North East Mental Health Alliance

Dual Diagnosis Capability Project 2013

BANYULE Community Health

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EXECUTIVE SUMMARY

This report reflects the commitment of the North East Mental Health Alliance (NEMHA) to improved service delivery for people who experience dual diagnosis. The ongoing development of a more robust and responsive workforce has been possible by continued use of an integrated partnership approach to planning, monitoring and evaluation. Since 2007, the NEMHA have been guided by Commonwealth and State policy targeting co-occurring mental illness and problematic substance use. In Victoria, the Dual Diagnosis Key Directions policy document gives clear recommendations in relation to priority areas for service development for this population group. To date, the partner agencies which make up the NEMHA have undertaken much collaborative work in the areas of;

- policy development
- joint training and professional development,
- partnership development and
- quality improvement.

PURPOSE

In 2013, The NEMHA made the decision to survey its collective level of competency to deliver services for people with a dual diagnosis, their carers and family members. The project, auspiced by Banyule Community Health aimed to capture data and deliver recommendations in relation to the strengths and gaps of partner agencies within the NEMHA as well as a picture its joint capability.

At the commencement of this project it was anticipated that a broad spread of capability existed across the alliance and that opportunities existed for agencies to support each other to improve dual diagnosis capability. It was also thought that opportunities for joint professional development would arise from the project. While the data collected can be used for baseline planning, it is expected that as a minimum outcome of this project, all agencies involved will ensure systematic screening for dual diagnosis and will be better resourced to identify and respond to this client group.

METHOD

The NEMHA, in consultation with members of the Victorian Dual Diagnosis Initiative (VDDI), decided to use the Gary Croton Dual Diagnosis Capability tool as the platform for capturing data. The tool was disseminated via survey monkey to staff working across twelve program areas in nine partner organisations;

- Banyule Community Health Service
- SHARC (Self Help Addiction Recovery Centre)
- MIND
- NEAMI
- ARAFEMI
- Carerlinks North
- Austin Health Community Mental Health
- Mental Illness Fellowship
- Office of Housing, Preston(DHS)

In partnership with Swinburne University, the data was then pooled and analysed for themes and trends.
RESULTS

The results of the project can been described in the following three ways; as

- a complete dual diagnosis skills and capability audit for each partner agency,
- a clear indication of collective staff training needs across the NEMHA and
- priority areas for dual diagnosis capability improvement at NEMHA executive level.

The survey was completed by eighty staff in total and as expected, highlights a broad spread of skills and capability. Recommendations for action across the NEMHA are discussed below. Specific results for each agency are listed in the appendices.

RECOMMENDATIONS

Based on the data analysis, the priority areas for staff training across the NEMHA are;

- Comprehensive Dual Diagnosis Assessment
- Treatment Responses (brief intervention, relapse prevention, withdrawal planning)
- Working within the broader service system (in line with reform activity across AOD and Mental Health sectors in 2014).

The areas for continued service development at executive level in order of priority are;

1. Building on and strengthening the broader service system (staff rotations, no wrong door approach, formal agreements, formal networks, integrated treatment plans, secondary consultation)
2. Agency policy and documentation (screening, mission statement, position descriptions, support and supervision structures)
3. Regular reviews of agency quality assurance systems (outcome measures, consumer and carer consultant positions, targeted quality control and auditing of treatment provided to dual diagnosis clients).

Whilst recommendations appear hefty, it is worth mentioning here that the NEMHA and its working groups have done much work already across these areas and have well developed systems for continual improvement. These recommendations will inform a NEMHA dual diagnosis action plan for 2014-2015.

This report includes detailed appendices relating to individual agencies. It is at the discretion of each agency to further analyse their specific dataset. For the purposes of this project, comments are made about collective capacity building opportunities at the frontline and at executive level as a partnership approach.
THE CONTEXT

Extensive international research indicates that when compared with people experiencing a mental health OR substance use disorder, people diagnosed with comorbid mental health and substance use disorders experience higher rates of:

- Severe illness course and relapse
- Violence, suicidal behaviour and suicide
- Infections and physical health problems
- Social isolation and family/carer distress
- Service utilisation
- Antisocial behaviour and incarceration
- Homelessness.

(Teesson & Proudfoot 2003; Kessler 2004; Compton et al. 2005; Conway et al. 2006). Furthermore, young people with comorbid mental health and substance use disorders are at risk of poorer outcomes because of their age and stage of physical, neurological, psychological and social development. (Dual diagnosis - Key directions and priorities for service development – 2007).

In response, the Commonwealth and State governments have invested in health initiatives to help curb this trajectory including: the Commonwealth Improved Services Initiative 2007 – 2010 and the Victorian Dual Diagnosis - Key directions and priorities for service development policy paper - targeting alcohol and drug and/or mental health agencies to improve capacity to better respond to the needs of people and/or their families with a comorbid mental health and alcohol and drug disorder.

The NEMHA Dual Diagnosis Project 2013 builds on the work of these initiatives and takes a ‘snapshot’ of the dual diagnosis capacities of mental health, AOD and PDRSS agencies within the alliance with the view to better respond to the needs of clients and/or their families across the alliance; addressing organisational limitations to improve outcomes for clients and/or their families.

THE PROJECT

SURVEY RESPONDANTS

Twelve programs across nine agencies with a total of 80 respondents participated in the project. The agencies included:

- SHARC and Banyule CHS AOD team - from the Alcohol and Drug sector,
- Austin Community Mental Health and Banyule CHS Mental Health Nursing - from the Mental Health sector and
- ARAFEMI, Mind, Neami, DHS Preston Housing Office, CarerLinks, Mental Illness Fellowship, Banyule CHS General Counselling and Banyule CHS Gamblers Help team - from the PDRSS sector. (Although not all agencies from this group receive PDRSS funding, the PDRSS survey was the survey tool that most closely reflected the work undertaken by these teams).

PROJECT SUPPORT

The lead agency, Banyule Community Health in consultation with Nexus and Gary Croton (Victorian Dual Diagnosis Initiative - Eastern Hume) and with the support of ProjectMindED and Swinburne University (Hawthorn) implemented the project.

The project was undertaken in the following stages:

1. Research and selection of dual diagnosis evaluation tool – ProjectMindED in consultation with the NEMHA
2. Implementation of dual diagnosis evaluation tool – NEMHA
3. Collection and input of data – Banyule Community Health and ProjectMindED
4. Data Analysis – Swinburne University and ProjectMindED
5. Report / Feedback – Banyule Community Health and ProjectMindED
SELECTING A MEASUREMENT TOOL

The Gary Croton suite of Checklist Tools was chosen as the preferred dual diagnosis evaluation tool. A comparison with the Compass - EZ™ identified the Gary Croton suite of tools to be more relevant to the needs of the NEMH Alliance. Whilst the Compass - EZ™ would build capacity across all agency programs in addition to complementary aims/objectives relevant to dual diagnosis, the Gary Croton tool was integral to building clinical skills at a base level and improving systems and processes. The additional benefit of Gary Croton being local to Victoria and available to help with the Project was considered a significant contributing factor.

GARY CROTON CHECKLISTS TOOLS

Each agency implemented two Checklist Tools specific to their sector. The first was a self-assessment tool for workers/clinical staff to assess dual diagnosis capabilities across five domains including: detection, assessment, treatment planning, treatment and working with the broader service system. The questionnaire included 44 questions with a 10 point Likert scale response.

The second evaluation tool was a self-assessment tool for the agency/service to assess their level of dual diagnosis capabilities across five domains including; policy, detection and assessment, integrated treatment, working with the broader service system and agency quality assurance. This included 58 questions with a 10 point Likert scale response.

Self-Assessment Checklist Tools listed:

- For Alcohol and Other Drug agencies: this included the Checklist – Dual Diagnosis Capability – Alcohol, Tobacco & Other Drug Workers (Version 6/2009)
- For Psychiatric Disability and Rehabilitation Recovery Services this included the Checklist: Mental Healt-substance use capability – Non-clinical (PDRSS) mental health workers(Version 2.0/2013)
- For Mental Health agencies this included: the Checklist – Dual Diagnosis Capability – Clinical Mental Health Workers. Version 6 / 2009)
- For ALL agencies this included: the Checklist – Dual Diagnosis Capability – Agency/ Service Level.

For the purpose of data collection, the self-assessment tool for workers/clinical staff was converted into a format for Survey Monkey enabling a more efficient process for data collection.

The self-assessment tool for Service Level/ Agencies were submitted in hard copy format.

STATISTICAL ANALYSIS

GARY CROTON SELF ASSESSMENT CHECKLIST FOR DUAL DIAGNOSIS CAPABILITIES OF WORKERS/CLINICAL STAFF

Two sets of data were analysed.

- The scores from questionnaires for each agency
- The scores from questionnaires across the alliance.

Method of analysis

- Descriptive statistics were used to evaluate mean scores across staff within agencies
- Descriptive statistics, single factor between subject analysis of variance (ANOVA) and SMK – Post Hoc Test were used to evaluate mean scores across the alliance. These were conducted by Dr Jahar Bhowmik of Swinburne University.

Agency individual reports are listed in the Appendices
RESULTS

PART A: NEMHA STAFF TRAINING NEEDS

Respondents completed three types of questionnaires depending on whether they belonged to the AOD, MH or PDRSS sector. These questionnaires were mostly similar, with some questions differing slightly to reflect the context of the agency i.e. AOD/MH OR PDRSS. These differences proved problematic for the purpose of statistical analysis; risking the integrity of the statistical analysis.

The alliance consisted of 12 programs; two from the AOD sector, two from the MH sector and 8 from the PDRSS sector. The total number of respondents included 15 from AOD, 8 from MH and 54 from the PDRSS sector. Given the small samples sizes for the AOD and MH sectors a decision was taken to run a statistical analysis for the PDRSS sector only. For small sample sizes it is difficult to run statistical analysis and validate the results.

Based on Anova analysis there no significant differences identified between PDRSS agencies however a pair-wise comparison using post-hoc test identified Office of Housing and Carerlinks as having significantly lower mean average scores compared to the others. Overall, staff training needs were identified when mean score averages of 6 or less were indicated across PDRSS agencies.

The following areas are considered for future training needs.

DOMAIN 1: Detection of co-occurring substance use problems
Q’s: 1.4 – 1.6:
- An understanding of the agency’s approach to and tools for co-occurring substance use and MH problems. This may be explained as part of staff orientation program and / or policy and procedure documentation.
- Knowledge of various screens and approaches to screening useful for detecting co-occurring substance use and/or MH problems including the screens most likely to detect the most prevalent co-occurring substance use and/or MH problems in the population of persons with mental health or substance use problems that the agency provides services to.
- Skills in deploying a range of screening approaches to detect possible co-occurring substance use or mental health problems.

Based on the use of descriptive statistics, these findings correspond with the training needs of SHARC and AUSTIN HEALTH however not for Banyule Community Health – AOD program and Mental Health Teams.

DOMAIN 2: Assessment of co-occurring substance use problems
Q’s: 2.3 – 2.4 – 2.5 – 2.7 – 2.11
- Knowledge of the ICD-10 criteria for substance use disorders and/or the DSM-V criteria for substance use disorder
- Developing as routine practice following a positive screen, a more detailed substance use assessment.
- Skill in conducting a substance use assessment with the goal of developing a treatment plan that addresses both substance use and mental health
- An understanding of the agencies approach to and related forms for assessment of co-occurring substance use problems
- Skill and confidence in recognising withdrawal (mild to severe) from a range of substances.

Based on the use of descriptive statistics, these findings correspond with the needs of Banyule Community health – Mental Health team however, not for SHARC, BCH – AOD team and Austin Health.
DOMAIN 3: Service Planning
Q’s: 3.1-3.2-3.3-3.4

- Operational understanding of the different cohorts of people with mental health-substance use disorders and pathways available for effective treatment
- Operational understanding of what constitutes integrated treatment and the pathways to achieve this.
- Skill and knowledge in developing a treatment plan for co-occurring mental health and substance use problems.
- Familiarity with collaborating with AOD and clinical mental health services in the development of an integrated treatment plan that documents arrangements around ongoing formal interactions and co-operation in providing services to the client.

Based on descriptive statistics, these findings do not correspond with SHARC, Banyule CH – AOD and Mental Health teams and Austin Health.

DOMAIN 4: Response to co-occurring substance use problems
Q’s: 4.1 – 4.3 – 4.4 – 4.5 – 4.6

- Knowledge and the skill to deliver brief interventions (FRAMES: Feedback, Responsibility, Advice, Menu of Options, Empathy, Self-efficacy)
- Understanding of Pharmacotherapies
- Confidence in arranging a withdrawal management plan
- Knowledge and confidence in provision of relapse prevention strategies – (rationale, enhance commitment to change, teaching coping skills, how to avoid temptation, preparing for a lapse, lifestyle issues, risk, cognitive distortions.)
- Skill in the use of outcome measures that capture changes in co-occurring substance use problems.

Based on descriptive statistics, SHARC and Banyule Community Health – AOD program do not support these findings however, Austin Health and BCH – MH program support training around developing withdrawal management plans and for BCH – MH program, the use of outcome measures that capture changes in co-occurring substance use problems.

Domain 5: Working with the broader service system
Q’s 5/8 – 5.9 – 5.11 – 5.12

- Understanding of approaches to detecting co-occurring mental health problems used by local AOD services
- Knowledge and Understanding of the AOD treatment system (target problems, component parts, strengths and challenges in detecting and responding to co-occurring MH problems)
- Knowledge and understanding of the primary care/general practice service systems (target problems, component parts, strengths and challenges in detecting and responding to co-occurring MH problems)
- Comfort/Confidence in providing MH services and consultations in AOD, clinical MH and primary care service settings

Based on descriptive statistics, the AOD AND MH clinical services identified needs different to the PDRSS sector. SHARC identified training to improve understanding of screening used by local specialist MH service for co-occurring substance use and a better understanding of the PDRSS sector. Banyule Community Health – AOD identified the need to develop processes to incorporate secondary consultation as part of routine practice and understanding the approach to screening by local specialist MH services for co-occurring substance use disorders whilst, Austin Health identified developing skills in seeking secondary consultation when working with comorbid MH and AOD disorders.
Conclusion

Whilst a number of areas were identified for staff training needs, these results must be considered in the context of a ‘self-rating’ style questionnaire based on self-perception. To further examine staff training needs an audit of ‘years of experience’ and Certificate level of training would provide more qualitative data. Whilst an attempt was made to collect this information, the process was not streamlined resulting in insufficient information collected.

