

BRIEF REPORT

Brief workshops to teach drug and alcohol first aid: A pilot evaluation study

VICTORIA R. KOSTADINOV¹ , ANN M. ROCHE¹, ALICE McENTEE¹, JULAINE M. ALLAN² , NICHOLAS R. MEUMANN² & LARA L. McLAUGHLIN²

¹National Centre for Education and Training on Addiction, Flinders University, Adelaide, Australia, and ²Lyndon, Australia

Abstract

Introduction and Aims. Health and community service workers frequently encounter people with alcohol and other drug (AOD) problems in the course of their work, yet few have had training on how to respond effectively. A Drug and Alcohol First Aid workshop was developed by Lyndon, a non-government organisation treatment provider, and delivered to community and health sector workers and the general public. It presented evidence-based information regarding AOD use and harm reduction and treatment options. A pilot evaluation of the workshop was conducted to assess changes in participants' knowledge about AOD, methods of responding to use and attitudes towards individuals who use AOD, over a 3 month period. **Design and Methods.** A self-report evaluation survey was developed and administered to workshop participants at three time points: before (T1), immediately after (T2) and 3 months after the workshop (T3). Paired samples *t*-tests examined changes in knowledge, role adequacy, motivation and personal views. **Results.** A total of 142 participants completed the T1 survey, 184 completed the T2 survey and 98 completed the T3 survey. Between T1 and T2, there were significant increases in scores for knowledge and role adequacy, indicating significant improvements in these areas. No significant differences were found for motivation and personal views. At T3, knowledge and role adequacy scores remained significantly higher than at baseline. **Discussion and Conclusions.** Drug and Alcohol First Aid appears to be a viable initiative to improve AOD-related knowledge and role adequacy. However, alternative strategies may be required to shift negative attitudes towards individuals who use AOD. [Kostadinov VR, Roche AM, McEntee A, Allan JM, Meumann NR, McLaughlin LL. Brief workshops to teach drug and alcohol first aid: A pilot evaluation study. *Drug Alcohol Rev* 2017]

Key words: training program, program evaluation, illicit drug, alcohol consumption.

Introduction

Alcohol and other drug (AOD) use imposes an extensive burden on society, both domestically and internationally [1,2]. In Australia, a quarter of the population drink alcohol at risky levels (>four standard drinks on one occasion) at least monthly, and 15% have recently used an illicit drug [3]. It is imperative to have a skilled workforce who can effectively identify and prevent problematic AOD use and minimise associated harms.

The AOD workforce includes specialist AOD/addiction workers as well as primary care providers, social workers, youth and mental health workers.

Many non-specialists also encounter individuals with AOD-related problems, and require the skills to respond appropriately. These include workers from the education, criminal justice and community services sectors, as well as family/friends of individuals who use AOD.

However, health professionals frequently lack adequate training in substance use, and commonly hold negative/stereotypical views of individuals with AOD-related problems [4,5]. This can result in not only poorer quality care, but may also reduce help-seeking behaviour and increase psychological distress among clients who use AOD [6,7].

Victoria R. Kostadinov MPsych, Research Officer, Ann M. Roche PhD, Director, Alice McEntee PhD, Research Associate, Julaine M. Allan PhD, Deputy CEO, Nicholas R. Meumann MHS, Project Coordinator, Drug and Alcohol First Aid, Lara L. McLaughlin BA, Project Coordinator, Drug and Alcohol First Aid. Correspondence to Professor Ann M. Roche, GPO Box 2100, Adelaide, SA 5001, Australia. Tel: +61 (0)8 8201 7535; Fax: (08) 8201 7550; E-mail: ann.roche@flinders.edu.au

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Similarly, non-specialist workers often have a limited understanding of the aetiology of AOD use, and can be influenced by stigmatising media ‘scare campaigns’ [8]. As a result, individuals who use AOD are frequently distrusted [9], potentially leading to discrimination and reduced likelihood of early intervention [10].

There is a need for targeted training initiatives for specialist and generalist workers, in order to reduce stigma and promote evidence-based knowledge of AOD, patterns of use and best practice in responding. This study describes the pilot evaluation of one such initiative—a Drug and Alcohol First Aid training workshop—recently developed by Lyndon.

Workshop development and implementation

Lyndon is a non-government organisation, which provides AOD services in New South Wales (NSW). In response to community demand, Lyndon developed and implemented a brief Drug and Alcohol First Aid workshop for specialist and non-specialist workers.

