No Wrong Door:

Mental Health Drug & Alcohol Change Management Project

PROJECT OVERVIEW

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Acknowledgements

The *"No Wrong Door"* 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). This project was managed by Heidi Becker, Senior Project Officer - NADA in collaboration with Tina Smith, Workforce Development - MHCC. The development of *No Wrong Door's* approaches and resources has involved the input, support and collaboration of many people and organisations. This Project Overview Resource was developed by Jenny Melrose of JAMECO Psychology.

NADA and MHCC gratefully acknowledge Aftercare for its participation in the pilot of this resource. Thank you to Pedro Diaz, Laurence O'Connor and the Aftercare Penrith team for their willingness, enthusiasm and contribution to the resource and project.

NADA and MHCC would like to thank the following individuals, organisations and groups for their invaluable participation in the consultation process and development of this project:

- ARAFMI NSW
- Aftercare
- Ciara Donaghy, NADA Student Placement
- Illawarra Institute of Mental Health, University of Wollongong
- Gillian Bonser of Paradigm Consulting Network
- Kedesh Rehabilitation Services
- MHCC Workforce Development Reference Group
- MHCC Learning & Development Unit
- NEAMI
- NSW Consumer Advisory Group (CAG)
- Schizophrenia Fellowship of NSW
- South Sydney Youth Services.

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This *No Wrong Door: Mental Health Drug & Alcohol Change Management Project* resource has been developed by the Network of Alcohol and other Drugs Agencies (NADA) in partnership with the Mental Health Coordinating Council (MHCC).

The project resources include the following:

- Project Overview
- Facilitator's Manual
- Participants' Folder
- Learning materials for five modules
- Nationally recognised training assessment materials.

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Contents

Acknowledgements .... **Error! Bookmark not defined.**
Contents 2
Introduction...3
Background...3
Literature Review...5
Co-existing Mental Health and Substance Use Problems..................................6
The Need for Training 7
Improving Transfer of Learning 8
Implications for This Project 9
References...10
Project Training and Evaluation Process Summary 14
Overview of the Training Modules..15
Module 1: Overview of Alcohol and Other Drugs 15
Module 2: Assessment and Referral 15
Module 3: Brief Interventions...15
Module 4: Relapse Prevention and Dealing with Relapses...............................15
Module 5: Self-Care and Review...15
Evaluation of Phase 1 16
Pilot Training and Evaluation Process Summary 17

Introduction

Background

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 a 'comorbidity' package to better integrate mental health and drug and alcohol services for people with both mental illness and substance use disorders.

One of the initiatives funded through this package has been the development of a cross training response to drug and alcohol and mental health issues in the non government sector across NSW by the Network of Alcohol and Other Drug Agencies (NADA).

Research into co-existing mental health and substance use issues 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 poor.

Developing staff and organisational capacity to better respond to this client group in the drug and alcohol and mental health non government sectors has been identified as a beneficial way to respond to this issue.

NADA's response has been twofold with the development of training initiatives across both sectors. Firstly, the Mental Illness and Substance Use (MISU) Capacity Building Project was developed in partnership with Kedesh Rehabilitation Services. This project consists of a comprehensive change management resource package responding to clients with mental health and drug and alcohol issues. This resource is being rolled out to drug and alcohol rehabilitation services in the non government sector across NSW.

Modelled along similar lines, NADA has developed *No Wrong Door* in partnership with the Mental Health Coordinating Council (MHCC). *No Wrong Door* has been designed to respond to consumers of the NSW community mental health sector who also have drug and alcohol issues. This resource consists of a comprehensive drug and alcohol change management package developed by consultant Jenny Melrose of JEMECO Psychology. A comprehensive evaluation process was developed and implemented for the project in collaboration with the Illawarra Institute of Mental Health, University of Wollongong.

The aim of the project was to develop and deliver a training resource that would:

a) Elicit staff attitudes, confidence levels and skill sets in working with clients who present with drug and alcohol 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.

b) Improve management and agency capacity to support clients within mental health agencies with alcohol and other drug issues.

A consultation process was undertaken directly with services in the community mental health sector. Further information was gathered through the MHCC's 2008 Annual Member Survey that confirmed the need for a resource designed specifically for the community mental health sector in responding to clients with drug and alcohol issues.

