Design and Implementation of the OOPS Emergency Department Project: Review to December 1998

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ISBN 1 87668402X

Acknowledgments

The OOPS ED Project is, by definition, a collaborative project. It would not exist, let alone function without the willing, constructive, and ongoing involvement of staff and volunteers from hospitals, emergency services, government agencies and non–government organisations. This document has attempted to describe these contributions as clearly as possible, but it is difficult to communicate in a government report the value of these interactions, both observed and experienced, for all of those involved.

Particular acknowledgement must go to the originators and developers of the ED Project itself, namely Allan Quigley, Myra Browne, Shane Moore, Ruth Birgin, Gretta Little, Grant Mahy, Damien Roper and Katrinia Robertson. Myra Browne, Shane Moore and Ruth Birgin also provided valuable feedback to drafts of this document.

Postscript

On 3 March 1999 the Western Australian Alcohol and Drug Authority was renamed Next Step Specialist Drug and Alcohol Services. This document describes events prior to this name change, and for this reason the older name has been retained throughout this document.

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Acronyms Used in this Report

AMA.....Australian Medical Association

ED .....Emergency Department

ED Project.....Emergency Department Project

NCRPDA.....National Centre for Research into the Prevention of Drug Abuse

NH&MRC .....National Health and Medical Research Council

OOPS.....Opiate Overdose Prevention Strategy

OOSG .....Opiate Overdose Strategy Group

RPH .....Royal Perth Hospital

SCGH .....Sir Charles Gairdner Hospital

UI.....Unique Identifier

WAAC .....Western Australian AIDS Council

WAADA.....Western Australian Alcohol and Drug Authority (now Next Step)

WADASO.....Western Australian Drug Abuse Strategy Office

WANADA.....Western Australian Network of Alcohol and Drug Agencies

WASUA .....Western Australian Substance Users Association

Executive Summary

In November 1997 the Western Australian Alcohol and Drug Authority (WAADA) received funding from the Government of Western Australia through special Treasury Allocations to design and implement the Opiate Overdose Prevention Strategy Emergency Department Project (OOPS ED Project). The ED Project is an intervention project targeted at injecting drug users who have just suffered an accidental opiate overdose.

The core aims of the initiative are to:

- Reduce the frequency of repeat overdose in Western Australia due to increased illicit opiate user awareness of the issues involved in safer use; and
- Increase the willingness of illicit opiate users to utilise emergency (000) services as a first rather than last response to opiate overdose.

The project also seeks to :

- Increase cooperativeness between illicit opiate users and hospital and 000 services staff;
- Provide information, education and support for hospital and 000 services staff regarding the non–medical aspects of opiate overdose;
- Develop resource materials in conjunction with other WAADA projects for clients and concerned others; and
- Assess the feasibility of peer–based community follow–up and home visits post-discharge from hospital.

The expected outcome is the reduction of the incidence of both non–fatal and fatal opiate overdose in Western Australia. The two major strategies to achieve this are the facilitation of the capacity of illicit opiate users to prevent overdose in the first place, and the reduction of known barriers to the utilisation of 000 services where overdoses do occur.

The project was developed using an action research model, which involves the use of iterative feedback loops to rapidly develop a conceptual model into a best practice project. The process of developing the project model towards best practice is documented here for the purpose of facilitating the implementation of the model in other jurisdictions.

The project is a world first in bringing together primary heath care and peer–based education models. An evaluation component is built into the structure of the project, and additional funding is currently being sought from the National Health and Medical Research Council (NH&MRC) to provide an extensive two year in depth evaluation of the long–term impacts of emergency service projects in collaboration with the DROP project initiated by Turning Point in Victoria.

Outcomes to Date

The ED Project callout service commenced 'official' operations on 10 June 1998. To date (26 February 1999) there have been 112 callouts, an average of just over one callout every two days. Acceptance by both clients and hospital staff has been high, with clients in several instances having already heard of the project through other agencies.

Most clients seen by the project were aged between 15 and 30; slightly more than half (59%) were male; 6% were of indigenous origin; and 5% were from non-english speaking backgrounds.

Initial data collected at the point of intervention and supported by surveys conducted amongst injecting drug users in the community suggest that the experience of contact with the ED Project in a hospital setting increases the likelihood of calling an ambulance as a first rather than last response to a friend overdosing. There are also some preliminary suggestions that the ED intervention may be reducing the frequency of overdose amongst those who have received the intervention when compared to their peers. These tentative indications will however, require verification via the more rigorous research currently in planning.

In summary, the ED Project has broken considerable new ground as a modality for reducing accidental opiate overdose, and as such has attracted considerable favourable attention both within Australia and overseas. Early indications suggest the core and secondary aims of the Project are being addressed, however a detailed analysis of the precise impacts of the project will not be available until longer–term research projects associated with the ED Project are complete.

Project Conceptual Model

Introduction

Heroin use in Western Australia increased significantly during the 1990s with the mortality rate peaking at 81 per annum in 1995[1]. By December 1998, mortality rates had declined only slightly, and St John Ambulance reports that as at the end of 1997 they were still responding on average to 2.4 callouts to opiate overdoses per day[2]. The Government of Western Australia responded to this situation in a number of ways, both expanding on existing strategies and developing new approaches, as detailed in *Together Against Drugs*[3] and *Finding the Right Balance*[4]. The ED Project represents one of those approaches.

Research and Pre-existing Projects

The OOPS ED Project was directed in its design by the findings of a number of research projects conducted in Western Australia and nationally.

Surveys of injecting drug users in Western Australia[5] and elsewhere[6] had shown that the depth of knowledge about the causes of overdose[7] amongst opiate users varies greatly, raising the possibility that some overdoses may effectively be being caused by ignorance of risk factors amongst users. Overdoses may therefore be potentially avoidable even where opiate users decline to reduce or abstain from opiate use.

Projects such as the WAADA's pre–existing Opiate Overdose Prevention Strategy (OOPS) peer education project had already had positive results in increasing opiate user knowledge about the causes of overdose through the provision of targeted and appropriate information via peer delivery[8]. However, while some opiate users are quite 'visible' in that they are regularly in contact with government and non–government agencies capable of providing them with information, others have little or no contact with any such sources of information. In a 1995 survey of those purchasing fitpacks from chemists in Western Australia found that as many as 49% of the sample of 511 had had no prior contact with any drug treatment agency including GPs (the most commonly accessed first source of information and treatment)[9].

In planning sessions conducted by OOPS into ways of reaching these 'invisible' opiate users, it was noted that in Western Australia, 80% of opiate overdoses attended by St John Ambulance are transferred to a hospital emergency department[10]. These transported overdose events were therefore identified as representing a unique opportunity to provide targeted interventions to injecting drug users who may have little or no other contact with support and treatment services.

A literature review revealed that there have been few documented attempts at making use of hospital emergency department presentations by injecting drug users as an initial point of contact for intervention programs. Of the two instances found in the literature, both were from the United States and both were aimed at initiating abstinence–based treatment with or without ongoing support and followup from the initiating project.

Andersen and colleagues (1993) utilised the nursing LIGHT model to provide delivery of treatment referral and followup by nurses for female clients presenting in emergency departments seeking treatment for substance misuse[11]. Bernstein and colleagues (1997) reported on the ASSERT Project run at a Boston public hospital which assessed incoming emergency department patients for alcohol and other drug use and referred them to abstinence based treatment programs[12]. Neither program provided any options for those refusing abstinence based treatment options, and neither program made use of peers in either project design or delivery.

The ED Project would therefore appear to be a world first in terms of its innovative mixture of peer education, support and information for those who may be unwilling to immediately enter abstinence–based treatment. The integration of the ED Project with hospitals and other emergency services in a cooperative manner would also appear to be unique in bringing together peer–based intervention and primary medical care.

Finally, research commissioned by the Western Australian Drug Abuse Strategy Office (WADASO) and conducted by the National Centre for Research into the Prevention of Drug Abuse (NCRPDA) in Western Australia during 1997 revealed a number of issues concerning the impact of emergency services procedures on the behaviour of opiate users in overdose situations[13]. In the Action Plan developed in response to this research (in early 1998), the ED Project was identified as an appropriate vehicle for addressing some of these issues. In particular, the ED Project was anticipated to be able to: a) provide information to hospital staff regarding the non–medical aspects of opiate overdose; b) increase the 'user friendliness' of the hospital environment; and hence c) increase the willingness of the community of opiate users to utilise emergency services as a first rather than last response to opiate overdose events. For a copy of those aspects of the *Forgetting to Breathe* report and Action Plan relevant to the ED Project, see appendix 2, p.A5.

Action Research

The ED Project was also partially derived from a proposal developed by the Directorate of Clinical Research and Policy Development within the WAADA for a one year research project, to be followed by a separate service delivery project based on the findings of the research. However, an increase in the number of fatal overdoses in Western Australia for the calendar year 1997 led to the service delivery component of the project being brought forward significantly. The role of other research projects in providing a conceptual model has been discussed above, however it was also recognised that in the absence of pre–existing operational models the intervention project would need an ongoing research component to provide both structure and ongoing feedback. A research officer with a background in opiate overdose issues was appointed to the project in April 1998.

The specific research model adopted for the project was an action research model. Action research is traditionally used in situations where there is a felt need for change in a given situation but where the exact nature of the changes needed are unclear. Action research is an iterative process, whereby the current situation is assessed, research is conducted into

the best way to achieve change, change is implemented, the situation reassessed again and so forth. This approach allows the rapid testing of ideas (including ideas about the basic structure and organisation of both research and project). Action research also places a heavy emphasis on the complete involvement of all those affected by the impacts of the processes of change in designing and shaping both the process and the changes it produces. This includes the integration of end users of the project (i.e. those to whom the intervention is directed) into the project structure, as both informants and collaborators[14].

The action research model was seen as particularly appropriate for the ED Project as it encompassed three of the Project's most significant needs: the need to be able to respond rapidly to future changes in drug use patterns; the need to develop effective structures to include peers in the design and operations of the Project; and the need to rapidly develop and implement an operational model from a conceptual framework.

Peer Education and the Use of Volunteers

As mentioned above, action research strongly emphasises the importance of including those who will be affected by a project in both the design and implementation of that project[15]. The immediate implication of this emphasis is the need to include opiate users at all stages of both project design and service delivery.

The wider literature on implementing change in the behaviour of illicit drug users also suggests that utilising the input of drug users is essential for developing effective strategies aimed at changing user behaviour. Moore (1993) argues that involving users in such projects results in the harnessing of "pre–existing social mechanisms and cultural practices for limiting harm"[16].

The WAADA already had a body of expertise in providing peer–based information and support to the wider opiate using community through the OOPS Project[17]. The OOPS Project, a peer based information and training project, had been praised by the Select Committee into the Misuse of Drugs Act 1981 which also recommended "increased funding for the OOPS Project" in it's Final Report in August 1998[18]. The OOPS Project is funded by special Treasury allocations and operated through the WAADA's Directorate of Clinical Education and Training. It was therefore seen as appropriate to make use of this peer education expertise and to pilot the ED Project as an extension of the OOPS Project.

Utilising a small full–time staff base to deliver what was intended to be a 24 hour service was quickly identified as being impractical and also an inappropriate use of skilled OOPS Project staff. To combine the benefits of the OOPS Project's pre–existing skill base and the "pre–existing social mechanisms and cultural practices for limiting harm" present in the wider opiate using community, it was suggested that service delivery component of the ED Project be carried out by peer volunteers who had received training from OOPS staff. A project officer with a background in peer education, community development, volunteer

coordination and volunteer training was appointed to the project in March 1998 to explore the possibility of using peer volunteers for service delivery and to develop a training program if the use of volunteers was found to be practical .

Project Formal Structure

Establishment and Reporting Structure

The OOPS Project is funded by special Treasury Allocations from the Government of Western Australia until 2000/2001. The OOPS Project consists of the pre–existing peer–education service and the Emergency Department Project. The OOPS Project as a whole is managed and operated by the WAADA through the Directorate of Clinical Education and Training.

The ED component of the OOPS Project works to a strategic plan developed in conjunction with the funding process. The strategic plan is appended to this document as appendix 1, p.A3. The core objective of the project as described in the strategic plan is "To develop in partnership with Perth teaching hospital emergency departments, St John Ambulance and other key stakeholders, a prevention, brief intervention and follow–up service for non fatal opiate overdoses."

The OOPS Project is managed by a Senior Project Officer who reports directly to the Director of Clinical Education and Training. The ED Project is also the responsibility of the Senior Project Officer but is managed on a day–to–day basis by an ED Project officer in collaboration with an ED Project Working Group. As will be discussed below, the makeup and role of the Working Group has altered on several occasions in response to the changing needs of the project and the reorganisations implicit in the outcomes of action research processes. As a minimum, the Working Group contains other OOPS staff members.

Reference Groups

Reference groups are an important part of any cross–sector project. They provide an opportunity for representatives from key organisations affected by the activities of the project to provide input to the project and receive updates on the current activities of the project.

By this definition, the ED Project effectively has three reference groups: the OOPS Project reference group; the Opiate Overdose Strategy Group (OOSG); and the ED Project Operational Stakeholder group.

OOPS Project Reference Group

The OOPS Project reference group provides feedback and advice for the entire OOPS Project. Its membership consists of representatives from WADASO, the Western Australian Substance Users Association (WASUA), NCRPDA, staff of the OOPS Project, and the Director of Clinical Education and Training. Since the introduction of the ED Project, this group has been extended to include the WAADA's Director of Clinical

Research and Policy Development. At various points representatives from St John Ambulance, Sir Charles Gairdner Hospital, and Royal Perth Hospital have also attended. The OOPS Project reference group meets approximately every three months.

Opiate Overdose Strategy Group (OOSG)

OOSG is a policy–level strategy group coordinated by the Government of Western Australia's Western Australian Drug Abuse Strategy Office (WADASO). Its membership consists of representatives from WADASO, WAADA, the Heath Department of Western Australia, NCRPDA, WASUA, Sir Charles Gairdner Hospital, the Western Australian Network of Alcohol and other Drug Agencies (WANADA), the Western Australian Police Service, the Pharmacy Guild of Australia (WA), St John Ambulance, and the Australian Medical Association. OOSG meets approximately every month. Participation in OOSG meetings allows the ED Project to be allocated specific responsibilities within the broader ambit of Western Australian measures to reduce opiate overdose, and to report on progress which may impact on other aspects of such measures. As an example, research conducted by NCRPDA in 1997 which revealed specific problems with interactions between hospitals and opiate users were reported to the OOSG group. This reporting allowed the ED Project to specifically address this issue and to coordinate these efforts with the efforts of others responding to these reports such as the hospitals themselves.

ED Project Operational Stakeholder Group

The Operational Stakeholder group was formed in September 1998 in response to an action research analysis cycle which identified weaknesses in the ED Project's capacity to access and address input from a number of its identified stakeholders. In particular, the Operational Stakeholder group was intended to bring together hospital staff who deal directly with overdose patients and ED volunteers who provide the service delivery component of the ED Project. In a broader sense, the Operational Stakeholder group is intended to provide a rapid and effective means to gain input into operational aspects of the project from those affected by the project on a daily basis. The Operational Stakeholder group has effectively taken over many of the consultative functions of the ED Working Group mentioned above. The Operational Stakeholder group consists of representatives from the emergency department nursing staffs of Sir Charles Gairdner Hospital and Royal Perth Hospital, the ED volunteers, WASUA, WAADA's Directorate of Clinical Research and Policy Development, and OOPS staff members. The group meets every six weeks.

Project Development and Design Process

The strategic plan, formal structure and conceptual model as described above served as a framework around which the ED Project could be developed. As noted, there were no pre–extant models on which to base the operational structure of the project, requiring the project's operational model to be developed from the ground up.

This development was coordinated by the ED Project Working Group. The Working Group initially consisted of the ED Project Officer, an ED Research Officer, OOPS Staff members and the OOPS Senior Project Officer.

Utilising the action research process, one of the earliest tasks identified by the Working Group was the necessity to identify stakeholders in the project. Stakeholders were defined as those who would be affected by the existence of the project and/or who could affect the success of their project. Methods could then be developed to incorporate stakeholder input into both project design and operations.

Within the context of the ED Project, where a specific research officer had been appointed, this process was broken down as follows:

- An initial list of stakeholders would be drawn up by the ED Project Working Group and later added to if necessary.
- The research officer, in consultation with the ED Project Working Group, would design and implement methods to include stakeholder input in initial project design and stakeholder involvement or participation in the ongoing project.
- Where initial stakeholder input was to be made via one–on–one interviews or focus groups or other formal research methods, the research officer would arrange and conduct these and report the findings back to the ED Project Working Group as an integral part of the project design process.

Within the action research process, the project development cycle is defined as an iterative process in which assessment is undertaken, change planned on the basis of that assessment, change instituted and then the project is reassessed and so on. For the purposes of the ED Project, this action research cycle took place at two levels. The basic process of assess, plan, change and reassess was integrated into the daily operations of the project, resulting in a project in which minor but frequent (at times daily) change took place as an integral part of project operations. These changes are frequently the result of stakeholder input or involvement. At a more structural level, the process of stakeholder identification and involvement was identified as the 'core cycle' of the action research process. On a regular basis (bi–monthly, or as needed) the ED Project Working Group met to reassess the efficacy of current stakeholder involvement and weaknesses in the project stemming from lack of adequate involvement and 'investment' in the project from one or more stakeholders. Where such weaknesses were identified, enhanced or alternative methods of involving those stakeholders were designed and implemented.

The following section describes the stakeholders in the ED Project and the multiple paths taken to include their needs and inputs in the project.

Stakeholder Identification and Needs Assessment

In April 1998 an initial list of stakeholders in the ED Project was created by the ED Project Working Group. The list has since been added to considerably, often at the behest of stakeholders from the initial list.

Specific methods used to incorporate input or operational involvement for each group and the outcomes of the interviews and focus groups are detailed further below.

The list as at 12 December 1998 was:

- Opiate Users
    - ED Project Clients
    - WASUA
    - Broader opiate using community
- Users 'Significant Others' (family and/or partners)
- Hospitals
    - Emergency Department Management
    - Emergency Department Nurses
    - Emergency Department staff development nurse
    - Emergency Department Doctors and interns
    - Social workers
    - Youth Self–harm team
    - Other relevant hospital staff
- St John Ambulance
    - Administration
    - Ambulance Officers
- ED Project Workers
- ED Project Working Group
- Cabinet, Government of Western Australia
- Mental Health Policy Unit and Executive
- WAADA Executive

- Director, Clinical Education and Training
- Director, Clinical Research and Policy Development
- Chief research officer, Clinical Research and Policy development
- WADASO
- NCRPDA
- WA Police Service
- AMA
- Media

Needs Assessment Outcomes

Opiate Users – ED Project Clients

Initial input about the needs of potential clients of the ED Project was sought via a series of anonymous interviews conducted in May 1998. Details of the format and outcomes of this process are given below in the section on the broader opiate using community.

In November 1998 a survey of 70 of the clients of the Western Australian AIDS Council's (WAAC) mobile needle exchange van who had been to hospital following an accidental overdose in the past six months was conducted. The survey was primarily intended to compare overdose rates between those who had been seen by the ED Project and those who had not, but also sought feedback on the project from those who had been seen by the project. This survey and its outcomes are discussed in more detail in the section below on data collection.

At the time of writing (December 1998) recruitment for a second round of volunteers is in planning, and at least one of those who has already indicated interest in applying had first contact with the project as a client.

Opiate Users – West Australian Substance Users Association (WASUA)

WASUA members were directly involved in the process of developing the content of the volunteer training course during a series of meetings in April and May 1998. Some volunteers are also members of WASUA, and WASUA is represented on all three of the reference groups to which the ED Project reports.

Opiate Users – Broader Opiate Using Community

As part of the initial design of the project, a short series of semi–structured interviews were conducted in May and June 1998 with people who had used heroin within the last six months and who had been to a hospital emergency department as a consequence of their drug use.

Flyers asking "Have you used heroin more than twice in the last six months? Have you ever been to a hospital Emergency Department because of drug use? Do you want $20 for an hour or so of your time?" and a mobile phone number, the ED Project Research Officer's first name and "This study is part of the OOPS Emergency Department Project" were distributed to users with the help of WASUA. See appendix 3, p.A7 for a copy of the full leaflet. Interviews commenced on 15 May 1998.

Initial interviews were exclusively with men, who were predominantly in their late 20's to early 40's. To access to a wider range of experiences and needs, Trinity Youth Options was approached on 25 May 1998 to assist in distributing flyers to younger women. In all, interviews were conducted with nine people between 15 May 1998 and 11 June 1998. Six of these were men and three women. Age ranges were from late teens to mid forties, with all women being under 25.

Interviews were all done with either one or two people, were conducted mostly in coffee shops or other public places, and were tape recorded with the respondent/s consent. See appendix 4, p.A9 for a copy of the consent form and appendix 5, p.A11 for the questions used as an interview outline.

- Respondents were universally receptive to the general concept of the callout project. The specific issues of distribution of taxi vouchers and support when dealing with hospital staff were seen as the two biggest attractions of the project.
- Almost all respondents stated they would prefer the callouts to be done by other users if given the choice. Most of the women interviewed stated without prompting that they would prefer it if the person doing the callout was also a woman, but that this was not essential. One respondent added that training was going to be more important than age or gender "because they're going to be copping it from staff, clients and parents and need to be able to get and maintain respect from all of these".
- Respondents were less positive about the use of the project to serve as a 'halfway step' between immediate emergency medical management and actual discharge, although several stated they would have no objection to having a coffee or a cigarette and that "you usually know you're still fucked even when you're scrambling to get out of the place".
- Two other specific suggestions of direct relevance to the project were made: firstly, that clients should not have to feel like they were being 'registered' as "users" because they were utilising the project; and that there might be a role for a callout based service in providing immediate support with dealing with police and other authorities in the event of a fatal overdose.

