Opiate Overdose Prevention Strategy (OOPS) Review

Drug and Alcohol Office
Department of Health

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This report summarises the findings of a Review of the Opiate Overdose Prevention Strategy (OOPS) Project conducted on behalf of the purchaser, the Alcohol and Drug Policy Branch, Department of Health, WA.

Executive Summary

The Opiate Overdose Prevention Strategy (OOPS) project commenced in 1997/1998 financial year in response to heroin overdose issues. It was funded under the Cabinet Anti-Drug Initiatives funding until the 2000/2001 financial year, and has been extended in 2001. The project has utilised a range of strategies which have developed over time including resource development, the use of volunteers, peer based facilitation/education and professional education and training. In addition, OOPS was expanded in 2000 with a one year pilot project called 'Breathe', conducted in partnership with the WA Substance Users Association (WASUA).

This review was undertaken by the purchaser in the first half of the 2001 financial year, and was considered a timely process in view of recent and future developments including: outcomes from the Drug Summit; the current heroin 'drought' and increasing prevalence of other drug overdose; the anticipated reorganisation of drug and alcohol service purchasing in WA; and the outcomes of the HARC Review, in particular the recommended alignment of Alcohol and other Drugs under a broad population portfolio perspective.

Research objectives were identified for the Review, and included investigating: the role and activities of OOPS (including the Emergency Department (ED) Project); the current and future capacity of the project; the financial aspects of OOPS; the attitudes of the key stakeholders; and experiences of the pilot BREATHE project.

To meet these objectives, information was gathered from a review of the literature, service reports and previous reviews of the OOPS project. A history of OOPS is outlined, tracking the evolution of the project. Service and financial reports are also analysed and presented.

A consultation process was undertaken with key stakeholders, involving four focus groups and 35 individual interviews. A total of 47 stakeholders were consulted on their role in relation to the OOPS project, and their perceptions of the aims, activities, target groups and future directions for OOPS. They were also asked about the key strengths, weaknesses, opportunities and threats for OOPS.

Recommendations in regards to the future of the OOPS project are as follows

Elements of this program should continue, with a clarification of available funds from 2002 financial year onwards. If the program continues to attract funding from 2002 onwards, it is recommended that:

1. Activities are refocussed with a greater emphasis on EAR training for agency staff. A Train the Trainer model should be developed and implemented, and the effectiveness of the program assessed and followed up.

2. Funding is reallocated to appropriate service providers to enable the following refocus of the program:

    - Fund the user group to continue to provide peer education components, particularly with regards EAR and other peer based overdose activities.
    - An assessment of current publication resources and health promotion based activity undertaken in the overdose area needs to occur, and the proportion of the OOPs budget that is allocated to resource development and distribution ascertained. Consideration should be then be given to reallocating this funding to service providers with appropriate expertise, enabling improved linkage with other such strategies.
    - Consideration is given to reallocating funds to encourage and enable Drug Service Team, Mental Health Services, Prison Health services and General Practitioner involvement in active case management.

3. The action research model is fully utilised, so that there is a greater capacity of the program to be flexible to be able to respond quickly to the changing drug context in the local community, for example to be responsive to other drug related overdose. The pilot project at SCGH should become part of the programs key functions.

4. If there is a reduction in resources available to Next Step to continue recommended elements of the program, there needs to be a consideration of value for money. For example, there is a high proportion of the budget allocation spent on overheads and salaries. A better buy may be identified both in terms of administrative efficiency and service delivery.

5. That the emphasis of the Volunteer Training Program is reduced and linked with other volunteer training programs offered within Next Step and elsewhere. Issues around recruitment and overlap with other programs should be addressed. Particular attention should be given to meeting the needs of peer based educators, rather than students value adding to their current addiction studies. The purpose of the program is not to value add to people's education, even though it may have a flow on, community development effect.

6. There is more collaboration with the user group in terms of sharing resources, communication and their involvement in the Volunteer Training Program. A particular strategy in this regard would be for the Next Step OOPs project to enable WASUA participation in prison visits.

7. That the issue of how to achieve a greater proportion of follow up in the ED Project be more assertively investigated. Options available are cross referral with Drug Service Teams and local GPs, utilising data management systems to track re-presentations and match intervention accordingly, and so on.

8. Linkages to the AOD and health sector are continued and improved, including with the Opiate Overdose Strategy Group, Community Drug Service Teams (CDSTs), hospitals, mental health services, GPs and prison health services.

9. Data collected is better coordinated and utilised. Other databases on overdose should also be utilised, such as the ED database, the coroner's database and St John Ambulance data. This could enable improved follow up and assist in the identification of multiple presentations.

10. Further research is undertaken by the program, including the replication of the User Survey and the ED Staff survey at RPH, SCGH and Fremantle Hospital. This will assist in assessing the effectiveness of the program.

11. The output indicators are formulated to better reflect the activities of the program, and that the purchaser then receives clear quantitative and qualitative information regarding the outcomes of the program.

12. That in the event that WA participates in a multisite naloxone trial, as per recommendations of the WA Community Drug Summit, that the OOPs project should be configured to coordinate WA contributions to this trial and to undertake necessary tasks. It is noted that some additional funding to OOPs may be required in this event, however refocus of OOPs core functions will support a substantial contribution to this trial.

13. If all of these recommendations are met and the program continues, a clarification of the roles and responsibilities of the program is required, both within Next Step and amongst other service providers, to prevent service duplication. This then needs to be communicated to the key stakeholders for the project.

Summary

It is clear from this Review process that OOPS is a highly regarded program in WA. Many of the stakeholders interviewed said that OOPS is a valuable service that should be continued. A number of key strengths of the project were identified in the consultation process, and include: the staff of the project; workforce development contribution through the Volunteer Training Program; benefits in access to appropriate sites through the location within a government agency; the ED Project; the action research model used; the philosophy and approach of OOPS; the reputation; community development and education; BREATHE; and the volunteers.

However, there were some areas identified that require improvement or a refocus, such as:

- OOPS being only opiate specific.
- Aspects of the ED project, including the lack of follow up with clients and ED staff. Follow up with ED staff continues to be addressed by the project. Follow up with clients has been acknowledged as a difficult area for reasons of confidentiality.
- A lack of clarity around roles of OOPS, the staff and the volunteers, with concerns about overlap with other services and agencies.
- Concentration on training volunteers and the problems that accompany such programs, such as attrition rates and maintaining motivation amidst low referral rates. There are also concerns that some volunteers are using the VTP as a way of value adding to their studies rather than to genuinely become volunteers . OOPS is sometimes seen as being synonymous with the VTP, rather than being seen as an overdose strategy.
- Database management needs to be improved. (This is currently being examined by OOPS in conjunction with the Research team at Next Step.
- Doing peer education from a government agency).
- A lack of marketing for OOPS, resulting in a lack of understanding of what they do amongst target groups
- Relationship with key stakeholder groups. There are obviously some tensions here, particularly with WASUA as a key partner, that require improvement.
- A lack of an evidence base for what the project does, and an inability to prove their effectiveness.
- Value for money. The projects receive considerably more funding than comparable projects in other states. The high cost of the program is largely due to high overhead costs and salaries.

Outcome of objectives

The following lists the objectives of the Review, with a summary of findings under each objective.

1. Determine the role and activities of the OOPS project over the four years of operation

The OOPS Project was initiated in WA as part of a national response to the growing problem of heroin overdose. The original target group was users, non-users who might be at risk of overdose and service providers.

The original aims of the project were to:

- increase the knowledge and skills of IDUs in dealing with overdose situations;
- establish close collaboration in addressing heroin overdose between user groups and other key stakeholders such as police, ambulance services and drug and alcohol agencies;
- inform service providers of the needs of IDUs in relation to heroin overdose; and
- inform the community about the issues associated with heroin overdose from a harm minimisation perspective.

A review of the OOPS pilot project in 1997 found that although it was difficult to determine whether it had any impact on the number of heroin overdoses in WA, it had acted as a catalyst for changes in the

approach of organisations in dealing with overdose issues, such as changes to the St John Ambulance Narcan policy and an amendment to police guidelines in dealing with overdose situations (Corry & Penna, 1997). The following recommendations were made, presented with commentary on whether they have been met.

- That greater collaboration and commonality of purpose be encouraged between key groups and organisations that are stakeholders in reducing drug related harm in the community. *This continues to occur, but needs more work.*

- That appropriate non-identifying information on overdose situations in WA be collated, made available to the OOPS Project and used to target credible education initiatives effectively. *Data continues to collected from a number of sources, for example, St John Ambulance and the ED Project database, however, this data needs to be utilised more effectively. A joint project is currently being undertaken with the Research team at Next Step to achieve this.*

- That close liaison with the WA Substance Users Association (WASUA) continues to be a priority in assisting the OOPS Project in identifying current patterns and trends of heroin use. The authors noted that the present funding structure tends to foster competition between agencies and does not facilitate the close collaboration required, therefore limiting the effectiveness of any strategy. *It is clear from the results of the consultation process that this continues to be an issue for the Project.*

- A variety of sub-projects be implemented which provide culturally appropriate resources for specific target groups both within and outside the metropolitan area, and that each project be developed in conjunction with the target group. *Various projects were run in prisons where prisoners created their own resources on overdose (for example, the 'Little Annie does time' booklet). The original model was to be based on the Tribes project designed by NUAA, however, according to OOPS staff, a lack of funding limited the implementation of this model.*

- That strategies be developed to encourage users to adopt safer behaviours in relation to polydrug use. *This has occurred within the ED Project, in that ED volunteers who attend callouts discuss polydrug use issues and strategies with clients. The recently initiated SCGH pilot project will also contribute to addressing this issue.*

- That overdose stories be documented, produced and distributed in a variety of media to provide more realistic information for users about the circumstances of overdose. This project would validate overdose experiences for users and provide an invaluable tool for peers. It would allow misinformation to be corrected, acknowledge the experience of those faced with overdose situations and provide an opportunity for people to discuss and deal with grief, loss and guilt issues. It would also provide a tool for raising community awareness about the issues associated with overdose situations. *This occurred with the Namaste Project.*

While some of these earlier recommendations have been achieved, there is still work to be done, which is reflected in the recommendations of this current Review.

The Review found that there is a varied understanding of the role and objectives of OOPS amongst both staff and stakeholders. Education, the ED Project and the Volunteer Training Program all featured strongly when people were asked what the main role or objective of OOPS was.

The objectives of OOPS are set out in the service specifications as part of their contract with the Purchaser. Table One shows how the objectives have changed slightly over the time OOPS has been in operation.

Year	Aims/Objectives
97/98	OOPS: To reduce the risk of overdose through the use of targeted peer education and health promotion strategies aimed at opiate drug users.
	ED Project: To develop in partnership with Perth teaching hospitals A&E Departments, St John Ambulance and other key stakeholders to provide a prevention, brief intervention and follow up service for non-fatal opiate overdoses.
98/99	OOPS (peer education service): To reduce the risk of overdose through the use of targeted peer education and health promotion strategies aimed at opiate drug users. To provide education, information and consultancy related to opiate use and opiate overdose to users, health care workers and community groups involved with opiate users using an outreach approach.
	ED: To develop in partnership with Perth teaching hospitals A&E Departments, St John Ambulance and other key stakeholders to provide prevention, brief intervention, referral and follow up service for non-fatal opiate overdoses. Concerned others, such as family, friends and staff of EDs will also be provided with education and information as appropriate.
99/00	OOPS: To provide education, information and consultancy related to opiate use and opiate overdose to users, health care workers and community groups involved with opiate users. Service includes peer education strategies through a 'tribes' network project, development and distribution of appropriate resource materials to drug users, education and training for workers responding to people using opiates, and education and training for peers, including resuscitation.
	ED: To provide peer support, brief intervention, education and referral for people who have been discharged from an ED following an accidental opiate overdose. Concerned others, such as family, friends and staff of EDs will also be provided with education and information as appropriate. Service includes peer based brief intervention, dissemination of resource materials aimed at the prevention of overdose and a volunteer program to train and support peers engaged in the brief intervention call outs.
00/01	OOPS (peer education project): To provide education, information and consultancy related to opiate use and opiate overdose to users, health care workers and community groups involved with opiate users. Service includes peer education strategies through a 'tribes' network project, development and distribution of appropriate resource materials to drug users, education and training for workers responding to people using opiates, and education and training for peers, including resuscitation.
	ED: To provide peer support, brief intervention, education and referral for people who have been discharged from an ED (Royal Perth, Sir Charles Gairdner and Fremantle Hospitals only) following an accidental opiate overdose. The service will be provided by staff and volunteers. Concerned others, such as family, friends and staff of EDs will also be provided with education and information as appropriate. Service includes peer based intervention at the ED, dissemination of resource materials aimed at the prevention of overdose and a volunteer program to train and support peers engaged in the brief intervention call outs, and follow up if negotiated at OOPS or in the community.
	BREATHE: Provide a community based brief intervention program to teach respiration skills to opiate users and staff of relevant community agencies. WASUA was contracted to provide some of the outputs.
01/02	Unchanged from 00/01
	Unchanged from 00/01

Table 1: Aims and objectives of OOPS from 1997/98 to 2001/02

The objectives and activities of OOPS have changed over time, as evidenced by the changes in the service specifications, as well as the results of the consultation process.

The following activities were identified for OOPS by the participants: the Volunteer Training Program; the ED Project; community development; agency liaison; peer support/education/outreach; BREATHE; education; resource development and distribution; expansion into other drugs; and research. The volunteers were seen as being involved in the following activities: ED Project; Volunteer Training Program; BREATHE; community development; and administrative duties.

There are some variations in people's understanding of the role, objectives, activities and target groups of OOPS. These all need to be clarified and advertised.

2. Determine the current and future capacity of the project to provide the service to the target groups identified.

The target groups as outlined by the service specifications for OOPS are set out in Table Two.

Year	Target Groups
97/98	Opiate drug users and other stakeholders.
98/99	Opiate users and people associated with them.
99/00	Opiate users and people associated with them. Health and welfare workers who work with potential or current opiate users.
00/01	OOPS: Opiate users, their networks, families and/or peers. Health and welfare workers who work with potential or current opiate users.
	BREATHE: individuals who use illicit opiates and other affected by that use.
01/02	As per 00/01

Table 2: Target Groups

Target groups that were identified in the Review were: drug users of varying descriptions (opiate users, injecting drug users, illicit drug users etc); agency and health workers; people who have contact with drug users; and the volunteers.

Perception of OOPS by the target groups as reported by participants was positive overall.

The capacity of the project to meet the needs of the target groups was determined to a certain extent through the Review., However, other measures need to be undertaken to further explore this issue, such as the replication of the user survey (Lollipop Survey) and the ED staff survey.

3. Identify the financial aspects of the project and assess the service in terms of value for money.

The financial reports of the OOPS project were reviewed. Table Three outlines the funding provided to the OOPS Project since 1997/98.

Year	Funding	
	OOPS	**ED Project**
97/98	$90,000	$60,000
98/99	$139,669 (including $120,000 treasury funds)	$163,884 (including $80,000 treasury funds)
	OOPS (all)	
99/00	$312,660	
00/01	$320,789 (plus $100,000 for BREATHE)	
01/02	$320,789	

Table 3: Funding for OOPS from 1997/98 to 2001/02

The future of funding for this program after 2001-02 is not certain and needs to be clarified.

It was found that the administrative costs of running the OOPS project from Next Step are high and it is recommended that more cost efficient ways of running the program should be considered if it is to continue.,

It is noted that similar projects in the Eastern States operate on budgets ranging from $70,000 to $120,000.

4. Identify key stakeholders and obtain an understanding of their attitudes to the service and their recommendations for the future of the service

Key stakeholders were identified and consulted with regard to their understanding of and attitudes to OOPS, as well as their recommendations for the future of the project. As noted earlier, there is a varied understanding of what OOPS does.

Overall, there was a positive attitude towards to project, from both staff and clients. There were, however, many comments made about the strained relationship between OOPS and the user group at times.

In terms of the future, the majority of participants supported the expansion of OOPS to include other drugs. As reported above, the service specifications for OOPS for 2001/02 already reflect this change. Improved liaison and linking was seen as necessary. Some felt that the location of OOPS needs a rethink. Some also felt that the VTP requires a rethink and perhaps a refocus. Improved marketing and data management were also seen as important, as well as the need for OOPS to be more involved in research in the overdose area.

5. Determine the role and activities of the Breathe project in relation to their enhancement or overlap with the OOPS project and make recommendations for the future of the Breathe project activities

BREATHE was piloted from July 2000 to June 2001 as a community based brief intervention program to teach respiration skills to opiate users and staff of relevant community agencies. WASUA was contracted to provide some of the outputs.

The target group for the BREATHE project were individuals who use illicit opiates and other affected by that use. The activities were: the training and support of OOPS volunteers and agency staff in BREATHE; peer based EAR training and support, which was carried out by WASUA; coordination and administration of the BREATHE project; and evaluation of the BREATHE project.

