCC LDU conducted an industry assessment validation in May 2008.

During the roll-out of “No Wrong Door” the CSTP underwent review and both MHCC and NADA contributed to this process. The new training package – CHC08 - was subsequently endorsed in March 2009 and all registered training organizations, including the MHCC LDU, are expected to be training against it from March 2010. The new training package includes a considerably revised Certificate IV in Mental Health and a new Diploma in Community Services (Mental Health and/or AOD).

The review made it necessary for the “No Wrong Door” training and assessment materials to be revised in-line with the new training package requirements to ensure enduring industry relevance beyond the “No Wrong Door” project.

In addition, our experience with the roll-out of subsequent courses had provided additional direction for training materials modification including:

- Recognition of existing knowledge and skills
- Course length to be reduced where possible
- Consideration of differential foundation worker and advanced practitioner training needs

To achieve this MHCC reviewed the units of competence & qualification frameworks possibly relevant to reconfiguration of “No Wrong Door” training. This process is more fully described in Section 6 - Resource Modification.

## Assessment Results

Successful completion of units of competence requires assessment that you possess the knowledge, skills and attitudes required by the unit. Therefore, assessment evaluation measures can include, for example:

- The number of course participants indicating an interest in achieving formal qualifications;
- The number of course participant submitting assessments to achieve Statements of Attainment for these units;
- The number of course participants successfully completing assessments to achieve Statements of Attainment for these units: and,
- The number of Statements of Attainments successfully achieved by all course participants.

As at 31 May 2010:

- 100 of 125 (80%) of No Wrong Door course participants had enrolled with LDU to complete assessments;
- 52 of those (52%) had successfully completed assessments; and,
- 38 of those (38%) had used the NWD/AOD pathway toward achieving their Certificate IV in Mental Health.

A number of these graduates received their qualifications from Dr Richard Mathews, Deputy Director General, Strategic Development Division, NSW Health at the 2009-09 LDU Graduation Ceremony held on 10 December.

The number of course participants successfully completing assessments has been growing rapidly since December and will continue to be monitored.

In summary, sector demand for AOD competencies is high and the project has identified numerous opportunities for continuing workforce development in this area that are being pursued as quality improvements to the LDU's AOD related coursework. Aspects of this quality improvement are considered next is discussing modification of the original No Wrong Door learning materials.

# 6. Resource Modification

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## Justification for Modification

MHCC's experience in delivering four NWD courses - along with pending changes to the CSTP previously discussed - signaled an urgent need for the learning and assessment materials to be further modified if they were to remain industry relevant beyond the life of the project.

The original pilot and subsequent training sessions were received extremely well by course participants as evidenced by the very positive qualitative evaluation feedback that was provided at the end of each session and for the overall course (see Attachments 3 & 4). However, this evaluation process yielded little specific feedback for modification of materials which was not surprising given that the course participants mostly had no formal qualifications and/or experience in AOD work and were assumed to have low confidence levels in their knowledge/skills for AOD work. Increases in skills, confidence and more positive attitudes towards working with people with AOD problems have been demonstrated in the early evaluation results and won't be fully known until the pre and post training quantitative evaluations are completed.

Specific reasons for considering modifications for delivery of the courses included:

- Concerns that the length of time involved in the NWD training over five/six sessions was prohibitive for workplaces with regard to time out of role;
- Travel and/or accommodation costs associated with delivery of the course in non-metropolitan areas;
- To reduce administrative burden by reducing the number of documents associated with delivery of the course (ie, less workshops meant fewer learning and assessment resources and this also provided the opportunity to integrate numerous additional handouts within the remaining materials).
- The need for the NWD training to be more specifically relevant to the mental health sector, based on feedback from the participants across five sites;
- Duplication and overlap with an existing "Mental Health and Substance Abuse" course that had been delivered by the LDU as part of its Certificate IV in Mental Health over the past two years (this course was aligned with CHCCS403A *Provide brief interventions*; and, CHCMH8A *Provide interventions to meet the needs of consumers with MH and AOD issues*); and,
- The need to align the learning materials with units of competence from the revised CSTP and to increase opportunities for achieving formal qualifications through the MHCC's LDU including: Certificate IV in Mental Health; Certificate IV in Alcohol and Other Drugs: and/or, Diploma in Community Services (Mental Health and/or AOD);

MHCC wrote to NADA in July 2009 seeking a project variation to increase the sustainability of the project. It was proposed that instead of proceeding with the remaining two courses that:

- The project learning and assessment materials are reconfigured against feedback and experience of delivery at the four sites to date and to align with the unit requirements of the new 2008 CSTP; and,
- The reconfigured materials are then piloted at one additional organization/location before being made available to the sector from 2010 onwards.

## Modification Process

MHCC convened a meeting in September 2009 with all relevant personnel including:

- NWD Project Coordinator;
- LDU Manager;
- Mental health/AOD trainers & assessors; and,
- Mental health/AOD course writers.

Extensive discussions about the content and configuration of the LDUs current and proposed mental health and AOD courses took place that guided the structure and content of the modified NWD course. Discussion about Diploma level AOD training was also included as there is strong articulation between this new qualification and the Certificate IV level qualification that the NWD training is aligned to. This was also important in responding to concerns that the NWD training was not meeting the needs of Mental Health Workers with more advanced qualifications and/or experience in AOD work.

This planning approach was undertaken to deliver more sustainable AOD training resources for the health and community services sector that can articulate toward both Certificate IV and the new Diploma level qualifications in mental health and/or AOD work. The approach was also relevant to creating a professional development pathway beyond NWD for learners seeking to develop more advanced skills.

Table 10 summarizes all CSTP AOD units of competence that were considered in the revision of the NWD resource.

It was agreed that the modified NWD training would now be aligned with five units of competence (note that CHCAOD411A is an additional unit added as a result of the review):

- |               |  |
|---------------|--|
| 1. CHCAOD402A | Work effectively in the alcohol and other drug sector                                  |
| 2. CHCMH408B  | Provide interventions to meet the needs of consumers with mental health and AOD issues |
| 3. CHCAOD408A | Assess the needs of clients with AOD issues  |
| 4. CHCCS403B  | Provide brief interventions  |
| 5. CHCAOD411A | Provide brief interventions for people with AOD issues                                 |

All except CHCMH408B are compulsory units within the Certificate IV in Alcohol and other Drugs.

Materials development commenced in October and a pilot of new materials was conducted in November. This body of work was sub-contracted to consultant. Alison Bell.

**Table 10: Overview of “No Wrong Door” Current/Possible Units of Competence and Their Relationship to Community Service Training Package MH & AOD Qualifications<sup>4</sup>**

	2002 Community Services Training Package (CHC02)		2008 Community Services Training Package (CHC08)				
	CHC41102 Certificate IV in MH Work (Non-clinical)	CHC41702 Certificate IV in AOD Work	CHC40508 Certificate IV in MH (4 electives)	CHC40408 Certificate IV in AOD	CHC50308 Diploma of Community Services MH (2 electives)	CHC50208 Diploma of Community Services AOD (2 electives)	CHC50408 Diploma of Community Services AOD & MH (no electives?)
<b>Original NWD Units</b>							
CHCAOD2C Orientation to AOD work to CHCAOD402A Work effectively in the AOD sector	1 of these 2 can be chosen as an elective	Compulsory	Compulsory	Compulsory	Elective	Compulsory	Compulsory
CHCAOD8C Assess the needs of clients with AOD issues to CHCAOD408A		Compulsory	Elective	Compulsory			
CHCCS403A Provide brief interventions to CHCCS403B	Compulsory	Compulsory	Elective	Optional compulsory\			
CHCMH8A Provide interventions to meet the needs of consumers who have mental health and AOD issues to CHCMH408B	LDU recommended elective.	n/a	Elective	Elective			
<b>Possible Use In Reconfigured NWD Materials</b>							
CHCAOD411A Provide interventions for people with AOD issues			Elective	Compulsory			
CHCAOD510A Work effectively to meet the needs of clients with complex AOD issues			Elective		Compulsory	Compulsory	Compulsory
CHCAOD511B Provide advanced interventions to meet the needs of clients with AOD issues					Elective	Compulsory	Compulsory
CHCAOD513A Provide relapse prevention strategies					Elective	Compulsory	Compulsory

<sup>4</sup> Note: The five units that the revised NWD courses are aligned with are highlighted in yellow. The new Diploma level AOD training aligns with the other units.

## Pilot of the Revised Resource

The consultant delivering the revised training provided the following feedback:

- The restructuring of the NWD training ... into two X two-day workshops instead of six sessions allowed for much greater continuity
- The reduction of handouts to two learner guides was far more manageable compared to the multiple handouts involved with the original NWD training
- Having two assessments instead of four was easier to manage and provided a broader, integrated assessment of the concepts covered over the two workshops/four days
- The greater inclusion of mental health specific information and scenarios helped to make the AOD information more relevant to the learners' workplace and consumer group
- the sequence of information flowed logically
- the learner guide was useful to assist with structuring the course and reinforcing the materials presented via PPT
- the activities were helpful with reinforcing the information, ideas and skills presented
- there were times when it was challenging to balance process and content, particularly when participants asked questions which were relevant to the context of the training and their work
- the content of the training, particularly in MH and AOD, was more relevant to those in case management roles. (Some staff) found some of the training, such as the interventions, less relevant to their work
- local knowledge about AOD and MH services would have been useful, particularly when discussing collaboration and referral options
- there was some confusion about some parts of the assessment .... These issues are currently being addressed.

Overall, the participants responded very well to the structure of the workshop, participating in all of the activities. In particular, some of the participants commented that they had altered their beliefs about AOD and the people who use them as a result of the reflective exercises and factual information presented. Many of the participants had a lot of relevant questions which were addressed within the workshops. This did mean some slight deviations from the program, however all questions were relevant to the focus of the course. This allowed for a balance between presenting the course content and using the workshop as a vehicle for learners to process the information.

A number of participants personally commented that they learned a great deal and felt it was a valuable learning experience. One participant presented me with a box of chocolates and a card expressing her thanks for the experience. Another participant commented:

*"I am nearly 70 and thought I didn't really need to learn much more. I have come to realize over this course that there is still so much to learn!"*

Some participants expressed a desire to have a longer training course as they felt there was too much to cover, particularly in the second two days of training.

A number of participants expressed a desire to undertake further training on motivational interviewing which was introduced during the second workshop.

Some further minimal changes to the course content were made as a result of the piloting of the revised materials.

# Summary of Revised Course Content and Structure

A complete copy of all learning and assessment materials is provided as Attachment 7. The following is a brief summary of the revised course content.

## Workshop 1 - Foundations of Alcohol and Other Drugs: Working Within the Mental Health Context

This course is aligned with CHCAOD402A *Work effectively in the alcohol and other drugs sector* and is mostly knowledge based.

The learning outcomes for this workshop are to:

- Understand AOD use within the mental health context
- Explore their attitudes and beliefs about AOD and people who use substances
- Learn about the changing historical, social, political and economic context of AOD use
- Develop an understanding of the different models of AOD use
- Explain the effects of a range of AOD on the body
- Discuss dealing with intoxicated, overdosing and withdrawing clients
- Explain the impact of AOD use on mental health
- Discuss the interaction between mental illness and AOD use
- Explore harm minimization
- Discuss the implications for consumers and case management.

This workshop covers the following topics:

### Day One

Session 1: Introduction to Foundations of AOD in the MH Context

Session 2: AOD use within the Mental Health Context

Session 3: Attitudes and Beliefs about AOD

Session 4: Understanding AOD Use

Session 5: Pharmacology

Session 6: Intoxication, Overdose and Withdrawal

### Day Two

Session 7: Review of Day One

Session 8: Impact of AOD on Mental Health

Session 9: Interactions between Mental Illness and AOD

Session 10: Harm Minimization

Session 11: Implications of AOD use for working with consumers

Session 12: Assessment Tasks, Workshop Review, Evaluation

Resources required:

- Foundations of AOD and MH Trainer Guide
- Foundations of AOD and MH Learner Resource/Handout
- Foundations of AOD and MH PowerPoint slides
- Video – “Substance Abuse”
- Documentary – “The Ice Age”
- Assessment
- Evaluation forms
- AOD Resources Pack – for display only

This course is a pre-requisite for the second workshop for those wanting improved skills in responding to people with both mental health and AOD issues.

## Workshop 2 - Assessing and Addressing the Needs of Mental Health Consumers Who Use Alcohol and Other Drugs

This course is aligned with:

- CHCAOD408A *Assess the needs of clients with AOD issues*
- CHCCS403B *Provide brief interventions*
- CHCMH408B *Provide interventions to meet the needs of consumers with mental health and AOD issues*
- CHCAOD411A *Provide interventions for people with AOD issues.*

This course builds on the first workshop by providing the practical skills for applying the knowledge from Unit 1 and in identifying and responding to people with both mental health and AOD issues.

The learning outcomes for this workshop are to:

- Explain the importance of assessing and addressing AOD use within the perspective of the mental health recovery framework;
- Understand the purpose of AOD assessment;
- Demonstrate the skills involved in assessing consumer needs;
- Utilize tools for screening and assessment of AOD and related concerns;
- Explain the referral process;
- Discuss some of the options within AOD services;
- Describe some guidelines for working collaboratively between mental health and AOD services;
- Understand readiness for changing AOD use;
- Explain the importance of evidence based practice;
- Explore a range of interventions for addressing consumer needs;
- Broadly understand motivational interviewing as one approach;
- Discuss the use of CBT, particularly in assisting consumers to maintain changes to AOD use;
- Apply the learning to the context of working with consumers who use AOD.

This workshop covers the following topics:

### Day One

- Session 1: Welcome, overview of workshop, group agreement
- Session 2: Review of Foundations of AOD and MH
- Session 3: Purpose of AOD assessment
- Session 4: Assessment skills
- Session 5: Tools for screening and assessment of AOD
- Session 6: Referral and AOD treatment options
- Session 7: AOD and MH – guidelines for collaboration

### Day Two

- Session 8: Day One Review
- Session 9: Understanding readiness for change
- Session 10: Overview of brief interventions and evidence based practice
- Session 11: Introduction to motivational interviewing
- Session 12: Overview of CBT – application to prevention of relapse
- Session 13: Putting it all into practice

Resources required:

- MH and AOD: Assessing and Addressing Needs – Trainer Guide
- MH and AOD: Assessing and Addressing Needs - Learner Resource
- MH and AOD: Assessing and Addressing Needs - PowerPoint slides
- Videos – WHO-ASSIST; Meaningful Conversations – Motivational Interviewing
- MH and AOD Assessment
- Evaluation forms

### Workshop Processes

The workshops have been designed to provide learners with opportunities to:

- Reflect on their current approach to working with consumers who use AOD;
- Gain new knowledge about a range of matters related to AOD use and effects;
- Learn and practice new skills and reinforce current skills for working with consumers who use AOD;
- Think critically about AOD use by consumers of mental health services;
- Reflect on the application of the learning within the reality of their work context.