Unrepresentative sample sizes limited the capacity to evaluate programs for the AOD and MH sector however the PDRSS sector had a large enough sample size to run statistical analysis that showed validity. Comparing the results for the PDRSS sector to the training needs identified in the AOD and MH sector there were some shared training needs identified however, again, these have to be considered in the light of smaller sample sizes.

For future investigation is the problem of multicollinearity for the questionnaires in which there are a number of survey questions in which the questions are related to each other; unusual for health related studies. See Swinburne Report p83 - 85.

It was interesting to note that some of the low mean scores identified for training needs were questions that were vaguely worded or obscure in language which may not necessarily indicate an area of need. These questions are listed as: Q1.5, 2.7, 3.1, 3.4, 5.8,. Once making allowances for these the following KEY areas for training can be summarised as:

1. Screening – policy, procedures, types and skills in deploying a range of screens.

2. Assessment –
   - ICD and/or DSM –IV/V criteria for substance use or MH disorders
   - How to conduct a comprehensive MH and AOD
   - How to recognise withdrawal symptoms from a range of substances
   - Once screened positive, the practice and understanding of how to conduct a comprehensive substance use assessment with follow up treatment plan

3. Service Planning –
   - Pathways for service delivery for different cohorts of people with comorbid MH and AOD disorders
   - Integrated treatment – what is it and the pathways to achieve this, development of treatment plans, formal agreements and processes.

4. Response to co-occurring substance use problems
• Skills in delivering brief interventions, relapse prevention strategies, withdrawal management plans
• Knowledge of AOD pharmacotherapies
• Use of outcome measures to capture changes in client co-occurring substance use.

5. Working with the broader service system
• Understanding the AOD, MH, primary care and PDRSS service systems
• Secondary consultation – how to access and deliver secondary consultation in different settings i.e. AOD/MH/primary care.

PART B: NEMHA AGENCY LEVEL RESULTS

The Gary Croton Service Level Agency Checklist was the tool used to determine dual diagnosis capabilities across services in the NEMH Alliance. Data sets were collected from 11 programs including:

• SHARC
• Austin Health
• MIND
• MIF
• NEAMI
• BANYULE COMMUNITY HEALTH
  o AOD
  o CMH
  o Gamblers Help
  o Counselling Team
• CARERLINKS
• ARAFEMI

Two sets of data were analysed.
• Mean scores for the NEMH Alliance as a group
• Mean scores for each program within the NEMH Alliance.

By analysing the two sets of data, agencies are in a better position to develop internal policies and procedures to improve how they respond to dual diagnosis clients. They can compare their agency to similar agencies within their sector as a benchmark for comparison and as an alliance can ‘jointly’ develop interagency protocols to better respond to the needs of people with comorbid mental health and alcohol and drug disorders within a regional boundary.

Each program provided a score based on a Likert scale of 1-10 for 5 Domains within their organisation. Each domain contained a series of questions. For each question, the program scored a number from 1 to 10 that mostly reflects the level of dual diagnosis capability pertaining to that question a score of 1 indicates a very low level of dual diagnosis capability and a score of 10 indicating an enhanced level of dual diagnosis capability. A mid-range of score of 5 is considered a moderate range of dual diagnosis capability in relation to the line of questioning.

The Domains were as follows:
• Domain 1: Agency Policy and Documentation (5 questions)
• Domain 2: Detection and Assessment of co-occurring Mental Health and Substance Use Disorders (12 questions)
• Domain 3: Integrated Treatment of co-occurring Mental Health and Substance Use Disorders (3 questions)
• Domain 4: Working with the broader service system (19 questions)
• Domain 5: Agency Quality Assurance (19 questions)
Scores across each question were compared across the 11 programs.
Questions left blank by programs were not included in determining the average across programs for that question. The proportion of questions that were left blank across Domains 1 - 5 is as follows:

<table>
<thead>
<tr>
<th>Domain 1</th>
<th>Domain 2</th>
<th>Domain 3</th>
<th>Domain 4</th>
<th>Domain 5</th>
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</thead>
<tbody>
<tr>
<td>2%</td>
<td>1%</td>
<td>0%</td>
<td>5%</td>
<td>5%</td>
</tr>
</tbody>
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**Domain 1: Agency Policy and Documentation (5 questions)**

Domain 1 consisted of five survey questions focussing on service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders.

**Mean score:** 5/10

**Range of scores:** 3-7

**Recommendations:**

Based on mean scores below 5:

1. Carerlinks, MIF and BCH CMH team particularly need support with this Domain.
2. In terms of the NEMH Alliance, the group would benefit from developing:
   - Position descriptions reflect the expectation that staff is dual diagnosis capable or are working towards this.
     - The minimum expectation is that staff can screen for dual diagnosis, are able to conduct a detailed assessment that enables the development of an integrated treatment and care plan, that they are aware and are able to refer clients within and between services and consult with others with more advanced knowledge and skills in making decisions about the most appropriate course of action.
     - For positions above base-grade, criteria around advanced dual diagnosis capabilities to be included. This would include: ability to demonstrate knowledge and skills in planning and delivery of integrated treatment and care and the provision of supervision and support to other staff providing treatment and care to people with a dual diagnosis.
Domain 2: Detection and Assessment of co-occurring Mental Health and Substance Use Disorders (12 questions)

Domain 2 consisted of 12 survey questions focusing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services

Mean Score: 7.5/10

Range of Scores: 6.2 – 8.4

Recommendations:

Based on mean scores below 5:

1. Carerlinks particularly needs support with this Domain.
2. In terms of the NEMH Alliance, scores demonstrate a moderate level of dual diagnosis capability. Questions 2.9 and 2.11 may be an area of interest to develop further:

   - Where it is outside staff capacity to conduct a comprehensive assessment of any detected co-occurring disorder formal arrangements exist with local specialist services to provide either secondary consultation or the required assessment.
   - Assessment proformas facilitate the identification of the clients Stage of Change for both disorders

Domain 3: Integrated Treatment of co-occurring Mental Health and Substance Use Disorders (3 questions)

Domain 3 consisted of 3 survey questions focusing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence

Mean scores: 6/10

Range of scores: 5 – 7

Recommendations:

Based on mean scores less than 5, Austin Health and Carerlinks need most support with Domain 3.
In terms of the NEMH Alliance, scores demonstrate a moderate level of dual diagnosis capability. Question 3.2 received a score of 4.9 and the NEMH Alliance would benefit from training to increase the percentage of workers who have well developed skills in providing treatment for co-occurring mental health or substance use disorders.

Domain 4: Working with the broader service system (19 questions)

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, preforms that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean score: 4.6/10

Range of scores: 3.1 – 5.9

Recommendations:
Based on mean scores less than 5, the majority of programs need support with this Domain. In particular: Mind, Neami, ARAFEMI and CarerLinks. The remaining programs are borderline i.e. Austin Health and BCH (all programs). In terms of the NEMH Alliance, scores demonstrate a low level of dual diagnosis capability.

The NEMH ALLIANCE would benefit from further developing:

- Staff orientation procedures that include a brief placement in the other sector
- Secondary consultation policy to support clinicians in providing effective secondary consultation that includes procedures and staff orientation manuals to support training around the skills of seeking and providing secondary consultation
- Formal agreements between local specialist AOD/MH services that define treatment pathways for the different cohorts of clients with a dual diagnosis
- Process for review of formal agreements to monitor their effectiveness in meeting needs of clients with a dual diagnosis and dispute resolution processes
- Formal agreements are formed and based on consultations between local AOD/MH services.
- Development of Individual Service Plans and an Integrated treatment proforma are based on collaboration between partner agencies
- Training around the concept of ‘no wrong door’ service system.
- Process between partner AOD/MH services to monitor, evaluate and plan around frequency of diagnosis, identification of cohorts of people with a dual diagnosis, provision of multi agency integrated treatment and outcomes for people with dual diagnosis.
Domain 5: Agency Quality Assurance (19 questions)

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training.

Mean score: 5/10

Range of scores: 2 – 6.8

Recommendations:
Based on mean scores less than 5, Austin Health, BCH – CMH, ARAFEMI and Carerlinks programs need further support with Domain 5. Neami and MIF are borderline.

In terms of the NEMH Alliance, scores demonstrate a low – moderate level of dual diagnosis capability. The NEMH ALLIANCE would benefit from further developing:

- Client data base to enable comparisons between outcomes for people with and without a dual diagnosis.
- Consumer and Carer consultant positions are appointed based on ‘experience and expertise in dual diagnosis
- Consumer and Carers involvement in the planning and evaluation of service responses for clients with a dual diagnosis
- Consumer and Carer involvement in evaluating education and training packages around dual diagnosis.
- File audit, quality control processes that audit the frequency of delivery of integrated treatment and screening and assessment of co-occurring disorders
- Staff appraisal procedures to include reference to clinician’s progress in developing dual diagnosis capability
- Outcome measures include measures that monitor outcomes of the treatment provided for any co-occurring disorder.
CONCLUSION

The limitations of a self-reporting style questionnaire are at risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project it is estimated that less than 10 staff per agency contributed to scoring the questionnaire across 11 programs. This was considered insufficient to run statistical analysis – instead descriptive statistics was considered appropriate.

What needs to be considered is the proportion of questions left blank; in the case of Domain 4 and 5 these amounted to 5%.

Given these limitation, the following recommendations are made:

To improve dual diagnosis capability across the programs involved with the NEMH Alliance Dual Diagnosis Project, scores indicate that the areas of greatest need for the NEMH Alliance in order of priority are:

1. Domain 4: Working with the broader service system (as detailed above)
1. Domain 1: Agency Policy and Documentation (as detailed above)
2. Domain 5: Agency quality assurance processes and procedures (as detailed above)
Appendix 1.01: SHARC Staff Survey Results (AOD Tool)

11/13 completed surveys

**Domain 1: Detection of co-occurring mental health disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening.

- **Average mean score:** 5/10
- **Range of mean scores:** 3.83 – 6.6
- **Lowest mean score:** Q1.5

50% of responses rated less than 5.

**Recommendation:**
- Staff training in a variety of screens, preferred organisational approach to screening, skills in using a screen and development of processes to incorporate screening into routine practice and expectation of what to enquire when undertaking a screening tool.

**Domain 2: Assessment of co-occurring Mental Health Disorders**

Domain 2 comprised 11 questions gauging level of knowledge of interactions between AOD and MH disorders, types and symptoms of MH disorders, the ICD criteria and/or DSM IV/V for psychiatric disorders, routine practice in response to screening, skills in MH assessment, suicide risk assessment, mental state examination, stages of change and client note taking.

- **Average Mean Score:** 6.5
- **Range of mean scores:** 5.44 – 8.33
- **Lowest Mean Score:** Q2.7

100% of responses rated more than 5.

**Recommendation:**
- Staff responses indicate a satisfactory level of confidence in assessing a co-occurring mental health disorder.

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

- **Average mean score:** 6.15
- **Range of mean scores:** 5.8 – 6.63
- **Lowest Mean Score:** Q3.3

100% of responses rated more than 5

**Recommendation:**
- Staff responses indicate a level of confidence in treatment planning around comorbid mental health and AOD disorders.
Domain 4: Treatment of co-occurring mental health disorders

Domain 4 comprises 8 questions gauging level of skill in delivering cognitive behaviour therapy, relaxation and stress reduction, managing self-harming behaviours, responding to personality disorders, providing psycho-education around MH disorders, psychotropic medication, management of suicide clients, and use of outcome measures to capture change.

Average mean score: 6.7

Range of mean scores: 6.14 – 7.56

Lowest mean score: Q4.3

100% of responses rated more than 5

Recommendation:

- Staff responses indicate a level of confidence in the treatment of comorbid mental health and AOD disorders.

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care.

Average mean score: 5.9

Range of mean scores: 4.5 – 7.73

Lowest Mean Score: Q5.8

15% of responses rated less than 5

Recommendation:

Survey responses indicate a satisfactory level of confidence in working with the broader service system. Areas in which improvement is needed include:

- Staff training to improve understanding of screening used by local specialist MH service for co-occurring substance use.
- Staff training to improve understanding of the PDRSS system.
Appendix 1.02 : SHARC Agency Level Survey Results (AOD Tool)

Domain 1: Service Agency Policy and Documentation
Domain 1 consisted of five survey questions focussing on Service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders.

Mean Score: 8/10.
Range of Scores: 8.

Recommendation
Relatively high scores for Domain 1 indicate SHARC policy and procedures are working towards an enhanced level of dual diagnosis capability. At this stage, SHARC would benefit from reviewing these scores annually and maintaining this standard.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders
Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean Score: 8.4/10
Range of Scores: 6 – 9
92% of questions scored between 7-9 and 8% scored 6.

Recommendation
Relatively med - high scores for Domain 2 indicates SHARC’s screening and assessment processes and procedures and supporting documentation are working towards an enhanced level of dual diagnosis. SHARC could further develop:

- Assessment proformas to include a section on the client’s Stage of Change in relation to both mental health and the alcohol and drug related problem.
- Allocate an in-house training workshop on ‘how to conduct an assessment of co-occurring substance use and mental health disorders’ –

Domain 3: Integrated Treatment of co-occurring Mental Health and Substance Use disorders
Domain 3 consisted of 3 survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 7.6/10
Range of scores: 7 – 9
67% of questions scored 7 and 33% scored 9

Recommendation:
Medium-high scores for Domain 3 indicate SHARC would benefit from developing policies and procedures to incorporate an integrated treatment model of care for clients with a dual diagnosis. In particular SHARC would benefit from:

- Workshop on ‘what is integrated treatment, what are the pathways and how to do integrated treatment.

Domain 4: Working with the broader service system
Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, preforms that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution
processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

**Mean Score: 8/10**

**Range of scores: 6 – 9**

Q 4.3 was marked blank. Of the remaining 18 questions 66.6% scored between 8-9, 22.2% scored 7 and 11.1% scored 6.

**Recommendations**

Med- high scores for Domain 4 indicate SHARC are working towards an enhanced level of capability in working with the broader service system for the shared purpose of dual diagnosis.

SHARC could improve their capacity through the development of:

- An Integrated Treatment Proforma between agencies
- Policy or processes in which agencies collaborate on the development of Individual Service Plans

**Domain 5: Agency Quality Assurance**

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client database, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training.

**Mean score – 8/10**

**Range of scores: 7 - 9**

Q5.11 and 5.12 were left blank. Of the remaining 17 questions, 100% scored between 7 - 10.