Users 'Significant Others' (family and/or partners)

Short talks were given at support meetings held for the parents and partners of drug users conducted by Palmerston, a drug treatment and support agency, on 27 May 1998 (Northbridge) and on 9 June 1998 (Fremantle). An outline of the ED Project and its aims

was given, and the need to involve parents and significant others in the process of designing the service was explained. Leaflets were then distributed asking "Have you ever been in contact with a hospital emergency department because your child or your partner overdosed on heroin or other opiates?" before giving more details of the project and a contact number and a statement to the effect that the study was a part of the OOPS Emergency Department Project. See appendix 7, p.A15 for a copy of this leaflet.

Leaflets were also distributed through Yirra's parent group. When none of these initiatives produced results, the WA Drug Abuse Strategy Office was approached for help, resulting in an interview with two mothers of injecting drug users. The interview was conducted at a private residence and was tape recorded with the consent of those present. See appendix 8 p.A17 for a copy of the consent form and appendix 9, p.A19 for the questions used as an interview outline.

One respondent could unfortunately only be present for a short time, and most of this time was spent discussing harm minimisation as a policy direction. The second respondent, however, spent several hours talking about a wide range of experiences in connection with her child's opiate use including a detailed breakdown of the last time the respondent attended a hospital in connection with an overdose event. Points raised of direct relevance to the ED Project included:

- The unwillingness of hospital staff to discuss the respondent's child's medical status on the phone until she revealed that she knew about her child's drug use.
- The lack of support of any kind from most hospital medical staff.
- The lack of referral to any other source of information or support – "at the time I thought of the hospital as the only place you could get help".
- The usefulness of taxi vouchers or similar assistance with transport, as the respondent had to make two trips back and forth until her child recovered enough to be discharged, and she is on a pension.
- The need for any future form of support to be appropriate. For example, while the respondent did not see the need for someone to serve as a liaison between herself and hospital staff, she would have appreciated someone who could tell her what questions she needed to be asking.

Since the commencement of the project, the OOPS Project has developed an arrangement with a parent of a now–deceased user to regularly comment on both general operations and specific resources on a regular basis. OOPS is also working with hospitals on a resource to be given to parents or significant others who were taking a child, partner or friend home from hospital following an overdose. The resource provides information about the immediate medical consequences of the overdose, suggestions for what might be done next and contact details for relevant government and non–government agencies.

Hospital Emergency Department Management

Senior staff from Royal Perth Hospital and Sir Charles Gairdner Hospital are members of the WADASO OOSG group and have also on occasion attended OOPS Project reference group meetings. Individual senior staff have been semi–formally interviewed by the ED Project Research Officer and/or the ED Project Officer at various points throughout the life of the project seeking their input on a number of relevant issues. Senior staff from the two hospitals have also been co–authors of a letter to the *Medical Journal of Australia* with ED Project Working Group members and other WAADA staff announcing the project. A copy of this letter is included in appendix 13, p.A31.

Royal Perth Hospital is also a participant in another overdose–related research project being run by the WAADA's Directorate of Clinical Research and Policy Development.

Hospitals Emergency Department Nursing Staff (including staff development nurse)

Combination in–service and focus groups were held at Royal Perth Hospital on 18 June 1998 and at Sir Charles Gairdner Hospital on 24 June 1998 with emergency department nursing staff. In all, approximately 20 hospital staff were involved. At these meetings the general nature and structure of the ED Project were explained to hospital staff (i.e. "what we can do, what we can't do, when we can be called and how to call us") and then a range of questions put to staff members about their experiences with patients who had experienced an accidental opiate overdose. Appendix 6, p.A13 lists questions used to start discussion.

Issues brought up by hospital staff as issues that might be relevant to the ED Project included:

- Patients frequently have concerns about where their belongings, clothes, money and friends are immediately on regaining consciousness, which hospital staff often can't answer.
- Patients frequently want to know how they got to hospital, where they were when picked up by the ambulance, and what happened immediately prior to being picked up by ambulance.
- Hospital staff said they still have difficulties with patients who are reluctant to tell hospital staff what other drugs they've taken in the past 24 hours and emphasised the need to "get the message out to users" that this information is only for medical management, "not so we can tell the cops or something".
- Hospital staff mentioned that the use of naloxone within the emergency department setting had previously caused some problems with patients regaining consciousness suddenly and being angry and aggressive. This had led to changes in protocols for using naloxone which included not using it at all, and using lesser quantities so the patient would have their respiratory rate increased and stabilised but still be drowsy.

- Friends of patients who came in with the patient were seen as a common source of problems because: a) they were frequently under the influence themselves; b) often encourage the patient to discharge early against medical advice; and c) want to be with their friend when the emergency department is too busy to accommodate the needs of anyone other than patients and staff.
- Hospital staff stated that they had little in the way of resources or information to provide both patients and / or next of kin upon discharge and they saw this as a regrettable weakness in their service provision.

In general, staff were enthusiastic about the project, clearly regarding it as an appropriate complement to their own efforts.

In–service sessions have been held at both hospitals for emergency department nursing staff on a regular basis both prior to, and since the commencement of, ED Project service delivery. Regular liaison has also taken place with hospital emergency department staff development nurses both as a source of representation of nursing staff opinion and input, and as a liaison point to report project structural or service changes.

In October 1998 a second short round of semi–formal interviews were conducted with a small number of nursing staff from both hospitals in search of broader feedback about the project (i.e. feedback relating to the broad aims of the project). Based on these interviews, it became clear that nursing staff sought more consistent feedback from ED Project workers following a callout. As a consequence of this feedback, a one page form was designed to serve as a tool for providing feedback to the nurse who had called the ED Project. A copy of the form is included in appendix 18. p.A41.

On reviewing this feedback, the ED Project Working Group decided that the project needed to focus more on finding adequate ways of involving nursing staff in project operations to ensure the needs of hospital ED staff were more quickly recognised and incorporated into the project.

As an interim measure, 100 survey forms were distributed to nursing staff at the two hospitals (50 each) to gain anonymous, detailed, feedback on the project. The structure and findings of these surveys are reported below in the Data Collection section. In brief, however, the surveys confirmed the need to formalise feedback to nursing staff following a callout, and also to provide broader feedback about the outcomes of the project.

These findings resulted in two key developments: the formation of the ED Project Operational Stakeholder Group and the creation of an ED Project Newsletter.

The ED Project Operational Stakeholder Group was formed as a solution to the problem that hospital staff are under multiple pressures and time constraints, so asking for more ‘hands–on’ involvement in project operational matters was not practical. The Operational Stakeholder Group allows stakeholders with a day–to–day contact with the ED Project

and/or the project's clients to come together collectively to meet with each other and to communicate their needs and concerns in a context which ensures these needs and concerns are addressed at the project's structural level.

The ED Project Newsletter was designed to communicate to hospital staff and other interested parties both current and upcoming changes to the ED Project (such as extensions to operating hours) and the outcomes of user surveys and the like which provide some indication of the success or otherwise of the project at meeting its stated goals. The first edition of the newsletter is included in this document as appendix 14, p.A33.

Hospitals ED Doctors and Interns

A combination in–service and needs assessment session was conducted in November 1998 by the ED Project Research Officer, the ED Project Officer and the WAADA's Director of Clinical Research and Policy Development (a medical doctor) by the request of the Royal Perth Hospital's Staff Development Nurse. The presentation covered the same basic material presented at in–service presentations to nursing staff, but from a doctor to doctor perspective. The main issue brought up by those present was the desire to see independent, formal research conducted to measure the efficacy of the project at achieving its core stated aim: namely, the reduction in prevalence of overdose amongst those who had been seen by the ED Project following an accidental overdose.

As an interim response to this query, a survey of 70 clients of the WA AIDS Council mobile needle exchange was conducted in late November. The design and outcomes of this survey are reported below in the section on Data Collection. At the time of writing, methods of combining the client data collected by the ED Project from the beginning of service delivery with other health databases to provide more rigorous answers to these questions are under design.

The 'doctor–to–doctor' nature of the meeting with Royal Perth Hospital doctors was seen as having been exceptionally constructive in its own right. As a consequence, the Director of Clinical Research and Policy Development has agreed to 'loan' the ED Project a medical doctor for future meetings of this nature and as a general medical resource.

Hospitals Self Harm Worker and Senior Social Work Nurse

A meeting with Royal Perth Hospital's Youth Self Harm Worker and Senior Social Work Nurse took place on 20 May 1998 during which the existence and basic intent of the ED Project was explained and input sought.

Again, these staff members were enthusiastic about and supportive of the project. As well as providing valuable information they expressed a willingness to advocate for the use of the project's services amongst emergency department doctors and nurses.

Specific points brought up included:

- The high frequency of overdose related clients with crisis accommodation needs.

- A comment that parents who had done Holyoake's parenting course seemed to be better equipped to deal with their child's overdose than those who hadn't.
- The number of clients who seem to be at risk or remaining at risk due to their parent's illicit drug use.

Ongoing contact with self harm and social work hospital staff has continued both though project updates and in the context of referral. At Sir Charles Gairdner Hospital, by request of the social work department, a copy of the callout feedback form filled in by the ED Project worker following a callout is also kept on the patient's medical record for use of the social work department.

Other Relevant Hospital Staff – Security Staff

Two members of Royal Perth Hospital's security staff were interviewed on 25 May 1998. They were informed of the existence and basic intent of ED Project and their input sought.

Key issues raised included:

- Security often have more problems with the friends of overdose patients than with the patients themselves – friends are often also under the influence and frequently want to remove their friend form the hospital before they are ready for discharge.
- Patients frequently seem to have concerns about the police turning up at the hospital, particularly once security has had to be called.

Security staff at both hospitals are now aware of the ED Project and have contact numbers for the ED Project Officer should the need arise.

St John Ambulance

St John Ambulance is represented on the OOSG group through which it receives regular updates on the progress of the ED Project.

Since July 1998 St John Ambulance crews have carried ED Project cards for distribution to overdose patients who refuse transport to hospital. In October 1998 the ED Project Research Officer visited ambulance depots north of the river with St John Ambulance's Eastern Regional Manager. At each location ambulance crews were informed of the nature and aims of the ED Project then asked for their feedback and information about their experiences with patients who had accidentally overdosed.

Key issues raised included:

- Patients refusing to communicate information about what drugs they had taken or denying they had used any drugs;
- Patients who refused transportation in the mistaken belief that this would prevent them being issued with a bill [billing occurs due to attendance, and in the metropolitan area is not linked to the act of transporting or the distance involved];

- The need of ambulance staff to have a witness to sign when the patient refuses transport;
- Problems in communicating the full detail of the social context of the overdose at the point of transfer to hospital care. This is of particular concern where ambulance staff feel that there are indications of self harm;
- Problems for ambulance staff with duty of care issues when children are present: since Crisis Care take too long to attend this means the ambulance crews have to either leave children in the care of neighbours or call police; and
- The point was also made that people need to realise that if they are aggressive or severely agitated while making the initial telephone call to 000, the police may be called automatically. Since the introduction of a police service 'non–attendance' protocol (appendix 15, p.A35) for heroin overdoses, this has been the main precursor to police attending an overdose.

The OOPS Project is, at the time of writing, developing a leaflet in conjunction with St John Ambulance to be given to overdose victims who refuse transport. The leaflet informs the reader what has just occurred, what the immediate medical implications of an overdose are, and who they can ring for more information or support.

ED Project Workers

During the first phase of operations, service delivery was provided by members of the ED Project Working Group and OOPS Project staff while the process of volunteer recruitment and training took place.

As part of the action research process, every callout made in the first two weeks of the project's operation was followed within 48 hours by an in–depth interview conducted by the ED Project Research Officer. The interviews were semi–structured, based on a pro–forma but open–ended in nature to allow other concerns to be explored. See appendix 10, p.A21 for a copy of the pro–forma.

Key points raised by these interviews include:

- The need for ED Project staff and volunteers to have some form of identification, both to identify project workers to hospital staff and to identify project workers to clients as being discrete from hospital staff.
- The need for the option of changing mobile phone networks to be explored due to the unreasonable number of technical glitches which have effectively left the telephone number unattended from the point of view of the hospitals.
- The need for formal arrangements to be made so debriefing is available after difficult callouts.
- The need for familiarisation tours of the hospitals for new staff members and volunteers.

- The fact that word about the existence of the project is already spreading on the street – one staff member was greeted with "are you my OOPS person?" from the client on arrival and was later informed that the client had heard of the service from WASUA.

Ongoing feedback to the ED Project Working Group from members of the group who participated in service delivery took place until Working Group members were replaced by volunteers.

Feedback and input from volunteers takes place through two main mechanisms: through the ED Project Officer as part of callout debriefing; and through volunteer representation on the ED Project Operational Stakeholder group. As part of normal operations, volunteers debrief by telephone and/or by meeting with the ED Project Officer after every callout. Input into day–to–day project design usually takes place at this point. A volunteer representative always attends all meetings of the ED Project Operational Stakeholder Group, providing a mechanism where somewhat more anonymous feedback can be brought to the project. The location of the OOPS and ED Projects at the WAADA's Carellis Centre in Mt Lawley also facilitates a 'drop–in centre' approach to project participation, leading to constant volunteer input to all aspects of the project.

Following the first round of volunteer training, anonymous feedback was sought from all volunteers regarding the quality and relevance of the training. At the time of writing (December 1998) the training program was being redesigned by the ED Project Officer and ED Project Coordinator with the assistance of input from current volunteers.

ED Project Working Group

The ED Project Working Group is the central management tool of the project. The Working Group coordinates the process of seeking and collecting stakeholder input and converts these inputs into operational procedures.

Cabinet, Mental Health, WAADA Executive

The Director of Clinical Education and Training reports to the WAADA Executive on the progress of the ED Project. This report is also intended to provide an outline of the ED Project's progress to date to any interested parties. Input into the project from funding bodies and/or the WAADA Executive takes place via the Director of Clinical Education and Training.

Director, Clinical Education and Training

The director receives regular reports from the OOPS Senior Project Officer and meets regularly with the ED Project Working Group. The director also receives summaries of callouts at the end of each month. The Working Group also clears all initiatives involving action or resource development or distribution external to the WAADA through the director before commencement.

Director and Chief Research Officer, Directorate of Clinical Research and Policy Development

The director of Clinical Research and Policy Development is regularly briefed on the progress of the ED Project, and has directly contributed to the project through the provision of expertise and liaison with medical staff and management at all hospitals involved in the ED Project. The directorate also conducts research which overlaps to some degree with the ED Project's area of operations, and this has necessitated a close working relationship to the benefit of both directorates. As part of this relationship, the ED Project Research Officer attends research team meetings and provides regular project updates to the directorate.

WADASO, NCRPDA, WA Police Service and the AMA

The WA Drug Abuse Strategy Office (WADASO) convenes an opiate overdose strategy group (OOSG) which includes representatives from NCRPDA, the Western Australian Police, the Pharmacy Guild, the Australian Medical Association, St John Ambulance, and WASUA.

A presentation on the ED Project, its progress and general aims was made to the overdose strategy group on 22 June 1998 and the opportunity taken seek input from those present. Regular updates on the project have been given at most meetings of the group since.

The OOPS Project reference group also has representatives from WADASO, WASUA, NCRPDA, and the WA Police Service, providing another avenue for the flow of information and input.

Media

The ED project operates under the same conditions with respect to the media as any other WAADA project or area of operations. All queries from the media are directed to the Executive Director of the WAADA through the Director of Clinical Education and Training.

To date, the ED Project has been the subject of two television reports, one on Channel 10 and one on ABC. Both of these took place in November 1998. The ABC report (Stateline) was generally positive in its reporting and discussed the project in the context of other responses to heroin use in Western Australia. The Channel 10 report (5pm News) was somewhat more neutral and mainly covered differing reactions from various segments of the community to the existence of the project.

Partially as a consequence of these two events, the ED Project Working Group developed a standard press release containing an outline of the project and its aims to be released to any media outlet seeking information on the project. Further queries or requests for interviews etc. remain subject to normal WAADA media policy. At the time of writing (December 1998) the press release is in the process of being approved by the WAADA Executive.

The ED Project has also been described in articles in the St John Ambulance staff newsletter, the WA Emergency Nurses Association newsletter and Yooz Magazine (the newsletter of the Western Australian Substance Users Association).

Discussion

This process of identifying and seeking input or direct participation from stakeholders has been of enormous value for the ED Project. The process has resulted in a project structure which, while continuing to meet the design criteria and outcomes delineated in the Strategic Plan, has also brought together a complex collection of needs, values and skills and successfully integrated them.

As noted above, the process of stakeholder identification and involvement has been identified as the 'core cycle' of the action research process associated with the ED Project. As a consequence, the list of stakeholders given above should not be taken as a final or complete list as other stakeholders will undoubtedly be added to the list in the future as a normal part of project operations. Likewise, the list of processes by which identified stakeholders have been involved in one way or another with the project can also be regarded as incomplete, in that these processes are also expected to change as a normal part of the ED Project's ongoing development and improvement.

Project Operational Structure and History

To date, the ED Project has had two main operational phases. In the first, service delivery was carried out by paid OOPS and ED Project personnel while volunteers were being recruited and trained. The second has been a transitional phase in which service delivery has increasingly been handled by trained volunteers. At the time of writing, the project is entering a third phase in which all service delivery will be carried out by trained and experienced volunteers, relegating paid staff to support and development roles.

Due to the developmental nature of the ED Project and the use of an action research process, all phases have been marked by constant, incremental changes to all facets of the project including operational structures. Further, the transition from service delivery via a small group of paid staff to service delivery via a larger group of peer volunteers has required substantial changes to the operational structure of the ED Project. Since the sheer number of incremental in–process changes precludes their documentation here, the following descriptions of the operational structures represent the most developed and stable forms of these structures for each phase. It should be noted that these forms represent the end of a development process oriented around the specific circumstances of *this* project and its available resources. Other sets of circumstances would undoubtedly have produced other operational structures.

Phase 1

Structure

- In–service training provided to Emergency Department staff at Royal Perth Hospital and Sir Charles Gairdner Hospitals by ED Project staff prior to the commencement of service delivery. Training covers what the project can and cannot do for patients and how and when to access the service. Posters with the ED Project's mobile phone number and patient criteria are displayed in Emergency Departments in both hospitals.
- Formal commencement of service delivery on 10 June 1998
- Project staffed by OOPS and ED Project Working Group staff from 9am to 9pm, seven days a week on a roster system. Each day is divided into two six–hour shifts, although in practice Saturdays and Sundays are usually covered by one person for the whole day. The roster is a 'double roster' system, in which one person is on–call and another is on backup. The backup person is available both to cover the rostered person if she/he is already on a call or otherwise unavailable and a second call comes through, and also to provide a first line of debriefing in the event of a problematic or distressing callout event outside normal WAADA operating hours.

- At the end of each rostered shift the mobile phone is either delivered to the next rostered person or switched through so that incoming calls divert to that person's personal mobile phone. Staff use a WAADA pool vehicle to attend hospitals. Staff on evening or weekend shifts take the pool vehicle home and pass on the vehicle with the phone at shift change.
- A 'callout kit' consisting of a lockable cashbox–style container is stored at each hospital. The kit contains spare data collection forms, cigarettes, phone card, petty cash, taxi vouchers, and a referral resource containing details of accommodation, drug treatment, legal and other support agencies. The kit is regularly restocked by the ED Project Officer, who also uses the opportunity to check with hospital staff that the project is running smoothly from their perspective.
- Normal process–oriented debriefing provided by the ED Project Officer and the Research Officer. In the event of a problematic or distressing callout event, debriefing and support provided by appropriately qualified staff from within the WAADA's Directorate of Clinical Education and Training.

Callout Process

- Emergency Department staff at Royal Perth Hospital or Sir Charles Gairdner Hospital make callouts to the ED Project's mobile phone number after obtaining consent from the client. Clients who do not give consent are given an ED Project card instead.
- Rostered ED Project staff member attends the hospital. Hospital staff member introduces ED Project worker to the patient then leaves. ED Project worker ensures the client is aware of what the project can and cannot do and consents to the presence of the ED Project worker.
- Brief harm–reduction oriented intervention with referral to other agencies where appropriate. Where appropriate the ED Project worker may also help the client in dealings with hospital staff or other third parties.
- When hospital staff are ready to discharge the client, the ED Project worker ensures the client has somewhere safe to go and the means to get there.

Volunteer Recruitment and Training

- During the first phase of operations a volunteer training program was developed and volunteers recruited. This process is described in more detail in the next section of this document.

Phase 2

Structure (Current at December 1998)

- In–service training provided to Emergency Department staff at Royal Perth Hospital and Sir Charles Gairdner Hospitals by ED Project staff on a regular basis. Training covers what the project can and cannot do for patients and how and when to access the service. Posters with the ED Project's mobile phone number and patient criteria are displayed in Emergency Departments in both hospitals.
- Project staffed by a combination of ED Project Working Group staff and ED Project volunteers from 9am to 9pm, seven days a week on a roster system. The roster is a 'triple roster' system, in which one person holds the mobile phone and coordinates callout response, and two other people are on–call via pagers to respond to and provide backup for callouts respectively. For the mobile phone roster each day is divided into two six–hour shifts; for the two callout rosters each day is divided into three four–hour shifts.
- Volunteers are accompanied on their first three callouts by a staff member or experienced volunteer.
- ED Project staff members or experienced volunteers are rostered to the mobile phone. The person on the mobile phone roster is responsible for coordinating volunteer response to callouts, accompanying inexperienced volunteers on callouts, providing a first line of support in the event of a problematic or distressing callout event outside normal WAADA operating hours. Finally, the person holding the mobile phone also acts as a third layer of redundancy if people rostered on the main and backup callout rosters are unable to attend callouts or there have been multiple simultaneous callouts.
- At the end of each rostered mobile phone shift the mobile phone is either delivered to the next rostered person or switched through so that incoming calls divert to that person's personal mobile phone.
- The ED Project Officer is responsible for rotating the pagers between volunteers. This pre– and post–shift contact also serves as a site for normal process–oriented debriefing. In the event of a problematic or distressing callout event, debriefing and support are provided by appropriately qualified staff from within the WAADA's Directorate of Clinical Education and Training.
- A 'callout kit' consisting of a lockable cashbox–style container is stored at each hospital. The kit contains spare data collection forms, cigarettes, phone card, petty cash, taxi vouchers, and a referral resource containing details of accommodation, drug treatment, legal and other support agencies. The kit is regularly restocked by the ED Project Officer, who also uses the opportunity to check with hospital staff that the project is running smoothly from their perspective.