A range of teaching strategies are employed within the two workshops:

- Each learner receives two separate learner guides for the workshops which they refer to throughout the course of the training;
- The learners guides include reflective exercises, case studies for applying the learning, information to support the learning and an extensive reference list for further learning following the training and to support the completion of the assessment tasks;
- Audio-visual resources about AOD and demonstrations for working with consumers;
- Didactic presentation of information from the two sets of PowerPoint slides specifically prepared to support the training;
- Activities involving individual reflection, reflection in pairs or small groups and consumer examples for role-playing and applying skills learned during the workshop.

## **2010 Course Offerings**

The following overview of LDU delivery of NWD courses for 2010 was current as at 15 January 2010 and is growing rapidly. This does not include Diploma level AOD coursework which was also in part informed by experiences of the NWD Project. A summary of all AOD courses offered by the LDU is provided as Attachment 8.

### Foundations AOD

- 19 & 20 April – Sydney
- 27-28 May – Dubbo
- 28 & 29 June – Newcastle
- 5 & 6 August – Sydney
- 19 & 20 August – Sydney
- 26 & 27 August – Sydney
- 18 & 19 October - Wollongong

### Assess AOD

17 & 18 May – Sydney  
30 & 31 August – Sydney  
20 & 21 September – Sydney  
29 & 30 September - Sydney

An additional three MHCC member organizations have arranged with LDU to deliver 18 AOD courses as part of their regular staff induction and professional development programs in the following communities:

- Sydney;
- Lismore;
- Gosford;
- Port Macquarie;
- Newcastle;
- Coffs Harbor;
- Robertson: and,
- Young.

This demonstrates that industry demand for AOD skills is strong and growing and that the final NWD Project materials are seen as being industry relevant.

# 7. Discussion & Recommendations

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## Discussion

The “No Wrong Door” project has provided a much valued opportunity for MHCC to explore and respond to the workforce development and learning needs of community managed organizations working with people with co-existing mental health and substance use problems.

“No Wrong Door” was designed to improve responses to consumers of the NSW community managed mental health sector who also have drug and alcohol issues. The specific aims of the “No Wrong Door” project are to develop and deliver a training resource that would:

1. Elicit staff attitudes, confidence levels and skill sets in working with clients who present with alcohol and other drugs (AOD) issues in the mental health sector and facilitate attitudinal change and an increase in staff confidence and skills in working with this client group.
2. Improve management and agency capacity to support clients within mental health agencies with alcohol and other drug issues.

The implementation phase of the project was planned to offer organisational change management approaches to workforce learning and development for up to 20 NGO Mental Health Workers at each of six course locations across NSW throughout 2009 to: facilitate workforce development in responding to co-existing problems; increase the knowledge, skills and confidence of Mental Health Workers and workplaces in responding to substance use problems; and, ensure robust evaluation of the project to maximise learning outcomes for all stakeholders.

Project evaluation to date indicates:

- Positive uptake of AOD training opportunities by both community mental health workers and workplaces (as indicated by both project participation and assessment completions)
- Significant improvements in training participants’ attitudes, knowledge and confidence in their capacity to work with people who have co-existing substance use and mental health problems
- Improved attitudes to adopting evidence based practices were also found, particularly in terms of the facilitation of growth oriented attitudes

In summary, MHCC’s successful roll-out of the “No Wrong Door” training and the community mental health sector’s enthusiastic uptake of the training opportunity, including short-term increases in self-perceived confidence to work better with people with co-existing problems, demonstrate that the aims of the project have been met in part. The extent to which increases in knowledge, skill and role adequacy have led to changes in individual practice or service delivery change will be further explored as project evaluation progresses throughout 2010. Finalization of the evaluation component of the project will also allow for more informed recommendations to be made for future sector development activity towards more effectively building capacity to reorient services to better address co-existing problems.

It is anticipated that these recommendations will extend beyond training content and process and also include recommendations in the areas of, for example:

1. Policy & procedure
2. Professional development & supervision

3. Linkages & partnerships
4. Quality improvement
5. Data collection

Some early recommendations arising from the implementation phase of the project are made next.

## Recommendations

A challenge in making recommendations at this stage of the project is that learning arising from the project is far from complete. In addition, it is anticipated that the list of recommendations arising from the project will be extensive and a process to prioritize them will also need to occur. Key recommendations arising from the project to date are that consideration be given to:

1. Additional community managed mental health sector funding for AOD workforce development
2. The development of a CMO targeted publication addressing the knowledge and skills required for effective work with people with coexisting problems and organizational development required to transfer skills into practice and service delivery
3. The development of recognized skill sets in mental health and AOD work (for people not wishing to pursue full qualifications)
4. The development of additional coursework at the Vocational Graduate Certificate/Diploma level
5. The development of a resource towards achieving common language in work with people with and coexisting problems including shared understandings of the concepts of rehabilitation and recovery as these relate to medical/treatment and social approaches to service delivery
6. The need for a template upon which mental health and AOD service level agreements/memorandum understanding might be based
7. The need for policy and procedure templates for working with coexisting problems
8. Strategies for enhancing consumer and carer participation in sector and workforce development
9. The need for targeted training to address issues related to smoking cessation and mental health
10. The need for targeted training regarding interactions between psychiatric medications and substance misuse
11. The need for targeted training regarding counseling skills/talking therapies (especially motivational interviewing & cognitive behavioural therapy)
12. The possible value of opportunities for cross sectoral staff exchanges

## 8. References

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Mental Health Coordinating Council (2008). Mental Health Recovery Philosophy Into Practice: A Workforce Development Guide.

Velleman, Richard & Baker, Amanda (2008) Moving away from medicalized and partisan terminology: a contribution to the debate, *Mental Health and Substance Abuse: dual diagnosis*, 1:1, 2-9.

## 9. Attachments

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1. 2008 MHCC Member Survey Items Related to the No Wrong Door Project
2. Summary of Qualitative Survey Responses for the Four Courses  
Delivered the Original Training Material
3. Summary of Qualitative Survey Responses for the One Course  
Delivered the Modified Training Material
4. Implementation Experiences
5. Dual Diagnosis Capability in Mental Health Teams Scale  
(modified version)
6. DDCMHT Administration Preparation Guidelines
7. NWD Learning and Assessment Materials (modified version)
  - Learner Guides (2)
  - Assessments (2)
  - PowerPoint Slides (2)
  - Trainer Guides (2)
8. Summary of MHCC LDU AOD Courses

# Attachment 1 – 2008 MHCC Membership Survey Items Related to the No Wrong Door Project<sup>5</sup>

## 1. Does your organization have a policy and/or procedure for responding to drug and alcohol issues? - 32 responses

Yes 54.9%  
No 40.9%

### Comments

- We are currently in the process of developing this piece of work.
- It is flexible, however, we are unable to work with clients who will not address their substance use issues. This flexibility is up to individual caseworkers. Personally, I may go further than others?
- We do not offer drug and alcohol services. We are currently developing a policy relating to client code of conduct that will include drug and alcohol use.
- Consultants (developing?)
- Not involved in these issues.
- XXX is quite small, too small to be able to manage a viable let alone competent program.
- Cultural negativity, lack of training, historically poor outcomes with dual diagnosis consumers.
- We are not seen as a drug and alcohol specialist area. We do see people with these issues as part of a more complex treatment procedure, such as substances/gambling/depression or relationship issues, so a set policy of treatment is not as relevant. Our clients are not seen as having a major mental illness usually although we do see these people they are seen as part of a continuum of clients services rather than a focus.

## 2. Please rate the overall confidence and skill level of your service in responding to drug and alcohol use issues (1 = poor, 10 = excellent) – 32 responses

1	-	3.1%
2	-	3.1%
3	-	9.4%
4	-	9.4%
5	-	12.5%
6	-	12.5%
7	-	21.9%
8	-	21.9%
9	-	6.3%
10	-	0%

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<sup>5</sup> These questions will be repeated in the 2011 MHCC Member Survey to measure change over time.

**3. Are qualifications/experience in responding to drug and alcohol issues an essential or desirable criteria in selecting direct care staff? – 33 responses**

Yes	51.5%
No	48.5%

Comments

- Staff shortages are serious and we do not have the luxury of being this restrictive.
- Or training provided.
- Desirable.
- We're "purely" mental health – recovery, employment, some arts & social ... also a few addicts on some legal substances.
- Staff appointed on counselling skills/experience rather than D&A as that is the main focus. MHCC courses appear to be focused toward mental health/D&A rather than as part of the more existential or personal crisis our clients are facing.

## Attachment 2 – Combined Qualitative Evaluation Data From the Four Courses Delivered the Original Training Materials

Module 1 – Overview of AOD				
	Strongly Disagree	Disagree	Agree	Strongly Agree
<b>The presentation:</b>				
Was interesting & challenging		2	38	26
Was relevant to my work		1	36	29
Provided me with information I can use with clients		2	39	25
Was worth attending		1	31	34
<b>The handouts provided during the session:</b>				
Are easy to read		3	28	35
Are relevant to my work		1	35	29
Are a useful resource for me as a staff member		1	29	36
Would be more useful to hand to clients (if applicable)		8	33	23
<b>The facilitator</b>				
Explained the information clearly		2	19	44
Directed the group well	1	2	19	43
Provided the opportunity to ask questions		1	13	50
<p><b>What did you like best about the module? What was most valuable?</b>            Learning about different classifications of drugs, history &amp; different models of dependence.            Content – clear, easy to understand relevant to work. The effects of drug &amp; alcohol on the neuro system.            Discussion/exploration.            All good – loved it.            Very, very interesting.            It was all good.            Info about stimulants &amp; depressants.            Facilitator presentation very interesting. Knowledge. Excellent training – informative, thought provoking.            Presenter is knowledgeable.            Enjoyed the presenter’s honesty and perspective.            Learning about how drugs affect the brain.            Information on serotonin &amp; dopamine.</p>				

Overview of all drugs provided clarity. Examples & stories around them solidified the information and made it relevant.  
Overall everything, enhancing my knowledge in AOD.  
Interesting personal work experience of the presenter.  
It gave a lot of information without getting into in-depth irrelevant details.  
The effects of withdrawals of certain drugs. This will help me when working with my clients to overcome addictions.  
Hearing other workers opinion.  
Different drug types – change of value systems.  
Learning effects of drugs, long term + short term, different ways to use drugs.  
Discussion on different usage AOD.  
Diverse range of AOD available, i.e. overseas.  
Discussion on different drugs there use and misuse and history socially and politically.  
Substance types – information about different drug classifications.  
The opportunity to network. The connection of information to what is happening on the streets.  
Info. On various drugs.  
The layout was easy to follow and the effects of different AOD on the body.  
Information on different drugs and the effects that each has on the body.  
Most valuable and enjoyable was group discussions and activities.  
Informative; ease of flow of information; time to ask questions and not to feel inadequate by asking. Clear answers beneficial.  
It was comprehensive and stimulated a lot of discussion.  
Learning about AOD that I never knew about.  
Learning about how one's beliefs can impact on the work with people suffering substance abuse. Learning about language.  
The withdrawal of alcohol and benzos.  
The over use of antidepressants.  
Alison's enthusiasm and knowledgeable presentation of the info. I found the descriptions of the physical/chemical processes of the nervous system very helpful.  
All of it was interesting and valuable.  
Very detailed.  
Detailed information about classes of drugs – particularly antipsychotics.  
Looking at own values was very useful also.  
Learning about the different drugs and effects.  
How to look at each case working with can have different meanings.  
The need to get the whole story of a client being aware of the mixture of drugs and prescribe drugs.  
Information provided in all areas.  
Basic overview of topic area.  
Easy to understand.  
Great information – particularly history of various drugs.  
All information was presented well and time was allowed for questions.  
Challenged preconceptions and got me to consider how I work with clients in terms of my own values and awareness.  
Open discussion.  
Able to explain complex notions easily.  
Understanding how they work in the brain.  
The wide range of areas covered.

Learn about all the substances and effects they have on the brain/body.

I liked the video as well.

Challenged attitudes towards drug use.

Information on different effects and signs/symptoms to look out for.

Learning more about AOD issues – withdrawal and statistics.

Very interesting information.

Very informative session.

Listening to others point of view.

Thinking about what creates drug addiction.

Types of substance actually recognized as a drug and called drug use ie tea/coffee/coke. Which changed my perception of a drug user.

Interaction between different sections of the group.

Diverse cross section of service providers.

Information learnt and the discussion groups.

Seeing others views on different issues.

The group interaction and experience of the different areas. This increased my knowledge of the topic along with the handouts.

Perceptions and health issues on certain types of drugs.

Being refreshed on drug withdrawals and their durations.

Discussions as a group.

Different substance, effects for use and withdrawing and overdose.

Effects of drugs and withdrawal.

Where to get more information.

All interesting and valuable.

**What did you like least about the module? What could be left out or changed?**

Nothing comes to mind.

Was a little slow moving. Noticed attention difficult at times & bum getting sore.

More info on cannabis.

It's not quite interactive, however, I felt engaged and learnt more than I would if I had just had the information to read from a book.

I just want to watch the video that understandably could not happen because the device was not in the room.

I believe everything was relevant.

Assume a greater level of knowledge amongst candidates.

Same information on projector as in books.

Very rushed due to a meeting with MHCC meet your neighbor.

Different info on projector, instead of the same that participants already have read.

Could not fault it. I see no reason to dislike one bit.

Greater detail on effects of AOD on the clients behavior would be good.

The discussion around hallucigen / stimulate / depressant could be changed to have the list on the initial pages. I generally don't know the names of the drugs.

All okay.

Group activities: chew up time better spent in large group discussions. Presentation of statistics seemed isolated, i.e.; not put into wider context, therefore were leading to false assumptions. Food; very limited vegetarian options.

A lot of stats.

Basic knowledge information, extremely detailed slides would be more beneficial to use them as basic conversation starters.  
Some repetition; needing more time perhaps.  
Some subject matter was 'skimmed over'. More time needed for group work.  
Talking about the individual drugs too much. ie. Marijuana and bong.  
Presentation was clear and light hearted.  
Recovery/detox/rehab strategies.  
Didn't get through everything.  
Yes. Policy and Procedures within the organisation around AOD.  
Material can be more advanced.  
More focus on practical application in client work.  
Worked practical examples during the session.  
Maybe use a more up to date video.  
Nil. It was all good/useful.  
A bit more structure would be very helpful.  
There was a lot of useful information presented and it would have been great if this info was presented in slides/or more visual sheets were given out.  
Found all very relevant!  
All good.  
Somewhat repetitive.  
I enjoyed all parts of the module.  
I thought it was all relevant.  
CPR.  
Sandwiches.  
All interesting. Wouldn't leave anything out.