BREATHE was seen as a valuable service by many interviewed. Some participants expressed disappointment that the pilot had ended. There were recommendations from some that BREATHE be included in the core business of OOPS. In fact, training users about resuscitation has been part of the OOPS contract since 1999/2000, and the Breathe pilot was commenced to structure up this important function. The BREATHE pilot project was successful in this regard, with over 800 people being trained in EAR for 2000/2001 and EAR related activities and strategies in general being formally developed.

It is recommended that the training of agency workers in EAR should continue as part of OOPS core business and funding. A Train the Trainer model should be developed and implemented. Improved documentation of the training, assessment, evaluation and follow up is also required.

It is further recommended that peer based activities in this regard should be undertaken by a user group, via a reallocation of funds. . Greater collaboration between the two agencies should occur, including regular meetings, and joint reports.

6. To provide a report including recommendations for the future of the OOPS Project.

This report will be presented to the recently formed WA Drug and Alcohol Office for consideration.

Background

The Opiate Overdose Prevention Strategy (OOPS) project commenced in 1997 in response to heroin overdose issues. The project has utilised a range of strategies which have developed over time including resource development, the use of volunteers, peer based facilitation/education and professional education and training. In addition, OOPS was expanded in 2000 with a one year pilot project called 'Breathe', conducted in partnership with the WA Substance Users Association (WASUA). 'Breathe' was extended by the first three months of the 2001 financial year whilst this review was undertaken.

This review was commenced by the purchaser in the first half of the 2001 financial year, and was considered a timely process in view of recent and future developments including: outcomes from the Drug Summit; the current heroin 'drought' and increasing prevalence of other drug overdose; the anticipated reorganisation of drug and alcohol service purchasing in WA; and the outcomes of the HARC Review, in particular the proposed realignment of Alcohol and Other Drugs (AOD) under a broad population portfolio perspective.

The following objectives were identified for the Review:

1. Determine the role and activities of the OOPS project over the four years of operation.
2. Determine the current and future capacity of the project to provide the service to the target groups identified.
3. Identify the financial aspects of the project and assess the service in terms of value for money.
4. Identify key stakeholders and obtain an understanding of their attitudes to the service and their recommendations for the future of the service.
5. Determine the role and activities of the Breathe project in relation to their enhancement or overlap with the OOPS project and make recommendations for the future of the Breathe project activities.
6. To provide a report including recommendations for the future of the OOPS Project.

The following process was undertaken to complete the Review:

1. A benchmarking process including a review of the literature around overdose and peer education, and an investigation into similar programs throughout Australia.
2. Collection of background information pertaining to OOPS (service reports, previous reviews);
3. Initial consultation with the Director and Manager of OOPS;
4. Initial consultation with staff (via staff meeting);
5. Focus Groups with staff and volunteers;
6. Development of a standard survey developed from information gathered about the organisation and from the focus groups;
7. Individual interviews with OOPS staff;
8. Individual interviews and/or focus groups with other key stakeholders;
9. Data analysis;
10. Report;
11. Survey feedback to OOPS staff

Recommendations were also produced as a result of this process. The final report will be presented to the newly formed Drug and Alcohol Office of WA.

It was an intention of the Review to also survey the using community about their knowledge, awareness and attitudes to OOPS. However, a tight timeline meant that this could not occur, so it has become one of the recommendations.

Note

The report uses the terms “heroin overdose”, “opiate overdose” and “opioid overdose” interchangeably. This report recognises that a range of opioids are involved in overdose, including methadone and morphine. It also recognises that polydrug use plays a major role in overdose.

Literature Review

Introduction

This literature search was conducted as part of the review of the OOPS project. Current literature on the nature of heroin related overdoses and the risk factors for overdose was reviewed. The use of peer based education as a strategy to reduce the risk of heroin related overdose and problems associated with evaluating these strategies were examined. As well as examining the literature in these areas, sources such as OOPS staff and interstate overdose prevention projects were consulted for this review.

Defining the problem

Heroin related overdose

In 1998 the National Drug Strategy Household Survey found that 2% of Australians had reported using heroin at sometime in their lives. Overdose remains the major cause of death among heroin users in Australia and elsewhere, and there has been a steady increase in heroin related deaths over the last decade. In 1991 there were approximately 250 overdose deaths in Australia according to the Australian Illicit Drug Report. There were 600 overdose deaths in 1997 and 737 in 1998, a rise of 23% (McKetin et al, 1999). In 1999 there were 958 deaths attributable to opioid overdose among 15-44 year olds (Warner-Smith et al, 2000). It has been estimated that overdose deaths represent over 20,000 years of life lost, given the average age of overdose deaths is 30 years (Warner-Smith et al, 2000). Non-fatal overdose is also common among heroin users, with estimates ranging from 12,000 to 21,000 non-fatal overdoses in Australia every year. This can result in permanent morbidity, such as brain damage (Warner-Smith et al, 2000).

In Western Australia, there has also been an overall increase in the number of fatal overdoses. In 1988 there were 18 deaths attributed to opioid overdoses, which rose to a high of 81 in 1995, dropping to 73 in 1999. Since the December quarter 1998 (25 deaths) there has been an overall downward trend in the number of heroin related deaths in WA, decreasing by 68%, with 8 deaths in the September quarter 2001 (WADASO, 2001).

Recent press reports and verbal communications with AOD agencies have reported a heroin drought in WA. Causes for this drought have been attributed to problems at the source of supply and more recent trends to amphetamine use thus reducing demand for heroin. This drought is thought to be contributing to the decreasing numbers of fatal heroin overdoses.

Up to 60% of heroin users have experienced at least one overdose, and up to 70% have witnessed an overdose (Gossop et al, 1996; Darke & Ross, 1996: McGregor et al, 1998; Loxley & Davidson, 1998; Strang et al, 1999). There is a significant burden of morbidity associated with non-fatal overdose including pulmonary, cardiac, muscular and neurological complications (Warner-Smith et al, 2000). It is difficult to quantify the health care costs associated with treating heroin related overdose, however the cost of ambulance attendance at overdoses in Australia in 1998/99 has been estimated at $7.7million (Warner-Smith et al, 2000).

Risk factors in heroin overdose

Extensive work has been done around the risk factors associated with heroin related overdoses. The majority of overdose deaths occur at the home of the user, however those injecting in public places are also at risk. The following risk factors have been identified for opioid related overdose.

Injecting heroin alone. However, injecting with other people is not risk free. McGregor (1998) found that an ambulance was only called in a small number of fatal overdose cases, even though there were people around in two thirds of cases.

Delay in seeking medical assistance. Death rarely occurs immediately after an overdose, there is often time to intervene (Hall et al, 1999). Prompt and appropriate bystander intervention and the provision of basic life support before the arrival of an ambulance can reduce the death rate of opioid overdose.

Reluctance in calling an ambulance
Fear of police involvement (McGregor, 1998)
Fear that parents or welfare would be informed (Loxley & Davidson, 1998)
Cost of ambulance attendance

Refusal of transport to hospital after naloxone administration
Due to user perception and experience of negative treatment in hospital emergency departments

Duration of use. Older more experienced users have higher rates of overdose than younger, less experienced users

Relationship between mental health and drug overdose. Most overdoses are probably unintentional, but heroin dependent people and those who have had a non-fatal overdose are at increased risk of suicide (Darke & Ross, 2000)

Injecting is more dangerous than non-injecting routes of administration for overdose

There is a moderate correlation between heroin purity and overdose deaths

Polydrug use. There is a significant risk of overdose if other drugs are used as well as heroin, particularly the use of CNS depressants such as alcohol and benzodiazepines (Darke & Ross, 1999)

Loss of tolerance to opiods. For example, for those recently released from prison, or who have started to use again after detoxification, abstinence based treatment or naltrexone maintenance (McGregor, 1999; Darke & Ross, 1999; Featherstone, 2000). Spiegel (2000) hypothesized that Pavolovian conditioning contributes to tolerance, and proposed that users using in unfamiliar circumstances are more at risk. This phenomena has also been referred to by Hargreaves and Lenton (2001), and has been anecdotally reported by OOPS staff.

What constitutes a heroin overdose – Is the term a misnomer?

Darke and Zador's (1996) paper "*Fatal Heroin Overdose : A Review*" examines the literature on deaths attributed to heroin overdose and examines the characteristics and circumstances of such death. They challenge the belief that heroin-related fatalities are overdose related. Fatalities involving only heroin are a rarity, most involve other CNS depressants. Deaths attributed to heroin overdose are likely to have morphine levels no higher than in those who survive. The term overdose is misleading as it implies the same mechanism of death in all cases. The authors propose that the term "overdose" is counterproductive in developing strategies to reduce morbidity and mortality associated with heroin use. They propose that the term "multiple drug toxicity" is more accurate.

Peer based education

What is peer based education?

Peer education has been growing in popularity since the 1960's. Much of its appeal rests with the view that it is rooted in a naturally occurring process and peers learn from each other as part of their every day life.

The NSW Health Department (1994) defines peer education as "a set of specific education strategies devised and implemented by members of a subculture, community or group of people for their peers where the desired outcome is that peer support and the culture of the target group is utilised to effect and sustain change" .

AIVL (The Australian Intravenous League), the national users group, is producing a policy statement on peer education which will be released in early 2002. To date, AIVL have decided unanimously that Morgan and Sidden's (2000) definition of a peer will be the starting point for the policy statement.

Peer education as a strategy is employed where the target group is not easily reached by mainstream strategies, is disenfranchised through illegal or unacceptable behaviours, identification with the group is significant factor in behaviour change or group has rituals and cultural norms not known to the wider community (CEIDA, 1997).

Peer based education has gained popularity as it is seen as an effective strategy to overcome dissatisfaction with inappropriate existing services. Its popularity has been attributed to its efficacy in targeting marginalised groups and helping to empower these disenfranchised groups. Parkin & McKegney (2000), however, cynically attribute the growth in this approach to the fact that it is cheap, being almost entirely dependent on volunteers.

Approaches to peer based education

Peer education can best be viewed as an umbrella term covering a range of different approaches (Shiner, 1999). The term peer education tells us little about the aims and the objectives of the intervention, including what is believed to constitute the basis for peer affiliation and what the role of peer educators will be.

Factors that must be considered when determining the type of peer approach to be undertaken (Shiner, 1999):

There is no clear consensus of what constitutes a peer. What defines "peerness"? How this is defined will determine the type of program that is delivered.

Lack of clarity about the aims and the methods of the intervention. This often means that more than one approach is utilised within a single project with the resulting difficulty in distinguishing between effective and ineffective interventions.

How are peer educators are involved? Peer workers may be described as educators, trainers, facilitators or counsellors. Projects need to be explicit about how the workers will be used. Milburn (1995) noted the plethora of terms being used to describe the helper is the result of the absence of empirically tested, theoretical basis for the entire concept of peer education.

Who owns the project? The ownership of the project will define the desired outcomes and has the potential to create conflict between the funder and the workers. Ownership is rarely clearly articulated.

There needs to be a fit between location, approach and client group. Good practice involves careful consideration of how the approach fits the location and the needs of the target group and circumstances.

Distinction between "peer development" and "peer delivery". In peer development the personal development of the peer educators is the focus of the intervention. This ties in with empowerment. Peer delivery focuses on the delivery of formal sessions and there is little to indicate that there is any advantage to using a peer over a professional.

In keeping with this distinction between "peer delivery" and "peer development" approaches. Kinder (1994) divides peer education into three categories:

- Peer influence – focus is on modifying peer norms
- Peer teaching or counselling – "expert peers" teach information and skills

- Peer participation – peers are developed through involvement in the planning, decision making and implementation of the project.

Peer teaching, the most popular type of peer education, is limited in that it is not that different from using professional teachers and is heavily dependent on finding the "right people". It also establishes a hierarchy of power that may become unacceptable to the group and may not match existing relationships among peer networks. It is difficult to define a peer purely by a single behaviour, in this case intravenous use of heroin. Peers should be identified by shared knowledge, experience and behaviour. Peer teaching or counseling is a top down response. Simply replacing a clinical educator with an injecting drug user does not create peer education.

Peer participation and peer influence acknowledge the expertise that exist in the group and the networks that are available to disseminate information. The process of identifying needs, planning and implementation constitutes community development. This model conforms to two of the components of the Ottawa Charter for Health Promotion: 1. strengthening community action and 2. developing personal skill. Deitze & Rumbold (1999) state in this approach it is important to focus on health messages, leaving the group to develop their own responses to it.

Peer based education as a strategy for opiate overdose prevention

Peer based education dates back to the 19th Century when student helpers were recruited to assist teachers. The approach grew strongly with the use of gay peers to provide HIV/AIDS education in the US. The peer based approach was seen as suitable for drug users, who along with gay men, were seen to be part of a hard to reach, socially outcast minority (Gore, 1997).

"Every user has seen someone OD"

In their study of 115 patients in a London hospital, Strang et al (2000) found that almost 50% of respondents had had an overdose and 97.4% had witnessed an overdose. Almost all the witnesses had taken some action to help and said that they would try to help someone even if they didn't know them. Fear of punishment was not a deterrent to action. Most expressed an interest in expanding their skills in resuscitation techniques and in the use of naloxone.

141 subjects were interviewed within minutes of being treated for OD by ambulance officers (Darke & Zador, 1996). Thirty four per cent returned later for a more in depth interview. It was found that:
Most users were aware of the dangers of concomitant use of CNS depressants, but felt the added pleasure that was achievable by poly-drug use was worth the risk
63% did not worry about future OD and 75% did not think it was likely.
77% said that they would reduce their level of use or try to use more safely, but only 11% said that they would seek treatment

Trautmann's (1995) work in the European Peer Support Project has consistently found that older, more experienced users pass information to younger inexperienced users. Friedman et al (1995) working in New York found that the realisation of safer use could be traced back to the model of behaviour set by other users.

Friedman et al (1995) argue that behavioural change among IDUs is shaped less by individual characteristics and more by the norms and behaviours of their social networks.

What the research says: users and overdose

Often, users do not see themselves at risk, but do see other users as being at risk. Those experiencing overdose cite amount and purity as the perceived reason for overdosing. This is not supported by other findings. Few respondents acknowledge the concomitant use of other CNS depressants or alterations in tolerance as factors. Unfamiliarity with the place of use is rarely seen as a factor (Hargreaves & Lenton, 2001)

80% of IDUs indicate that they employ some form of prevention strategy to minimise their risk of overdose. Loxley & Davidson (1998) found that not using alone was commonly mentioned. This is supported by McGregor et al's (1998) findings. The avoidance of concomitant use of other drugs is adopted less often. Darke (1994) found that only 6% avoided concomitant use of alcohol and 5% avoided benzodazepines. McGregor et al (1998) found that 20% used with the door locked.

Studies show a low rate of seeking of medical assistance (Darke & Ross, 1996) Reluctance is based on the fear of police involvement. Loxley & Davidson (1998) found cost to be a factor. This does not correspond with McGregor's findings who found that cost was not a factor for any of the respondents. For younger users fear of parents finding out through the hospital was deterrent. Hospital staff attitudes were also a factor (Gore, 1997).

Strang et al (2000) states that the first priority of prevention is to reduce the frequency of overdoses. In particular there is a need to inform about the danger of mixing drugs. The second priority is to reduce the number of fatal overdoses by improving heroin user's responses to overdoses of their peers.

Hall and Darke (1998) advocate teaching peers how to do CPR and about the use of naloxone. They also discusses the need to address fears about calling an ambulance with drug users.

An important issue was raised in the report on VIVAIDs Heroin Overdose Prevention Project (1999) around the literacy levels of users. They found that many users who participated in their education program were unable to fill out the evaluation sheet, which raised questions for them as to how useful the many written resources on overdose would be to this population. They called for a need to diversify from using print resources only, to include different approaches and different forms of media talk to users about overdose.

What the users think

A meeting of Australian drug user groups in 1995 outlined the following elements of effective peer education (Burrows, 1995):

- The sharing of information within networks of users, respecting knowledge, skills and experience that users may already have.
- Place less emphasis on the correct way of doing things and more on the health message. Allows for groups to respond by developing their own strategies.
- Is based on an understanding of the cultural and situational aspects of injecting for each social and friendship network
- Provides information in a way that enables other users to pass on the information
- Shares power between drug users rather than a formal program that places peer educators in a position of authority.

Education programs and strategies need to be relevant to the context of street drug use situations and scenarios (Morgan, 2001). There is a need to target strategies carefully (Hall & Darke, 1998).

Summary of peer education

Peer education is seen as the best way of achieving the following aims (Deitze & Rumbold, 1999):

- To increase the knowledge and skills of IDUs in the management of OD eg resuscitation and first aid techniques
- Increase knowledge about risk factors associated with OD and harm minimisation techniques
- Improve knowledge among IDUs on ambulance and police policy in relation to attendance to ODs
- Develop resources that can be used in future peer education and training workshops
- Disseminate harm reduction information through networks within the target group.
- Increase knowledge of and responses to OD

- Explode OD related myths.
- Identify social and contextual factors that increase the risk of overdose

Evaluation of the effectiveness of peer based interventions

Peer education has become an increasingly popular way of carrying out health promotion work with young people and other marginalized groups such as drug users but evaluations of its effectiveness remain largely unpublished. Research has failed to keep up with the growing popularity of peer based education and there is a consequent lack of empirically based work on which future policy and practice can draw (Beckett-Milburn & Wilson, 2000).