Two focus groups were held in 2014 to establish the workshop’s scope and develop appropriate materials. The focus groups highlighted a need for evidence-based information among the general community and community/health sector workers regarding AOD types and effects, patterns of use and harm reduction/treatment approaches. Under the guidance of a Working Group (comprising five of Lyndon’s senior clinical staff), a 6 h workshop was designed to meet this need, building on the successful format used by Mental Health First Aid [11].

In 2015 four pilot workshops were conducted, and workshop content was refined according to feedback. Final content included information regarding types of drugs and their effects; harm reduction and treatment options; responding to overdose and crisis; and communicating with people who use AOD. An Aboriginal community consultation was undertaken to ensure content was appropriate for Aboriginal and Torres Strait Islander participants.

Workshop implementation began in October 2015, facilitated by Lyndon staff members. In order to ensure program quality and fidelity, facilitators were required to have relevant qualifications and experience, and all underwent training prior to delivering the workshops.

Evaluation

An independent AOD research centre was commissioned to undertake a pilot evaluation of the

workshops. The evaluation sought to address the following research questions:

1. Immediately after attending the workshop, did participants demonstrate:
 - a. Increased knowledge of alcohol and drug use (i.e. types of drugs, their effects, patterns of use, treatment approaches)?
 - b. Improved self-efficacy and motivation regarding responding to alcohol and drug use?
 - c. More empathetic attitudes towards individuals who use alcohol and drugs?
2. Were any improvements in the above areas sustained 3 months after the workshop?

Method

All participants who registered to attend a workshop between October 2015 and June 2016 ($n = 230$) were invited to participate in the evaluation via email prior to the workshop. Workshop participants included specialist and non-specialist health and community service workers, as well as members of the general public. Outcome evaluation measures were assessed using self-report surveys.

Data collection

A survey was developed to evaluate participants’ knowledge and attitudes regarding AOD use. Individuals who consented to participate completed the survey before (T1), immediately after (T2) and 3 months after (T3) the workshop. The T1 and T3 surveys were completed online. The T2 survey was completed on paper at the conclusion of the workshop. Participation was anonymous; however, participants were requested to create a de-identified code to enable individual responses over the three time points to be matched.

Measures

Constructs of interest were knowledge, role adequacy, motivation and personal views.

Knowledge (the accuracy of participants’ knowledge of AOD, their effects and appropriate responses) was measured with 14 multiple-response questions assessing workshop content. *Role adequacy* (the extent to which participants perceive themselves to be capable of responding to individuals who use AOD), *motivation* (the extent to which participants are motivated to

respond to individuals who use AOD) and *personal views* (the extent to which participants hold negative/stereotypical views of individuals who use AOD) were assessed using the Role Adequacy, Individual Motivation and Reward, and Personal Views subscales of the Work Practice Questionnaire, respectively. The Work Practice Questionnaire is a valid and reliable tool for assessing alcohol- and drug-related training [11].

Demographic characteristics (age, gender, Indigenous status, education, employment status and occupation) were additionally collected at T1.

Ethics

Ethics approval was obtained from the Flinders University Social and Behavioural Research Ethics Committee.

Analysis

All analyses were conducted using SPSS version 22. Frequency analyses explored demographic characteristics. Asymptomatic sign tests were attempted to assess changes in individual scale scores over time; however, the number of participants for whom matched data were available across all three time points was too low. Aggregate analyses using paired-samples t-tests were therefore utilised instead. Two t-tests were conducted for each variable of interest (to compare changes from T1-T2 and T2-T3).

Results

Sample characteristics

Fifteen workshops were conducted within the evaluation period, attended by a total of 209 participants. The majority of participants completed the T1 (68%, $n = 142$) and T2 (88%, $n = 184$) surveys. Less than

half (47%, $n = 98$) completed the T3 survey, representing a 31% T1-T3 attrition.

Most participants were female (81.9%), employed (91.9%), had tertiary qualifications (94.1%) and did not identify as Aboriginal or Torres Strait Islander (91.2%). Mean age was 41.7 years (SD: 11.9). The majority (93%) were employed in community services or the health sector, with one-third (33%) describing themselves as case managers/workers.

Changes over time

Between T1 and T2, there were significant increases in scores for knowledge and role adequacy. No significant differences were found for motivation and personal views (Table 1).