**Recommendation**

The relatively high scores for Domain 5 suggest SHARC are working towards an enhanced level of quality assurance in the area of dual diagnosis. To maintain this level of a capacity SHARC need to continue to monitor and refine their dual diagnosis programs,

**Conclusion:**

The limitations of a self-reporting style questionnaire are the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Domains 1 - 5 consistently scored an average of 8. This significantly high score indicates that SHARC are working towards an enhanced level of dual diagnosis. SHARC are encouraged to review these scores annually and refine programs as required.
SHARC MEAN SCORES PER DOMAIN

- Domain 1
- Domain 2
- Domain 3
- Domain 4
- Domain 5
Appendix 2.01: BCH AOD Staff Survey Results (AOD Tool)

4/5 Completed Surveys

**Domain 1: Detection of co-occurring mental health disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening.

*Average mean score:* 8.9  
*Range of mean scores:* 8.25 – 9.5  

**Recommendation:**  
Survey responses indicate a high level of confidence in screening and detecting co-occurring mental health disorders.

**Domain 2: Assessment of co-occurring Mental Health Disorders**

Domain 2 comprised 11 questions gauging level of knowledge of interactions between AOD and MH disorders, types and symptoms of MH disorders, the ICD criteria and/or DSM IV/V for psychiatric disorders, routine practice in response to screening, skills in MH assessment, suicide risk assessment, mental state examination, stages of change and client note taking.

*Average Mean Score:* 8.3  
*Range of mean scores:* 6.5 – 9.25  
*Lowest Mean Score:* Q2.3  

**Recommendation:**  
- Staff responses indicate a high level of confidence in assessing a co-occurring mental health disorder.

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

*Average mean score:* 8.2  
*Range of mean scores:* 8 – 8.25  

**Recommendation:**  
- Staff responses indicate a high level of confidence in treatment planning around comorbid mental health and AOD disorders.

**Domain 4: Treatment of co-occurring mental health disorders**

Domain 4 comprises 8 questions gauging level of skill in delivering cognitive behaviour therapy, relaxation and stress reduction, managing self harming behaviours, responding to personality disorders, providing psycho-education around MH disorders, psychotropic medication, management of suicide clients, and use of outcome measures to capture change.

*Average mean score:* 7.31
Range of mean scores: 6.5 - 7.75
Lowest mean score: Q4.8

Recommendation:
- Staff responses indicate a satisfactory level of confidence in the treatment of comorbid mental health and AOD disorders.

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care.

Average mean score: 7.5
Range of mean scores: 6.25 - 8.5
Lowest Mean Score: Q5.5, 5.8, 5.9, 5.10

Recommendation:
Survey responses indicate a satisfactory level of confidence in working with the broader service system. Areas in which improvements could be directed include:
- Incorporating secondary consultation as part of routine practice
- Understanding the approach to screening by local specialist MH services for co-occurring substance use disorders

![Graph showing domain scores for Banyule Community Health - AOD](image-url)
Appendix 2.02: BCH Clinical Mental Health Staff Survey Results (MH Tool)

2/3 surveys completed

Domain 1: Detection of co-occurring substance use disorders
Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

Average mean score: 7.2
Range of mean scores: 4 – 9.5
Lowest mean score: Q1.5
11% of mean scores were less than 5.

Recommendation:
Survey responses indicate a high level of confidence in screening and detecting comorbid substance use. An area in which training would be of benefit includes:

- Developing skills in seeking secondary consultation when working with comorbid MH and AOD disorders.

Domain 2: Assessment of co-occurring Substance Use Disorders
Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

Average Mean Score: 6.3
Range of mean scores: 3.5 - 10
Lowest Mean Score: Q2.7
33% of mean scores were less than 5

Recommendation:
Survey responses indicate a satisfactory level of confidence in assessing a co-occurring substance use disorder. However given the range of mean scores in this Domain, training in the following areas is highly recommended:

- Establishing skills in and routine practices of conducting detailed substance use assessment following a positive screen
- Induction training around organisation preferred approach to assessment of co-occurring substance use

Domain 3: Treatment Planning
Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

Average mean score: 7.8
Range of mean scores: 6.5 – 8.5

Recommendation:
- Staff responses indicate a high level of confidence in treatment planning around comorbid mental health and AOD disorders.
Domain 4: Treatment of co-occurring substance use disorders

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change.

Average mean score: 7.2
Range of mean scores: 5.5 – 9
Lowest mean score: Q4.4 & 4.6

Recommendation:
Survey responses indicate a high level of confidence in the treatment of co-occurring substance use disorders. An area in which training could be of benefit includes:

- The skill of developing a withdrawal management plan.
- The skill in using outcome measures that capture changes in client's co-occurring substance use disorders.

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the 'no wrong door philosophy.'

Average mean score: 9.2
Range of mean scores: 8.5 - 10

Recommendation:
Survey responses indicate a very high level of confidence in working with the broader service system.

Appendix 2.03: BCH General Counselling Staff Survey Results (PDRSS Tool)

3/4 surveys completed
Domain 1: Detection of co-occurring substance use disorders
Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

Average mean score: 7/10
Range of mean scores: 4 - 8
Lowest mean score: Q1.5
11% of mean scores were less than 5

Recommendation:
Survey responses indicate a strong level of confidence in screening and detecting comorbid substance use. Training would benefit respondents in the following areas:

- Orientation to cover service’s preferred approach to and tools for screening co-occurring substance use disorders
- Skills in deploying a range of screening approaches to detect co-occurring substance use problems.

Domain 2: Assessment of co-occurring Substance Use Disorders
Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

Average mean score: 7.75
Range of mean scores: 7 – 8.5

Recommendation:
Survey responses indicate a strong level of confidence in assessing a co-occurring substance use disorder.

Domain 3: Treatment Planning
Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

Average mean score: 8.1
Range of mean scores: 7.5-8.5

Recommendation:
Survey responses indicate a strong level of confidence in treatment planning around co-occurring MH and AOD disorders.

Domain 4: Treatment of co-occurring substance use disorders
Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change

Average mean score: 7.7/10
Range of mean scores: 7 – 8.5

Recommendation:
Survey responses indicate a strong level of confidence in the treatment of co-occurring MH and AOD disorders.

Domain 5: Working with the broader service system
Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.

**Average mean score:** 8.5/10  
**Range of mean scores:** 7.5 – 9.5  
**Recommendation:**  
Survey responses indicate a very strong level of confidence in working with the broader service system.
Appendix 2.04: BCH Gamblers Help Staff Survey Results (PDRSS Tool)

9/16 Completed Surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

- **Average mean score:** 7.5/10
- **Range of mean scores:** 4.75 – 7.33
- **Lowest mean score:** Q1.5

11% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a strong level of confidence in screening and detecting comorbid substance use. Training would benefit respondents in the following areas:

- Orientation to cover service’s preferred approach to and tools for screening co-occurring substance use disorders
- Skills in deploying a range of screening approaches to detect co-occurring substance use problems.

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

- **Average mean score:** 6.4
- **Range of mean scores:** 4.88 – 7.5
- **Lowest mean score:** Q2.8

8.3% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a satisfactory level of confidence in assessing a co-occurring substance use disorder. Training would benefit respondents in the following areas:

- Comprehensive substance use assessment to include a full range of possible substances of abuse
- Orientation program to include services preferred approach to and form for assessment of co-occurring substance use problems.

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

- **Average mean score:** 6.3/10
- **Range of mean scores:** 4.57 – 7
- **Lowest mean score:** Q3.4

25% of mean scores are less than 5

**Recommendation:**

Whilst survey responses indicate a satisfactory level of confidence in treatment planning around co-occurring MH and AOD disorders, respondents would benefit from training in regard to:
- Operational familiarity with collaborating with the AOD and clinical MH services in developing an integrated treatment plan that documents formal interactions between services and the client.

**Domain 4: Treatment of co-occurring substance use disorders**

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change.

**Average mean score:** 5.8/10  
**Range of mean scores:** 4.63 – 7.38  
**Lowest mean scores:** Q’s: 4.6 - 4.1 - 4.4 - 4.3  
17% of mean scores were less than 5

**Recommendation:**  
Survey responses indicate a satisfactory level of confidence in the treatment of co-occurring MH and AOD disorders. However with 17% of means scores less than 5, and 50% of respondents scoring a 5 training would be of most benefit in the following areas:

- Ability to deliver effective ‘brief interventions’  
- An understanding of AOD pharmacotherapies  
- Confidence in arranging a withdrawal management plan  
- Use of outcome measures to capture change in co-occurring substance use problems.

**Domain 5: Working with the broader service system**

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.’

**Average mean score:** 7.2/10  
**Range of mean scores:** 5 - 9.25  
**Lowest mean score:** Q5.8

**Recommendation:**  
Survey responses indicate a satisfactory level of confidence in working with the broader service system. Respondents would benefit from further training in:

- Understanding approaches used by local AOD services in detecting co-occurring MH problems.
Appendix 2.05: BCH General Counselling & AOD Agency Level Survey Results (Agency Tool)

Domain 1: Service Agency Policy and Documentation

Domain 1 consisted of five survey questions focussing on service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders.

**Mean Score:** 6/10

**Range of scores:** 3 – 8

60% of questions scored 8 and 40% scored 3.

**Recommendations:**
The relatively high percentage of high scores for Domain 1 indicates the BCH – AOD program are working towards an enhanced level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developments in the following areas:

- Development of position descriptions that incorporate expectations around dual diagnosis capabilities for all levels of staff.
- Target position descriptions referring to above base grade and include criteria around advanced dual diagnosis capability i.e. planning, integrated treatment, provision of supervision and care to people with a dual diagnosis.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

**Mean score:** 9/10

**Range of scores:** 6 – 10

83.3% of questions scored 10 and 16.6% scored 6

**Recommendations:**
The percentage of exceptionally high scores for Domain 1 indicates that BCH – AOD program is working towards an enhanced level of dual diagnosis capacity in relation to Screening and assessment policy and procedures and could benefit further from developments in the following areas:

- Routine service entry documentation includes a screen to detect the presence of possible co-occurring substance use or mental health disorders.
- Formal arrangements with local specialist providers where it is ‘outside’ staff capacity to conduct a comprehensive assessment of a co-occurring disorder.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

**Mean score:** 6/10

**Range of scores:** 5 – 9

66.6% of questions scored 5 and 33.3% scored 9.

**Recommendations:**
The high percentage of low scores for Domain 3 indicates that BCH – AOD program is working towards a moderate level of dual diagnosis capacity in relation to incorporating integrated treatment policy and procedures and could benefit further from developments in the following areas
- A well-developed understanding of integrated treatment and the possible pathways to achieve integrated treatment.
- Developing clinicians skills in the treatment and support for people with a dual diagnosis

Domain 4: Working with the broader service system

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, preforms that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean score: 5.9/10
Range of scores: 1 – 10

Q4.11 was left blank. Of the remaining 18 questions, 55% scored between 5 to 8, 28% scored 10 and 17% scored 1.

Recommendations:
The relatively high percentage of med-high scores for Domain 4 indicates that BCH – AOD program is working towards a moderate to enhanced level of dual diagnosis capacity in relation to working with the broader service system and would further benefit in the following areas:
- Staff orientation includes a brief placement in the other service sector
- Development of formal agreements with other AOD/MH services around pathways for treatment across different cohorts of people with dual diagnosis
- Evidence of collaboration on the development of Individual service plans between partner services

Domain 5: Agency Quality Assurance

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

Mean score: 6.8/10
Range of scores: 1 – 10

53% of questions scored 10, 26% scored 1 and 21% scored between 5 - 8.

Recommendations:
The relatively high percentage of med-high scores for Domain 5 indicates that BCH – AOD program is working towards a moderate to enhanced level of dual diagnosis capacity in relation to quality assurance and would further benefit in the following areas:
- File auditing processes to include auditing the frequency of:
  - screening for and assessment of co-occurring disorders
  - Frequency of integrated treatment to people with a dual diagnosis
- Staff Appraisal procedures include levels of dual diagnosis capability
- Client data base can distinguish between outcomes for clients with dual diagnosis and those without
- Consumer and Carer position appointments reflect experience and expertise in dual diagnosis.

Conclusion

The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.
Across Domains 1 - 5, BCH AOD program achieved a mean score of 6.876, with Domain 2 being the best performing area with a score of 9.3 and Domain 1 rated lowest with a score of 6. Overall, BCH – AOD program is working towards moderate to enhanced level of dual diagnosis capability and to maintain this, review and refinement on an annual basis is needed.
Appendix 2.06: BCH Clinical Mental Health Agency Level Survey Results (Agency Tool)

**Domain 1: Service Agency Policy and Documentation**

Domain 1 consisted of five survey questions focussing on service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders

**Mean Score:** 3.4/10  
**Range of scores:** 1 - 9  
60% of questions scored less than 2, 20% scored 9 and 20% scored 4.

**Recommendations:**

The exceptionally high percentage of low scores for Domain 1 indicates that BCH – Clinical Mental Health program is working towards a moderate level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developing:

- Position descriptions that reflect expectations of dual diagnosis capability across AOD/MH roles.
- Screening and assessment protocols establishing preferred approaches to detecting and assessing AOD/ MH disorders.
- Service descriptions and mission statements that identify clients with and providing integrated treatment for co-occurring MH and substance use disorders.

**Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders**

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

**Mean Score:** 5.5/10  
**Range of scores:** 1 - 10  
67% of questions scored 6 or less and 33%, scored 9 to 10

**Recommendations:**

The high percentage of low scores for Domain 2 indicates that BCH – Clinical Mental Health program is working towards a moderate level of dual diagnosis capacity in relation to screening and assessment and would benefit further from developing:

- Staff orientation manuals that help facilitate the service’s preferred approach to screening/assessment for dual diagnosis.
- Staff are trained and show confidence in the agency’s screening tool and process for dual diagnosis clients and the selected screening tools reflect sensitivity and specificity
- Intake documentation includes assessment criteria for comorbid AOD and MH conditions.
- Stages of change for dual diagnosis clients are reported in assessment proformas for both AOD and MH conditions

**Domain 3 Integrated Treatment of co-occurring MH and substance use disorders**

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

**Mean Score:** 7/10  
**Range of Scores:** 5 – 10
Scores were evenly distributed including a score of 5, 7 and 10 respectively.

**Recommendations:**

The even spread of above average scores for Domain 3 indicates that BCH – Clinical Mental Health program is working towards a moderate - enhanced level of dual diagnosis capacity in relation to incorporating integrated treatment and would benefit further from developing:

- Training around clinical skills in providing treatment of or support for dual diagnosis clients.

**Domain 4: Working with the broader service system**

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, preforms that facilitate multi-agency interaction, staff rotation between agencies, MOU's, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

**Mean Score:** 5.75/10

**Range of Scores:** 1 - 10

7 out of 19 questions were left blank. These included questions: 4.5, 4.6, 4.7, 4.9, 4.12, 4.14, and 4.16. Of the 12 questions remaining, 58% scored between 5 – 8, 25%, scored 4 or less and 17% scored 10.