The project has produced four resources:

1. this project overview document providing the background to the project

2. a facilitator's manual providing all the resources required to deliver the project to a community mental health service

3. a participants' folder providing all the resources that participants receiving training from the project require.

4. nationally recognised training assessment materials.

This project is not about making mental health workers drug and alcohol specialists or vice versa. Rather, it is about them gaining knowledge, learning new skills, consolidating current skills within a drug and alcohol context and increasing confidence. It is about a whole of agency response that supports staff to support people accessing their services who are experiencing mental health and drug and alcohol issues. It is about building relationships across the two sectors and strengthening our research base in the area of the non government mental health and drug and alcohol sector in NSW. Most of all, it is about supporting both sector's responses in obtaining successful outcomes for service users experiencing mental health and drug and alcohol issues.

NADA and MHCC – Working Together

No Wrong Door is one of several projects in which NADA and MHCC have collaborated. NADA and MHCC have worked in partnership across projects, reference groups and working parties and a joint conference in areas covering research and infrastructure, mental illness and substance use and workforce and sector development. MHCC and NADA have identified many areas of commonality within our sectors and will work in future in partnership across areas such as service delivery, information technology management, funding models and sector development.

Project Name

This project has been based upon the principle that all people should receive care that addresses the full spectrum of their mental health and substance use issues regardless of what type of service they present to (ie there is no wrong door). This 'no wrong door' principle clarifies that the responsibility of providing care addressing a range of health and social needs is the responsibility of the care provider/service where the client presents. It is acknowledged that this requires

services to provide care and/or facilitate access to service delivery that falls beyond their specific focus. It removes the onus of negotiating different services and providers from the client and thereby aims to reduce the incidence of people 'falling through the cracks' of a complex service delivery system (Center for Substance Abuse Treatment, 2005).

Literature Review

Co-existing Mental Health and Substance Use Problems

Co-existing mental health and substance use problems, often referred to as comorbidity or dual diagnosis, is now acknowledged to be widespread and is associated with poor treatment outcomes and high service use (AIHW, 2005). Co-existing mental health and substance use disorders are common in the general population (Kessler, 2004; Andrews, Hall, Teesson & Henderson, 1999) and much more common in people receiving treatment for either a mental health or a substance use disorder (Weaver, Madden, Charles, Stimson, Renton, Tyrer, Barnes, Bench, Middleton, Wright, Paterson, Shanahan, Seivewright, & Ford, 2003; Weaver, Charles, Madden, & Renton, 2002; Jablensky, McGrath, Herrman, Castle, Gureje, Morgan & Korten, 1999).

The rates of clients with co-existing mental health and substance use problems in the United States (Center for Substance Abuse Treatment, 2005), Britain (Department of Health, 2002) and Australia (Davis, 2003) are estimated between 30-90% depending on the type of mental and substance use disorders measured in the study. Interestingly, the majority of studies exclude nicotine dependence as a drug-use disorder. If this were included the rate of co-existing mental health and substance use problems would be even higher. As such a minimum of one in three clients presenting for help with mental health problems will have a co-existing alcohol or other drug (AOD) issue.

In 1997 the Australian National Survey of Mental Health and Wellbeing was carried out (ABS, 1998). This survey provided the first Australian data on the prevalence and patterns of mental disorders among Australian men and women, highlighting the extent of co-existing mental health and substance use problems in the general population. Results of this survey show a considerable degree of co-existing mental health and substance use problems within the Australian population (ABS, 1998). The results show that about one in four people with an anxiety, affective or substance use disorder also had at least one other mental disorder (Teesson, Hall, Lynskey & Degenhardt, 2000). This meant they had two or more different classes of disorder, such as an anxiety and affective disorder, or an anxiety and a substance use disorder. A small proportion of men (0.8%) and women (0.8%) had all three types of disorder (ie an anxiety, affective and substance use disorder). For those with psychosis, 73.2% of the men and 56.3% of women had used nicotine within the last 12 months, 30% had an alcohol use disorder and 25% a cannabis use disorder (Jablensky, et al, 1999). A second national survey was completed in 2007. Initial results were published late in 2008, however the results are still being analysed in regards to comorbidity.