Callout Process

- Emergency Department staff at Royal Perth Hospital or Sir Charles Gairdner Hospital make callouts to the ED Project's mobile phone number after obtaining consent from the client. Clients who do not give consent are given an ED Project card instead.
- Person holding the mobile phone pages the rostered volunteer. If the volunteer is still completing mentored callouts, the person holding the phone organises to meet the volunteer and accompany them to the hospital. If the volunteer has completed mentored callouts, the person holding the phone passes on relevant details and the volunteer proceeds to the hospital alone.
- Hospital staff member introduces ED Project worker/s to the patient then leaves. ED Project worker/s ensure the client is aware of what the project can and cannot do and consents to the presence of the ED Project worker/s.
- Brief harm–reduction oriented intervention with referral to other agencies where appropriate. Where appropriate the ED Project worker/s may also help the client in dealings with hospital staff or other third parties, and where possible the client is encouraged to contact OOPS again for follow-up or further support.
- When hospital staff are ready to discharge the client, the ED Project worker/s ensure the client has somewhere safe to go and the means to get there.

Volunteer Recruitment and Training

- A second round of volunteers to be recruited in February 1999 for training to start in March 1999. Emphasis on recruitment from the Fremantle area to allow ease of expansion to Fremantle Hospital on completion of training.

Phase 3

- Second round of volunteers allows service to expand to cover Fremantle Hospital and bolster Perth area volunteer numbers.
- First group of volunteers provide backup and some support for second group of volunteers.
- Ongoing rounds of training to replace attrition and to allow expansion of the service to cover other metropolitan hospitals.

Volunteer Training

Design Process

The training program for volunteers was developed jointly over several months by ED project working group members, WAADA Clinical Education & Training staff, and WASUA. Input was also provided by the Police Education Unit, Youth Legal Service, Hospital ED Staff, St John Ambulance and the Hepatitis C Council. The process of designing the training program was coordinated by the Project Officer, who had originally been hired to assess the practicality of using peer volunteers within the ED Project.

Package Contents

The training package developed during this process has an estimated duration of eight full–time days. Major areas covered included the history of the project, harm reduction, utilisation of emergency services, IDU issues, pharmacology, general counselling skills, boundary issues, working with young people, working with people in crisis, overdose-oriented first aid, legal and civil rights, gender issues, sexuality and blood borne viruses. The course also included reporting obligations and accountability issues.

Recruitment

Recruitment of volunteers took place during May–June 1998. The project was advertised in a bulk mailout to the membership of WASUA and in advertisements placed in *Xpress Magazine,* a local free music magazine. Approximately 50 people responded in writing to these advertisements and were interviewed by the ED Project Officer and at least one other member of the ED Project Working Group. This process produced a shortlist of 20 people, who commenced training on 23 July 1998. On agreement with volunteers and those providing elements of the training program, the course was conducted one day per week over eight weeks. Training was provided by individuals from WAADA, WASUA, the Police Education Unit, Youth Legal Service, Hospital ED Staff, St John Ambulance and the Hepatitis C Council.

Package Extension

The training program was extended by one week to cover additional material developed by the ED Project working group as a consequence of their experiences with actual service delivery. These additional materials also addressed needs expressed by volunteers during feedback components of earlier training sessions.

Manual

All volunteers receive during training a manual describing reporting protocols, expected behaviour, resources and support provided by the project and the WAADA. The manual is attached to this document as appendix 21, p.A47.

Induction Process

Before the first round of volunteers had completed their training, the ED Project working group developed an induction process to provide support for volunteers undertaking their first callouts. The induction process also provided a final opportunity to assess the suitability of the individual volunteers for ED Project service delivery.

The induction protocol requires that volunteers are accompanied on their first three callouts by an ED Project staff member or by an experienced volunteer. During the first callout, the new volunteer acts as an observer; on the second the callout is handled jointly; and on the third the ED Project staff member acts solely as an observer.

Support and Counselling

Prior to the commencement of ED Project operations, a support and counselling system was instituted to serve all those conducting callouts. The system provides for both immediate crisis support 24–hours a day and for access to appropriately qualified WAADA staff during normal working hours for ongoing or less critical support. Volunteers were informed during training how to access this system, along with standard WAADA incident/accident reporting procedures (see appendix 20, p.A45, and appendix 21, p.A47 for documentation and procedures respectively).

Insurance

All WAADA volunteers are covered by personal accident and public liability insurance while engaged in volunteer activity for the WAADA.

Training Package Revision

At the time of writing, the training course is undergoing revision based on the experiences of the first round of volunteers. A stand–alone course manual and associated documentation are an expected outcome of this process.

Data Collection

Formal data collection is identified as a necessity in measuring the outcomes set for the ED Project in the strategic plan (appendix 1, p.A3). Data collection is also an integral component of the action research model which drives the ongoing development of the ED Project.

Ethics

Data collection in the context of the ED Project is a sensitive issue. On the one hand, data needs to be collected for a variety of reasons, including but not limited to accountability and outcomes measurement for the project. On the other hand, both prior research[19] and the first–hand experiences of Western Australian injecting drug users[20] strongly suggest that processes of data collection have in the past negatively affected the lives of users and as a consequence users are reluctant to participate in projects which involve excessive or name–identified data collection.

During the early design stages of the ED Project, the project research officer conducted extensive discussions about these issues with peer members of the ED Project Working Group. As mentioned above, interviews were also conducted with injecting drug users regarding their past experiences with Western Australian hospitals in the context of an opiate overdose. During these interviews, a number of respondents spontaneously mentioned concern about collection of name–identified data in the context of the operations of the ED Project. These concerns were also raised during the discussions mentioned above.

Consequent to the above discussions, the ED Project Working Group agreed on the development of one pre–eminent design consideration for all data collection directly connected to individual clients: that in order to generate the trust relationships necessary for the project to be successful, project volunteers and staff members could not be required to collect any data which could identify the client to third parties; and could not be required to collect any data that the client did not reveal spontaneously (i.e. which necessitates asking the client to reveal information about themselves).

All proposed data collection processes were first tested against this design criteria before being put to the ED Project Working Group for comment and trial.

All data collected, whether stored digitally or in hardcopy, is kept securely under WAADA guidelines for the storage of confidential data. All staff members and volunteers sign the *WAADA Confidentiality Statement* (see appendix 22, p.A67) at the commencement of employment or completion of volunteer training as applicable.

Data Collection Components

The formal data collection for the ED Project consists of four components. These are: data collection undertaken at the point of intervention; data collection undertaken in connection with followup meetings with the client; data collection undertaken amongst the wider opiate using community to assess the impact of the project; and baseline data taken at participating hospitals to assess the coverage provided by the project.

A fifth component, consisting of quantitative and qualitative data collection over two years with comparative analysis against a similar body of data collected by the DROP Project conducted by Turning Point in Victoria, is currently the subject of an NH&MRC grant application.

Data collection undertaken at the point of intervention and in connection with followup meetings is entered into a computerised database at the WAADA's Carellis Centre by the ED Project Officer. Original hardcopy forms are stored in a secured cabinet to provide backup in the event of corruption or loss of electronic data. The database is used to generate monthly summaries for the Director of Clinical Education and Training.

Data collection at the Point of Intervention

Unique Identifier (UI) Form (appendix16 p.A37)

In order to track repeat overdose events requiring ambulance attendance by the same person, some means of identifying a client was required which nevertheless did not breach the need to maintain client confidentiality. A Unique Identifier system was designed to produce a code which could be reliably generated every time the client presented but which did not rely on the client to reveal identifying data to ED Project workers and which could not be 'reverse engineered' by third parties to identify the client[21].

The Unique identifier form is given to hospital staff to be filled in from the client's medical record at the time of the callout.

The UI system produced to meet these requirements consists of the last two letters of the client's first name; the day of the month the client was born on; the first two letters of the first name of the client's next of kin; and a single letter to indicate the client's gender. A client whose first name was Peter; who was born on the 20th of October and whose mother's first name was Hazel (for example) would have the UI 'ER20HAM'. Identifying information such as a client's name or date of birth cannot easily be extracted by a third party from a UI generated using this method.

An initial calculation suggested that two different clients would have the same UI approximately once in every 28 million cases, however this assumes all letters of the alphabet are evenly distributed in all first names found in Western Australia which is manifestly not the case. A more reliable figure would probably be somewhere in the order of an eighth of this initial figure, giving a non–unique incidence of a UI approximately once in every 3 million cases, still more than robust enough for the project's needs.

At the time of writing the UI is being reassessed because: a) not all UIs collected are complete due to difficulty in consistently collecting next–of–kin data; and b) standard coronial file summaries do not include date of birth, making cross–matching in later studies more difficult.

Callout Form (appendix 17, p.A39).

The two–page Callout Form is the main data collection tool for data collection at the point of intervention. The form details: when and where the callout took place; some basic client demographics such as approximate age and gender (which do not require specific questions to be asked of the client to be collected); a list of the resources provided to or organised for the client; and some broad–based questions giving the volunteer the opportunity to give some general comments about the way the callout went and to detail any difficulties that may have arisen. The design of the form also allows easy collection of resource and operational data such as taxi voucher and petty cash use.

The Callout Form is completed by the volunteer during and immediately following the callout and is returned to the Project Officer at the next debriefing.

Hospital Feedback Form (appendix 18, p.A41)

In response to requests from hospital staff for more information about callout outcomes, a one–page form was designed to allow on–the–spot feedback at the completion of a callout. The form provides information for staff about the intervention outcomes, including what referrals were provided or organised

The Hospital Feedback Form is completed by the volunteer immediately following the callout. The form is either hand–delivered to the hospital staff member who made the initial telephone call or (if that staff member is too busy or otherwise unavailable) left with the client's medical record (SCGH) or in the staff member's pigeon hole (RPH).

Data Collection during followup meetings with clients

Followup Event Form (appendix 19, p.A43)

ED Project workers are required to document follow–up contacts with clients. Follow–up events may include both meetings requested by the client or less formal chance encounters in the community. The Followup Event Form differentiates between first contacts (post ED callout) and later contacts, and also leaves space to document referral to other agencies where appropriate. The Followup Event Form is completed by the ED Project worker and handed over to the ED Project Officer at the next available opportunity.

Data Collection in the Wider Opiate Using Community

During November 1998 a survey was conducted with clients of the WA AIDS Council Mobile Needle Exchange Van. The survey assessed respondents experience of overdose and, for those who had been to hospital following an overdose, their experiences of the ED Project. Outcomes of this survey are reported below.

A longer–term data collection project which will allow case–matched analysis of ED Project outcomes over two years is currently under design.

Baseline Data Collection

The ED Project benefits from an Opioid Overdose Survey project being conducted by the WAADA's Directorate of Clinical Research and Policy Development in conjunction with Royal Perth Hospital. This survey involves data gathering on every patient who presents to Royal Perth Hospital with an opioid related overdose. As such, it provides a benchmark against which callout rates can be measured. It also provides useful data about average and mean times spent by patients in the ED and the percentage of patients who are admitted to other parts of the hospital. Being a separate project, the aims, methods and outcomes of the Opioid Overdose Survey will be reported elsewhere.

Project Outcomes

The ED Project callout service commenced 'official' operations on 10 June 1998. To date (26 February 1999) there have been 112 callouts, an average of just over one callout every two days. Acceptance by both clients and hospital staff has been high, with clients in several instances having already heard of the project through other agencies.

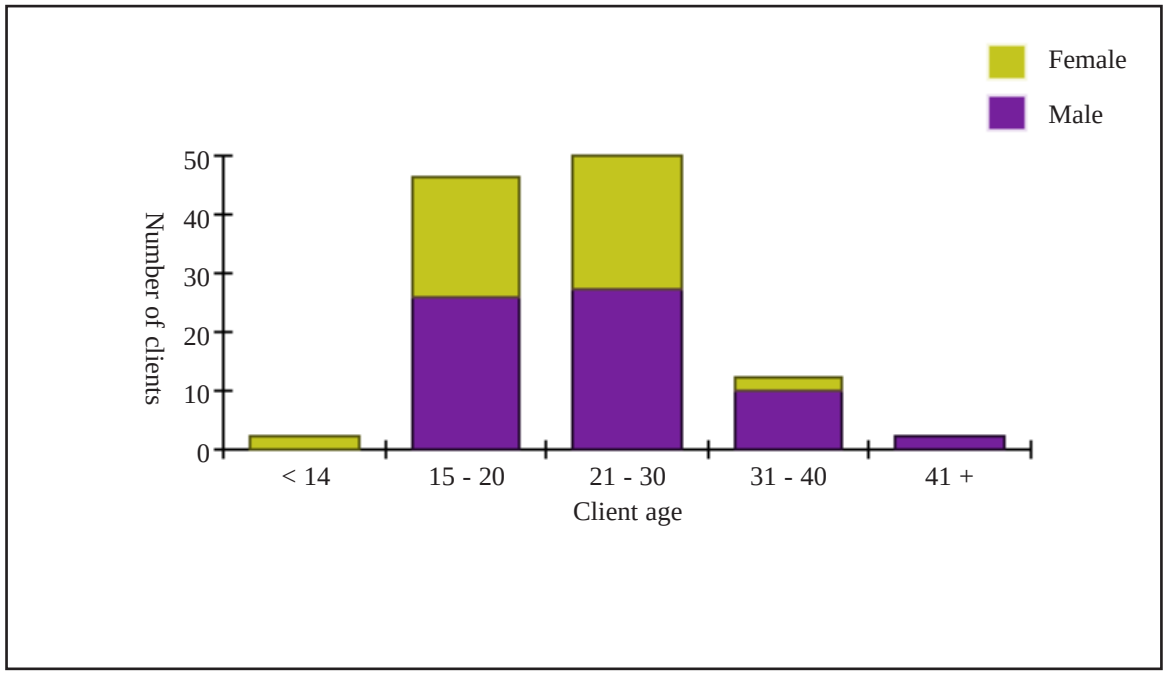
Information about project outcomes has come from three main sources: data collection at the point of callout; surveys of injecting drug users; and surveys of hospital emergency staff. Presented below are client demographics drawn from point-of-callout data collection; client satisfaction and intervention impact data drawn from injecting drug user surveys; and hospital staff satisfaction data drawn from hospital staff surveys.

Outcomes at the Point of Intervention

Demographics

Of the 112 callouts, 108 clients were seen by ED Project workers. The remaining 4 had departed before the Project worker arrived at hospital. Of the clients seen by the project, 44 were female (40.74%) and 64 male (59.26%). 7 (6.48%) clients were of Aboriginal or Torres Strait Islander origin, and 6 (5.55%) from non–english speaking backgrounds.

Figure 1: Callouts by client age and gender



Fourteen clients (12.5%) self–reported being enrolled in the naltrexone program. To date there has been no documented client self–report of current or recent (within the past month) enrollment in the methadone program.

Repeat Presentations

Based on the use of the Unique Identifier system discussed above, there have been three definite repeat callouts and another three possible repeat callouts. 'Possible repeats' occur where not all of the Unique Identifier can be collected and the resultant partial UI matches with another UI. It should also be noted that the use of Unique Identifier collection does not preclude clients attending hospitals other than Royal Perth Hospital or Sir Charles Gairdner Hospital, clients presenting outside current ED Project operating times, clients not being offered the option of being seen by the Project by hospital staff unfamiliar with the project, or clients refusing consent for hospital staff to call the Project on a repeat presentation. A two–year matched–case research project is currently under design which will utilise the data already collected and match it to other sources of information to provide a more rigorous assessment of the precise impact of ED Project interventions on overdose presentations.

The Callout

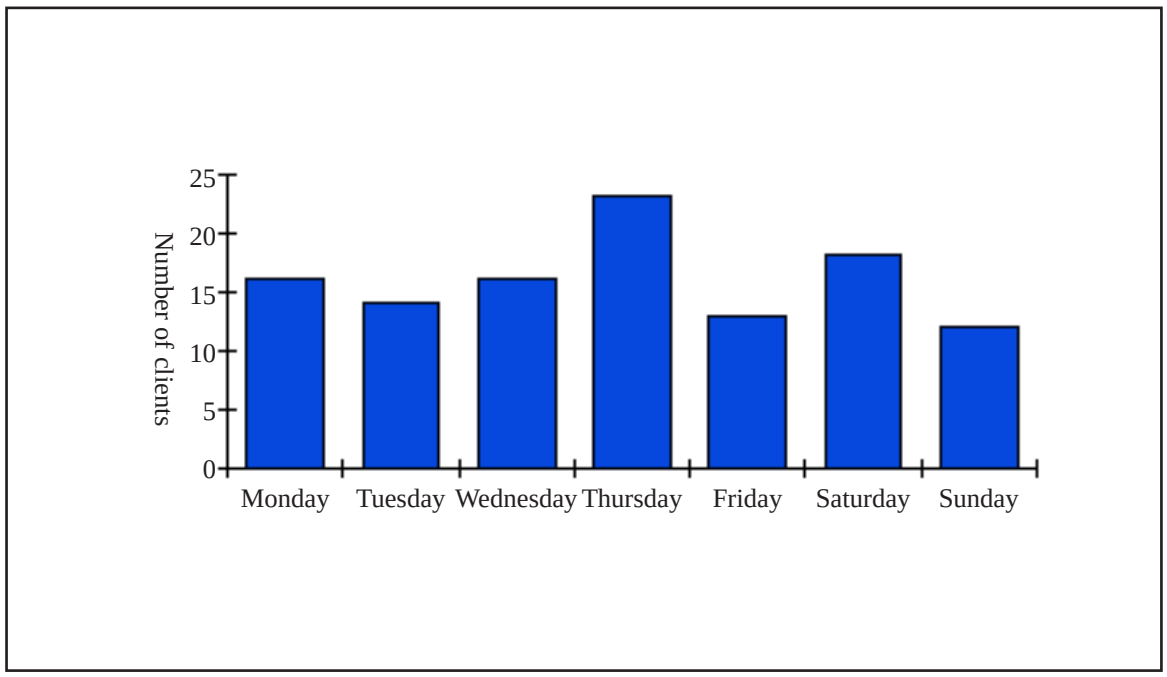
Duration

Average callout duration (from arrival of ED Project worker at the hospital until departure from hospital) was 1 hour 26 minutes. Minimum duration was <5 minutes (client did not wait); maximum duration was 5 hours 30 minutes.

Day of the Week

Callouts were evenly spread across the week, with the only standout day being Thursday. It should be noted that this pattern may owe more to differences in exposure to the ED Project amongst weekend vs weekday hospital staff than any reflection on overdose patterns in Perth.

Figure 2: Callouts by day of week



Client Needs

At least 12 clients (11.1%) required some form of crisis accommodation. While in all cases to date ED Project workers have been able to find some immediate solution for each case, there is a definite need for a more permanent solution such as a pre–booked bed set aside for the project at some suitable location.

Clients have been referred in a 'semi–formal' manner to other agencies in 51 (47.2%) cases. In this context, semi–formal means the client's needs were discussed with the client and a suggestion made as to who might be best suited to assist the client. Contact details were then provided in writing. In some instances the ED Project worker has been able to follow referral up, assisting the client to make contact with the agency in question. These experiences have also led to the development of a referral resource, providing a guide to services available in Perth (appendix 23, p.A69) .

Clients were provided with taxi vouchers to get them home in 53 (49%) cases. In many instances, the ED Project worker was able to organise for a friend or family member to provide transport and post–discharge monitoring.

Followup Events

While formal collection of data concerning followup events was only implemented in early August 1998, at least 31 clients have been in contact with OOPS and/or ED Project staff since the original callout, 15 by the direct request of the client (as opposed to accidental meetings in social settings).

Opiate Using Community Survey Results

70 surveys were distributed to WA AIDS Council Needle Exchange Van clients by Needle Van staff and volunteers over three weeks in November 1998. A copy of the survey form is reproduced as appendix 11 p.A27. The header to the survey form explained that we were seeking anonymous feedback on experiences with and impressions of the OOPS ED Project. All respondents who filled in a form were given a freddo frog on return of the form to the Needle Van staff member. 61 of the 70 forms were completed and returned.

Screening Question:

Respondents were asked if they had filled in an OOPS survey form before, with the proviso that "You'll still get a frog if you have – just fill it in again so the van person doesn't know!". Survey forms with "Yes" ticked at this question, and forms blank below this point were excluded from analysis.

Number of excluded responses: 2

How many times have you been to a hospital since June because you overdosed?

0: 33 (56%) *1*: 13 (22%) *2*: 10 (17%) *3+*: 3 (5%)

Respondents who stated that they hadn't been to hospital since June were asked to stop filling in the form at this point.

On any of the times since June where you went to hospital, did the hospital staff ask you if you wanted an OOPS person to come out and see you?

Yes: 12 *No*: 14

Respondents who answered "No" were asked to stop filling in the form at this point.