At T3, knowledge and role adequacy scores remained significantly higher than at baseline. No other significant differences were found between T1 and T3 (Table 2).

Discussion

Results of this pilot evaluation demonstrate that Drug and Alcohol First Aid workshops can lead to significant and sustained improvements in AOD-related knowledge and role adequacy. Although improvements were not seen for all measures, findings were nonetheless encouraging. Further research into Drug and Alcohol First Aid is warranted.

Participants' baseline scores were relatively high, potentially due to many working in the community services/health sectors. As participants also self-selected to attend the workshop, the sample was likely knowledgeable and motivated. The fact that the workshop contributed further knowledge to this already skilled group indicates that the content was relevant and appropriate.

Table 1. T1/T2 changes in mean scores^a

Construct	Mean score (SD)		Mean difference (SD)	95% CI		<i>t</i>
	T1	T2		Lower	Upper	
Knowledge ($n = 95$)	11.51 (2.03)	12.85 (1.36)	1.35 (2.01)	0.94	1.76	6.52*
Role adequacy ($n = 95$)	15.49 (4.26)	19.25 (2.90)	3.76 (3.47)	3.05	4.46	10.57*
Motivation ($n = 95$)	10.27 (1.45)	10.51 (1.64)	0.23 (1.45)	-0.06	0.53	1.56
Personal views ($n = 95$)	10.40 (1.62)	10.62 (1.59)	0.22 (1.59)	-0.10	0.54	1.36

* $P < 0.01$. ^aParticipants who did not have complete scores on relevant scales at both T1 and T3 were excluded from analyses. CI, confidence interval.

Table 2. T1/T3 changes in mean scores^a

Construct	Mean score (SD)		Mean difference (SD)	95% CI		<i>t</i>
	T1	T3		Lower	Upper	
Knowledge (<i>n</i> = 34)	11.51 (2.03)	12.88 (1.39)	0.71 (1.62)	0.14	1.27	2.53*
Role adequacy (<i>n</i> = 37)	15.49 (4.26)	19.46 (3.95)	3.38 (4.17)	1.99	4.77	4.93**
Motivation (<i>n</i> = 36)	10.27 (1.45)	10.72 (1.47)	0.42 (1.32)	-0.03	0.86	1.90
Personal views (<i>n</i> = 36)	10.40 (1.62)	10.89 (1.33)	0.25 (1.27)	-0.18	0.68	1.18

P* < 0.05; *P* < 0.01. ^aParticipants who did not have complete scores on relevant scales at both T1 and T3 were excluded from analyses. CI, confidence interval.

The workshop was less successful in improving personal views and motivation. Attitudinal change can be difficult to achieve, particularly with one-off educational sessions [12]. If achieving improvements in motivation and personal views is a priority, more targeted strategies may be necessary (e.g. practical strategies for recognising, preventing and reducing stigma).

These results support the use of brief educational interventions to increase the knowledge and role adequacy of health professionals and lay individuals. The workshops were not only effective but also popular. They are also relatively easy and inexpensive to implement. Consequently, they hold considerable potential for promoting improvements across a range of health and AOD topics.

Limitations

The self-report measures used in the evaluation instrument may have been subject to bias. Differences may also exist between follow-up responders and non-responders, as only a moderate follow-up response rate was achieved, and the requisite data was not available to empirically test for differences between the two groups. Despite attempts to track individual responses across all three time points, many participants were unwilling or unable to provide a unique identifying code to enable this. Thus, less robust aggregate analyses were by necessity utilised. Finally, sub-group analyses examining differences in outcomes by age, gender and staff discipline were not feasible due to the relatively small and homogeneous sample. Future research with a larger and more diverse sample should examine whether the workshop is equally effective for all participant sub-groups.

Conclusion

These findings support short-term training as a complement to long-term professional development. Drug

and Alcohol First Aid meets an identified need for evidence-based AOD education. The workshops produced significant improvements in knowledge and role adequacy, which were maintained after 3 months. Further research into strategies for combating stigma and stereotypical attitudes towards individuals who use AOD is needed.

Conflict of interest

JA, NM and LM are employed by Lyndon and were involved with workshop development and implementation. The National Centre for Education and Training on Addiction was funded by Lyndon to conduct the evaluation. There are no other conflicts of interest to declare.

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