**Will this module help you with your work? If so, how? If not, why not?**

Yes, useful to know effects & withdrawal symptoms, look forward to models of intervention.  
Acceptance, understanding, confidence, hope, enthusiasm to work with AOD consumers.  
Yes – better educated into drugs that need to be incorporated into ISP practice.  
Yes, explanation of drugs, their classification and biological impact was incredibly enlightening. It will help me to understand the impact the drugs consumers use may have on them.  
It gave me more understanding about drugs and the effects that they have.  
Yes.  
Some basic info for myself for better understanding when working with people.  
Yes – to inform the client about the drug they are taking & how it affects the body.  
Yes, information to assist consumers.  
Yes. Understanding of common drugs and how they affect people. Helps me understand what is happening for clients. Demystifies.  
Understanding better consumers who use AOD.  
The information would be useful with clients.  
This module will help me to understand the effects of AOD and the withdrawal symptoms people can experience.  
No, we don't have many AOD clients.  
Yes – better understanding of types of drugs, drug uses and drug effects.  
Yes have more knowledge of effects of drugs, how to use drugs and different names of drugs.  
Yes it will assist to provide me with more information on AOD issues. Made me look at my own values and views.

Definitely, high percentage of clients with AOD, dual co-existing diagnosis. Also work with high percentage of smokers, this module will be very helpful in addressing these issues.

Gives a broader understanding and a refresh of information that is helpful in discussing issues with clients.

Yes – gives me a greater understanding of the complexity of AOD issues.

Not at the moment because of where I am up to with clients.

Yes it will help because I have 4% of clients with co-existing conditions and others on various medications.

Majority of knowledge was simplistic; I have personally covered and extended on a good deal of it. Seemed very basic.

Will help better understand how people are feeling and dealing with things.

Yes, will prove helpful in identifying clients who have Drug and Alcohol issues and assist in directing them to proper services to address these issues.

It will give me a greater knowledge of valuable information to better serve clients in the future.

As general information very helpful, but not relevant to my clients as I have now.

Yes. It is a good resource and reference.

Yes how do know about client that have AOD disorder.

Yes, it will. It has changed my attitude towards persons using particular drugs which are socially deemed worse than others.

It will help me understand how hard withdrawal is.

Yes, better understanding of physical and historical context of drug use.

Yes. Practical and knowledge increase.

Gives better understanding on relationship between antipsychotics etc and street drugs.

Remembering to check my own assumptions when working with clients.

Harm minimization strategies.

Yes. Awareness of my clients medication and there side effects good/bad.

Not really.

Basic information already known.

No practical or strategies discussed for client work.

Definitely – has provided strategies to go about talking to clients about alcohol and drug use. Shown ways to discuss ham minimising practices.

Yes. Now understand more about how they affect people and the withdrawals.

Yes. Practical background knowledge and will support my work with clients with co-existing drug/alcohol use.

Yes. Increased confidence to assist clients with AOD issues.

Yes. Makes me more aware of my clients and their addictions.

Not at this stage. No real strategies explained.

Yes, it will. We have a lot of varied clients from recovering alcoholic to cannabis users and amphetamine addicts.

Will help me understand the problems of addiction that face my clients.

Will help me accept them better with facing/dealing with their problem.

It will help me understand drug use and how to deal with it from the client's point of view.

Yes. It gives me a better understanding of clients experience and dependency.

Yes. Better understanding of the issues.

Yes, very much so. Drug/alcohol issues are common in my workplace and today's module was very helpful.

Yes, as we have several clients with AOD problems.

Yes, as more confident in understanding of AOD.

Yes, with better understanding of different effects that it has on the person.

Yes, will help with knowledge and understanding of where clients are "coming from".

**Other comments you would like to make about the training?**

Very engaging.  
On come to mind – oh yes – the movie please, can we watch it at some time. Thanx – much appreciated.  
None, it was great.  
Best training I have attended and I was not looking forward to it.  
Very interesting and enjoyable. Nice lunch. Excellent facilitator. Thankyou.  
Light and fun approach of trainer made it enjoyable.  
Was very good. Excellent presentation of the topics. Very good presenter.  
Good presentation style.  
Looking forward to the next session.  
Great resources, materials, facilitator.  
Some people in the group were allowed to talk too much, while others did not get a chance to talk.  
Some participants hog the floor with their chatter!  
Going well so far.  
Maria was approachable and the PowerPoint was easy to read and understand.  
Venue was fine.  
No, thank you it has been a long day!  
The presenter was very good.  
Teacher (Alison) was very knowledgeable on the topic.  
Presenter presented well.  
Need more practical application than just information or awareness session.  
Very interesting and Alison is extremely engaging. By far the most interesting and informative training I have done in a while.  
Great info and easily understood.  
Very good presentation and looking forward to rest of modules  
Very good.  
Very informative.  
Thank you.  
Looking forward to continuing with more modules and training.  
Great day. Thanks.  
Enjoyable.  
Kept moving along.  
No dull moment.  
Presented well.  
Maria had a lot of good discussion groups.  
No.  
Yes.  
Resources are very good.  
Thank you Maria.  
It is very entertaining.

## Module 2 – Assessment & Referral

	Strongly Disagree	Disagree	Agree	Strongly Agree
<b>The presentation:</b>				
Was interesting & challenging	2	2	35	24
Was relevant to my work			31	32
Provided me with information I can use with clients		2	19	42
Was worth attending		4	20	39
<b>The handouts provided during the session:</b>				
Are easy to read			31	32
Are relevant to my work			35	27
Are a useful resource for me as a staff member		2	25	36
Would be more useful to hand to clients (if applicable)		8	29	22
<b>The facilitator</b>				
Explained the information clearly		3	18	41
Directed the group well	1	3	18	30
Provided the opportunity to ask questions		1	13	48

**What did you like best about the module? What was most valuable?**

Confidence. Importance of readiness scale. Questioning/interviewing techniques. Stages of change. Remembered to ask what they like about using. Challenging attitudes of clinicians. Stages of change model. Learning how to engage with a clients wanting to stop using drugs or alcohol. Strategies for doing successful assessments. Group discussions regarding harm reduction techniques. Emphasis on “meeting clients where they are at”. Practical ways of ensuring non-discriminatory practice. Useful content about how to run an assessment, eg, questioning style. The info on all different interview techniques and styles. Information & direction of effective ways/tools to conduct assessments. Copies of assessments to undertake. Stages of change. Quite interactive & realistic, not moralistic information. Strong interaction from the trainer to the students. Making the information relevant to us. Discussion around the assessment & referral process. Discussion around taking assessments/history. Harm reduction. Group discussion. All good. Client testing tools provided. Assessment overviews.

Sharing of resources & experiences. The experience of Maria was invaluable.  
AOD tools, resources. Stages of change.  
Assessment tools.  
Clear information given; encouragement of interaction; good examples used.  
The handouts / assessment tools.  
About methadone treatments.  
Discussions about application of material to client scenarios.  
Seeing and hearing other opinions and staff experiences.  
Assessment tools were enlightening.  
Its relevance to my work. The resource content.  
Assessment tools for clients with dependency issues.  
Assessment information was very relevant in regard to clients with Drug / Alcohol dependence, pharmacotherapy's was probably not as relevant as referral in regard to working with clients.  
Assessment options / screening options. Reading direct from PowerPoint .  
Information on medication to help people withdraw from AOD use.  
Learning about the stages of change and using our own examples to exemplify this.  
Strategies to questioning important things to client with a respectful approach.  
Different models of change/balance.  
Role play with Brad.  
How to not push my ideas on other people.  
To try and ask them to come up with the answer.  
Relevance, real applications.  
Stages of change.  
Intervention strategies/demonstrations.  
The use of language, and the importance of initial intervention and rapport development for effective service delivery.  
Informal.  
Enjoyable.  
The skills that surround assessment and screening tools.  
Understanding what makes a good assessment.  
Everything/well presented.  
Best explanation yet of stages of change.  
Motivational interviewing techniques and stages of change.  
These are already included in the model we use for mental health but good to see role plays apply it to D & A.  
Good refresher.  
The techniques and tools provided to work with clients and the role play session.  
How to conduct assessment.  
Effect of different questioning.  
Looking at the screening tool.  
Group discussions.  
Hearing co-workers stories AOD affect all people no matter what or where they're from.  
Learning new strategies to do my work.  
The assessment tools they explored. The clients issues and environment.

Pharmacology.  
Assessment tools.  
Group participation.  
Sharing information.  
Difference in drug groups.  
Assessment tools  
Assessment tools that were easy to understand and timely to administer – to realistically be implemented into work day.  
Provided information that I was not aware of.  
The assessment tools that I can use with service user.  
Stage of change.  
Assessment tools.  
Collaboration between services.  
Would be good if there was further discussion on working together interservice.  
Assessment tools and pharmacology.  
Interaction with other organisations.  
Made me think about safe use rather than abstain only.  
The AOD assessment tool.  
Happy with it all.  
Very informative.  
Assessment tools and stages of change will assist me in the workplace.

**What did you like least about the module? What could be left out or changed?**

More assistance with completing the assessment forms & biopsychosocial assessment.  
At times the training seemed to lack direction, however, the trainer was able to bring it back when required.  
All was relevant.  
Nothing leapt out as not being useful.  
Not enough time/too much content for time allowed.  
Time - lack of – we did not touch on referrals at all 0 only assessments but all info given was relevant and worthwhile. Session needs to be longer.  
Too many handouts.  
More room – desk space!  
I gained more strategies for change.  
Nothing.  
More on the nature of interactions between services and clients who have prior experience with the legal system.  
Maybe the referral process.  
The module could benefit by the inclusion of a case study.  
Stages of change – only because I have sound knowledge of this already.  
Move focus on referral processes and coordinated care with clients.  
It's hard to make comparisons to work because I have no clients with AOD issues.  
Going off on tangents.  
Referral process not being covered as it is important part of assessment and post-assessment.  
It is not always so easy to get a client to participate.  
Actual discussion about what strategies can be used to motivate people to progress through the stages of change.  
Could have been more structured.

Discussion this morning on staff's research was too long.

Nil. All relevant to learning.

Nil.

Nothing.

Nothing. All interesting content.

Nothing.

**Will this module help you with your work? If so, how? If not, why not?**

Yes, to have more knowledge and insight into a client's current drug & alcohol use.

Yes – to engage appropriately with drug & alcohol clients.

Yes – I learnt some new techniques regarding assessment and strategies to work with people at the different stages of change.

Questioning style – use of reflective language.

It will by making the conversations re AOD use more open & easily flowing, not rigid & lacking conversation.

Yes. AOD use is a large contributor to consumer's lifestyle & it is useful to have extra information on effective methods of intervention.

Yes, most of our consumers are users of alcohol or other drugs.

Yes – as it showed me how to use assessment tools more effectively.

Yes it will. It will help me to be mindful of how I conduct assessments. The content included referral info & the different stages of change that people experience.

Yes, gave practical info that I put into practice immediately.

No – already trained in this area – helpful as a refresher.

Yes.

Gave helpful ideas on addressing client issues.

Gaining more knowledge on assessment tools.

Yes, by being more aware of clients issues.

Definitely.

Different assessment tools allow for different client situations.

Not directly at the moment due to having no clients appropriate – but am now more fully informed when and if new client presents with these problems / issues of if existing client needs change.

The assessment tools will aid in evaluating clients needs and for myself to better assist my clients – increase my knowledge / understanding of clients AOD problems.

Help me understand more about client with AOD.

Yes. Provides tools & techniques to assist clients with their recovery.

Not really. I haven't been made aware of anything I didn't already know.

I think it will be helpful to carers who have a loved one with DOA issues. Re understanding the assessment process.

Yes – it will allow a more informed intervention with alcohol issues / mental health client combo.

Yes – information on different styles of pharmacotherapy's, more professional to have the information, able to be more resourceful to / for clients.

Yes – especially in regards to initial assessment with clients.

Again, too basic – not action focused.

I think this will help me in assessing my clients to see if they have AOD issues.

Yes, addressing clients need to stop smoking.

Yes. Improve my techniques to assess my client needs.

I'm not sure yet. I think so, will try with clients.

Gives more ideas of and new approach to my clients.

Yes it will help with my work.  
I will try to get the clients to come up with ideas about their goals and motivation and not push my ideas on them.  
Challenging clients for readiness and willingness of change.  
Yes. Development and reinforcement of intervention and assessment strategies.  
Yes. A couple of current clients have these issues.  
Yes, definitely.  
Definitely. We are working with more clients with D & A use.  
I supervise 17 staff who have not all had training.  
Yes.  
Yes. A lot of new techniques learnt.  
The group discussions/listening to other peoples change ideas helped.  
Yes. Get clients story  
Yes. It gave more strategies to deal with situations I may come across in my work place.  
Yes. It gives me more insight into people experiencing addictive behaviours.  
Understanding pharmacology.  
Using different assessment tools, especially the tools that involved the client.  
Yes. Help to access AOD use and impacts on overall functioning ie. Cost etc.  
Yes, assessment tools.  
Substance use tool.  
Better understanding of different drugs and their effects.  
Yes, as I deal with service users who have a mental health problem and AOD issues.  
Yes, more service cooperation.  
This will be helpful in assessment tools available and different methods of pharmacological treatment available and also in relation to stages of change and recognising areas that service users may be in relation to change.  
Yes, with ideas given out during class.  
Help monitor and assess better.  
Yes. Better knowledge of AOD assessment tools used.  
Very helpful.  
Tools to use to assess.  
Confidence to ask the questions.  
Yes. Housing NSW will use some of the material to train/coach/mentor staff just to give them a deeper understanding.

**Other comments you would like to make about the training?**  
Trainer is very skilled and her experience in the field allows her to give very good examples of case studies.  
Very enjoyable.  
A run through of the assignments would be helpful.  
I found the assessment tasks contradict meeting our consumers where they are at, ie, asking consumers to alter their drug use/take assessments when they may not be ready for it.  
No.  
Great training  
Need more time for all but the info session so far.  
Where are our biscuits?  
Person talking over others.

It was very well put together & relevant.

Morning tea / afternoon tea food?

No.

Biscuits for morning / afternoon tea ???

Could the sandwiches for lunch include whole meal bread and grain bread – all white bread not attractive or healthy.

Getting better all the time.

Perhaps before developing the course material the evaluation regarding workers knowledge should be implemented into course materials. Underestimated once again. Better than last time.

I'm finding it very informative and helpful for work.

Better time management so all module is covered..

I enjoyed it.

Good varied approach.

Activities in 2s.

Role Plays.

Discussions.

Organised chaos – loved it, although not enough time was allowed for this module.

Not enough time allowed for each allocated module.

Too much information for the trainer to get through in a short time.

Great.

Excellent presented.

Good information.

Presented in an easy to understand and learn format.

I felt that the module was easy to follow and it was relevant.

Well worthwhile and applicable to work place.

No.

Good content and learning lots of useful information.

All good.