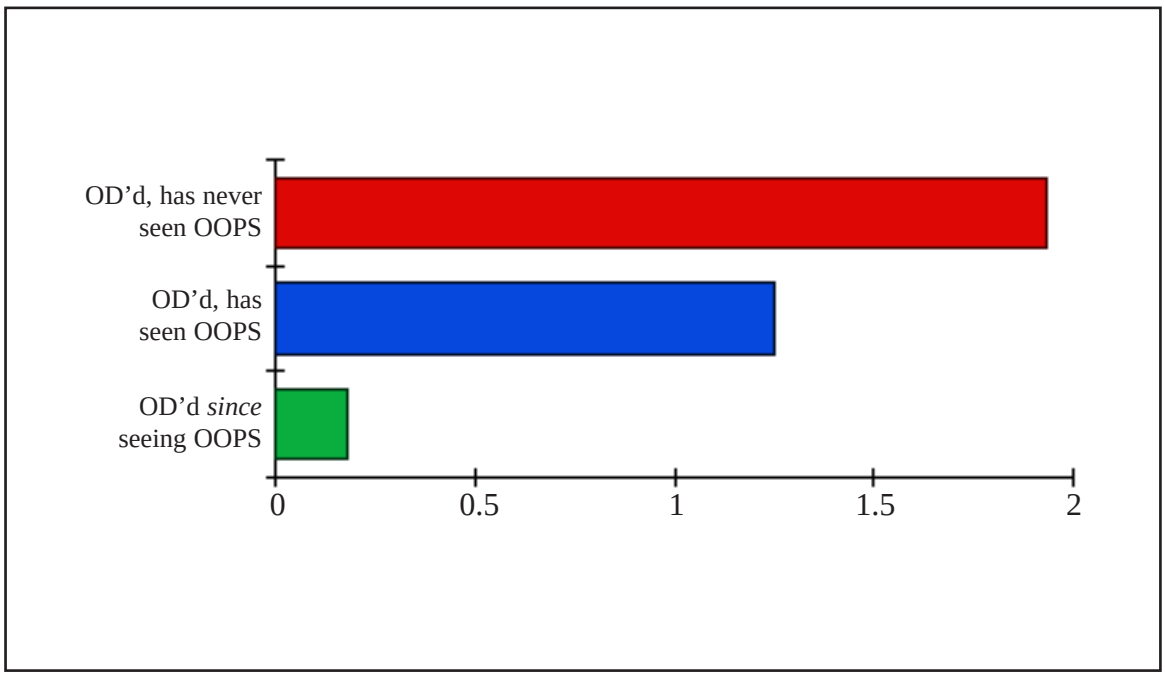
Of 59 valid responses, 33 (56%) had not been to hospital since June 1998 as a consequence of an overdose and 26 (44%) had. The remainder of this report will discuss the 26 respondents who had been to hospital. All percentages will be calculated on this basis (i.e. n=26).

Those who had seen OOPS were asked how many times they'd overdosed and been to hospital *again* since seeing OOPS.

0: 9 (75%) *1*: 2 (17%) *2*: 0 (0%) *3+*: 0 (0%) No Response: 1 (8%)

Since one of the main purposes of doing this survey was to see if the ED Project was impacting on overdose rates, responses to this question were cross indexed with responses to the total number of times the respondent had been hospitalised since June as a consequence of overdose. The results of this cross-indexing are shown below in figure 3.

Figure 3: Average number of overdoses by ED Project intervention status



All averages in the above figure assume "3+" overdoses is equal to 3 overdoses.

Only one respondent had definitely overdosed again and been to hospital as a consequence following a hospital presentation during which they had seen OOPS. One other respondent had overdosed twice since June, had seen OOPS on at least one occasion and had not overdosed since. Due to the design of the survey, there was no way to see if the respondent had seen OOPS twice or only on the second occasion.

Was there anything the OOPS person did which was annoying or a waste of time? (All responses)

No

Can't remember

No

Woke me up

No way

No

No

No

Don't know I did a runner

Was there anything they did which you thought was particularly good? (All responses)

Not sure

Let use there phone

Gave me info about why I over dosed

Yeh taxi ride home

Got me into detox

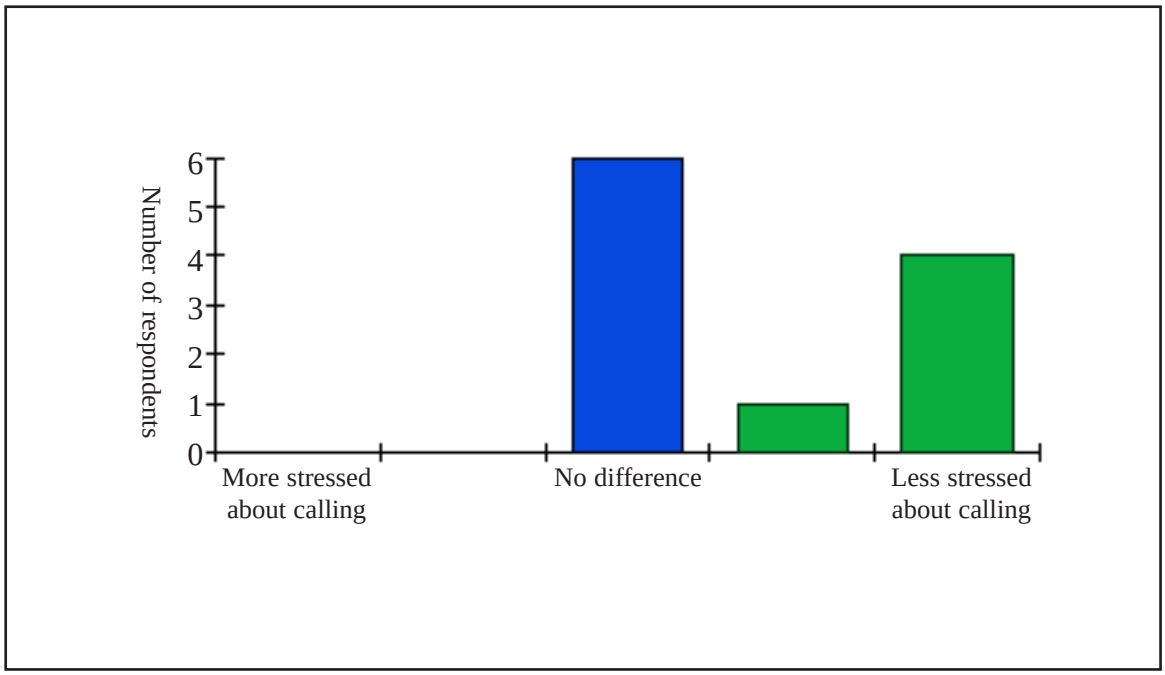
Was having the OOPS person there useful enough that you'd want to see them turn up again if you ended up at hospital again?

Yes: 11 (92%) *No:* 0 (0%) No Response: 1 (8%)

If you knew in advance that an OOPS person would definitely be there at the hospital, would that make you more or less stressed about calling an ambulance if a friend overdosed?

More stressed	Slightly more	*No difference*	Slightly less	*Less stressed*
0 (0%)	0 (0%)	6 (55%)	1 (9%)	4 (36%)

Figure 4: Impact of ED Project intervention on client willingness to call an ambulance



Discussion

This survey was conducted by AIDS Council staff and volunteers at the WA AIDS Council mobile needle exchange. There are some obvious sources of bias inherent to using such a sampling point – most obviously, those sampled were either already in touch with an agency capable of providing information and support, or were amongst those seen by the ED Project who were successfully referred to the van. i.e. the survey was biased towards sampling those for whom the ED Project intervention could be said to have been successful.

Having said this, the survey provides some of the first indications the project has had that a brief intervention delivered at the point of hospital emergency department contact can have a noticeable impact on the behaviour of users. Approximately half the sample of 59

had not been to hospital in the four month period since the ED Project commenced. Of the remainder, approximately half had seen an ED Project worker. Those who had not seen an ED Project worker had an average overdose rate for the 5 months of 1.93; those who had seen an ED Project worker at some point had an average rate of 1.25. The average number of overdoses *since* seeing an ED Project worker was 0.18. From these figures, it would appear that seeing an ED Project worker had some correlation with a lower number of presentations and re–presentations at hospital for overdose. This apparent correlation should be regarded with considerable caution however due to the small size of the sample; and the obvious biases inherent to sampling at one of the agencies to whom the ED Project refers clients; and the fact that the comparison is between average overdoses over a four month period and average overdoses over an unknown period of less than four months. Again, it is hoped that research currently in planning will clarify these results.

The other heartening outcome was the responses to the question about whether or not the presence of the ED Project would raise or lower the stress associated with calling an ambulance for a friend who had overdosed. At worst, the presence of the ED Project made no difference, but for nearly half of those who responded the knowledge that the ED Project would be at the hospital reduced the stress associated with calling an ambulance for a friend. Given one of the desired outcomes of the ED Project was an increase in the use of ambulances as a first rather than last response to overdose, this is a definite indication that we are moving in the right direction.

User satisfaction with the service appeared to be high. *All* those who answered a question about whether the ED Project was “useful enough that you’d want to see them .. again if you ended up at hospital again” answered yes.

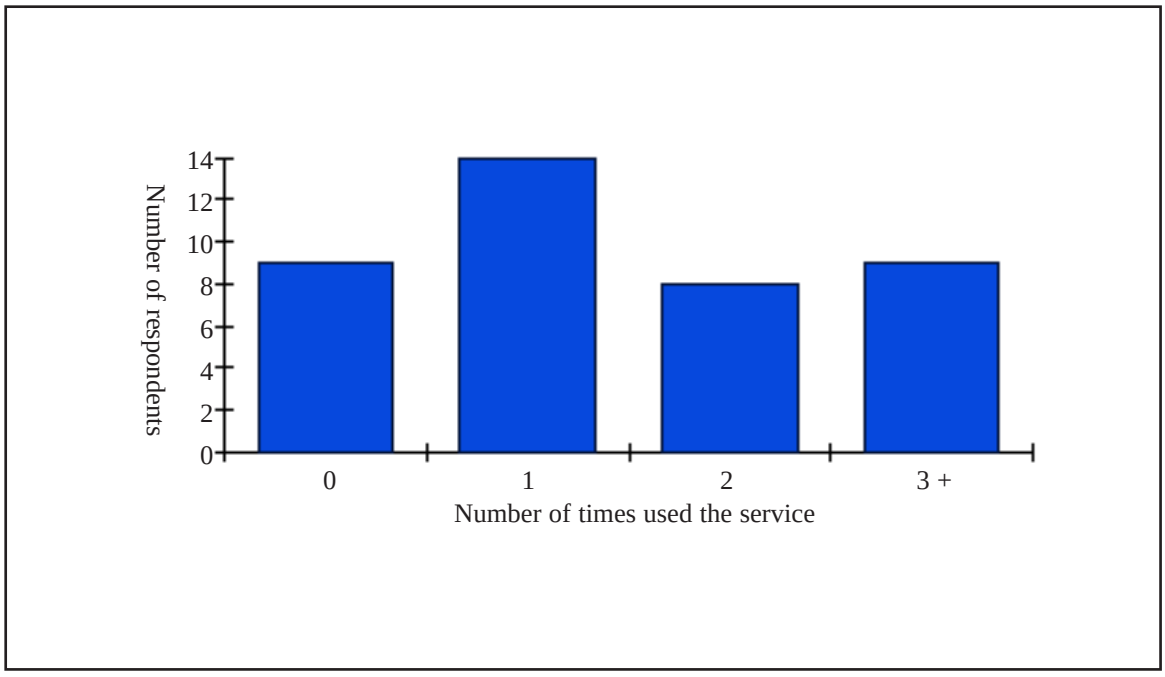
Royal Perth Hospital ED Staff Survey Results

50 surveys were distributed to emergency department staff at Royal Perth Hospital by the Emergency Department Clinical Nurse Specialist in November 1998. A copy of the survey form is reproduced as appendix 12 p.A29. The header to the survey form explained that we were seeking anonymous feedback on experiences with and impressions of the ED Project. Emergency Department staff who filled in a form were given a freddo frog on return of the form to the Clinical Nurse Specialist or other delegated person. 41 of the 50 forms were completed and returned. One response was blank, leaving 40 valid returns.

How many times have you used OOPS?

0: 9 (22%) *1*: 14 (35%) *2*: 8 (20%) *3*: 9 (22%)

Figure 5: Number of times RPH Emergency Department staff had used the ED Project



Never used the service:

31 of the 40 respondents (78%) had used the service. The remaining 9 respondents (22%) were asked two questions about their understanding of the project and given the opportunity to comment further. Note that all percentages given below are the percentage of respondents who had not used the service, not total respondents. i.e. n=9.

If you've never used OOPS before, have you heard enough about it to feel comfortable knowing when and how to use the service if it was appropriate?

Yes: 8 (89%) *No*: 1 (11%)

Have you heard anything about OOPS from any source which has/might influence your choice to use or not use OOPS should the opportunity arise?

Yes: 3 *No*: 6

[Note: This question was intended to see if anyone wasn't using the service due to negative

comments by other staff. However, given that several of the 'yes' answers were coupled with positive comments, it seemed clear that the question had been put in such broad terms that people were ticking 'yes' to mean that they had had positive comments from other staff and that this would positively influence their choice to use the service.]

Comments:

Had the talk from OOPS lady. Never had the opportunity to refer.

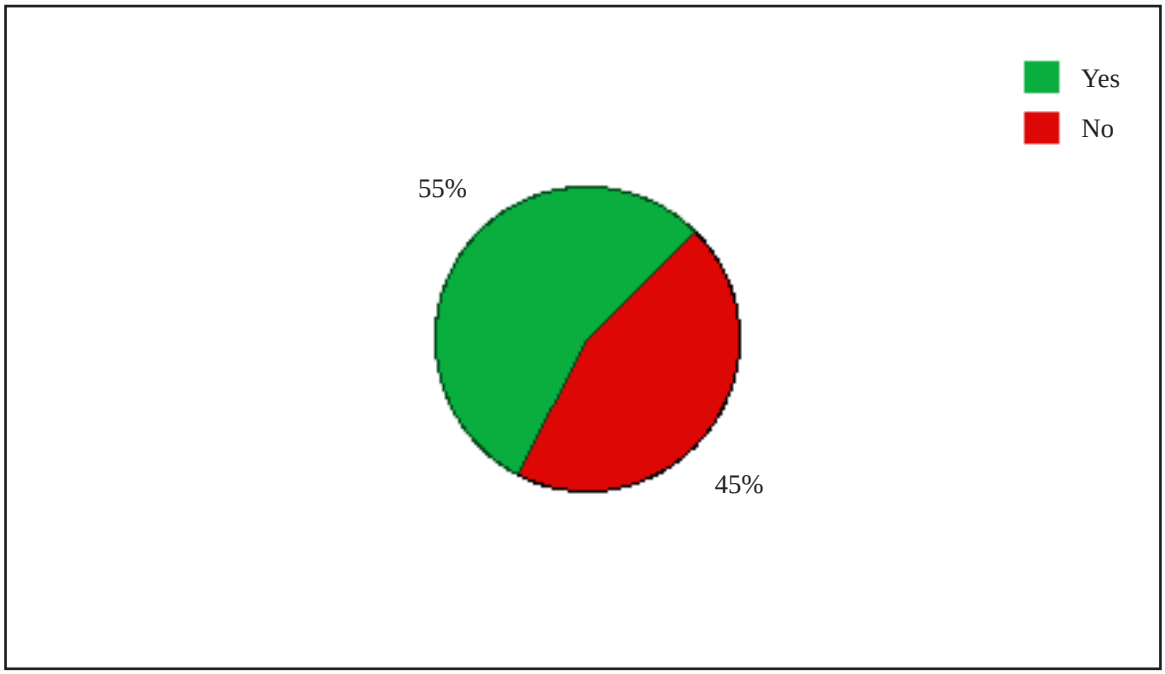
Had used the service:

The 31 respondents (78%) who had used the service were asked a range of questions about their experiences with and impressions of the service. Note that all percentages given below are the percentage of respondents who had used the service, not total respondents. i.e. n=31.

In general, have OOPS staff provided you with appropriate feedback after they had seen the patient?

Yes: 17 (55%) *No*: 14 (45%)

Figure 6: Appropriate feedback received from ED Project workers



Comments: (All responses)

Have not met any OOPS staff yet! [Had used OOPS 3+ times]

No Feedback

Feedback good: They use a report form and follow up actions

No feedback given – I get the impression that our 'clientele' see OOPS as a taxi service home – do any of them use the service as anything else??

No feedback also they could show a better appreciation of our problems

Was there anything OOPS staff have done which was either particularly good or particularly bad from a professional point of view? (All responses)

Taking an obnoxious patient away was wonderful

Education

Stayed with the patient during their time in ED

No

I found them very polite and friendly and helpful over the phone to assist my patients once they left ED

Patients seemed to think it was just a lift home – did they use the service effectively? – Usually patient has/is going to be discharged and therefore OOPS is used as followup after hospital

No. Very impressed with speed of service and their patience

No but it's good to have somewhere to send the patients home with that they don't feel threatened by

Usually very useful

I often get the impression from patients that they see OOPS as an easy solution to getting a free ride home and aren't really interested in changing their drug taking habits

Inform us of their plan of action

Gave the patient something else to focus on and wanting to leave department

Particular patient had further OD on heroin after discharge into OOPS care and deceased

Provided transport home for patient

No

They are quick to respond to calls

Gave patient good support

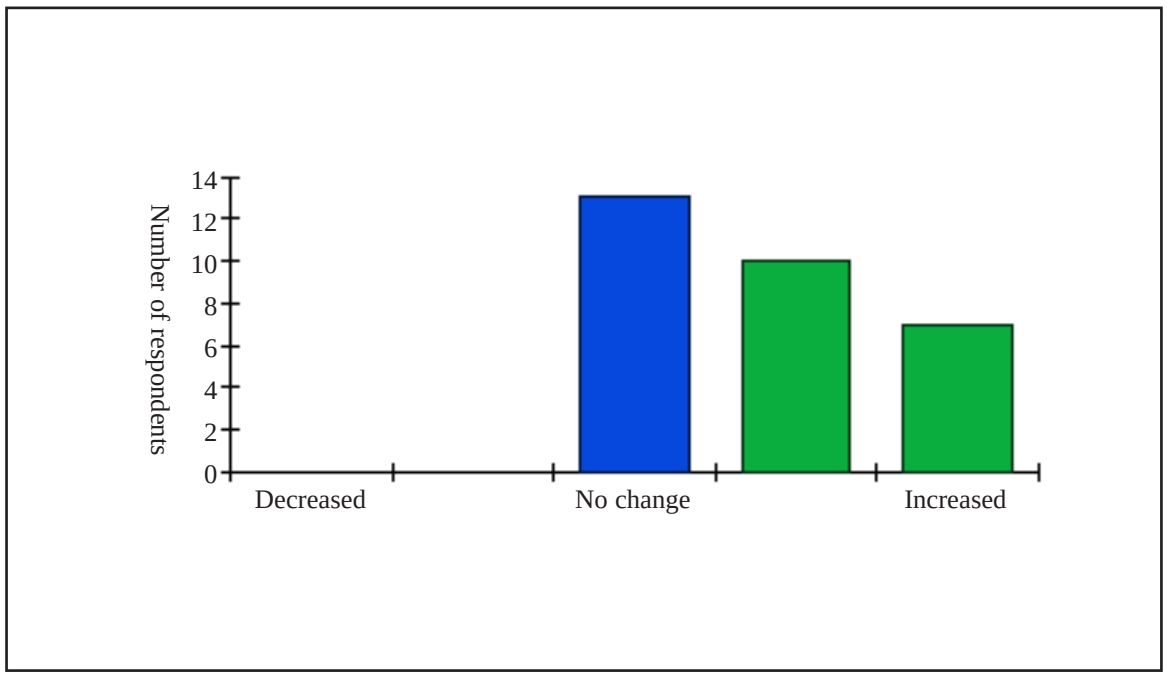
Support discharged patient well

Did your use of the OOPS Project increase or decrease your overall satisfaction with the outcomes achieved for your patient?

Decreased	Decreased partially	*No Change*	Increased partially	*Increased*
0 (0%)	0 (0%)	13 (42%)	10 (32%)	7 (22%)

No response: 1 (4%)

Figure 7: Changes to RPH Emergency department staff satisfaction with patient outcomes

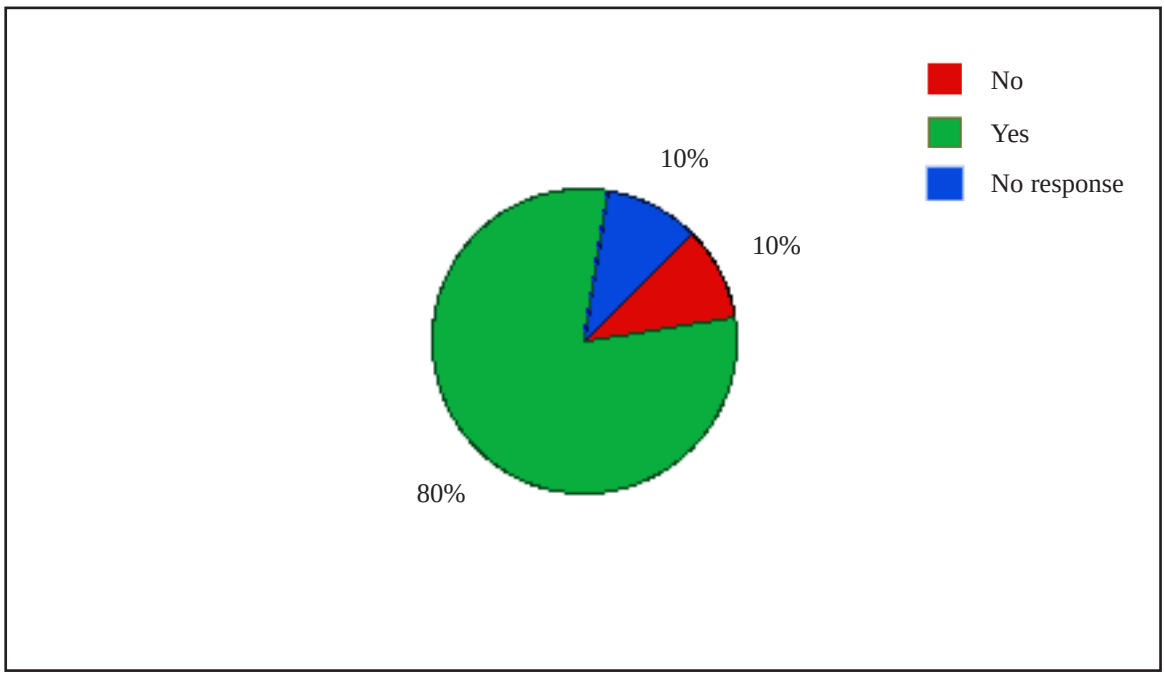


One respondent ticked "*increased*", but followed this with: "In saying this – for particularly aggressive / obnoxious patients who could take up time ++ – which means less patient care to other patients"

Was having the OOPS person there useful enough that you'd want to utilise them again?