**Recommendations:**

The seven questions not attempted related to the establishment of formal agreements between MH and AOD service agencies and should be revisited. The percentage of med to high scores for Domain 4 indicates that BCH – Clinical Mental Health program is working towards a moderate - high level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developing:

- Staff orientation practices to include a brief placement in the other service sector
- Routine evaluation process with partner agencies that monitors and plans around frequency, identification of, provisions of integrated treatment and outcomes for people with a dual diagnosis.
- Staff skills in seeking and providing effective secondary consultation

**Domain 5: Agency Quality Assurance**

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis service planning, education and training.

**Mean Score:** 4/10

**Range of scores:** 1 - 10

Questions 5.15 to 5.19 were left blank. No explanations were provided. Of the 14 remaining questions, 57% scored between 1 to 4, 29% scored between 5 - 8 and 14% scored 10.

**Recommendations**

What these scores indicate is the need to explore the reason why the 5 questions related to client data base systems incorporating outcomes for dual diagnosis clients and the involvement of consumer and carers in dual diagnosis service planning, education and training were not attempted. Based on the 57% of scores with a rating of 4 or less, the service agency would benefit from developing:

- Routine practices around monitoring, evaluating and planning around frequency of screening, assessment, provision of integrated treatment and outcomes for clients with a dual diagnosis
- File audits to include criteria to enable routine practices as noted above
- The ability to access clinical supervision to support staff working with clients with a dual diagnosis.
• Remuneration and workload allocation for dual diagnosis portfolio holders properly reflects demands of the role
• Client Database to enable recording of positive screens and follow up i.e. assessment and integrated treatment.

Conclusion

The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Across Domains 1-5, BCH CMH program achieved a mean score of 5.26, with Domain 3 being the best performing area with a score of 7.3 and Domain 1 rated lowest with a score of 3.4.

Interestingly Domain 3: Integrated Treatment of co-occurring MH and substance use disorders achieved high scores suggesting workers understand integrated treatment and the pathways to achieve this. Inconsistently, Domain 4 included five questions that were left blank that related to an understanding of formal agreements between agencies. This raises doubt in the confidence of staff in working with an integrated model of treatment and this domain should be reviewed in addition to the skills and practices in treating and recording information about clients with a dual diagnosis.

A mean score of 3.4 and 4.35 for Domain 1 and Domain 5 respectively indicates that BCH CMH program would benefit from further investment and training in the following areas priority listed:

1. Policy and procedures – in particular incorporating dual diagnosis expectations in position descriptions across levels of qualification and the development of a screening and assessment protocol that explains the service’s preferred approach to detecting and assessing clients with a dual diagnosis.
2. Agency quality assurance processes. incorporating an audit of the frequency of screening and assessment of cod, integrated treatment, outcome measures monitor outcomes for the treatment of cod, service routine practice to evaluate dual diagnosis practices and plans, the incorporation of clinical supervision to support staff working with clients with a dual diagnosis, staff orientation procedures to reflect screening assessment and treatment practices, staff appraisals to reflect dual diagnosis capabilities and development of staff, client data bases includes outcomes for clients, with a dual diagnosis.

Appendix 2.07: BCH Gamblers Help Agency Level Survey Results (Agency Tool)

Domain 1: Service Agency Policy and Documentation
Domain 1 consisted of five survey questions focussing on Service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders

Mean Score: 6/10
Range of Scores: 3-8
60% of questions scored 8 and 40% scored 3.

Recommendations
The percentage of high scores for Domain 1 indicates that BCH – Gamblers Help and Counselling team is working towards a moderate to enhanced level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developing

- Clinician Position descriptions that reflect the expectation that all staff are dual diagnosis capable or working towards this in addition to criteria expected of advanced dual diagnosis capability.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of preforms, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean Score: 9/10
Range of Scores: 6-10
83% of questions scored 10 and 17% scored 6.

Recommendations:
The percentage of exceptionally high scores for Domain 2 indicates that BCH – Gamblers Help and Counselling team is working towards a moderate to enhanced level of dual diagnosis capacity in relation to screening and assessment and based on 60% of staff who have received training in conducting an assessment of clients with a dual diagnosis, training across the team would help improve this percentage.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 6/10
Range of Scores: 5-9
67% of questions scored 5 and 33% scored 9.

Recommendations
The percentage of low scores for Domain 3 indicates that BCH – Gamblers Help and Counselling team is working towards a moderate level of dual diagnosis capacity in relation to incorporating integrated treatment practices and would further benefit from developing:

- Clinicians understanding of integrated treatment and the possible pathways to achieve this
- Based on approximately 50% of clinicians perceived as having well developed skills in providing treatment and support for co-occurring AOD and MH disorders, Gambler’s Help and the counselling team would benefit from training MH clinicians in the provision of brief interventions, motivational interviewing, relapse prevention, psychopharmacology for AOD disorders and AOD clinicians would benefit from learning evidence based treatments for anxiety, depression, PTSD and personality disorder.

Domain 4: Working with the broader service system
Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, proformas that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean Score: 6/10
Range of Scores: 1-10

Q4.11 was marked N/A. Of the remaining 18 questions, 50% scored 5, 33% scored between 8-10 and 17% scored 1.

Recommendations
The percentage of low scores for Domain 4 indicates that BCH – Gamblers Help and Counselling team is working towards a moderate level of dual diagnosis capacity in relation to working with the broader service system and would further benefit from developing:

- Staff orientation procedures including a placement in the other sector
- Formal agreements between agencies are based on consultation and collaboration and include pathways for the primary treatment responsibility for the different cohorts of people with a dual diagnosis, dispute resolution processes, development of Integrated Treatment Plans and proformas, collaboration on the development of Individual Service Plans, reciprocal delivery of assessment and treatment from the premises of the partner agency
- Strategies are in place to promote formal and informal contacts with local AOD and MH services including the experience of delivering assessment and treatment on the premises of the ‘partner’ agency and vice versa
- Developing a secondary consultation policy and process to support clinicians/workers that includes training and orientation manuals
- ‘No wrong door’ philosophy and practice as part of staff ongoing training.
- Developing routine practices with partner agencies that monitors, evaluates and plans around frequency, screening, integrated treatment and outcomes for clients with a dual diagnosis.

Domain 5: Agency Quality Assurance

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client database, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

Mean Score: 7/10
Range of Scores: 1 - 10

58% of questions scored between 8-10, 26% scored 1 and 16% scored between 5-7.

Recommendations
The percentage of med to high scores for Domain 5 indicates that BCH – Gamblers Help and Counselling team is working towards a moderate to enhanced level of dual diagnosis capacity in relation to quality assurance and would further benefit from developing:

- File audit, quality-control processes to include criteria to audit the frequency of screening, assessment and integrated treatment for of AOD and MH disorders.
- Outcome measures monitor outcomes of the treatment of people with a dual diagnosis
- The client database to include information pertaining to outcomes for people with a dual diagnosis to enable comparisons with people without a dual diagnosis
- Consumer and Carer processes include position descriptions that incorporate the expectation of dual diagnosis experience/expertise and their involvement in the planning and evaluation of service responses
- Staff appraisal procedures to include clinician’s progress towards becoming dual diagnosis capable
Conclusion
The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

BCH – Gamblers Help and the Counselling team achieved an average score of 6.8 across Domains 1 – 5. Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders, achieved the highest score of 9.3 and Domain 4: Working with the broader service system being the least performing; 5.8. BCH –Gamblers help and the counselling team should concentrate refining their dual diagnosis policy and practices across domains 1, 3, and 4.
Appendix 3.01: OoH Staff Survey Results (PDRSS Tool)

3 Completed surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening.

*Average mean score: 4/10*

*Range of mean scores: 1.5 – 5.33*

*Lowest mean score: Q1.8*

67% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a low level of confidence in screening and detecting comorbid substance use. With 67% of mean scores less than 5, training is strongly encouraged in the following areas:

- Develop screening/substance use assessment as routine practice
- Orientation to cover service’s preferred approach to and tools for screening co-occurring substance use disorders
- Knowledge of various screens, use, function for detecting co-occurring substance use disorders

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

*Average mean score: 4*

*Range of mean scores: 1.5 - 6*

*Lowest mean scores: Q2.3/2.7/2.5*

75% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a low level of confidence in assessing a co-occurring substance use disorder. With 75% of mean scores less than 5, training is strongly encouraged in the following areas:

- An understanding of the ICD-10 Criteria for substance use disorders and/or the DSM-I/V criteria for substance use disorder
- Development of skills in conducting a substance use assessment with the goal of developing a treatment plan that addresses both substance use and MH problems.
- Orientation training to include agency approach to and forms of assessment of co-occurring substance use problems.
- Development of skill and confidence in recognising withdrawal(mild to severe) from a range of substances
- Developing screening/substance use comprehensive assessment as part of routine practice
- An understanding of the stage of change model applied to comorbid MH and substance use disorders
Domain 3: Treatment Planning

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

Average mean score: 4.5
Range of mean scores: 4-5
Lowest mean scores: Q3.4
75% of mean scores were less than 5

Recommendation:
Survey responses indicate a low level of confidence in treatment planning. With 75% of mean scores less than 5, training is strongly encouraged in the following areas:

- Operational familiarity with collaborating with the AOD and clinical MH services in developing an integrated treatment plan that documents formal interactions between services and the client.
- All aspects of developing ‘integrated treatment’ pathways for different cohorts of clients with comorbid AOD and MH disorders (mild to severe)

Domain 4: Treatment of co-occurring substance use disorders

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change

Average mean score: 4.7
Range of mean scores: 3.5 - 7
Lowest mean scores: Q4.5
67% of mean scores were less than 5

Recommendation:
Survey responses indicate a low level of confidence in treatment of co-occurring substance use disorder. With 67% of mean scores less than 5, training is strongly encouraged in the following areas:

- Ability to deliver effective relapse prevention strategies
- Confidence in arranging a withdrawal management plan
- Ability to deliver effective ‘brief interventions’
- An understanding of AOD pharmacotherapies

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.

Average mean score: 4.7
Range of mean scores: 2 – 8.5
Lowest mean scores: 5.13/5.9/5.12/5.8/5.11/5.7/5.10/5.2
62% of mean scores were less than 5

Recommendation:
Survey responses indicate a low level of confidence in treatment of co-occurring substance use disorder. With 62% of mean scores less than 5, training is strongly encouraged in the following areas:

- Knowledge and understanding of ‘No wrong door’ philosophies/goals
Well-developed knowledge and understanding of the AOD treatment system, clinical mental health system, primary care/general practice service system
Confidence in providing MH services and consultation in AOD, clinical MH and primary care service settings
Familiarisation of local specialist services able to provide secondary consultation around the treatment needs of people with substance use problems
Familiarisation of approaches used by local AOD services to detect/screen for co-occurring MH problems
Familiarity with service policy and procedures in regard to providing and receiving secondary consultation including ‘duty of care’ principles.
Appendix 4.01: Austin Health Staff Survey Results (Clinical Mental Health Tool)

6/6 completed surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening.

*Average mean score: 7.5*

*Range of mean scores: 5.83 – 8.33*

*Lowest mean score: Q1.5*

**Recommendation:**
Survey responses indicate a satisfactory level of confidence in screening and detecting comorbid substance use. An area in which improvement could be detected includes:

- Training in preferred approach (and tools for) screening for co-occurring substance use disorders.

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

*Average Mean Score: 7.2*

*Range of mean scores: 5.8 – 8.83*

*Lowest Mean Score: Q2.7*

**Recommendation:**

- Staff responses indicate a high level of confidence in assessing a co-occurring mental health disorder.

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

*Average mean score: 7.3*

*Range of mean scores: 6.83 – 7.5*

**Recommendation:**

- Staff responses indicate a high level of confidence in treatment planning around comorbid mental health and AOD disorders.

**Domain 4: Treatment of co-occurring substance use disorders**

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change.

*Average mean score: 5.9*

*Range of mean scores: 4.33 – 6.8*
Lowest mean score: Q4.4
17% of mean scores are less than 5.

Recommendation:
- Survey responses indicate a satisfactory level of confidence in the treatment of co-occurring substance use disorders. An area in which training would be of benefit includes: the skill of developing a withdrawal management plan.

**Domain 5: Working with the broader service system**

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.

**Average mean score:** 7.8
**Range of mean scores:** 6.33 - 9
**Lowest Mean Score:** Q.5.1

**Recommendation:**
Survey responses indicate a high level of confidence in working with the broader service system. Areas in which improvements could be directed include:
- Developing skills in seeking secondary consultation when working with comorbid MH and AOD disorders.

![AUSTIN Domain Chart](chart.png)
APPENDIX 4.02 : Austin Health Agency Level Results (Agency Tool)

Domain 1: Service Agency Policy and Documentation

Domain 1 consisted of five survey questions focussing on service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders.

Mean Score: 5.6/10

Range of scores: 1 – 10

40% of scores were rated at 8 or above and 60% at 5 or below.

Recommendation:

The high percentage of relatively low scores for Domain 1 indicates Austin Health would benefit from developments in the following areas in order to work towards a moderate to enhanced level of dual diagnosis capability:

- develop a policy that embodies a ‘no wrong door’ philosophy – indicating that the presence of a comorbid MH and AOD disorder will not exclude persons from receiving services
- Development of position descriptions that incorporate expectations around dual diagnosis capabilities for all levels of staff.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean score: 7.5/10

Range of scores: 3 - 10

58.8% of questions scored between 9 and 10, 25% scored between 5 and 6 and 16.6% scored a 3.

Recommendation –

The percentage of relatively low - medium scores for Domain 2 indicates Austin Health are working towards a moderate to enhanced level of dual diagnosis capacity and would benefit further from developments in the following areas:

- staff orientation manuals to include Austin Health’s screening and assessment approach and protocols for people with a dual diagnosis
- Review of assessment documentation to include both MH and AOD and other relevant diagnosis.
- Review intake procedures to incorporate routine screening for people with a dual diagnosis

Domain 3: Integrated Treatment of co-occurring Mental Health and Substance Use disorders

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 3/10

Range of scores: 2 - 4

100% of questions scored between 2 - 4.

Recommendation –

The relatively high percentage of low scores for Domain 3 indicates Austin Health are working towards a moderate to enhanced level of dual diagnosis capacity in relation to integrated treatment and would benefit further from developments in the following areas:

- Dedicate an in-house training workshop on ‘what is integrated treatment, what are the pathways and how to do ‘integrated treatment’. 
• Develop a process and training for workers to be able to record comorbid AOD and MH diagnoses in client notes with equal prominence.

