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

BRIEF OVERVIEW OF EVALUATION FINDINGS
January 2011

All post training data collection has now been completed and discussions are continuing with the Illawarra Institute of Mental Health/Trevor Crowe to interpret the data in the context of completing the final project report including making recommendations for further sector development in this most important area. Research journal articles may also arise from this project. The quantitative data was presented for the first time at the MHCC & NADA Research into Practice Conference in December.

Dual Diagnosis Capability in Mental Health Teams (DDCMHT)
The data indicates gains 12 months post training with CMOs approaching "dual diagnosis capable" on most domains of the DDCMHT tool with an average increase of 9.12%. This average improvement is significant [Pre mean 2.05 (.20), 12 months mean 2.72 (.39)] at t=-4.38, p=.007. This means that there was a notable increase in systematic monitoring of interaction between substance use and mental health.

Co-Morbidity Problems Perception Questionnaire (CMPPQ)
There were also significant changes in trainees' (n = 57) attitudes and confidence in working with people with co-existing issues as measured on all domains of the CMPPQ (Role Adequacy, Role Support, Work Satisfaction, Task Self Efficacy & Role Legitimacy) compared to a control group (n=48, non-trained workers) who showed a non-significant negative trend (t=-2.05, p = .05) suggesting that attitudes and confidence tended to decline over time without specific training. However, these immediate training gains did not significantly change after training to 12 month follow-up and Self Efficacy regarding completing specific tasks (eg, having confidence in one's knowledge to appropriately advise about the effects of AOD) significantly declined over the 12 months post training (t = -9.34, p = .00). This may reflect inadequate implementation of specific tasks learned in training and needs to be further explored?

Evidence Based Practice Attitudes Scale (EBPAS)
There were also significant improvements overall in trainees' attitudes towards adopting evidence based practices using the EBPAS (t = -3.25 , p = .00). The control group (n=47) scores did not vary in a significant manner (t = 1.17, p = .25). Some EBPAS subscales showed that trainees significantly improved in: being more likely to adopt an EBP if it were *intuitively appealing,* could be used correctly, or was being used by colleagues who were happy with it (t = -2.45 , p = .02); and, an increased *openness to new practice* –and generally open to trying new interventions (t = -2.20, p = .03). There were no significant changes for "Likelihood of adopting EBP given *requirements* to do so" and "Perceived *divergence* with usual practice with research based/academically developed interventions". This suggests that adoption of EBP is more likely as a result of growth opportunities (eg, supervision, mentorship, training) than being told what to do. These immediate training gains did not significantly change after training to 12 month follow-up in terms of overall in trainees' attitudes towards adopting EBPs.

Implementation Experiences Survey
Analysis of the Implementation Experiences Survey – a qualitative tool based on the nine pathways identified in MHCC's WFD guide – has not yet been completed and may yield further information to help data interpretation and to inform final recommendations.