Yes: 25 (80%) *No*: 3 (10%) No Response: 3 (10%)

Figure 8: Percentage RPH Emergency Department staff willing to use the ED Project again



Discussion

Of those who had used the OOPS service, no–one said they felt that the use of the program *decreased* patient outcomes, and the vast majority of respondents (80%) said they would be happy to use the service again. Having said that, there were a considerable number of concerns relating to the appropriateness or effectiveness of the project and to the provision of appropriate feedback to emergency department staff.

Nearly half of the respondents said feedback following a callout was not satisfactory. 100% of those who said they would not be using the service again (5 respondents) cited lack of feedback as one of the problems with the service.

On the positive side, the introduction of written feedback forms in response to early returns from this survey and from Sir Charles Gairdner Hospital had already produced one positive response by then end of data collection: “Feedback good: They use a report form and follow up actions”. A continuation of this policy and of the new policy of requiring ED Project workers to make an active effort to find the emergency department staff member who made the call to provide verbal feedback is clearly necessary.

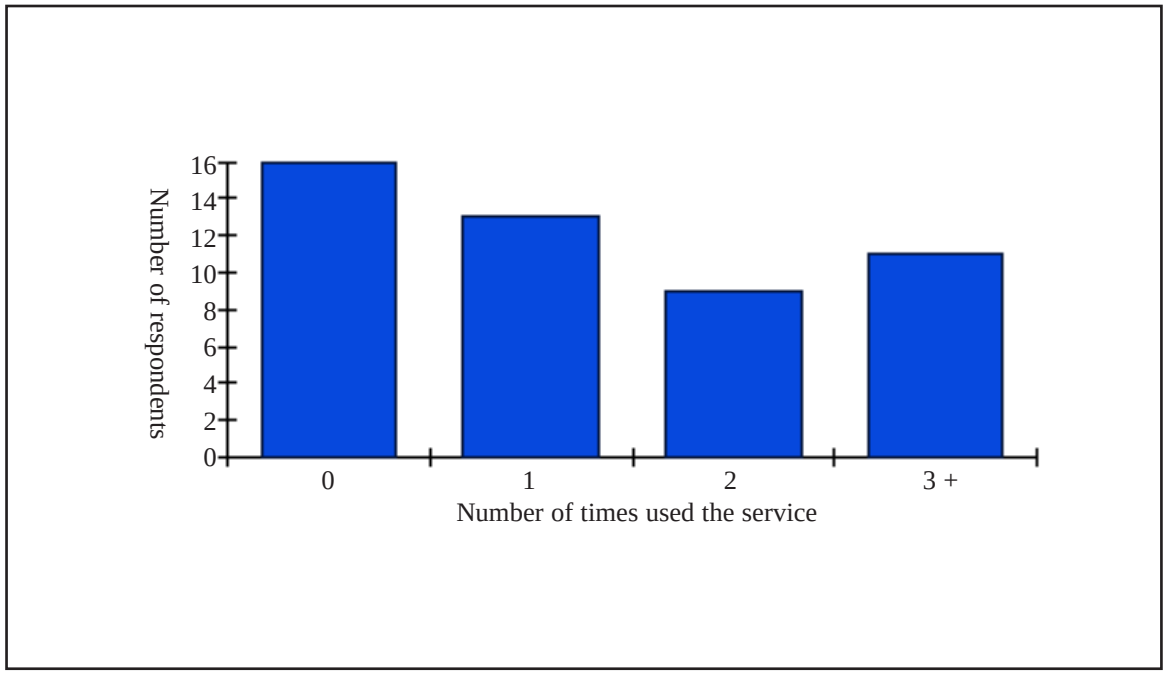
Sir Charles Gairdner Hospital ED Staff Survey Results

50 surveys were distributed to emergency department staff at Sir Charles Gairdner Hospital by the Nurse Manager of the Emergency Department in November 1998. A copy of the survey form is reproduced as appendix 12 p.A29. The header to the survey form explained that we were seeking anonymous feedback on experiences with and impressions of the ED Project. Emergency Department staff who filled in a form were given a freddo frog on return of the form to the Nurse Manager. 49 of the 50 forms were completed and returned.

How many times have you used OOPS?

0: 16 (33%) *1*: 13 (27%) *2*: 9 (18%) *3*: 11 (22%)

Figure 9: Number of times SCGH Emergency Department staff had used the ED Project



Never used the service:

33 of the 49 respondents (67%) had used the service. The remaining 16 respondents (33%) were asked two questions about their understanding of the project and given the opportunity to comment further. Note that all percentages given below are the percentage of respondents who had not used the service, not total respondents. i.e. n=16.

If you've never used OOPS before, have you heard enough about it to feel comfortable knowing when and how to use the service if it was appropriate?

Yes: 12 (75%) *No*: 4 (25%)

Have you heard anything about OOPS from any source which has/might influence your choice to use or not use OOPS should the opportunity arise?

Yes: 4 *No*: 11 No response: 1

[Note: This question was intended to see if anyone wasn't using the service due to negative comments by other staff. However, given that several of the 'yes' answers were coupled with positive comments, it seemed clear that the question had been put in such broad terms that people were ticking 'yes' to mean that they had had positive comments from other staff and that this would positively influence their choice to use the service.]

Comments: (All responses)

I know it exists, and would learn more when I deal with someone with heroin OD

Would have used it 3+ times except that it's been after 2100 and they are not available

Unfortunately every time I would like to use OOPS it is between 2100–0900. If the service was available 24/24 I estimate I would have used it at least 10x in the past 2/12

Haven't had the opportunity to utilise service

Unavailable when most needed

Staff who have used it here say it's great!

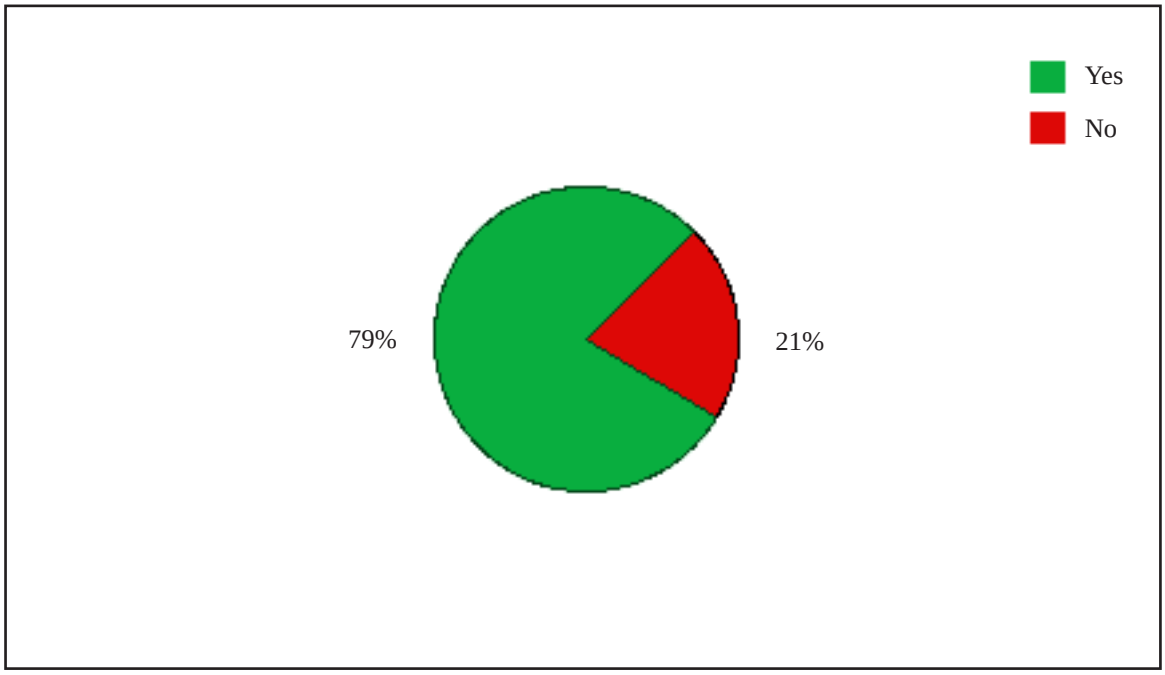
Had used the service:

The 33 respondents (67%) who had used the service were asked a range of questions about their experiences with and impressions of the service. Note that all percentages given below are the percentage of respondents who had used the service, not total respondents. i.e. n=33.

In general, have OOPS staff provided you with appropriate feedback after they had seen the patient?

Yes: 26 (79%) *No*: 7 (21%)

Figure 10: Appropriate feedback received from ED Project workers



Comment: (All responses)

No feedback was given

Very professional

Very good

[Under increased or decreased satisfaction] no change ticked as no feedback

[Under a ticked 'no' box] probably because we were too busy

Staff friendly and informative

Sufficient service

Communicate well

Due to a lack of night cover with OOPS this leaves a deficit at times when OOPS would be most useful

No feedback

Was there anything OOPS staff have done which was either particularly good or particularly bad from a personal of professional point of view? (All responses)

Approachable, easy to talk to, provide feedback

Good for discharge planning

Respected the patient for who they were

Provide a service which nursing staff do not have personal insight into – very appropriate resource – excellent

Good interpersonal; very rapid response

Extremely good rapport with patients and staff

They care

No

Friendly attitude

No [note above question had "staff friendly & informative"]

Been very supportive

Always enthusiastic

Good

Very approachable and willing to help at anytime

It was good that they sat with the patient the whole time and went out for cigarettes with patient etc.

Excellent for calming patients

Generally good

Constant discussion with the patient

Arrived very quickly when required

Able to relate with patient

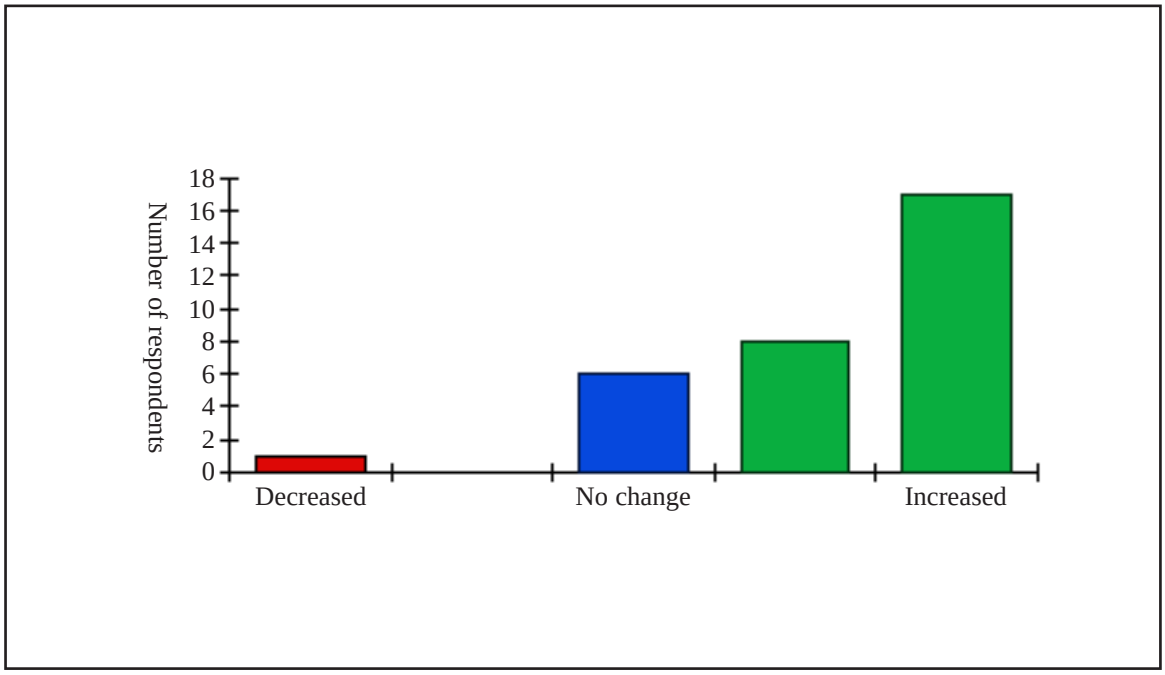
Did your use of the OOPS Project increase or decrease your overall satisfaction with the outcomes achieved for your patient?

Decreased:	Decreased partially:	*No Change*:	Increased partially:	*Increased*:
1 (3%)	0 (0%)	6 (18%)	8 (24%)	17 (52%)

No response: 1 (3%)

[Combined increased partially & increased is 76%.]

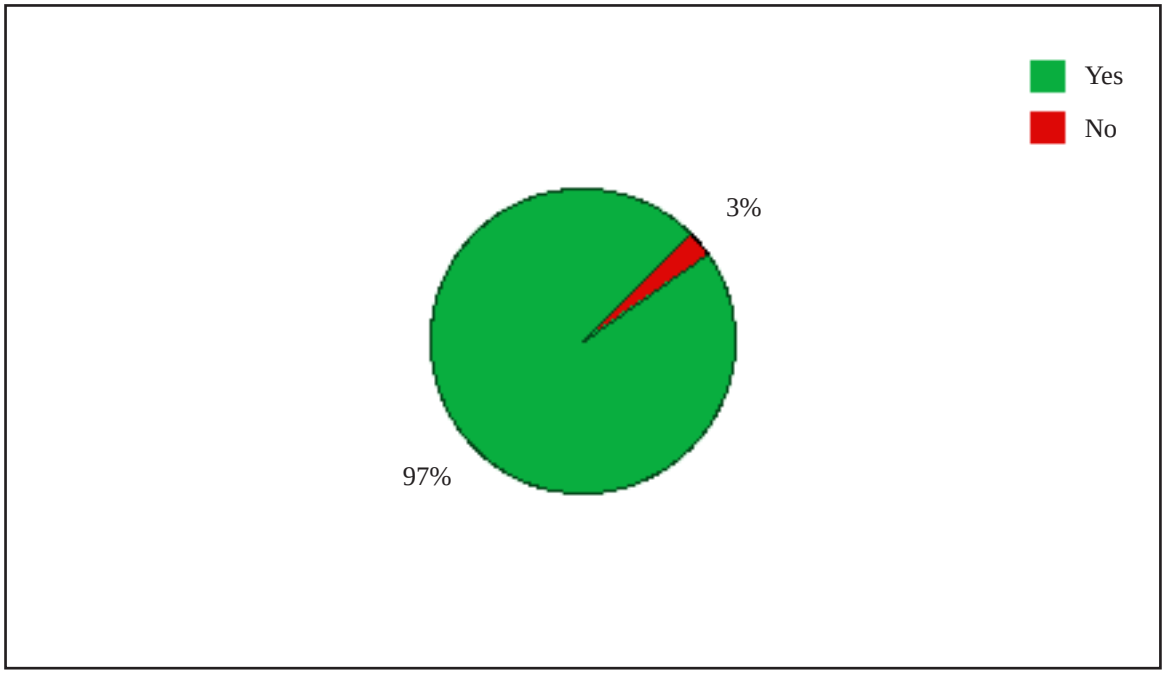
Figure 11: Changes to SCGH Emergency department staff satisfaction with patient outcomes



Was having the OOPS person there useful enough that you'd want to utilise them again?

Yes: 32 (97%) *No*: 1 (3%)

Figure 12: Percentage SCGH Emergency Department staff willing to use the ED Project again



Staff were also encouraged to write additional comments on the back of the form if they needed the space: (All responses)

Is gratifying to be able to refer patients needing OOPS service so readily. Much needed service

Can the service be a 24 hour service rather than its present time frame

Discussion

72% of the 89 respondents had used the service. Generally speaking the service was well received by hospital staff, with 89 % of respondents stating that they found the service useful enough that they'd want to use it again. More than half of those who had used the service said they felt that the use of the service had increased their overall satisfaction with outcomes achieved for the patient. Only one person stated that they felt outcomes had decreased.

Four respondents specifically said the service definitely needed to be available 24 hours and that this would mean an increase in the number of callouts the service received.

The single biggest concern amongst those who had used the service was the lack of feedback from OOPS personnel following a callout. 33% of respondents who had used the service stated that feedback was not satisfactory. Approximately a week into data collection (2 weeks total) as this dissatisfaction became apparent, ED Project operational procedures were altered to take this into account. A one–page feedback form was developed for use immediately following a callout. The form is delivered in person wherever possible and accompanied by verbal feedback, or left with the client's medical record where the staff member who made the call is unavailable. Based on the responses of those who filled in a survey toward the end of the data collection period, these procedures were seen as highly acceptable.

Conclusion

This report has given a brief overview of the initial structure of the Emergency Department Intervention Project and the processes by which this initial structure was modified to integrate the needs and ideas of a variety of crucial stakeholders.

The resulting structure, while still in the process of ongoing evolution, has already demonstrated its ability to remain flexible to the needs of the 'ultimate' stakeholders – the end users of the project – while maintaining an effective organisational coherence.

The ED Project has had promising beginnings and has managed, for the most part, to operate in a way acceptable to both its clients and to hospital staff. There are some positive indications that the service may be impacting on client use behaviour and perception of emergency services, although these indications must be regarded with some caution until more comprehensive outcomes measurement can be conducted.

Endnotes

1 Swensen,G. (1997) *Opioid deaths in Western Australia, 1996* (WA Drug Abuse Strategy Office: Perth)

2 Jacobs,I. & Oxer,H. (1998) *The use of naloxone in the pre–hospital management of narcotic overdose* (Western Australian Pre–Hospital Care Research Unit: Perth, Western Australia)

3 Western Australian Drug Abuse Strategy Office (1997) *Together Against Drugs: The WA Strategy Against Drug Abuse Action Plan* (WADASO: Perth)

4 Select Committee into the Misuse of Drugs Act 1981 (1988) *Finding the Right Balance: Working Together as a Community to Prevent Harm from Illicit Drugs and to Help Individuals and Families in Need Final Report August 1998* (Legislative Assembly of Western Australia: Perth)

5 Loxley,W. & Davidson,P. (1998) *Forgetting to breathe: opioid overdose and young injecting drug users in Perth* (National Centre for Research into the Prevention of Drug Abuse: Perth, Western Australia), Corry,A. & Penna,F. (1997) *Review of the opiate overdose prevention strategy project: June–August, 1997* (Murdoch University: Perth, Western Australia)

6 Gore,C. (1997) *Report of the pilot heroin overdose peer education project March 1997* (Centre for Education and Information on Drugs and Alcohol: Sydney, NSW)

7 'Overdose' usually has multiple causes, including but not limited to coingestion of other central nervous system depressants and reduced tolerance due to temporary abstinence.

8 Corry,A. & Penna,F. (1997) *Review of the opiate overdose prevention strategy project: June–August, 1997* (Murdoch University: Perth, Western Australia)

9 Lenton,S. & Tan–Quigley,A. (1997) *The fitpack study: a survey of 'hidden' drug injectors with minimal treatment experience* (National Centre for Research into the Prevention of Drug Abuse: Perth, Western Australia)

10 Jacobs,I. & Oxer,H. (1998) *The use of naloxone in the pre–hospital management of narcotic overdose* (Western Australian Pre–Hospital Care Research Unit: Perth, Western Australia)

11 Andersen,M. et al. (1993) 'LIGHT Model: An effective intervention model to change high–risk AIDS behaviors among hard–to–reach urban drug users' *American Journal of Drug & Alcohol Abuse* 19(3) pp.309–325

12 Bernstein,E. et al. (1997) 'Project ASSERT: An ED–based intervention to increase access to primary care, preventative services, and the substance abuse treatment system' *Annals of Emergency Medicine* August 1997 pp. 181–189

13 Loxley,W. & Davidson,P. (1998) *Forgetting to breathe: opioid overdose and young injecting drug users in Perth* (National Centre for Research into the Prevention of Drug Abuse: Perth, Western Australia)

14 Sarantakos,S. (1993) *Social Research* (MacMillan Education Australia: Melbourne)p.8

15 Dick,B. (1998) *Action Research Sessions – Session 2: The change process and action research session 2 version 8.01w* (http://www.scu.edu.au/schools/sawd/areol/areol–session02.html) p.5

16 Moore,D. 1993 'Social control, harm minimisation and interactive outreach: the public health implications of an ethnography of drug use' *Australian Journal of Public Health* 17(1) pp.58–67

17 Corry,A. & Penna,F. (1997) *Review of the opiate overdose prevention strategy project: June–August, 1997* (Murdoch University: Perth, Western Australia)

18 Select Committee into the Misuse of Drugs Act 1981 (1988) *Finding the Right Balance: Working Together as a Community to Prevent Harm from Illicit Drugs and to Help Individuals and Families in Need Final Report August 1998* (Legislative Assembly of Western Australia: Perth) Recommendation 18, pp.194–196

19 For example, the *Forgetting to Breathe* study found that even among younger users, there is a reluctance to contact emergency services as a first rather than last response to a friend's overdose because of the perception that hospitals refer users to other agencies such as Family and Children's Services. Loxley,W. & Davidson,P. (1998) *Forgetting to breathe: opioid overdose and young injecting drug users in Perth* (National Centre for Research into the Prevention of Drug Abuse: Perth, Western Australia) pp.33–35

20 For examples see Anon. 1998 'Letters of Abyooz' *Yooz Magazine* vol 5 March p.4 and Anon. 1998 'The Pain and the Prejudice' *Yooz Magazine* vol 5 March p.5–6

21 Winchester,L. et al. (1996) 'Anonymous record linkage using respondent–generated identification codes – a tool for health promotion research' *Health Promotion Journal of Australia* 6(2) pp.52–54

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Andersen,M. et al (1993) 'LIGHT Model: An effective intervention model to change high–risk AIDS behaviors among hard–to–reach urban drug users' *American Journal of Drug & Alcohol Abuse* 19(3) pp.309–325

Anon. 1998 'Letters of Abyooz' *Yooz Magazine* vol 5 March p.4

Anon. 1998 'The Pain and the Prejudice' *Yooz Magazine* vol 5 March p.5–6

Bernstein,E. et al (1997) 'Project ASSERT: An ED–based intervention to increase access to primary care, preventative services, and the substance abuse treatment system' *Annals of Emergency Medicine* August 1997 pp. 181–189

Corry,A. & Penna,F. (1997) *Review of the opiate overdose prevention strategy project: June–August, 1997* (Murdoch University: Perth, Western Australia)

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Gore,C. (1997) *Report of the pilot heroin overdose peer education project March 1997* (Centre for Education and Information on Drugs and Alcohol: Sydney, NSW)

Jacobs,I. & Oxer,H. (1998) *The use of naloxone in the pre–hospital management of narcotic overdose* (Western Australian Pre–Hospital Care Research Unit: Perth, Western Australia)

Lenton,S. & Tan–Quigley,A. (1997) *The fitpack study: a survey of 'hidden' drug injectors with minimal treatment experience* (National Centre for Research into the Prevention of Drug Abuse: Perth, Western Australia)

Loxley,W. & Davidson,P. (1998) *Forgetting to breathe: opioid overdose and young injecting drug users in Perth* (National Centre for Research into the Prevention of Drug Abuse: Perth, Western Australia)

Moore,D. (1993) 'Social control, harm minimisation and interactive outreach: the public health implications of an ethnography of drug use' *Australian Journal of Public Health* 17(1) pp.58–67

Sarantakos,S. (1993) *Social Research* (MacMillan Education Australia: Melbourne)

Select Committee into the Misuse of Drugs Act 1981 (1988) *Finding the Right Balance: Working Together as a Community to Prevent Harm from Illicit Drugs and to Help Individuals and Families in Need* Final Report August 1998 (Legislative Assembly of Western Australia: Perth)

Swensen,G. (1997) *Opioid deaths in Western Australia, 1996* (WA Drug Abuse Strategy Office: Perth)

Western Australian Drug Abuse Strategy Office (1997) *Together Against Drugs: The WA Strategy Against Drug Abuse Action Plan* (WADASO: Perth)

Winchester,L. et al. (1996) 'Anonymous record linkage using respondent–generated identification codes – a tool for health promotion research' *Health Promotion Journal of Australia* 6(2) pp.52–54

Appendices

Note:

To save space and maintain document integrity, appendices marked with an asterisk (*) have been reproduced with an emphasis on content rather than original layout. All other appendices are exact or near–exact facsimiles.

