



Western Australian Network of  
Alcohol & other Drug Agencies

# **Review of the Impact of the AOD Improved Services Initiative in Western Australia**

**December 2011**



**Australian Government**

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**Department of Health and Ageing**

## Table of Contents

1.	Introduction .....	3
2.	Summary of Suggested Strategies to Ensure Sustainability and Continued Capacity Building .....	4
3.	Evaluation Methodology.....	5
4.	Results.....	6
4.1	DDCAT Assessments .....	6
4.1.1	Dimension I: Program Structure .....	6
4.1.2	Dimension II: Program Milieu .....	9
4.1.3	Dimension III: Clinical Process: Assessment.....	11
4.1.4	Dimension IV: Clinical Process: Treatment .....	19
4.1.5	Dimension V: Continuity of Care .....	29
4.1.6	Dimension VI: Staffing.....	34
4.1.7	Dimension VII: Training.....	39
4.2	Policies and Procedures .....	42
4.3	Professional Development .....	43
4.4	Linkages and Partnerships.....	45
4.5	Data Collection.....	48
4.6	Continuous Quality Improvement .....	49
4.7	The Consortium Approach .....	51
5	Conclusion .....	52
	Appendix A: Organisations invited to participate in the evaluation.....	58
	Appendix B: Survey Questions.....	59
	Appendix C: DDCAT Index Items by Dimension.....	61
	Appendix D: Summary of Policies and Procedures developed/reviewed .....	63
	Appendix E: Clinical Education Resources Developed During the Project.....	65
	Appendix F: Summary of Professional Development activities undertaken from 2008 - 2010 .....	67

## 1. Introduction

In July 2006, a National Action Plan on Mental Health (2006 – 2011) was endorsed by the Council of Australian Governments (COAG). As part of their contribution, the Commonwealth Department of Health and Ageing (DoHA) provided funding for the *Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative* (the Improved Services Measure). Funding was initially for a three year period from January 2008 – December 2010 and was open to non-government AOD services.

The *Improved Services Initiative* (ISI) was intended to equip Alcohol and Other Drug (AOD) Non-Government Organisations (NGOs), workers, and managers with mechanisms and resources to achieve improvements in mental health services. Support was provided through a range of strategies that sought to better qualify, train and professionally develop the workforce, build capacity of the NGO sector, increase organisational responsibilities through the development and dissemination of resources, and enhance partnerships with related professionals through linkage activities.

The WA Network of Alcohol and other Drug Agencies (WANADA) facilitated the development of a consortium approach to help ensure that capacity building was spread as far across the sector in WA as possible. Five consortia, including 20 organisations initially were funded and a further six organisations received individual funding under the program (note: some organisations were involved in more than one consortium and may also have received individual funding for a specific site).

WANADA was also directly funded under the *Cross-Sectoral Support and Strategic Partnership Project* (CSSSPP), to support grant recipients to undertake capacity building and service improvement initiatives, as well as to enhance cross-sectoral support and strategic partnerships between mental health and alcohol and other drug organisations.

This review examines the achievement of capacity building as indicated by the *Dual Diagnosis Capability in Addiction Treatment Toolkit*<sup>1</sup> (DDCAT). This measure was undertaken by the grant recipient lead agencies and their consortium members as part of the contractual funding agreement. The report also includes feedback from the grant recipients and their consortium members on their achievement of the five key activity areas of the ISI funding agreements: policies and procedures; professional development; partnerships and linkages; data collection; and continuous quality improvement.

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<sup>1</sup> The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Toolkit, adapted for use in the Improved Services Initiative for People with Drug and Alcohol Problems and Mental Illness Initiative for the Department of Health and Ageing (April 2008).

## **2. Summary of Suggested Strategies to Ensure Sustainability and Continued Capacity Building**

1. To improve the DDCAT assessment process, assessments could be conducted independently to ensure objectivity in assessment and consistency of interpretation in the assessment process. A suitable process could then be applied across the WA AOD service sector;
2. Consideration be given to the development of a collective approach to the delivery of training on comorbidity for the broader WA AOD sector;
3. A significant continuing focus on comorbidity professional development and workforce capability will be required to ensure the sustainability of capacity gains made across the sector in WA. WANADA should consider investigating strategies to coordinate workforce capacity and workforce development needs on a sector wide basis;
4. Further consideration be given to establishing a sector-wide and inter-sector staff exchange/secondment framework;
5. Research could be undertaken on good practice in clinical supervision with a view to establishing a sector-wide position, which may include the establishment of a register of suitably qualified persons who are willing to provide registration supervision;
6. Consideration be given to developing resources for the sector on how to establish and maintain successful linkages and partnerships, based on the experiences of the ISI grant recipients/participating organisations;
7. A significant continuing focus on forming and maintaining linkages and partnerships will be required to ensure the sustainability of capacity gains made to date by participating organisations in WA. WANADA is well placed to coordinate the identification of advantageous linkages and partnerships on a sector to sector basis; and
8. Consideration be given to conducting a literature review on consortium models and developing resources for the sector on how to establish and maintain successful consortia, based on the experiences of the ISI grant recipients and their consortium members.

### 3. Evaluation Methodology

The evaluation has been undertaken using qualitative and quantitative data. Twenty organisations who had participated in the ISI project were asked to provide their DDCAT Assessments for the period 2008 – 2010. A list of organisations who were invited to participate in the evaluation is included as Appendix A.

A survey of 27 questions for interview was developed, based on the ISI project key activity areas used for reporting progress to Department of Health and Ageing (DoHA) (policies and procedures, professional development, linkages and partnerships, data collection and quality improvement), as well as the recommendations included in the 2006 National Centre for Education and Training of Addiction (NCETA) report *Improved Services for People with Drug and Alcohol Problems and Mental Illness*<sup>2</sup>. Gathering feedback on these recommendations was intended to ensure the intent behind the objectives of the key activity areas was addressed. Where participating organisations were members of a consortium, an additional three questions were asked, seeking their views on the success of the consortium approach. The survey questions are included as Appendix B.

The interview questions were circulated to participants approximately two weeks prior to the conduct of the interview and organisations were encouraged to identify their responses and forward these prior to the interview, to facilitate a more focussed discussion. Most organisations also provided their progress reports to DoHA for the period 2008 – 2010, as an alternative to listing all policy development and review and professional development activities undertaken on the written questionnaire.

In addition, four of the consortiums provided evaluation reports for aspects of, or the entirety of their consortium's activities.

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<sup>2</sup> Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative, NCETA (2006)

## **4. Results**

### **4.1 DDCAT Assessments**

Seventeen organisations provided their Dual Diagnosis Capability in Addiction Treatment (DDCAT) Assessments for the period 2008 – 2010. The assessments were averaged over the organisations to provide an aggregate for performance across the sector over the first three years of the ISI project.

The DDCAT includes 33 index items across seven dimensions: I. Program Structure; II. Program Milieu; III. Clinical Process: Assessment; IV: Clinical Process: Treatment; V. Continuity of Care; VI. Staffing; and VII. Training. Index items are rated on a scale of 1 – 5, with 1 indicating a program is capable of delivering Alcohol and Drug Services only, 3 indicating a program is Dual Diagnosis Capable and 5 indicating a program is Dual Diagnosis Enhanced. A list of the DDCAT index items by dimension is included as Appendix C.

Most participating organisations reported that they conducted the annual DDCAT assessment as a group process with staff, facilitated by the consortium Project Officer, where the organisation was a member of a consortium. One organisation reported that a different process was used each year (first year all staff participated, second year was conducted by management and the third year with representatives from each program area).

The following sections examine average sector performance by DDCAT index item. Comments on enablers and barriers are provided for each index item, together with comments on the sustainability of capacity gains.

#### **4.1.1 Dimension I: Program Structure**

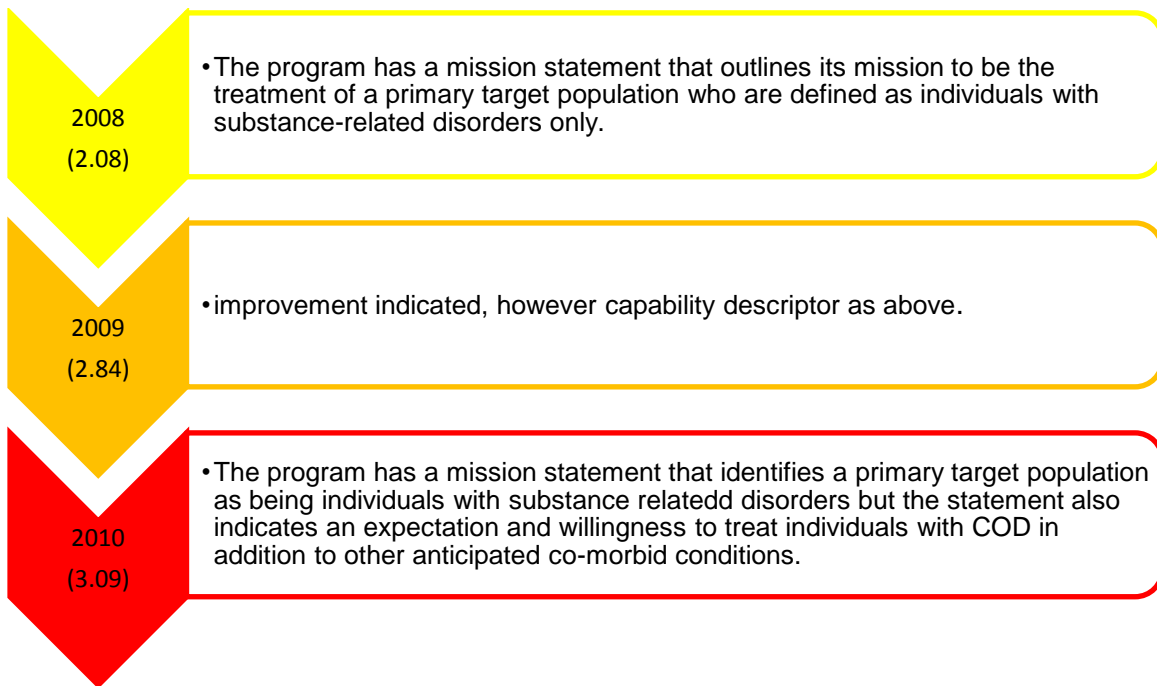
Dimension I “focuses on general organisational factors that foster or inhibit the development of Co-occurring Disorders (COD) treatment” (p 6, DDCAT Toolkit, DoHA, 2008) and includes two index items, Program Structure and Program Milieu.

During the period 2008 - 2010, assessment against both index items (IA and IB) increased from AOD only services dual diagnosis capable. Performance against each of the index items is detailed below.

**IA. Primary treatment focus as stated in mission statement.**

DDCAT definition – Programs that offer treatment for individuals with COD should have this philosophy reflected in their mission statements.

Year/Av Score      DDCAT descriptor for rating



During the period 2008 - 2010, the WA AOD Sector’s average capacity increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capacity for most AOD specific organisations and appears sustainable over the long term.

**IB. Coordination and collaboration with mental health services.**

DDCAT definition – Programs that transform themselves from ones that only provide for substance related disorders into ones that can provide integrated COD services typically follow a pattern of staged advances in their service systems. The steps indicate the degree of communication and shared responsibility between providers who offer services for mental health and substance related disorders.

Year/Av Score      DDCAT descriptor for rating

2008 (1.76)	•Programs that have a system of care that meets the definition of “Minimal Coordination”.
2009 (3.11)	•Programs that have a system of care that meets the definition of “Collaboration”.
2010 (3.24)	•Improvement indicated, however capability descriptor as above.

During the period, the sector’s average capacity increased from AOD only services to dual diagnosis capable. The DDCAT definitions for “minimal coordination” and “consultation” are provided below.

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

Collaboration is a more formal process of shared responsibility for treating a person with co-occurring conditions, involving regular and planned communication, sharing of progress reports, or memoranda of agreement. In a collaborative relationship, different disorders are treated 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.

This would appear to be an appropriate level of capacity for AOD specific services, as to achieve a rating of dual diagnosis enhanced, organisations would need to demonstrate that it provided integrated care for people with co-occurring mental health and substance misuse disorders.



Sustainability in this area will be dependent upon the formation and maintenance of partnerships with the mental health sector (see section 4.4).

#### 4.1.2 Dimension II: Program Milieu

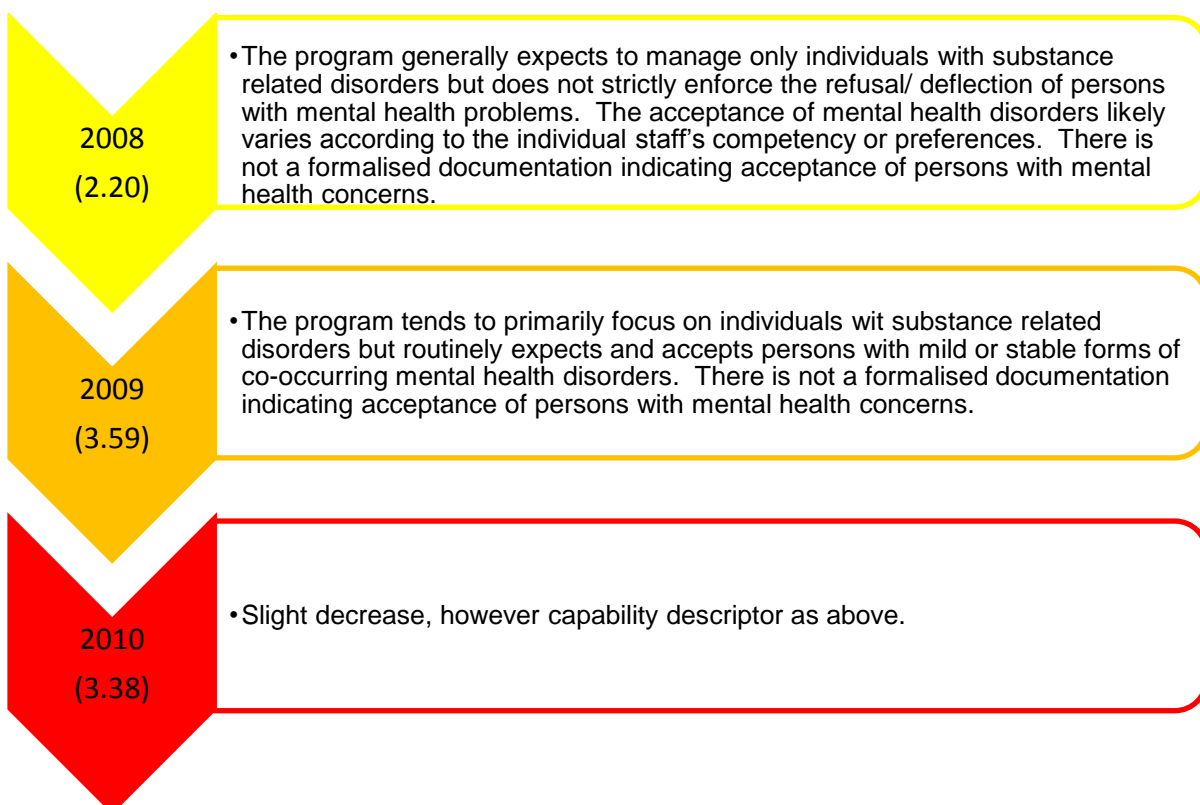
Dimension II “focuses on the culture of the program and whether the staff and physical environment of the program are receptive and welcoming to persons with COD” (p 6, DDCAT Toolkit, DoHA, 2008). This dimension includes two index items, Routine expectation of and welcome to treatment for both disorders; and Display and distribution of literature and client educational materials.

During the period 2008 - 2010, assessment against both index items IIA and IIB increased from AOD only services to dual diagnosis capable services. Performance against each of the index items is detailed below.

##### IIA. Routine expectation of and welcome to treatment for both disorders.

DDCAT definition – Persons with COD are welcomed by the program or facility, and this concept is communicated in supporting documents. Persons who present with co-occurring mental health disorders are not rejected from the program because of the presence of this disorder.

Year/Av Score      DDCAT descriptor for rating



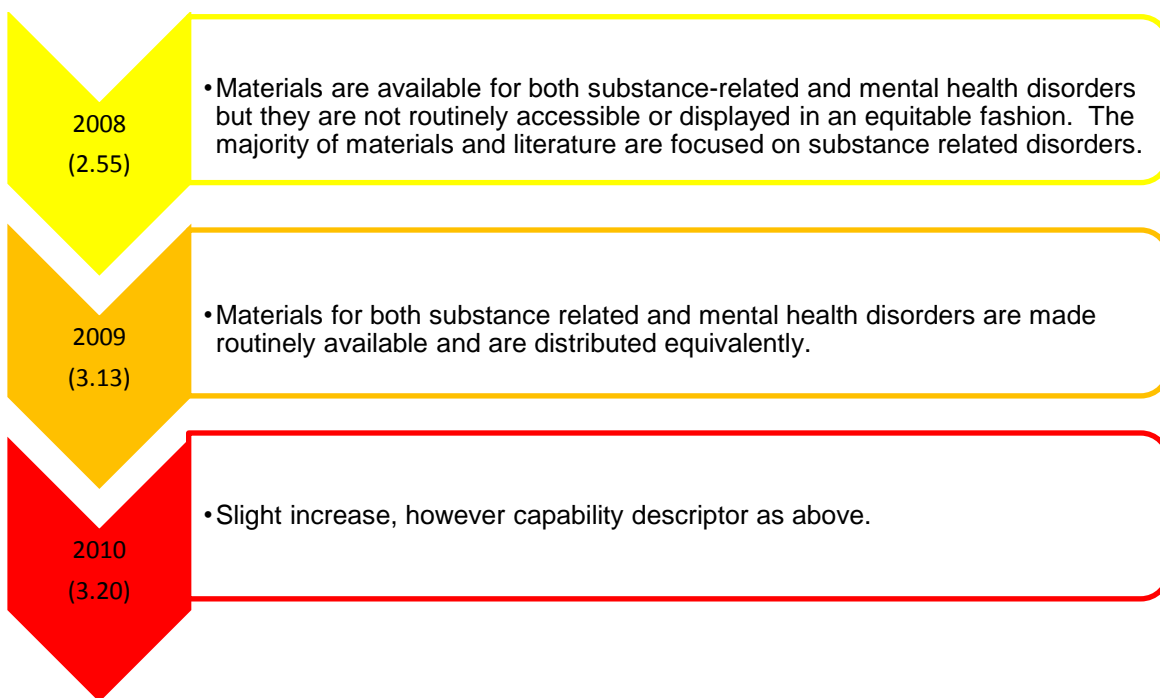
During the period, the sector's average performance increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capacity for AOD specific services, as to achieve a rating of dual diagnosis enhanced, organisations would need to demonstrate that they accepted individuals with co-occurring disorders, regardless of severity.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3).

**IIB. Display and distribution of literature and client educational materials.**

DDCAT definition – Programs that treat persons with co-occurring disorders create an environment which displays and provides literature and educational materials that address both mental and substance use disorders.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. These gains would appear to be sustainable over the long term. To progress to a rating of dual diagnosis enhanced, literature would need to specifically address COD issues, such as the interaction of COD on psychological function and may be achievable in the longer term, but would most likely require the support and input of mental health agencies or research institutions.

### 4.1.3 Dimension III: Clinical Process: Assessment

Dimension III “examines whether specific clinical activities achieve specific benchmarks for COD assessment” (p 6, DDCAT Toolkit, DoHA, 2008). This dimension includes seven index items: routine screening methods for psychiatric symptoms; routine assessment if screened positive for psychiatric symptoms; psychiatric and substance use diagnoses made and documented; psychiatric and substance use history reflected in client record; program acceptance based on psychiatric symptom acuity (low, moderate, high); program acceptance based on severity of persistence and psychiatric disability (low, moderate, high); and stage-wise treatment (initial).

During the period, assessment against five of the seven index items (IIIC, IIID, IIIE, IIIF and IIIG) increased from AOD only services to dual diagnosis capable services, with assessment against the remaining two index items (IIIA and IIIB) increasing but remaining within the dual diagnosis capable range. Performance against each of the index items is detailed below.