Evaluations that are available are quantitative in nature. Qualitative methods are rarely reported (Beckett-Milburn & Wilson, 2000). The quantitative research tends to focus on short term impacts and are unable to evaluate process. Peer education can involve a wide range of factors that are difficult to capture in a survey.

Some success with use of peers in adolescent smoking and reading programs has been shown. This is attributed to the influence of peers among adolescents.

In drug education programs, those involving an interactive approach with peers, were shown to result in an increased level of knowledge uptake compared to non-interactive approaches. Knowledge uptake was specific to how the group saw the relevance of the information to themselves.

Hunter et al (1997) reported on a community based peer intervention where peers were used to disseminate information pamphlets. This study showed that knowledge of drug information was increased, but drug using behaviours were not affected. There is no clear evidence that peer intervention was more effective than other drug education and prevention strategies.

Posavac et al's (1999) meta-analysis of peer based interventions examined the effects of 47 peer-based health education programs described in 36 studies published between 1978 and 1997. The overall effect size was small. The authors suggest that the costs of innovative programs should be considered to ascertain whether the results are worth the costs.

In Australia there is very little published literature that reports on the evaluation of peer based interventions targeting heroin users. Some of the projects that have been initiated have produced operational reports. Any evaluation that has been conducted has been limited to surveys measuring participant satisfaction. Process evaluation was not undertaken with any of these projects.

A thorough evaluation of a peer based intervention targeting heroin users was undertaken by the Drug and Alcohol Services Council in South Australia in 1999, in conjunction with the user group, SAVIVE. Major aims of the project were to decrease the concomitant use of CNS depressants and to encourage users to call an ambulance. The intervention included the production and dissemination of information materials, peer education training and the establishment of partnerships with police and ambulance services.

Pre- and post-intervention surveys were administered. Post-intervention surveys showed an increased awareness of risk factors associated with OD, including the concomitant use of CNS depressants. More users reported calling an ambulance and indicated less fear of police involvement. The study showed that heroin users will respond to appropriate targeted health education messages developed in conjunction with the user community and implemented using an intersectoral approach (McGregor et al, 1999).

While it may be possible to calculate incidence of heroin overdose, it is virtually impossible to accurately calculate prevalence, or changes in this over time. It is also difficult to determine causal factors, such as the impact of policing, changes to policy regarding pharmaceutical products, changes

in street heroin availability or quality, all have impact on overdose numbers. In this way, any evaluation of peer based interventions to reduce overdose will be difficult.

Overview of other programs operating in Australia

A review was undertaken of the various overdose related intervention projects throughout Australia. This information was gathered from reports of these projects, as well as via telephone and email communication.

Nine heroin related overdose projects were identified in Australia (there may well be other projects in existence which were not discovered, due to the time constraints on the review). A description of each project, including the agency it is located in, the timeframe, the target group and, where available, the funding, follows.

Pilot Heroin Overdose Peer Education Project (CEIDA, NSW; 1997-current; targets IDUs at risk of overdose; funding; $70,000).
This project aims to: reduce overdose frequency through behavioural change; increase the number of IDUs using harm minimisation techniques to manage ODs and; evaluate the effectiveness of peer education as a strategy. The model used was to resource existing networks of users, not to train expert peer educators, as these were considered limited by changes in information and their circumstances. The project was implemented at four sites in Sydney over three stages: a research survey; action research and intervention development and; evaluation and resource dissemination. The resources that were produced were two posters, two story booklets and one sticker for fitpacks.

Opiate Overdose Prevention Project (CEIDA, NSW; 1998; targets methadone clients who are polydrug users; funding: not available)
Aim: To reduce risk of overdose among methadone clients who were poly drug users. A project officer worked collaboratively with local agencies to develop responses that suited local needs. Health promotion training workshops were a key element of this strategy. A "Z card" resource was developed.

Direct Response to Overdose Program (DROP) (Turning Point, VIC; to 2000; targets users who have recently overdosed; funding: $75,000 to fund 1.0FTE)
Aim: To improve client health and welfare through the provision of overdose-specific information, support, advocacy and referral. DROP has been incorporated into the Collaboration, Care and Innovation Program (CCI) at Turning Point which is an outreach community development project that works collaboratively with Police to assist users at the point of arrest. DROP works at the site of OD either on the street or in the hospital. They provide brief intervention, ongoing case management, and agency education and development work within the hospital. Two thirds of cases are seen in follow-up. Three staff are trained to respond to police or DROP calls. Primarily DROP is responsible for education and development. More recently, DROP has assumed an assertive outreach model, with the aim of engaging chaotic, hard to reach users in treatment. The team works closely with the home detox team at Turning Point (funding: $80,000; timeframe: current).

Project DOV (Drug Visitation Project) (collaborative project between Queensland Ambulance Service (QAS) and Teen Challenge; six month pilot 2000/2001; targets users and significant others; funding: cost neutral)
DOV is part of the *Drugs "We can Help" Project.* Aim: To provide counselling, information and referral to people who have overdosed, and their friends and families. Follow up support is provided by a Teen Challenge counsellor within 48 hours of an overdose attended by QAS. During the trial 30 people were offered follow up. Nine requested home visits. There was good feedback from significant others and ambulance services. The project will be extended.

Heroin Overdose Prevention Project (VIVAIDS, VIC; six month pilot 1999; targets IDUs; funding: not available)

Aim: To increase the knowledge among IDUs of the risk factors, prevention and management of overdose. The project included: a needs assessment through focus groups; user information gathered at focus groups was used to develop workshop and manual content; 30 workshops were held to increase user knowledge; a manual was developed to be used in workshop and for use in further peer training. The project was evaluated using pre- and post workshop surveys to assess increase in knowledge and skills. Attendees were paid $50 in recognition of the knowledge they bring to the workshops.

This Project has been funded for one year as a result of the pilot described above. (2001; $89,000). This project consists of three parts.
Part 1: Aim – to adapt the manual developed in the pilot to meet the needs of users who have experienced environmental abstinence (such as people leaving detoxification programs and prison). Peer based workshops will be used to develop the manual. Plan to deliver 15 workshops including Asians and Kooris.
Part 2: Aim - to provide information for users who do not access drug treatment services and are not reliant on government benefits. This project is an adaptation of the OOPS/Breathe project. The project will employ a snowball technique to disseminate information. Ten peers will work together to design a 15 minute education package that can be used in any environment. Education will focus on EAR and overdose response. Each peer will then teach 10 friends.
Part 3: Aim - to reduce the risk of overdose in users who use alone through reducing risk taking behaviours rather than reducing use. This will involve ten x two day intensive workshops.

Heroin Overdose Project (collaborative project between SAVIVE and DASC, SA; 1997; target: IDUs; funding: $120,000)
Aim: to reduce the concomitant use of CNS depressants and to increase the amount of users calling ambulances for overdose. This pilot project was a partnership including DASC, the user group, police and ambulance. There were three strands to the project: resource development; peer educator training and; partnerships to develop supportive policies. The project involved pre and post intervention evaluation and produced a number of resources including postcards. This project produced the report "Don't slow it alone", plus various journal articles (McGregor et al, 1998; McGregor et al, 1999).

Tribes Project (NUAA, NSW; 1992-ongoing; target: IDUs; funding: unavailable)
This community development program supports sub-cultural groups of drug users in the development and implementation of their own peer education/health promotion projects. Projects have included Indo-Chinese and Koori sub- groups. 8-12 projects are funded annually. 45 projects have been run to date.

First Step Project (Illawarra Area Health Service, NSW; 2001; funding: unavailable)
This project is a peer inspired intervention for the management and prevention of heroin overdose. The project is part of a Masters thesis. A brief intervention booklet on first aid was produced as a resource. Pre and post intervention evaluation is planned.

Community Drug Summit Recommendations

The Community Drug Summit was held from 13-17 August 2001 at Parliament House, WA. The recommendations from the Summit will be used to inform ongoing drug strategy in this state, and may have implications for OOPS in the future, particularly those from the section "Reducing the harm to individuals and the community caused by continued illicit drug use". For example, Recommendation 41 recommends that:

Local communities, local governments and non-government organisations should be resourced, encouraged and funded by governments to develop locally appropriate responses to hazards arising out of illicit drug use, including resourcing peer education, which targets harms arising from the use of a variety of illicit drugs and provides information on treatment options and referral opportunities.

Recommendation 42 recommends that:

Law reform be undertaken which will enable the undertaking of a trial for the provision of naloxone hydrochloride (Narcan) to peers by significant others. Participants in this trial should be given peer based resuscitation training, overdose prevention, Narcan administration training as well as ambulance and hospital protocol training.

In a study into the feasibility of a trial of the provision of naloxone to heroin users for the prevention of fatal heroin related overdoses in WA (Hargreaves & Lenton, 2001), the following issues were amongst those raised for consideration:

- Polydrug use (although the use of other CNS depressants such as alcohol and benzodiazepines is common in overdoses involving heroin, it is believed that the removal of the opioid contribution to the respiratory depression of an overdose by naloxone administration will, in most cases, prevent the overdose becoming a fatality);
- Naloxone as only one component of First Aid Management (important to ensure the ability to administer EAR);
- The impact of peer administered naloxone on heroin use (the outcome of people using heroin in a hazardous way as a result of naloxone being available for peer administration was thought to be unlikely);
- Undermining other overdose strategies (Some believe that the provision of naloxone may result in many of these overdose prevention and management messages being ignored or discarded as the perception may be that the threat from fatal overdose is reduced);
- Ethical and medico-legal issues (naloxone is currently a Schedule 4 drug, available only by prescription);
- Morbidity (One of the arguments in favour of the more widespread distribution of naloxone is that it will help reduce both the morbidity and mortality associated with overdose as it allows for earlier intervention and consequently a more rapid recovery. However, it is possible that there may be an increase in morbidity if naloxone is made more widely available and is either not appropriately administered, or results in other First Aid strategies, such as providing breathing support, not being implemented); and
- Rapid detoxification (a large amount of Narcan would be needed for this to occur).

However, overall the authors believe there is a good case for a carefully monitored trial and evaluation of a restricted distribution of naloxone for peer administration as part of a comprehensive overdose prevention and management education intervention.

Focus groups held with over 200 users in NSW (Gore, 1997) revealed that many users don't like Narcan and would rather they didn't have to use it at all, but wanted the choice of being able to access it. Access would need to include simple and clear educational messages relating to how and why Narcan works, that it wears off in a short period of time and that it blocks the effects of heroin, rather than destroying the drug.

The Naloxone Feasibility Study report (Hargreaves & Lenton, 2001) was received by the Health Department of WA in July 1999 recommending that a limited trial on increased naloxone availability take place.

The Health Department of WA subsequently convened two advisory groups; one comprising Departmental representation responsible for naloxone registration and legal services representation, and the second enabling expert clinical advice on the safety of naloxone provision. The Expert Clinical Advisory Group was unanimous in its opposition to increased availability of naloxone, on clinical, methodological and practical grounds (HDWA, 1999).

However, the Government in its response to the Drug Summit indicated that new research had come to light that warranted reinvestigation of the trial, and that WA would proceed to establish an expert

Advisory Group to consider WA's participation in a multi-centre trial, if the support of other States is forthcoming.

It is considered that components of the OOPs would support the conduct of a trial should this ultimately occur, and therefore that the OOPs project should be directed to facilitate the trial. It is acknowledged that a trial would require additional resources beyond the scope of OOPs, but that OOPs should fulfil at least part of the WA contribution to a trial through alignment of existing strategies and resources.

National Action Plan on Illicit Drugs 2001-2002/03

The National Action Plan on Illicit Drugs 2001-2002/03 states, under the section on Reducing Drug Related Harms, that reducing drug overdose mortality is a major goal of the Action Plan. This issue is addressed in detail in the National Heroin Overdose Strategy, which was developed under the auspices of the Ministerial Council on Drug Strategy.

National Heroin Overdose Strategy

The National Heroin Overdose Strategy (NHOS) released in July 2001 recognizes that overdose and it's associated consequences are preventable. Strategies that have been developed to prevent overdose and/or improve the management of overdose include peer education, support and follow up programs, increased access to treatment, increased collaboration between law enforcement and health workers, changes in ambulance and police protocols for dealing with overdose situations and intervention programs in hospital emergency departments (OOPS ED). The Strategy emphasises the importance of evaluating these strategies in order to gain evidence of their effectiveness in preventing overdose and/or reducing morbidity. It raises the importance of engaging drug users in the development of strategies as a way of enhancing uptake and effectiveness. It also recognizes that overdose is a complex problem with multiple risk factors that requires a range of coordinated, complementary intervention strategies, which can only be achieved through a partnership approach.

The NHOS outlines two key strategy areas:

- Preventing heroin related overdose
- Improving the management of overdose

The following key action areas and examples of strategies outlined in the NHOS are relevant to this review of the OOPS Program.

Preventing Heroin Related Overdose

What is to be achieved	Key Action Areas	Examples of Strategies
Reduction in the incidence of fatal and non-fatal heroin OD	Increase the number of drug users entering and remaining in treatment	* Expand the provision of drug treatment in prisons. * Ensure prison treatment services are linked with drug treatment services in the community. * Provide priority access to drug treatment programs for individuals being released from prison
	Assist drug users to reduce their risk of OD and increase awareness regarding the consequences of OD	* Provide information to opioid users through a range of means, including peer education, regarding factors that contribute to OD or death from OD and the potential consequences of OD. Such information should address: Factors such as poly drug use, using alone, using following a period of abstinence and Possible consequences of non-fatal OD, including the risk of long term disability resulting from, for example, neurological or muscular complications * Provide education to families and friends of opioid users, needle and syringe program workers, health workers, police and other who come into contact with opioid users, regarding factors which increase or reduce the risk of OD. Education materials need to be appropriately disseminated using a range of mediums and produced in commonly spoken languages. * Engage drug users, drug user organizations and families and friends in the development of education programs to ensure that they adequately reflect target group needs. * Develop pre-release and post-release education, information and support programs for prisoners and individuals completing detoxification programs. * Disseminate to opioid users and their families and friends, information on the increased risk of OD where opioids are consumed following the use of naltrexone
	Improve the evidence base to inform strategies and programs to reduce OD	Undertake research into key areas such as: An exploration of the relative impact of particular behaviours on the occurrence of OD through systematic research into circumstances surrounding non-fatal and fatal OD
	Increase the timeliness and reliability of data in respect to OD	* The relationship between local street heroin markets, purchasing decisions, consumption and OD * The impact of periods of abstinence on risk of OD, including the impact of naltrexone treatment * Barriers to seeking medical assistance when OD occurs * Implement or maintain data collections from ambulance services, police services and hospital emergency departments

Improving the Management of Overdose

What is to be achieved	Key Action Areas	Examples of Strategies
Reduction in OD related morbidity and mortality	Increase the confidence of drug users, family and friends in respect to identifying and managing OD	* Widely disseminate information to opioid users, family and friends on the signs and symptoms of OD and actions to take should an OD occur. Such information should: Clearly articulate the signs and symptoms of OD, including the significance of snoring and noisy breathing in those who are asleep Address barriers to bystanders seeking medical assistance, including clarifying the circumstances under which ambulance services may call on police to attend drug ODs Emphasis the importance of basic life support while waiting for medical assistance; and Articulate the need for longer term supervision post-recovery, as there is a risk of a second OD where long acting opioids, such as methadone, have been consumed or where other drugs, such as alcohol and benzodiazepines, are involved. Encourage opioid users, family (including children of users), friends and the wider community to undertake training in basic life support that would assist in an OD situation, such as maintaining an airway, expired air resuscitation etc. Such training could be provided through existing treatment services, such as methadone maintenance and needle and syringe programs.
	Increase the confidence of opioid users, family and friends in contacting emergency services in the event of an OD	* Development of protocols between police and ambulance services clarifying the circumstances under which ambulance services may call on police to attend an OD * Development of clinical protocols, supported by training which addresses attitudes, knowledge and skills, for accident and emergency workers in respect to managing OD. * Development of local level partnerships between police, paramedics, accident and emergency staff and specialist drug treatment services which encourage provision of information, referral and follow up of opioid users who experience on OD
	Development of evidence base to inform improved management of OD	* Consider conducting carefully evaluated trials of peer administered naltrexone * Develop, implement and evaluate follow up support programs for those who experience an OD, or others that may be affected by witnessing an OD

The Strategy also outlines a number of monitoring and performance measures which will be used to assess the effectiveness of efforts to reduce overdose in Australia. These measures will be based on analysis of existing data sets and consistent with measures identified in other related strategies such as the National Action Plan on Illicit Drugs.