Appendix 1 – Strategic Plan

Opiate Overdose Intervention Program

Component 1: Emergency Department Intervention

Objective

To develop in conjunction with Perth Teaching Hospital A&E Departments, St John Ambulance and other key stakeholders, a prevention, brief intervention and follow–up service for non–fatal opiate overdoses.

Strategies

- Developing appropriate models of clinical practice for the prevention, management and follow–up of non–fatal opiate overdoses.
- Assess the feasibility of community follow–up and home visits post overdose discharge from hospital.
- Develop in conjunction with the OOPS Project, resource materials to be provided to non fatal overdoses and concerned others.

Linkages

- This project will develop close links with emergency departments of Perth's teaching hospitals, St John Ambulance, OOPS peer education project, WA Substance Users Association (WASUA) and other IDU groups.

Outputs

- The development and implementation of best practice demonstration projects.
- The development of best practice protocols and procedures for the prevention, management and follow–up of non fatal opiate overdoses in Perth emergency departments.
- Number of OOPS information cards distributed.
- Number of user focused opiate overdose information packages distributed.
- Number of brief interventions.
- Number of referrals.

Outcomes

Over the life of the project;

- All emergency department clients will have the opportunity to engage in harm minimisation activities and follow–up options.
- Best practice initiatives will be implemented in all emergency departments with follow–up offered to all opiate overdose clients.
- Assess satisfaction of stakeholders and agencies with service outcomes.

Appendix 2 – *Forgetting to Breathe* Action Plan

RECOMMENDATIONS	AGREED ACTIONS	KEY STEPS	WHO
3. Education about the causes and mechanisms of overdose is vital if it is to be prevented. All drug users must be taught about the risks of mixing CNS depressants and that this is the primary cause of overdose; the length of time that should elapse between using different drugs; the approximate period it takes to establish and lose tolerance and the fact that the majority of overdoses are not instantaneous but occur gradually over some hours.	• develop a resource for IDUs on "guarding against overdose" • OOPS • WASUA • continuing and continuous development of a range of materials	• convene expert group to provide pharmacology/toxicology content • develop resource in tandem with user groups • development of user friendly resources	WADASO, UWA, hospitals W A D A S O , WASUA, OOPS WADASO, Health, WASUA
10. The message that police will not attend with ambulances is known and believed by some young users, but not by all. Continued effort to spread this message is needed. Police should be encouraged toi respect the ambulance protocol and their responses should be monitored.	• see 3. • Police and St John Ambulance continue to stress this message • Police protocol to be made available to respective agencies		Police service, St John Ambulance Police Service, WADASO
11. The singe biggest reason why young people do not utilise emergency services is fear of unwanted intervention by police, parents and/or welfare. Because of this, on site treatment is preferred by most users, and ambulance staff should be encouraged to consider whether treatment can be appropriately delivered at the site without recourse to hospital.	• continue discussion of this issue between St Johns, A&E, AMA, WASUA • ED follow–up project to inform • ambulance to carry information for IDUs developed in consultation by ED Project	• Opiate Overdose Strategy group • ED Project reports • development of resource	WADASO (convenor) ED Project ED Project

RECOMMENDATIONS	AGREED ACTIONS	KEY STEPS	WHO
12. Drug users repeatedly complain about poor treatment at the hands of hospital staff, and it should be clear that users have the same rights to humane and ethical treatment as anyone else. Where users are underage there is a particular problem, in terms of the hospital's duty of care. While it might be appropriate to notify the parents of juveniles with suspected overdoses, it would be helpful to discuss such notification with the young person, particularly if they are aged between 16 and 18. If parents are to be called in, the young person should be informed of this as a matter of course.	• ED follow–up project to inform • clariofy A&E policies and explore potential for uniformity	• ED Project reports • consult with relevant hospital staff	ED Project WADASO
13. If parents are called in, particularly when they have no prior knowledge of the young person's drug use, they should be provided with some information and support so that they can be helped to react in an appropriate and informed manner.	• establish linkages with A&E dept social services • establish linkages to established parent services (Palmerston, Cyrenian, Yirra, PDIS)	• consult with relevant staff • liase with parent services	ED Project ED Project
14. Welfare services in hospitals should be made aware that harassment of juveniles by them reduces the likelihood that the young person will call an ambulance on future emergency occasions.	• to the extent that this may occur, sevices should monitor and address	• ED Project reports • liase with OOPS, needle exchange sites for user information	ED Project
15. A variety of education strategies are needed, including materials such as posters and pamphlets, peer education and train the trainer courses for youth workers and treatment agencies. Innovative ways to make contact with young people, such as many of those in this study who were not in touch with standard agencies, should be developed.	• see 3. • material to be developed and disseminated through pharmacies, needle exchange sites and peer support agencies • train the trainer for peer support agencies	• convene working group to develop material • appropriate reference groups to ensure credibility of content • liase with peer support agencies	WADASO, OOPS, WASUA, Health OOPS

Appendix 3 – IDU Recruitment Leaflet

Have you used heroin in the last 6 months?

Have you been to a hospital Emergency

Department yourself or with a friend

because of heroin use in the last 2 years?

Do you want **$20** for an hour or so of your time?

PTO

We're doing interviews to find out about people's experiences of overdose-related hospital treatment.
You won't be asked to give any information that could identify you.
If you're interested, call

Peter on 041 890 9815

This study is a part of the OOPS Emergency Department Project

Appendix 4 – IDU Consent Form

CONSENT FORM – OPIATE OVERDOSE STUDY – INTERVIEWS.

You have been asked to participate in a study of drug users and their needs following an opiate overdose. The aim of the study is to help develop a program designed to offer assistance to people who have been brought to a hospital emergency department in connection with an opiate overdose.

If you agree to participate in the study, you will be asked to take part in an interview, in which you will be asked a number of questions, the answers to which will be recorded on a tape recorder. You may be asked questions about your drug use, your experiences of overdose, and your experiences with ambulance and emergency department people and procedures. At no time will information which can identify you (e.g. full name or address) be recorded, and you are free to give a false first name if you so desire. You will be paid $20 for your participation. You are free to choose not to participate in the study and there will be no negative consequences if you so choose.

Your information will be computer coded and then kept securely. Tapes will be transcribed by the researchers and kept securely. All data files are locked to unauthorised access.

This study is being conducted by researchers from the OOPS ED Project funded by the Western Australian Drug and Alcohol Authority.

- Do you have any questions?
- Are you willing to continue with the interview?
- What name would you like to use?

Appendix 5 – IDU Question Base

Opiate Users Interview Questions

Two main blocks of questions:

- Personal experiences of hospital procedure, either on the receiving end or as a friend / significant other of an overdose victim.
- Exploration of acceptable / desirable models for intervention at this point.

Personal Experience

Has this happened to you or a friend? (i.e. were you there.?If no, can do something with reported experiences then go on to exploratory stuff).

What happened?

- How did you got there? (Taxi, ambo, private vehicle, on foot..)
- Who helped you get there? (Friend/s, family, lover, strangers, ambo staff only, alone..).
- About what time of day was it (6 am – noon, noon – 6p m, 6 pm – midnight, midnight – 6 am), & on what day of the week?
- What they did to you medically? (Ventilation, CPR, narcan..).
- What were general staff attitudes toward you were? (Hostile, rude, friendly, impersonal etc).
- How long were you there? (Half an hour, several hours, overnight..).
- What other forms of intervention did they initiate? (Call parents / police / welfare / suicide prevention worker / other).
- Did anyone stay with you? (Friend/s, family etc – and were these the people who brought you in or did they arrive later; also, what were the hospital staffs reaction to them – tried to get rid of them, asked them to stay, didn't care etc).
- Where did you go afterwards? (Your home, parent/s home, friends home, just wandered around..)
- How did you leave? (On foot, private vehicle, taxi, other).
- Who did you leave with? (Friend/s, parent/s, other family member, alone..).
- Did you have anything else (pills, alcohol, opiates) afterwards?
- Did you have any problems with going back on the nod after leaving hospital (especially if narcan administered)?

- Any other aftereffects / side effects of either social or medical intervention? (Police called again, problems with friends / family etc, side effects of medical procedures).

Exploration

Was the method of & destination after leaving hospital last time ideal? i.e. would they have preferred to have gone elsewhere and or used another form of transport?

Would they have appreciated some form of assistance to get home/wherever – e.g. taxi voucher?

Would it have been useful to have someone from outside the hospital there to keep hospital staff off your back & make sure you were being treated ok?

If the hospital had to call your parents because you're under 18, would it have been useful to have someone from outside the hospital there to talk to your parents to help calm them down or whatever?

Are there any other problems or bad things that happened where it would have been good to be able to call in someone who was used to this sort of thing to help you deal with it?

If someone was to come and help in this way, would you have preferred it to be: a social worker; an independent member of hospital staff; someone from a non–government organisation; someone else who uses or used to use (a WASUA member); ..?? Would you prefer the person to be male or female, or wouldn't it really make any difference (cross–reference to gender of respondent).

If someone was to turn up and help with this sort of stuff, when you were discharged from the hospital would you just want to get home / wherever as soon as possible, or would having a coffee or something to eat with that person first sound ok?

"We're starting to develop a program which might be able to offer people who have od'd and ended up in hospital various kinds of assistance and /or help. I'm going to run some ideas past you and I'd like you to think back to the last time you wound up in hospital and about how useful or annoying or whatever each of these things would have seemed to you at the time".

Hospital staff give out cards with a contact number on; if you ring the number someone turns up to give you a taxi voucher & see if there's anything else they can help you with. They'd also be willing to either have a coffee &/ food with you or meet with you in a day or so to talk about ways to continue using but which make it less likely you'll overdose or get BBV's like hep c or hiv.

Appendix 6 – Hospital Staff Question Base

A&E Staff Interview Questions

- Walk me through a typical overdose where the person has been brought in by ambulance. – stick to non–medical stuff

- Point at which other agencies are called in – welfare, youth self harm, parents, other agencies..

- What problems do you experience working with heroin overdose (verballing; violence; rudeness; lack of cooperation)

- Other specific problems with OD patients.

- Issues & problems with friends and/or family

- Information you always / sometimes / never provide to clients

- Information you always / sometimes / never provide to family or friends

- Information you're asked for which you don't really have – what do you do in these situations / who do you refer to?

- Services you're asked for which you can't / don't have – what do you do in these situations / who do you refer to?

Appendix 7 – Parent Recruitment Leaflet

Have you ever been in contact with a hospital emergency department because your child or your partner overdosed on heroin or other opiates?

The Alcohol and Drug Authority is setting up a support program for people who have been brought to an emergency department after an overdose. We are currently trying to assess the needs of parents and other family members in an overdose situation to help us make this support project more useful to everyone concerned.

We're doing interviews to find out about people's experiences with dealing with hospital emergency departments when their child or partner has overdosed. The interviews take approximately 30 – 45 minutes, and can take place at a time and location to suit you.

You won't be asked to give any information that could identify you.

If you're interested, please call

Peter on **041 890 9815**

This study is a part of the OOPS Emergency Department Project

Appendix 8 – Parent Consent Form

CONSENT FORM – OPIATE OVERDOSE STUDY – PARENTS

You have been asked to participate in a study of the parents or partners of drug users and their needs following an opiate overdose. The aim of the study is to help develop a program designed to offer assistance to people who have been brought to a hospital emergency department in connection with an opiate overdose.

If you agree to continue with this interview, you will be asked a range of questions which may include information about your knowledge of your child or partner's drug use, your experiences with ambulance and hospital staff in connection with an overdose experienced by your child or partner, and your experiences with other government and non–government agencies in providing you with information about drugs and drug use. This interview will be recorded on a tape recorder.

At no time will information which can identify you (e.g. full name or address) be recorded, and you are free to give a false first name if you so desire. You are free to choose not to participate in the study and there will be no negative consequences if you so choose.

Information collected during this interview will be computer coded and then kept securely. Tapes will be transcribed by the researchers and kept securely, and all data files are locked to unauthorised access.

This study is being conducted by researchers from the OOPS ED Project funded by the Western Australian Drug and Alcohol Authority.

- Do you have any questions?
- Are you willing to continue with the interview?
- What name would you like to use?

Appendix 9 – Parent Question Base

Parents Interview Questions

Two main blocks of questions:

- Personal experiences of hospital procedure, either on the receiving end or as a friend / significant other of an overdose victim.
- Exploration of acceptable / desirable models for intervention at this point.

Personal Experience

What happened the last / first time you went to / were contacted by ED regarding your child/partner's overdose?

- How did you first hear about it? (phone call – from staff, from friends; someone came by..)
- What information did they give you during that initial contact? (what had happened, medical status..)
- Was this the first you knew of your child/partner's opiate use?
- Were you able to go to the hospital?
- If no – when did you next see your child/partner?
- If yes – how did you get there? (taxi, ambo, on foot, private vehicle, public transport..)
- Did anyone else go with you – partner, friend, relative..
- Did you have any problems accessing transport? (public transport stopped running etc)
- About what time of day was it? (6 am – noon, noon – 6p m, 6 pm – midnight, midnight – 6 am), & on what day of the week?
- What do you know of what was done to your child/partner medically? (Ventilation, CPR, narcan..).
- How communicative were staff to you concerning what had been done, what your child/partners general condition was, how long before they could leave etc?
- How much information did staff offer you in terms of: info about drugs/drug use generally; info about referrals (especially if this was first knowledge of child/partners opiate use)
- What were general staff attitudes toward you? (Hostile, rude, friendly, impersonal etc).
- What were general staff attitudes toward your child/partner?

- How long were you there? (Half an hour, several hours, overnight..).
- What other forms of intervention did the hospital staff initiate? (Call police / welfare / suicide prevention worker / other).
- Did you ask for any specific help or resources while you were there? (e.g. social worker, suicide prevention, welfare etc)
- If so, how useful were these services to you at the time? How useful in the longer term?
- Did anyone stay with you? (Friend/s, family etc – and were these the people who brought you in or did they arrive later; also, what were the hospital staffs reaction to them – tried to get rid of them, asked them to stay, didn't care etc).
- Where did you go afterwards? (Your home, elsewhere)
- How did you leave? (On foot, private vehicle, taxi, other).
- Who did you leave with? (Friend/s, parent/s, other family member, alone..).
- Did you have any problems with your child/partner going back on the nod after leaving hospital? (especially if narcan administered)?
- Any other aftereffects / side effects of either social or medical intervention? (Police called again, problems with friends / family etc, side effects of medical procedures).
- What resources have you accessed concerning your child/partner's opiate use since that overdose? How did you find out about these resources?

Exploration

Was the method of & destination after leaving hospital last time ideal? i.e. would they have preferred to have gone elsewhere and or used another form of transport?

Would they have appreciated some form of assistance to get home/wherever – e.g. taxi voucher?

Would it have been useful to have someone from outside the hospital there to provide you with a) liaison with hospital staff; b) more information about opiate use; c)..

Would you have a problem with such a person being an ex–user themselves?

If hospital staff had given you a card with a 24 hour contact number on it & said this person could provide you with more information about opiates and opiate use and could help your child/partner with further information, would you have felt comfortable about accessing such a service?

What about if you knew the main focus of such a person's job was to provide the person who'd OD'd with information about safer use with respect to overdose and BBV's (as opposed to completely ending use).

Appendix 10 – Pilot Phase Callout Report

Callout Questionnaire Sheet – Pilot Project, Phase 1

Fill in the top section of this form every time you go on a callout. If you can't talk to Pete within 12 hours of the callout, fill in the rest of the form as well.

Confidentiality: Individual forms will not be seen by anyone other than Pete – only group data or un–attributed comments will be reported unless I get specific permission from you first. When you've filled in a form, please put it in my pigeon hole at Carellis.

- Your Name: _____
- Hospital: _____
- Date: _____
- Time you were called: _____
- Time you got to the hospital: _____
- Time you left the hospital: _____

- Were you called by (circle): The client Hospital staff family / friends others

- Was the client still there when you got to the hospital (circle): Yes No

- Client refusal (if called by someone other than client): Refused

- Client data (circle):

  Gender: Male Female Transgender

  Approximate age: <14 15–20 21–30 31–40 40+

  Aboriginal / Torres Strait Islander: Yes No Don't know

Resources Provided:

- Follow–up card: ☐

  Comments / details: _____

- Lift or Taxi Voucher: ☐

  Comments / details: _____

- Referral: ☐

  Comments / details: _____

- Counselling on the spot ☐

  Comments / details: _____

- Phone calls made for or by client ☐

  Comments / details: _____

- Liaison with hospital staff ☐

  Comments / details: _____

- Liaison with parents or other family ☐

  Comments / details: _____

- Liaison with police or other agencies ☐

  Comments / details: _____

- Any other resources provided ☐

  Comments / details: _____

- Ok, now I need you to put down a general outline of the sequence of events from when you first got called until you left the client. I just need a bit of a mental picture of what went on. No prizes for literary style – "this happened then this happened then this happened" is fine. And no, you don't need to fill the page.. ☺

Part 2 – You don't need to do this unless you can't speak to Pete within 12 hours of the callout

Some of this is going to run back over what was asked above in more detail. (sorry..) The idea of this section is to look at the callout as an 'event' and try and get a detailed picture of the whole experience. Of particular interest is what didn't work out so well – what obstacles there were, what the client wanted / needed that you couldn't help with, what problems or concerns you had with your safety or security and so on. **Please don't give any information which might identify the client such as a name or an address.**

- Did you have any problems with the hand over of the mobile phone or beeper?
- Did you have any other problems in connection with the logistics of being 'on call'?
- How did you get to the hospital once you were called out? E.g. taxi, private vehicle, on foot
- Did you experience any problems or delays? E.g. taxi took forever to show up
- Were there any delays finding the client once you got to the hospital? E.g. had to explain presence to a security guy & 2 nurses
- Was the client still there when you arrived? (if no, that's it. Thanks for filling this in.)

- If the client called you direct, what services or resources did they ask for as soon as you arrived? E.g. taxi voucher only etc
- If the hospital staff or someone else other than the client called you, was the client expecting you when you arrived?
- If the hospital staff or others had called you, was it because they thought the client might need your services or because they wanted some other assistance with liaising with the client or family etc
- If so, did you feel that the role you were being called upon to fulfil was appropriate / within the bounds of what the ED program is meant to be doing?
- Did you have to deal in **any** way with third parties such as family, friends, hospital security staff, police or welfare staff? If so, please describe what went on in as much detail as possible:
- Did you have any difficulties communicating with the client due to language barriers, intoxication, disability, or gender or ethnicity sensitivities? If so, what happened, or what were you concerned about. E.g. "I don't speak Vietnamese" or "client was a young man who didn't seem to be comfortable discussing BBV transmission vectors with a woman"
- Did all your contact with the client take place in the emergency department or did you go with the client somewhere after they were discharged – e.g. coffee shop, elsewhere in the hospital? If so, where did you go?
- Was the place you went a good place in terms of privacy (for the client) security (for you) and comfort (for both of you)?
- Would you recommend it as somewhere to take clients for other volunteers? Yes ☐ No ☐

  Would you specifically suggest **not** going there? Yes ☐ No ☐

  If not, why?

- When the client left, did they leave with anyone – if so, with who? E.g. friends, relatives etc
- Did the client say where they were going? E.g. home, to a friends house etc
- If they left alone, did they say anyone would be around at the place they were going? E.g. friend, relative etc
- Did you get to organise a follow–up meeting?

  Yes ☐ No ☐ Card offered ☐
- If so, what sort of location did you organise? E.g. private house, coffee shop etc
- Have you got any comments about the callout to make which you didn't get a chance to mention above?

That's about it. Now you've filled it in, make sure you **PUT THIS FORM IN PETE'S PIGEON HOLE AT CARRELLIS!** If you made an appointment for a follow–up, there is another form (yeah, I know..) to fill in after that. It's the same deal – a short section to fill in, followed by a longer section if you can't get a hold of me within 12 hours of the follow–up (if it was a no–show, just fill in the top of the form).

Many thanks, Pete

Appendix 11 – IDU 'Freddo' Survey

Freddo Frog Survey [Users]

The OOPS Project now provides a callout service to Royal Perth Hospital and Sir Charles Gairdner Hospital so people who have been brought in because of an overdose can have someone there to help them deal with hospital staff and also to make sure they have a way to get home to a safe place afterwards. We're doing a survey to find out about people's experiences with hospitals and with the OOPS Project (if you've had any contact with it).