I am finding this very helpful.

**Module 3 – Brief Interventions**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
<b>The presentation:</b>				
Was interesting & challenging		3	35	20
Was relevant to my work		3	30	25
Provided me with information I can use with clients		1	24	33
Was worth attending		4	23	30
<b>The handouts provided during the session:</b>				
Are easy to read			32	26
Are relevant to my work		2	34	21
Are a useful resource for me as a staff member		2	36	19
Would be more useful to hand to clients (if applicable)		10	28	18
<b>The facilitator</b>				
Explained the information clearly		2	19	37
Directed the group well		4	22	32
Provided the opportunity to ask questions		2	18	38

**What did you like best about the module? What was most valuable?**

Practical component.  
 Open structure.  
 Was all good.  
 Seeing some practical examples.  
 All good.  
 Provided concrete tools to use.  
 Use of motivational interviewing, Brief interventions.  
 MI interview.  
 Further my knowledge of MI & techniques to apply it to my practice.  
 To watch the interviews.  
 Found emphasis on question style useful. Enjoyed the critical/political approach the presenter utilized.  
 Motivational interviewing.  
 The role play of motivational interviewing.  
 Motivational interviewing & harm reduction info.  
 Very helpful. Raise confidence in my ability to practice.

The MI was very interesting.  
Hearing others opinions and experiences.  
It provided good coverage of the top and good opportunities for clarification.  
Provoked / initialed discussion on topics that were at times challenging previous thought.  
Group discussions. Peoples insights.  
Motivational interviewing, brief interventions, strategies to change.  
CBT.  
Resources – Handouts.  
Group work & lots of interaction between participants.  
Group work with brief interventions.  
Group activities, class discussions.  
Training with different people.  
Explaining the components of CBT.  
Still underestimating existing skills.  
Motivational interviewing skills, readiness for change discussions..  
Model of 5 directives for motivational interviewing.  
Learning the techniques of motivational interviewing.  
It was all very interesting and presented brilliantly.  
Motivational interviewing.  
It was all very interesting and very informative.  
Interaction with other attendees.  
Being allowed by presenter to discuss and question topic covered.  
Interesting asking what they liked most and what they liked least about their AOD use.  
Assessment tools  
Understanding BI.  
Motivational interviewing.  
Motivational interviewing.  
D & A interview style.  
Role playing and practice of BI.  
Feedback and contributions from the group.  
The group exercises.  
Able to understand that my role will be a brief intervention and understanding what a BI is and how to do it.  
I enjoyed the DVD and gained knowledge on how to engage and work with clients.  
I found the group discussions informative.  
Looking at which interventions are more appropriate for which clients as to when and what would be effective. Also when would not likely to be effective.  
Looking at use of diaries etc.  
Understanding behaviour modification.  
Gaining information and ideas that relate to workplace.  
The tasks throughout made it more realistic rather than just looking at, for example, a table.  
I felt that the BI and behaviour medication will assist me when working with service users.  
Learning/thinking differently about interview process.  
Discussing different interventions.

Provision of questionnaires and assessment info.  
Good pace for presentation.

**What did you like least about the module? What could be left out or changed?**

Too many handouts.  
Not enough time for the content.  
Became a little unfocused in the afternoon.  
Lack of opportunity to experience/practice motivational interviewing in a safe learning environment in order to get feedback on skills/ability to allow growth/development.  
All relevant.  
N/A.  
CBT, diaries etc very short. Could be longer or self learning.  
Outdated videos.  
The video.  
Nothing.  
Constant group work in pairs.  
Video example – real life situations are FAR more useful compared to scripts, Pairs / role playing – again, hard to apply to real-life situations, not as useful as huge group activities.  
Not sure all secured relevant.  
Nothing I believe was negative about this module.  
N/A  
I prefer group discussion, but the pair work was ok.  
Nothing.  
Don't remember.  
All was interesting and relevant.  
Terminology used in the substance use diary.  
CBT activity – too brief and difficult to understand.  
Decisional balance form.  
Did not like 9/18 decisional balance.  
Headings became confusing.  
Page 9/18 got very confusing.  
Write down what you mean.  
The wording use in decisional balance was confusing and I feel diagram to write on could be more structured and clear.  
Liked everything.  
Handouts would need to be simplified to become more user friendly for my clients eg low education etc

**Will this module help you with your work? If so, how? If not, why not?**

Yes – more insight into MI techniques.  
Yes – especially use of motivational interviewing.  
Yes.  
Yes – practical.  
Yes – all relevant to day-to-day practice.  
Yes. It will help me engage & get better, more detailed info.  
Yes – will apply strategies to working with clients.

Yes – very much considering the number of consumers who have D&A issues.  
Use of role plays and feedback helped me to employ the concepts.  
Yes, especially with clients contemplating giving up drug use.  
Yes. It will help when talking to clients about their drug use. Tips on how to talk to a client more effectively.  
The MI may be helpful with carers.  
Yes I work with a number of clients who may benefit from new skills I've learnt.  
Yes – assessment models are very adaptable to a range of addictions.  
New theories can be put into practice; expanding on existing practices used – giving more confidence to worker.  
Yes. AOD resource and client interview techniques are very applicable.  
Yes, AOD clients i.e. in denial.  
CBT, Goal setting handout.  
Some aspects may prove useful.  
Yes motivational techniques are great.  
Lots of handout & ideas to use with clients.  
Yes – it has provided detailed intervention handouts which will be useful to use with clients.  
Will benefit from this module. Useful information that can be utilized.  
How to show client about diaries.  
The intervention information will help me with my clients.  
Existing knowledge – refresher basics.  
Interviewing process.  
Yes. Reinforce professional relationships; facilitate a more effective process.  
Yes.  
Yes, definitely.  
There are a lot of practical tips and facts.  
I can see myself practising motivational interviewing and some of the assessment skills.  
There are lots of similarities between this course material and principles of CRM – collaborative recovery model. Finding that this reinforces my understanding of both models and consequently finding the implementation of my learning easier.  
Yes. A few clients (both mine and colleagues) have D & A issues in addition to mental health and I found that this module was very useful.  
I believe this module will help me at work.  
There are a couple of clients that I will be able to use the substance diary for.  
Yes, in bringing it into practice interventions and motivating change.  
Yes. Client user friendly.  
Empowering the client to make decisions.  
Self determination.  
Yes. Taking people through the stages and prompting to change.  
Yes, give some guidance, especially for those who will not be referred to DACS.  
The motivational interviewing and CBT is not useful as motivation is important for clients. CBT is useful as it can help change clients thoughts and feelings and behaviours when applied sensitively.  
Yes. See 1<sup>st</sup> question.  
Yes, I will utilise decisional balance form and substance use diary.  
Yes, when most appropriate to use interventions.  
At what stage an individual was at ie. Precontemplative and what intervention. Though could have greater focus on this.

Yes. Introduce assessment tools to better understand how to work with each individual.  
Yes, it will help as I feel that my knowledge will assist with the ongoing support and change for those service users.  
Yes, with interview techniques and review.  
Yes. Better understanding of suitable interventions.  
Yes. Up until now I have referred straight to D & A counselling at Tamworth Base.  
Now have confidence to do preliminary assessment and incorporate into general counselling to better prepare client before handover.

**Other comments you would like to make about the training?**

Great.  
None.  
No. I have enjoyed very much all the days.  
Thanks.  
Case studies would be helpful.  
I felt more comfortable & confident to express myself this week – in the first part of the session – decreased in the second part.  
Overall very good.  
Hard to get a word in sometimes.  
No.  
N/A.  
No.  
Alison is fantastic!  
Alison is an entertaining and informative trainer.  
Excellent and enjoyable.  
Interesting and informative.  
Venue was cold today.  
Well presented.  
Specific and useful.  
All good thank you.  
Enjoying the interaction with other workers in the industry.

**Module 4 – Relapse Prevention & Dealing With Relapse**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
<b>The presentation:</b>				
Was interesting & challenging		3	28	19
Was relevant to my work		1	25	24
Provided me with information I can use with clients		1	25	24
Was worth attending		3	23	24
<b>The handouts provided during the session:</b>				
Are easy to read			18	32
Are relevant to my work			26	24
Are a useful resource for me as a staff member		2	21	26
Would be more useful to hand to clients (if applicable)		5	23	22
<b>The facilitator</b>				
Explained the information clearly		1	20	29
Directed the group well		1	23	26
Provided the opportunity to ask questions		1	20	30

**What did you like best about the module? What was most valuable?**

Discussing why some people may choose to relapse.  
 Understanding the different types of relapse and how it can be addressed.  
 Clear examples.  
 Practical resources – places to start with people we are working with.  
 Learning practical skills regarding relapse prevention. Discussion regarding Marlott & Saunders approach to relapse prevention.  
 Everything in general.  
 Making a plan for relapse. Looking at “lapse” not being a full relapse.  
 To learn that it is OK to inform clients about a lapse.  
 Relapse ideas for early intervention and prevention.  
 Techniques that can be used to work with clients.  
 The ability to throw ideas into the group & discuss them in a light-hearted manner.  
 Handouts.  
 Talk about how we work with clients.  
 Information on and practical activity on contingency plans. group discussions.  
 Looking a lapse and relapse.

Option around lapses 2 relapses.  
The contingency plan I think will be really useful.  
Hearing other people's opinions & experiences.  
Learning about lapse relapse and cravings in a productive way that can be applied in multiple ways.  
The tools/reflection sheets.  
All info was extremely valuable.  
How to identify different factors involved in relapse.  
It helped me to realise it was important to contact other services my client was going too.  
Defining the difference between lapse and relapse.  
The game about services.  
Assess to practical strategies to work with client in relapse (prevention and reduction strategies)  
Learning about the chain of events which leads to relapse.  
Discussion of alternatives.  
Referral game – hard going, but good demonstration of ideas.  
Chain of events.  
The "cravings" diary.  
Group interaction.  
Hearing others point of view.  
Easy to follow.  
How to challenge people's thoughts about self blame with relapse.  
Learning strategies to challenge beliefs.  
Cravings diary etc.  
All.

**What did you like least about the module? What could be left out or changed?**

The info on self-care wasn't really interesting.  
Felt long in the morning prior to break.  
More practical suggestions – working with consumers who currently do not respond to structured interventions.  
N/A.  
More examples on how to deal with a client that has relapsed.  
N/A  
Fine! Ok.  
Just people playing on their mobile phones during the teaching session.  
Less group activities.  
Nothing.  
Not much can be left out. There is so much to learn.  
Did not follow handout over the place.  
The activity. (&but made some good points)  
Nothing.  
All good.  
Nothing thank you.

**Will this module help you with your work? If so, how? If not, why not?**

Yes, by understanding the relapse/lapse process.

Yes, to assist with consumers planning & understanding lapses.

Yes – will be useful for consumers who are at the contemplation stage of change.

Yes, most definitely.

Discussing the Lapse with the people I work with from a strengths approach.

Yes. A lot of my clients have alcohol problems and have tried to stop drinking on many occasions and have had relapses and lapses. This course has helped to deal with that issue.

Yes is tools.

Yes direct client reference and intervention.

Some great ideas on how to discuss concepts with clients.

Client relapse prevention models.

N/A

Yes informative.

Yes, reminds us of what we can do!

I think it will be helpful to use with carers in regards to self esteem and how they cope within their caring roles.

I think the drug refusal skills will help at my work.

Yeah. Improves service delivery with AOD clients.

Yes it has multiple levels of application.

Currently dealing with a client who has alcohol problems.

Yes. Very useful for a couple of my clients and those of colleagues.

Very definitely. I particularly think the drug refusal skill information will be very useful.

Yes. I am more confident to talk about drugs and alcohol with clients.

Yes, many clients who have gone through relapse/lapse, so the module teaching how to support the client.

Yes, identify and being aware of the process of relapse and how it can be beneficial for a client to use as a learning experience.

Yes – parts very closely aligned to recovery tools, so good to explore further.

Yes. Have several clients with AOD issues. Have confidence to initiate conversation and work on issues.

Yes. By identifying cravings and the explanation can be used for clients.

Yes. It will help in challenging people with relapse and lapse.

Yes. Will give more options.

Yes. Help with relapse planning for AOD and other behavioural changes and clients.

Handouts for craving will assist when working with clients.

**Other comments you would like to make about the training?**

Fantastic, thanks Maria.

It is really help me to understanding AOD and about how client will act.

Yay. Good stuff.

Enjoyable and entertaining.

Once again a brilliant training session.

I needed to be disciplined and sit down and do homework.

Great work. Thanks Maria.

Thank you Maria.

**Module 5 – Self Care & Review**

	<b>Strongly Disagree</b>	<b>Disagree</b>	<b>Agree</b>	<b>Strongly Agree</b>
<b>The presentation:</b>				
Was interesting & challenging		2	25	27
Was relevant to my work			19	34
Provided me with information I can use with clients		4	24	25
Was worth attending		1	22	31
<b>The handouts provided during the session:</b>				
Are easy to read			21	33
Are relevant to my work			21	33
Are a useful resource for me as a staff member			22	32
Would be more useful to hand to clients (if applicable)	1	5	20	24
<b>The facilitator</b>				
Explained the information clearly			15	39
Directed the group well		1	16	37
Provided the opportunity to ask questions		1	15	38

**What did you like best about the module? What was most valuable?**

Useful information about “reframing” lapses & relapses – working with relapse. Useful information on self-care & strategies.  
 Handout a resource that I will look at later.  
 Strategies to put in place to avoid stress & burnout.  
 Little need to revisit and was reviewed quickly.  
 Good refresher about self-care.  
 It is good to be reminded of the need for self-care in a profession with potential for relapse.  
 Learning more strategies and information on relapse and prevention. Reviewing referral process was most valuable information.  
 Trainer style/knowledge/commitment.  
 The activities.  
 Skinner Module. Blaming – require – visitor.  
 Open plan office stats. Burnout and stress consequences.  
 Learning about blocks to de-stressors.  
 Brought many issues to light. Gave a lot of ideas and time for everyone to interact and the interaction was very useful. Brought forward that I need to reflect.  
 Exactly targets workplace conditions. Generated very useful discussion.  
 Group discussions activities.

Useful strategies outlined.  
The information on stress and burnout.  
Looking at stressors & how to improve.  
Exercise on stressor / de stressor / blocks etc.  
The opportunity to explore what I need to have the resources to best assist my clients.  
Sharing experience of workplace stress without judgment.  
Self care module page 8 and 9.  
Practical tips for self care.  
Knowing how to identify where I am at now.  
Opportunity to talk about it openly.  
The group/shared experiences.  
Self awareness of issues of stress and practical tools to use to identify level of stress/burnout.  
Be aware about self care.  
Notable symptoms of possible burnout.  
Discussion about things that we have found positive.  
Checklists both positive and negative.  
Very relevant.  
An important and under emphasized area in this industry.  
Focus on self care and considering ways of reducing stressors.  
Self-care worksheet good.  
Making me look at my work practices.  
That it reinforced the importance of self care.  
Unhelpful relating styles – self care.  
Self reflection.  
The facilitator's knowledge on subject.  
Lots of helpful information.  
It's good to take a look at yourself and your practice.  
Got people thinking accurately "cost-benefit" of working without self care.  
Learning ways to distress.  
Understand that everyone experiences stress.  
The bucket activity. It made me think about stress.  
Loved the explanations sharing of information.  
Really enjoyed entire course.  
Group discussions.  
Discussing workplace stressors and how to reduce.  
Relapse info.  
Brief interventions.  
Being aware of stress and burnout.