Performance Measure	Data Source	Frequency of Data Collection
Number of fatal ODs	**Australian Bureau of Statistics National Coroners' Information System (Illicit Drug Module)**	**Annually**
Trends in self-reported OD	**Illicit Drug Reporting System (IDRS)**	**Annually**
Trends in ambulance call outs to OD	**Ambulance Services**	**Annually**

Reporting on achievements in respect to the Strategy will form part of the annual report to the Ministerial Council on Drug Strategy regarding progress under the National Drug Strategic Framework.

Conclusion

Heroin overdose clearly costs the community in terms of lives and resources. Peer based programs have become a popular strategy to help reduce the risks of heroin related overdose. Evaluation of peer based education to reduce the risk of overdose is very limited and evaluation results available on other peer based projects fail to show improved outcome for peer based over other strategies.

It is important to understand how peer based projects fit with the overall strategies of the agency they are part of or they run the risk of being seen as being peripheral to the aims of the agency. To improve on the planning and delivery of peer based projects there is a need to (Parkin & McKegney, 2000):

- Clarify the aims of peer education projects
- Formulate ways to evaluate them
- Distinguish between those that give information and those that aim to change behaviour
- Distinguish between those that aim to change community norms and those that are targeting the individual.

The cost of peer based intervention also needs to be taken into consideration. The question needs to be asked: Are the results of innovative programs worth the cost?

Peer based education should only be seen as one strategy aimed at reducing the risk of heroin related overdose. A broad based collaborative approach that also addresses legislative and policy issues is required, along with:

- promotion of healthy public policy
- working cooperatively with police and ambulance services to create policies that facilitate people to seek medical help.
- education in hospital to address the attitudes of health professionals towards drug users.

History of OOPS

The OOPS! project was funded by a special Treasury Allocation until 2001/2002 under the 'Cabinet Anti Drug Initiatives' (CADI) received by Health. In 2001/2, the Mental Health Division continued to fund the project (but not other elements of CADI) from core budget. Funding availability beyond this current financial year is therefore unclear.OOPS!

OOPS! consists of two distinct but overlapping projects - the peer education service (also called OOPs) and the Emergency Department Project (ED Project). The OOPS! Project is managed and operated by Next Step (previously WAADA) through the Directorate of Clinical Education, Training and Research.

The OOPS! project is currently managed by a Coordinator (1.0FTE), who reports to the Manager of Information Services, who reports to the Director of Clinical Education, Training and Research. There are also three community development officers: a Volunteer Coordinator (1.0FTE); an ED Project Coordinator (0.6FTE); and a Peer Facilitation Project Officer (0.8FTE).

The OOPS! Project has evolved over time. This section outlines the growth and development of OOPS! in it's various phases.

The beginning

OOPS! was initiated in WA as part of a national response to the growing problem of heroin overdoses. The original objectives outlined in the Cabinet Anti-Drug Submission were:

"The Opiate Overdose Project involves former heroin users working with current users to reduce the risk of overdose, encourage calling an ambulance to any overdose and use of simple resuscitation methods. The pilot phase for the project was launched by the Minister for health some months ago and it's progress has been encouraging. The project should continue."

This statement described the three month pilot for OOPS, and it's continued peer education focus.

"The St John Ambulance is currently being called to between 5-10 overdoses per day. Patients are transported but there is no follow up once they are released and the opportunity for drug education and counselling is lost. A program of follow up home visits for heroin overdose by a nurse practitioner is proposed"

This statement refers to the ED component of the OOPS project. The current Coordinator of OOPS was originally asked to take up the position of nurse practitioner to follow up patients outside of hospital. After discussions with stakeholders, it was decided this model was not workable for various reasons, including issues around confidentiality and safety, which resulted in the strategy of seeing clients in hospital Emergency Departments (ED) after an overdose was developed.

The OOPS! project began as a pilot with a time frame of three months, from June to August 1997. During the initial three months, the project targeted users, non-users who might be at risk of overdose and a diversity of service providers. The outreach workers were to meet with users on a one-on-one basis, provide workshops for service providers and establish a drop-in centre for users. Users were accessed through the Needle Exchange Van, and through already existing contacts. The project fostered collaboration with St John Ambulance Association and the WA Police Service. The information was also disseminated through regional Alcohol and Drug Authority centres (now Next Step Specialist Drug and Alcohol Services) and through local retail and media sources. This pilot phase of the project was reviewed by Corry and Penna (1997).

In an endeavour to reduce the number of fatal overdoses nationally, selected key workers from IDU groups and relevant government drug and alcohol agencies across Australia were invited to the

National Forum on Strategy Development for Heroin Overdose in February 1997. As a result of this forum, Commonwealth funding was provided for the national distribution of harm minimisation materials. These materials were from a South Australian overdose intervention research projectwhich developed resources in association with heroin using groups (McGregor, 1999). They aimed to provide the heroin using community with information about overdose management and to increase the knowledge and skills of heroin users in dealing with overdose situations.

At the time this initiative was implemented nationally, WA was the only state/territory within Australia which did not have a funded IDU users' group, so established user networks were not readily accessible. A unique approach was required.

The WA Health Department provided initial funding for the wages of one full time equivalent outreach worker for a three month period in June 1997. The WAADA employed two part time peer education outreach workers with this funding. One, recommended by the (at that stage unfunded) WA Substance Users Association (WASUA), had extensive peer outreach experience and the other had links with the alternative music culture in Perth. The OOPS Project was established in June 1997. Given the limited budget for this initiative there were no funds available for formal evaluation of the project.

Until June 1997, there had been no policy changes in line with the National Strategy on Heroin Overdose recommendations in many organisations (e.g. Police and Ambulance services) in WA. However, it was becoming less common for police to attend overdose scenes unless there was a fatality, or unless requested by ambulance service personnel. At the commencement of OOPS, naloxone (Narcan), used widely by ambulance services throughout the country to manage overdose, was not available in ambulances in WA.

Much of the existing literature on the effective use of strategies or public health messages which target drug using populations emphasise the need for peer involvement. Friedman (1993) points out that while providing information may raise awareness, it will not necessarily be sufficient in reducing risk behaviours. The OOPS Project aimed to:

- Increase the knowledge and skills of IDUs in dealing with overdose situations (through the use of the resources mentioned above)
- Establish networks and close collaboration in addressing heroin overdose issues between user groups and key stakeholders including police, ambulance services, drug and alcohol agencies and other relevant groups
- Inform service providers of the needs of IDUs in relation to heroin overdose
- Inform the community about the issues associated with heroin overdose from a harm minimisation perspective

For the OOPS Project to be successful in achieving these aims in a limited time frame and with limited funds, a number of approaches were adopted. These included a combination of social marketing, community education, community development, peer education and outreach.

Social marketing involves the application of basic marketing principles to promote social behaviour. This strategy primarily provides information and adds issues to community discourse. It has been used in many traditional health education campaigns, using a range of educational materials, such as those available to the OOPS project and has also been seen as a useful strategy in targeting subsets of the community

Community education covers strategies that use community based events and situations to promote health enhancing messages as part of the social environment. This can occur through organising special events which incorporate information dissemination, or when the event is promoted using a health education message.

Community development involved liaison with community organisations and groups so the community itself takes responsibility for the desired health enhancing message. This approach may involve education and training and providing support for community organisations and networks

Peer education and outreach strategies traditionally use peers of a target group not only to disseminate information, but to develop the personal skills of the target group enabling them to respond and maintain that response, to health enhancing messages

The priority for the OOPS project in those first three months was to distribute all of the resources (9000 postcards, 1200 posters, 300 fridge magnets and 1000 booklets) and conduct ten workshops. Evaluation of the project's effectiveness was not seen as a priority. It would be very difficult to determine causal factors if any change were observed in overdose frequencies. Many other events occurred concurrently with the OOPS Project's initial three months, such as the impact of changes in Narcan policy, changes in policing, simultaneous education strategies, media coverage of overdose events, changes in the availability and quality of street heroin, all of which may influence numbers (Gore, 1997).

OOPS collaborated with St John Ambulance to produce a five minute video depicting an overdose situation, covering expired air resuscitation and how and when to contact emergency services, employing WASUA members as actors and advisors to the video. Sixty videos were produced and distributed to key service providers.

The Ministerial launch of the OOPS! Project was held at St John Ambulance Headquarters six weeks after the project commenced (July 1997). A music launch event was also held in July 1997 in an endeavour to achieve maximum involvement of young people. The launch, attended by more than 200 people, was held in association with WASUA and included local bands and performers.

For the last six weeks of the pilot project a drop in centre was run to provide an opportunity for those attending to discuss overdose issues at locations known to be frequented by people who use heroin. It was felt that this type of activity would be most appropriately located on the premises of WASUA when they became available.

Workshops were held for more than 50 service providers and their clients, including alternative youth educational institutions, hotel staff, alcohol and other drug agencies, youth agencies, health providers and universities. The resources were made available to as many service providers and agencies as possible. They were distributed through the southwest region through the Pharmacy Guild, and placed in select entertainment venues and music outlets in the inner city, Northbridge, Leederville and Fremantle areas.

Contact was made with users through Needle and Syringe Exchange vans and existing networks using snowball techniques, with the peer educators using the resources as a focal point for discussion on overdose prevention and management.

A total of 107 questionnaires were completed during this pilot phase, however this was considered a small proportion of the number of people who were exposed to the information, which was conservatively estimated at approximately 500. The questions were designed to obtain pattern of use information and to access the knowledge and beliefs of both heroin users and non-users about overdose. Sixty six percent of respondents had injected heroin, and at least half of these were generally aware of the signs of overdose and what action to take during an overdose situation. Over half of those that had been present at an overdose had contacted an ambulance, and most were aware that combining drugs, especially CNS depressants, may lead to overdose.

Corry and Penna (1997) concluded that although it would be difficult to determine the true impact of the OOPS! Project in relation to a decrease in heroin overdoses, the importance of projects similar to it could not be underestimated. The OOPS! Project was successful in establishing networks in a

community with minimal existing networks, and also effectively disseminated overdose and prevention management information to a broad range of groups.

The authors found that although it was difficult to determine whether the OOPS! Pilot Project had any impact on the number of heroin overdoses in WA, it was evident that the project had acted as a catalyst for changes in the approach of organisations in dealing with overdose issues. Achievements included changes to St John Ambulance Narcan policy and an amendment of the police guidelines in dealing with overdose situations. Several recommendations were made by the authors, some of which have been met (see Summary).

That greater collaboration and commonality of purpose be encouraged between key groups and organisations that are stakeholders in reducing drug related harm in the community

That appropriate non-identifying information on overdose situations in WA be collated, made available to the OOPS Project and used to target credible education initiatives effectively

That close liaison with the WA Substance Users Association (WASUA) continues to be a priority in assisting the OOPS Project in identifying current patterns and trends of heroin use. The authors noted that the present funding structure tends to foster competition between agencies and does not facilitate the close collaboration required, therefore limiting the effectiveness of any strategy

A variety of sub-projects be implemented which provide culturally appropriate resources for specific target groups both within and outside the metropolitan area, and that each project be developed in conjunction with the target group.

That strategies be developed to encourage users to adopt safer behaviours in relation to polydrug use

That overdose stories be documented, produced and distributed in a variety of media to provide more realistic information for users about the circumstances of overdose. This project would validate overdose experiences for users and provide an invaluable tool for peers. It would allow misinformation to be corrected, acknowledge the experience of those faced with overdose situations and provide an opportunity for people to discuss and deal with grief, loss and guilt issues. It would also provide a tool for raising community awareness about the issues associated with overdose situations.

The Emergency Department (ED) Project

In November 1997 the WAADA received funding through CADI to design and implement the Opiate Overdose Prevention Strategy Emergency Department Project (OOPS ED Project). The ED Project is an intervention project targeted at IDUs who have just experienced an accidental overdose. The core aims were to:

- Reduce the frequency of repeat overdose in WA 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 sought to:

- Increase the 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 other; and

- Assess the feasibility of peer-based community follow-up and home visits post-discharge from hospital

The expected outcome was the reduction of the incidence of both non-fatal and fatal opiate overdose in WA. The two major strategies employed to achieve this were the facilitation of the capacity of illicit opiate users to prevent overdose in the first instance, and the reduction of known barriers to the utilisation of 000 services where overdoses do occur.

Previous research guided the direction of the ED Project within OOPS, in particular Loxely and Davidson's (1998) report on their investigation into opiate overdose and young injectors. Seventeen of the twenty one recommendations made in this report were considered to be within the OOPS remit.

The ED project was developed using an action research model. Davidson (1999) documented the process of developing this model in his review of the ED Project to December 1998.

An evaluation component was built into the structure of the project, resulting in Davidson's report (1999), and further funding was sought at the time from the NH&MRC to provide an extensive two year in depth evaluation of the long term impacts of the ED project. This funding proposal was unsuccessful.

The pre-existing OOPS peer education project had had positive results in increasing opiate user knowledge about the causes of overdose through the provision of targeted and appropriate information via peer delivery. However, while some opiate users are quite 'visible' in that they are regularly in contact with agencies, others have little or no contact with any such sources of information, as Lenton & Tan-Quigley's (1997) fitpack study revealed, with 49% of the sample of 511 having no prior contact with any drug treatment agency including GPs.

In planning sessions conducted by OOPS into ways of reaching these 'hidden' opiate users, it was found that in WA, 80% of opiate overdoses attended by St Johns Ambulance were transferred to a hospital emergency department. These transported overdose events were therefore identified as representing a unique opportunity to provide targeted interventions to IDUs who may have little or no contact with support and treatment services.

Davidson (1999) reports that the project appears to be a world first in bringing together primary health care and peer-based education models, as a literature review revealed that there have been few documented attempts at making use of hospital emergency department presentations by IDUs as an initial point of contact for intervention programs. The two instances found in the literature, both from the US, were aimed at abstinence based treatment, and neither program made use of peers in either project design or delivery. Moore (1993) argues that involving users in such projects results in the harnessing of "pre-existing social mechanisms and cultural practices for limiting harm".

It was recognised that in the absence of pre-existing operational models the ED Project required an ongoing research component to provide structure and ongoing feedback. A research officer with a background in opiate overdose issues was appointed in April 1998. The specific research model adopted for the project was an action research model. Action research is used in situations were there is felt a need for change in a given situation but where the exact nature of the changes needed are unclear. It 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 and places an emphasis on the involvement of all those affected by the impacts of the processes of change in designing and shaping a project. This model was seen to appropriate for the ED Project as it encompassed three of it's 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.

The OOPS project provided a body of expertise for the ED Project in providing peer-based information and support. The project was praised by the Select Committee into the Misuse of Drugs Act 1981, which recommended "increased funding for the OOPS Project" in it's final report in August 1998. It was 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 an inappropriate use of staff. To combine the benefits of the OOPS Project's pre-existing skill base and the "pre-existing social mechanisms and cultural practise for limiting harm" present in the wider opiate using community, it was suggested that the 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 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.

The core objective of the ED Project, as outlined in the strategic plan developed in conjunction with the funding process 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 ED Project is the responsibility of the Coordinator of OOPS, but is managed on a day-to-day basis by an ED Project Officer in collaboration with an ED Working Group.

Reference groups are an important part of any cross sector project, providing an opportunity for representatives from key organisations affected by the activities of a project to provide input and receive updates on activities. The OOPS project effectively has three reference groups: the Opiate Overdose Strategy Group (OOSG); the OOPS project reference group; and the ED Project Operational Stakeholder Group/Working Group.

OOSG is a policy level strategy group coordinated by the WA Drug Abuse Strategy Office (WADASO), and first met in September 1997. It's membership consists of representatives from WADASO, Next Step, the Department of Health, the National Drug Research Institute (previously NCRPDA), WASUA, Sir Charles Gairdner Hospital (SCGH), the WA Network of Alcohol and other Drug Agencies (WANADA), the WA Police Service, the Pharmacy Guild of Australia (WA), St John Ambulance and the Australian Medical Association . OOSG initially met every month and now meets every 6-8 weeks. It allows the OOPS Project to be allocated specific responsibilities within the broader ambit of WA measures to reduce opiate overdose, and to report on progress which may impact on other aspects of such measures.

The OOPS project reference group provided feedback and advice for the entire OOPS project. It's membership consisted of representatives from WADASO, WASUA, NDRI, staff of the OOPS project and the Director of Clinical Education and Training. At various points, representatives from St John Ambulance, SCGH and Royal Perth Hospital (RPH) also attended. The reference group met approximately every three months, then was subsumed into the OOSG when it began in September 1997.

The Ed Operational Stakeholder Group was formed in September 1998 in response to an action research cycle which identified weaknesses in the ED Project's capacity to access and address input from a number of its identified stakeholders. The 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. It initially met every six weeks, it currently meets every 6-8 weeks. The group consists of representatives from the emergency department nursing staffs of SCGH, RPH and Fremantle Hospital, an ED volunteer representative, WASUA, Next Step's Director of Education, Training and Research and relevant OOPS staff members.