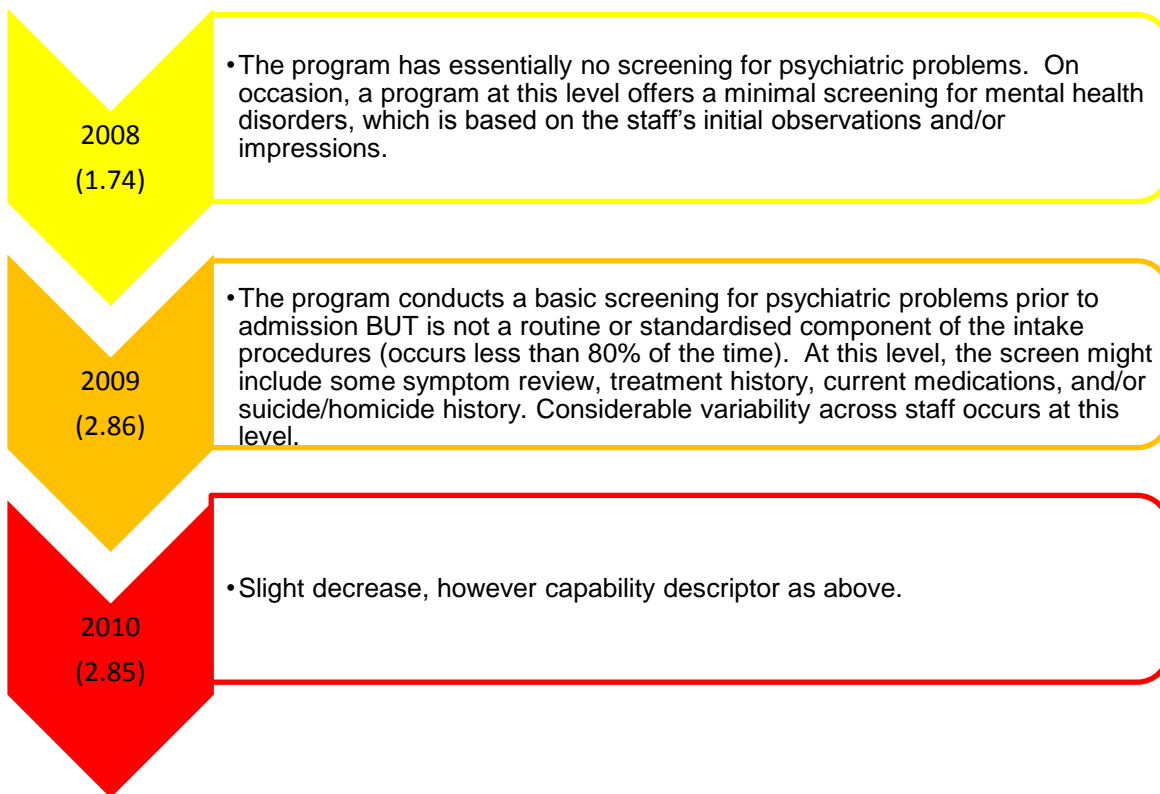
#### IIIA. Routine screening methods for psychiatric symptoms.

DDCAT definition – Programs that provide services to individuals with COD routinely and systematically screen for both substance related and mental health disorders. The following text box provides a standard definition of “screening”.

**Screening:** The purpose of screening is to determine the likelihood that a person has a co-occurring substance use or mental health disorder. The purpose is not to establish the presence or specific type of such a disorder, but to establish the need for an in-depth assessment. Screening is a formal process that typically is brief and occurs soon after the client presents for services. There are three essential elements that characterise screening: intent, formal process, and early implementation.

- Intent. Screening is intended to determine the possibility of a co-occurring disorder, not to establish definitively the presence, or absence, or specific type of such a disorder.
- Formal process. The information gathered during screening is substantially the same no matter who collects it. Although a standardised scale or test need not be used, the same information must be gathered in a consistently applied process and interpreted or used in essentially the same way for everyone screened.
- Early implementation. Screening is conducted early in a person’s treatment episode.

Year/Av Score      DDCAT descriptor for rating



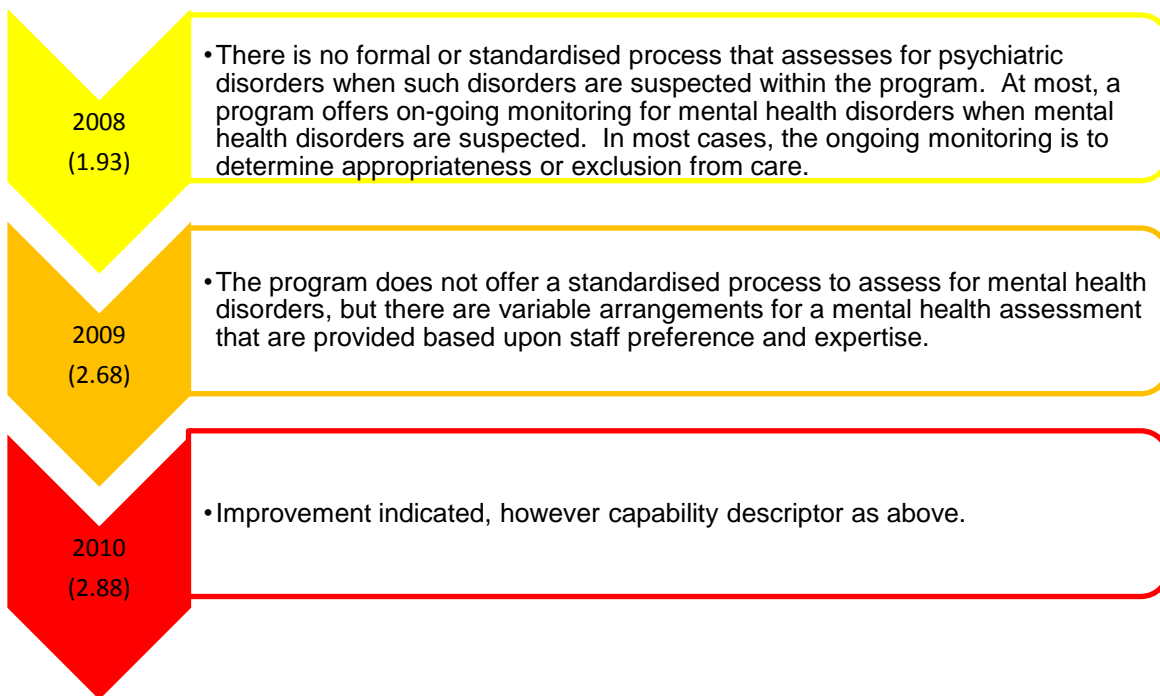
During the period, the sector's average capacity increased, but remained within the AOD only services range. In order to achieve a rating of dual diagnosis capable, the sector would need to conduct basic screening for psychiatric problems at least 80% of the time. It seems likely that the sector will achieve dual diagnosis capability in this area in the near future.

Sustainability in this area will depend upon the maintenance of a documented screening process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

### **IIIB. Routine assessment if screened positive for psychiatric symptoms.**

DDCAT definition – Programs that provide services to persons with COD should routinely and systematically assess for psychiatric problems as indicated by a positive screen. The following text box provides a standard definition of “assessment”.

Year/Av Score      DDCAT descriptor for rating



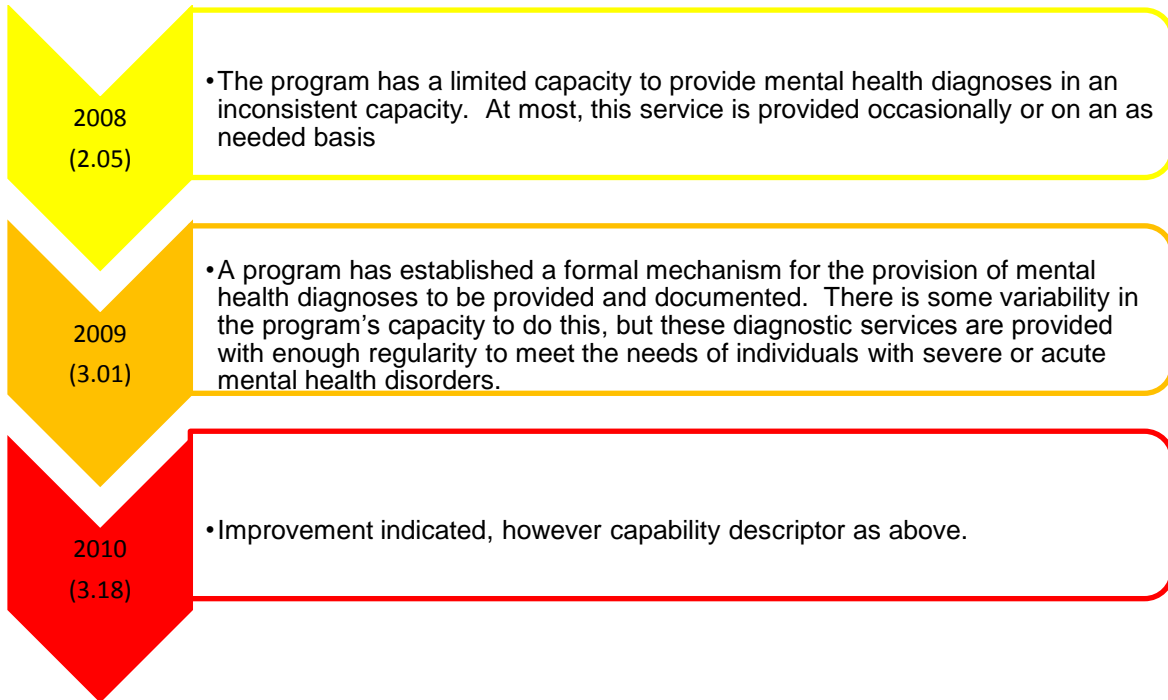
During the period, the sector's average capacity increased but remained within the AOD only services range. This would appear to be an appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis capable, organisations would need to demonstrate that programs have a regular mechanism for providing a formal mental health assessment where indicated by a positive screen.

Sustainability in this area will depend upon the maintenance of a documented assessment process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure a positive screen triggers a more thorough assessment (see section 4.6).

### **IIIC. Psychiatric and substance use diagnoses made and documented**

DDCAT definition – Programs serving persons with co-occurring disorders have the capacity to routinely and systematically diagnose both mental health disorders and substance related disorders.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. The sector appears to have developed as far as is appropriate for AOD specific services, as the capability to provide mental health diagnoses 'in-house' is required to achieve a rating of dual diagnosis enhanced.

Sustainability in this area will be dependent upon maintaining strong linkages and partnerships with the mental health sector (see section 4.4).

### **IIID. Psychiatric and substance use history reflected in client record**

DDCAT definition – COD assessment processes routinely assess and describe past history and the chronological or sequential relationship between substance related and psychiatric disorders or problems.

Year/Av Score      DDCAT descriptor for rating

2008 (2.51)	<ul style="list-style-type: none"><li>• In addition to the routine collection of substance use history, the program encourages the collection mental health history but this history is neither structured nor incorporated into the standardised assessment process. The degree and variability in collection methods varies considerably by staff preference and competency. -OR- The program provides a means of collecting a formal mental health history (as set by the standard in DDC) but the program does so only variably (&lt;80% of the time).</li></ul>
2009 (2.71)	<ul style="list-style-type: none"><li>• Improvement indicated, however capability descriptor as above.</li></ul>
2010 (3.28)	<ul style="list-style-type: none"><li>• In the course of routine collection of substance use history, there is a routine narrative section in the record that discusses mental health history within the record. -AND- This documentation occurs at least 80% of the time. This would be evident in the records of the majority of individuals assessed which would document and discuss mental health histories; even for those individuals without mental health histories there would be a narrative section where the absence of mental health related history is noted.</li></ul>

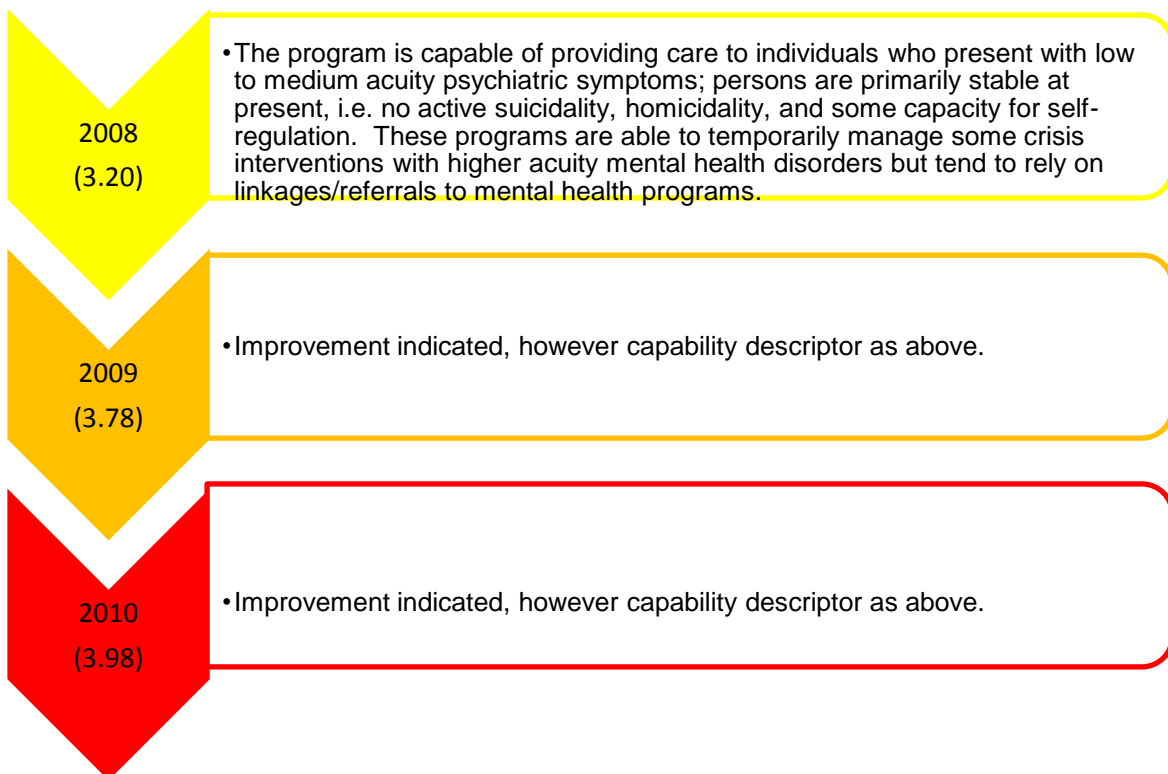
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. To achieve a rating of dual diagnosis enhanced, the sector would be required to include a specific standardised section of the assessment that is devoted to both mental health and substance misuse histories. It seems likely that with further work, the sector could achieve this.

Sustainability in this area will depend upon the maintenance of a documented assessment process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

### IIIE. Program acceptance based on psychiatric symptom acuity: low, moderate, high

DDCAT definition – Programs offering services to individuals with CODs use psychiatric symptom acuity or instability within the current presentation to assist with the determination of the individual's needs and appropriateness, and whether the program is capable of effectively addressing these needs.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased but remained within the dual diagnosis capable range. This would appear to be an appropriate level of achievement for AOD specific services, as to achieve a rating of dual diagnosis enhanced, the sector would need to develop the capability to deal with high acuity, psychiatrically unstable presentations (rather than referring to or sharing care with the mental health sector).

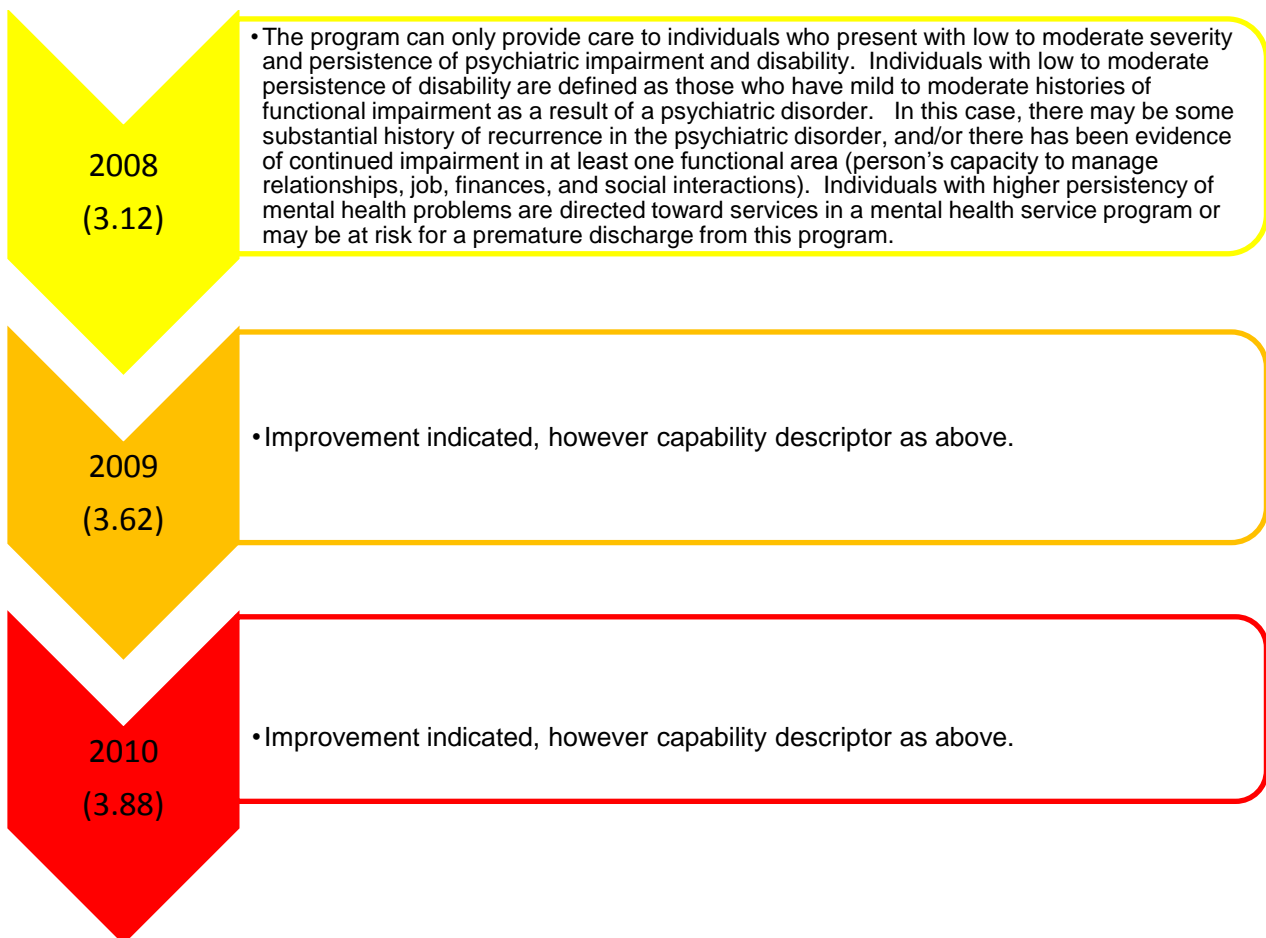
As the average sector capability was assessed as dual diagnosis capable at the commencement of the project, it seems likely that this position is sustainable over time, provided linkages and partnerships with the mental health sector are maintained (see section 4.4).



**IIIF. Program acceptance based on severity of persistence and psychiatric disability: low, moderate, high**

DDCAT definition – Programs offering services to individuals with CODs use severity as defined by the diagnosis, persistence, and disability as an indicator to assist with the determination of the individual’s needs and whether the program is capable of effectively addressing these needs.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector’s capacity increased, but remained within the dual diagnosis capable range. This would appear to be an appropriate level of achievement for AOD specific services, as to achieve a rating of dual diagnosis enhanced the sector would need to develop the capability to deal with moderate to high severity or persistence of mental health disability.