Don't write your name on this paper anywhere. Fold it in half when you've finished so the van person can't see what you've written.

Have you filled in one of these before? (You'll still get a frog if you have – just fill it in again so the van person doesn't know!)

Yes ○ No ○

How many times have you been to a hospital *since June* because you overdosed?

0 ○ 1 ○ 2 ○ 3+ ○

If you haven't been to a hospital because of an overdose since June, then that's it. Fold this in half & give it back to whoever gave it to you to get your frog.

On any of the times since June where you went to hospital, did the hospital staff ask you if you wanted an OOPS person to come out and see you?

Yes ○ No ○

If you've never seen an OOPS person at a hospital, then that's it. Fold this in half & give it back to the van person to get your frog.

If you did see an OOPS person, did they help with keeping hospital staff off your back or getting you out of there quicker?

not at all		a bit		a lot
○	○	○	○	○

Did they help with getting you home or to somewhere safe with a taxi voucher or whatever?

Yes ○ No ○

Was there anything the OOPS person did which was annoying or a waste of time?

_____

Was there anything they did which you thought was particularly good?

_____

Was having the OOPS person there useful enough that you'd want to see them turn up again if you ended up at hospital again?

Yes ○ No ○

How many times have you been to hospital because you overdosed *since* the time where an OOPS person was called?

0 ○ 1 ○ 2 ○ 3+ ○

If you knew in advance that an OOPS person would definitely be there at the hospital, would that make you *more* or *less* stressed about calling an ambulance if a friend overdosed?

more stressed about calling		no difference		less stressed about calling
○	○	○	○	○

That's it – fold this in half & give it back to the person who gave it to you to get a freddo frog.

Appendix 12 – Hospital Staff 'Freddo' Survey

Freddo Frog Survey [ED Staff]

The OOPS Project provides a callout service to Royal Perth Hospital and Sir Charles Gairdner Hospital to provide immediate post–discharge support to patients who were admitted following an accidental opiate overdose. The service has been running since June and is available 9am to 9pm.

We are now seeking anonymous feedback from emergency department staff on your experiences with and impressions of the OOPS Project. Please feel free to write further comments on the back of the form if the questions posed do not allow you to express your concerns.

Don't write your name on this paper anywhere. Fold it in half when you've finished and return it to whoever gave it to you to get a freddo frog. ☺

If you've never used OOPS, please skip to **SECTION 2** below

SECTION 1

How many times have you used OOPS?

1 ○ 2 ○ 3+ ○

In general, have OOPS staff provided you with appropriate feedback after they had seen the patient?

Yes ○ No ○

Comment:_____

Was there anything OOPS staff have done which was either particularly good or particularly bad from a personal or professional point of view?

Comment:_____

Did your use of the OOPS Project *increase* or *decrease* your overall satisfaction with the outcomes achieved for your patient?

decreased		no change		increased
○	○	○	○	○

Was having the OOPS person there useful enough that you'd want to utilise them again?

Yes ○ No ○

That's it. If you've got any other comments to make about the OOPS Project, feel free to write all over the back of this form. When you've finished, give the form back to whoever gave it to you to get a freddo frog. ☺

SECTION 2

If you've never used OOPS before, have you heard enough about it to feel comfortable knowing when and how to use the service if it was appropriate?

Yes ○ No ○

Have you heard anything about OOPS from any source which has/might influence your choice to use or not use OOPS should the opportunity arise?

Yes ○ No ○

Comment:_____

That's it. If you've got any other comments to make about the OOPS Project, feel free to write all over the back of this form. When you've finished, give the form back to whoever gave it to you to get a freddo frog. ☺

Appendix 13 – *MJA* Letter

Opiate Overdose Intervention Trial: Use of Hospital ED as Intervention Site

To the Editor,

We would like to report a community outreach program for patients with opioid overdose who are discharged from emergency departments. Such a system, aimed at preventing repeated opioid overdose, has not been previously described.

In the decade to 1990 mortality due to opioids increased by 170% (1) and in Western Australia the mortality nearly doubled in the period 1994–1995 (2).

Heroin overdose represents a syndrome of multiple causes rather than simple opioid intoxication. Contributory factors include co–ingestion of other central nervous system depressants (alcohol and benzodiazepines)(3,4), reluctance to seek medical assistance (4), poor tolerance (3,4), and high street purity (2).

Further, as many as 49% of injecting drug users have little or no contact with any source of treatment or information including GPs (5) (the most commonly used first point of contact for users seeking help or information).

Non–fatal overdose resulting in presentation to an emergency department therefore represents a critical point in a drug users life, and provides an important opportunity for focussed preventative interventions amongst injecting drug users who have little or no other contact with support and treatment services.

In collaboration with the emergency departments at Royal Perth Hospital and Sir Charles Gairdner Hospital, the Western Australian Alcohol and Drug Authority has commenced a peer–based intervention and follow–up service for patients following non–fatal opioid overdose. The service, an extension of the pre–existing peer–based Opioid Overdose Prevention Strategy (OOPS), is funded by the Health Department of Western Australia.

Consenting patients in the emergency department are referred to the service by appropriate emergency department staff. OOPS ED Project staff are available from 9:00 to 21:00 seven days a week and are accessed via mobile telephone. OOPS workers meet the patient on or shortly before discharge to discuss strategies to prevent future overdose and to provide immediate post–treatment support such as transport and referral to other related services. Patients who refuse ambulance transport to hospital and patients who reach hospital but decline immediate OOPS assistance are given an OOPS card so they may access the service at a later date.

The collaborative program is prospectively collecting demographic and other data aimed at measuring the efficacy of the program in preventing future opioid overdose. The project represents a significant and timely collaborative effort between emergency service staff, hospitals and community outreach workers and a full report on the project and its outcomes will be published early in the new year.

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Appendix 14 – ED Project Newsletter

This is the first of what will be a bi–monthly newsletter produced to let Emergency Department staff know about outcomes from, and changes to, the OOPS Emergency Department Project. For those of you who are not familiar with the OOPS Project, there is a basic description of the project and what we do on the back of this newsletter.

Surveys, surveys, surveys

You may have filled out one of our freddo frog surveys. (thankyou, thankyou, thankyou!). The surveys were designed to find out how to improve our services. We also conducted surveys with clients of the AIDS Council needle van to find out if OOPS has reduced the risk of overdosing.

Hospital staff survey results

We have recovered about 75% of the forms so far. A two–page report will be ready in a few weeks, when we have the last of the forms back, showing exactly what people had to say.

For the most part people have been quite positive about the project. The biggest issue was the need for more consistent feedback from OOPS staff after seeing one of your patients. A number of people said when they rang us, someone would turn up and sail out the door with the patient and that would be the last you would see of either the OOPS person or the patient. We have introduced strategies to overcome this.

Firstly, we have drawn up a one page form that we fill in after every callout describing what we did with the patient, who we referred them to and anything else that is relevant. From now on, if you call OOPS for a patient, you should get one of these forms.

Secondly, we have changed our volunteer training and our operational procedure so that the person called out reports to the Emergency Department staff member who made the call. If the OOPS person cannot find you (or if you are too busy to talk) the form will be left with your name on it at the triage desk.

If this does not happen, please ring Ruth Birgin (9370 0363) and let us know.

Extended hours

People also wanted to be able to call us 24 hours a day. Unfortunately, we cannot provide a 24 hour service until we are sure we can guarantee a response. However, we *will* be changing our current 9am to 9pm operating hours to an 8am to midnight schedule in January. This change will be accompanied by fanfare and cakes and large posters and so on.

Opiate users survey results

About half of the survey forms have been returned so far, and there will be a short report circulated giving the detail as soon as we have more returns.

Preliminary results show that people who have been to hospital for an overdose and spoke to an OOPS person are less likely to re–present later than someone who did not see an OOPS person. We are aware that there could be biasing factors involved in the survey. (For example, only people accessing the needle van filled in a form, so we may only be surveying people who took our advice and started using such services, and missing those who ignored the advice provided). Nevertheless, this is still an encouraging interim result.

The other pleasing result from this survey was that if people knew for certain there would be an OOPS person at the hospital, in about 40% of cases they would be “less stressed about calling an ambulance” for a friend who had overdosed. The other 60% said it would make no difference, and no one said they would be “more stressed”.

Project Background

In response to the increasing incidence of opiate overdose in the late 1990s, the Opiate Overdose Prevention Strategy (OOPS) was formed. OOPS is a peer based strategy aimed at encouraging heroin users to develop their own strategies to avoid and manage overdose.

The Health Department of Western Australia funds OOPS through the West Australian Alcohol and Drug Authority. OOPS manage a number of peer education and targeted resource projects, including the more recently initiated Emergency Department Project which operates in collaboration with the emergency departments at Royal Perth Hospital and Sir Charles Gairdner Hospital.

Opiate overdose often represents a mixture of causes rather than just heroin intoxication. Contributing factors include a reduced tolerance due to temporary abstinence, and use of other central nervous system depressants (such as alcohol and benzodiazepines).

Recent research conducted in WA indicates that up to 50% of all injecting drug users have sought no support or treatment (including GPs) in relation to their drug use. Surveys also demonstrated that opiate users' knowledge about overdose causes and symptoms varies enormously. Therefore, when a person who uses opiates presents at an Emergency Department with non–fatal overdose, a unique opportunity exists for introducing peer focussed preventative intervention.

Volunteers

The OOPS Emergency Department Project has been piloted by OOPS staff since July this year, and has completed the first comprehensive training course for volunteers who are now prepared to respond to hospital call outs. In addition to equipping volunteers with the skills necessary to provide effective preventative intervention, emphasis was given to the 'bigger picture' in Emergency Departments.

Emergency Department staff were invited to talk to the trainees who have gained a clear understanding of the frustration that is experienced by many Emergency Department staff in dealing with overdose patients.

Volunteers will provide mediation between patients and staff, but only where staff indicate

this would be appropriate (for example, in dealing with 'difficult patients' and encouraging patients to remain in hospital until officially discharged).

Procedure

Patients in the Emergency Department are referred to the service by appropriate Emergency Department staff. The OOPS ED Project Team are available from 9:00 to 21.00 seven days a week and are accessed via a mobile telephone as advertised on posters in the department. People who refuse ambulance transport to hospital and patients who reach hospital but decline immediate OOPS assistance are given an OOPS card so they may access the service at a later date.

If you are making a referral to OOPS then you will be asked to give your name. This is so that the OOPS person attending can ask to see you for any necessary background information (e.g. patient has or has not been discharged by the doctor) and to be introduced to the patient. In addition, you will be given a comments sheet once the patient has left the OOPS worker. The comment sheet will give you information about what referrals were made and any other relevant case notes.

The project is committed to providing feedback to and encouraging feedback from the key stakeholders.

It is important to stress that the OOPS Emergency Department project does not offer medical care. The role of the OOPS workers and volunteers is confined to meeting the client to discuss strategies to prevent future overdose, to mediate between staff and clients as required, and to provide immediate post–treatment support such as transport and referral to other services. Parents and friends accompanying opiate overdose patients are also offered information and referral by OOPS Emergency Department volunteers at the hospital.

This Project is expected to extend its service to a full 24–hour coverage this year.

Next issue…

Steering committees and other ways you can help us improve the service…

Appendix 15 – WA Police Overdose Attendance Protocol

AD–24.16 Guidelines for Police Attending Drug Overdoses

In line with the National Drug Strategy's major objectives of harm minimisation and that law enforcement should be directed at suppliers rather than users, the use of discretion is encouraged at every stage in the enforcement of self administration laws.

Where police are called to attend the scene of a drug overdose and there is evidence of other drug related activity, if the offences only relate to self administration or simple possession, it is in the greater public interest to use discretion with regard to prosecuting simple offences. This action will have the effect of removing the fear of prosecution and encourage people present at overdoses to call for assistance without delay. In determining whether it is appropriate to charge those present at the scene with simple possession or use offences, consideration should be given to:

- the need for full cooperation from potential witnesses at the scene;
- the legal criteria for search and seizure under the Misuse of Drugs Act 1981; and
- occupational health and safety issues involving handling used syringes and needles.

If illicit drugs are evident they are to be seized and processed in the normal manner.

Inquiries to Acting Senior Sergeant Brennan, Alcohol & Drug Coordination Unit, Telephone (08) 9231 7045.

Appendix 16 – Unique Identifier Form

Opioid Overdose Prevention Emergency Department Project

This project will run over an extended period. During this time we will be tracking repeat presentations for opioid overdose. Since we don't want to have to collect and store data that could identify the patient, but still need to uniquely identify the people we see, the following coding system will be used to link presentations without identifying the patient.

Unique Identification

1. Put the last two letters of the patient's ***first name*** in the box provided

   e.g. Peter [E][R] [ ][ ]

2. Put the numerical day of the patient's ***birth*** in the box provided

   e.g. 4/11/65 [0][4] [ ][ ]

3. Put the first two letters from the first name of the patient's ***next of kin*** in the box provided. If only a first initial is in records, give the initial followed by a dash.

   e.g. Jane Doe [J][A] or J. Doe [J][–] [ ][ ]

4. Put the first letter of the patient's ***sex*** in the box provided

   e.g. male [M] or female [F] [ ]

Thank You!

Appendix 17 – Callout Form

Your Name: _____

Callout date: _____ Hospital (circle): *RPH* *Charlies*

Time you were called: _____ Time you went home: _____

Who were you called by (circle): *Hospital Staff* *Other*

Was the client still there when you got to the hospital (circle): *Yes* *No*

If No, do not fill in any further. Also, do not fill in Unique Identifier form.

Client Gender (circle): *Male* *Female* *Transgender*

Client approximate age (circle): *<15* *15–20* *21–30* *31–40* *41+*

Client ethnicity (circle): *Anglo* *NESB* *ATSI**

Did the client mention being on the naltrexone program (circle): *Yes* *No*

Resources Provided: **Comments**

To third parties: _____
Did you talk/ provide resources to someone other than client?

Taxi Voucher: _____
If you gave the client a lift, leave the check box empty

Referral: _____
List agency or agencies you referred the client to

Accommodation: _____
Tick the box only if *you* arranged 'official' emergency accommodation for the client. All other accommodation comments over the page.

Other: _____
Details, please..

Kit Stuff you used:

Taxi vouchers: _____

Estimated value or destination suburb (ask driver)

Petty Cash: _____

How much?

You must leave either a receipt or a signed card stating the amount of petty cash you spent, the date & what it was used for <u>in the kit</u>

Cigarettes: Tick here if you used the last cigarettes in a pack (i.e. the pack needs replacing)

Other: Anything else we should have or that needs replacing?

Other Stuff:

Did you have any problems with the client or with helping the client (e.g. difficulties with communication or the client asking for things you couldn't help with such as accommodation)?

Did you have any problems with anyone else (e.g. hospital staff dissatisfied for any reason with anything you did, client family had problems with you being there or asked for resources you couldn't provide etc.)?

Have you got any comments about the callout to make which you didn't get a chance to mention above?

Appendix 18 – Hospital Feedback Form

Place patient sticker here

Opiate
Overdose
Prevention
Strategy

THANK YOU FOR REFERRING
YOUR PATIENT TO OOPS!

OOPS! CONTACT SHEET

Not seen by OOPS! ☐

Was seen by OOPS! ☐

Referred by OOPS! ☐

If you have ticked this box, please circle to where

FEEDBACK?

Contact OOPS! ED Team Leader Ruth Birgin on 9370 0363

Accommodation
Crisis Care Unit
Detox
Central Drug Unit
Bridge House
Treatment Options
ADIS
Counselling
Marrilac
Perth Women's Centre
Yirra
Palmerston
Legal Assistance
Youth Legal service
Sexual Assault
SARC
Other

Appendix 19 – Followup Event Form

ED Project Followup Notification

If you have had contact with someone you saw as an ED Project client, please fill in the following & hand it in to the coordinator or pass it on with your next regular callout sheet. Thanks.

Your Name: _____

The date of the contact: _____

Was the contact '**formal**' (i.e. client rang you & requested to meet) ❑

Or '**informal**' (i.e. bumped into them on the street etc) ❑

Was this the first time you have had contact with the client since seeing them in hospital? ❑

Appendix 20 – ED Project Worker Incident Form

Western Australian Alcohol and Drug Authority

ACCIDENT/INCIDENT EMPLOYEE REPORT FORM

IMPORTANT NOTES:

1. This form should be completed by the staff member most directly involved in the incident or by their proxy, and forwarded to their Manager/Coordinator.

2. Please read policy and procedure manual instructions before completing.

3. This form must be completed for all accidents/incidents, as this form will be of use in the event of a later claim for workkers compensation.

4. If space is insufficient please attach additional details.

A PERSON REPORTING

Name: ..... (Surname) (Given Name/s)

Occupation: ..... Work Location: .....

Other Person(s) involved	Role (i.e. witness, assistant, etc)	Contact details or UR No. if appropriate

B INCIDENT DETAILS (Please Tick)

Type of incident: ☐ Disruptive Incident ☐ Motor Vehicle Accident ☐ Other Accident ☐ Procedural Error ☐ Other: .....

Date of Incident: ..... Time: .....

Where incident occured: ☐ Carrellis ☐ Central Drug Unit ☐ William St Clinic ☐ Community Team ☐ Other: .....

Exact Location where incident occured: .....

At the time of the incident you were ☐ On duty? ☐ Travelling to or from work? ☐ Other: .....

What happened immediately before the incident?

.....

.....

Describe the incident in terms of your actual observations i.e. “What I saw, What I did”. Include times, places and any other relevant details.

.....

.....

What happened immediately after the incident? 9Include actions, emotions, etc, for yourself and for others involved.)

.....

.....

State any immediate preventative or remedial action taken.

.....

.....

Emergency services involved:

☐ Police ☐ Fire Brigade ☐ Ambulance ☐ P.E.T. ☐ None

C OUTCOME DETAILS

Describe any injuries sustained by any of the persons involved

.....

.....

Did anyone receive medical attention / first aid? ☐ YES ☐ NO

Intervention Name	1. On site	2. By whom	3. Time	4. Own GP	5. Hospital
.....	☐	.....	.....	☐	☐
.....	☐	.....	.....	☐	☐
.....	☐	.....	.....	☐	☐

D 1. DATE INCIDENT NOTIFIED TO THE OCC. HEALTH & SAFETY REP.....
2. DATE INCIDENT NOTIFIED TO HUMAN RESOURCES.....

E SIGNATURES (Reporter and Manager/Coordinator must sign and date the form)

Reporter's signature: ..... Date .....

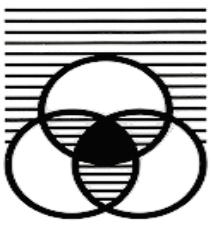
Manager/Coordinator name (Please print) .....

Signature ..... Date .....

Appendix 21 – Volunteer Procedures Manual

OOPS!

Emergency Department
Volunteer Policy, Procedures & Information



WESTERN AUSTRALIAN
ALCOHOL & DRUG
AUTHORITY

Welcome

I would like to take this opportunity to welcome you to the Western Australian Alcohol and Drug Authority (WAADA).

This booklet contains valuable information and outlines the Authority's and the Opiate Overdose Prevention Strategy's (OOPS) policies in a number of areas which may affect you in the course of your work. Therefore, I encourage you to read the booklet carefully.

CARLO CALOGERO

EXECUTIVE DIRECTOR

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4.6 Harassment*

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– Media

– Other Agencies

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– Emergency Procedures

– Telephones

– Personal Property

– Lost and Found

– Smoking

*NB. All staff and volunteers working for WAADA are subject to WAADA Policy. The policies marked * above are intended as summaries for ready access only. If volunteers wish to access detailed WAADA policy, they are encouraged to do so by asking anyone at OOPS to see the manual or view it on the Intranet.*

1. OOPS Emergency Department Project Volunteer Policy Statement

The Emergency Department (ED) Project is committed to anti–discrimination philosophies and practices.

1.1 Project Expectations of Volunteers

- Attend as rostered for at least eight hours per week, over a minimum period of 6 months.
- Adhere to policy and procedures.
- Attend training.
- Strictly observe client confidentiality (see WAADA Policy for further information).
- Follow reporting/documentation procedure.
- Be aware of and act upon own limitations.
- Participate in hand–over at the end of a shift.
- Be reliable and fulfil the negotiated commitments.
- Remain open to constructive feedback related to work performance.
- Report unusual incidents to the ED Team Leader.

1.2 Responsibilities of ED Project to Volunteers

- Strongly encourage volunteers to actively participate and contribute to program development and ongoing reviews of the program.
- A program steering committee (comprising of the ED Team Leader, a WASUA delegate, an OOPS representative, an ED Volunteer and hospital staff development officers) will meet quarterly.
- Ensure volunteers will not work more than sixteen hours per week.
- Ensure a duty of care for volunteers.
- Initial and on–going skill based training (including first aid and counselling skills) and provide support to volunteers in their work with the ED program.
- Provide volunteers with regular feedback, debriefing sessions and regular events to facilitate the opportunity for peer support.

- Recognise volunteers for their input and service to the program by an honorarium calculated on the attendance to call outs to Emergency Departments.
- The OOPS Coordinator will act as a referee for volunteers who have successfully completed the minimum period of six months service.

1.3 Insurance

Volunteer Insurance Cover (including personal accident and public liability) is provided for all authorised volunteers.

Note: Any accident, however small, must be REPORTED IMMEDIATELY to your Team Leader and an Incident Report Form completed where necessary. Failure to do so may affect any ensuing claim for insurance.

1.4 Training

An initial nine day training course (including two days orientation) will provide volunteers with the knowledge and skills requisite to becoming an OOPS Volunteer. At the conclusion of the course, volunteers will be notified about their acceptance into the ED project.

- Initially all ED volunteers will work on a probationary basis. After they have attended three call–outs, their progress will be reviewed and full entry to the program determined accordingly.
- Experienced volunteers may be required to support newer volunteers through a "buddy" system.
- Volunteers will be resourced with appropriate pamphlets and referral cards to provide to clients on request.
- Volunteers will be strongly encouraged to attend bi–monthly continuing education and training organised to support the work of OOPS.