Effects on service delivery

The high rates of co-existing mental health and substance use issues have a number of implications for service delivery. People with both mental and substance use disorders have been recognised as having a poorer prognosis than those without both sets of problems and their problems are more likely to become chronic and disabling and result in greater service utilisation (Teesson, Hall, Lynskey & Degenhardt, 2000). For instance, people with psychosis and substance use problems are more likely to

experience a range of negative outcomes including increased levels of medication non-compliance, psychosocial problems, depression, suicidal behaviour, re-hospitalisation, homelessness, poorer mental health, higher family burden (Drake, Mueser, Clark & Wallach, 1996), higher rates of relapse (Croton, 2005) and violence and victimisation (Drake, Essock, Shaner, Carey, Minkoff & Kola, 2001). People with co-existing mental health and substance use problems also report having more contact with the criminal justice system, family and relationship problems and histories of childhood abuse (Andersen, 1997; AIHW, 2005; Johnson, 2000). Assertive follow-up is made more difficult by increased rates of mobility and homelessness (Mueser, Bellack & Blanchard, 1992).

The current health and community services systems are designed to deal with distinct mental health or substance use disorders. Substance use and mental health services are administered and funded separately giving little incentive for each to assess and treat co-existing conditions (Proudfoot, Teesson, Brewin & Gournay, 2003). This leads to arguments about 'which problem came first' or 'what is the primary diagnosis' to determine what service the client needs to access. The common result is that people with both mental and substance use problems describe the predicament of not being eligible or welcome for treatment at services because of their co-existing problems (Mental Health Council of Australia, 2005). People with co-existing mental health and substance use problems fall through the cracks (Proudfoot et al, 2003).

Longitudinal and twin studies have shown however that there is broad convergence of risk factors for both substance use and mental disorders (Teesson, Degenhardt, Proudfoot, Hall & Lynskey, 2005). Separating the issues is therefore not helpful as service providers need to manage the problems associated with both conditions simultaneously to be effective (Kavanagh, Greenaway, Jenner, Saunders, White, Sorban & Hamilton, 2000). In fact, as the problems are often intertwined, deferring services to address the 'secondary disorder' could have a negative effect on the 'primary disorder' (Kavanagh, Mueser & Baker, 2003).

Research now clearly supports the idea that the needs of these clients requires help to be provided for both mental health and substance use issues regardless of whether they present to mental health or substance use services (Fenton & Mosher, 2000; Drake et al, 2001; Kavanagh et al, 2000). Integrated services for substance use disorders and mental disorders tend to have superior outcomes than standard treatment (Kavangah et al, 2003) especially with clients with psychosis and substance use (Kavangah, 2001).

The Need for Training

If the community mental health sector can improve the effectiveness of its responses to people with co-existing substance use problems there will be corresponding gains in their clients' capacity to manage their mental illness (Croton, 2005). People with severe mental illness are at a much greater risk of developing substance use problems (Abou-Saleh & Janca, 2004) and this development negatively impacts on their ability to manage their mental illness. Therefore community mental health services and workers must become more active in improving their skills in helping clients manage *both* mental health and substance use problems (Croton, 2005).

It is relatively clear that one of the primary ways that organisations can improve service delivery to clients presenting with co-existing mental health and substance use problems is to provide effective education and training programs to enhance the existing skills, knowledge, abilities and general work practice of both substance use and mental health organisations (AIHW, 2005; Croton, 2004).

Improve skills in developing a positive helping relationship

One of the main skills in doing good work with clients with substance use issues is being able to develop a positive helping relationship or "therapeutic alliance" (Meier, Donmall, Barrowclough, McElduff & Heller, 2005). This positive alliance develops if the worker promotes an environment of encouragement, acceptance and understanding (Cartwright & Gorman, 1993). In fact Bohart, O'Hara, Leitner, Wertz, Stern and Schneider (1997) go as far to say that the capacity to engage clients and nurture hope *is considered more important* than professional expertise. Additionally, good therapeutic alliance has been found to retain clients with moderate and severe psychiatric problems (Montoya, 2006). Since mental health support services (as compared to government clinical services) are mostly structured around voluntary attendance they recognise the value of ongoing relationships and place emphasis on strengths rather than psychopathologies. This makes these services well placed to do work with people with co-existing mental health and substance use problems (Croton, 2005).