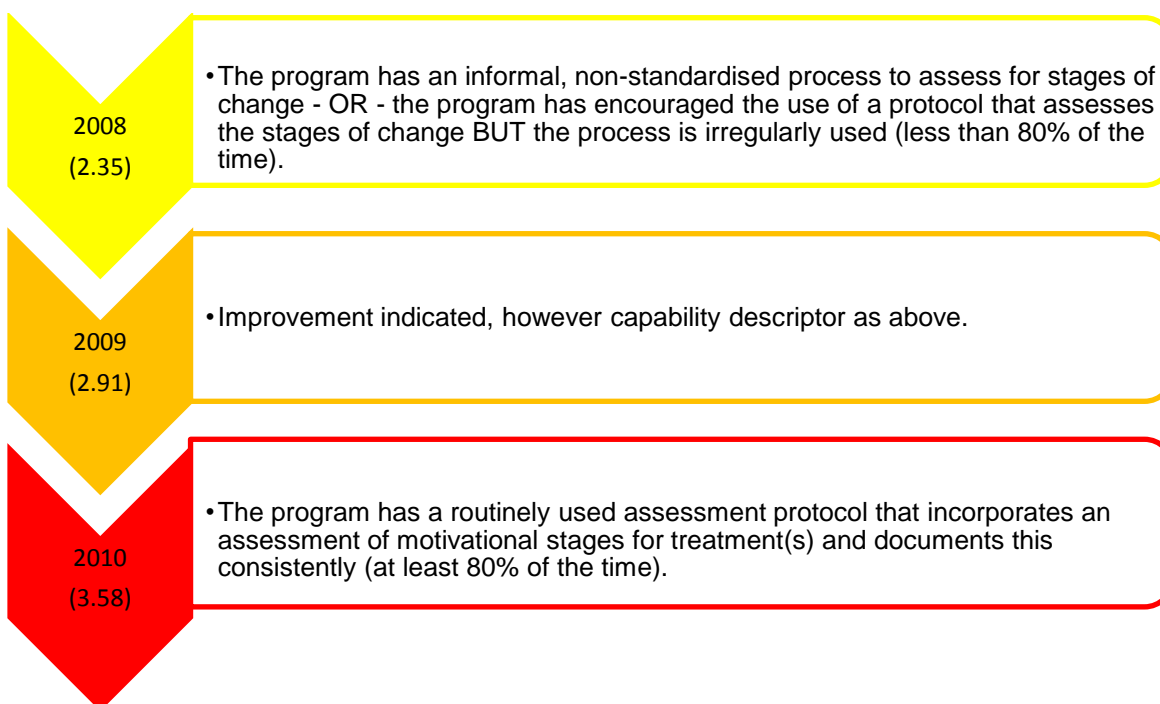
Given the average sector capability was assessed as dual diagnosis capable at the commencement of the project, it seems likely that this position is sustainable over time,

provided staff expertise is maintained through ongoing access to professional development (see section 4.3).

### IIIG. Stage-wise treatment: Initial

DDCAT definition – For individuals with substance related and mental health disorders, the assessment of readiness for change for both disorders is essential to the planning of appropriate services. The stages of change model has its origin in fostering intentional behaviour changes and has therefore been used readily in the Alcohol and Other Drug field; assessment of motivational stages across the individual's identified areas of need (including both substance related and mental health) is a more comprehensive approach and helps to more strategically and efficiently match the individual to appropriate levels of service intensities.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's capacity increased from AOD only services to dual diagnosis capable. To achieve a rating of dual diagnosis enhanced, the sector would need to demonstrate the routine use of an assessment protocol for the stage of change that incorporates the use of a standardised instrument to assess and document stages of motivation for change. This would be achievable for at least parts of the sector.

Sustainability in this area will depend upon the maintenance of a documented assessment process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection

processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

#### **4.1.4 Dimension IV: Clinical Process: Treatment**

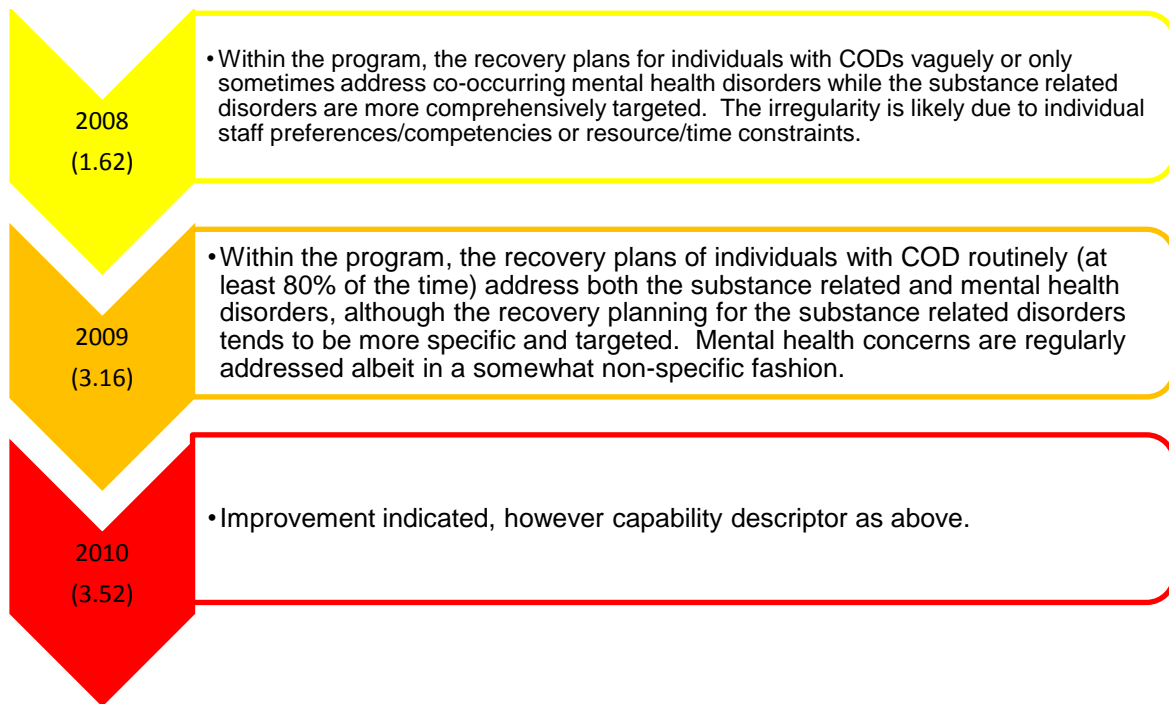
Dimension IV “examines whether specific clinical activities achieve specific benchmarks for COD...treatment” (p 6, DDCAT Toolkit, DoHA, 2008). This dimension includes ten index items: recovery plans; assess and monitor interactive courses of both disorders; procedures for psychiatric emergencies and crisis management; stage-wise treatment (ongoing); policies and procedures for medication evaluation, management, monitoring and adherence; specialised interventions with mental health content; education about psychiatric disorder and its treatment, and interaction with substance use and its treatment; family education and support; specialised interventions to facilitate use of (COD) self help groups; and peer recovery supports for clients with mental health.

During the period, assessment against seven of the ten index items (IVA, IVB, IVD, IVE, IVF, IVG and IVH) increased from AOD only services to dual diagnosis capable services, the remaining three index items (IVC, IVI and IVJ) increased but remained within the AOD only services range. Performance against each of the index items is detailed below.

#### **IVA Recovery Plans**

DDCAT definition – In the treatment of individuals with CODs, the recovery plans indicate that both the psychiatric disorder as well as the substance related disorder will be addressed.

Year/Av Score      DDCAT descriptor for rating



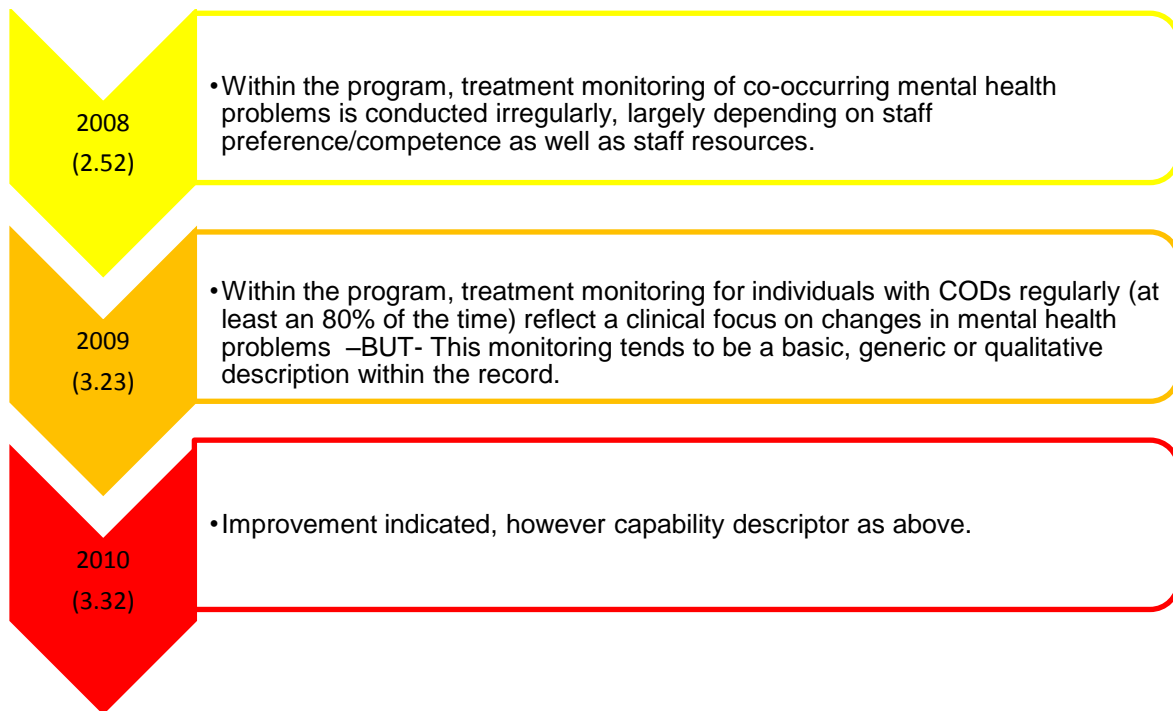
During the period, the sector’s average capacity increased from AOD only services to dual diagnosis capable. This would appear to be the appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis enhanced, organisations would need to demonstrate that recovery planning regularly and equivalently addressed both substance related and mental health disorders.

Sustainability in this area will depend upon the maintenance of a documented treatment planning process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

**IVB. Assess and monitor interactive courses of both disorders**

DDCAT definition – In the treatment of persons with CODs, the continued assessment and monitoring of substance related and mental health disorders as well as the interactive course of the disorders is necessary.

Year/Av Score      DDCAT descriptor for rating



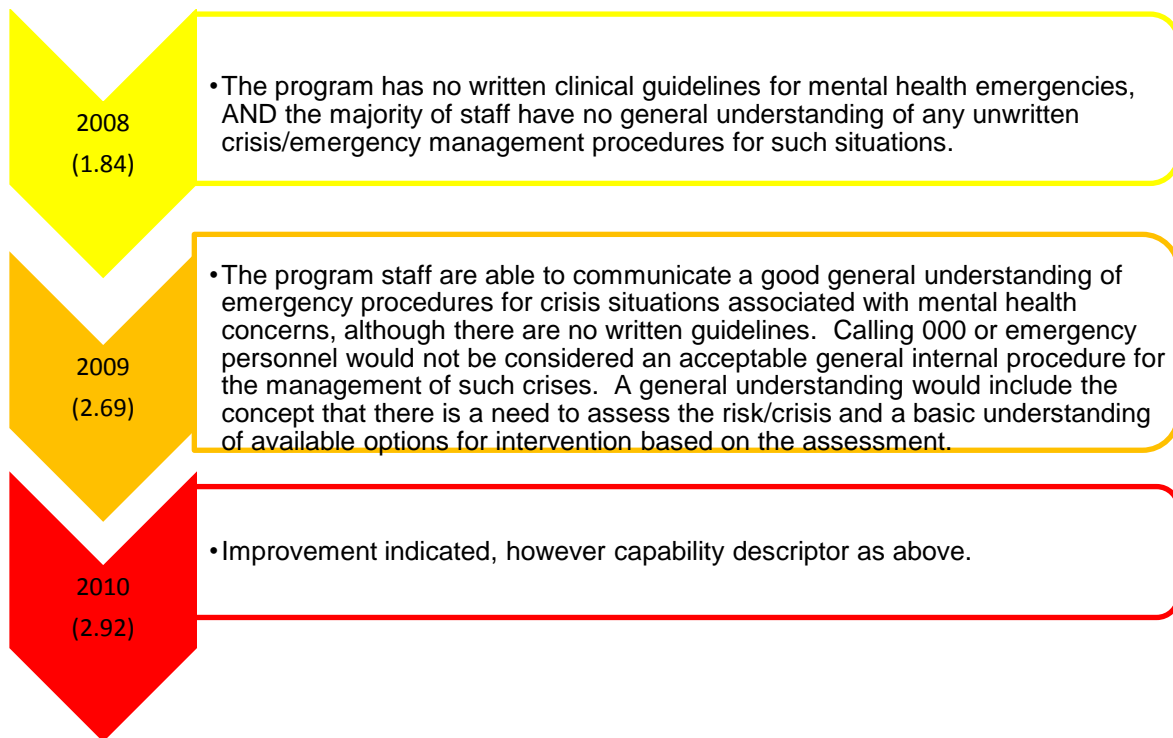
During the period, the sector’s average capacity increased from AOD only services to dual diagnosis capable. This would appear to be the appropriate level of achievement for AOD specific services, as to achieve a rating of dual diagnosis enhanced, the sector would be required to demonstrate a detailed, systematic and in-depth focus on both mental health and substance related concerns for at least 80% of consumers with identified co-morbidity.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

**IVC. Procedures for psychiatric emergencies and crisis management.**

DDCAT definition – Programs that treat individuals with CODs use specific clinical guidelines to manage crisis and mental health emergencies, according to documented protocols.

Year/Av Score      DDCAT descriptor for rating



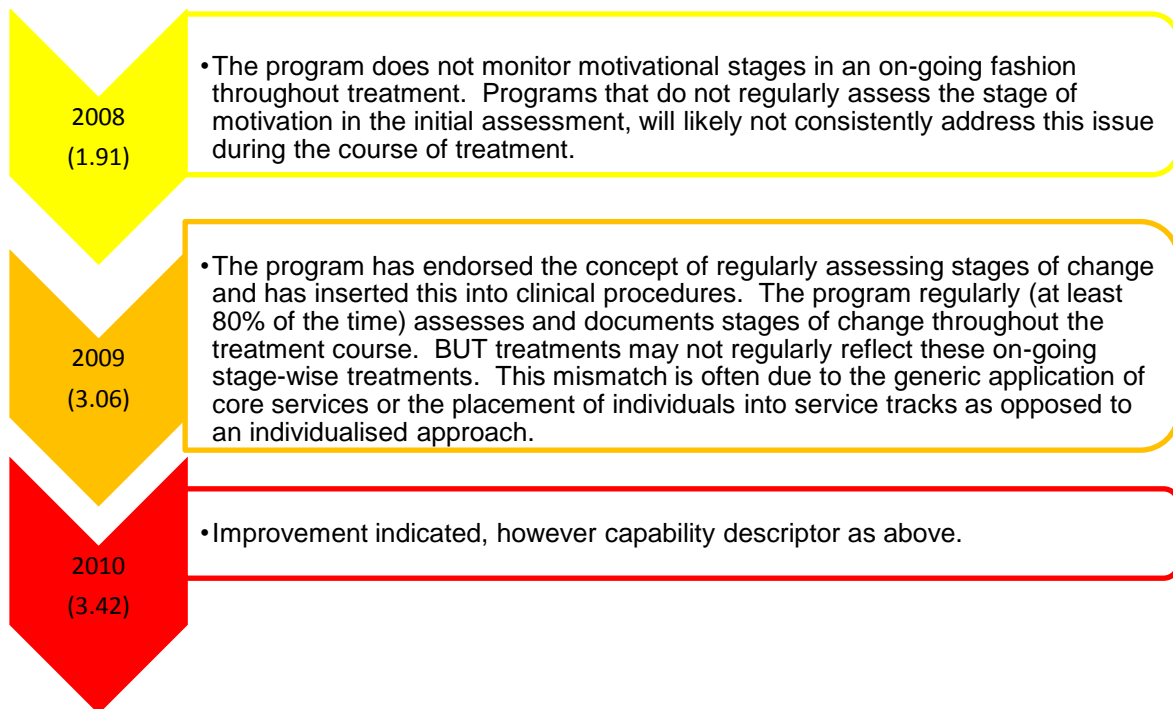
During the period, the sector's average capacity increased, but remained within the AOD only services range. To achieve dual diagnosis capability, written guidelines for mental health crisis/emergency management that includes a standard risk assessment that captures mental health emergencies would need to be developed. The written guidelines would also define the available intervention strategies that are matched to the assessed risk, though some of these strategies would include linkage with other providers or entities. It seems reasonable to assume that with minimal further work, the sector could achieve dual diagnosis capability in the future.

Sustainability in this area will depend upon the maintenance of written guidelines for crisis management (see section 4.2), maintaining staff expertise through ongoing access to professional development (see section 4.3) and some type of monitoring of crisis management processes (see section 4.6).

**IVD. Stage-wise treatment ongoing**

DDCAT definition – Within programs that treat individuals with COD, ongoing assessment of readiness to change contributes to the determination of continued services which appropriately fit that stage, in terms of treatment content, intensity, and utilisation of outside agencies.

Year/Av Score      DDCAT descriptor for rating



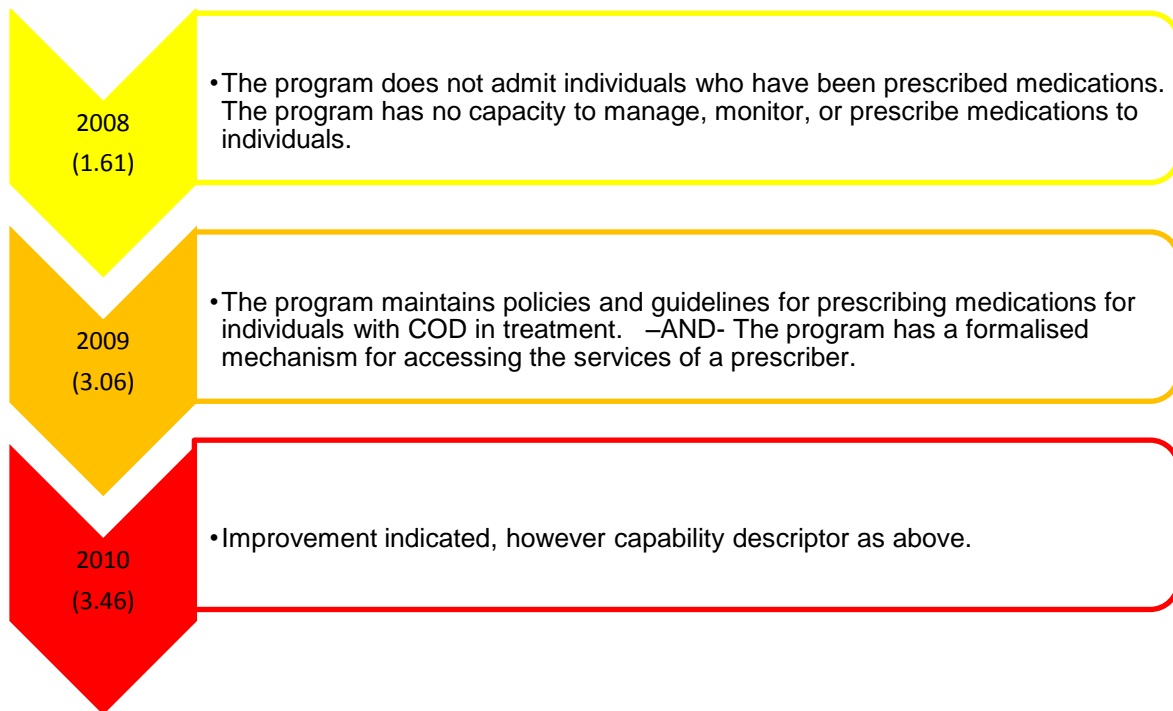
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. Considering the progress made over the period, it appears that with further work, at least parts of the sector could achieve a rating of dual diagnosis enhanced in the future. The requirement for a rating of dual diagnosis enhanced is that motivational stages are regularly re-assessed and documented.