1.5 Security

- Volunteers should ensure that they stay in "public view" whilst with the client.
- If an incident occurs, look after your own safety first. Retreat from the situation if a client becomes agitated or aggressive. When possible, contact ED Team Leader, "buddy" and/or necessary bodies (police etc). Complete an Incident Report Form as soon as possible.
- At NO time are volunteers to transport clients in their own vehicles or to accompany clients in taxis.

- Volunteers must not be in possession of/intoxicated by alcohol or any other drugs while working or training.
- Volunteers must not engage in the supply, distribution, purchase or sale of any illicit substance while working or training.
- Common courtesies and cultural observances should be observed.
- Volunteers are advised to carry only small amounts of cash and no valuables.
- Do not give clients any identifying information about yourself (home address, phone no.)
- In the event of a critical incident, volunteers will be offered additional debriefing and counselling support.

1.6 Taking Time Off

To assist planning, rostering and program continuity, volunteers are requested to advise the ED Team Leader of their intention to take a holiday or a break at their earliest convenience. Ideally, this should be communicated in writing to the ED Coordinator and include an expected date of return.

1.7 Resignation

If a volunteer decides to leave the program, 2 weeks notice is required and an Exit Interview with the ED Team Leader is offered. Volunteers are strongly encouraged to provide feedback about their experience, constructive criticism or make suggestions that may contribute to the project's enhancement.

2. OOPS Emergency Department Project Procedures and Other Information

2.1 Roster Procedure

Emergency Department call–outs operate on a roster system with workers (volunteer and staff) allocated to shifts. There are two (2) rosters: the **on duty roster** and the **back–up roster**.

The on duty roster indicates who is allocated to attend the first call–out at an Emergency Department. The back–up roster is also an on duty roster which becomes operational in the event that there is more than one call–out, the volunteer is uncomfortable with the client or is unfit to attend.

A roster will be sent out every 20th day of each month with shift details for the month ahead. If you are unavailable for any reason, please inform the ED Team Leader as soon as possible (minimum of 24 hours notice). The ED Team Leader will arrange for your replacement and re–schedule the shift. Shift changes should also be negotiated with the ED Team Leader.

Each volunteer will receive a pager, taxi vouchers and/or parking permits before their shift. (Pagers may also be allocated for a fixed period and in this situation check if it is turned on before the start of the shift.) Volunteers may also call the ED Team Leader to check/test equipment.

Shift times: 9am – 1pm

1pm – 5pm

5pm – 9pm

2.2 Call–Outs

When the pager (beeper) signals, the volunteer contacts the ED Team Leader for the call–out details. *Be sure to get the name of the Doctor or Nurse who phoned.*

The volunteer should be neatly presented and be wearing their OOPS identification badge.

On arrival in the Emergency Department (ED), ask Triage to call the Doctor or Nurse who phoned. The Doctor/Nurse should provide the volunteer with a brief handover of the key information/issues and a personal introduction to the client.

Proceed with role and provide:

- Assistance and support to people recovering from an accidental overdose following or immediately prior to discharge;
- Education, information and referral (including to follow up peer education programs) as appropriate and practical;
- Assistance, as necessary, in any negotiations between ED staff and client;
- Education, information and referral for parents and/or significant others.

Before leaving the hospital, it is good practice for the volunteer to report back to the contacting doctor/nurse and thank them for contacting OOPS and inform them of any referrals made.

Note: If the contacting Doctor/Nurse is unavailable, the volunteer should provide any feedback to Triage and request them to handover the information at an appropriate time.

Should any problems arise which the volunteer is unsure how to manage, contact the ED Team Leader.

Data Forms should be completed immediately after call–out and returned to the ED Team Leader at the earliest opportunity.

2.3 Parking

Parking permits are available for both hospitals. See ED Team Leader.

2.4 Risk Assessment

It is NOT the role of ED Volunteers to conduct risk assessments with clients. However, if there are presenting indicators of self harm or suicidal ideation, or if the volunteer is otherwise concerned that self harm or suicide may be a possibility, use the following procedures:

- Ask to see the duty Social Worker at the hospital.
- If the duty Social Worker is unavailable, bring the matter to the attention of the Doctor/Nurse or Triage and provide clearly stated reasons for your concern.
- Document the staff person's name and details in the "comments" section of the data form.
- Provide the ED Team Leader with the details(over the or the next day).

2.5 Debriefing/Supervision

Debriefing is a supportive strategy that offers workers an informal opportunity to express their feelings, thoughts and reactions about an unpleasant, negative or difficult work experience to a peer, "buddy" or supervisor. (This is what I experienced.)

Supervision provides workers with an opportunity to actively review their work practices and seek advice, structure and direction from a more experienced worker in a supportive environment. (What would I do differently?)

Volunteers also have access to the following strategies to support them in their work.

- Access to the ED Team Leader prior to and following each rostered shift.
- The OOPS office provides an informal drop–in centre for volunteers to chat with staff and peers or to access resources related to their volunteer work.
- The first three call–outs are mentored/"buddied" by OOPS staff.
- The OOPS Coordinator is available for support, debriefing, supervision and case review.
- The two–tier roster system provides access to immediate support and peer debriefing.
- Every 2 months, there is a one–day group supervision session for all ED volunteers which includes new training initiatives, playback theatre and group discussion.

Finally, if there is a more difficult incident, volunteers have the option of debriefing with a counsellor. This can be arranged through the ED Team Leader or the OOPS Coordinator. This will be offered routinely if a volunteer has been involved in a critical incident.

2.6 Research Component

The ED Project is based on action research principles. Its research findings will help to guide the ongoing development of the ED Project.

The Data Form is one of the tools designed by the WAADA's Research Officer to monitor the project. It is, therefore, of primary importance that volunteers complete and return the forms after each call–out.

In addition, the Research Officer will meet with volunteers at regular intervals to seek feedback about your training needs and/or other supports that are considered necessary to progress the Project.

2.7 Petty Cash/ED Kit

An ED Kit is available on your arrival at the hospital from the Triage Nurse. The combination is recorded on the side of the lock itself.

Inside are referral cards, taxi vouchers, a small cash float, cigarettes and a record book. When a volunteer opens the ED Kit, remember to count and record the amount of cash. If the sum you count does not accord with the amount previously written in the record book, contact the ED Team Leader immediately. If you spend any cash, please record the details of the expenditure, together with the date and signature.

The cash float is only intended to cover coffee, cool drink and small snacks, phone calls and local public transport costs for the client.

2.8 Taxi Vouchers

Volunteers

Each volunteer has a taxi voucher to attend a call out in the event that they have no transport of their own. To return home, another can be

taken from the kit box as long as this is recorded and signed for in the Record Book.

Clients

Taxi vouchers should only be given when the client is in clear need and as a last resort. Efforts should first be made to explore options of ringing friends or family to assist with transport.

If a taxi voucher is to be used, the volunteer should ascertain to which suburb the client is travelling. The volunteer should fill out the voucher (destination, purpose “ED Project”, signature) **and hand it to the taxi driver**. The use of a taxi voucher must be documented on the Data Form and in the Record Book.

Note: Take extreme care of the taxi vouchers as any misuse may prevent further use by the ED Project.

2.9 Issues Regarding Hospital ED Staff

Each call–out provides an opportunity to impress upon ED staff the professionalism and competence of the ED Project. It is vital to the success of the Project that volunteers are polite and deferring to ED staff at all times.

If a volunteer considers there is a clear reason for complaint about hospital staff member's behaviour, discretely take as many of their details as possible and discuss your concern with the ED Team Leader.

2.10 Volunteer Honorarium

Volunteers will receive ten dollars ($10) for each of their three mentored call–outs and subsequently twenty five dollars ($25) per call–out.

Payments will be made periodically by cheque or by arrangement with the ED Team Leader.

3. OOPS Emergency Department Project Follow–up Procedure Guidelines

3.1 Statement

Where a client requests on–going contact with a specific volunteer and that volunteer is amenable to follow–up contact, this can proceed provided that the ED Team Leader is aware of these arrangements and has given approval. Note: The ED Volunteer is under no obligation.

In some cases, particularly where a client is otherwise not in contact with treatment services, this relationship can provide the impetus for the client to consider minimising their high risk practices.

Volunteers should be mindful of their own boundaries and time restrictions when negotiating follow–up contact with clients.

3.2 Aims

To ensure the ED Project reaches its full potential in assisting clients to develop harm reduction strategies to prevent, manage and/or treat opiate overdose.

To maintain the professional and ethical status of OOPS as an effective resource for clients and the opiate using community.

3.3 Procedure

Follow–up work consists of:

- Referral
- Involvement in OOPS peer education projects
- Home visits

3.4 Referral

- In most cases, referral information should be provided by phone from the OOPS office.
- If a volunteer has arranged to introduce a client to a particular service, the initial meeting should occur at the service providers' address.
- ED Volunteers can request an OOPS staff member to accompany them.
- The ED Team Leader can assist in making appointments for a client provided advanced notice is given.
- ED Volunteer should remain "in public" with the client at all times.

3.5 Involvement in OOPS Peer Education Projects

If a client has requested further contact with the OOPS Project/ED Volunteer, a suitable time should be negotiated through the ED Team Leader. The client should contact OOPS for this information.

3.6 Home Visits

Home visits should be regarded as a last option for follow–up contact. Other possibilities are meeting in a coffee shop or another public place. In cases of special need, a taxi voucher may be offered to assist the client with transport. Regular contact can also be maintained through scheduled telephone contact from the OOPS office.

During your visit you should:

– Introduce yourself and the OOPS staff member

– Observe common courtesies

– Terminate session if client or other persons becomes agitated or aggressive.

– Consider your safety at all times

– Document visit

– Debrief with ED Team Leader following visit and discuss outcomes.

Home visits will only be conducted in pairs (ED Volunteer + OOPS staff member) and should initially be discussed with the ED Team Leader. The ED Team Leader must be aware of all the relevant details (reason for visit, day and time of visit, who's going, address, length of visit). Consider potential safety issues and other/or concerns with the ED Team Leader prior to making a home visit. Take a mobile phone.

Before leaving, confirm the appointment by phone and advise the client that someone is coming with you. Assess the home situation (who's home, what is their relationship to the client).

If the client requests on–going visits, discuss with ED Team Leader.

4. General OOPS Volunteer Policy and Information

4.1 Confidentiality

- Volunteers involved in the ED Project are obliged to safeguard personal client information.
- Volunteers will not give out identifying information (beyond first name) of themselves or any other volunteers.
- Volunteers will not ask for identifying information beyond a client's first name.
- If hospital staff provide volunteers with additional client information, this should also be treated confidentially.

With the exception of certain persons especially authorised because of their duties (eg. ED Team Leader, OOPS Coordinator, supervisor) no volunteer/staff member is permitted to divulge client–related information to another without client consent. (see WAADA Policy for full details)

4.2 Code of Conduct

The Authority requires its employees and volunteers to be familiar with and work within the principles, values and behaviours outlined in the Public Sector Code of Ethics and Code of Conduct.

The intent of this Code is to:

- Be fair, use and share power for the common good and take non–discriminatory action.
- Respect the right of others and act to empower others to claim their rights.
- Contribute to the well–being of individuals and the common good of society.

4.3 Grievance Procedure

A grievance procedure should encourage open dialogue and the early resolution of a dispute.

If a volunteer has a complaint against a staff member or another volunteer, it is advisable to speak directly to the person in the first instance in an attempt to reach a resolution.

If a resolution is not achieved, your grievance should be taken to the OOPS Coordinator for further action.

4.4 Disciplinary Matters

Any failure by a volunteer to uphold OOPS Policy and Procedures may lead to disciplinary action (this can range from a formal meeting with the ED Team Leader through to termination of a volunteer's contract).

4.5 Disclosure of Client information to the Police or other Authorised Agents.

There is no *legal* obligation upon WAADA staff and volunteers to report an offence to the Police or to assist Police with their inquiries.

In WA, an offence is committed only where a person takes active steps to prevent or obstruct the discovery or investigation of an offence. This means that while it would be an offence to *mislead* the Police, it would not be an offence simply to *decline* to provide information requested.

Where a WAADA staff member or volunteer, in good faith and in the interest of the public discloses to the Police or other authorised agencies information relevant to an offence or suspected offence, the WAADA staff member or volunteer will not be liable for damages to a client for breach of confidentiality. Equally, the WAADA could not treat such a disclosure as a breach of discipline, even though it contravenes the Authority's rules.

The definition of what constitutes an offence that *should* be disclosed has not been defined, except that court cases show that a very liberal interpretation is placed by them on the type of offence, misdeed or civil wrong that is covered. What is important, is that the matter should be in the public interest.

Public interest can also include cases where individuals can be hurt by the offence or proposed offence, and the need for disclosure is not confined solely to the Police. For example, evasion of tax is against the public interest and in this case, the public duty rests with the Taxation Department.

Note: The above is a summary of the advice received from Crown Law. Ultimately any decision of this kind rests with the individual. (see WAADA Policy for further details)

4.6 Harassment

The WAADA is committed to the prevention of harassment in its workplace.

Harassment is defined as any unwelcome, offensive comment or action concerning a person's race, colour, language, ethnic origin, sex, pregnancy, marital status, family responsibility or status, age, impairment or political or religious conviction.

Physical harassment of staff or volunteers by clients or clients by staff or volunteers should be dealt with immediately by the intervention of other staff or volunteers in the area and the matter reported as soon as possible to the OOPS Coordinator.

If you feel you are being harassed, contact the ED Team Leader or the OOPS Coordinator for support, advice and assistance. (See WAADA Policy for further details)

4.7 Pending Coronial Inquests

In some circumstances it is possible that a death of a client may require a coronial inquest. The death of a client subject of a Coronial Inquest is considered to be a serious matter. The assistance of the Crown Law Department in representing the WAADA Volunteer may be necessary. In all cases where coronial inquest is pending the volunteer should seek support, advice and supervision from the OOPS Coordinator.

4.8 Availability of Statistical Information

Any requests for statistical information should be forwarded to the OOPS Coordinator.

4.9 Health and Safety

Needlestick Injuries

If you experience a needlestick injury, advise your ED Team Leader immediately. A WAADA medical officer (MO) should in the first instance, review the volunteer. The MO can also arrange an immediate referral to the Department of Immunology at Royal Perth Hospital for ongoing management.

Note: An Incident Report Form needs to be filled out and lodged with the OOPS Co–ordinator as soon as possible. Incident Report forms can be obtained at the OOPS office.

4.10 You as an Authority Representative

Media

The Executive Director, or delegated deputy, is the **only** authorised person who can speak on behalf of the WAADA. Therefore, any requests from the media for comment must be referred to the Executive Director.

Other Agencies

When in contact with other agencies, volunteers should make their role clear, and are not authorised to speak on behalf of the WAADA.

Borrowing or Accepting Gifts from Clients

Borrowing or accepting gifts from clients is prohibited and any breach of this rule will result in disciplinary action.

4.11 WAADA Hours of Operation

Normal WAADA opening times (including the OOPS offices) are 8.00am to 5.00pm, Monday to Friday. If you intend to drop–in to talk with OOPS staff, it is advisable to ring first and check availability.

4.12 Home Address

Your home address is a necessary part of the WAADA's records. Please advise, the OOPS Coordinator or ED Team Leader of any change of address as soon as possible.

4.13 Next of Kin

It is necessary to have the name and address of your next of kin, and the person who is to be notified in the event of accident, illness or other emergency. Any changes should be notified to the OOPS Coordinator or ED Team Leader as soon as possible.

4.14 OOPS Drop In Centre

Volunteers are encouraged to use the Drop In Centre for meeting other volunteers, following up with clients or as a resource base for matters connected with volunteer duties.

The OOPS Drop In Centre is located on the ground floor of the OOPS annex connected to the Carellis Centre, 7 Field St, Mt Lawley, and is open 5 days a week from 9am to 5pm.

Smoking is prohibited in this area.

- **Emergency Procedures**

  It is important that you are familiar with the safety procedures in your area including the location of fire extinguishers and emergency exits. In any emergency the protection of life takes priority over the protection of property. All instruction given by a Fire Warden must be responded to immediately.

- **Telephones**

  Telephones in OOPS offices are for official use only. Private calls may only be made in an emergency or with permission of the ED Team Leader.

- **Personal Property**

  The WAADA accepts no responsibility for personal effects, cash or equipment brought to the OOPS offices. If you lose property while at the Authority, check with Reception to ensure it has not been handed in. If you have private property stolen, report the loss to the police.

- **Lost and Found**

  Money and valuables found on WAADA premises should be handed in to Reception during working hours, or to the ED Team Leader out of working hours.

- **Smoking**

  WAADA is a smoke free workplace. Facilities for smokers are provided outside each building in allocated areas.

Appendix 22 – WAADA Confidentiality Statement

WAADA

CONFIDENTIALITY

A person appointed or employed under the Alcohol and Drug Authority Act No.32 of 1974, or authorised to discharge any function of the Authority or any function on behalf of the Authority shall not, except to the extent necessary to perform his or her official duties or discharge such a function, either directly or indirectly, whether before or after ceasing to be so appointed, employed or authorised, make record of, or divulge or communicate to any person, any information that is gained by or conveyed to him or her by reason of his or her being so appointed, employed or authorised, or make use of any such information, for any purpose other than the discharge of his or her official duties or the discharge of that function.

Any breach of this undertaking will lead to appropriate action being taken by the Authority.

Carlo Calogero

EXECUTIVE DIRECTOR

NEW APPOINTEE TO COMPLETE

I certify that I have read and understand the above undertaking.

NAME:_____ DATE:_____

SIGNATURE:_____

Appendix 23 – Agency Referral List

LEGAL ASSISTANCE

Aboriginal Legal Service of WA (Inc.) 9265-6666
From anywhere in WA Freecall 1800-019-900
Legal Aid General Info Line Freecall 1800-809-616
Legal Aid Commission
Perth 9261-6222
Midland 9274-3327
Fremantle 9335-7108
Youth Legal Service 9328-9907
Ombudsman 9220-7568
General Enquiries 9220-7555

HEALTH SERVICES AND INFORMATION

Family Planning Association of WA (Inc).
Northbridge 9227-6177
Mirrabooka 9344-2277
Telephone Information Service 9227-6178
Fremantle (For Under 25's) 9430-4544
Clinic K Fremantle Hospital 9431-2149
4K Royal Perth Hospital 9224-2178
S.E.C.C.A. (Sexuality, Education, Counselling & Consultancy) 9227-0133
Aboriginal Medical Service of WA Inc. 9227-3888
S.I.E.R.A. Inc. (Support Information Education Referral for Sex Industry Workers) 9481-0811
Hepatitis C Council of WA 9328-8538
Freecall 1800-800-070
Western Australian AIDS Council 9429-9900
AIDS Council Health Centre 9429-9982
Mobile Needle and Syringe Exchange 015-443-760
Womans Health Centre (Multicultural) 9430-4545
Ishar Multicultural Centre for Woman's Health 9345-5335
Perth Woman's Centre 9227-9032
Rockingham Womans Health & Info Centre 9527-8221
Mental Health Psychiatric Centres, Clinics, Community Accommodation Support Program 9382-0740
Inner City Community Mental Health Services 9224-1720
Hillview Child & Adolescent Clinic 9362-5188
Joondalup Mental Health Services 9300-0369
Kwinana Living Skills Centre 9439-1622
Psychiatric Emergency Team 24 Hrs (PET) 9227-6822

USERS GROUPS

Western Australian Substance Users Association 9227-8654
Gay and Lesbian Users Group 9328-7342

DRUG AND ALCOHOL TREATMENT SERVICES

Alcohol & Drug Authority 9370-0333
Alcohol & Drug Information Service (24 Hrs) 9442-5000
Freecall - Country Callers Only 1800-198-024
Central Drug Unit 9421-1833
Cyrenian House 9328-9200
Holyoake 9328-9733
Noongar Alcohol & Substance Abuse Service (Inc). (NASAS) 9221-1411
Palmerston Drug Research & Rehabilitation Association 9328-7355
William Street Clinic 9328-3066
Yirra (Youth Treatment Service) 9370-5244
Alcoholics Anonymous 9325-3566
Narcotics Anonymous 9227-8361

SOCIAL AND OTHER SUPPORT SERVICES

Broken Chain 9250-3056
Outcare (Inc) 9227-5555
Employment & Training 9227-5555
Domestic Violence Unit 9261-6254
Incest Survivors Association (Inc). 9227-8745
Sexual Assault Referral Centre (SARC)
Crisis Line 24 Hours 9340-1828
Suicide Counselling Samaritans 9381-5555
Youthline Samaritans 9388-2500
From Anywhere in WA Freecall 1800-198-313
Samaritans Crisis Line 24 Hours 9340-1828
Country Areas Freecall 1800-199-888
Crisis Care Unit 24 Hrs (Family or Personal Crisis) 9325-1111
Fremantle City Mission 9337-4460
Perth City Mission 9421-1199
Youth Services 9470-4080
Grief Support Service 9481-6044
Wesley Mission Perth 9321-9711
Wesley Care & Support services 9321-9711
Fremantle Wesley Mission 9335-1775
Tranby Day Centre 9321-2451
Salvo Care Line (24 Hr Crisis Counselling) 9227-8655
Salvation Army Correctional Services 9227-7010
Salvation Army Social Services 9227-7010
Salvation Army 24 Hrs 9227-7035
Salvation Army Graceville Woman's Centre 9328-8529
Alglicare - Anglican Health Welfare Services 9321-7033
Teenshare / Youth Focus 9321-7033
Step 1 Incorporated 9325-4699
Mobile Service 018-942-475
Interpreter Services - Commonwealth 9321-9333
Parent Help Centre 9272-1466
Family Mediation Service - Relationships Australia (WA)
East Victoria Park 9470-5109
Fremantle 9336-2144
Joondalup 9470-5109
Mandurah 9535-5711
Midland 9250-1242
Mirrabooka 9470-5109
Trinity Youth Options 9325-9239
Gay & Lesbian Counselling Service 9328-9044
Perth Inner City Youth Service 9388-2791
Youthlink 9224-1700