**What did you like least about the module? What could be left out or changed?**

Could look at ways the organization could better facilitate self-care and ways organizational structures may interfere with self-care. Strategies: unions, collective action, etc. Discussion re-addressing team conflict.  
Time period.

N/A.

Lack of opportunity for those who may have had questions or need support with pc.

It was all good.

Nil.

Info too simplistic (self-care).

N/A

Nothing all good.

Relaxed & Flexible delivery. I wouldn't change it.

I think everything was relevant.

Nothing.

Nil.

I didn't understand why Karpman's model was in the material. Would it be possible to concentrate on things that are helpful for stress.

Not enough time to talk about stress. Well actually we probably did.

Not really revolutionary info.

Nothing left out. Could have been longer.

Making me look at my work practices but definitely needs to be done.

NIL.

All good.

Interruption from golf club.

I would love to see a little more modules offered for entire course as it is difficult to move through course one on one as opposed to the group.

Role play.

All interesting.

1<sup>st</sup> Aid Certificate as mandatory.

**Will this module help you with your work? If so, how? If not, why not?**

Yes, it is good to be aware of self-care and have it recognized as an important aspect of work.

Yes, as we have several consumers with complex needs.

No, strategies already in place prior to training.

Yes – essential to working in the sector.

Yes it will help me to know what to do about being stressed and how to work that I can relax and take time out for myself

Yes – brief interventions

Definitely.

Yes work + personal, de-stressing preventing burnout.

Will help to increase awareness of stressors de-stressors and self-care therefore flow on to clients if in less stressed and more able to work effectively.

Yes it covers many aspects of my contact with client and provides a framework for discussions with co workers and senior management.

Yes – address organisational policies / allow for staff discussion.

Yes! Mapping supports.

It will help me manage my stress.

Yes to identify stressors & blocks.

Excellent to look at self care and stressors & burnout – good resource to have & relook at for personal self care.

It has refreshed my understanding & reminded me to commit to reflective practice.

Yes – it wasn't really drug and alcohol based and was very broad however definitely makes for greater benefit to workers in the field. Validating feelings about work stress.

Yes. The self care module 5 was great especially pages 8 and 9.  
Knowing where I'm at and how to address issues as they come up.  
Yes, always good to discuss self care with other workers.  
Knowing when to say "stop it" to myself.  
Ensure work is effective.  
Staff retention.  
Yes, with self care.  
Yes. Have decided my org scores poorly on organisational strategies. Will try to address with management.  
Help with self preservation.  
It will help me by encouraging me to take time for self care.  
Yes. Dealing with unhelpful attitudes.  
Yes, if I can recognise when things are stressful and use positive strategies to decrease the stress.  
This module will assist me to continue to focus on managing my own stress levels. The organisation I work for offers enormous amount of services to assist staff.  
Yes. Working in mental health is stressful and you need to look after yourself.  
Yes. Made me think and consider using some strategies in my work culture.  
Yes. Provide better ways to deal with stress and see stress in others.  
Yes. Help me identify areas I need to work on to reduce stress.  
Yes. More and more the referrals we are getting are mental health and drug and alcohol clients. This course allows for more training and reference points for new and existing staff.  
Yes. To identify and deal with workplace stressors.  
Yes. I work with AOD/mental health clients daily. This course refreshed my knowledge and understanding of AOD issues, cycles of chance etc.  
Yes. How to be aware of stressors and what blocks distressing.

**Other comments you would like to make about the training?**

Great presenter – thankyou.  
Excellent. If possible would be great to involve other (support workers) from other sites of (organization).  
No.  
Excellent!  
Thank you  
I felt more comfortable today – less intimidated and due to a lack of constant background talk I gained more today (a smaller group).  
Well done Maria!  
A very important module.  
Many thanks Maria.  
Great to know that Accessline assists with debriefing.  
The teacher was open and approachable.  
Alison has been a fantastic trainer throughout the series of workshops. It has been really great having her share her knowledge and experiences.  
Alison is a great trainer- engaging, challenging and fun but also very informative.  
Thanks Alison.  
Great course overall.  
Well presented.  
Very relevant to work.  
I have found all the sessions very informative and helpful.

All good thank you.  
I would recommend to others.  
Very informative.  
Well worthwhile.  
Would like to see training return to allow other staff to take advantage of various courses offered.  
Excellent training .  
Really enjoyed it  
Thank you Maria.  
An excellent course which I would recommend to all in the industry.

## Overall Evaluation

### What was your opinion of the training?

Very useful, good mix of theoretical perspectives, practice examples and exercises.

Very valuable/excellent trainer.

Very good & relevant to many in my consumer group.

I found the training valuable and informative. A great amount of useful information & knowledge for staff members to use for future endeavors with our clients.

Training was well organized and relevant to our area of work. It also increased my knowledge and professional practice when working with consumers that have AOD use.

Good and useful.

All good.

I thought it was great. I learnt a lot and revisited other training that I had done.

Excellent – very well delivered.

Was incredibly beneficial to my practice & my interests in working with consumers who have AOD issues.

Very good – felt rushed for Modules 1, 2 & 3 especially.

Was very useful.

Excellent, well worth attending.

Very good, very informative, good range of mediums used.

Well structured.

Broad based – and factual.

Excellent will be very helpful within my role as a carer advocate.

Very helpful.

AOD information was very beneficial and have already utilized some new skills and tools e.g. AUDIT document.

Good. A lot of information. Good presentation at times thought provoking.

A fantastic consolidation of my previous learning.

Interesting, helpful, informative useful.

Valuable.

Very useful and informative.

I really enjoyed the training and found it very informative and interesting.

Very useful (AOD).

Beneficial, interesting, engaging.

Very interesting. Am able to take lots from it to work with clients.

Excellent – helped to consolidate bits and pieces into a coherent whole.

Very good. Easy to understand and useful in day to day practice.

I found the package informative and clear. It was effectively and efficiently presented.

Should be done by all staff working with dual diagnosis.

Up to date, research based and from someone with personal experience. Very good!

Relevant to my role.

I found the training very valuable. The Facilitator was excellent. Material provided very good.

I felt the training was very good and gave me some helpful strategies to work with service users.

Very informative relaxed environment.

Good.

Very informative – learnt a lot. Would love to complete more modules.

Very good.

Very well presented. A lot of discussion between group for answers.

Excellent, very informative and good group discussion.

Really enjoyed the training. Good content.

Very informative.

**Do you think it impacted the way you work with/understand clients who use AOD? If so, how?**

Yes, now feel equipped with greater knowledge, skills and understanding re working with AOD clients – great emphasis on horizontal client centered approach.

Re-enforce what we already do – strengths-based motivational interviewing. Understanding of range of drugs & interventions.

Yes. A greater amount of understanding and knowledge about drugs, alcohol, effects, processes, etc.

Yes – increased knowledge and skills, as well as increased tools/assessments to assist with carrying out my role.

Yes – it has made me realize the treatment they receive from different services and how it works or doesn't work with the client.

Yes – everyday work.

Yes. It has given me more of an idea how to approach AOD.

Yes, better strategies to put in place when working with consumers or mentoring other staff.

It has provided me with some theoretical underpinnings/structured ways of working with consumers who use AOD.

Yes – reinforced skills already there, provided new skills & tools to use & increased confidence.

Yes – have increased knowledge & also techniques.

Yes, it has given me knowledge and confidence in how I work with clients with AOD.

Understanding clearly so confidence in practice has grown.

Positively.

Yes my training has helped me gain confidence and records to intervention where I was stressed.

I will now have a greater understanding also more resources to refer to.

Yes knowing what to do with a client who has a mental illness and AOD.

Definitely, better understanding, more effective understanding of cycles of change.

Yes – difficulties highlighted and strategies given that are practical.

Yes, assisting my knowledge to be applied to clients with AOD issues.

Yes given me more resources also different ways to approach D & A topic.

Yes – more knowledge therefore understanding of issues.

Yes, many practical guidelines.

I have never worked with or undertaken AOD training before, so I think it will impact greatly on how I work with future clients.

Not clients – I think it will help with carers.

Yes – given me tools to use in supporting clients in maintain rehabilitation and making the decision toward it.

Greater understanding of AOD issues in general, confidence to use some techniques taught.

Yes. Will feel more confident about counselling and assessment in initial stages rather than immediately handing to another agency.

Yes. More willing to attempt some interventions.

Yes. It has given me a greater understanding of addictive behaviour and how to best help clients.

Yes. I will be impacted with more info.

Yes. I have always been of the opinion that abstinence was the only approach. This training opened my mind to a safe use approach, as well as helpful direction to assist clients.  
Increased my understanding of the issues and problems associated with AOD use.  
Yes. I am much more confident and have learnt quite a bit which will help me to deal with clients in a more appropriate manner.  
It gave me some new ideas for working with AOD clients.  
Yes, changed my perspective of people that use AOD.  
Yes, more confident and more willing to try new things to work on AOD issues. Opened my mind more.  
Yes, using other techniques/skills. Being aware of other examples.  
Different ways to approach things.  
Better understanding of how to instigate change.  
It reinforced the methods I use are correct.  
Reminded me of the difficulty AOD clients have when they present for help. Reminder = for me to be patient and look at where the clients are with the circle of change.  
Yes, being able to work with and understand clients other than merely referring to another service.

**What did you like most or what was most useful in the training?**

Motivational interviewing/brief interventions was fantastic. Assessment presentation was great.  
Trainer style/knowledge/enthusiasm.  
Referral & assessment. A useful guide when referring and sharing information between services to hurry along the sometimes slow process.  
Handouts were well explained, training was in an open format and non-judgmental.  
Motivational interviewing.  
Information on drugs.  
Brief interventions.  
Motivational interviewing. For me, it's the most important step to engaging with consumers.  
Motivational interviewing & brief interventions.  
Practical tools & concrete examples for working with people.  
Strengthened my knowledge and also my understanding of what consumers needs are.  
Brief intervention was most useful and interesting.  
Handouts.  
It was through & relevant.  
Self care AOD measurement tools.  
All of the training.  
Listening to other workers that have client with AOD.  
Strategies, tools, resources.  
Good examples by facilitator; time for group work; definitions clear.  
Local contacts.  
Question forms for clients.  
Group activities, discussions.  
Pharmacology, Effects of drugs, OD & withdrawal.  
I found all of the training useful. I enjoyed the handouts and PowerPoint presentations.  
Learning about AOD.  
Assessments, relapse prevention interventions as well as self care.  
Has given confidence to approach clients about their AOD issues.

Assessment questionnaires.  
Small group good interaction.  
The forms and tables that I can use with clients.  
Communication with clients and other services.  
Background information that provided greater understanding of the effects and problems associated and lunch was great.  
Assessment tools.  
Resource material and references very helpful. I think the facilitator's experience and knowledge of the sector was helpful.  
I think that everything that was covered in the course was useful to my current position in working with AOD and mental health.  
Brief interventions, assessment tools.  
Did like use of videos showing how brief interventions could work.  
Having real examples.  
Group discussions.  
How to encourage change in a client. How to work more positive towards the changing process.  
Group discussion, sharing different methods used etc.  
Venue for parking.  
Teacher – excellent. Knew information well.  
Times of the course.  
All aspects are applicable to my workplace.

**What did you like the least? What changes would you suggest?**

No thank you.  
Can't think of any – perhaps less paperwork.  
Most assessments implied we have access to consumers who were ready to change/address AOD issues in their life. Also, some assessment questions were repetitive/redundant to the point of the assessments.  
N/A.  
Have the changing days closer together. More structure and discussion of the purpose of each module.  
Lack of time, rushed modules.  
The gap between training days. Easy to lose focus in between when there are weeks between sessions.  
It was all helpful.  
N/A  
Nothing  
More space in room for writing for participants.  
Venue. Room too small.  
Rushing important areas.  
Screening tools.  
N/A  
Size of room too small for amount of people involved in training.  
Nil.  
Combine last two days.  
Communication.  
Venue.  
Better venue.  
Would love to see all modules offered. Great workshop.

Role play.  
Not being a very out there person I found some a little confronting.  
Too many assessments.  
Nil.

**Was it difficult to comply with the training structure/timing/format? Would you recommend any changes?**

No – worked well.  
Have not yet had time at work to fit any study/assignments.  
No, I did not find it difficult.  
Module 4 & summary put into one day, not 2 half days.  
More time for some of the modules. More time for assessment & referral.  
No.  
Less days and longer ones.  
Reduce the period between training. More varied ways of learning.  
No, completing tasks “formally” between sessions was difficult.  
Timing – I think fortnightly was too far between modules.  
No.  
No.  
No.  
Structure etc fine with me.  
No.  
To balance with work more effectively ,maybe every 3 weeks instead of every 2 weeks.  
Time management problems.  
Training offered in Albury would be fantastic!  
No. good every 2 weeks.  
No.  
It was fairly rushed to get through everything.  
N/A  
2 half days merged into one as half days are a bit of a nuisance.  
No. All good.  
No difficulty and no to changes.  
No.  
It was easy to comply.  
Time after training to discuss assessments.  
No, but may struggle to complete assessments.  
Good structure/timing and format.  
No.  
No.  
No.  
No, but time length of each module could be shortened.  
No, not at all. Very informative. Excellent trainer.  
No.  
No. Structure was good. Format excellent. Instruction was very good.

No.

No. The difficulty for me is to find time to complete 1<sup>st</sup> aid.

No, structure fitted well and was notified in time to rearrange workload.

**Which handouts did you like? Why?**

All useful with our practice: substance use assessment; Fagerstran Nicotine Dependence Scales; WHO Assist V3; Substance Use Diary.

Most were relevant and if we did not cover sections in the workbook I would look at the handouts for answers.

Practical ones.

All well done.

I found the handouts useful & will look at them again when I review the course.

Handouts for Modules 4 & 5.

All were clear and relevant.

AOD screening tools.

All – more information for references the better.

All.

AOD tools i.e. Audit, WHO Assist.

Most were very good – clear.

Ones that are easily applied to assist clients.

Usage charts, WHO audit.

All handouts were useful especially ones that can be adapted to client care / support.

I liked all the handouts, they were informative and easy to read.

Dependence, Tolerance & withdrawal new info for me.

Still reading them.

All good. Relevant info and contact details for further info.