Sustainability in this area will depend upon the maintenance of a documented assessment process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

**IVE. Policies and procedures for medication evaluation, management, monitoring, and adherence**

DDCAT definition – Programs that treat individuals with COD are capable of evaluating medication needs, coordinating and managing medication regimens, monitoring for adherence to regimens, and responding to any challenges or difficulties with medication adherence, as documented in policy/procedure.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capacity for AOD specific services, as to achieve a rating of Dual Diagnosis Enhanced, organisations would need to demonstrate that the staff included a person who is a prescriber and is fully integrated into the program's treatment team.

Sustainability in this area will depend upon the maintenance of prescribing policies and guidelines (see section 4.2) and the maintenance of linkages with prescribers (see section 4.4).

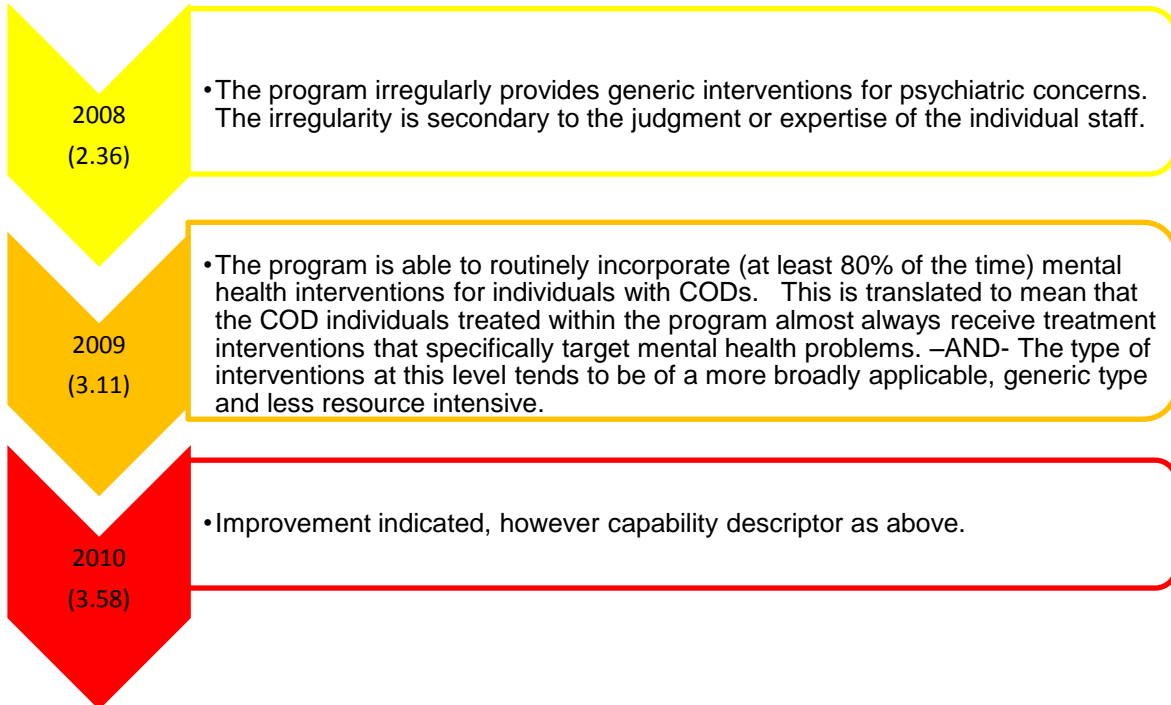
#### **IVF. Specialised interventions with mental health content**

DDCAT definition – Programs that treat individuals with COD utilise specific therapeutic interventions and practices that target specific mental health symptoms and disorders. There is a broad array of interventions and practices that can be effectively integrated into the treatment of individuals with co-occurring disorders that target mental health symptoms and disorders. Some interventions can be generically applied to programs; these interventions might include stress management, relaxation training, anger management, coping skills, assertiveness training, and problem solving, etc. [In some cases, Alcohol and Other Drug treatment programs may already use some of these techniques in the treatment of substance related disorders.] Other more advanced mental health interventions that could be applied to persons with CODs include brief motivational or cognitive behavioural



therapies that target specific disorders such as: PTSD, depression, anxiety disorders, and Axis II disorders.

Year/Av Score      DDCAT descriptor for rating



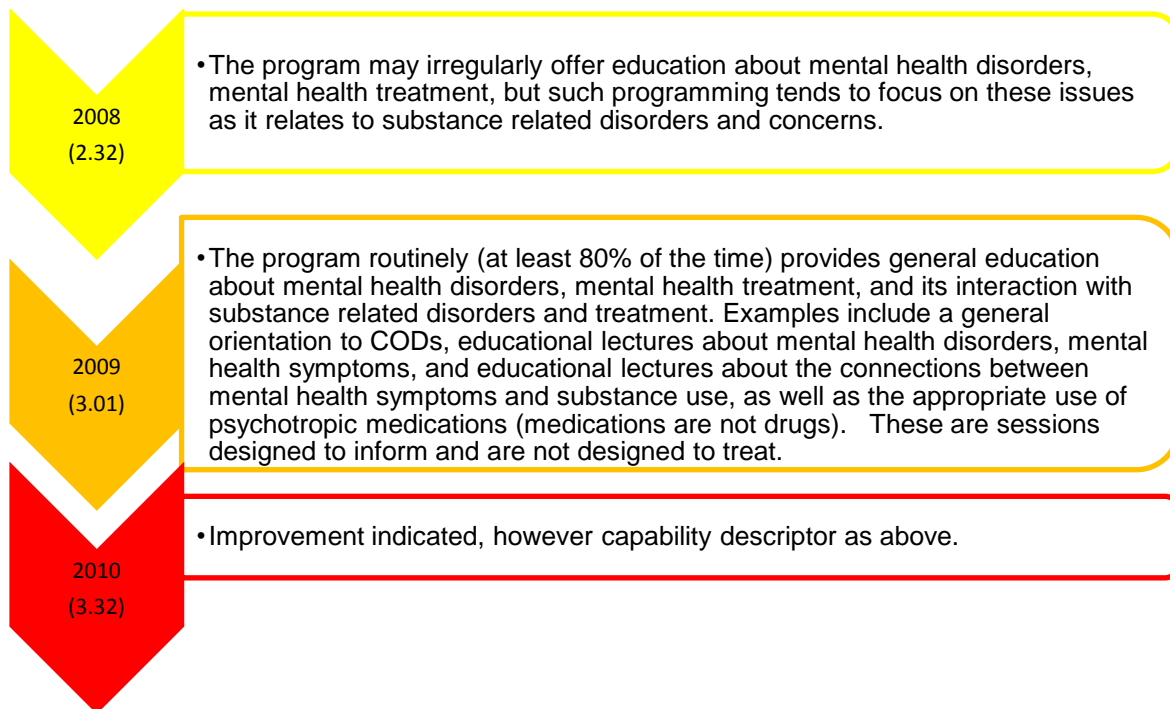
During the period, the sector’s average capacity increased from AOD only services to dual diagnosis capable. This would seem to be an appropriate level of capability for the AOD sector, as to achieve a rating of dual diagnosis enhanced requires more individualised and skilled interventions that target specific mental health disorders.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

**IVG. Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment**

DDCAT definition – Programs that offer treatment to individuals with COD provide education about mental health and substance related disorders, including treatment information and the characteristics and features of both types of disorders as well as the interactive course of the disorders.

Year/Av Score      DDCAT descriptor for rating



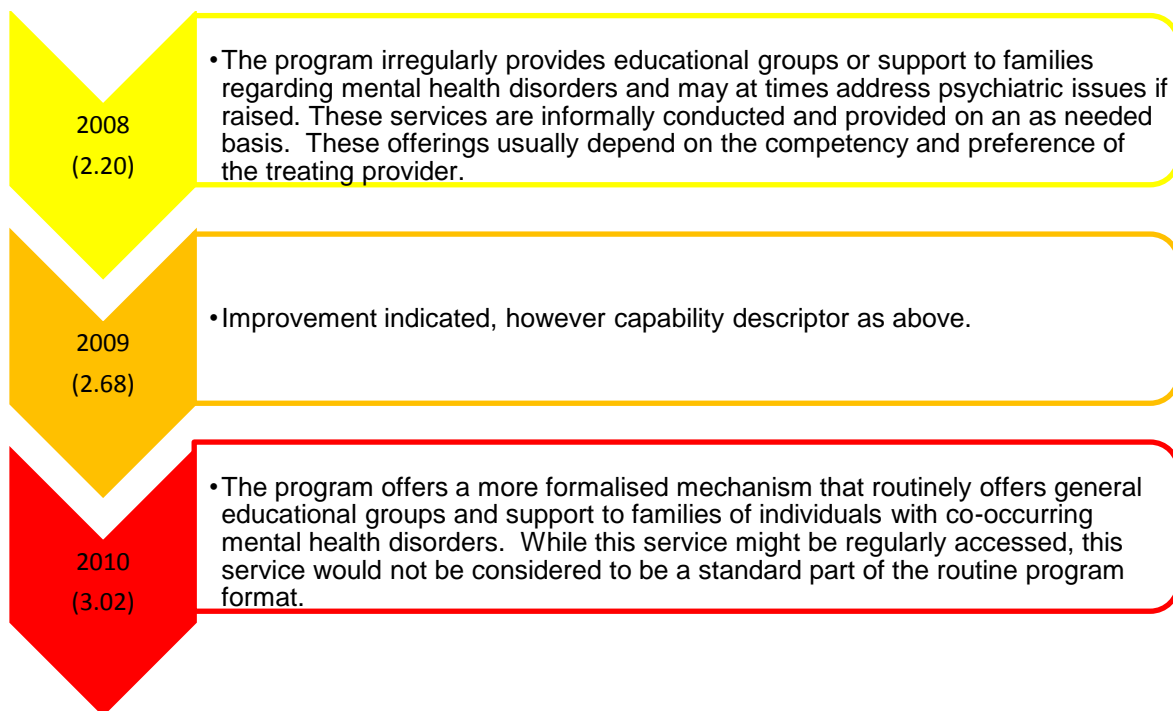
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. This would seem to be an appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis enhanced requires more individualised instruction that addresses specific issues within mental health disorders.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

#### **IVH. Family education and support.**

DDCAT definition – Programs that offer treatment to individuals with COD provide education and support to the individuals' family members (or significant others) regarding CODs, including treatment information and the characteristics and features of both types of disorders in order to educate collaterals about realistic expectations and the interactive course of the disorders.

Year/Av Score      DDCAT descriptor for rating



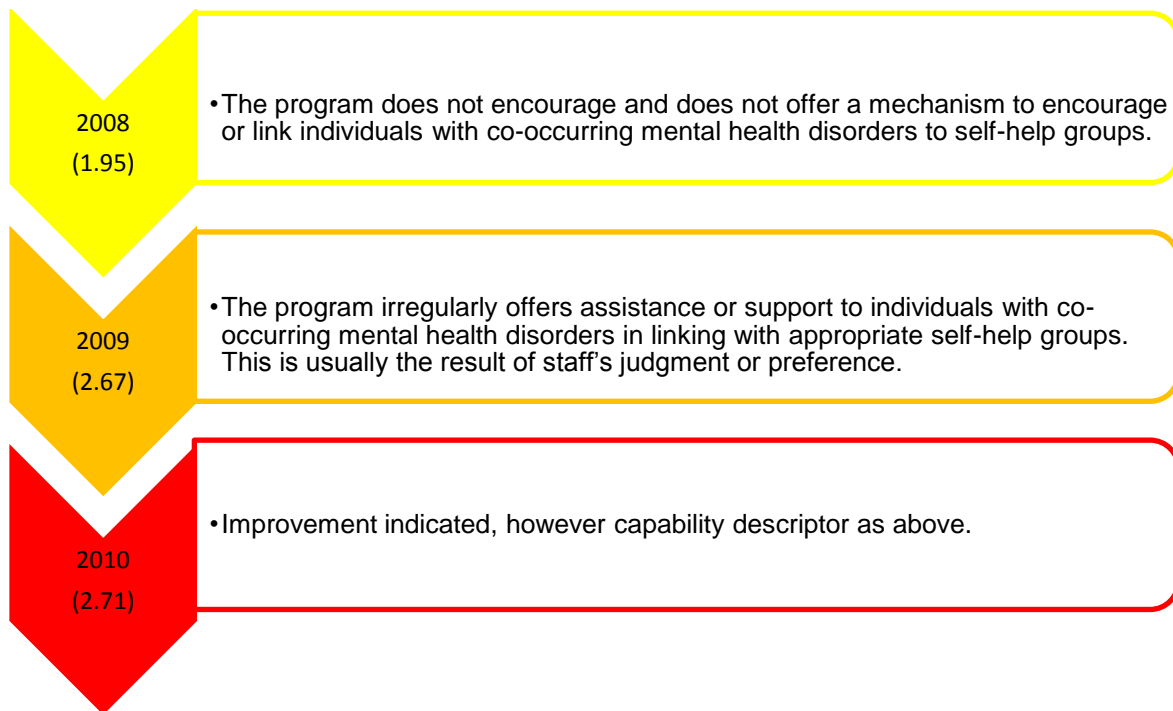
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. It would appear that, depending on demand from consumers, at least some organisations would be able to achieve a rating of dual diagnosis enhanced, which requires that the majority of families of individuals with COD attend specific education and support groups for families of individuals with COD.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of treatment planning processes to ensure the benchmark of 80% is met (see section 4.6).

#### **IVI. Specialised interventions to facilitate use of (COD) self-help groups**

DDCAT definition – Substance abuse programs that offer treatment to individuals with COD provide assistance to individuals in developing a support system through self-help groups. Individuals with mental health symptoms and disorders often face additional barriers in linking with self-help groups and require additional assistance such as being referred/ accompanied/ introduced to self-help groups by clinical staff, designated liaisons, or mutual self-help group peer volunteers. Specific issues related to the use of pharmacotherapy by individuals with COD also require additional education and guidance with regard to linking with self help groups.

Year/Av Score      DDCAT descriptor for rating

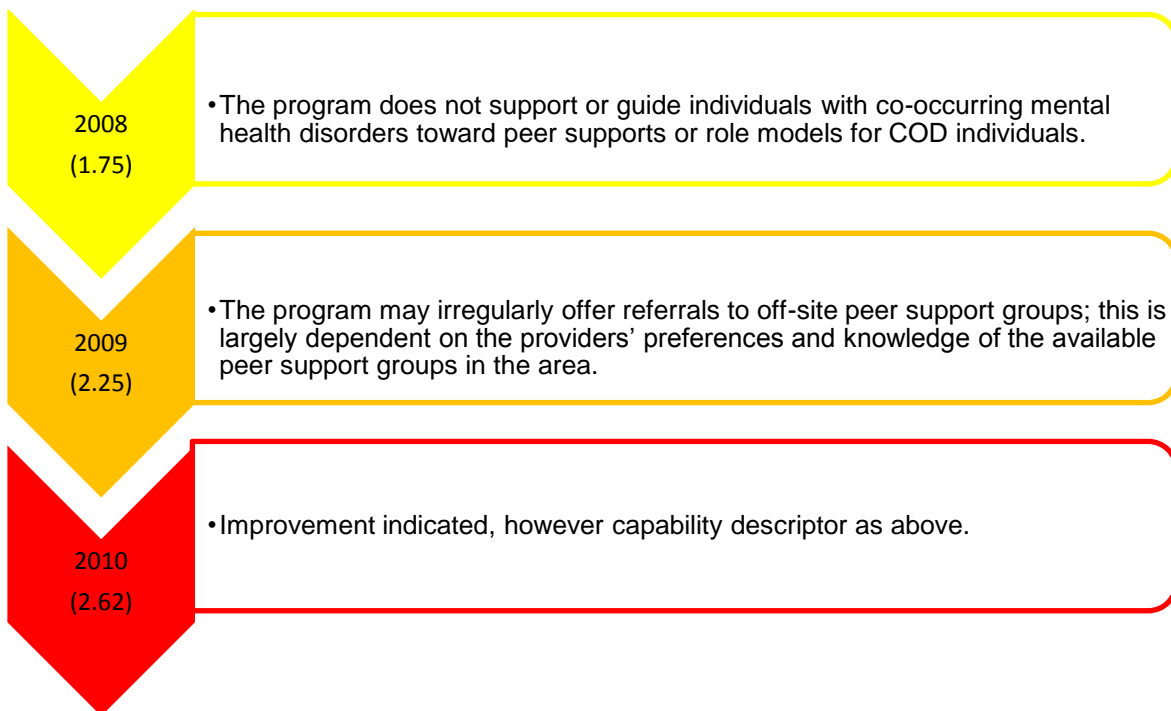


During the period, the sector's average capacity increased but remained within the AOD only services range. To achieve dual diagnosis capability, the sector would need to demonstrate routinely encouraging the use of self-help groups for their consumers with co-occurring mental health disorders. It may be that there is a lack of self-help groups in WA for organisations to refer or link consumers with co-occurring mental health disorders.

#### **IVJ. Peer recovery supports for clients with MH**

DDCAT definition – Substance abuse programs that offer treatment to individuals with a co-occurring mental disorder encourage and support the use of peer supports and role models that include consumer liaisons, alumni groups, etc.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased but remained within the AOD only services range. To achieve dual diagnosis capability, the sector would need to demonstrate routine attempts to refer and link individuals with co-occurring mental health disorders to peer supports and role models located off site. It may be that there is a lack of peer supports and role models in WA for organisations to refer or link consumers with co-occurring mental health disorders.

#### 4.1.5 Dimension V: Continuity of Care

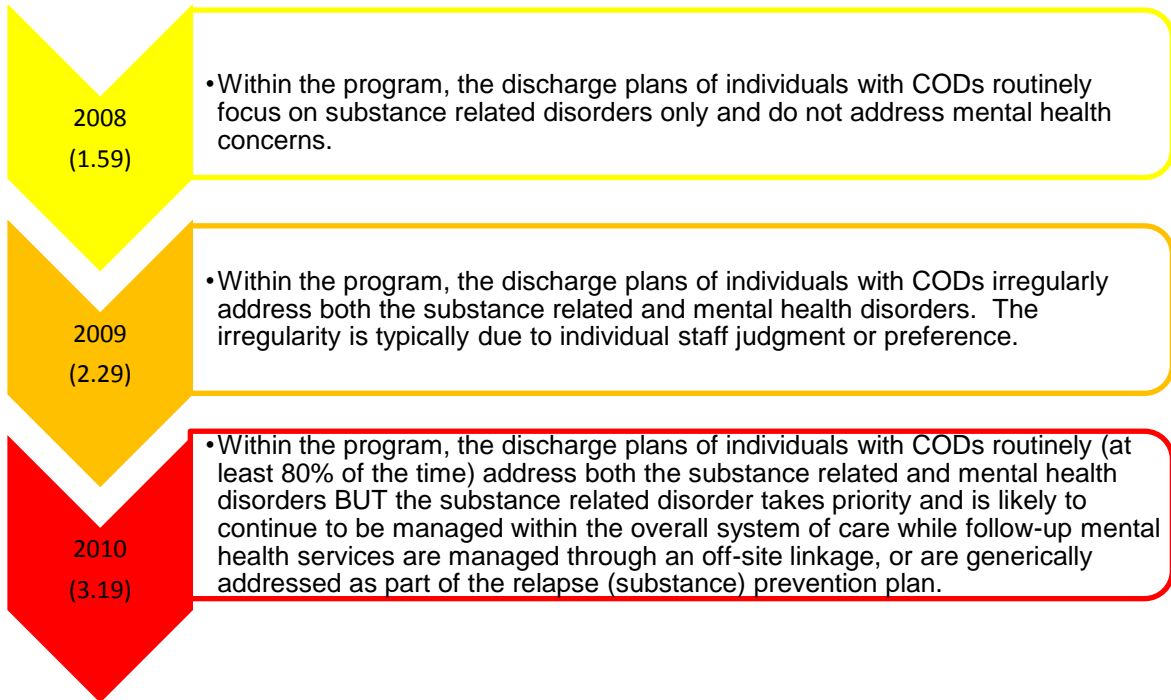
Dimension V "examines the long-term treatment issues and external supportive care issues commonly associated with persons who have COD" (p 6, DDCAT Toolkit, DoHA, 2008). This dimension includes five index items: co-occurring disorder addressed in discharge planning process; capacity to maintain treatment continuity; focus on ongoing recovery issues for both disorders; facilitation of self-help support groups for COD is documented; and sufficient supply and adherence plan for medications is documented.

