MEASURING THE PROVISION OF EVIDENCE-BASED MENTAL HEALTH TRAINING:

IT’S NOT EASY!

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Beautiful Gold Coast
People come to play...
Leading to....
Co – morbidity stats

Australian National Survey of Mental Health and Wellbeing (2007):

• 35% of individuals with a substance use disorder (31% of men and 44% of women) have at least one co-occurring affective or anxiety disorder.
Within AOD treatment….

- Mental disorders range from 51–84% (Brems and Johnson 1997, cited in NDARC 2010)
- Most common are mood, anxiety and personality disorder
- Rates of trauma exposure and Post Traumatic Stress Disorder (PTSD) are high
- Increase in psychosis with increasing use of methamphetamine
Treatment stats

- Campbell et al. (2010), WHO’s rehabs = average age of clients (33); 59% diagnosed mental health disorders.
- GCDC (2013) = average age (24); 48.8% mental health diagnosis.
- GCDC = 12% with Schizophrenia or Drug Induced Psychosis. WHOS = 9%.
Harms associated with comorbidities

- Poorer physical health
- Increased stress on relationships (family and friends)
- Greater drug use severity
- Increased risk of violence
- Increased risk of self harm and suicide
- Increased homelessness
- Poorer occupational and social functioning
- Poorer mental health

Harms associated with comorbidity
Figure 3
The Quadrant Model for understanding co-occurring mental health and alcohol and other drug use disorders (dual diagnosis)

Quadrant I
Less severe mental disorder, less severe AOD use
- ATODS have primary responsibility
- Integrated care to be provided by ATODS
- Referral to GPs/private providers/NGOs if required – assistance to link clients into these services is to be provided.

Quadrant II
Less severe mental disorder, more severe AOD use
- ATODS have primary responsibility
- Integrated care to be provided by ATODS
- Co-management with GPs/private providers/NGOs if clinically indicated. Ongoing collaboration between services required.

Quadrant III
More severe mental disorder, less severe AOD use
- MHS have primary responsibility
- Integrated care to be provided by MHS
- Consultation/advice from ATODS if required
- Co-management if integrated care unable to be provided by MHS. Ongoing communication and collaboration between services required.

Quadrant IV
More severe mental disorder, more severe AOD use
- MHS have primary responsibility
- Integrated care to be provided by MHS
- Consultation/advice from ATODS required
- Co-management if clinically indicated i.e. opioid replacement therapy and if integrated care unable to be provided by MHS. Ongoing communication and collaboration between services required.
Heads Up DD Forum
Content of program
DUAL DIAGNOSIS
co-occurring mental health and alcohol and other drug problems
co-occurring mental health and alcohol and other drug problems
Speakers
Advertising

YOUTH NETWORK

qnada

APS Australian Psychological Society

NGO

Introducing Lives Lived Well

Queensland Government

Queensland Health

coccurring mental health and alcohol and other drug problems
Attendance – GCDC 2012
Attendance – BIC 2012
Evaluation Methodology

• Pre and post test measure of knowledge
• Satisfaction questionnaire
• Qualitative feedback from participants
• Feedback gathered post sessions from ‘word of mouth’ discussions
Findings – 1\textsuperscript{st} attempt

- T-Score analysis - cohort and individual - no changes at 95% Confidence level.
- Consistent trend of improvement. No reverse trend. If chance, both present.
- People learnt of services they had not known about and how to refer into them
However.....

OBSERVED DOMAIN IMPROVEMENTS

• more at ease with people with DD
• More confident in ability to assess presence of DD
• Knowledge of substances and their effects.
• Ability to provide appropriate mental health information
• Ability to work holistically
• Knowledge about severe mental illness and its symptoms
• Ability to communicate, irrespective of problems
• Knowledge of housing accessibility
• Where to obtain support and help
• Provide drug treatment information
• Referral networks
• Overcoming ambivalence and reluctance
And later.....

- Discovery that some items needed to be reverse scored!

In Workshops 1 & 3:
- 100% - training very relevant/ relevant.
- 100% - very professionally/ professionally delivered and
- 100% - content easy to understand
Results!
## Knowledge Change 2013

*Pre- and Post-Workshop Competency Questionnaire Scores for Each Workshop.*

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<th>Competence Questionnaire</th>
<th>Pre-Workshop</th>
<th>Post-workshop</th>
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<td>$M$</td>
<td>$SD$</td>
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<tr>
<td>Workshop One</td>
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<td>Workshop Six</td>
<td>25.35</td>
<td>4.55</td>
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</tbody>
</table>
Conclusions:

• Each workshop increased participants’ competency.

• Competency increased over each successive workshop - effects are cumulative.

• Competency did not vary as a function of years of experience

• Participants with fewer years of experience did not benefit significantly more or less from the workshops than participants with over five years of experience
Our Learnings

- Don’t loose your data!!! Makes it hard to do further analyses that you hadn’t considered initially!
- Have someone who understands numbers and statistical analysis (if you don’t)!
- Devise an evaluation framework that is specific in terms of its outcomes
Suggestions for Others?

- Time
- Other professionals
  - interprofessional and interagency collaboration is possible!
- Clear ‘advertising’ and booking procedure
- Pre and post test measurement
  - thesis or doctorate anyone??!
- Satisfaction surveys
  - evidence base/ psychometric robustness?
  - Link with local universities to improve?
Benefits to Clients

- Improved outcomes, less harm
- More confident Workers – better questions asked, better knowledge of sources of support for self and client, increased knowledge of possible interventions.
- ‘No wrong door’
Final Words

• Outlined a dual diagnosis training methodology (‘implementing evidence based practice’);
• Discussed our attempt to develop an evaluation methodology (‘what to measure’);
• Shared our learning from this experience (‘improving data quality’).
Contact Information

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