Assessment tasks.

Again the handouts that I could use with clients eg ASIST sheet.

The handouts did not have an overload of information.

Assessment tools that include client involvement – improve rapport, working together.

All of the handouts are useful and each can be used with different sus.

Assessment tools, able to take back to workplace and implement.

All handouts were very informative, other staff will greatly benefit from the correspondence received.

All the handouts were informative. Gave information relevant to subject.

All were relevant to subject matter.

All. Very informative. Excellent resources. Easy reading. Relevant.

**Which handouts did you dislike? Why?**

The one on self-care.

Drug Refusal Skills: Addresses initial “would you like a drink/drug of choice?” but not how to deal with peer pressure or increased pressure (both internal and/or external) when struggling with AOD issues.

N/A

None – all good.

N/A

N/A

At times almost too much information

Assessments!

N/A

Still reading them.

Nil.

Nil.

N/A

All relevant.

None.

All good.

No.

**Do you believe the training met your expectations? If yes, how? If no, why not?**

Yes.

Yes – Had little knowledge of AOD use and associated issues, and now have the knowledge /tools to assist consumers in this area.

Yes.

Yes, a lot of information and resources to go through.

The training did meet my expectations and has clarified my current practice. I think it could have gone further into discussing different approaches and working with people with both MH & AOD.

Yes – feel need more though on BIs & motivational interviewing – have a basis now need to build confidence and skills though.

Yes – it was very useful for personal knowledge and professional practice.

It exceeded expectations. (Trainer) is fantastic in providing training. She is very knowledgeable and I never got bored.

Yes, better knowledge.

Yes It covered topics very well, it allowed for input and discussion.

This course has allowed me to structure some brief intervention and assist clients identify the need for change.

Yes – need to have a good understanding of AOD & mental health as lots of carers are struggling to come to terms with the AOD side of person they care for

Yes it is giving me a chance to go further in training.

Yes although more in-depth for motivational interviewing, solution – focused therapy, alternative therapies.

Definitely. Wealth of information.

Yes by reinforcing and reminding me of my training.

Yes did give me new information and ideas.

Yes – developed broader knowledge base.

Yes! I'm working as a S/W in PHaMs program.

The training addressed all areas of AOD and how it relates to mental health and support working with these clients.

Yes. I've learnt much more on AOD.

Yes.

Yes. Training excellent.

Yes. – gave me the confidence to confront my previous bias ie D & A counselling.

Yes, it met my expectations.

Yes – latest information that made sense to me.

Yes, enjoyable learning environment. Increased my skills.

Yes. The content was very good and delivery most appropriate.

Yes, I have previously not been able to find specific training which was AOD for mental health. This has been the best AOD training I have done.

Yes, gave me a greater interest in DOA. Keen to further training in area.

Yes, I guess my expectations were limited. I found the training fantastic and very informative.  
Yes. Made to think of new way to deal with things.  
Yes. Interaction with other agency people. Across the board discussions.  
Yes – good to learn how other work places deal with similar issues.  
Yes – impressed that the course was free and because it's free I expected a low grade course. However, impressed overall with the structure of the course and will recommend this to others.  
Yes – being able to work with clients and understand issues instead of referring, although also when to refer to other services.

**Would you recommend this training to staff at other community mental health services? What would you tell them?**

Most definitely.  
Yes – It's a good session to increase knowledge and skills in a wholistic approach to AOD use/abuse, and how to better assist consumers with AOD issues.  
Yes.  
Yes – very good.  
Yes, very informative & practical.  
Yes – It's so important to reduce the ? between mental health and AOD services.  
Yes – give basic practical knowledge, tools, skills.  
Yes – very useful & practical, but some good “big picture” stuff. I thought (trainer) was an excellent trainer with much experience in the section, good anecdotes and illustrations.  
I definitely recommend it. It is very valuable with the consumer group we work with.  
Yes.  
Yes, Tell them to talk to their boss.  
Yes.  
Yes – I would give them an overview of training & tell them how the training has provided me with more tools to worker with cares & consumers.  
Yes it was helpful to me work with people with a mental illness that have AOD and the training was easy and well informed.  
Yes comprehensive course in regard to increasing knowledge & understanding with all clients / people in regard to AOD and mental health.  
Yes. If info was needed, clarification needed this course provides both.  
Yes it is a great way to get an understanding of the complexities.  
Yes useful in learning ways to approach and set goals with clients with D & A issues.  
Yes – refresher, informative.  
Yes.  
I would let people know that this training provides lots of in-depth information and management strategies for working with clients with AOD.  
Yes as MI & AOD seem to go hand in hand. I think this training is very helpful.  
Yes. Its beneficial for a refresher and has a number of useful tools to use when working with clients.  
Yes, would recommend and encourage other workers to attend, gives insight and techniques to work with clients.  
Yes – gives a good basic intro to D & A.  
I would recommend the training and tell them that it was clear, helpful and well presented.  
Yes – open up the way you think about the problems associated with drug and alcohol use.  
Yes – improve skills and understanding to work better with AOD clients.  
Yes.  
Yes.  
Great training. Very relevant.  
Yes, adds to their knowledge and ability which would allow them to achieve more with their clients.  
Yes, definitely would love my existing staff to participate in training.

Yes. It was enjoyable.  
It is informative. Helps to understand drug and alcohol issues.  
Yes – all should attend similar training.  
Absolutely.  
Yes, this training is very relevant to work place.

**What future training do you believe would be useful?**

Increased training on MI (motivational interviewing) as well as increased knowledge base of AOD services within NSW and local area.  
More role play.  
More motivational interviewing.  
More motivational interviewing. More brief intervention.  
Just to revisit up ahead in the future.  
Time Management.  
Any.  
Cert IV in Mental Health Non Clinical.  
Diploma in AOD, Stress management, Assertiveness Encouragement, Motivational Affirmation.  
Motivational interviewing, strengths based training, CBT.  
Cert IV mental health.  
'Critical incidents' training as I did this yesterday.  
I would like training that focuses on gambling or other addictive behaviors that impact on a clients recovery.  
Stress, relapse.  
Active listening training tailored towards support workers who are unfamiliar with counseling techniques which may be useful in a non counseling setting.  
Diploma  
I would like to undertake the Diploma.  
A Diploma in this area.  
Mental Health Diploma.  
Role playing.  
Complete course in mental health.  
I'd like to do the Diploma.  
AOD counselling.  
Would love to do the Diploma am very interested in this.  
Diploma in mental health work and AOD.

## Attachment 3 – Qualitative Evaluation Data From the One Course Delivered the Modified Training Materials

Module 1 – Foundations of AOD				
	Strongly Disagree	Disagree	Agree	Strongly Agree
<b>The presentation:</b>				
Was interesting & challenging			6	9
Was relevant to my work		2	6	7
Provided me with information I can use with clients			8	7
Was worth attending			6	9
<b>The handouts provided during the session:</b>				
Are easy to read			11	4
Are relevant to my work		11	10	3
Are a useful resource for me as a staff member			10	5
Would be more useful to hand to clients (if applicable)		1	8	3
<b>The facilitator</b>				
Explained the information clearly			5	10
Directed the group well		1	5	9
Provided the opportunity to ask questions			2	13
<p><b>What did you like best about the module? What was most valuable?</b>            All.            Lots of real examples.            Lively teacher.            Humour good discussions, videos.            Tutor answered all questions, had extensive knowledge and experience.            Information was presented in a relevant and professional manner.            AOD and mental illness.            Poly drug use – potentiation.            The effects of polyuse of drugs and alcohol.            Informative.</p>				

Just getting the information is great and having it explained was so great.  
The scope of the information and explanations given for the topics.  
Big group discussions were continually encouraged.  
Facilitator has excellent knowledge and understanding of the topic  
Very informative and relative to today's society and the issues faced by some callers to the Lifeline telephone counselling service.  
Learning about the immediate effects and AOD and about the types and different drugs.  
Understanding the difference between stimulants, depressants and hallucinogens.  
The facilitator was very knowledgeable.  
Easy to understand and effective materials in explaining complex concepts.  
Well presented information, very informative legal and historical information to help answer some of the whys.

**What did you like least about the module? What could be left out or changed?**

N/a.  
Nil.  
Nil. All great information  
At times it was hard to stay focused.  
No detail on how to talk to clients.  
Some trainees are visual and do like the slides.  
Nil.  
No comments to make.  
I didn't enjoy the video from the ABC Four Corners programme. I find it horrific that people come to these choices.

**Will this module help you with your work? If so, how? If not, why not?**

Yes.  
Yes, greater understanding of drugs, poly drug use, harm minimization, statistics, research, new theories.  
Yes. I will now have a better understanding of different substances and their effect on the central nervous system.  
Yes – greater understanding of why people use, thought processes – why some people have difficulty abstaining – frontal lobe damage etc.  
Yes – understanding the effects of AOD.  
With drug use (prescribed) the interactions of differing types. Tolerance and withdrawal.  
Yes. Again having the information at hand.  
Yes. Enable me to give more accurate referrals.  
Provided a greater base for understanding.  
Harm minimisation is a great concept for us to work with.  
Understanding the neuro implications for the brain of drug use.  
Yes – understanding the cause and effect on callers who are challenged with substance abuse or addiction.  
Recognising drug use better.  
I'm better informed about AOD. Harm minimisation considered with clients rather than abstinence being the only option.  
I will have a better understanding of a caller under the influence or under medication.

**Other comments you would like to make about the training?**

Would have liked to discuss “referrals” specific to our area.

Great trainer – massive knowledge but presented in an amusing/sensitive manner.

Excellent presenter.

Really enjoyed the training.

Thank you Alison.

Really enjoyed this and gave me an opportunity to learn from other service providers in the similar field.

I learn/work better by following booklet.

Thanks Alison. I enjoyed the 2 days very much.

So much to cover in so little time. Really enjoyed the information and how it was delivered.

Enjoyed the style of the trainer – found that I retained more information.

## Overall Evaluation

### **What was your opinion of the training?**

Excellent coverage.  
Excellent materials.  
Excellent trainer.  
Great.  
Excellent.  
Great training.  
Good trainer with excellent knowledge.  
Practical stuff I can implement with my clients.  
Excellent presentation. Lots of information from real experience.  
Good.  
Very new for me – very beneficial.  
Great, learnt abt, inspiring.  
Excellent. Very informative. Very helpful and I liked the changes on the horizon.  
Informative and interesting.  
Excellent.  
Alison made it very easy to understand.  
Very informative.  
Excellent, good knowledge and trainer, experience examples, humour, stimulating.  
Great deliver – not enough time.  
Very informative, interesting and thought provoking.  
Great information just the best.  
Excellent.  
Very relevant.

### **Do you think it impacted the way you work with/understand clients who use AOD? If so, how?**

Yes – motivational interviewing technique is an excellent tool.  
Yes. It will as I feel more confident with motivational interviewing etc to apply in a practical context.  
Yes. Better understanding.  
Yes – client centred approach is something I will practice.  
Yes. I now have more respect for them. I feel more positive.  
Yes, most definitely to be more CC focuses.  
I have a deeper understanding therefore I will be a better counsellor.  
Yes.  
Yes, because things were easy to understand therefore explain.  
I don't have clients with AOD but if I do in the future it will help and I feel friends and family will be helped by my new level of knowledge.

Increased knowledge of all aspects of AOD and therefore understanding of a client's issues, needs, behaviour, concerns.  
Heightened understanding – loved “soft bottom” approach.  
Yes – a greater understanding of the challenges faced by users of AOD.  
It opened my eyes and ears.  
Definitely – Have a greater understanding of how AOD affects persons, neurologically, physiologically etc.  
Definitely better understanding as to why they use. Provided tools to engage clients due to better understanding.

**What did you like most or what was most useful in the training?**

All very useful, especially the group input (ie other people's attitudes, views etc)  
Motivational interviewing.  
All topics were interesting.  
Trainer.  
Motivational interviewing.  
The trainer and her training style to cover such a large amount of info.  
Knowledge and enthusiasm from trainer.  
Role playing, being able to ask any questions. Harm minimisation importance, denial is OK.  
I liked all the training. I feel very privileged to be involved with this training.  
Effective materials.  
Learnt lots and found it all very useful.  
Alison's history of information and examples.  
Assessments and interview techniques.  
All.  
Enthusiastic delivery. Passion of instructor.  
Many wonderful aspects during the 4 days especially liked the referral game.  
To keep on learning.  
Acquiring tools and the opportunities to practice using tools to assist service provision to clients.  
Trainer was excellent.  
Pharmacology.  
Neurological responses to drugs and pharmacotherapies.

**What did you like the least? What changes would you suggest?**

I liked it all – found everything very useful.  
Too much in too little time.  
N/A  
Too short.  
Not so much/many units in 1 day.  
At times went off the subject.  
None.  
The DVD on the first unit 1.  
N/A.  
N/A – An extra day to cover topics!

NA.  
Too much too quick – I don't have workplace evidence that I can send in for assessment.  
Nothing. Maybe more time.  
The day did get a bit long as I am not used to it.  
More time.  
No suggestions.  
Nil. Loved it all.

**Was it difficult to comply with the training structure/timing/format? Would you recommend any changes?**

No difficulty.  
Yes – break into more sections.  
No.  
No.  
Not so much/many units in 1 day.  
?  
No.  
No. I really appreciated Alison's life experiences.  
No.  
An extra day to cover topics!  
Only more time.  
Trying to take it all in.  
More time for 4 modules.  
Was happy to go with the flow. Many thanks for the knowledge.  
Not at all.  
No – facilitator made it easy.

**Which handouts did you like? Why?**

All very useful – clear and precise.  
All.  
All were useful.  
All of them.  
There wasn't many which in ways is good.  
All.  
All clear.  
All. Learning.  
All.  
Moodle handouts.  
Booklets on resources for DOA.  
All handouts were good. Have been able to read the first one not 2<sup>nd</sup> one.  
All – easy to read, great prompts – format well laid out etc.

**Which handouts did you dislike? Why?**

N/A  
N/A  
N/A  
None.  
N/A.  
None.  
Nil.  
Nil – all good.

**Do you believe the training met your expectations? If yes, how? If no, why not?**

Yes. Ongoing training is especially useful in any field.  
Yes – loved the trainer – expertise, delivery, interactions.  
Yes.  
Exceeded expectations as I actually gained skills as well as knowledge.  
More than especially after a previous trainer.  
Yes – given me more insight working with client AOD.  
Yes – gave me information I didn't have.  
Yes – increased my knowledge.  
Yes.  
Yes – will use techniques and more understanding in my work.  
No expectations. Great delivery.  
Well above my expectation.  
Yes - Definitely – Have a greater understanding of how AOD affects persons, neurologically, physiologically etc. Acquiring tools and the opportunities to practice using tools to assist service provision to clients.  
Excellent depth of knowledge and quite entertaining at times.  
Enjoyed her style of teaching. Encouraged interaction without forcing it.