During the period, assessment against three of the five index items (VA, VB and VC) increased from AOD only services to dual diagnosis capable services and the remaining two index items (VD and VE) increased but remained within the AOD only services range. Performance against each of the index items is detailed below.

## VA. Co-occurring disorder addressed in discharge planning process

DDCAT definition – Programs that offer treatment to individuals with a co-occurring mental health disorder develop discharge plans that include an equivalent focus on needed follow-up services for both psychiatric and substance related disorders.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capacity for AOD Specific Services, as to achieve a rating of dual diagnosis enhanced, organisations would need to demonstrate that equivalent emphasis is placed on both substance related and mental health disorders in discharge planning.

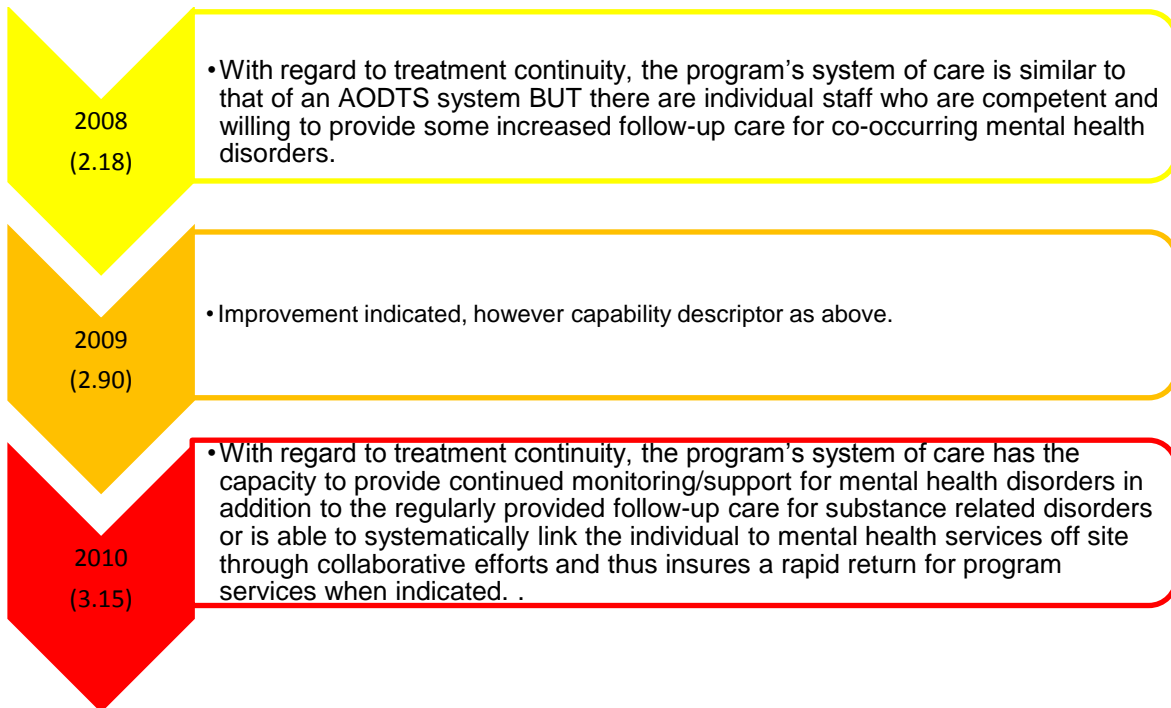
Sustainability in this area will depend upon the maintenance of a documented discharge process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the maintenance of linkages and partnerships with the mental health sector (see section 4.4), the continuing integrity of data collection processes (see section 4.5), and some type of monitoring of discharge planning processes to ensure the required benchmark of 80% is met (see section 4.6).

## VB. Capacity to maintain treatment continuity

DDCAT definition – There should be a formal mechanism for providing on-going needed mental health follow-up. The program emphasises continuity of care within the program's

scope of practice but if a linkage with another level of care is necessary it sets forth the expectation that treatment continues indefinitely with a goal of illness management.

Year/Av Score      DDCAT descriptor for rating



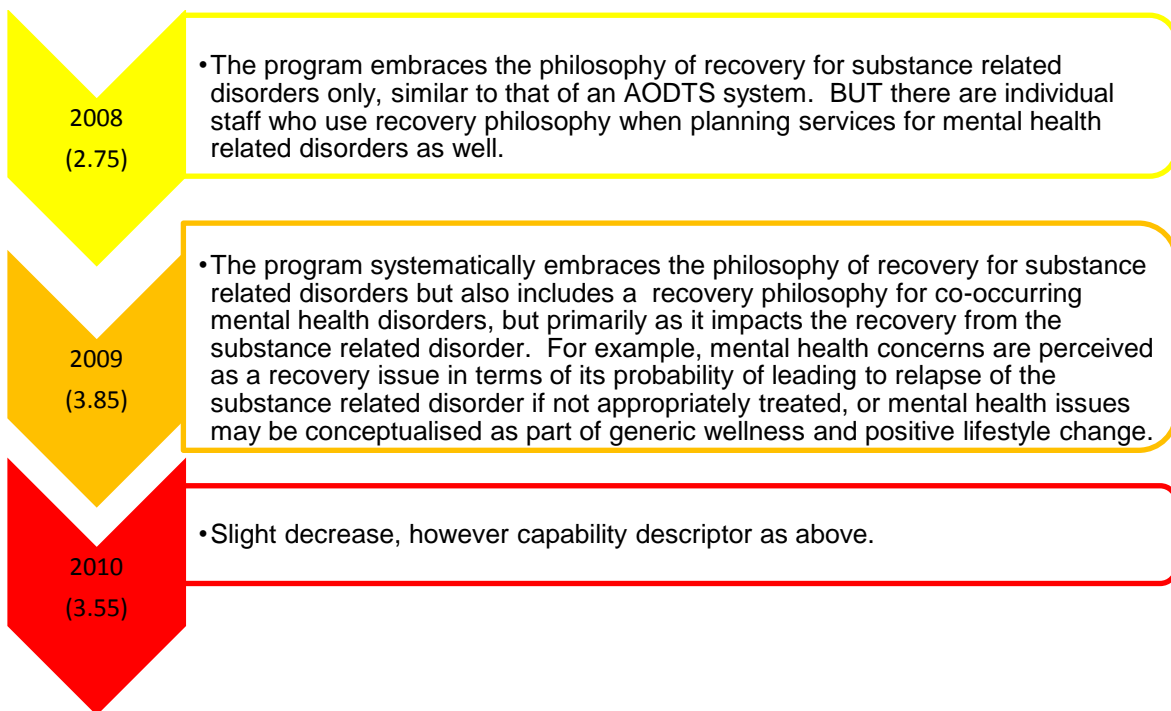
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis enhanced the sector must demonstrate the capacity to monitor and treat both mental health disorders and substance related disorders over an extended or indefinite period.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3), and the maintenance of linkages and partnerships with the mental health sector (see section 4.4).

#### **VC. Focus on ongoing recovery issues for both disorders**

DDCAT definition – Programs that offer services to individuals with COD support the use of a recovery philosophy (vs. symptom remission only) for both substance related as well as mental health disorders.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capability for the AOD sector, as to achieve a rating of dual diagnosis enhanced the sector must demonstrate that equivalent focus is placed on mental health and substance use disorders.

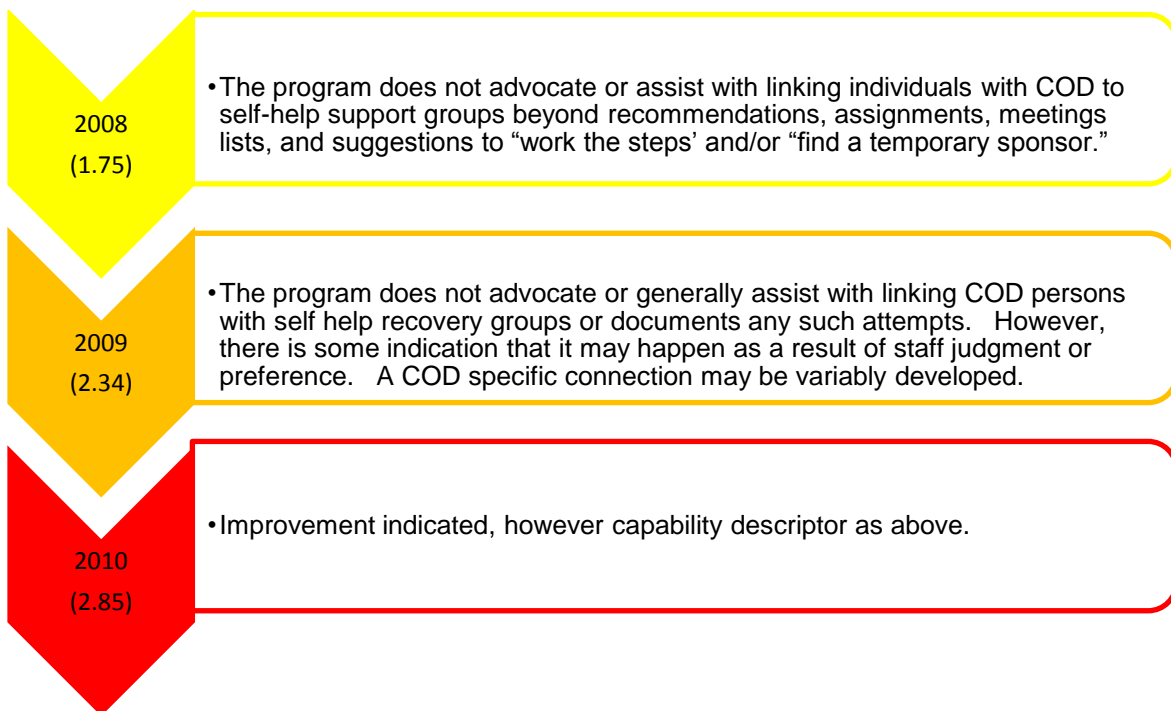
Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3), the maintenance of linkages and partnerships with the mental health sector (see section 4.4).

#### **VD. Facilitation of self-help support groups for COD is documented**

DDCAT definition – Programs that offer services to individuals with COD anticipate difficulties that the individuals with COD might experience when linking or continuing with self-help support groups and thus provide the needed assistance to support this transition beyond active treatment.



Year/Av Score      DDCAT descriptor for rating



During the period, the sector’s average capacity increased but remained within the AOD only services range. To achieve dual diagnosis capability, the sector would need to demonstrate facilitating the process of linking individuals with COD to self-help recovery groups at discharge. It may be that there is a lack of self-help groups in WA for organisations to refer or link consumers with co-occurring mental health disorders.

**VE. Sufficient supply and adherence plan for medications is documented**

DDCAT definition – Programs that serve individuals with a co-occurring mental health disorder have the capacity to assist these individuals with psychotropic medication planning, prescription and medication access and monitoring, and providing sufficient supplies of medications at discharge.

Year/Av Score      DDCAT descriptor for rating

2008 (1.03)	<ul style="list-style-type: none"><li>•When an individual with a co-occurring mental health disorder is discharged, the program does not offer any accommodations with regard to medication planning or supplies other than recommending the individual consult with a prescriber or making an appointment on her/his behalf.</li></ul>
2009 (1.61)	<ul style="list-style-type: none"><li>•Improvement indicated, however capability descriptor as above.</li></ul>
2010 (2.64)	<ul style="list-style-type: none"><li>•Improvement indicated, however capability descriptor as above.</li></ul>

During the period, the sector's average capacity increased but remained within the AOD only services range. This appears to be an appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis capable, organisations would need to demonstrate that they can provide for medication planning (up to 30 days post discharge).

#### 4.1.6 Dimension VI: Staffing

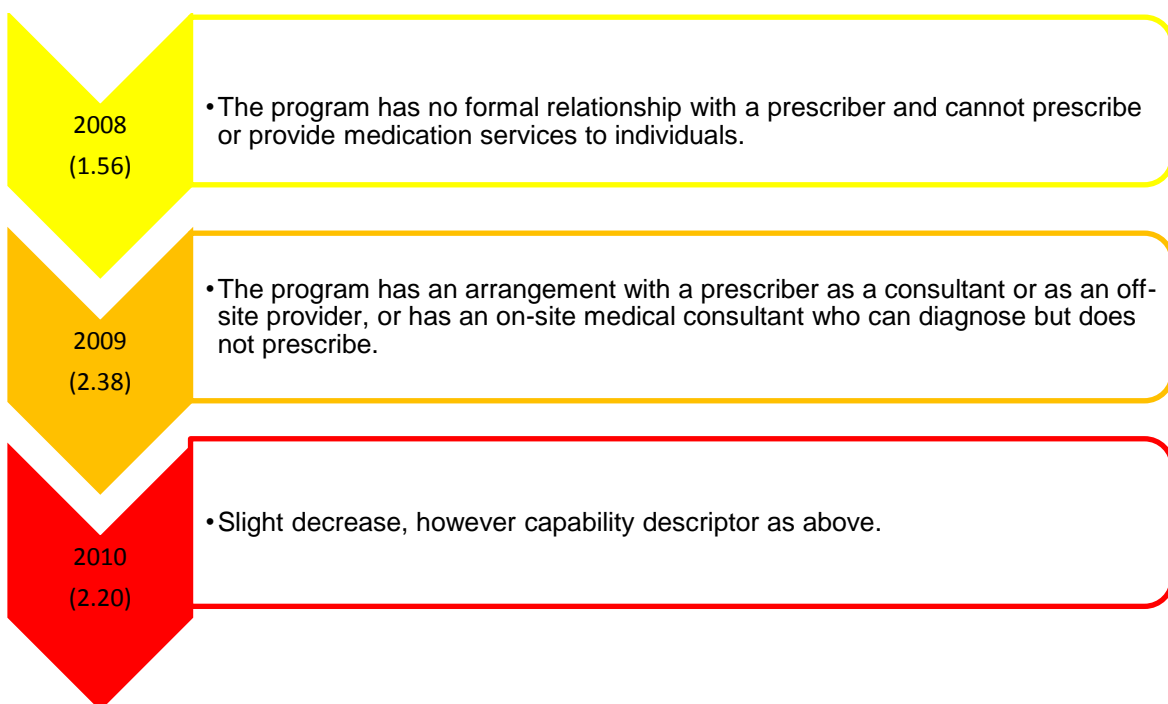
Dimension VI "examines staffing patterns and operations that support COD assessment and treatment" (p 6, DDCAT Toolkit, DoHA, 2008). This dimension includes five index items: psychiatrist or other prescriber; on-site staff with MH qualifications or formal training; access to mental health supervision or consultation; supervision, case management or utilisation review procedures emphasise and support COD treatment; and peer/alumni supports are available with COD.

During the period, assessment against three of the five index items (VIB, VIC and VID) increased from AOD only services to dual diagnosis capable services and the remaining two index items (VIA and VIE) increased but remained within the AOD only services range. Performance against each of the index items is detailed below.

## VIA. Psychiatrist or other prescriber

DDCAT definition – Programs that offer treatment to individuals with COD offer pharmacotherapy for both the mental health disorder as well as the substance related disorder through the services of prescribing professionals. These programs may have a formal relationship with a psychiatrist, physician, or nurse practitioner who works with the clinical team to increase medication adherence, to decrease the use of potentially addictive medications such as benzodiazepines, and to offer medications such as disulfiram, naltrexone, or acamprosate that may help to reduce addictive behaviour.

Year/Av Score      DDCAT descriptor for rating

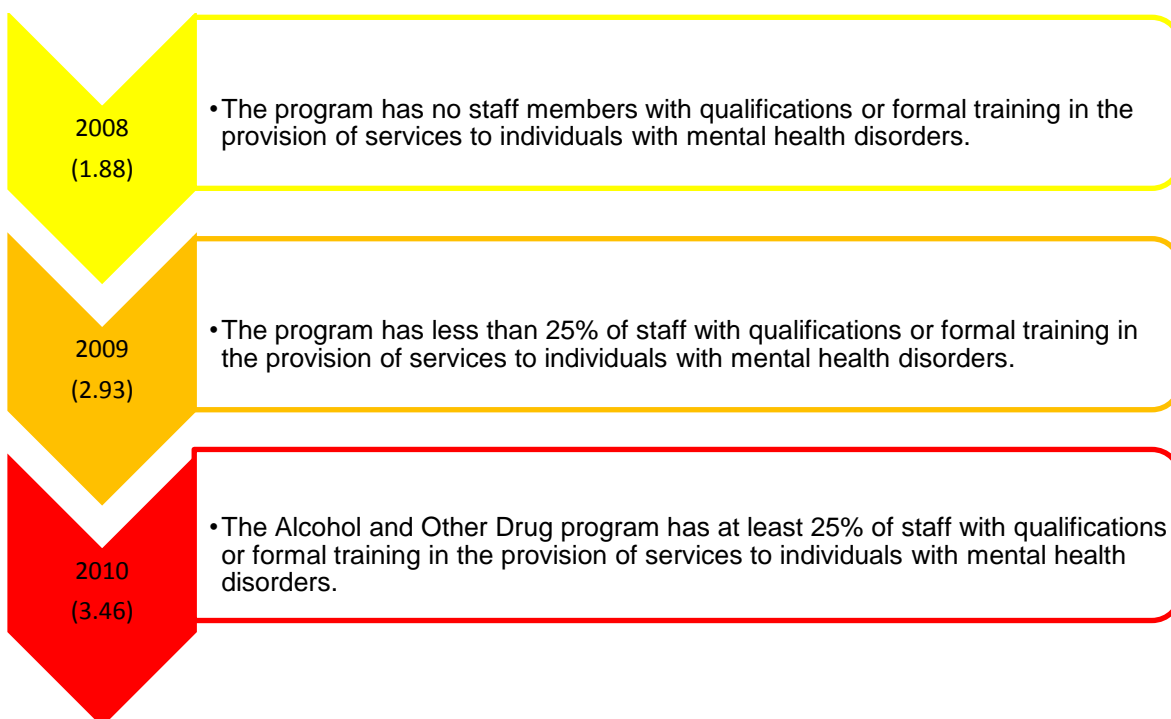


During the period, the sector's average capacity increased but remained within the AOD only services range. This would appear to be an appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis capable, organisations would need to demonstrate a relationship with a consultant or contractor who provides prescribing services on site. It may be that the level of severity and persistence of co-occurring disorders is such that organisations have been able to manage prescribing requirements through an off-site relationship, or that prescribers have been reluctant to commit to providing services on site.

## **VIB. On site staff with MH qualifications or formal training**

DDCAT definition – Substance abuse programs that offer treatment to individuals with COD employ persons with mental health qualifications or formal training to enhance their capacity to treat the complexities of mental health disorders that co-occur with substance related disorders.