In April 1998 an initial list of stakeholders in the ED Project was created, which has been added to over time. From May 1998 these stakeholders were consulted in a needs assessment.

In November 1998 a survey of 70 clients from the WAAC mobile needle exchange van who had been to hospital following an accidental overdose in the past six months. Another survey was conducted with the broader opiate using community in May and June of 1998.

WASUA was seen as a key stakeholder, and WASUA members were directly involved in the process of developing the content of the volunteer training course, some volunteers are members of WASUA and WASUA is represented on all three reference groups. Other key stakeholders to be consulted were: users' significant others (family and/or partners), accessed via support groups; hospital ED senior management, also members of OOSG; hospital ED nursing staff, including staff development nurses, hospital ED doctors and interns and hospital self harm worker and senior social workers accessed via focus groups and inservices; other relevant hospital staff, including security staff; St John Ambulance; ED project workers; ED project Working Group; WAADA; HDWA; WADASO; NCRPDA; WA Police Service; the AMA; Media. The process of identifying and seeking input from stakeholders has been of value to the ED Project. This initial process resulted in a project structure which, while continuing to meet the performance criteria and outcomes of the purchaser, has also brought together a complex collection of needs, values and skills and has successfully integrated them. This consultation process with key stakeholders has occurred on an ongoing basis, both formally and informally, with the project.

Phases of the ED Project

To date the ED project has had four main operational phases. In the first, service delivery was carried out by paid OOPS and ED Project staff while volunteers were being recruited and trained. The second was a transitional phase in which service delivery was increasingly handled by volunteers. The third phase was where all service delivery was carried out by trained and experienced volunteers, relegating paid staff to support and development roles. The fourth phase involves the SCGH Pilot Project and the possible expansion of OOPS.

Phase One

Structure

In-service training provided to ED staff at RPH and SCGH by ED Project staff prior to commencement of service delivery. Training covers what the project can and cannot do for patients and how and when to access the service. Posters advertising the service are displayed in the ED.

Formal commencement of service delivery on 10 June 1998

Project staffed by OOPS and ED Project staff from 9am to 9pm, seven days a week on a roster system. Each day is divided into two six hour shifts with a double roster system, where one person is on callout and another on backup. Soon after the project began, it was recognised that call-outs were predominantly occurring at night, so the hours were changed to 9am-12midnight. Research done at RPH with ED nursing staff (Bartu et al, 2000) showed that OD's admitted after 12 midnight would usually be kept overnight and could be accessed in the morning. This is why the service has not extended to 24 hours to date.

At the end of each shift the mobile phone is delivered to the next rostered person or diverted to a personal mobile phone. Staff use a WAADA pool vehicle to attend hospitals during business hours, according to availablility.

A callout kit consisting of a bag which contains a lockable cash-box style container is stored at each ED. It also contains spare data collection forms, cigarettes, phone card, petty cash, taxi vouchers, various resources pertinent to heroin overdose and a referral resource. 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 is provided after callouts. This is provided by OOPS staff.

Callout Process
ED staff 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 patient then leaves. ED Project worker ensures the client is aware of what the project can and cannot do and consents to their presence

Brief harm reduction oriented intervention with referral to other agencies where appropriate. The ED Project worker may also help the client in dealings with hospital staff where appropriate

When hospital staff are ready to discharge the patient, the ED Project worker ensures they have somewhere safe to go and the means to get there

People who refuse ambulance transport are given an ED Project/OOPS pamphlet by St John Ambulance Officers so they may access the service at a later date. This pamphlet contains information about how an opiate overdose can occur, a summary of preventive strategies, the effects and duration of narcan, expired air resuscitation instructions and highlights the importance of monitoring the person's condition for some hours after the overdose. Fifteen thousand of these pamphlets have been printed. It is unknown how many pamphlets are actually given to users.

A range of printed resources are also available to be given to parents, partners and significant others at the hospital. They outline what has happened to the opiate overdose patient and how a family and others can best respond. This is particularly useful outside ED Project service hours or when people are leaving before the ED Project can arrive. Parents are provided information on the Parent Drug Information Service (PDIS).

Volunteer Recruitment and Training
During the first phase of operations a volunteer training program was developed and volunteers recruited.

Recruitment of the first intake of volunteers took place during May-June 1998. The project was advertised in a bulk mailout to WASUA membership, and advertisements were placed in *Xpress Magazine*, a local free music publication. Approximately 50 people responded in writing to these ads and were interviewed by the OOPS Coordinator and the ED Project Officer. This process produced a shortlist of 20 people who commenced training on 23 July 1998. The course was conducted one day per week for eight weeks.

Phase Two

Structure
Inservice training provided to ED staff on a regular basis.

Project staffed by a combination of ED Project staff and ED Project volunteers. Have now moved to a triple roster system where one person holds the mobile phone and coordinates the callout response, including being available for debriefing (the 'phone holder'), and two other people are on call via pagers to respond to and provide backup for callouts.

Volunteers are accompanied on their first three callouts by a staff member or experienced volunteer (or 'mentor'). Depending on their performance during this period, volunteers can then attend callouts alone. To become a mentor, volunteers must undergo a 'focus test', where they talk through various

scenarios. Experienced mentors are also placed in more responsible positions in the project, such as representing the project at various events. As of October 2001, there were approximately a dozen mentors within the volunteers.

The ED Project Officer is responsible for rotating pagers between volunteers. This pre and post-shift contact also provides an opportunity for debriefing.

Volunteer Recruitment and Training
A second round of volunteers was recruited in February 1999 and began training in March 1999. Emphasis was on recruitment from the Fremantle area to allow ease of expansion to Fremantle Hospital on completion of training

Phase Three

Service expanded to Fremantle Hospital, for weekends only at first, commencing on 1 July 1999
Ongoing rounds of training to replace attrition and to allow of expansion of service to cover other metropolitan hospitals (see Table Two: Volunteer Team Base)

Haven't had to advertise for the last two intakes

Before applicants are interviewed, they undergo a two day orientation (held over two weeks), which is also considered a community development activity. They are then interviewed and if successful go on to complete the eight day training course (held over eight weeks). On Week nine a graduation ceremony is held. People with non-judgemental attitudes towards drug use and some knowledge of overdose issues are favoured. People who have had or still have direct involvement in the opiate using community are regarded as having experiencewhich can be invaluable to the project (they are not required to disclose their using status). Approximately a quarter of current volunteers are students, with many completing Addiction Studies. There are also a number of parents, along with current and ex-users.

Year	Intake	Completed Orientation Only	Completed ED Training	Did not complete ED Training	Retention Rate (%)
1998	1st	n/a	13	0	2 (15%) (current staff)
1999	2nd	1	14	0	1 (7%)
1999	3rd	5	20	3	8 (40%) (including 1 staff member)
2000	4th	2	16	0	12 (75%)
2000	5th	13	12	1	6 (50%)
2000	6th	5	19	1	10 (53%)
2001	7th	1	11	1	6 (55%)
2001	8th	4	22	2	20 (91%)
2001	9th	3	underway	-	-
Total	**9**	**34**	**128**	**8**	**65 (51%)**

Table 4 : Volunteer Team Base

There have been 170 people trained in some capacity from the Volunteer Training Program. 128 completed both orientation and ED training, 34 completed orientation only and 8 left the program without completing the full 9 week requirement. The overall retention rate is 51%, with an average rate of 48.25% over intakes. There have been 373 application forms and OOPS information packages sent in relation to enquiries for OOPS Volunteer Training since 1998. As of October 2001 there were 46 volunteers rostered to work on the ED Project.

Volunteers can also be involved in activities outside of the ED program, such as:

Breathe Project – volunteers are appropriately trained in EAR skills and are involved in assisting with the facilitation of Breathe workshops in agencies and prisons. The prison project is a community based harm minimisation intervention program that educates prison and remand inmates at Banksia Hill, Rangeview Remand Centre and Bandyup Women's Prison how to identify, manage and prevent opiate overdose.

Community Development – volunteers are offered appropriate skills to work on OOPS stalls and displays, for example:

- Big Day Out: approximately 2000 contacts were made and 1500 resources distributed
- Perth Royal Show, where the OOPS program appeared on a stall with the WA Police Service on fatal overdoses: approximately 300 contacts were made and 200 resources distributed
- WA Pharmacy Guild Fair – Needle and Syringe Project: approximately 200 resources distributed and 50 contacts made
- Rockingham Youth Suicide Forum: approximately 50 resources distributed and 40 contacts made
- Rockingham Senior High School: approximately 150 contacts made
- Cyril Jackson Senior Campus Health Happening Day: approximately 500 resources distributed and 200 contacts made

External Agency Collaborative Projects – OOPS volunteers have recently been offered 'fast track' training by the WAAC to work on the needle and syringe exchange vans. This is a collaborative endeavour between the two agencies to expose volunteers to a different type of client contact while the heroin drought impacts on the amount of callouts a volunteer can be involved in. It is an opportunity to utilise volunteers that may otherwise be inactive, wasting the training they have received.

Grief and Loss Project – a continuing project of OOPS that involved volunteers distributing Namaste Books to various agencies. Volunteers are also asked to participate in annual days of reflection that focus on the loss of individuals who have died from opioid overdose. OOPS organised the plaque in Hyde Park to commemorate those who have died as result of illicit drug use and also used to organise the Remembrance Day.

Phase Four

Expansion to other drugs at SCGH due to heroin drought
The project aims to have two intakes of twenty each for 2002.

Volunteer Training Program

The training program for volunteers was developed jointly over several months by ED Project Working Group members, WAADA Clinical Education and 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, who also participate in presenting the course.

The training package develop during this process had an estimated duration of eight full time days (56 hours). Major areas covered include the history of the project, harm reduction, utilisation of emergency services, IDU issues, pharmacology, general helping skills, boundary issues, working with young people, working with people in crisis, overdose oriented first aid, legal and civil rights, gender issues, sexuality, discrimination and blood borne viruses. Emergency department nurses present a session on management of opiate overdose patients in EDs. The course also includes reporting obligations and accountability issues. All volunteers complete a St John Ambulance basic life support certificate course featuring an overdose component. Confidentiality is seen as a key issue, in terms of its application in a hospital setting. At the conclusion of training all successful volunteer candidates must sign a full confidentiality statement before proceeding with the role.

After the first round of training, the course underwent revision. The training program was extended by one week to include additional material developed by the ED Project Working Group as a consequence of their experiences with actual service delivery. This revision process has continued to occur after each intake.

See Appendix One for an outline of the ED Volunteer Training Course as of November 2001.

There is time set aside for teambuilding and volunteers are required to attend bi-monthly training updates where knowledge and skill related to the role are extended. The project also holds regular inservices for hospital staff about the project, sometimes incorporating attitudes exercises. A biannual newsletter was also provided to interested parties, with project highlights and modifications. A volunteer newsletter is produced monthly and is sent with the rosters. ED staff and other interested people now receive the volunteer newsletter.

All volunteers receive a manual describing reporting protocols, expected behaviour, resources and support provided by the project and Next Step. After the completion of training all volunteers undertake an induction process, which requires that they are accompanied by an OOPS staff member or mentor on their first three callouts. During the first callout the volunteer acts as an observer, the second is handled jointly and on the third the staff member/mentor acts as an observer only.

All volunteers have access to a 24 hour support and counselling system. All volunteers are covered by personal accident and public liability insurance while engaged in volunteer activity for Next Step.

Eligibility for employment within OOPS is now only open to those that are working toward completion of the ED training.

In a small study done with the OOPS volunteers (Allan, 2001), ten were interviewed with the main finding that: "Clearly what came through as a central theme was the belief that the OOPS training was countering hegemony (ruler of ideas and creator of norms) in our society" and that "those of them who were in the front lines with the most opportunity to touch the lives of others have an important role in not defining poverty, drug use or suffering as individual aberrations in society rather than an integral part in it". It was also noted that volunteers themselves benefit from being involved in the program, in terms of support, networking and possible job opportunities.

Many resources have been developed and distributed by OOPS. The process begins with a need being identified. Then a search is undertaken to see if there is already a resource available to meet that need. If a gap is identified, the resource is developed with input from users.

Resources

The following is a list of resources produced by OOPS:

- Z card – Breathe information to manage an overdose.
- Parent booklet – for parents who have just found out there child is using heroin.
- Referral booklets – designed for volunteers as a quick reference for agencies most likely to be useful for OOPS clients.
- OOPs pamphlets – general information about the project.
- Just Say Know series – given to participants in training programs. Includes information on heroin overdose, harm reduction and injecting drug use and alternate treatments for heroin dependency.
- Volunteer information, including role, rights and responsibilities, application forms and procedures.
- Travelling mural
- Various overdose information
- St John Resource for people refusing to go to a hospital following OD.
- Matches – with OOPS contact details

- Breathe Manual for users in prisons and remand.

Data Collection

Formal data collection was identified as a necessity in measuring the outcomes set for the ED Project, and is also a component of the action research model which drives the ongoing development of the project. However, as injecting drug users are subject to much research, it was identified early in the planning for the project that, to help achieve a high level of client credence, the service provision should maintain an informal "no paperwork for the client" flavour. Data is only recorded once the client has departed and depends on information naturally gleaned in the course of the intervention as opposed to any structured questionnaire process. The data collection process consists of four components.

Data collection undertaken at the point of intervention
Unique identifier form – as a way to track repeat overdose events
Callout form – when and where the callout took place, basic demographics, resources provided, other comments. Questions have been added over the years, for example around naltrexone.
Hospital feedback form – to allow on the spot feedback for hospital staff at the completion of a callout, informing staff of intervention outcomes, referrals

Data collection undertaken during follow up meetings with clients
Follow up event form

Data collection in the wider opiate using community
November 1998 survey conducted with client of WAAC needle exchange van – assessed respondents experience of overdose and for those who had been to hospital following overdose, their experiences of the ED Project (Freddo Frog Survey)
This survey was replicated in February 2000 (Lollipop Survey)

Baseline data collection
The ED Project benefited from the Opioid Overdose Survey being conducted by WAADA in conjunction with RPH. The survey involved gathering data on every patient who presents to RPH with an opioid related overdose, and provided a benchmark against which callout rates can be measured (Bartu et al, 2000).

An ACCESS database is used to record all data collected by OOPS.

Results for June 1998 to February 1999

The ED Project callout service commenced 'official' operations on 10 June 1998. By the end of February 1999, 112 callouts were received, and acceptance by both hospital staff and clients was high. The average duration of callouts was 1 hour 26 minutes (range – 5 minutes to 5 hours 30 minutes). Eleven per cent of clients required some form of crisis accommodation. Almost half of clients seen were referred in a 'semi-formal' manner to other agencies. Clients were provided with taxi vouchers in 53 (49%) cases. At least 31 clients (28%) have been in contact with OOPS and/or ED staff since the original callout, 15 by direct request of the client (as opposed to accidental meetings in social settings).

Results to August 1999

As at August 1999, the project had attended 250 callouts (Birgin, 1999). Just over 20% of callouts were with clients who identified as being involved in naltrexone treatment. Approximately 6% of all clients have been attended by the ED Project on more than one occasion, two of them on three separate occasions. Nearly 60% of the multiple presentations involved the use of alcohol, benzodiazepines or naltrexone. Twelve (25.5%) of the 45 clients receiving naltrexone were also consuming benzodiazepines prior to overdosing (Featherstone, 2000).

The majority of clients were of Anglo descent (90%), with 5% from Culturally and Linguistically Diverse (CALD) backgrounds and a further 5% identified as Aboriginal or Torres Strait Islander (ATSI). Considering that people of ATSI descent make up 1.4% of the Perth metropolitan population, it would appear that they were overrepresented in these figures.

Seventeen clients had received services from the ED Project on multiple occasions, all of these were under 30 years of age and over half involved the use of alcohol, benzodiazepines or naltrexone. A considerable number of these repeat presentations had a very small number of days elapse between them, and in a number of cases this was less than a week. The author hypothesises that this possibly indicates a crisis period in these clients' lives at the time. In the six instances where an individual overdosed twice in a week, four (66%) of them had received naltrexone treatment recently.

An average of one in five clients have been involved in follow up contact with OOPS, usually in the form of assisted referral, or more casual contact to discuss the overdose and related issues. At least one client has gone on to become an OOPS volunteer.

ED Callouts to November 2001

Figure One shows the number of callouts the ED has received from May 1998 to November 2001, further broken down by hospital. It should be noted that operations in Fremantle did not begin until July 1999. Also, the ED project did not begin until May 1998. See Appendix Two for a breakdown of callouts by month, year and by hospital for the ED Project.