Domain 4: Working with the broader service system

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, preforms that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean Score: – 5/10

Range of scores: 2 - 8

79% of questions scored between 2- 6 and 21% scored 8.

Recommendations:
The relatively high percentage of low scores for Domain 4 indicates Austin Health are working towards a moderate to enhanced level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developments in the following areas:

• Provision for staff rotation in other agencies as part of orientation procedures
• Development of formal agreements, policies and procedures with other agencies that define, monitor and evaluate client care pathways based on consultations and ongoing communications, both formal and informal between agencies based on a history of trust and understanding.
• Development of dispute resolution procedures between agencies
• Facilitate routine collaboration on Individual Service Plans
• Development of an Integrated Treatment Plan proforma
• Reciprocate ‘assessment and treatment’ at the other agency as required
• Develop a Secondary Consultation Policy and process that supports workers in receiving and providing secondary consultation services including the opportunity for training.
• Incorporate ‘no wrong door’ values into all service and agency descriptions
• Receive ongoing training around what constitutes a ‘no wrong door’ philosophy

Domain 5: Agency Quality Assurance

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training.

Mean score: 2.4/10

Range of scores: 1 - 7

96% of questions scored between 1 to 5 or below.

Recommendation -
The relatively high percentage of low scores for Domain 5 indicates Austin Health are working towards a moderate level of dual diagnosis capacity in relation to quality assurance processes and would benefit further from developments in the following areas

• File audits to determine the frequency of screening and assessment of comorbid mental health and AOD disorders
• File audits to determine the frequency of delivering integrated treatment for comorbid mental health and AOD disorders
• File audits to determine outcomes for people with comorbid mental health and AOD disorders and the treatment provided
- Dual diagnosis clinical supervision is available to support workers
- Staff orientation to include Austin Health’s approach to integrated screening, assessment and treatment
- Review dual diagnosis capabilities within individual staff appraisal procedures
- Support and reward a dual diagnosis portfolio holder or an interested staff member
- Check dual diagnosis screening, assessment and integrated treatment of a client has been captured in client data base
- Incorporate consumer and carers with dual diagnosis experience in consultant positions, to help plan and evaluate service responses and education and training programs.

**Conclusion:**

The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders attracted the strongest scores with the average being 7.5. This was followed by Domain 2 with a mean score of 6. The remaining Domains 3-5 attracted average ratings between 2-5. Austin Health would benefit from addressing the recommendations as set out in the relevant sections.

![AUSTIN MEAN SCORES PER DOMAIN](chart.png)
APPENDIX 5.01: MIND Staff Survey Results (PDRSS tool)

13/? Completed surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

*Average mean score*: 7.5

*Range of mean scores*: 4.54 - 7.23

*Lowest mean score*: Q1.4

11% of mean scores were less than 5.

**Recommendation:**

Survey responses indicate a high level of confidence in screening and detecting comorbid substance use. An area in which training would be of benefit includes:

- Developing knowledge of various screens useful for detecting co-occurring substance use problems.

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

*Average Mean Score*: 5.9

*Range of mean scores*: 3.2 - 7

*Lowest Mean Scores*: Q2.3 & 2.11

17% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a satisfactory level of confidence in assessing a co-occurring substance use disorder. However given the range of mean scores in this Domain, training in the following areas is highly recommended:

- Knowledge of the ICD-10 Criteria for substance disorder and/or DSM-IV criteria for substance disorder
- The recognition of withdrawal (mild to severe) from a range of substances

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

*Average mean score*: 5.5

*Range of mean scores*: 4.82 - 6.27

*Lowest mean scores*: Q3.1 & 3.2

25% of mean scores were less than 5
Recommendation:
Survey responses indicate a satisfactory level of confidence in treatment planning around comorbid mental health and AOD disorders. However, areas in which training would be of benefit include:

- An understanding of the different cohorts of people with comorbid AOD and MH disorders and their pathways for service delivery.
- An understanding of what constitutes integrated treatment and pathways to achieve this.

Domain 4: Treatment of co-occurring substance use disorders

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change

Average mean score: 5.1

Range of mean scores: 4.27 – 6.45

Lowest mean scores: Q4.1/4.4/4.5

50% of mean scores were less than 5

Recommendation:
Survey responses indicate a marginal level of confidence in the treatment of co-occurring substance use disorders. With 50% of mean scores less than 5, training is strongly recommended in the following areas:

- Learning how to deliver brief interventions
- Learning how to deliver relapse prevention strategies
- Confidence in arranging a withdrawal management plan.

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.

Average mean score: 5.7

Range of mean scores: 4.44 - 6.89

Lowest mean scores: Q5.8/5.9/5.11

23% of mean scores were less than 5.

Recommendation:
Survey responses indicate a satisfactory level of confidence in working with the broader service system. Additional training in the following areas is indicated:

- Knowledge of the approach used by local specialist AOD service to detect/screen for co-occurring MH problems.
- Knowledge and understanding of the AOD treatment system
- Knowledge and understanding of the primary care/ general practice systems
- Knowledge of local/state-wide services/clinicians that provide secondary consultation for persons with substance use disorders.
APPENDIX 5.02 : MIND Agency Level Survey Results (Agency tool)

Domain 1: Service Agency Policy and Documentation

Domain 1 consisted of five survey questions focussing on service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders

Mean Score: 6/10
Range of scores: 5-10
80% of questions scored 5 and 20% scored 10

Recommendations:
The high percentage of medium scores for Domain 1 indicates that MIND is working towards a moderate level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developing:

- Service descriptions, mission statements, policies including access to services for clients with a dual diagnosis, position descriptions incorporating dual diagnosis requirements across levels of qualification when working with AOD and MH clients,

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean score: 9/10
Range of scores: 1 - 10
92% of questions scored 7 or above and 8% scored 1.

Recommendations:
The percentage of high scores for Domain 2 indicates that MIND is working towards a moderate to enhanced level of dual diagnosis capacity in relation to screening and assessment and would benefit further from developing

- Formal arrangements with local specialist services to provide secondary consultation and/or assessment of dual diagnosis clients where it is outside their staff capacity.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client's notes with equal prominence.

Mean score: 9/10
Range of scores: 8 – 10
Scores are evenly distributed 8, 9 and 10 respectively.

Recommendations:
What these scores indicate is that MIND has a well-developed understanding of integrated treatment and possible pathways to achieve this, 90% of clinicians/workers have well developed skills in providing treatment of, support for and recording of clients with a dual diagnosis. No further training is required.

Domain 4: Working with the broader service system
Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, pro formas that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

**Mean Score:** 2.8/10

**Range of Scores:** 1 - 10

68% of questions scored 1, 16% scored 5 and 16% scored between 8 to 10.

**Recommendations:**

The percentage of low scores for Domain 4 indicates that MIND is working towards a moderate level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developing:

- Staff orientation procedures including a placement in the other sector
- Formal agreements to be developed through collaboration between AOD and MH services in relation to client care pathways for the different cohorts of clients with a dual diagnosis, evaluation, monitoring and planning processes reviews, dispute resolution processes, development of individual service plans and integrated Treatment Plans.

**Domain 5: Agency Quality Assurance**

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

**Mean Score:** 6.63/10

**Range of scores:** 1 - 10

58% of questions scored between 5 – 8, 26% scored 10 and 16% score between 1 to 3.

**Recommendations**

The percentage of med - high scores for Domain 5 indicates that MIND is working towards a moderate - high level of dual diagnosis capacity in relation to quality assurance and would benefit further from developing:

- Ongoing, recurrent education and training around screening, assessment and integrated treatment for clients with a dual diagnosis.
- A review of remuneration and workload allocation for dual diagnosis portfolio holder’s that reflects the complexity and demands of the role.
- Selection criteria for portfolio holders include seniority and standing within the team to influence practice of co-workers and service delivery.

**Conclusion**

The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire. For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Four out of five domains scored an average rating of 6 or above; Domain 4 – working with the broader service system received the lowest mean score of 2.84. Domain 3 and Domain 2 scored 9 and 8.6 respectively indicating strong confidence in screening and assessment of clients with a dual diagnosis and indicating an understanding of integrated treatment of clients with a dual diagnosis. This latter point however, was not consistent with the results for Domain 4.
MIND would benefit from concentrating their quality improvement efforts in how to improve 'working with the broader service system' as recommended in the section attributed in Domain four above.
APPENDIX 6.01 – NEAMI Staff Survey Results (PDRSS tool)

6 Completed Surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

*Average mean score: 8*
*Range of mean scores: 6.4 - 8.4*

**Recommendation:**
Survey responses indicate a high level of confidence in screening and detecting comorbid substance use. An area in which training could be of benefit includes:

- Developing knowledge of deploying a range of screens for detecting co-occurring substance use problems.

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

*Average mean score: 6.7*
*Range of mean scores: 4.17 - 8.67*
*Lowest mean scores: Q2.3*

8% of mean scores were less than 5

**Recommendation:**
Survey responses indicate a satisfactory level of confidence in assessing a co-occurring substance use disorder. Training in the following area is highly recommended:

- Knowledge of the ICD-10 Criteria for substance disorder and/or DSM-IV criteria for substance disorder

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

*Average mean score: 5.6*
*Range of mean scores: 6 – 6.17*

**Recommendation:**
Survey responses indicate a satisfactory level of confidence in treatment planning around comorbid mental health and AOD disorders. However, given the limited range of scores areas in which training would be of benefit include all four questions:

- An understanding of the different cohorts of people with comorbid AOD and MH disorders and their pathways for service delivery.
- An understanding of what constitutes integrated treatment and pathways to achieve this.
• Developing treatment plans for co-occurring AOD and MH disorders
• Collaborating with other services to formulate an Integrated treatment plan

Domain 4: Treatment of co-occurring substance use disorders

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change

Average mean score: 5.75
Range of mean scores: 4.83 - 7.5
Lowest mean scores: Q4.1 & 4.4
17% of mean scores were less than 5

Recommendation:
Survey responses indicate a marginal/satisfactory level of confidence in the treatment of co-occurring substance use disorders. With 17% of mean scores less than 5, training is strongly recommended in the following areas:

• Learning how to deliver brief interventions
• Confidence in arranging a withdrawal management plan.

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the 'no wrong door philosophy.'

Average mean score: 6.5
Range of mean scores: 5.83 - 7.5

Recommendation:
Survey responses indicate a satisfactory level of confidence in working with the broader service system.

APPENDIX 6.02 – NEAMI Agency Level Survey Results (Agency Tool)

Domain 1: Service Agency Policy and Documentation
Domain 1 consisted of five survey questions focussing on Service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders

Mean Score: 7.6/10
Range of Scores: 4-10
60% of questions scored between 8 – 10 and 40% scored between 4 - 6

Recommendations:
The percentage of high scores for Domain 1 indicates that NEAMI is working towards a moderate – enhanced level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developing:

- position descriptions that incorporate expectations of dual diagnosis requirements across qualifications when working with AOD and MH clients

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean Score: 7.8/10
Range of scores: 1 - 10
75% of questions scored between 8 - 10 and 25% scored between 1 – 5.

Recommendations:
The percentage of high scores for Domain 2 indicates that NEAMI is working towards a moderate – enhanced level of dual diagnosis capacity in relation to screening and assessment and would benefit further from developing:

- Assessment proformas to include reference to stages of change for both MH and AOD disorders.
- Screening tools to reflect adequate sensitivity and specificity to detect clients with a dual diagnosis.
- Intake documentation includes comprehensive assessment criteria for co-occurring AOD and MH disorders.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 7/10
Range of Scores: 5 – 9
Scores are evenly spread including 5, 7, and 9 respectively.

Recommendations:
What these scores indicate is that NEAMI has a well-developed understanding of integrated treatment and possible pathways to achieve this, 70% of clinicians/workers have well developed skills in providing treatment of, and support for clients with a dual diagnosis. NEAMI however, could further develop processes to record dual diagnosis with equal prominence of both AOD and MH disorders in client notes.

Domain 4: Working with the broader service system

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, proformas that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution
processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

**Mean Score:** 3.4/10  
**Range of scores:** 1 - 10

68% of questions scored between 1 to 3, 16%, scored between 5-7 and 16% scored between 8 – 10.

**Recommendations:**

The relatively high score attributed for Domain 3 is inconsistent with that attributed to Domain 4. The percentage of low scores for Domain 3 indicates that NEAMI is working towards a moderate level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developing

- Staff orientation procedures including a placement in the other sector
- Formal agreements between agencies are based on consultation and collaboration and include pathways for the primary treatment responsibility for the different cohorts of people with a dual diagnosis, dispute resolution processes, development of Integrated Treatment Plans, reciprocal delivery of assessment and treatment from the premises of the partner agency
- Developing routine practices with partner agencies that monitors, evaluates and plans around frequency, screening, integrated treatment and outcomes for clients with a dual diagnosis.
- Embedding ‘no wrong door’ values into service and agency descriptions.
- Developing a secondary consultation policy and process to support clinicians/workers that includes training and orientation manuals

**Domain 5: Agency Quality Assurance**

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

**Mean score:** 5.4/10  
**Range of scores:** 1 - 10

Questions 5.10.5.15 and 5.16 were scored as N/A. Of the 16 remaining questions, 44% scored between 1-4, 31 scored between 8 - 10 and 25% scored between 5-7.

**Recommendations**

The high percentage of low scores for Domain 5 indicates that NEAMI is working towards a moderate level of dual diagnosis capacity in relation to quality assurance and would benefit further from developing

- A Client database system to record assessment and integrated treatment once a positive screen has been identified
- Consumer and Carer policy procedures in relation to planning and evaluation of services for clients with a dual diagnosis,
- Consumer and Carer involvement in and review of education training of dual diagnosis.
- Outcome measures for the treatment of clients with a dual diagnosis
- Routine practices that monitor, evaluate and plan around screening, assessment, integrated treatment and outcomes for clients with a dual diagnosis.