Year/Av Score      DDCAT descriptor for rating



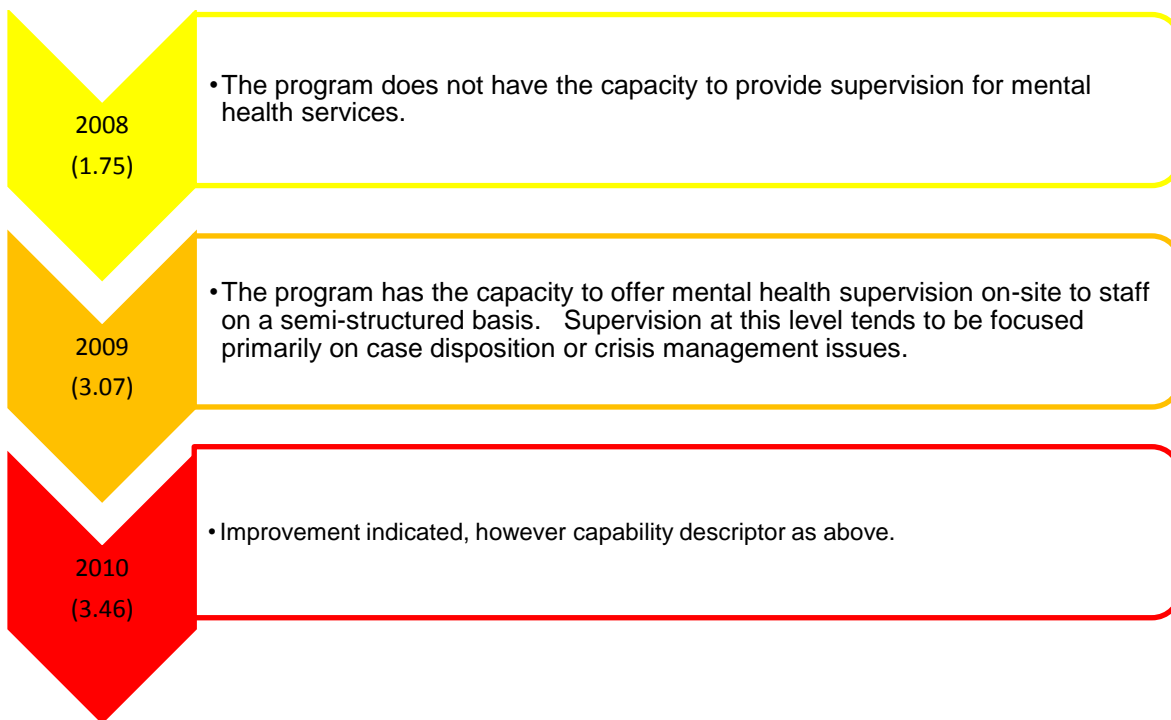
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. To achieve a rating of dual diagnosis enhanced, at least 50% of staff would need to have formal mental health training. Given the progress made from 2008 – 2010, it seems reasonable that if dedicated professional development funding were provided recurrently, this may be achievable for some organisations, though staff turnover would pose a significant barrier to the maintenance of such a high proportion of formally trained staff.

Sustainability in this area will depend upon the maintenance of staff expertise through ongoing access to professional development (see section 4.3).

## **VIC. Access to mental health supervision or consultation**

DDCAT definition – Programs that offer treatment to individuals with a co-occurring mental health disorder provide formal mental health supervision for trained providers of mental health services who are unqualified or who have insufficient competence or experience in the treatment setting.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. To achieve a rating of dual diagnosis enhanced, supervision would need to be structured and focussed on assessment and/or treatment skill development. With further work, this may be achievable for some parts of the sector.

Sustainability in this area will depend upon the maintenance of a documented clinical supervision process (see section 4.2) and maintenance of staff expertise through ongoing access to professional development (see section 4.3).

**VID. Supervision, case management or utilisation review procedures emphasise and support COD treatment**

DDCAT definition – Programs that offer treatment to individuals with a co-occurring mental health disorder conduct COD-specific case reviews or engage in a formal utilisation review process of COD cases in order to continually monitor the appropriateness and effectiveness of services for this population.

Year/Av Score      DDCAT descriptor for rating

2008 (2.11)	<ul style="list-style-type: none"><li>•The program has an off-site consultant who occasionally conducts reviews of COD cases. Documentation may not be available and appears to be a largely unstructured and informal process.</li></ul>
2009 (2.78)	<ul style="list-style-type: none"><li>•Improvement indicated, however capability descriptor as above.</li></ul>
2010 (3.46)	<ul style="list-style-type: none"><li>•The program has a regular procedure for reviewing co-occurring mental health cases through supervision or utilisation review by an on-site supervisor. This process is not routine or systematically on only COD cases but is a regular procedure within the program that allows for the review of COD cases. There is some minimal documentation that supports the consideration of COD services within this process (e.g. weekly staffing meetings).</li></ul>

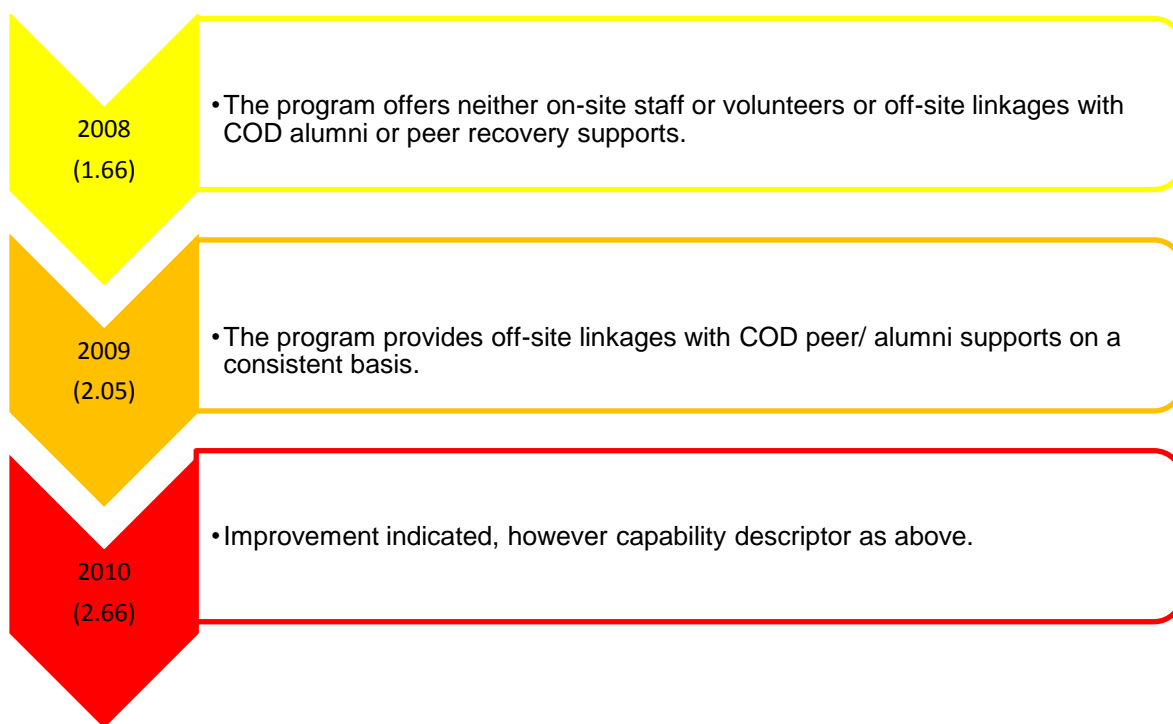
During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. This would appear to be an appropriate level of capability for AOD specific services, as to achieve a rating of dual diagnosis enhanced the sector must demonstrate a systematic and critical review of targeted interventions for COD cases in order to determine appropriateness or effectiveness.

Sustainability in this area will depend upon the maintenance of a documented clinical supervision process (see section 4.2), maintenance of staff expertise through ongoing access to professional development (see section 4.3), the continuing integrity of data collection processes (see section 4.5) to identify COD cases.

#### **VIE. Peer/Alumni supports are available with COD**

DDCAT definition – Programs that offer treatment to individuals with co-occurring mental health disorders maintain staff or enlist volunteers who can serve as COD peer/alumni supports.

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased but remained within the AOD only services range. To achieve dual diagnosis capability, the sector would need to demonstrate it provides off site linkages with COD peer/alumni supports on a consistent basis. It may be that there is a lack of peer/alumni supports in WA for organisations to refer or link consumers with co-occurring mental health disorders.

#### 4.1.7 Dimension VII: Training

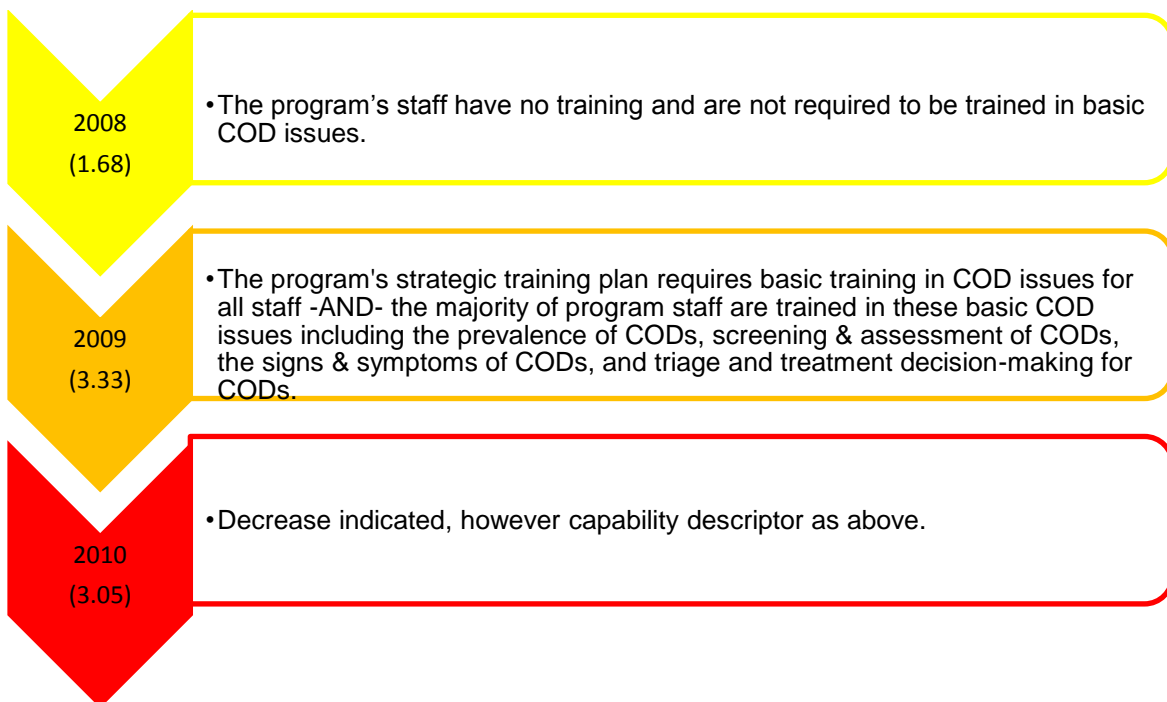
Dimension VII "measures the appropriateness of training and supports that facilitate the capacity of staff to treat persons with COD" (p 6, DDCAT Toolkit, DoHA, 2008). This dimension includes two index items: basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders; and staff are cross-trained in mental health and substance use disorders, including pharmacotherapies.

During the period, assessment for index item VIIA increased from AOD only services to dual diagnosis capable, while index item VIIB increased but remained within the AOD only services range. Performance against each of the index items is detailed below.

## VIIA. Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders

DDCAT definition – Programs that provide treatment to individuals with co-occurring mental health disorders have staff with basic skills and/or training in the prevalence of CODs, the screening & assessment of CODs, the signs & symptoms of CODs, and in triage and treatment decision-making

Year/Av Score      DDCAT descriptor for rating



During the period, the sector's average capacity increased from AOD only services to dual diagnosis capable. Interview participants attributed the decrease in capability from 2009 to 2010 to staff mobility within the sector. This would appear to be an ongoing issue that will affect the WA AOD Sector's ability to maintain dual diagnosis capability.

Sustainability in this area will depend upon the continued availability of funding for professional development activities (see section 4.3).

## VIIB. Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies.

DDCAT definition – Programs that offer treatment to individuals with CODs support cross-training of their staff to increase the needed capacity to provide COD treatment within the program. This aspect of training is incorporated into the program's strategic training plan.



Year/Av Score      DDCAT descriptor for rating

2008 (1.63)	<ul style="list-style-type: none"><li>•The program has no staff who are cross-trained in COD services and has not incorporated the concept of cross-training into the program's training plan.</li></ul>
2009 (2.55)	<ul style="list-style-type: none"><li>•The program has at least 33% of staff but not more than 50% who are cross-trained in COD services. Cross-training has not necessarily been incorporated into the overall training plan for the program.</li></ul>
2010 (2.94)	<ul style="list-style-type: none"><li>•Improvement indicated, however capability descriptor as above.</li></ul>

During the period, the sector's average capacity increased but remained within the AOD only services range. To achieve a rating of dual diagnosis capable, organisations would need to ensure that at least 50% but not more than 75% of staff are cross-trained in COD services and that cross-training has been incorporated into an overall training plan for the program (but may not have yet been fully implemented). It would seem that with further work and the right support, at least some parts of the sector would be able to achieve this.

Sustainability in this area will depend upon the continued availability of funding for professional development activities (see section 4.3).

## 4.2 Policies and Procedures

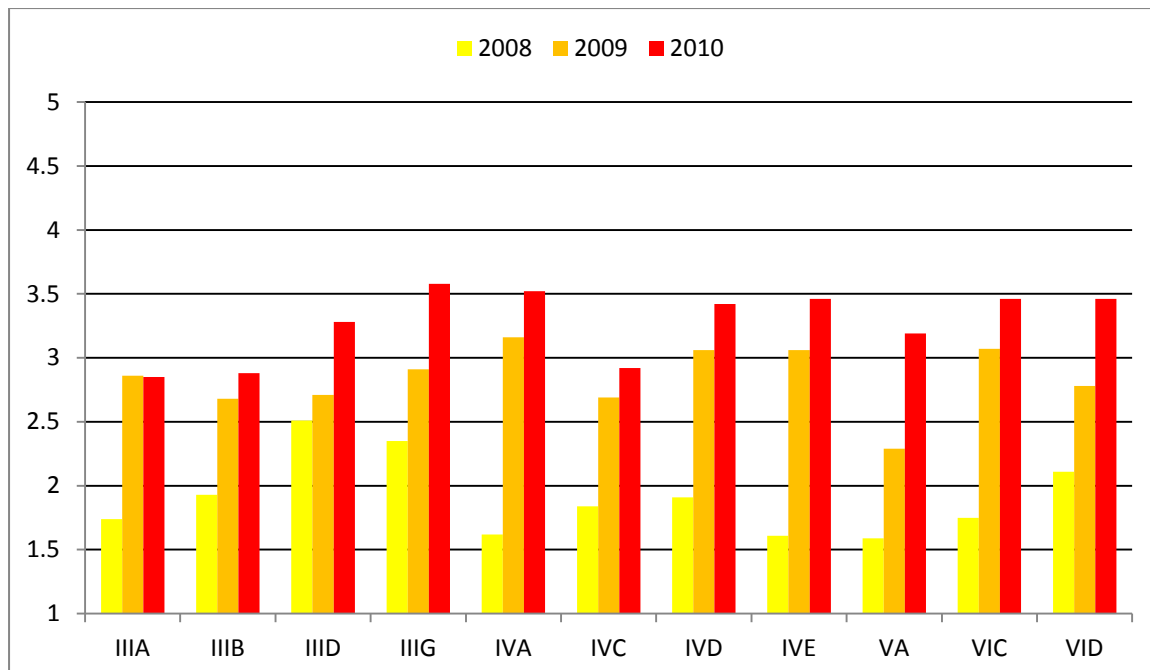
The 2006 NCETA report identified that “Organisational policies and procedures play an important role in any organisation’s functioning. It was noted by Forum participants that treatment of individuals with co-morbid conditions are often excluded in AOD agency policies. Explicitly addressing co-morbidity as “core business” within AOD NGO’s treatment management policies was supported as an approach which would:

- provide an established framework or structure within which mental health screening, assessment, treatment and referral services can be placed
- “legitimise” the importance and relevance of co-morbidity screening, assessment and treatment practices within the organisation
- ensure a systematic and consistent approach to managing co-morbid clients within (and potentially between) an organisation.<sup>3</sup>”

All participating organisations reported they had reviewed key policies and procedures relating to service delivery to ensure coverage of co-morbidity. A sample list of the policies and procedures developed/reviewed by organisations is included as Appendix D.

Eleven DDCAT index items include reference to documented policies and procedures. These index items are examined in the graph below.

**Graph 1: Assessment ratings for DDCAT Index Items related to policies and procedures**



<sup>3</sup> Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative, NCETA (2006)

Graph 1 shows that the average capability of the WA AOD Sector achieved dual diagnosis capability for 73% of index items which related to policies and procedures (a rating of 3 is the minimum benchmark for dual diagnosis capability).

The sector is well placed to ensure sustainability in the area of policy and procedure development and maintenance. Organisations have been working with the WA AOD Sector Quality Framework (QF) since 2005. The QF includes guidance on the development of policies and procedures relating to screening and assessment, treatment planning, staff development and clinical supervision (amongst others), which are also referenced by the DDCAT index items identified above. WANADA is currently undertaking a project to further develop the QF to a third-party accreditation framework, which has been cross-referenced with the DDCAT index items.

Several organisations have developed document control/quality management system approaches to policy and procedure development and maintenance, which will provide mechanism for the periodic review and improvement of policies and procedures. In addition, a number of clinical education resources were developed during the project, which are listed in Appendix E.

### **4.3 Professional Development**

The 2006 NCETA report identified a “range of workforce capacity building activities as strategies to enhance the skills, competence and knowledge of the current cadre of AOD clinicians. Key activities identified as pertinent to enhancing clinicians’ skills and abilities in the area of co-morbidity included:

- Education and Training;
- Clinical supervision;
- Mentoring; and
- Cross-organisational placements and staff exchanges<sup>4</sup>.

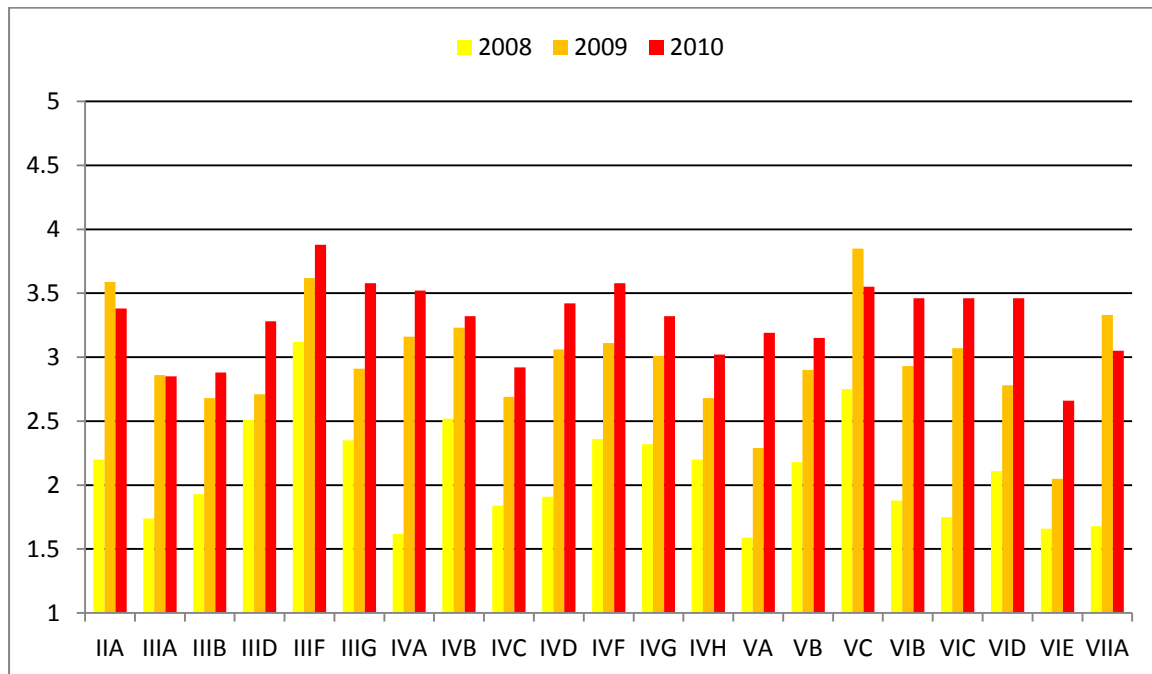
All participating organisations reported that they were able to offer more frequent and a wider range of professional development activities for staff during the project. Dedicated funding for professional development activities was cited by almost all organisations interviewed as the most significant factor in organisational capacity building over the life of the project. A summary of professional development activities undertaken in Western Australia from 2008 – 2010 is included as Appendix F.