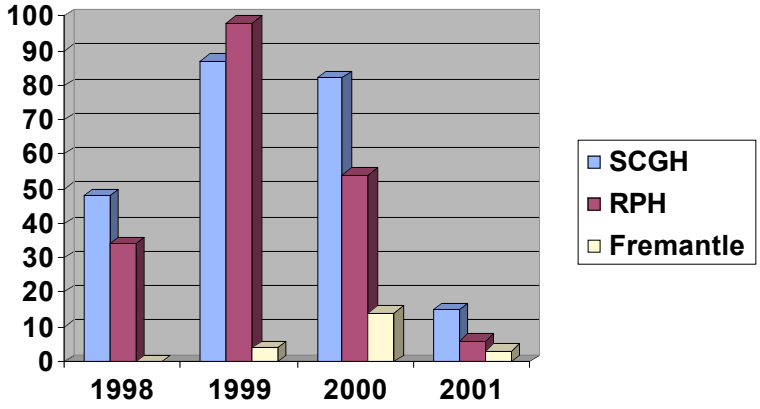

Figure 1: Callouts to the ED Project by year and hospital

User Survey November 1998

Seventy surveys were distributed to WAAC Needle Exchange van clients over three weeks in November 1998. This was colloquially referred to as the "Freddo Frog" survey, as chocolate frogs were given out on completion of the form. Sixty one of the 70 forms were completed and returned. Of 59 valid responses, 26 (44%) had been to hospital since June 1998 as a consequence of an overdose. Two of those (17%) had overdosed and been to hospital again since seeing OOPS. 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. 92% said that the OOPS person was useful enough that they would want to see them if they ended up at hospital again. 45% said that they would be less stressed about calling an ambulance if a friend overdosed if they knew is advance an OOPS person would definitely be there at the hospital (55% said it would make no difference).

User Survey February 2000

This survey was replicated in February 2000, with some differences to the survey questions and the methods of administration. A limitation of the Freddo Frog survey was that it resulted in a sample who were in quite regular contact with AOD services, and thus were not necessarily representative of the heroin using population of Perth. With a view to overcoming this problem, the "Lollipop Survey" (lollipops were given out instead of Freddo Frogs) was administered by OOPS volunteers across a number of locations, to access respondents who may not be in contact with AOD services. This was also seen as a good way to involve the volunteers in the project beyond the ED Project. A total of 54 surveys were returned, some of which were conducted from within WASUA's fixed site needle exchange. Eleven respondents had actually been seen by the ED Project and 23 were aware of the project's existence; 63% of the sample were aware of OOPS. Table Three shows how these respondents became aware of OOPS.

Mode of awareness	Number
As a result of own overdose episode	11
Word of mouth, from friends	11
Through WASUA	6
As a result of someone else's overdose	6
Via stalls at gigs	3
Through first aid training	1
Could not recall	2
Other sources	2
Missing	12
Total	54

Table 5: How respondents became aware of OOPS

In this sample, 48 episodes of non-fatal overdoses were reported, 32 of which resulted in admission to hospital. Of those who did not go to hospital, 7 were resuscitated by others, 4 were provided with some form of intervention such as a shower or being walked around, 3 were resuscitated by the ambulance officers at the scene, 1 could not remember and one had been administered Narcan by an unspecified person.

Of those who did attend hospital, 18 were transported by ambulance, 12 were transported by people they had used with and 2 had no recollection of how they arrived at hospital. Ten went to RPH, 9 to SCGH, 8 to FH and 4 to another unspecified WA hospital. At the time of the survey, the Ed project was operating only from RPH and SCGH. Of overdoses admitted, 70% were offered the services of the ED Project at RPH, with 62.5% offered at SCGH. The reasons most commonly given for declining the offer of the ED Project services were: I just wanted to get out; it was just another social worker and; friends were waiting.

No individuals who had been seen by the ED Project had experienced any subsequent overdoses at the time of the Lollipop survey, whereas 17% reported doing so in the Freddo Frog survey. Table Four outlines the types of responses respondents found useful from the ED volunteers.

Useful response from ED volunteer	Number
Talked about strategies to avoid overdose	10
Kept hospital staff "off my back"	6
Got me out of ED quicker	6
Provided me with a means of getting home (usually a taxi voucher)	4
Arranged overnight accommodation for me	4
Helped arrange contact with other services	3
Let me use their phone	2
Helped me find my car	1

Table 6: What respondents found useful from ED volunteers

When asked if the knowledge that it would be 100% certain that OOPS would be present in the ED would affect their willingness to call an ambulance as a first response to overdose, 72% said they would be more likely to do so, 25% said it would make no difference and 3% said they would be less likely to do so. When this question was asked again with the amendment that there was only a 50% chance of an OOPS worker being in attendance, only 35% said they would be more likely to call an ambulance, 39% said it would make no difference and the number of respondents who said they would be less likely to do so rose to 26%. This was seen as a clear indication of the value opiate users place on knowing that the services and support offered by the OOPS project will be available to them in the event of overdose. When compared to the same question asked in the Freddo Frog survey, only 36% said it would make them less stressed, and 55% said it would make no difference. This improvement was seen as an indication of how the profile and reputation of the project had increased from November 1998 to February 2000.

ED Staff Survey 1998

One hundred surveys were distributed to emergency department staff at SCGH and RPH in November 1998.

At RPH, 41 of the 50 forms were completed and returned. Of the 40 valid responses, 78% had used the OOPS service. Of those who hadn't used OOPS before, 89% said that they would feel comfortable using it when appropriate. Of those who had used OOPS, 55% said that they were provided with appropriate feedback after they had seen the patients. 54% said that their use of the OOPS project increased their overall satisfaction with the outcomes achieved with the patient (42% said there was no change). 80% said that the OOPS person was useful enough that they would use them again. There was a considerable number of concerns relating to the appropriateness or effectiveness of the project and to the provision of appropriate feedback to ED staff. 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. A continuation of the policy of requiring ED project workers to make an active effort to find the ED staff member who made the call to provide feedback is necessary.

It's important to bear in mind that this was very early in the project… since then we have specific procedures to ensure feedback is given to staff for each call out)

At SCGH, 49 of the 50 forms were completed and returned. Of these, 67% had used the OOPS service. Of those who hadn't used OOPS before, 75% said that they would feel comfortable using it when appropriate. Of those who had used OOPS, 79% said that they were provided with appropriate feedback after they had seen the patients. 76% said that their use of the OOPS project increased their overall satisfaction with the outcomes achieved with the patient (18% said there was no change). 97% said that the OOPS person was useful enough that they would use them again.

Overall, 72% of the 89 ED staff respondents at SCGH and RPH had used the service. Generally the service was well received, with 89% saying they would use the service again. Four respondents

specifically requested that the service be available 24 hours. The single biggest concern was lack of feedback, with 33% of those that had used the service saying that feedback was unsatisfactory.

In a separate research project conducted at RPH into non-fatal overdose, it was found that of the 114 referrals made to OOPS, 74 (65%) patients accepted and 40 (35%) refused this option. There was no significant difference detected between those who accepted OOPS in terms of age, gender, or in repeat presentations. This proportion of acceptance compared favourably with the acceptance of referrals offered to other services (26.5%) (Bartu et al, 2000).

Davidson (1999) concluded that the ED Project had broken considerable new ground as a modality for reducing accidental overdose, and had attracted favourable attention from within Australia and overseas. He surmised that there were some positive indications that the service may be impacting on client use behaviours and perception of emergency services, and also demonstrated an ability to remain flexible to the needs of all stakeholders.

The OOPS project recently won the Award for Social or Community Development at the 2001 Premiers Awards for Excellence and Public Sector Management. OOPS was one of three volunteer programs at Next Step recognised by this award (along with the Volunteer Addiction Counsellors Training Program and the Parent Drug Information Service Volunteer Training Program).

The OOPS project has not undergone a review since Davidson's in 1999. The structure and content of the Project has continued to undergo changes and evolve. This Review will attempt to identify how that evolution has unfolded, via the consultation process, as described in a later section, as well as by examining the service report of the Project.

Service Report Reviews: Outputs and Descriptive Reports

The service specifications, including outputs and outcome measures, for 1997/98 to 2000/2001 are outlined in Appendix Five.

Output reports

1997-98 and 1998-99

A review of the ADPB files indicates that the reporting for both these years was limited. The outputs were difficult to determine without an established baseline and were developed throughout the first year. The only record of activity reports for 1997-98 for the OOPS and the ED Projects is:
17 peer based education and training events
0 education and training events for drug workers and other professionals

See Appendix Six for outputs as outlined in the service specifications for 1998-99.

For the OOPS Project, 22 peer based strategies were undertaken, 456 peer-based education and training events occurred along with 588 peer-based outreach consultations. There were also 52 education and training events for drug workers and other professionals. A total of 9,973 resources were distributed to networks including opiate users and 12 collaborative projects were conducted with other key agencies.

For the ED Project, 165 brief interventions occurred, and there were 1,312 OOPS information cards distributed, as well as 165 user focused opiate overdose information packages.

During 1998-99 several requests were made by the ADPB to Next Step for information about the projects. A copy of a survey carried out with 50 staff from the Sir Charles Gairdner Hospital (SCGH) was presented in November 1998 which indicated that the OOPS project was well received and regarded as valuable. Possible improvements were related to the need for a 24 hour service and the need to consistently provide feedback to ED staff after a callout.

In March 1998 a request for reporting on specific outputs for both OOPS and the ED Intervention projects was made due to inadequate reporting being provided.

In May 1999 a written report provided further information about the project which provided information on: volunteer training and orientation for both projects, basic first aid certificate training for OOPS workers and some statistics on the ED project which included that by May 1999 157 call outs had been attended and 44 separate follow ups had occurred.

1999-2000

For the OOPS project, there were 26 peer based education and training events and 15 education and training events for drug workers and other professionals.

For the ED Project, 138 brief interventions were completed and 15 volunteers completed the ED Volunteer Training Program. Information on the number and type of follow up intervention was not provided.

2000-2001

For the OOPS project, there were 32 peer based education and training events and 38 education and training events for drug workers and other professionals.

For the ED Project, 91 brief interventions were completed with 5 follow up interventions. The number of volunteers completing the ED Volunteer Training Program was unable to be determined from the report.

Table Five outlines the output measures reported for the OOPS Project and the ED Project from 1997/98 to 2000/2001.

Output	1997-98	1998-99	1999-2000	2000-01
ED Project				
No of brief interventions (by Hospital 2000-01)		165	138	91
Number and type of follow up intervention		(44 over 11 months)	Not provided	5
Number of volunteers completing ED program			15	Unable to determine from report
OOPS				
Number of peer based education and training events	17	456	26	32
Number of education and training events for drug workers and other professionals	0	52	15	38

Table 7: Output measures for the OOPS and ED Projects 1997/98 – 2000/2001

Descriptive reports

No descriptive reports were specified by the Purchaser in the 1997-1998 or 1998-1999 reporting periods. However the report of May 1999 (see above) provided some general information about the projects for that year.

Summary of descriptive reports from January to June 2000

The two descriptive reports for this 6 month period provide general information about the projects, not as specified in the output indicators.

Statistics about "call outs" and demographics of clients (age, ethnicity, gender) are provided for the ED project. A statement about the change in recording callouts is given as "previously only call outs were recorded when a volunteer saw a client in the ED" but no explanation for the criteria for a recording a "call out" since the change.

The Volunteer Program is highlighted with information about the number of volunteers completing training in both cases, but it is not clear what the volunteers then do either in the ED project or in the OOPS project following their training.

A significant focus for the reports appears to be on Resource Development and distribution and it seems that the following resources were being developed or in development during that period:

- Z cards (on EAR)
- St Johns/OOPS resource
- Referral booklet
- Pamphlets on OOPS
- OOPS Business card
- OOPS Website

Under the heading Liaison and Training in both reports there is a list of 8 or 9 agencies (some the same in each report) where there has been contact but it is not clear apart from "identifying staff and

client needs" what in fact has been done. It is unclear also whether the activity has targeted "peers" or workers but as most activity is in agencies it is presumed that it is targeted at workers in the agencies. No "outreach" is documented.

Summary of descriptive reports for the 2000-2001

ED Project

Information provided about the ED Project in the descriptive reports mainly relates to numbers of "call outs" and some limited comments about factors influencing the overdoses and current issues ie "low rate of call out…….. is reflective of the heroin drought".

Follow ups are minimal.

Information titled "Volunteer Project" gives details of the process of recruitment and when programs started but it is very difficult to ascertain, from the report, how many volunteers were recruited for the full year, how many completed training and were engaged in the project and what the purpose of the training program was. An evaluation of the OOPS Volunteer Training Program sent in February 2001 provides some information on assessment of the participants to gauge the impact of the training process on them. The summary provides details of improvements in participants at the conclusion of training in five domains including attitudes, knowledge, self esteem, personal confidence and understanding of professional practices.

OOPS Project

Resource production

- Resources developed or updated over this time included:
- OOPS pamphlets
- Audio visual resources collected for volunteer training
- WADASO funded posters and cards "Can you see it coming"
- Matches and t-shirts
- KKK resource

Resource dissemination

Approximately 8670 resources were disseminated over the 2000-01 year.

Education and training for workers

A large focus for training events during the 2000-01 year has been at SCGH, with some other events at other hospitals, youth agencies, government and non government agencies. Limited information is given about the type of event and the target group.

Liaison with Agencies

Reporting indicated that there is about 10-15 agencies each quarter (many the same each quarter) with whom the project liaises, mainly hospitals, youth agencies, government and non government agencies.

Education for peers

Over the reporting period there was some activity at the following centres which it appears was targeted at injecting drug users:

- Rockingham Youth Service
- Rangeview
- Banksia Hill
- Big Day Out

Summary of service specification reporting documentation

Reporting against the service specifications in the early years of the project was limited and it is difficult to ascertain the real activity of the projects from them. However looking comparatively at the

activity over the years 1997 to 2001, the greatest amount of activity reported occurred in the 1998-99 year (see Table Five). It is likely that this is partly due to some change in identification of what a "peer based education and training event" is, but may also be due to a change in focus of the project from peer based activity to peer "facilitation" activity.

The general impression of the project from the service reports is that over the years it has changed from one where there was originally a major focus on activity targeting opiate users to activities targeted people who work with opiate users and the general community. There has been and continues to be a significant emphasis on resource development and distribution and volunteer training and support. The role and importance of the volunteers in the projects is not clearly identified in the reports.

It is recommended that the output indicators are formulated to better reflect the activity of the project. The purchaser needs to receive clear quantitative and qualitative information regarding the outcomes of the project. The changing environment in which the project is located necessitates a flexible approach to provide a service which meets the needs of the target group. Current output indicators and the way in which they are reported provide a very limited view of the benefits or otherwise of these projects in their current form.

Breathe

The 'BREATHE' project was piloted from July 2000 to June 2001 as a community based brief intervention program to teach respiration skills to opiate users and staff of relevant community agencies. WASUA was contracted to provide some of the outputs. The OOPS project at Next Step employed a Breathe worker (0.4FTE), as did WASUA (0.6FTE).

The overall objective of the Breathe project was to increase the likelihood of someone being able to effectively assist in an overdose situation. Each training session focused on providing participants with skills in Emergency Air Resuscitation (EAR) and knowledge on how to recognise and deal with an overdose. At the end of each session, participants should have been able to:

- identify the signs of an overdose;
- understand what causes an overdose;
- respond to an overdose; and
- keep the person breathing.

The service specifications, including the outputs and output measures for the 'BREATHE' project are outlined in Appendix Four.

Training and support of OOPS volunteers and agency staff in 'BREATHE'

OOPS staff were to utilise a Train the Trainer model to train staff of relevant agencies to carry out 'BREATHE' training in group or individual settings. They were also to train OOPS volunteers to support agency staff in the 'BREATHE' project. OOPS were also to identify and refer clients who may be suitable for 'BREATHE' training with WASUA.

A total of twenty eight different agencies were engaged, with a total of 573 participants attending the training. A number of agencies had multiple training sessions, with different participants attending each session. See Table Six for a breakdown of agency attendance and participation.