**Conclusion**

The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.
For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Three out of five domains scored an average rating of 7 or above; with Domain 5, averaging 5.4. Domain four – working with the broader service system is the outlier with the lowest mean score of 3.4. This result is inconsistent with the score of 7 attributed to Domain 3: Integrated treatment of co-occurring mental and substance use disorders. NEAMI would benefit from concentrating their quality improvement efforts in how to improve ‘working with the broader service system’ as recommended in the section attributed in Domain four above.
APPENDIX 7.01 – MIF Staff Survey Results (PDRSS tool)

7/7 Completed Surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

- **Average mean score:** 7.2
- **Range of mean scores:** 5.33 - 7.57

**Recommendation:**
Survey responses indicate a high level of confidence in screening and detecting comorbid substance use. An area in which training could be of benefit includes:

- Developing knowledge of deploying a range of screens for detecting co-occurring substance use problems.
- Training in preferred organisational approaches to and tools for screening for co-occurring substance use disorders

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

- **Average Mean Score:** 5.8
- **Range of mean scores:** 3.29 - 7.86
- **Lowest mean scores:** Q2.7/2.4/2.3
- **33% of mean scores were less than 5**

**Recommendation:**
Survey responses indicate a satisfactory level of confidence in assessing a co-occurring substance use disorder. However, given the wide range of scores and 33% below a 5, I strongly recommend training in the following areas:

- Orientation training of service approach to (and tools for) assessment of co-occurring substance use disorders
- Incorporating as part of routine practice, conducting a detailed substance use assessment following a positive screen.
- Knowledge of the ICD-10 Criteria for substance disorder and/or DSM-IV criteria for substance disorder

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

- **Average mean score:** 5.7
- **Range of mean scores:** 5 – 6.17

**Recommendation:**
Survey responses indicate a satisfactory level of confidence in treatment planning around comorbid mental health and AOD disorders. However, given the limited range of scores areas in which training would be of benefit include all four questions:

- An understanding of the different cohorts of people with comorbid AOD and MH disorders and their pathways for service delivery.
- An understanding of what constitutes integrated treatment and pathways to achieve this.
- Developing treatment plans for co-occurring AOD and MH disorders
- Collaborating with other services to formulate an Integrated treatment plan

Domain 4: Treatment of co-occurring substance use disorders

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change

Average mean score: 5.1
Range of mean scores: 3.83 - 6.17
Lowest mean scores: Q4.4
50% of mean scores were less than 5

Recommendation:
Surveys responses indicate a marginal level of confidence in the treatment of co-occurring substance use disorders. With a wide range of mean scores and 50% less than 5, training is strongly recommended in the following areas:

- Confidence in arranging a withdrawal management plan.
- Learning about brief interventions and how to deliver them
- An understanding of AOD pharmacotherapies

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.

Average mean score: 5.6
Range of mean scores: 3.83 - 7.5
Lowest mean scores: 5.11/5.9/5.8/5.12/5.7
38% with a mean score less than 5

Recommendation:
Surveys responses indicate a satisfactory level of confidence in working with the broader service system. However given the wide range of scores and 38% with a mean score less than 5 training is strongly recommended in the following areas:

- Knowledge of the primary care /general practice service system
- Knowledge of the AOD treatment system
- Knowledge of approaches AOD services use to screen mental health problems.
- Confidence to provide MH services and consultation in AOD, clinical MH and primary care services
- Policies and procedures surrounding the provision and receipt of secondary consultation including ‘duty of care’.
APPENDIX 7.02: MIF Agency Level Survey Results (Agency tool)

Domain 1: Service Agency Policy and Documentation

Domain 1 consisted of five survey questions focusing on service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders.

Mean Score: 1.6/10
Range of scores: 1-4

80% of questions scored 1 and 20% scored 4

Recommendations:
The exceptionally high percentage of low scores for Domain 1 indicates that MIF is working towards a moderate level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developing:

- Service descriptions, mission statements, and inclusion policies that support service delivery for clients with a dual diagnosis.
- Position Descriptions to incorporate dual diagnosis expectations of staff across all work types.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focusing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean Score: 8/10
Range of Scores: 5 - 10

75% of questions scored between 8 - 10 and 25% scored between 5 – 6.

Recommendations:
The percentage of high scores for Domain 2 indicates that MIF is working towards a moderate to enhanced level of dual diagnosis capacity in relation to screening and assessment and would benefit further from developing:

- Training and experience to improve skills and confidence in screening and assessment of clients with a dual diagnosis.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focusing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 7/10
Range of Scores: 5 – 10

Scores are evenly distributed including 5, 7, and 10

Recommendations:
What these scores indicate is that MIF has a sound understanding of integrated treatment and possible pathways to achieve this, client notes include reference to both MH and AOD disorders however, further training to support 50% of clinicians/workers to develop skills in providing treatment of, and support for clients with a dual diagnosis would be of benefit.
Domain 4: Working with the broader service system

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, pro formas that facilitate multi-agency interaction, staff rotation between agencies, MOU's, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean Score: 6.3/10
Range of Scores: 1 - 10

53% of questions scored between 8-10, 31%, scored between 1-3 and 16% scored between 6-7.

Recommendations:
The percentage of high scores for Domain 4 indicates that MIF is working towards a moderate to enhanced level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developing

- Staff orientation procedures including a placement in the other sector
- Developing a secondary consultation policy and process to support clinicians/workers that includes training and orientation manuals
- Staff training around the concept of a 'no wrong door' service delivery system.
- Service and Agency descriptions to incorporate 'no wrong door values'
- Formal agreements between external agencies include dispute resolution processes,

Domain 5: Agency Quality Assurance

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client database, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

Mean Score: 6/10

Range of Scores: 1 – 10

Question 5.16 was left blank. Of the 18 remaining questions, scores were evenly distributed with 39% scoring between 8-10, 33% scoring between 1-3 and 28% scoring between 5-7.

Recommendations
MIF is working towards a moderate to enhanced level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developing

- Assigning a dual diagnosis portfolio holder, with the required experience and standing amongst his peers, to be responsible for building capacity amongst co-workers and organisational practices to recognise and respond effectively to clients with a dual diagnosis. Remuneration and workload allocation for this role to adequately reflect, complexity and demands of the role
- Modifying the agency client database to enable comparisons between outcomes for clients with and without a dual diagnosis.
- Developing experience and training in interested workers for the role of dual diagnosis portfolio holder where none currently exists.
- Developing file audit processes to include criteria to check the frequency of delivery of integrated treatment to clients with a dual diagnosis.
Conclusion
The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Four out of five domains scored an average rating between 5.6 - 8 Domain one – Agency policy and procedure is the outlier with the lowest mean score of 1.6. MIF would benefit from concentrating their quality improvement efforts in Domain 1 as recommended in the preceding section and to some extent Domain 4: Working with the broader service system as described in the section on Domain 4 above.
Domain 1: Detection of co-occurring substance use disorders

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening.

Average mean score: 8
Range of mean scores: 5.67 - 7.75

Recommendation:
Survey responses indicate a high level of confidence in screening and detecting comorbid substance use. An area in which training could be of benefit includes:

- Developing knowledge of various screens for detecting co-occurring substance use problems.

Domain 2: Assessment of co-occurring Substance Use Disorders

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

Average mean score: 6.5
Range of mean scores: 4.5 – 7.33

Lowest mean scores: Q2.3
.08% of mean scores were less than 5

Recommendation:
Survey responses indicate a satisfactory level of confidence in assessing a co-occurring substance use disorder. However, given the wide range of scores, I suggest training in the following areas:

- Knowledge of the ICD-10 Criteria for substance disorder and/or DSM-IV criteria for substance disorder

Domain 3: Treatment Planning

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

Average mean score: 6.6
Range of mean scores: 5.92 - 7.33

Recommendation:
Survey responses indicate a satisfactory level of confidence in treatment planning around comorbid mental health and AOD disorders.

Domain 4: Treatment of co-occurring substance use disorders

Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change.
Average mean score: 5.9
Range of mean scores: 5 – 6.75
Lowest mean scores: Q4.6

Recommendation:
Survey responses indicate a satisfactory level of confidence in the treatment of co-occurring substance use disorders. The low range of scores indicates a need for training across the following areas:

- Knowledge of and how to deliver brief interventions
- Use of outcome measures to guide changes in clients with co-occurring AOD and MH disorders.

Domain 5: Working with the broader service system

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.’

Average mean score: 6.8
Range of mean scores: 6.25 - 8.08

Recommendation:
Survey responses indicate a satisfactory level of confidence in working with the broader service system.
Domain 1: Service Agency Policy and Documentation

Domain 1 consisted of five survey questions focussing on service descriptions, mission statements, local policy, position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders

Mean Score: 6/10
Range of Scores: 1-10
60% of questions scored between 7 – 10 and 40% scored between 1 - 3

Recommendations
The percentage of high scores for Domain 1 indicates that ARAFEMI is working towards a moderate to enhanced level of dual diagnosis capacity in relation to policy and procedures and would benefit further from developing

- Policy and procedures that explicitly state that the presence of a co-occurring MH and AOD disorder is never used to exclude people from receiving services.
- Position descriptions to include the expectation that all staff are dual diagnosis capable or working towards this and in the case of senior positions, criteria around advanced dual diagnosis capability i.e. demonstrating skills in planning, delivery of integrated treatment and care and provision of supervision to staff working with dual diagnosis.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focussing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean Score: 8/10
Range of Scores: 1 - 10
Q2.12 was marked as N/A. Based on the remaining 11 questions 70% scored between 8 - 10 and 30% scored below 5.

Recommendations:
The percentage of high scores for Domain 2 indicates that ARAFEMI is working towards a moderate to enhanced level of dual diagnosis capacity in relation to screening and assessment and would benefit further from developing

- Intake documentation that includes comprehensive assessment criteria for co-occurring substance use or mental health disorders once a screen has returned a positive result. For MH services this includes a full AOD assessment proforma and for AOD services this includes a full Mental State Assessment proforma.
- Assessment Proformas to include information regarding the client’s stage of change for both MH and AOD disorders
- Based on approximately 50% of clinicians perceived as trained in conducting an assessment of co-occurring AOD and MH disorders, ARAFEMI would benefit from further training in this area.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focussing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 7/10
Range of Scores: 3 – 10
67% of questions scored between 7 – 10, and 33% scored 3.

Recommendations

Based on approximately 50% of clinicians perceived as having well developed skills in providing treatment and support for co-occurring AOD and MH disorders, ARAFEMI would benefit from training MH clinicians in the provision of brief interventions, motivational interviewing, relapse prevention, psychopharmacology for AOD disorders and AOD clinicians would benefit from learning evidence based treatments for anxiety, depression, PTSD and personality disorder.

Domain 4: Working with the broader service system

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, proformas that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean Score: 2/10

Range of Scores: 1 - 10

Q4.7 was marked N/A. Of the remaining 18 questions, 83% scored between 1-3 and 17%, of questions scored between 6-10.

Recommendations

The high score attributed to Domain 3 is inconsistent with the significantly low score for Domain 4. The percentage of low scores for Domain 4 indicates that ARAFEMI is working towards a moderate level of dual diagnosis capacity in relation to working with the broader service system and would benefit further from developing

- Staff orientation procedures including a placement in the other sector
- Formal agreements between agencies are based on consultation and collaboration and include pathways for the primary treatment responsibility for the different cohorts of people with a dual diagnosis, dispute resolution processes, development of Integrated Treatment Plans and proformas, collaboration on the development of Individual Service Plans, reciprocal delivery of assessment and treatment from the premises of the partner agency
- Strategies are in place to promote formal and informal contacts with local AOD and MH services including the experience of delivering assessment and treatment on the premises of the ‘partner’ agency and vice versa
- Developing routine practices with partner agencies that monitors, evaluates and plans around frequency, screening, integrated treatment and outcomes for clients with a dual diagnosis.
- Embedding ‘no wrong door’ values into service and agency descriptions.
- Developing a secondary consultation policy and process to support clinicians/workers that includes training and orientation manuals

Domain 5: Agency Quality Assurance

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

Mean Score: 5/10

Range of Scores: 1 - 10

Q 5.11 and 5.12 were scored as N/A. Of the 17 remaining questions, 53% scored between 1-2 and 47% of questions scored between 6-10.

Recommendations
The evenly high and low distribution of scores for Domain 5 indicates that ARAFEMI is working towards a moderate level of dual diagnosis capacity in relation to quality assurance and would benefit further from developing:

- File audit, quality-control processes to include criteria to audit the frequency of screening, assessment and integrated treatment for of AOD and MH disorders.
- Staff orientation procedures include training in ARAFEMI’s approach to integrated screening, assessment and treatment.
- Staff appraisal procedures to include clinician’s progress towards becoming dual diagnosis capable
- Outcome measures monitor outcomes of the treatment of people with a dual diagnosis
- Consumer and Carer processes include:
  - position descriptions that incorporate the expectation of dual diagnosis experience/expertise,
  - Their involvement in the planning and evaluation of service responses and education and training packages regarding dual diagnosis.
  - Involvement in the delivery of education and training packages around dual diagnosis.

**Conclusion:**

The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Four out of five domains scored an average rating between 5 - 8 Domain Four – Working with the broader service system scored the lowest mean score of 2. ARAFEMI would benefit from concentrating their quality improvement efforts in Domain 4 as recommended in the preceding section and to some extent Domain 5: Agency Quality Assurance in particular in relation to file audit process, consumer and carer involvement and determinants of outcome measures as earlier mentioned.
APPENDIX 9.01 – CarerLinks Staff Survey Results (PDRSS tool)

4/4 Completed surveys

**Domain 1: Detection of co-occurring substance use disorders**

Domain 1 comprised 10 survey questions gauging level of knowledge of prevalence, harms and unwanted outcomes of comorbid AOD and MH problems and, screens, skills in screening and routine practices around screening

- **Average mean score:** 3.6
- **Range of mean scores:** 1.5 – 4.75
- **Lowest mean score:** Q1.1 – 1.9
- 100% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a low level of confidence in screening and detecting comorbid substance use. With 100% of mean scores less than 5, training is strongly encouraged across all questions pertaining to Domain 1.

**Domain 2: Assessment of co-occurring Substance Use Disorders**

Domain 2 comprised 12 questions gauging level of knowledge of interactions between AOD and MH disorders, nature and effects of substances used the ICD criteria and/or DSM IV/V for substance use disorders, routine practice in response to screening, skills in substance use assessment, substance use withdrawal symptoms, stages of change and client note taking.

- **Average mean score:** 3.2
- **Range of mean scores:** 1 - 5
- **Lowest mean scores:** Q2.1 – 2.12
- 92% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a low level of confidence in assessing a co-occurring substance use disorder. With 100% of mean scores less than 5, training is strongly encouraged across all questions pertaining to Domain 2.

**Domain 3: Treatment Planning**

Domain 3 comprises 4 questions gauging understanding of service delivery pathways for cohorts of people with comorbid MH and AOD disorders, integrated treatment, in-house treatment plans and integrated processes for client service delivery.

- **Average mean score:** 2.8
- **Range of mean scores:** 2.75 – 3
- **Lowest mean scores:** Q3.1 – 3.4
- 100% of mean scores were less than 5

**Recommendation:**

Survey responses indicate a low level of confidence in treatment planning. With 100% of mean scores less than 5, training is strongly encouraged across all questions pertaining to Domain 3.