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<sup>4</sup> Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative, NCETA (2006)

Twenty-one DDCAT index items include reference to workforce capacity/professional development. These index items are examined in the graph below.

**Graph 2: Assessment ratings for DDCAT Index Items related to workforce capacity/professional development**



Graph 2 shows that the average capability of the WA AOD Sector achieved dual diagnosis capability for 81% of index items which related to workforce capacity/professional development (a rating of 3 is the minimum benchmark for dual diagnosis capability).

While all organisations reported a significant amount of activity around professional development, there was a degree of dissatisfaction that access to the variety of training was not always offered across organisations, consortia groups or across the sector. It was reported that project officers worked together to ensure professional development activities were accessible to the maximum number of staff, they were confined by their respective funding agreements.

‘Train-the-Trainer’ sessions were delivered in some instances as a strategy to embed capacity gains by removing the need to seek external providers for key training activities. This approach worked well within a single organisation, but posed a new problem in that the ‘trainer’ was not available to sector workers from other organisations.

There were suggestions for the establishment of a funding pool, to be used to deliver key professional development activities across the sector.

A number of organisations also expressed the view that an agreed minimum qualification for working with consumers with co-occurring conditions would have been beneficial (the Certificate IV in Mental Health was most often cited as an appropriate qualification). This is something that could be explored at a policy level.

All participating organisations reported their staff had access to regular clinical supervision, though the method varied across organisations. Most kept clinical supervision arrangements in-house and focussed on group supervision and support, while a small number of organisations arranged for external, one-on-one clinical supervision for staff. Regional organisations were more likely to take a group approach to clinical supervision.

While the development and implementation of cross-organisational placements and staff exchanges was identified as a recommendation in the 2006 NCETA report as a means of building organisational capacity, only one of the participating organisations had engaged the strategy during the period 2008 – 2010. Difficulties around determining partner organisations for exchange, as well as the need to maintain therapeutic relationships with consumers were cited as impediments to their implementation. Several organisations expressed a desire to further investigate this possibility in future, particularly where staff could be exchanged between metropolitan and regional or remote organisations. A number of organisations indicated they thought that WANADA could play a coordinating role in overcoming some of the barriers and linking interested organisations.

Interviewed organisations expressed the view that future funding for professional development activities would be crucial to maintaining these capacity gains.

#### **4.4 Linkages and Partnerships**

The 2006 NCETA report identified that partnerships between organisations in the AOD and mental health fields “had the potential to facilitate access to a range of resources including financial, human, and informational. For example, partnerships could facilitate access to:

- funding through collaborative grant applications
- appropriate cross-institutional mentors
- knowledge and skill development via staff exchange programs between organisations<sup>5</sup>.

All participating organisations reported undertaking work to establish or formalise relationships with mental health, primary health, homeless and justice services to provide

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<sup>5</sup> Improved Services for People with Drug and Alcohol Problems and Mental Illness Initiative, NCETA (2006)

more integrated services for shared consumers, with a significant number of relationships solidified into Memoranda of Understandings or formal partnership agreements developed during 2008 – 2010. In addition, all organisations reported a strengthening of referral processes and pathways, both between AOD organisations and between AOD organisations and other service sectors (eg mental health, homelessness, justice services).

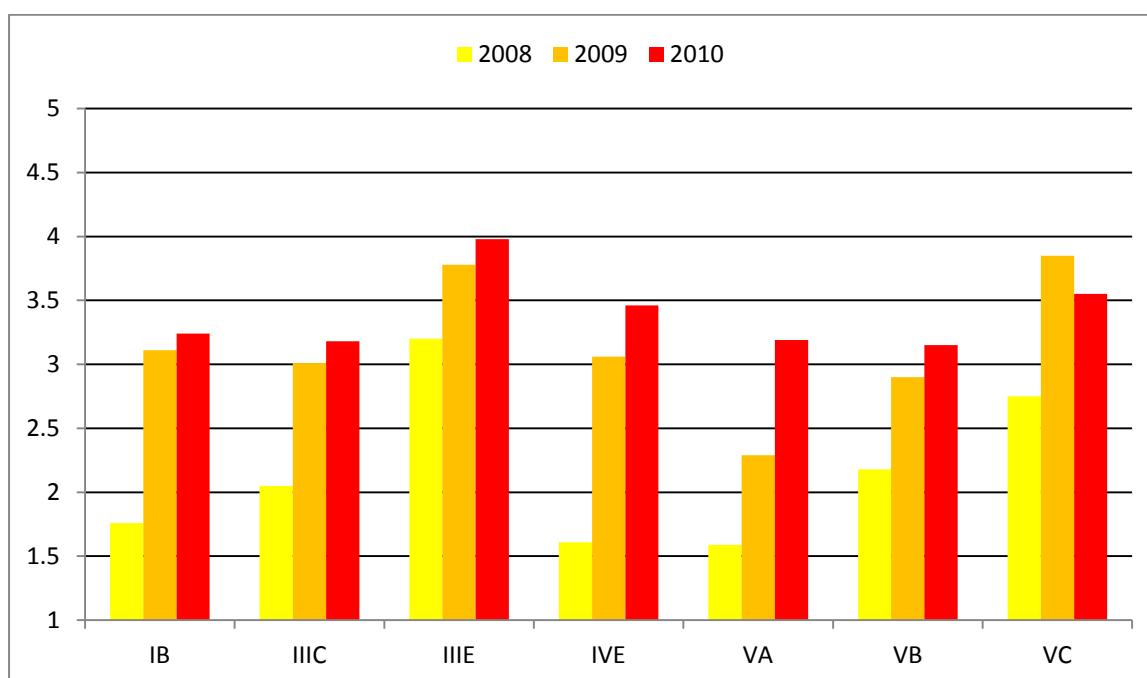
The effect of successful linkages and partnerships cannot be underplayed. In response to the question 'What effect did linkages and partnerships have on the success of the project', a sample of organisation responses are provided below:

- 'Significant, particularly around the exchange of benefit ie, we offered clinic sessions and they provided input at clinical development meetings; local staff got to know each other; relationships on the ground are key – this had a flow on effect in terms of staff knowledge and skills improving as well as ongoing awareness around the importance of co-morbidity capacity';
- 'Increased collaboration and awareness within the AOD and NGO mental health sector; increased staff knowledge and confidence to respond to co-occurring presentations and increased peer support and sharing of expertise within the AOD sector'; and

'Better referral outcomes for clients, enhanced professional development opportunities and enhanced community development opportunities'.

Seven DDCAT index items include reference to linkages and partnerships. These index items are examined in the graph below.

**Graph 3: Assessment ratings for DDCAT Index Items related to linkages and partnerships**



Graph 3 shows that the average capability of the WA AOD Sector achieved dual diagnosis capability for 100% of index items which related to linkages and partnerships (a rating of 3 is the minimum benchmark for dual diagnosis capability).

Organisations reported this was perhaps the most difficult area in which to achieve progress over the period, as the development and maintenance of relationships takes an extended period of time and relies upon the interest and commitment of staff from other sectors, who have not been funded under the ISI project and therefore do not attach the same level of priority and urgency to formalising relationships with the AOD sector.

Organisations universally acknowledged the importance of linkages and partnerships across sectors to provide a more 'seamless' experience for consumers. It appears that the formation of linkages and partnerships were more successful in regional and remote areas, where services were more likely to have existing relationships through local networks which provided a solid grounding for formal arrangements.

Metropolitan organisations expressed some difficulties around engaging with government mental health services and primary health care services, though a number of partnership arrangements were successfully brokered during the period. Clearly time and resources need to be dedicated to the development and maintenance of partnerships, with increased clarity and information sharing on 'what makes partnerships work' needed. There is a growing body of research, including some involving the WA AOD sector exploring these

factors, and it is hoped key approaches can be identified and applied in innovative ways for ongoing partnership and linkages success.

#### **4.5 Data Collection**

While the 2006 NCETA report did not make any recommendations relating to data collection, DoHA required each organisation use a validated tool to assess the services capacity to serve clients with dual diagnosis in drug and alcohol services and suggested that the *Dual Diagnosis Capability in Addiction Treatment* (DDCAT) be used. Services were expected to use the results of the DDCAT process to plan and prioritise their ongoing capacity building strategies. Services were required to undertake an initial self assessment in 2008 and then to repeat the self assessment annually<sup>6</sup>.

Participating organisations most often reported that they used the DDCAT assessment process to identify strategies to enhance the services provided to co-morbid clients.

In particular, most organisations reported the project had provided an invaluable opportunity to review their screening and assessment processes, with many implementing a standardised approach to screening and assessment, which included the use of mental health screening tools such as Psycheck, the Mental State Exam (MSE) or the Australian Integrated Mental Health Initiative in the Northern Territory (AIMHI) suite of tools.

The requirement that organisations use the Drug and Alcohol Office (DAO) developed Service Information Management System (SIMS) database was often cited as an impediment to effective data collection and reporting in relation to co-occurring disorders, with a number of organisations reporting they had contacted DAO with improvement suggestions for the planned SIMS2 development. Minimal outputs related to co-occurring issues can currently be gleaned from SIMS and the data at this stage does not allow any reporting or analysis of outcomes achieved with this client group.

Some organisations implemented client relationship management (CRM) systems to sit alongside SIMS to enhance data collection, though this was an avenue unavailable to smaller organisations due to cost considerations. Almost all participating organisations indicated there was still work that could be done in this area, though most felt this could only be done in conjunction with DAO.

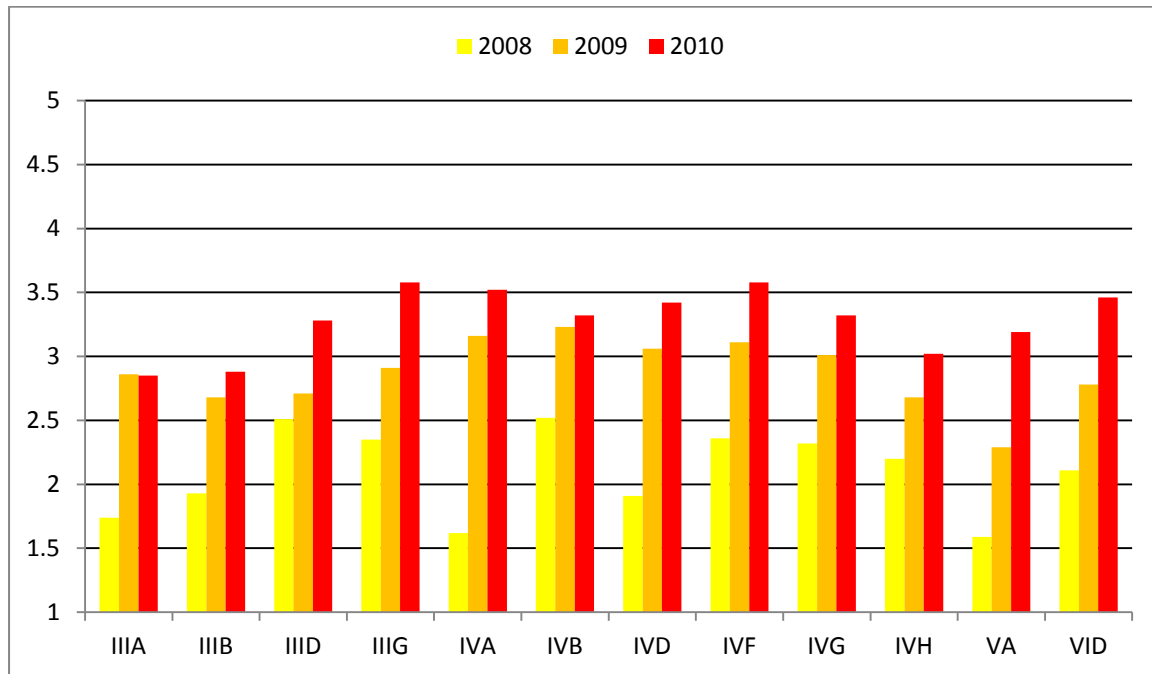
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<sup>6</sup> The Dual Diagnosis Capability in Addiction Treatment (DDCAT) Index Toolkit, Adapted for use in the Improved Services Initiative for People with Drug and Alcohol Problems and Mental Illness Initiative for the Department of Health and Ageing, April 2008.



Twelve DDCAT index items include reference to data collection. These index items are examined in the graph below.

**Graph 4: Assessment ratings for DDCAT Index Items related to data collection**



Graph 4 shows that the average capability of the WA AOD Sector achieved dual diagnosis capability for 83% of index items which related to data collection (a rating of 3 is the minimum benchmark for dual diagnosis capability).

Measuring outcomes is becoming a priority for the sector, in readiness for both the state and commonwealth reforms. WANADA is aware that DAO have been reviewing outcomes data approaches and intends to present some options to the sector in early 2012. A standardised approach across the sector would be welcomed to enable outcomes to both inform individual service approaches as well as provide a basis for collective analysis.

#### **4.6 Continuous Quality Improvement**

While the 2006 NCETA report did not make any recommendations relating to continuous quality improvement, DoHA required each organisation to report on improvement activity every six months, as part of the ISI project reporting framework. DoHA identified that “Quality improvement processes and systems allow organisations and services to systematically review and improve their services. Capacity building and quality improvement are closely linked. This objective is aimed at improving the overall progression of your Quality Improvement System. This may comprise many elements including reviews, audits, self assessment and external accreditation/certification processes. For the purpose of the

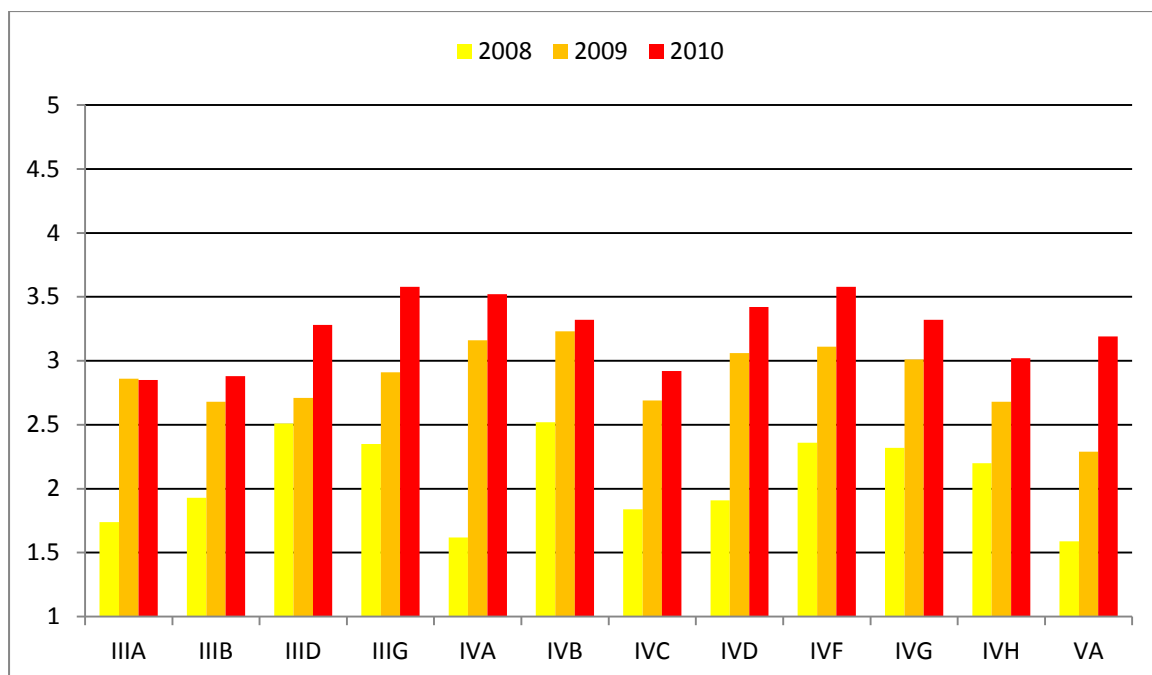
Improved Services initiative, there is particular interest in how client participation will be developed and/or enhanced to assist in the quality improvement process”<sup>7</sup>.

Almost all participating organisations reported that the ISI project had little impact on their approach to continuous quality improvement (CQI), as they were already working within a CQI framework. The introduction of the WA AOD Sector Quality Framework in 2005 and the implementation of the voluntary Peer Review process (funded by OATSIH and DAO, coordinated by WANADA and delivered by the Institute for Healthy Communities Australia Ltd) appears to have been successful in building the capacity of the WA AOD Sector in this regard.

A significant number of participating organisations, however, acknowledged that the ISI project had strengthened their commitment to CQI and saw the value in keeping co-morbidity at the forefront of organisational thinking around CQI.

Twelve DDCAT index items include reference to continuous quality improvement monitoring processes. These index items are examined in the graph below.

**Graph 5: Assessment ratings for DDCAT Index Items related to continuous quality improvement**



Graph 5 shows that the average capability of the WA AOD Sector achieved dual diagnosis capability for 75% of index items which related to data collection (a rating of 3 is the minimum benchmark for dual diagnosis capability).

<sup>7</sup> Capacity Building Grants Reporting Template, DoHA, 2008.

The introduction of the Accreditation Framework, which has been cross-referenced to the DDCAT index items will only enhance the sector's commitment to CQI and focus on co-morbidity issues. To improve the DDCAT assessment process, assessments could be conducted independently to ensure objectivity in assessment and consistency of interpretation in the assessment process.

#### **4.7 The Consortium Approach**

The intent of the consortia approach in WA was primarily to support a broader capacity building of as much of the sector as possible (not just the grant recipient organisations), and in so doing support a key sector principle of maintaining the effectiveness of a diverse range of services. The approach was also intended to generate inter-sectoral support, collaboration and unity, with a focus on improving service delivery and therefore outcomes for consumers accessing the sector.

The consortium approach was resoundingly endorsed by participating organisations as an effective model for developing better relationships within the AOD sector and producing better outcomes for clients. Four of the consortiums were managed through a reference group and where membership of the reference group remained relatively stable, the perception of capability gains was greatest.

A number of the positive comments made on the consortium model are listed below:

- 'Provided essential training to participants that had not been affordable for our agency';
- 'Increased collaboration between services, improved referrals, sharing of resources and knowledge of consortium services';
- 'Weaknesses of the current situation for all participants could be identified'; and
- 'I have developed some useful contacts and relationships and believe others in the consortium feel the same'.

There were some issues identified around the establishment and maintenance of consortiums, given the importance of relationship building and the relatively high mobility of staff in the AOD sector.

A number of impediments were also identified, including:

- 'It can be resource intensive trying to get 'buy in' from the agencies';
- 'Larger organisations were more dominant';

- 'There was inadequate appreciation of the diversity of organisations involved and the need to address diverse working cultures/diverse clients';
- 'Like most relationships it took significant time for the consortium to strongly have an effective partnership which staff felt a part of and positively impacted by.'

In a recent partnership assessment one of the consortium staff stated that 'it only now really feels like a partnership between consortium members'.