Improve attitudes of workers towards clients with co-existing mental health and substance use problems

A positive therapeutic alliance can not be formed unless attitudes of workers towards their clients are addressed (Croton, 2004; Cupitt, Morgan, & Chalkley, 1999) as attitudes have long been recognised as predictors of behaviour (Eagly & Chaiken, 1993). It has also been found that the attitudes of workers towards their clients can predict the quality of care delivered (Watson, Maclaren, Shaw & Nolan, 2003). Further, clients who perceive a negative attitude, in particular rejection and devaluation by staff, will have worse outcomes (Nordt, Rossler, & Lauber, 2006). It is therefore advised that when training is provided about co-existing mental health and substance use problems that it target attitudes held by staff about their clients (Croton, 2004). Training that does not include an attitudinal component is likely to be less effective (Croton, 2004).

Improving Transfer of Learning

While training is an important component of improving a community mental health organisation's capacity to address the needs of its clients with co-existing mental health and substance use problems, training merely focuses on the individual worker. It is imperative to also look at the organisational context in which that worker operates (Roche, 2001). When trying to change workers' levels of skill in working with substance using clients there are three integral components that need to be addressed (Shaw, Cartwright, Spratley & Harwin, 1978). The first is the workers' beliefs that they have the ability to do the job, otherwise known as 'role adequacy'. The second is the workers' beliefs that the tasks they do are a legitimate part of their

job role and they therefore have a legitimate right to be involved in the work. This is known as 'role legitimacy'. The final component is the workers' beliefs that they will be supported by the organisation they work for to do the tasks required, known as 'role support'. Providing training in skills to work with AOD will increase workers' role adequacy but is unlikely to change their behaviour if their role legitimacy and support are not taken into consideration.

It is not uncommon for community mental health workers to have a perception that addressing the substance use issues of their clients is not part of their job. This lack of role legitimacy will act as a barrier to the transfer of learning on AOD skills into work practice (Pidd, Freeman, Skinner, Shoobridge & Roche, 2004; Skinner, Freeman, Shoobridge & Roche, 2003).

Not only is training needed but a top-down organisational approach is required focusing on the capacity of the organisation to respond effectively to the issue of co-existing mental health and substance use problems (Skinner et al, 2003; Croton, 2004). It is now recognised that training within organisations should have a strategic approach and be custom designed to achieve specific organisational goals (Shoobridge, 2002; Skinner et al, 2003). In this way, employee training can be viewed as a mechanism for enhancing teamwork and organisational effectiveness thus integral to facilitating organisational change (Shoorbridge, 2002).

Training should include both management and staff and be on-going (Croton, 2004) since ad-hoc, one off training is insufficient for appropriate transfer of learning (Roche & Macdonald, 2001). Effective transfer of learning is evident when the knowledge, skills and abilities acquired in the training context produce the desired behavioural change in the context of the workplace (Pidd, 2002). When training is provided with the aim of increasing transfer of learning the following characteristics need to be included:

- opportunities for practice
- an organisational climate that values the training
- development of policies and procedures to support and be consistent with what is taught in the training
- supervisor support to ensure that trainees can access resources and strategies that will facilitate transfer of learning to work practice (Shoobridge, 2002).

Implications for This Project

As a result of the research provided above, the following components will be built into *No Wrong Door*:

1. To increase worker role adequacy:

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

2. To increase worker role legitimacy:

   a. a pre-prepared meeting agenda item relating to the training will be provided to supervisors for use within team meetings
   b. concrete resources will be provided for use with clients
   c. an emphasis will be placed on the fact that many of the existing techniques being utilised to support clients with mental health issues are effective strategies for addressing substance use issues
   d. following the training modules participants will have the opportunity to be assessed for up to four units of competency from the 2002 Community Services Training Package.