**Domain 4: Treatment of co-occurring substance use disorders**
Domain 4 comprises 6 questions gauging level of skill in delivering brief interventions, motivational interviewing, knowledge of pharmacotherapies, providing withdrawal management plans, relapse prevention strategies, use of outcome measures to capture change

**Average mean score:** 3.3  
**Range of mean scores:** 1.5 – 4.75  
**Lowest mean scores:** Q4.1 – 4.6  

100% of mean scores were less than 5

**Recommendation:**
Survey responses indicate a low level of confidence in treatment of co-occurring substance use disorder. With 100% of mean scores less than 5, training is strongly encouraged across all questions pertaining to Domain 4.

**Domain 5: Working with the broader service system**

Domain 5 comprises 13 questions gauging skills in seeking secondary consultation services, its use as routine practice, confidentiality, policy, procedures and documentation of secondary consultations, knowledge of screens used by local MH service for co-occurring substance use disorders, understanding of the MH treatment system, PDRSS service system, and primary care and the ‘no wrong door philosophy.

**Average mean score:** 4.3  
**Range of mean scores:** 2 – 7.5  
**Lowest mean scores:** All questions except for: 5.1, 5.3, 5.4, 5.6, and 5.7  

62% of mean scores were less than 5

**Recommendation:**
Although responses indicate clinical workers have more confidence in working within Domain 5 compared to Domains 1 – 4, survey responses are below a mean average of 5 indicating a low level of confidence in working with the broader service system. Training is strongly encouraged across the following areas:

- Familiarisation of local specialist services able to provide secondary consultation around the treatment needs of people with substance use problems
- Incorporating secondary consultation as routine practice
- Familiarisation of approaches used by local AOD services to detect/screen for co-occurring MH problems
- Well-developed knowledge and understanding of the AOD treatment system, clinical mental health system, and primary care/general practice service system.
- Comfortable in providing MH services and consultation in AOD, clinical MH and primary care service settings
- Knowledge and understanding of ‘No wrong door’ philosophies/goals.
APPENDIX 9.02 – CarerLinks Agency Level Survey Results (Agency Tool)

Domain 1: Service Agency Policy and Documentation

Domain 1 consisted of five survey questions focusing on Service descriptions, mission statements, local policy, and position descriptions across all levels of staff and screening and assessment protocols in relation to comorbid mental health and drug and alcohol related disorders.

Mean Score: 1/10
Range of Scores: 1

Q 1.4 was marked N/A. Of the remaining four questions, 100% scored one.

Recommendations:

Carerlinks would benefit from developing policy and processes across Domain 1 questions to incorporate dual diagnosis practice. Recommend working with NEXUS, the VDDI Education and Training Unit and leading NEMH Alliance agencies with experience to help support dual diagnosis practice.

Domain 2: Detection and Assessment of Co-occurring Mental Health and Substance Use Disorders

Domain 2 consisted of 12 survey questions focusing on screening and assessment processes and procedures across service delivery including: use of proformas, manuals, staff orientation procedures, intake, training, assessment of staff confidence and competence, access to secondary consultation services.

Mean Score: 1/10
Range of Scores: 1

100% of questions scored one.

Recommendations:

Carerlinks would benefit from embedding screening and assessment practices for dual diagnosis across all Domain 1 questions. Recommend working with NEXUS, the VDDI Education and Training Unit and leading NEMH Alliance agencies with experience to help support and guide building dual diagnosis capacity.

Domain 3 Integrated Treatment of co-occurring MH and substance use disorders

Domain 3 consisted of three survey questions focusing on assessing the percentage of workers who have an understanding of integrated treatment and pathways to achieve this, who have well developed skills to treat and support comorbid mental health and AOD problems and that both disorders are recorded in the client’s notes with equal prominence.

Mean Score: 1/10
Range of Scores: 1

100% of questions scored one.

Recommendations:

Carerlinks would benefit from education and training and policy review in terms of developing clinical skills and knowledge around integrated treatment, treatment and support and accountability for people with a dual diagnosis.

Domain 4: Working with the broader service system

Domain 4 consisted of 19 survey questions addressing worker skills in accessing and delivering secondary consultation including training, proformas that facilitate multi-agency interaction, staff rotation between agencies, MOU’s, level of planning, collaboration/agreement/review/evaluation/progress between agencies in relation to client with dual diagnosis needs, networking opportunities between agencies, dispute resolution processes, cross service delivery, no wrong door philosophy embedded in service descriptions and worker culture.

Mean Score: 1/10
Range of Scores: 1
Q4.10 was marked N/A. Of the remaining 18 questions, 100% scored one.

**Recommendations**
Carerlinks would benefit from developing their capacity to work with the broader service system to support their work with clients with a dual diagnosis across all Domain 4 questions.

**Domain 5: Agency Quality Assurance**

Domain 5 consisted of 19 survey questions addressing the extent to which the agency oversees screening, assessment, provision of integrated treatment and outcomes for people with a dual diagnosis. This is through evaluating degree of planning, monitoring, reviewing, file audits, staff training, staff orientation processes and procedures, staff appraisal processes, dual diagnosis staff recruitment, identification, development of, financial commitment toward, client data base, measuring client outcomes, involvement of consumer and carers with a dual diagnosis in planning, education and training

**Mean Score:** 1.6/10

**Range of Scores:** 1 - 7

Q5.9 scored 7, the remaining 18 questions scored between 1 – 3.

**Recommendations**
Carerlinks would benefit from developing quality assurance that reflects dual diagnosis practice across all Domain 5 questions.

**Conclusion**
The limitation of a self-reporting style questionnaire is the risk of inflating scores because of a bias towards social desirability; the inclination to inflate the score to what you would like it to be. This must be considered when reviewing results of the questionnaire.

For results to be statistically significant, a minimum sample size of 30 is standard. In this project less than 10 staff contributed to scoring the questionnaire and the results need to be considered in this light.

Scores for Domains 1 -5 were consistently low; with a mean score of 1. As an organisation Carerlinks needs to determine the extent of dual diagnosis practice that needs to be and can be incorporated within the organisation. Upon formulating these views, investment in policy and procedures to support strategy needs to be planned and executed. Carerlinks would benefit from education and training across all Domains.
Appendix 10: Swinburne University of Technology

Evaluation for the dual diagnosis data provided by Banyule Community Health

Dr Jahar Bhowmik
Faculty of Life and Social Sciences
Swinburne University of Technology
Hawthorn 3122
Victoria
Some outcomes (for PDRSS):

Sector: PDRSS

Table 1: Detection of co-occurring substance use problems (Domain 1)

<table>
<thead>
<tr>
<th>No.</th>
<th>Survey question</th>
<th>Mean Score (n)</th>
<th>Percentage score 5 or below (n)</th>
<th>Percentage score 6 or above (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1</td>
<td>I have a well-developed knowledge of the prevalence of co-occurring substance use problems in persons receiving treatment for mental health problems.</td>
<td>6.89 (57)</td>
<td>21.1 (12)</td>
<td>78.9 (45)</td>
</tr>
<tr>
<td>1.2</td>
<td>I have a well-developed knowledge of the harms and unwanted outcomes strongly associated with co-occurring substance use and mental health disorders.</td>
<td>7.04 (57)</td>
<td>17.5 (10)</td>
<td>82.5 (47)</td>
</tr>
<tr>
<td>1.3</td>
<td>I have a well-developed, operational understanding of the function of screening as primarily providing only a quick yes/no guide as to whether a more detailed substance use assessment is warranted. (Screening is only a component of an assessment. Where a positive AOD screen is returned workers should conduct a more detailed substance use assessment).</td>
<td>6.39 (57)</td>
<td>31.6 (18)</td>
<td>68.4 (39)</td>
</tr>
<tr>
<td>1.4</td>
<td>I have a developed knowledge of various screens (and approaches to screening) useful for detecting any possible co-occurring substance use problems. (including the screens most likely to detect the most prevalent co-occurring substance use problems in the population of persons with mental health problems that my agency provides services to)</td>
<td>5.42 (57)</td>
<td>50.9 (29)</td>
<td>49.1 (28)</td>
</tr>
<tr>
<td>1.5</td>
<td>I have received training in my service's preferred approaches to (and tools for) screening for co-occurring substance use problems.</td>
<td>5.18 (55)</td>
<td>56.4 (31)</td>
<td>43.6 (24)</td>
</tr>
<tr>
<td>1.6</td>
<td>I have well developed skills in deploying a range of screening approaches to detect possible co-occurring substance use problems.</td>
<td>5.26 (54)</td>
<td>51.9 (28)</td>
<td>48.1 (26)</td>
</tr>
<tr>
<td>1.7</td>
<td>I have well developed skills in sensitively introducing substance use screening to persons receiving assessment (e.g. normalising/providing a rationale for screening for substance use problems).</td>
<td>6.63 (56)</td>
<td>28.6 (16)</td>
<td>71.4 (40)</td>
</tr>
<tr>
<td>1.8</td>
<td>My routine practice is to screen all clients for a possible co-occurring substance use problem (or to conduct a detailed substance use assessment). NOTE: If a mental health worker has the capacity, time and expertise to incorporate assessment of co-occurring substance use problems into their routine assessment process, then screening is superfluous.</td>
<td>6.34 (53)</td>
<td>35.8 (19)</td>
<td>64.2 (34)</td>
</tr>
<tr>
<td>1.9</td>
<td>My routine practice is to screen or assess clients for a possible co-occurring substance use problem as close as possible in time to initial assessment. NOTE: One would usually not screen for a co-occurring substance use problem when the client is intoxicated</td>
<td>6.44 (55)</td>
<td>30.9 (17)</td>
<td>69.1 (38)</td>
</tr>
</tbody>
</table>
### Sector: PDRSS

#### Table 2: Assessment of co-occurring substance use problems (Domain 2)

<table>
<thead>
<tr>
<th>No.</th>
<th>Survey question</th>
<th>Mean score (n)</th>
<th>Percentage score 5 or below (n)</th>
<th>Percentage score 6 or above (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1</td>
<td>I have a well-developed knowledge of the range of possible interactions between co-occurring substance use problems and mental health disorders</td>
<td>6.48 (54)</td>
<td>24.6 (14)</td>
<td>75.4 (43)</td>
</tr>
<tr>
<td>2.2</td>
<td>I have a well-developed knowledge of the nature of possible effects of the various substances that people may be using.</td>
<td>6.41 (54)</td>
<td>24.6 (14)</td>
<td>75.4 (43)</td>
</tr>
<tr>
<td>2.3</td>
<td>I have a developed knowledge of the ICD-10 criteria for... - Substance: Harmful Use (ICD _ _ .1) - Substance Dependence (ICD _ _ .2) - Substance Withdrawal (ICD _ _ .3) &amp;/or... I have developed knowledge of the DSM-IV criteria for... - Substance Abuse - Substance Dependence - Substance Withdrawal</td>
<td>4.25 (51)</td>
<td>59.6 (34)</td>
<td>40.4 (23)</td>
</tr>
<tr>
<td>2.4</td>
<td>My routine practice, in response to clients returning a positive screen, is to then conduct a more detailed substance use assessment. (Screening only provides a quick indication of whether a co-occurring substance use problem may be present. Assessment will confirm whether this is so and provide further information necessary for effective treatment planning).</td>
<td>5.21 (51)</td>
<td>49.1 (28)</td>
<td>50.9 (29)</td>
</tr>
<tr>
<td>2.5</td>
<td>I have well developed skills in conducting a substance use assessment with the goal of developing a treatment plan that addresses both substance use and mental health problems.</td>
<td>5.63 (51)</td>
<td>48.2 (27)</td>
<td>51.8 (29)</td>
</tr>
<tr>
<td>2.6</td>
<td>I have well developed skills in facilitating clients to provide an accurate account of their substance use (e.g. normalising, using non-judgmental language, using open ended questions...).</td>
<td>6.74 (53)</td>
<td>23.2 (13)</td>
<td>76.8 (43)</td>
</tr>
<tr>
<td>2.7</td>
<td>I have received training in my service's preferred approach to (and related forms for) assessment of co-occurring substance use problems.</td>
<td>5.25 (52)</td>
<td>51.8 (29)</td>
<td>48.2 (27)</td>
</tr>
<tr>
<td>2.8</td>
<td>In conducting a substance use assessment I will (with all clients) routinely enquire sequentially about a full range of possible substances of abuse (i.e. asking individually about a client's use of caffeine, nicotine, alcohol, cannabis, amphetamine-type stimulants, opiates, hallucinogens,...).</td>
<td>6.63 (52)</td>
<td>29.1 (16)</td>
<td>70.9 (39)</td>
</tr>
<tr>
<td>2.9</td>
<td>In conducting a substance use assessment I will, at a minimum, routinely enquire about (for each substance): - quantity, frequency, pattern of use - last use - length of drinking/drug problems - consequences of drinking/drug use - symptoms of harmful use or dependence - assessment of need for detoxification.</td>
<td>6.58 (52)</td>
<td>29.1 (16)</td>
<td>70.9 (39)</td>
</tr>
<tr>
<td>2.10</td>
<td>I have a well-developed knowledge of the stages of change model and routinely use the model in describing clients' attitudes to both substance use and mental health disorders.</td>
<td>6.45 (53)</td>
<td>32.1 (17)</td>
<td>67.9 (36)</td>
</tr>
<tr>
<td>2.11</td>
<td>I am skilled and confident in the recognition of withdrawal (mild to severe) from a range of substances.</td>
<td>5.40 (53)</td>
<td>49.1 (26)</td>
<td>50.9 (27)</td>
</tr>
<tr>
<td>2.12</td>
<td>My routine practice is to record, with equal prominence, a client's mental health and substance use concerns or problems.</td>
<td>6.43 (53)</td>
<td>34.0 (18)</td>
<td>66.0 (35)</td>
</tr>
</tbody>
</table>
## Sector: PDRSS