The Lead Agency Forums coordinated by WANADA were well received and participating organisations almost universally stated that it was invaluable to have a forum where they could hear what other organisations were doing and share their concerns about how to approach certain activities. Some regional organisations raised issues with participating via teleconference or videoconference link up, saying it was sometimes difficult to follow the conversation in the room if more than one person was speaking and reported occasionally finding it difficult to find a break in the conversation to offer their thoughts. However, all valued the opportunity to hear what was happening in other organisations and expressed a desire to continue a similar type of forum for sharing ideas and frustrations.

Two organisations that received individual funding reported they would seriously consider participating in a consortium if the model were adopted for future projects.

Working in a consortium clearly has pros and cons. If consortia of services for ISI were to continue there was a request for more discussions on what makes them work and incorporating these specific partnership relationships into a CQI review process. As with partnerships and linkages there is a growing body of research on the practicalities of effective collaboration. Principles from this research would be of use to support improved consortia models.

## **5 Conclusion**

It is clear from the analysis of DDCAT data and interviews with participating organisations that the ISI project has proven to be very effective in raising the capability of AOD services with regard to consumers with co-occurring substance use and mental health disorders.

In 2008, the participating organisations assessed themselves as dual diagnosis capable against 6% (n=2) of DDCAT index items. In 2009, 46% (n=15) of index items were rated dual diagnosis capable and by 2010, 70% (n=23) of index items were rated dual diagnosis capable. This performance reflects the effectiveness of the project in providing a framework for the participating organisations to improve and represents a 64% increase in capability over the initial project timeframe of three years.

While the participating organisations on average did not achieve a rating of dual diagnosis enhanced for any index items during the period 2008 – 2010, it seems likely that with further work, parts of the WA AOD sector may be capable of achieving a dual diagnosis enhanced rating for a number of index items (including IIB, IIID, IIIG, IVD, IVH, VIB and VIC).

Of the ten index items which remained within the AOD only services range, there are three where it appears likely that with further work the participating organisations could attain dual diagnosis capability (index items IIIA, IVC and VIIB).

The average DDCAT assessment results should be read in the context of the validity of self-assessment generally. It is acknowledged that self-assessment is generally seen as the least rigorous of assessment processes. Implementing an independent DDCAT assessment process would ensure objectivity in assessment and consistency of interpretation in the assessment process. A suitable process could then be applied across the WA AOD service sector.

#### **Suggestion 1**

To improve the DDCAT assessment process, assessments could be conducted independently to ensure objectivity in assessment and consistency of interpretation in the assessment process. A suitable process could then be applied across the WA AOD service sector.

Average performance against the DDCAT index items is also useful for indicating comorbidity capability against the five key activity areas of the ISI project.

Seventy-three percent of DDCAT index items which included a policy or procedural component were rated as dual diagnosis capable by 2010. It would appear that the participating organisations engagement with the WA AOD Quality Framework has provided a solid foundation for sustainability in this area, which will only be enhanced by the release of the Culturally Secure Accreditation Framework planned for early 2012.

Eighty-one per cent of DDCAT index items which included a professional development component were rated as dual diagnosis capable by 2010. Participating organisations frequently cited the provision of dedicated funding for professional development activities as the most significant factor in building their organisation's capability around comorbidity. Some organisations, however expressed the view that this could have been approached on a more collective basis for improved access and broader benefits.

### **Suggestion 2**

Consideration be given to the development of a collective approach to the delivery of training on comorbidity for the broader WA AOD sector.

The relatively high level of staff mobility in the sector will present a challenge to maintaining the required proportion of comorbidity trained staff over time. Ongoing funding for professional development, as well as a sector-wide approach will be crucial to ensuring sustainability in this area.

### **Suggestion 3**

A significant continuing focus on comorbidity professional development and workforce capability will be required to ensure the sustainability of capacity gains made across the sector in WA. WANADA should consider investigating strategies to coordinate workforce capacity and workforce development needs on a sector wide basis.

While the development and implementation of cross-organisational placements and staff exchanges was identified as a recommendation in the 2006 NCETA report as a means of building organisational capacity, only one of the participating organisations had engaged the strategy during the period 2008 – 2010. Difficulties around determining partner organisations for exchange, as well as the need to maintain therapeutic relationships with consumers were cited as impediments to broader implementation of this strategy. Several organisations expressed a desire to further investigate this possibility in future, particularly where staff could be exchanged between metropolitan and regional or remote organisations. A number of organisations indicated they thought that WANADA could play a coordinating role in overcoming some of the barriers and linking interested organisations.

### **Suggestion 4**

Further consideration be given to establishing a sector-wide and inter-sector staff exchange/secondment framework.

There was a level of variability in terms of the type of clinical supervision available across participating organisations. Some organisations offer group supervision, others also offer

internal clinical supervision (sometimes combined with line supervision) and a small number offer external supervision to clinical staff, including registration supervision. It may be useful to undertake some research on good practice in clinical supervision and to establish a register of suitably qualified persons who are willing to provide registration supervision to the sector.

#### **Suggestion 5**

Research could be undertaken on good practice in clinical supervision with a view to establishing a sector-wide position, which may include the establishment of a register of suitably qualified persons who are willing to provide registration supervision.

One hundred per cent of DDCAT index items which related to linkages and partnerships were rated as dual diagnosis capable by 2010. Participating organisations universally acknowledged the importance of linkages and partnerships across sectors to provide a more 'seamless' experience for consumers, but also frequently reported, however that this was the most difficult area in which to achieve progress, as the development and maintenance of relationships takes significant time and resources and relies upon a reciprocal interest and commitment from organisations and staff in other /sectors. A number of organisations expressed the view that resources on how to develop and maintain effective partnerships would be useful.

A continuing focus will be required to ensure established linkages and partnerships are maintained.

#### **Suggestion 6**

Consideration be given to developing resources for the sector on how to establish and maintain successful linkages and partnerships, based on the experiences of the ISI grant recipients/participating organisations.

### **Suggestion 7**

A significant continuing focus on forming and maintaining linkages and partnerships will be required to ensure the sustainability of capacity gains made to date by participating organisations in WA. WANADA is well placed to coordinate the identification of advantageous linkages and partnerships on a sector to sector basis.

Eighty-three per cent of DDCAT index items which related to data collection were rated as dual diagnosis capable by 2010. The requirement that organisations use the Drug and Alcohol Office (DAO) developed Service Information Management System (SIMS) database was often cited as an impediment to effective data collection and reporting in relation to co-occurring disorders. Minimal items related to co-occurring issues can currently be gleaned from SIMS and the data at this stage does not allow any reporting or analysis of outcomes achieved with this client group. A number of organisations reporting they had contacted DAO with improvement suggestions for the planned SIMS2 development.

Measuring outcomes is becoming a priority for the sector, in readiness for both the state and commonwealth reforms. WANADA is aware that DAO have been reviewing outcomes data approaches and intends to present some options to the sector in early 2012. A standardised approach across the sector would be welcomed to enable outcomes to both inform individual service approaches as well as provide a basis for collective analysis.

Seventy-five per cent of DDCAT index items which related to continuous quality improvement were rated as dual diagnosis capable by 2010. A significant number of participating organisations reported having a sound CQI process in place and this project has ensured their CQI incorporates comorbidity considerations.

The sector's ongoing engagement with the WA AOD Quality Framework (soon to become the Culturally Secure Accreditation Framework) will ensure the sustainability of CQI processes in the sector.

The consortium approach was resoundingly endorsed by participating organisations as an effective model for developing better relationships within the AOD sector and producing better outcomes for an increased number of clients. There were some issues identified around the establishment and maintenance of consortium effectiveness, given the relatively high mobility of staff in the AOD sector.



If consortia of services for capacity building were to continue there was a request for more discussions on what makes them work and incorporating these specific partnership relationships into a CQI review process.

**Suggestion 8**

Consideration be given to conducting a literature review on consortium models and developing resources for the sector on how to establish and maintain successful consortia, based on the experiences of the ISI grant recipients and their consortium members.

## **Appendix A: Organisations invited to participate in the evaluation**

Aboriginal Alcohol and Drug Service (AADS)

Centrecare Goldfields/Esperance

Cyrenian House

Cyrenian House North Metro Community Drug Services Team (CDST)

Drug Arm Rosella House

Hepatitis Council of WA

Holyoake

Jungarni Jutiya Alcohol Centre

Mercy Addiction Support Team

Milliya Rumurra Aboriginal Corporation

Mission Australia

Ngnowar Aerwah Aboriginal Corporation

Outcare

Palmerston Association

Serenity Lodge

St John of God Drug and Alcohol Withdrawal Network (DAWN)

The Salvation Army Bridge Program

Uniting Care West

WA Substance Users Association (WASUA)

Women's Health and Family Services

## Appendix B: Survey Questions

1. Have any specific policies been amended or developed to embed co-morbidity practice at your service?
2. Are there current clinical and non clinical guidelines on co-morbidity that you follow?
3. Have any job descriptions been updated to include mental health tasks, activities, skills and knowledge?
4. What professional development opportunities were offered during the project?
5. Were you able to address all the identified workforce development needs during the project?
6. What strategies have you put in place to ensure the knowledge and skills gained by individual staff through this project can be sustained by your organisation over time?
7. During the project did you have anything in place to measure attitude change of worker/student/volunteers to co-morbidity?
8. What mentoring/supervision programs were implemented to support the maintenance of staff knowledge?
9. Have you developed any work based learning materials/packages on managing consumers with co-morbidity issues?
10. Have you developed new resources for consumers and significant others?
11. Have you developed or used any resources that can be shared across sectors?
12. As part of the project were you involved in cross organisational placements and staff exchanges?
13. Has the project provided opportunities for backfill funding?
14. How has the project impacted on the way your agency approaches quality improvement?
15. How did you identify appropriate linkages and partnerships for the project?
16. What linkages and partnerships do you have in place with local mental health services to support your agencies co-morbidity services to the community?
17. What linkages and partnerships do you have in place with local primary health care services to support your agencies co-morbidity services to the community?
18. What partnerships & linkages have you developed with other sector services in terms of co-morbidity services to your consumers (eg DCP homelessness, justice )?
19. Do you have any effective regional AOD/MH specialists your agencies works with ?  
Improved response; Why works well/not; Future need for this?
20. What effect did linkages and partnerships have on the success of the project?
21. How did you identify new data collection needs to enhance the services provided to co-morbidity clients?

22. What process/es did you put in place to ensure data collection requirements were met?
23. How did the use of data collected impact on services provided to co-morbidity clients?
24. What process did you use to complete the DDCAT? Did you change the process during the project?
25. What were the benefits of the consortium approach?
26. What were the impediments of the consortium approach?
27. Would you consider using the consortium approach again? Why?

## Appendix C: DDCAT Index Items by Dimension

### *Dimension I: Program Structure*

- IA Primary treatment focus as stated in mission statement.
- IB Coordination and collaboration with mental health services.

### *Dimension II: Program Milieu*

- IIA Routine expectation of and welcome to treatment for both disorders.
- IIB Display and distribution of literature and client education materials.

### *Dimension III: Clinical Process: Assessment*

- IIIA Routine screening methods for psychiatric symptoms.
- IIIB Routine assessment if screened positive for psychiatric symptoms.
- IIIC Psychiatric and substance use diagnoses made and documented.
- IIID Psychiatric and substance use history reflected in client record.
- IIIE Program acceptance based on psychiatric symptom acuity: low, moderate, high.
- IIIF Program acceptance based on severity of persistence and psychiatric disability: low, moderate, high.
- IIIG Stage-wise treatment: Initial

### *Dimension IV: Clinical Process: Treatment*

- IVA Recovery plans.
- IVB Assess and monitor interactive courses of both disorders.
- IVC Procedures for psychiatric emergencies and crisis management.
- IVD Stage-wise treatment ongoing
- IVE Policies and procedures for medication evaluation, management, monitoring and adherence.
- IVF Specialised interventions with mental health content.

- IVG Education about psychiatric disorder and its treatment, and interaction with substance use and its treatment.
- IVH Family education and support.
- IVI Specialised interventions to facilitate use of (COD) self-help groups.
- IFJ Peer recovery supports for clients with MH.

*Dimension V: Continuity of Care*

- VA Co-occurring disorder addressed in discharge planning process.
- VB Capacity to maintain treatment continuity.
- VC Focus on ongoing recovery issues for both disorders.
- VD Facilitation of self-help support groups for COD is documented.
- VE Sufficient supply and adherence plan for medications is documented.

*Dimension VI: Staffing*

- VIA Psychiatrist or other prescriber.
- VIB On site staff with MH qualifications or formal training.
- VIC Access to mental health supervision or consultation.
- VID Supervision, case management or utilisation review procedures emphasise and support COD treatment.
- VIE Peer/Alumni supports are available with COD

*Dimension VII: Training*

- VIIA Basic training in prevalence, common signs and symptoms, screening and assessment for psychiatric symptoms and disorders.
- VIIIB Staff are cross-trained in mental health and substance use disorders, including pharmacotherapies.

## Appendix D: Summary of Policies and Procedures developed/reviewed

Policies/Procedures developed/reviewed during 2008 - 2010	
Cultural Appropriate Policy Assessment	Guidelines on Comorbidity.
Alteration of Alcohol and Other Drug Workers Duty Statements	Procedure: record keeping, CDST and Mental Health Clinicians case files
Procedure: Referral Process	Policy on Dual Diagnosis
Induction manual for all staff on comorbidity	Procedure: Case Management
Procedure: CDST Clinician case files	Procedure: Mental Health Clinician case file
Co morbidity case management forms	Standardised Assessment Tools : PsyCheck
Working with Indigenous Health Services (IHS)	Intake Procedure
Referral Process	Initial Inquiry Procedure
Critical Incident Policy	Case Management
Screening and Assessment	Client Rights and Responsibilities
Integrated Treatment Plans	Critical Incident Policy and Procedure
BBV Testing Procedures	Child Protection Policy.
Case management	Integrated Treatment Plans
Supervision	Child Protection Policy
Diversion Screening Procedure	Initial Enquiry Procedure
Department of Corrective Services Screening Procedure	Supervision Policy
Initial Assessment Procedures for YAP Clients	Case Management Procedure for YAP Clients
Authority to Obtain Information	Authority to Release Information
Screening and Assessment	Referral process and forms
Treatment Pathways	Initial Inquiry Procedure
Client File procedure	New employee induction procedure
Response to Suicide Risk Procedure	Management of Clients Whilst Intoxicated

<b>Policies/Procedures developed/reviewed during 2008 - 2010</b>	
	Procedure
Service Evaluation – Work Instruction and form	Follow up for Clients who do not Present (for an appointment) – work instruction
Local Service Agreement Protocol and Procedures (LSA)	Clinical governance Policies and Procedures
Administration procedure and protocol	Cross Sector Audit Team (CSAT) – Incident Referral Form
Access to service	Waitlist and Critical Incident.
Managing of Waitlist	Consumer and Carer Involvement
Incident Review procedures	Consumer Participation
Cultural Appropriate Policy Assessment	Co-morbidity screening protocol and procedures
Gender Impact Assessment Tool	IT Security



## **Appendix E: Clinical Education Resources Developed During the Project**

### **Understanding the Mental State Examination: A Basic Training Guide.**

The Perth Metropolitan Non-Residential and Family Alcohol and other Drug Services Consortium developed and produced an education resource for sector workers titled *Understanding the Mental State Examination: A Basic Training Guide*. This resource can be ordered for no cost through the Palmerston website. The booklet which accompanies the dvd states ‘This resource has been designed to strengthen the capacity of alcohol and other drug (AOD) clinicians in completing a baseline Mental State Examination (MSE) with their clients. The DVD has been designed using visual case study scenarios, and is accompanied by this instructional training booklet, to help clinicians test their skills in completing an MSE. The overall purpose of the DVD is to introduce clinicians to the MSE assessment tool with the view that more comprehensive training on the MSE be completed in the future’<sup>8</sup>.

### **Trauma-Informed Treatment Guide for Working with Women with Alcohol and Other Drug Issues**

The Women’s Consortium developed and produced the ‘Trauma-Informed Treatment Guide for Working with Women with Alcohol and Other Drug Issues’, which use ‘evidence based practice principles from integration of current research literature, informed clinical experience of the authors and the experiences of women with trauma and alcohol and other drug issues’<sup>9</sup>. The resource can be ordered at a small cost through the Women’s Health and Family Services website.

### **Pod-casts**

The Women’s Consortium developed and produced a range of pod casts, which can be accessed on the Women’s Health and Family Services website. Podcasts cover topics such as complex issues for women affected by mental health, substance use problems and the experience of violence and a trauma-informed approach

### **Video Conferencing Facility**

The Perth Residential Consortium established a video conferencing facility as a way to allow workers to remain on site at their primary place of employment while attending training. The

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<sup>8</sup> Available at: <http://www.palmerston.org.au/publications.htm>

<sup>9</sup> Trauma-Informed Treatment Guide for Working with Women with Alcohol and other Drug Issues, Marsh, A., Towers, T., & O’Toole, S. (2011).

facility also allowed interstate or overseas presenters to conduct training and mentoring sessions without incurring the costs of bringing them to WA. In their own evaluation of the facility, the consortium found feedback ranged a broad spectrum from 'This has broken down almost every conceivable obstacle to training. It is the way of the future' to 'We got absolutely no benefit from this at all. It has been a complete waste of time'. The evaluation notes that most feedback was positive, with the major impediments to effective use of the facility relating to attitudes towards technology and the cost of implementing the technology.

## Appendix F: Summary of Professional Development activities undertaken from 2008 - 2010

Training Offered	
Indigenous Risk Impact Screening Tool and Brief Intervention	Psychosis Training
Indigenous Risk Impact Screening Tool and Brief Intervention – Train the Trainer	Working Through Hearing Voices and Working Through Paranoia
Solution Focused Brief Therapy – Comorbid clients focused	Management of Anxiety and Panic Disorder
Mental Health First Aid	Management of Depression
Indigenous Mental Health First Aid	Acceptance Commitment Therapy (ACT)
Advanced Techniques for Clinicians working with difficult clients	Better Outcomes for Clients with Co-morbidity
Induction for new workers in Drug and Alcohol	Building Systems Towards Better Outcomes for Clients with Co-morbidity
Silver chain Mental Health Training	Working with Complex Clients
Solution focused brief therapy	Changing the World: Welcoming Integrated Services and Systems for People with Mental Health and Substance Use Disorders
Advanced Techniques for Clinicians in Co-morbidity	Our Mob Our Minds
Guidelines for Managing Co-occurring Mental Health and Substance Use in an AOD setting	Supporting Young People from CaLD Backgrounds
Guidelines for Managing Co-occurring Mental Health and Substance Use in an AOD setting – Train the Trainer	Dealing with a Personality Disorder in a Residential Setting
Helping Change: Volunteer Program. Counselling Skills in AOD Issues (Train the Trainer)	Certificate IV Mental Health (Aboriginal)
Motivational Interviewing	The Use of Mindfulness in Managing Anxiety

<b>Training Offered</b>	
Suicide Prevention Gatekeeper Training	Understanding Psychopharmacology
Psycheck	Advanced Psychopharmacology for psychologists
Psycheck (Train the Trainer)	Mental State Examination
NSW Mental Health Reference Resource for AOD Workers	Understanding Depression
AIMHI	Understanding Bipolar Disorders
AIMHI (Train the Trainer)	Understanding Psychosis
Indigenous Mental Health Workshop	CBT and Brief Intervention
Working with Co-morbid Clients (Train the Trainer)	MSEX – Medical Messaging & Communication Tool
In-Service workshops	Neuroplasticity
Certificate III in AOD	Domestic Violence
Postgrad Diploma in Mental Health & Addiction	Power of Positive Psychology
ASIST Suicide Prevention	Helping Change (Train the Trainer)
Family Therapy	Smart Recovery Facilitator Training
Clinical Supervision	Residential Psychodrama Training
Signs of Safety	Cert IV in Training and Assessment
AOD Postgrad Diploma in Mental Health Nursing	Working with Families and Significant Others
Mindfulness and PTSD/ADHD	Postgrad Training in Narrative Therapy
Sad Mad or Bad Forensic	Building Resilience 0 – 25
Traditional Mindfulness	Co-morbidity Guidelines (Train the Trainer)
Sand Play Therapy	