3. To increase worker role support:

   a. all levels of staff including supervisors, managers and service delivery workers will be encouraged to participate in the training
   b. a review of current policies, procedures and other documentation pertaining to working with clients with co-existing mental health and substance use problems will occur before the training commences and feedback will be provided including suggestions of improvements to better service these clients
   c. ensuring that facilitators have a good alliance with both staff and managers as well as an understanding of the difficulties that the organisation faces working with this client group.

4. To increase transfer of learning:

   a. learning tasks will be developed for participants to work through between modules to provide practice opportunities
   b. buy-in by each level of the organisation receiving the training will be achieved before training commences
   c. the training will be spread out over a few months to allow for practice between modules.

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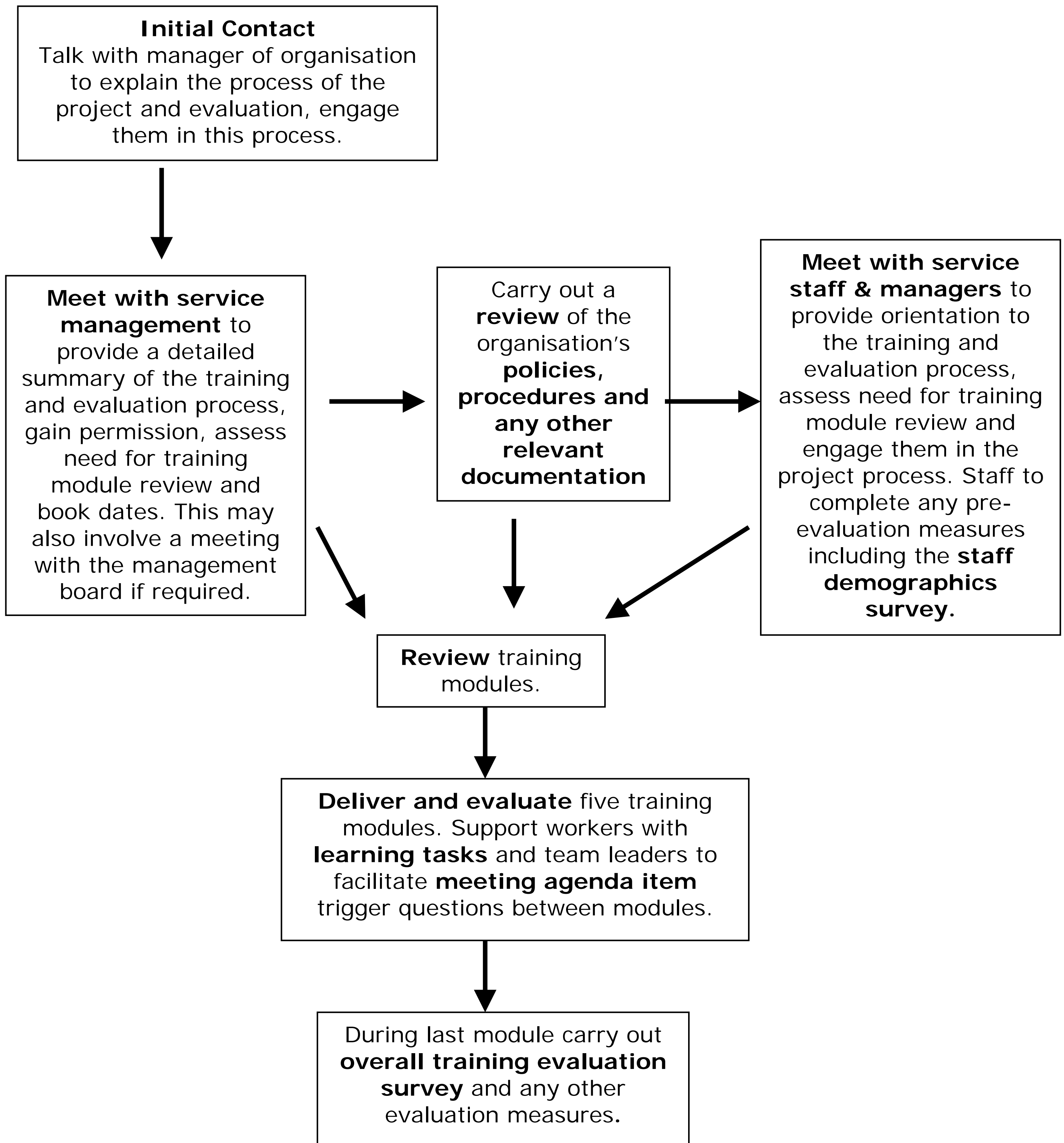
Project Training and Evaluation Process Summary