	Agency	Date	Attended	Evaluated
1.	Cyril Jackson High School	5 July 00	20	-
		4 April 00	20	
2.	WA AIDS Council	13 July 00	12	-
3.	Newpark Fitness	17 Aug 00	12	-
4.	Bandyup Prison	18 Aug 00	8	-
5.	Next Step Calendar event	20 Aug 00	12	-
6.	Cyrenian House	31 Aug 00	17	-
	Cyrenian House Women's Project	17 Nov 00	15	-
	Cyrenian House Rick Hamersley Centre	24 Nov 00	15	-
	Cyrenian House	21 Sept 01	18	18
7.	Geraldton Ambulance Sub Station – ambulance officers	4 Sept 00	2	-
8.	Midland Youth Agencies	5 Sept 00	20	-
9.	Rockingham Youth Centre	14 Sept 00	4	-
		5 Oct 00	5	-
		12 Oct 00	5	4
		29 Mar 01	15	-
10.	Rockingham High School	19 Sept 00	10	-
11.	WASUA Volunteer Training	7 Oct 00	20	-
12.	Marrilac Centre	11 Oct 00	10	-
13.	Yirra	25 Oct 00	7	7
		30 Oct 00	11	-
14.	Palmerston	27 Oct 00	8	5
15.	Pat Giles Women's Refuge	21 Nov 00	11	11
16.	Ava Maria House	22 Nov 00	8	7
17.	Phoenix Outreach Workers	20 Feb 01	2	2
18.	Rural Needle and Syringe Exchange Program Workers	22 Feb 01	26	25
19.	Perth Inner City Youth workers (done jointly with WASUA)	3 Mar 01	6	-
20.	Central Treatment Services, Next Step	8 Mar 01	6	-
21.	Rangeview Remand Centre (x4 sessions)	4-25 Apr 01	24	-
	(x5 sessions)	2-30 May 01	30	-
	(x4 sessions)	6-27 Jun 01	24	-
	(x4 sessions)	4-25 Jul 01	24	-
	(x4 sessions)	1-29 Aug 01	30	-
	(x4 sessions)	4-26 Sept 01	24	-
22.	Holyoake	16 Apr 01	15	15
23.	Banksia Hill Detention Centre	17 Apr 01	7	7
		16 Jun 01	7	7
		19 Jun 01	6	6
		31 Jul 01	6	6
24.	Lynwood Youth Centre	17 July 01	6	6
25.	Joondalup Youth Service	26 July 01	3	-
26.	Anchors Youth Service	27 July 01	4	4
27.	Armadale Youth Service	2 Aug 01	10	10
28.	OOPS Volunteer Training Program	11 Sept 01	10	10
		21 Sept 01	18	18
	TOTAL		**573**	**168**

Table 8: BREATHE Agency attendance and participation

As the first three months of the project involved the development and refinement of the training module, evaluations did not begin until October 2000.

Initially a three hour mouth to mouth training session was trialled with users. This proved to be impractical, and was converted into a 20-40 minute Breathe session.

Of the 573 participants, according to the BREATHE Project Worker, approximately 80% were staff and 20% were clients. Multiple sessions at agencies usually occurred to train new staff as well as to update staff that had been trained previously.

There is no documented evidence that staff do train clients using the manikins, however the Project Worker says that anecdotal and opportunistic feedback was obtained from agency staff on subsequent visits (for example, when the manikins needed to be cleaned). Informal discussions around the use of the BREATHE training occurred, for example where they had trained clients, or actually used the training to intervene in an overdose.

The descriptive report of OOPS volunteer involvement in Breathe seems to be based around attending agency training sessions and helping look after the manikins placed in the agencies.

Peer Based EAR training and support

Next Step were to contract WASUA to provide peer training in 'BREATHE' by outreach workers through peer outreach with current client networks and via referrals from agencies. WASUA were also to identify and refer clients who may be suitable for 'BREATHE' training with OOPS.

The number and dates of peer training sessions were provided, and generally ranged from one on one to groups of 14. See Table Seven for a breakdown of peers trained and assessed.

	1st Quarter	2nd Quarter *	3rd Quarter	4th Quarter	**TOTAL**
Number	43	41	70	94	**248**
Passed final assessment	42	41	70	91	**232**

Table 9: Total Number of Peers Trained

* BREATHE worker was absent for 4 weeks in this period on annual leave

248 trained of which 232 passed a final assessment (i.e. demonstrated correct EAR technique)

A range of activities undertaken by the WASUA outreach worker were described including: liaison with other agencies; resource distribution; integration of 'BREATHE' activities with other WASUA activities; representation on interagency committees.

Coordination and administration of 'BREATHE' project

Next Step and WASUA were to be jointly responsible for the coordination and administration of the 'BREATHE' project, including participating in a reference group to oversee the project. Membership of the Reference Group was described as coordinators and project officers of both programs.

A descriptive report of coordination and administration activities included: First Aid Training; Agency contact/communication; database development; BREATHE Training Manual. Protocol development was not presented in the reports.

Evaluation of the 'BREATHE' project

To assess the effectiveness of the 'BREATHE' training in the Train the Trainer model the trainees were measured and monitored to assess their competence at EAR. Client and agency satisfaction with 'BREATHE' was also measured.

Both evaluations involved a pre- and post-test questionnaire, measuring people's knowledge levels before and after the training, and measuring if people were able to demonstrate the correct technique of EAR on the manikin. Both reported extremely positive results.

Summary of service specification reporting documentation

Both agencies (Next Step and WASUA) accessed relatively high numbers of participants. WASUA reached their target of "peers" and provided skills based training either one to one or in small groups with reported high success rates.

NS provided training to participants who either were staff or clients of various agencies in and around Perth, some on numerous occasions.

For the 821 people trained over the last 12 months the question remains:
"*Have they or would they be able to use correct EAR skills to assist someone who has experienced an opiate overdose"*. A delayed follow up skills based test (3-6 months after training) would be the only way of getting any feedback on this. Using statistics on reported overdose would be unreliable as there are too many other factors that affect the results.

The other thing that seems notable by its absence in the reports is the "collaborative " partnership between Next Step and WASUA and how well or otherwise this worked.

Future plans as submitted by both agencies

WASUA have submitted a peer strategy which is based on similar programs in Victoria and NSW and uses the technique of contracting trained peers to train a certain number of their peers. The success or otherwise of these other projects would be interesting to explore. The concept certainly is one aimed at reaching the hardest to reach and probably the most "at risk" target group.

Next Step have given a brief proposal to continue what they did in the pilot which is concentrate on agency staff.

Financial Report Review

Background

The OOPS and ED Project were funded under the Cabinet Anti-Drug Initiatives (CADI) (special allocation from Treasury) from 1997, with 2000/2001 being the outlier year. In 2001/2002, funding for these programs was picked up by the Mental Health Division (MHD). BREATHE was also funded out of CADI for $125,000, $25,000 of which was provided by the Mental Health Division. Table Eight shows the funding for these projects over time. Next Step also contribute a proportion of their core funding to the project.

Funding	1997-98	1998-99	1999-2000	2000-01	2001/2002 (MHD)
ED Project	90.00	120.00	120.00	120.00	
OOPS	60.00	80.00	80.00	80.00	200.00
BREATHE				125.00	

Table 9: Funding for OOPS 1997/98 to 2000/2001

This section is based on the financial reports of the previous two years.

1999/2000

Budget as per Health Service Agreement (H.S.A.): $312,700.00

Area	Expenditure	%age
OOPS	208,272	66.6%
Accident and Emergency	97,859	31.3%
Business Overhead Costs	6,569	2.1%
Total	312,700	100%

Opiate Overdose Project:

Area	Expenditure	%age
Salaries and Related Staff Costs	157,062	75.4%
Patient Support Costs	425	0.2%
Additional Equipment, Alterations and Repairs	5,694	2.7%
Administration Accounting & Consultancy Fees Advertising Printing & Stationery Rental Property Staff Training Staff Travel Telephone Rental Administration Other Total	 4,603 666 14,614 228 685 4,532 5,853 13,909 45,090	 21.7%
Total	208,272	100%

Emergency Department Project

Area	Expenditure	%age
Salaries and Related Staff Costs	70,790	72.3%
Patient Support Costs	281	0.3%
Additional Equipment, Alterations and Repairs	3,608	3.7%
Administration Accounting & Consultancy Fees Advertising Printing & Stationery Staff Training Staff Travel Telephone Rental Telephone Other Administration Other Total	 7,808 2,411 1,365 80 1,906 296 1,671 7618 23,180	 23.7%
Total	97,859	100%

Business Overhead costs are items such as office space, lighting, electricity, time from Human Resources and Financial Management. Administration Other refers to costs of running the Volunteer Training, such as catering and printed material as well as other volunteer costs including out of hours payments, reimbursement for travel and phone calls.

2000/2001

Budget as per H.S.A.: $420,789.00 (including $100,000 for BREATHE)

Area	Expenditure	%age
WASUA – payment for BREATHE	42,000	9.8%
Business Overhead Costs on $378,789 @ 15%	56,818	13.3%
OOPS	275,195	64.4%
Accident and Emergency	53, 577	12.5%
Total	427,590	100%
Deficit	-6801*	

* this figure was spent on another print run of the Z card resource

Opiate Overdose Project:

Area	Expenditure	%age
Salaries and Related Staff Costs	157,587	57.5%
Patient Support Costs Food Purchase of External Services Total	 69 7463 7542	 2.5%
Additional Equipment, Alterations and Repairs	339	0.1%
Administration Accounting & Consultancy Fees Advertising Books and Magazines Printing & Stationery Rental Property Staff Training Staff Travel Telephone Rental Administration Other Total	 1,640 2,639 1,884 16,127 94 68 957 4,696 81,581* 109, 727	 39.9%
Total	275,195	100%

* This figure includes the Breathe project ($57,759), leaving $23,822 expended on costs relating to the Volunteer Program.

Emergency Department Project

Area	Expenditure	%age
Salaries and Related Staff Costs	38,479	71.8%
Patient Support Costs	155	0.3%
Additional Equipment, Alterations and Repairs	2,352	4.4%
Administration Accounting & Consultancy Fees Advertising Printing & Stationery Staff Training Staff Travel Telephone Rental Telephone Other Transfer of Patients Administration Other Total	 6,303 787 640 80 997 132 450 18 3184 12,591	 23.5%
Total	53,577	100%

Breathe 2000/2001

HDWA Funding: $100,000

Next Step $57,759
WASUA $42,241*

* this amount differs over various documents. This is the figure from the Next Step final report. The WASUA final report lists the amount of funding for their aspect of the project as $43, 257.00, then lists $39, 351.82 as their Next Step grant in their income and expenditure statement.

Next Step

Area	Expenditure	%age
Salaries and Wages (1x0.4FTE)	22,450	38.8%
Supplies/Dummies	9,954	17.3%
Administration Costs: Travel Expenses Mobile Phone Catering Evaluation Advertising	 1,200 1,500 500 4000 115	
	7,315	12.7%%
Printing and Stationery (2xreprinting of ZCARDS @ $9020)	18,040	31.2%
Total	57,759	100%

WASUA

Area	Expenditure	%age
Salaries and Wages (1x0.6FTE)	32,826.45	78.2%
Workers Comp & Insurance	892.90	2.1%
Superannuation	2617.72	6.2%
Travel Expenses	805.26	1.9%
Administration costs	46.64	0.1%
Bank charges	29.19	0.07%
Consumables	105.54	0.25%
Electricity/Gas/Water	99.42	0.2%
Equipment purchases	580.20	1.4%
Freight	14.54	0.03%
Medical supplies	15.20	0.04%
Insurance	418.73	1%
Membership subscriptions	24.76	0.06%
Postage	64.64	0.15%
Printing	375.50	0.9%
Repairs & Maintenance	93.33	0.2%
Rental rates	854.55	2%
Security	61.49	0.1%
Stationery	248.18	0.6%
Telephone	1801.82	4.3%
Total	41976.06	100%
Deficit	-2624.24	

Expenditure on training

It has been estimated that training cost the OOPS Project $61.30 per participant per hour for 2000/2001. This includes the Volunteer Training Program, BREATHE and all other training.

Consultation Process

The consultation process for the Review occurred from August to November 2001. A total of 47 key stakeholders were consulted (see Appendix Three for list). A list was provided by OOPS staff, and other stakeholders were also contacted on top of this.

Four focus groups were held: one with OOPS staff (n=4); two with OOPS volunteers (n=6; and n=4); and one with the Emergency Department Liaison Workers (n=3; representatives from Royal Perth Hospital, Sir Charles Gairdner Hospital and Fremantle Hospital). The focus groups asked participants what the OOPS project did, what the OOPS volunteers did and then utilised a SWOT analysis (Strengths, Weaknesses, Opportunities and Threats) to gather further information about the project.

Thirty five individual interviews were also completed. Participants were asked the following open-ended questions: what is their role in relation to OOPS; what is the overall aim of OOPS; what are the key activities of OOPS; what are the target group/s of OOPS; what is the perception of OOPS by the target group/s and; what are future directions for OOPS. A SWOT analysis was also undertaken with each participant. SWOT provides a framework that allows information to be gathered in a manner that separates various forces acting upon a given situation, achieving greater clarity (Hogan 1998).

The percentages reported in the following section may not add up to 100%, as some participants gave more than one response. Frequencies of responses are recorded. It should also be noted that the five people who participated in a focus group were also included in the individual interviews.

Question One: What is your role in relation to OOPS?

The answer to this question varied depending on the stakeholder. The question was asked to provide a context for the Interviewer and answers will not be reported here.

Question Two: What is the overall aim of OOPS?

When asked about the overall aim of the OOPS project, 40% of participants talked about peer education and outreach to drug users at risk of overdose. A further 20% specified follow up, education and support for victims of overdose and their families and friends in Emergency Departments as the aim of OOPS, with another 20% saying the aim is to prevent accidental fatal overdose, or "to save lives".

Training the volunteers was seen as the aim by 28% of participants, and training of hospitals and agencies about overdose was mentioned by 12% of the sample.

Seventeen per cent talked specifically about the BREATHE project when answering this question, particularly the work done in prisons. Expansion of the project to include other drugs was seen as the aim by 12% of those interviewed. Other aims raised were:

- Resource development
- Develop an awareness of OD issues in health and the broader community
- Being a link between a government agency and non treatment opioid users
- Putting forward some voice to the higher powers to promote OD prevention

Figure Three is a graphical representation of these results.

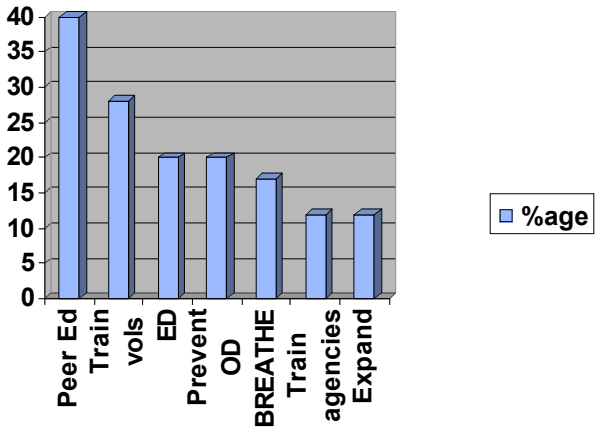

Figure 3: Aim of OOPS – frequency reported by percentage

The following are the aims as described by staff and management of OOPS:

- Educative strategy to put information out there to users, significant others, professionals and the community about the issues around using opiates and overdose working within a harm minimisation framework using practical pragmatic strategies
- Prevention of overdose using harm reduction strategies that involve talking to the users, peer based, what are they already doing? Get them to think about new strategies.
- Come from a teaching, educative stance, fluid, adapt to changing trends, under harm reduction framework
- Provide support and clear simple information to prevent future overdoses with clients. Support individual needs of volunteers. Provide a peer facilitation response with a harm minimisation theme to key stakeholders
- To raise awareness in the community of overdose, to prevent accidental heroin overdose using an action learning model, involving users
- To respond to overdose at an individual level and also at a population level, to reduce the likelihood of overdose occurring, re-occurring and being fatal. To enhance the response to overdose from drug users and services.

From these results, it can be seen that there is a variety of understanding and knowledge about the overall aim of OOPS in this group.

Question Three: What are the activities of OOPS?

The following activities of OOPS were described by participants. They are ranked in order of frequency, and quotes are added where pertinent. Figure Four is a graphical representation of these results.

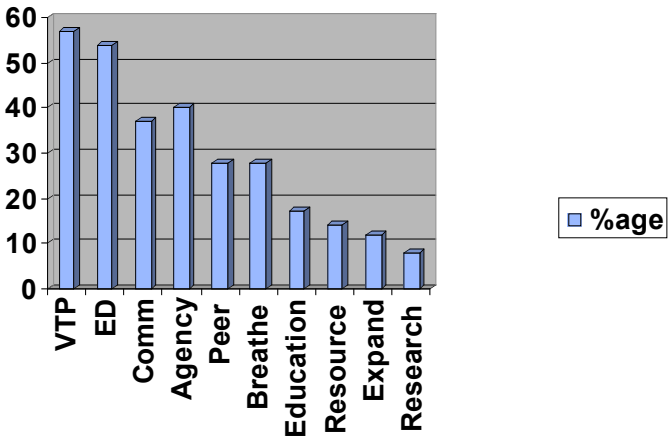

Figure 4: OOPS activities – frequency reported by percentage

Volunteer Training Program (VTP)

The VTP was referred to by 57% of those interviewed as being a key activity for the OOPS Project. Nine per cent said that the OOPS Project was now mainly focused on volunteer recruitment and training. The following comments were made in relation to this aspect of OOPS:

- There are a lot of volunteers, e.g. considering there were only 2 callouts for overdose last month, but the VTP is a good way of diffusing information, a lot of them are peers, there is a peer element to the program. They go on to become people who can influence the field. We are trying to lift the game amongst drug users and people responding to people at risk of overdose.
- There is a flow on effect to community in general as a result of the volunteer training. It gives the trainees a new perspective.
- It increases the level of knowledge and skills amongst users.
- Each intake for the volunteer training we get more people from agencies, the course has a good name out there.
- I was surprised at how many students do the VTP.