**Would you recommend this training to staff at other community mental health services? What would you tell them?**

Yes.  
Yes.  
Yes.  
Dot it. Great trainer with heaps of knowledge and enthusiasm.  
Probably.  
Yes. Everyone should do this.  
Yes.  
Yes – it is effective.  
Definitely. Greater understanding behind the reasons for using and then hopefully being less judgemental.  
Yes. Excellent.  
Yes.  
Yes. Excellent, informative, engaging.

Yes - important info.

Yes.

Yes. Excellent course., easy to understand information – everyone should learn how we can help/assist/be more understanding of other's issues.

**What future training do you believe would be useful?**

Whatever is offered.

Motivational training.

More in-depth motivational interviewing.

I need to research.

N/A.

Pharmacology.

Rehab visits, program specifics as an understanding of what clients experience in rehab.

Follow up – refreshers.

TAFE.

More motivational interview

More on CBT

More on pharmacology, pharmokenesis etc.

More on motivational interviewing, CBT and pharmacology.

# Attachment 4 – Implementation Experiences Survey

## No Wrong Door: Mental Health Drug and Alcohol Change Management Project

### IMPLEMENTATION EXPERIENCES SURVEY

Name \_\_\_\_\_ Date \_\_\_\_\_ Service \_\_\_\_\_

*Please circle the number that best describes your level of confidence in questions 1 to 9 below.*

1. How confident are you in your ability to assess the drug and alcohol use of the consumers you support?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

2. How confident are you in your ability to develop relapse prevention plans with the consumers you support?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

3. How confident are you in your ability to build linkages with AOD services?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

4. How confident are you in your ability to get access to up to date information regarding different drugs and alcohol?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

5. How confident are you in your ability to conduct motivational interviews with the consumers that you support?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

6. How confident are you in your ability to determine consumers' level of readiness to address different behaviours associated with drug and alcohol use?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

7. How confident are you in your ability to provide brief AOD interventions with the consumers you support?

Not at all confident      1    2    3    4    5    6    7    8    9    10    Very confident

8. How confident are you in your ability to engage in self-care activities?

Not at all confident      1      2      3      4      5      6      7      8      9      10      Very confident

9. How confident are you in your ability to deal with consumers' AOD relapses?

Not at all confident      1      2      3      4      5      6      7      8      9      10      Very confident

**Since completing the No Wrong Door training how often have you engaged in the following activities:**

1. Completed AOD screening/assessment using a formal tool (e.g. AUDIT, CAGE, WHO – ASSIST)

0                      1                      2                      3                      4                      5  
 Never              A few times      Once a month      A few times a month      Once a week      A few times a week

*Please describe as many barriers to implementing this strategy and solutions you think may help overcome these barriers*

<i>Barriers</i>	<i>Solutions</i>

2. Completed other AOD related assessment (e.g. bio-psycho-social history)

0                      1                      2                      3                      4                      5  
 Never              A few times      Once a month      A few times a month      Once a week      A few times a week

*Please describe as many barriers to implementing this strategy and solutions you think may help overcome these barriers*

<i>Barriers</i>	<i>Solutions</i>

3. Searched for up to date information on drugs and alcohol

0                      1                      2                      3                      4                      5  
 Never              A few times      Once a month      A few times a month      Once a week      A few times a week

*Please describe as many barriers to implementing this strategy and solutions you think may help overcome these barriers*

<i>Barriers</i>	<i>Solutions</i>









Becoming a culturally competent workforce	
Professional Development	
Supervision, Mentoring and Coaching	
Evaluation and Routine consumer Outcome Monitoring	

Are there any other comments that you would like to make about the “No Wrong Door” project?

# DDCMHT

## Dual Diagnosis Capability in Mental Health Teams

(Developed by Gotham, H. J., Brown J. L., Comaty J. E., & Mc Govern, M. P.  
and adapted October 2008 for use by MHCC & NADA).

### MENTAL HEALTH AND DRUG & ALCOHOL CHANGE MANAGEMENT PROJECT

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Please note that Version 3.2 of the DDCMHT has been adapted by the Mental Health Coordinating Council (MHCC) to better reflect the preferred language of the NSW NGO community mental health sector and the Australian service delivery context. This includes adjustments to Item 1B (“Organizational Certification & Licensure” changed to “Performance & Funding Agreement/s”) and the deletion of Item 1D (Financial Incentives”). The work of Communio is adapting the Dual Diagnosis Capability in Addictions Treatment (DDCAT) for use with programs funded under the Commonwealth Department of Health and Ageing “Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative” has also been considered in this process.

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#### Program Identification

Date: \_\_\_\_\_ Rater/s: \_\_\_\_\_ Time Spent (Hours): \_\_\_\_\_

Agency Name: \_\_\_\_\_

Program Name: \_\_\_\_\_

Address: \_\_\_\_\_

Contact Person 1: \_\_\_\_\_

Contact Person 2: \_\_\_\_\_

Phone: \_\_\_\_\_

Fax: \_\_\_\_\_

Email: \_\_\_\_\_

State: \_\_\_\_\_

Region: \_\_\_\_\_

Program ID: \_\_\_\_\_

Time Period: (1 = baseline, 2 = 1<sup>st</sup> follow-up, 3 = 2<sup>nd</sup> follow-up, 4 = 4<sup>th</sup> follow-up, etc)

#### Evaluation Sources:

File Review  Brochure Review  Policy/Procedure Review  Forms Review  Site Tour

Team Meeting Observation  Supervision Observation  Service Delivery Observation

Interview Manager/s  Interview Staff  Interview Clients (# )  Interview Other Services

Other: \_\_\_\_\_

Total # of sources used: \_\_\_\_\_

## DDCMHT DIMENSIONS

### 1. Program Structure

Focuses on the general organizational factors that foster or inhibit the development of integrated mental health and substance use services.

### 2. Program Milieu

Focuses on the culture of a program and whether the staff and physical environment of the program are receptive and welcoming to people with both mental health and substance use problems.

### 3. Assessment

Examines whether specific activities achieve specific benchmarks for mental health and substance use assessment.

### 4. Service Delivery

Examines whether specific activities achieve specific benchmarks for mental health and substance use assessment.

### 5. Continuity of Care

Examines the long term service delivery issues and external supportive care issues commonly associated with persons who have both mental health and substance use issues.

### 6. Staffing

Examines staffing patterns and operations that support assessment and service delivery.

### 7. Training

Measures the appropriateness of training and supports that facilitate the capacity of staff to help people with both mental health and substance use problems.

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## DDCMHT SCORING

*Instructions:* Please rate your service on a scale of 1 (Mental Health Service Only/MHOS) to 5 (Dual Diagnosis Enhanced/DDE) in each of the domains presented in the table that follows. Note that this is not a continuum where, for example, DDE may be seen as better than MHOS but simply a way of for organizations to explore how a service is responding to people with co-existing mental health and substance use problems across a number of service dimensions.

### 1 - Mental Health Only Service (MHOS)

Services that are only aiming at providing services with a focus on clients with a mental health problem.

### 3 - Dual Diagnosis Capable (DDC)

Services capable of providing services to some individuals with co-existing problems but has greater capacity to help people with mental health problems.

### 5- Dual Diagnosis Enhanced (DDE)

Services capable of providing services to any individual with co-existing problems, and the program can address both types of problems fully and equally.

	1 Mental Health Only Service (MHOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
<b>1. PROGRAM STRUCTURE</b>					
<b>1A. Organization's focus as stated in mission statement. (If program has mission, consider program mission).</b>	Mental health only.		Primary focus in mental health but also provide services to people with substance use issues.		Primary focus is on people with both mental health & substance use issues
<b>1B. Performance &amp; Funding Agreements</b>	Mental health services only.	Has no actual barrier, but staff report there to be access barriers for people with substance use issues.	Has no barrier to providing services for people with substance use problems within the context of mental health service delivery.		Is funded to provide both mental health & substance use services.
<b>1C. Coordination &amp; collaboration with substance use services.</b>  Note: See back page for definitions.	No document of formal coordination or collaboration. Meets the SAMHSA definition of Minimal Coordination.	Vague, undocumented or informal relationship with substance use agencies or consulting with a staff member from that agency. Meets the SAMHSA definition of Consultation.	Formalized or documented coordination or collaboration with mental health agency. Meets the SAMHSA definition of Collaboration.	Formalized coordination & collaboration, and the availability of case management staff, or staff exchange programs (variably used). Meets the SAMHSA definition of Collaboration and has some informal components consistent with Integration.	Most services are integrated within the existing program, or routine use of case management staff or staff exchange programs. Meets the SAMHSA definition of Integration.

<b>2. PROGRAM MILIEU</b>					
<b>2A. Routine expectation of and welcome service for both disorders.</b>	Expect people with mental health problems only, refer or deflect persons with substance use problems.	Documented to expect people with mental health problems only (eg, admission criteria, target population), but have informal procedure to allow entry for some people with substance use problems.	Expect people with mental health problems, and, with documentation, accepts people with substance use problems by routine and if mild and relatively stable.	Program formally defined like DDC but staff and program informally expects and provides services for people with both disorders, <u>not</u> well documented.	
<b>2B. Display and distribution of literature and patient educational materials</b>	Mental health or peer support only.	Available for both mental health & substance use problems but not routinely offered or formally available.	Available for both mental health and substance use problems but distribution is less for substance use disorders.	Available for both mental health & substance use problems with equivalent distribution.	Available for the interaction between both mental health & substance use disorders.

	1 Mental Health Only Service (MHOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
<b>3. ASSESSMENT</b>					
<b>3A. Routine screening methods for substance use.</b>	Pre entry screening based on client self-report. Decision based on staff inference from client presentation or history.	Pre-entry screening for substance use & service history prior to entry.	Staff have routine set of standard interview questions for substance use using generic framework	Screen for substance use problems standardized or formal instruments with established psychometric properties.	Standardized for formal instruments for both mental health and substance use problems with established psychometric properties.
<b>3B. Routine assessment if screened positive for substance use.</b>	Ongoing monitoring for appropriateness or exclusion from program.	More detailed biopsychosocial assessment, history of substance use and services, and staff driven.	Increased capacity to access (not necessarily in-house) substance use assessments, although not standardized or routine.	Formal substance use assessment, if necessary, typically occurs (in-house).	Standardized or formal integrated assessment is routine in all cases.
<b>3C. Psychiatric and substance use diagnosis made and/or documented.</b>	Substance use disorder diagnosis are not made or recorded.	Substance use disorder diagnostic impressions made and/or recorded variably.	Substance use disorder diagnosis variably recorded in chart (ie, about 40% of the time).	Substance use disorder diagnosis more frequently recorded but inconsistently (ie, more than 40% but less than 90% of the time).	Standard & routine substance use disorder diagnosis consistently made.
<b>3D. Psychiatric and substance use history reflected in medical record.</b>	Collection of mental health history only.	Standard form collects mental health history only. Substance use disorder history collected inconsistently.	Routine documentation of both mental health and substance use disorder history in record in narrative section.	Specific section in record dedicated to history and chronology of course of both problems.	Specific section in record devoted to history & chronology of course of both problems and the interaction between them is examined temporarily.
<b>3E. Program acceptance based on substance use disorder symptom acuity: low, moderate, high.</b>	Accepts people with low to no acuity.		Accepts people in program with low to moderate acuity, but who are primarily stable.		Accepts people in program with moderate to high acuity, including those unstable in their substance use problem.
<b>3F. Program acceptance based on severity of persistence and disability: low, moderate, high.</b>	Accepts people in program with no to low severity of persistence of disability.		Accepts people in program with low to moderate severity.		Accepts people to program with moderate to high severity.
<b>3G. Stage-wise assessment.</b>	Not assessed or documented.	Assessed & documented variably by individual staff.	Staff assessed & routinely documented, focused on mental health motivation for change.	Formal measure used & routinely documented but focusing on mental health motivation for change only.	Formal measure used & routinely documented, focus on both substance use and mental health motivation for change.

	1 Mental Health Only Service (MHOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
<b>4. SERVICE DELIVERY</b>					
<b>4A. Service plans</b>	Address mental health only substance use not listed).	Variable by individual staff.	Mental health problems addressed as primary, substance use problems as secondary.	Systematic focus is available but variably used.	Address both as primary, both listed in plan consistently.
<b>4B. Assess and monitor interactive courses of both mental health &amp; substance use problems</b>	No attention to or documentation of progress with substance use problems.	Variable reports of progress on substance use problems by individual staff.	Staff focus in narrative g, (service plan or progress note) on substance use problem change.	Systematic focus is available but variably used.	Clear, detailed and systematic focus on change in both substance use & mental health problems.
<b>4C. Procedures for intoxicated/ high clients, relapse, withdrawal or active users.</b>	No guidelines conveyed in any manner.	Verbally conveyed in-house guidelines.	Documented guidelines: referral or collaborations (to local substance abuse treatment agency, detox or E/R).		Routine capability or a process to ascertain risk with ongoing psychiatric symptoms: maintain in program unless alternative placement (ie, detox, commitment) based on acute risk is warranted.
<b>4D. Stage wise treatment.</b>	Not addressed or explicit in service plan.	Stage or motivation documented variably by individual staff in service plan.	Stage or motivation routinely incorporated into individualized plan, but no specific stage-wise service delivery.	Stage or motivation routinely incorporated into individualized plan & general awareness of adjusting services by individual stage of readiness on mental health motivation for treatment only,	Stage or motivation routinely incorporated into individualized plan and formally prescribed and delivered stage-wise services for both substance use & mental health issues.

	1 Mental Health Only Service (MHOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
<b>4. SERVICE DELIVERY (Continued)</b>					
<p><b>4E. Policies and procedures for evaluation, management, monitoring and compliance for/of medications for substance use disorders.</b></p> <p>This includes: (i) Medications to treat intoxication states, decrease/eliminate withdrawal symptoms, decrease reinforcing effects of abused substances, promote abstinence and prevent relapse; (ii) Policies about the use of benzodiazepines or other potentially addictive medication).</p>	No capacities to monitor, guide or provide medications related to substance use disorders. Clients with active substance use are routinely not accepted into program.	Certain types of medications may be prescribed for substance use problems and some capacity to monitor medications related to substance use. Variable by provider.	Present, coordinated policies regarding medications for substance use problems. Some types of medications are routinely available. Monitoring of the medication is largely provided by the prescriber.	Present, coordinated policies regarding medications for substance use problems. The prescriber might more regularly consult with other staff regarding medication plan and recruit other staff to assist with medication monitoring.	Present coordinated policies regarding all types of medications for substance use problems. There is access to a provider with these specialties on the team.
<p><b>4F. Specialized services/interventions with substance use content.</b></p>	Not addressed in program content.	Based on judgment by variable staff. Irregular penetration into routine services.	In program format as generalized intervention. More regular penetration into routine services. Routine staff adoption of evidence-based mental health practice (eg, CBT, MI, ACT, family education, skills training, supported employment)	Some specialized interventions by specifically trained staff in addition to routine generalized interventions.	Routine substance use symptom management groups. Individual services/therapies focused on specific problems. Systematic adoption of all evidence-based mental health practice (eg, CBT, MI, ACT, family education, skills training, supported employment).
<p><b>4G. Education about substance use problems and services, and interactions with mental health problems and services.</b></p>	No.	Variably.	Present in generic format & content and delivered in individual and/or group formats.		Present specific content for specific co-existing mental health and substance use problems and delivered in individual and/or group formats.