Overview of the Training Modules

Module 1: Overview of Alcohol and Other Drugs

Module 1 runs for 6.5 hours and provides an overview of important alcohol and other drugs (AOD) concepts, models and terminology. During this module participants will have the opportunity to:

- 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.

Module 2: Assessment and Referral

Module 2 runs for 5.25 hours and provides an overview of assessment methods, service delivery options and referral processes. During this module participants will have the opportunity to:

- use a variety of screening and assessment techniques for substance users
- learn about service delivery options for both illicit and licit substance users
- explore different referral processes.

Module 3: Brief Interventions

Module 3 runs for 5.75 hours and provides an overview of a variety of brief interventions to use with clients who use substances. During this module participants will have the opportunity to:

- learn about brief interventions and when they can be used
- assess the need for brief interventions
- practise a variety of brief interventions.

Module 4: Relapse Prevention and Dealing with Relapses

Module 4 runs for 3.25 hours and provides an overview of strategies to reduce the frequency of relapse and the severity of relapse when it occurs. During this module participants will have the opportunity to:

- develop an understanding of how and why relapses occur
- practise strategies to help clients anticipate and avoid relapses
- learn to use several strategies to help clients manage lapses if they do occur.

Module 5: Self-Care and Review

Module 5 runs for 3.25 hours and provides an overview of self-care, stress, burnout and vicarious traumatisation within the workplace as well as some prevention strategies. During this module participants will have the opportunity to:

- learn about the symptoms and causes of stress, burnout and vicarious traumatisation

- explore both individual and organisational strategies to reduce stress, burnout and vicarious traumatisation
- consider how they currently self-care and how they can improve on this
- review topics covered throughout the whole program.

Evaluation of Phase 1

No Wrong Door has been conceptualised as three different phases. Phase 1 consisted of the development of the project resources and pilot delivery of the project, phase 2 is the roll out of the project in a further five sites and phase 3 involves the project evaluation and funding body reporting phase. To date phase 1 has been completed. This was carried out between February 2008 and March 2009.

The five modules were delivered to Aftercare Penrith staff between 3rd December 2008 and 25th February 2009 at The Log Cabin, a conference centre in Penrith, Western Sydney. The extended delivery timeframe occurred due to Christmas, New Years and Australia Day holidays. The modules were attended by between 13 and 17 Aftercare staff. The participants included Personal Helpers and Mentors (PHaMs) workers, Housing and Accommodation Support Initiative (HASI 2) workers, a HASI for Kooris worker, a peer support worker, team leaders, a social work student doing placement at Aftercare and the program coordinator as well as the NADA Senior Project Officer, a student from NADA and the MHCC Workforce Development Project Officer.

Evaluations were completed at the end of each module to gain information about each particular session. Overwhelmingly participants responded well to evaluation questions for all five modules. The presentation, handouts used and facilitator skill all evaluated very positively for each module. The overall evaluation was completed at the end of the last module. Again, they were overwhelmingly positive.

Comments about the pilot included:

- *I can already see a change in my own way of thinking and the change in the language used by staff around D&A.*
- *I think it will be helpful in supporting drug using clients to change or reduce their drug use.*
- *It has provided me with understanding of AOD and how to work with clients.*
- *I would definitely recommend the training and would say it is a thorough introduction to AOD issues for your clients and you will benefit from it so much I highly recommend it and suggest it should be mandatory.*
- *So much information and valuable knowledge.*
- *It gave me a solid introduction in the area – de-mystified some areas of D&A and gave practical models of how to approach different situations.*
- *I thought the training was a fantastic introduction for me and I feel I have gotten a lot from it personally and professionally.*
- *I now have proven strategies for supporting clients with D&A issues and a greater understanding and expectations of recovery*

Pilot Training and Evaluation Process Summary