### Table 3: Service planning (Domain 3)

<table>
<thead>
<tr>
<th>No.</th>
<th>Survey question</th>
<th>Mean score (n)</th>
<th>Percentage score 5 or below (n)</th>
<th>Percentage score 6 or above (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1</td>
<td>I am able to describe the principal cohorts of persons with mental health - substance use problems and have a developed operational understanding of where, in the service system, they are most likely to receive effective treatment.</td>
<td>5.46 (52)</td>
<td>53.8 (28)</td>
<td>46.2 (24)</td>
</tr>
<tr>
<td>3.2</td>
<td>I have a well-developed operational understanding of what constitutes integrated treatment and of the possible pathways to achieving integrated treatment.</td>
<td>5.89 (53)</td>
<td>45.3 (24)</td>
<td>54.7 (29)</td>
</tr>
<tr>
<td>3.3</td>
<td>I have well developed skills in and knowledge around developing a treatment plan that addresses both a client's mental health and substance use problems.</td>
<td>5.96 (52)</td>
<td>38.5 (20)</td>
<td>61.5 (32)</td>
</tr>
<tr>
<td>3.4</td>
<td>I have a well-developed operational familiarity with collaborating with (each of) AT&amp;OD and clinical mental health services and workers in the development of an integrated Individual Treatment Plan that documents our arrangements around ongoing formal interaction and co-operation in providing services to the client.</td>
<td>5.84 (50)</td>
<td>44.0 (22)</td>
<td>56.0 (28)</td>
</tr>
</tbody>
</table>

### Table 4: Response to co-occurring substance use problems (Domain 4)

<table>
<thead>
<tr>
<th>No.</th>
<th>Survey question</th>
<th>Mean Score (n)</th>
<th>Percentage score 5 or below (n)</th>
<th>Percentage score 6 or above (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.1</td>
<td>I have a developed knowledge of the theory of, indications for, and strategies to deliver effective brief interventions (FRAMES: Feedback, Responsibility, Advice, Menu of Options, Empathy, Self-Efficacy).</td>
<td>4.88 (51)</td>
<td>58.8 (30)</td>
<td>41.2 (21)</td>
</tr>
<tr>
<td>4.2</td>
<td>I have a developed understanding of motivational interviewing principles and am skilled in the provision of motivational interviewing strategies (MI spirit, principles, and skills).</td>
<td>6.53 (51)</td>
<td>31.4 (16)</td>
<td>68.6 (35)</td>
</tr>
<tr>
<td>4.3</td>
<td>I have a general understanding of AOD pharmacotherapies.</td>
<td>5.38 (52)</td>
<td>48.1 (25)</td>
<td>51.9 (27)</td>
</tr>
<tr>
<td>4.4</td>
<td>I am confident in arranging for my client to be provided with a withdrawal management plan.</td>
<td>4.78 (51)</td>
<td>62.7 (32)</td>
<td>37.3 (19)</td>
</tr>
<tr>
<td>4.5</td>
<td>I have a developed understanding of, and am confident in the provision of relapse prevention strategies (e.g. provide rational for RP, enhance commitment to change, teach coping skills, hints to avoid temptations, prepare for a lapse, address lifestyle issues, high risk situations, address cognitive distortions..)</td>
<td>5.82 (51)</td>
<td>49.0 (25)</td>
<td>51.0 (26)</td>
</tr>
<tr>
<td>4.6</td>
<td>I am skilled in using outcome measures that capture changes in clients' co-occurring substance use problems.</td>
<td>5.08 (51)</td>
<td>52.9 (27)</td>
<td>47.1 (24)</td>
</tr>
</tbody>
</table>
## Sector: PDRSS

### Table 5: Working with the broader service system (Domain 5)

<table>
<thead>
<tr>
<th>No.</th>
<th>Survey question</th>
<th>Mean score (n)</th>
<th>Percentage score 5 or below (n)</th>
<th>Percentage score 6 or above (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>5.1</td>
<td>I have developed skills in seeking secondary consultation in order to attempt to provide (or facilitate the provision of) the most effective possible responses to the range of problems that clients may present with.</td>
<td>6.76 (49)</td>
<td>28.6 (14)</td>
<td>71.4 (35)</td>
</tr>
<tr>
<td>5.2</td>
<td>I have a well-developed knowledge and familiarity with local (and state-wide) specialist services and clinicians able to provide secondary consultation around the treatment needs of persons with substance use problems.</td>
<td>6.29 (49)</td>
<td>32.7 (16)</td>
<td>67.3 (33)</td>
</tr>
<tr>
<td>5.3</td>
<td>I have a well-developed understanding of my obligations around confidentiality in seeking secondary consultation.</td>
<td>7.76 (50)</td>
<td>16.0 (8)</td>
<td>84.0 (42)</td>
</tr>
<tr>
<td>5.4</td>
<td>I have a developed understanding of my obligations around documenting the circumstances, purpose, content and outcomes of any secondary consultation that I have sought.</td>
<td>7.31 (48)</td>
<td>18.8 (9)</td>
<td>81.2 (39)</td>
</tr>
<tr>
<td>5.5</td>
<td>Seeking secondary consultation is a routine part of my practice.</td>
<td>6.59 (49)</td>
<td>30.6 (15)</td>
<td>69.4 (34)</td>
</tr>
<tr>
<td>5.6</td>
<td>I have a well-developed understanding of my obligations around documenting the circumstances, purpose, content and outcomes of any secondary consultation that I may provide.</td>
<td>6.86 (49)</td>
<td>22.4 (11)</td>
<td>77.6 (38)</td>
</tr>
<tr>
<td>5.7</td>
<td>I am familiar with my service's policies and procedures in regard to provision and receipt of secondary consultation and am clear about any duty of care I may owe to the consulate or to the client involved.</td>
<td>6.50 (48)</td>
<td>29.2 (14)</td>
<td>70.8 (34)</td>
</tr>
<tr>
<td>5.8</td>
<td>I have a developed knowledge of the approach to detecting co-occurring mental health problems used by local specialist AOD services (ie tools and methods used, their responses to positive MH screens).</td>
<td>5.06 (50)</td>
<td>50.0 (25)</td>
<td>50.0 (25)</td>
</tr>
<tr>
<td>5.9</td>
<td>I have a well-developed knowledge and understanding of the AOD treatment system (e.g. target problems, component parts, strengths and challenges in detecting and responding to co-occurring mental health problems).</td>
<td>5.28 (50)</td>
<td>44.0 (22)</td>
<td>56.0 (28)</td>
</tr>
<tr>
<td>5.10</td>
<td>I have a well-developed knowledge and understanding of the clinical mental health service system (e.g. target problems, component parts, strengths and challenges in detecting and responding to co-occurring mental health and substance use problems).</td>
<td>5.88 (51)</td>
<td>43.1 (22)</td>
<td>56.9 (29)</td>
</tr>
<tr>
<td>5.11</td>
<td>I have a well-developed knowledge and understanding of the Primary Care/General Practice service systems(e.g. component parts, strengths and challenges in detecting and responding to co-occurring substance use and mental health disorders).</td>
<td>5.27 (49)</td>
<td>49.0 (24)</td>
<td>51.0 (25)</td>
</tr>
<tr>
<td>5.12</td>
<td>In general I am comfortable in providing mental health services and consultation in AT&amp;OD, Clinical Mental Health and Primary Care service settings.</td>
<td>5.63 (48)</td>
<td>45.8 (22)</td>
<td>54.2 (26)</td>
</tr>
<tr>
<td>5.13</td>
<td>I have a well-developed knowledge and understanding of No Wrong Door goals and philosophies</td>
<td>6.00 (50)</td>
<td>36.0 (18)</td>
<td>64.0 (32)</td>
</tr>
</tbody>
</table>
• For Domain 1, participant’s responses to the survey questions 1.4-1.5 are not satisfactory (below average) and participants need further training in these areas.
• For Domain 2, participant’s responses to the survey questions 2.3-2.5, 2.7 and 2.11 are not satisfactory (below average) and participants need further training in these areas.
• For Domain 3, participant’s responses to the all of the survey questions are not satisfactory (below average) and participants need further training in this area.
• For Domain 4, participant’s responses to the questions 4.1, 4.3-4.5 are not satisfactory and participants need further training in these areas.
• For Domain 5, participant’s responses to the questions 5.8, 5.9, 5.11 & 5.12 are not satisfactory (below average) and participants need further training in these areas.
Average score among non-clinical (PDRSS) mental health workers across agency and domain

- Domain 1
- Domain 2
- Domain 3
- Domain 4
- Domain 5

Agency

Average score out of 10

MIND  NEH  NEAMI  BCHGC  CLN  BCHGH  MIF  ARAFEMI
Domain 1: Comparing agencies for each question

Average score out of 10

Domain 1 questions

Q1.1 Q1.2 Q1.3 Q1.4 Q1.5 Q1.6 Q1.7 Q1.8 Q1.9

MIND NEH NEAMI BCHGC CLN ARAFEMI Total
Domain 2: Comparing agencies for each survey question

Average score out of 10

Domain 2 survey questions

Q2.1  Q2.2  Q2.3  Q2.4  Q2.5  Q2.6  Q2.7  Q2.8  Q2.9  Q2.10  Q2.11  Q2.12

- MIND
- NEH
- NEAMI
- BCHGC
- CLN
- BCHGH
- MIF
- ARAFEMI
- Total
Domain 3: Comparing agencies for each survey question

Average score out of 10

Domain 3 survey questions

MIND
NEH
NEAMI
BCHGC
CLN
BCHGH
MIF
ARAFEMI
Total
Domain 4: Comparing agencies for each survey question

Average score out of 10

Domain 4 survey questions

MIND
NEH
NEAMI
BCHGC
CLN
BCHGH
MIF
ARAFEMI
Total
Domain 5: Comparing agencies for each survey question

Average score out of 10

Domain 5 survey questions

MIND
NEH
NEAMI
BCHGC
CLN
ARAFEMI
Total
Comparison between agencies

For all domains, the mean response score received from the participants working with Office of Housing and CLN are very low as compared to all other agencies. Overall, for all domains no significant difference of the mean response score was found between agencies (F(7,34)=1.63, p=0.162). However, this study is not sufficiently powerful. With 7 and 34 degrees of freedom, there was only 51% chance of detecting moderate effect sizes. This study should be repeated with more participants.

For domains 1-5, there was no significant difference found in the mean response score between agencies ( Domain 1: F(7, 51)=2.02, p=.075; Domain 2: F(7, 47)=1.62, p=0.157; Domain 3: F(7,48)=1.80, p=0.114; Domain 4: F(7,49)=0.954; Domain 5: F(7,46)=1.43, p=0.222)*. However, a post-hoc test (S-N-K) revealed that for domain 3 mean response score for the agency CLN (only 4 participants) was significantly lower as compared to the mean response score received from other agencies.

*This study is not sufficiently powerful (at most 51% power to detect a moderate effect size of 0.06). To observe any significant difference between the agencies for different domains with respect to participants mean response score this study should be repeated with more participants.
### Multicollinearity Check

<table>
<thead>
<tr>
<th>Q1.1</th>
<th>Q1.2</th>
<th>Q1.3</th>
<th>Q1.4</th>
<th>Q1.5</th>
<th>Q1.6</th>
<th>Q1.7</th>
<th>Q1.8</th>
<th>Q1.9</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pearson Correlation</strong></td>
<td><strong>Sig. (2-tailed)</strong></td>
<td><strong>N</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Q1.1</td>
<td>1.00*</td>
<td>.755**</td>
<td>.521*</td>
<td>.512*</td>
<td>.450*</td>
<td>.575*</td>
<td>.411**</td>
<td>.551**</td>
</tr>
<tr>
<td>Q1.2</td>
<td>.755**</td>
<td>1.00*</td>
<td>.742**</td>
<td>.836**</td>
<td>.436**</td>
<td>.670**</td>
<td>.684**</td>
<td>.629**</td>
</tr>
<tr>
<td>Q1.3</td>
<td>.742**</td>
<td>.836**</td>
<td>1.00*</td>
<td>.760**</td>
<td>.564**</td>
<td>.747**</td>
<td>.809**</td>
<td>.674**</td>
</tr>
<tr>
<td>Q1.4</td>
<td>.521**</td>
<td>.436**</td>
<td>.760**</td>
<td>1.00*</td>
<td>.757**</td>
<td>.821**</td>
<td>.742**</td>
<td>.609**</td>
</tr>
<tr>
<td>Q1.5</td>
<td>.512**</td>
<td>.630**</td>
<td>.780**</td>
<td>.757**</td>
<td>1.00*</td>
<td>.701**</td>
<td>.583**</td>
<td>.629**</td>
</tr>
<tr>
<td>Q1.6</td>
<td>.512**</td>
<td>.630**</td>
<td>.780**</td>
<td>.757**</td>
<td>.701**</td>
<td>1.00*</td>
<td>.798**</td>
<td>.759**</td>
</tr>
<tr>
<td>Q1.7</td>
<td>.450*</td>
<td>.554*</td>
<td>.594*</td>
<td>.757**</td>
<td>.701**</td>
<td>.798**</td>
<td>1.00*</td>
<td>.701**</td>
</tr>
<tr>
<td>Q1.8</td>
<td>.575**</td>
<td>.670**</td>
<td>.747**</td>
<td>.821**</td>
<td>.701**</td>
<td>.798**</td>
<td>.742**</td>
<td>1.00*</td>
</tr>
<tr>
<td>Q1.9</td>
<td>.411**</td>
<td>.684**</td>
<td>.809**</td>
<td>.742**</td>
<td>.563**</td>
<td>.798**</td>
<td>.742**</td>
<td>.701**</td>
</tr>
</tbody>
</table>

**Correlation is significant at the 0.01 level (2-tailed).**

- Q1.3 is significantly related to Q1.7
- Q1.4 is significantly related to Q1.6
- Q1.6 is significantly related to Q1.4 and Q1.7
- Q1.7 is significantly related to Q1.3 and Q1.6
- Q1.8 is significantly related to Q1.9
- Q1.9 is significantly related to Q1.8
<table>
<thead>
<tr>
<th></th>
<th>Q2.1</th>
<th>Q2.2</th>
<th>Q2.3</th>
<th>Q2.4</th>
<th>Q2.5</th>
<th>Q2.6</th>
<th>Q2.7</th>
<th>Q2.8</th>
<th>Q2.9</th>
<th>Q2.10</th>
<th>Q2.11</th>
<th>Q2.12</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2.1</td>
<td>1.00</td>
<td>0.99</td>
<td>0.95</td>
<td>0.95</td>
<td>0.93</td>
<td>0.88</td>
<td>0.85</td>
<td>0.87</td>
<td>0.87</td>
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<td>0.85</td>
<td>0.88</td>
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** Correlation is significant at the 0.01 level (2-tailed).  
* Correlation is significant at the 0.05 level (2-tailed).

- Q2.1 is significantly related to Q2.2
- Q2.4 is significantly related to Q2.5
- Q2.5 is significantly related to Q2.11
Q3.1 is significantly related to Q3.2

Q4.3 is significantly related to Q4.4
Q4.4 is significantly related to Q4.3 & Q4.5

Similarly
Q5.1 is significantly related to Q5.2
Q5.9 is significantly related to Q5.10 etc