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<b>4. SERVICE DELIVERY (Continued)</b>					
<b>4H. Family education and support.</b>	For mental health problems only.	Variably or by individual staff judgment.	Substance use issues regularly but informally incorporated into family education or support sessions. Available as needed.	Generic group on site for families on substance use & mental health issues variably offered. Structured group with routine accessibility.	Routine & systematic co-existing problem family group integrated into standard program format. Accessed by the majority of families with family member with both mental health & substance use problem.
<b>4I. Specialized interventions to facilitate use of peer support groups in planning or during service delivery (eg, TSF).</b>	None used to facilitate either use of substance use or mental health peer support.	Used variably or infrequently by individual staff, for individual clients, mostly for facilitation of mental health peer support groups.	Present, generic format on site, but no specific or intentional facilitation based on substance use. More routine facilitation of traditional mental health peer support groups (eg, GROW, SFNSW, consumer run).	Present but variable facilitation to peer support groups targeting specific addiction issues either to traditional peer support groups or those specific to both (eg, AA, NA, Double Trouble).	Routine & specific to need of co-existing problem special programs on site, routinely targeted to specific issues, either to traditional peer support or groups specific to both (eg, AA, NA, Double Trouble).
<b>4J. Availability of peer recovery supports for people with co-existing problems.</b>	Not present, or if present not recommended.	Off site, recommended variably.	Present, off-site & facilitated with contact persons or informal matching with peer supports in the community, some co-existing problem focus.	Present, off-site, integrated into plan, and routinely documented with co-existing problem focus.	Present, on site, facilitated & integrated into programs (eg, alumni groups). Routinely used & documented with co-existing problem focus.

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<b>5. CONTINUITY OF CARE</b>					
<b>5A. Co-existing problems addressed in discharge planning process.</b>	Not addressed.	Variably addressed by individual staff.	Substance use systematically addressed as secondary in planning process for off site referral.		Both mental health & substance use problems seen as primary, and plans made & insured, on site, or by arrangement – off site at least 80% of the time.
<b>5B. Capacity to maintain service continuity.</b>	No mechanism for managing ongoing care of substance use issues when mental health program is completed. .	No formal protocol to manage substance use issues once program is completed, but some individual staff may provide extended care until appropriate linkage takes place. Variable documentation.	No formal protocol to manage substance use issues once program is completed, but when indicated, most individual staff provide extended care until appropriate linkage takes place. Variable documentation.	Formal protocol to manage substance use issues indefinitely or until appropriate linkage takes place, but variable documented evidence that is routinely practiced, typically within the same program or agency.	Formal protocol to manage substance use issues indefinitely or until appropriate linkage takes place and consistent documented evidence that is routinely practiced, typically within the same program or agency.
<b>5C. Focus on ongoing recovery issues for both mental health &amp; substance use problems.</b>	No.	Individual staff determined.	Routine focus is on recovery from mental health problems, substance use issues are viewed as potential relapse issues only.		Routine focus on both substance use & mental health recovery, both seen as primary and ongoing.
<b>5D. Facilitation of peer support groups for co-existing problems is documented and a focus in discharge planning, and connections are ensured to community peer recovery support groups.</b>	No.	Rarely, but addressed by individual staff.	Yes, variable, but not routine or systematic, focus on co-existing problem peer support community connection (engagement in meetings or functions off-site).		Yes, routine & systematic, at least 80% of the time with focus on co-existing problem peer support community connection (engagement in meetings or functions off-site).
<b>5E. Sufficient supply and compliance plan for substance use related medications is documented.</b>	No medications in plan.	Sometimes can be provided. Variable by provider.	Yes, a 30-day or short-term supply to next appointment off-site.		Maintains medication management in program with provider.

	<b>1 Mental Health Only Service (MHOS)</b>	<b>2</b>	<b>3 Dual Diagnosis Capable (DDC)</b>	<b>4</b>	<b>5 Dual Diagnosis Enhanced (DDE)</b>
<b>6. STAFFING</b>					
<b>6A. Psychiatrist or other physician.</b>	No formal relationship with prescriber for this program.	Consultant or contractor off-site.	Consultant or contractor on-site.	Staff member, present on-site for clinical matters only.	Staff member, present on-site for clinical supervision, treatment team, and/or administration.
<b>6B. On site staff with substance abuse qualifications or formal study.</b>	No formal relationship with program.	1 – 24% of staff members.	25 – 33% of staff members.	34 – 49% of staff members.	50% or more of staff members.
<b>6C. Access to substance use supervision or consultation.</b>	No.	Yes, off-site by consultant, undocumented.	Yes, on-site supervision provided as needed. Informal process.	Yes, on-site supervision. Provided regularly. Irregular documentation.	Yes, on-site, documented regular supervision sessions.
<b>6D. Case review, staffing or utilization review procedures emphasize and support services for co-existing problems.</b>	No.	Variable by off-site consultant, undocumented.	Yes, on-site, documented as and with co-existing problem issues.		Yes. Documented, routine & systematic coverage of co-existing problem issues.
<b>6E. Peer/alumni supports are available for people with co-existing problems.</b>	No.		Present, but as part of community, and routinely available to program clients, either through informal relationships or more formal connections such as thru peer support service groups.		Present, on-site, either as paid staff, volunteers or routinely available program "alumni".

	1 Mental Health Only Service (MHOS)	2	3 Dual Diagnosis Capable (DDC)	4	5 Dual Diagnosis Enhanced (DDE)
<b>7. TRAINING</b>					
<b>7A. Direct care staff members have basic training in prevalence, common signs &amp; symptoms, screening and assessment for substance use problems and disorders.</b>	Not trained in basic skills.	Variably trained, not documented as part of systemic training plan, but encouraged by management.	Trained in basic skills per agency strategic training plan.	Trained in these skills per agency strategic training plan, and also have some staff with advanced training in specialized co-occurring problem approaches, but this is not part of the program's training plan.	Trained in these skills per agency strategic training plan, and also have staff with advanced training in specialized co-occurring problem approaches as part of plan.
<b>7B. Direct care staff members are cross-trained in mental health and substance use problems, including pharmacotherapies, and have advance specialized training in treatment of persons with co-existing problems.</b>	Not trained, or documented.	At least 33% are trained.	At least 50% are trained.	At least 75% are trained.	At least 90% are trained.

## DDCMHT SCORING SUMMARY

<p><b>1. Program Structure</b></p> <p>A</p> <p>B</p> <p>C</p> <p>Sum Total     /3 = Score</p>	<p><b>4. Service Delivery</b></p> <p>A                    F</p> <p>B                    G</p> <p>C                    H</p> <p>D                    I</p> <p>E                    J</p> <p>Sum Total        /10 = Score</p>	<p><b>5. Continuity of Care</b></p> <p>A                    D</p> <p>B                    E</p> <p>C                    G</p> <p>Sum Total        /5 = Score</p>
<p><b>2. Program Milieu</b></p> <p>A</p> <p>B</p> <p>Sum Total        /2 = Score</p>	<p><b><u>DDCMHT Scoring: Scaling Method</u></b></p> <p><b>Overall Score: (Sum of scaled scores/7)</b></p> <p><b>Dual Diagnosis Capability:</b></p> <p><b>MHOS (1 – 1.99)</b>  <b>MHOS/DDC ( 2 – 2.99)</b>  <b>DDC (3 – 3.99)</b>  <b>DDC/DDE (4.5 – 5.0)</b></p> <p><b><u>DDCMHT Scoring: Criterion Method</u></b></p> <p><b>% Criteria met for MHOS (# of “1” or &gt; /35)</b></p> <p><b>% Criteria met for DDC (# of “3” or &gt; scores/35)</b></p> <p><b>% Criteria met for DDC (# of “5” or scores/35)</b></p> <p><b>Highest level of DD capability (80%) or more:</b></p> <p style="text-align: center;">1     2     3     4     5</p>	<p><b>6. Staffing</b></p> <p>A                    D</p> <p>B                    E</p> <p>C</p> <p>Sum Total        /5 = Score</p>
<p><b>3. Assessment</b></p> <p>A                    E</p> <p>B                    F</p> <p>C                    G</p> <p>D</p> <p>Sum Total        /7 = Score</p>		<p><b>7. Training</b></p> <p>A</p> <p>B</p> <p>Sum Total        /2 = Score</p>

### SAMHSA DEFINITIONS OF STEPWISE INCREASE IN SERVICE INTEGRATION<sup>6</sup>

<sup>6</sup> Adapted from Substance Abuse & Mental Health Service Administration (2004)  
 MHCC Adapted DDCMHT 10/08

**Minimal coordination, consultation, collaboration and integration** are not discrete points but bands along a continuum of contact and coordination between service providers. “Minimal coordination” is the lowest band along the continuum and integration is the highest band. Please note that these bands refer to behaviour, not to organizational structure or location. “Minimal coordination” may characterize provision of services by two persons in the same agency working in the same building; “integration” may exist even if providers are in separate agencies in separate buildings.

**Minimal coordination** - “Minimal coordination” exists if a service provider meets any of the following: (1) is aware of a co-existing problem but has no contact with other providers; or (2) has referred a person with a co-existing problem to another provider with no or negligible follow-up.

**Consultation** – Consultation is a relatively informal process for helping people with co-existing problems, involving two or more service providers. Interaction between or among providers is informal, episodic and limited. Consultation may involve transmission or exchange of information regarding a person’s problem/s, status or progress. The threshold for “consultation” relative to “minimal coordination” is the occurrence of any interaction between providers after the initial referral, including active steps by the referring party to ensure that the referred person enters the recommended services.

**Collaboration** – Collaboration is a more formal process of sharing responsibility for treating a person with co-existing conditions, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different client problems are serviced by different providers, the roles and responsibilities of the providers are clear, and the responsibilities of all providers include formal and planned communication with other providers. The threshold for “collaboration” relative to “consultation” is the existence of formal agreements and/or expectations for continuing contact between providers.

**Integration** – Integration requires the participation of substance use and mental health services providers in the development of a single service delivery plan addressing both sets problems, and the continuing formal interaction and cooperation of these providers in ongoing service delivery and review. The threshold for “integration” relative to “collaboration” is the shared responsibility for the development and implementation of a service plan that addresses the co-existing problems. Although integrated services may often be provided within a single program in a single location, this is not a requirement for an integrated system. Integration might be provided by a single individual, if qualified to provide services that are intended to address both mental health and substance use problems.

### MHCC & NADA “No Wrong Door: Mental Health Drug & Alcohol Change Management Project”

#### **DDCMHT ADMINISTRATION – PREPARATION GUIDELINES**

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MHCC & NADA are working with the University of Wollongong/Illawarra Institute of Mental Health to evaluate the “No Wrong Door” project. This involves the administration of several measures before, during and after training. One of these measures is called “Dual Diagnosis Capability in Mental Health Teams” (DDCMHT)<sup>7</sup> and looks at organizational responses to people with both mental health and substance abuse problems.

Administration of the DDCMHT measurement is typically a one day process. The process typically includes a series of 3 X 1 hour focus group interviews with up to six people in each as follows:

1. Clients (eg, 10:00-11:00AM) – Note: \$35 participation payment is offered.
2. Direct care staff (eg, 11:30AM - 12:30PM)
3. Managers / Team Leaders (eg, 1:30 - 2:30PM)

The intent of the meetings is to complete the DDCMHT with different stakeholder groups and then reach consensus in scoring with one key staff person at the end of the day. It is suggested that this staff person also act as a liaison to us in this process and is also asked to individually complete a DDCAT for forwarding to us in advance of the interview day. This person should preferably be a senior frontline manager/team leader.

There are a range of documents that we will also need to arrange for the day (ie, policies/procedures, paperwork/forms, etc - see below for examples of the materials the DDCMHT looks for) . It would be great if you could get these ready for the visit. We'll probably spend some time with them during the day and after the last focus group.

1. Mission statement / program description
2. Any formalized agreements that you have with other organizations (e.g. memorandums of understanding, service agreements, etc)
3. Any training logs you have for staff in relation to substance use problems
4. Criteria/procedures for people entering the service
5. Procedures for people being transferred to other services (e.g. residential substance use programs)
6. Procedures for referring clients to other services
7. Medication policy / procedures
8. Procedures for discharge planning
9. Minutes from team meetings
10. Statistics on how frequently staff/case managers meet with their clients
11. Supervision policy and procedures
12. Records of staff member attendance at supervision
13. Procedures for people with co-existing substance use problems (e.g. emergencies)

You will be provided with information regarding the DDCMHT results that may be useful in identifying and prioritizing quality improvement and service development activities at your workplace for improving responses to people with both mental health and substance abuse problems. I hope this information is helpful to your preparation. Please contact me if you have any other questions.

Regards – Tina Smith, MHCC workforce Development  
([tina@mhcc.org.au](mailto:tina@mhcc.org.au), 95558388 ext 111, 0432052684).

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<sup>7</sup> Adapted from the Dual Diagnosis Capability in Mental Health Treatment measurement.

# Attachment 7 – NWD Learning and Assessment Materials

## Attachment 8 – Summary of MHCC LDU AOD Courses

### Foundations of Alcohol and Other Drugs: Working Within the Mental Health Context - 2 days

CHCAOD402A Work effectively in the alcohol and other drugs sector

### Assessing and Addressing the Needs of Mental Health Consumers Who Use Alcohol and Other Drugs - 2 days

CHCMH408A Provide interventions to meet to needs of consumers with MH & AOD issues

CHCAOD408A Assess the needs of clients with AOD issues

CHCCS403B Provide brief interventions,

CHCAOD411A Provide brief interventions for people with AOD issues

### Integrated Practice - Part 1 & Part 2 (Complex needs) - 2 X 2 days

CHCCOM403A Use targeted communication skills to build relationships

CHCCS504A Provide services to clients with complex needs

CHCCW503A Work intensively with clients

CHCMH501A Provide advanced supports to facilitate recovery

CHCAOD510A Work effectively with complex alcohol and other drug issues

CHCMH504D Provide a range of services to people with mental health issues

### Integrated Practice (AOD/Complex needs) – 3 days

CHCAOD511B Provide advanced interventions to meet the needs of clients with alcohol and/or other drug issues

CHCAOD513A Provide relapse prevention strategies

CHCAOD512A Develop and implement a behaviour response plan