Some respondents commented on the benefits the volunteers enjoy from being part of the VTP and OOPS:

- It is of personal and community benefit.
- They get good knowledge, plain info, a lot of subjects, a well structured course, it's good for network forming, and it opens doors.
- Gives volunteers a support network, and can be empowering.
- Many of them go on to get paid employment in the AOD field.

The Emergency Department (ED) Project

The Ed Project was mentioned by 54% of the sample as a key activity of OOPS. A few participants agreed with the following respondents comment, that "the ED Project has essentially become OOPS". The following activities were listed as part of the ED Project:

- Respond to callouts to provide an immediate response to those who have overdosed.
- Sit with patients and their significant others; provide support; talk to them about opiate overdose strategies, including EAR, and how to avoid overdosing in the future. "Educating users in the ED is the primary OOPS function".
- Provide them with practical assistance, including: tea or coffee; cigarettes; a safe trip home (via bus fare or a taxi voucher) and; referral if appropriate.

- The OOPS ED volunteers free ED staff up in an area they may not have expertise in.
- They can defuse stress between the patients and the ED staff.
- They also have a PR role with the ED staff.
- "The ED Project provides a safe, smooth transition from hospital back to the community after an overdose".

Community Development

Community development, awareness and education was an activity discussed by 37% of participants. The following activities were mentioned as part of community development:

- Presentations at high schools (such as Cyril Jackson, Rockingham Senior High School and Mt Lawley Senior High School) (14%)
- Royal Show – worked with the AOD Collaboration Unit of WA Police Service to co-host a Forensic display on fatal overdoses at the Royal Show (11%)
- The Big Day Out (9%)
- Pride, Health Expos, Hepatitis C Week (3% each)
- A few participants pointed out that the community development OOPS does is presented from a peer base rather than a treatment base

Agency Liaison

Agency liaison and training was listed by 40% of participants as a key OOPS activity. This included: sitting on external committees (such as the Opiate Overdose Strategy Group); internal committees (such as the steering group) and; reference groups. One participant commented that "It is a role of OOPS to build links between these committees and groups, the users and relevant services".

Peer support/education/outreach

Peer related activities were reported as something OOPS does by 28% of the sample. A couple of people commented that peer education has evolved to "peer facilitation" over time with the OOPS Project. One respondent said that OOPS "supposedly" does peer education, and another claimed OOPS was an alternative to other user based organisations.

BREATHE Project

Twenty eight per cent of the group mentioned the BREATHE Project as a key OOPS activity. Several people said that resuscitation training is something that OOPS should be doing as core business, even though the BREATHE pilot and funding has finished.

Education

Education was seen as an OOPS activity by 17% of those interviewed, with education in prisons (specifically Rangeview, Banksia Hill and Bandyup) (14%) and education with hospital staff (9%) being particularly mentioned, along with harm minimisation education (11%).

Within prisons, education includes dispelling myths among the users and staff, and discussions of harm minimisation strategies. In hospitals, working with staff to challenge their beliefs about drug users and minimise prejudice was seen as part of this education process.

"Education also occurs via osmosis, as we dispel myths we come across in everyday life"
An OOPS volunteer.

"OOPS seems to be moving more into training around overdose and drugs".

Two people mentioned that, in terms of doing training with agencies, OOPS provides a different focus to that of the Clinical Education and Training section of Next Step and other training providers, due to their background and experience.

Resource development and distribution

Resources were mentioned by 14% of the sample, with the following resources specifically listed: fitpack cards; pens; matchbooks; the Z card; Namaste book; stress balls; travelling mural and; pamphlets.

"OOPS use resources such as stress balls and matches to develop a market presence and lift their profile. In terms of the target audience this is quite appropriate, as the market is very diffuse. It gives the program a sense of presence, and contributes to the legitimacy of the program"
(An OOPS manager.)

Broadening to other drugs due to the opiate drought

This was mentioned by 12% of the sample, with most of these referring to the pilot project at Sir Charles Gairdner Hospital. Some comments made about this pilot project were: "this is essential"; "it's the way OOPS should progress" and; "it's a great idea".

Research

Eight per cent of participants talked about research as an activity of OOPS.

Question Four: What activities are the volunteers involved in?

This question was asked of the focus groups only. The following activities were listed as volunteer activities:

BREATHE Project
- The volunteers are trained in EAR
- Some visit the prisons (Banksia, Rangeview, Bandyup), agencies (Cyrenian House), youth centres (Joondalup Youth Service), and cafes with the BREATHE Project Officer to assist in presentations and training

Community education/development
- Royal Show, highschools (Rockingham, Cyril Jackson) to man stalls for health/open days, Big Day Out, Pharmacy Guild (forum), Labour Day Rally (stall – "Drugs in the Workplace"), involvement in Drug Summit, present papers (for example a volunteer presented at the International Year of the Volunteer Conference 2001).

ED Project
- Primarily debrief the client and undertake a brief intervention. Ask them "Why did this happen this time?", "Is there something you can do next time so you don't end up in ED?". Led by what they wish to talk about, cover any other issues, referral component. Debunk many myths, many are misinformed by other users. Reorienting (where are their clothes, car, kids, how will I get home, can I go outside for a ciggie, help them liaise with hospital staff).
- Support for users, and family and friends of users, in the ED setting
- Provide a non-judgemental attitude and a friendly face
- Quite often the OOPs volunteer is the first person the client has seen. They find us not scary, open minded ad non judgemental. May lead to info sharing, and even engagement in treatment.
- "Welcoming someone back into the human race"
- Inform hospital staff of poly drug use, breaks barriers, we get the "whole story" as they will tell us things they won't tell the ED staff
- Usually takes around 1.5 hours, make the connection with client.

- Very rewarding personally
- We make a difference

Volunteer Training Program
- We learn about communication which can be used with our own families and friends
- It's positive, people are interested in what you do
- Volunteer work is a lot about your own stuff, we learn more about ourselves as well as drug use and BBVs
- Volunteers are made to feel like gold, they are held in the highest esteem, treated like equals here (compared to other agencies), as we bring information and skills to the program

Administration
- Sit in the office and do administrative tasks, wait for callouts, being ready for callouts to minimise wasting time to get to the client

Question Five: Who are the key target group/s for OOPS?

When asked who they thought were the key target group/s for OOPS, participants specified the following (in some cases, answers were influenced by the participant's particular involvement with OOPS):

- Drug users (32%)
- Opiate users (34%)
- Injecting drug users (14%)
- Heroin users who overdose (9%)
- Illicit drug users who are at risk of overdose (6%)
- Drug users in prison (6%)
- Accidental overdoses (3%)
- Hospitalised recently overdosed people (3%)

Along with these various descriptions of drug users, the following groups were also identified as targets for OOPS:

- Agency and health workers in general (34%)
- Workers who are in contact with opiate users (20%)
- The community in general (26%)
- People who may have contact with drug users who may overdose (i.e. workers, family, friends, police) (20%)
- The volunteers (9%)
- Politicians with money (3%)

There are some variations in people's understanding of OOPS target groups. This needs to be clarified and marketed.

Question Six: How is OOPS perceived by their target group/s?

Eighteen per cent of people who were interviewed said they couldn't answer this question. Of those that did respond, 31% reported a positive response from target groups to OOPS. Comments included that OOPS are seen as being: responsive; highly regarded; worthwhile; creative; realistic; pragmatic; open; knowledgeable; with high standards of presenting and communicating and; are pretty good. Three people (9%) said that OOPS' good reputation in the community was evidenced by how many requests for training they get, and how they don't have to advertise for each volunteer intake anymore.

In terms of the perceptions of specific target groups towards OOPS, the following comments were recorded:

Users

- I don't think users know they exist apart from those they come across in ED
- There is a reasonable amount of awareness, depending on their location (i.e. those users in the CBD, and who access WASUA will be more aware of OOPS than regional users)
- The majority of users now know of OOPS
- Quite well
- Very positive
- Pretty well respected by users
- Users find what OOPS have to say empowering
- They are highly regarded for their professionalism and the way they treat users
- Seen as a trusted and reliable source of information, valued system of support while in hospital for an overdose
- Seen as really user friendly, have street credibility, clients who have ended up in hospital have talked about the support they received from OOPs (an ED worker)
- At first clients who had overdosed were quite hesitant, but now they are a lot more willing to talk and spend time with OOPs over us (ED staff). We wear uniforms, and don't offer them cigarettes or talks in the park. They are quite accepting of OOPs.
- The clients all rate Shane very highly (a clinician who sees users who have had contact with OOPS)

ED staff

- In the past, OOPS was not perceived too well
- The perception of OOPS has improved, staff have become more positive, and OOPS is getting an improved profile in the ED (from a SCGH ED staff member)
- Very well respected at SCGH, and it's improving in RPH and Fremantle. Problems experienced at RPH and Fremantle are more to do with general attitudes to drug users rather than the OOPs program
- They see it as a worthwhile strategy
- It takes a load off them

ED patients

- We've received positive feedback on OOPS from the patients (ED workers)
- Some of them have no real understanding of who OOPs were - they thought they had seen a social worker
- Some see OOPS as a free cigarette and taxi service

Agencies

- There is a reasonable awareness of OOPS with agencies
- Very well, really positive; good reputation; highly regarded
- Seen as quite a valuable resource for info and support, not just on opiate overdose, but also about the using culture and patterns of use

BREATHE – prisoners

- The prisoners spoke highly of them, they enjoyed it
- Positive, well accepted by the prisoners
- Very well, impressed; the prisoners were blown away
- I have had negative feedback from agencies for pulling BREATHE out
- The BREATHE program is well liked by the Ministry of Justice

Volunteers – all seem really impressed
Police – see OOPS as a big assistance
Parents - think OOPS is respectful of them
High school students – OOPS are seen as someone who understands
Private industries – highly regarded

People who do peer education and overdose prevention nationally – see OOPS as innovative
OOPS is seen as an important part of the health care system

Question Seven: Other comments

Some participants added other comments. They were:

- It's a very valuable program, we're very happy with service
- The OOPs project is valuable, the fact it sits in a government department is groundbreaking. I would like to see it keep going – I fully endorse it.
- OOPS do a really good job, from a particular angle
- It should be ongoing, it's a really necessary service
- It would be a real shame to lose OOPS, it is one of the better, more user friendly programs out there
- It would be a shame if they folded up
- It's a large investment that shouldn't get wasted

SWOT analysis

All participants were asked to do a SWOT analysis as part of the consultation process. This involved asking people the Strengths, Weaknesses, Threats and Opportunities of the OOPS Project.

Strengths

A number of strengths were identified by respondents. Sixteen key themes emerged, and are listed below, ranked in order of frequency.

Staff
Twenty eight per cent of the participants thought that the staff of OOPS were a key strength for the project. Staff were described as:

- Knowledgeable in the field of opiates and overdose
- Diverse, with a good range of expertise – able to work with both peers and professionals
- Versatile, passionate, dedicated, non-judgemental, not rigid, encouraging, approachable, committed, personable, likeable, popular, wildly enthusiastic, imaginative, supportive, willing, good communication skills, inspirational, wise, professional, incredibly dedicated
- Available
  Generous with their time
  Quick in their response to helping other agencies
  "I find them very valuable and accommodating, at the last minute you can call them in and in a week they are there"

There were also positive comments about the current mix of staff on the OOPS team:

- I like the current mix of staff, it's a very good combination
- The collective whole is the value
- Wouldn't want to lose them, they've finally got a team that functions beautifully

Volunteer Training Program
The Volunteer Training Program (VTP) was seen as a key strength by 26% of the sample. Some of the comments related to the VTP itself, including that it is intensive, comprehensive, thorough and well thought out. Other comments included:

- There is 2 weeks orientation plus 8 weeks training, and ongoing learning options that include community speaking workshops and BREATHE training

- There is alot of stuff around values; the training gives the volunteers what they need in a situation that could be quite stressful and still lets allows them to be giving in that role
- It's not too rigid, so it suits the target group
- "I've done Certificates III & IV on AOD at TAFE, which weren't as strong as programs"

Some participants spoke of the professionalism of the VTP:

- OOPS is seen as credible and professional due to the volunteer training
- It is recognised as a credible program by agencies and the community

The volunteers also benefit from the VTP:

- Supportive environment for volunteers, "like a family"
- Provides opportunity for people in the community who have an interest or issue with OD to do something
- It's as valuable for the peers as it is for the clients
- There is a career path for volunteers – they can become a phone holder, and there is a mentor system

Another group referred to the community development and workforce development aspects of the VTP:

- There is an increasing group of people out there who have been to the training, have learnt CPR etc, and that has to be a plus.
- It's a service that is essential for training the community – the more people that get the right message the better.
- There is a flow on effect from the volunteer training to the users – volunteers have contacts and can pass on information about harm minimisation and safe using. The more that gets dispersed, the less people will have problems.
- It's another way to get information out there, not just while the volunteers are doing the ED work, but when they go back to their own peer group. It's a good idea to have volunteers cycling through all the time.
- Because they have trained so many volunteers there is a good body of people who now understand harm minimisation and that's a very valuable community asset.
- If we are training 90 volunteers a year, in ten years we will have 900 people out there who have been exposed to that training – we are lifting the game of the AOD field.

Being located in a government agency (Next Step)
"The fact that it sits in a government department is groundbreaking"

The OOPS project being located within a government agency (Next Step) was seen as being a strength by 26% of those consulted.

The advantages to being situated at Next Step are:

- The ability to gain access to hospitals and prisons.
  They have acceptability and 'conservative credibility'.
  "What they say can be powerful"
- They are very well resourced, having access to such Next Step resources as:
  Clinical Education and Training team, the Research team, the reception desk, the library, the building, cars, computers and administrative support.
  "They have a huge bureaucracy behind them"
- The boundaries and hierarchy that comes with a government organisation can stop innovation from spinning off out of control

- Sometimes question the support OOPS receives from Next Step. It's unique to have a government organisation that keeps a peer based organisation within its doors. The credibility Next Step could gain from this is missed. Next Step could become a Centre of Excellence.
- On the one hand it's good that it's located in Next Step, it would have had a hard time operating in an NGO, so Next Step has to suspend the way it works with a unit like that. If you tried to change the way they operated, i.e. there's not much interaction out there in the annexe, they work funny hours etc, you would change the character of OOPS
- "They get away with being an independent body who is government funded"

A few respondents talked specifically about the ED Project being located in Next Step:

- Not being located in a hospital is an advantage
- "If the ED program wasn't located in Next Step it would be doomed to fail"

ED Project

Twenty three per cent of participants thought that the ED Project was a key strength of the OOPS Project. The following aspects of the ED Project were specifically mentioned:

- The project is pioneering, the first of it's kind in the world
- Provides a service where there was a void
- Available seven days a week
- A reliable service
- Able to be confidential
- Able to offer something tangible (phone call, coffee, cigarette, can get them home)
- Also good at talking to family and friends
- Relationships with hospitals are strong. The entrée into SCGH has been particularly successful
- The volunteers fit in, are low key, work well with staff, unobtrusive, don't make waves
- Able to free up ED staff for other purposes (e.g. development of Bereavement Program at SCGH); a big help for ED staff
- Training with nurses – leads to a consistent approach, all giving the same message and have the same goal
- May be the only time a client is in touch with an agency
  Users don't feel threatened, volunteers build rapport; are non-judgemental, and still have professional boundaries
  Really good way to access people who may not otherwise get in touch with service, it's a good opportunity to link people in, possibly for referral

Action Research Model/ Social Action Learning Model

Another key strength of the OOPS Project, according to 23% of respondents, was the model under which the project operates. The following points were raised in relation to the model:

- This model allows the program to be adaptable, flexible and responsive, with the ability to react and be proactive which can lead to innovation.
- There is a willingness to think laterally, and play with ideas. There are clear guidelines, but change is expected.
- Market trends can be followed, for example opioid use and overdose has decreased, so they are trialling something else (the SCGH pilot)
- There is a continual review of the role of their programs, which has led to improvements and evolution over time (for example, the move from peer education to peer facilitation).
- "It is not a research project, they are trying to gather information in the best way they can and they do a reasonable job at that. They try to be responsive and assess whether they are doing a good job, using a feedback system, which is an appropriate model for what they do – overdose is not a randomised controlled event"

Philosophy/approach

The philosophy or approach of OOPS was also considered to be a key strength by 23% of participants. The harm minimisation approach of OOPS was mentioned by 14%:

- Not abstinence based
- They work out a strategy with the user using the harm minimisation hierarchy – it is a more participative than directive approach
- Has encouraged ambulance use and hospital attendance

The peer education/facilitation approach was talked about by 11%:

- given the population they are dealing with are marginalised, it's good that they've gone for a peer education approach, it is relaxed, volunteers are given good information to convey to clients, and they often have their own experiences
- most of the information comes from users, it is two way, providing support and education but also listening to people, which generates a good understanding of what is happening for people
- with peer education the power hierarchy is removed, it's not a formalised intervention
- "we don't own overdose, users do and they can choose to prevent it"

The program was also described as non-judgemental, respectful, sincere, holistic and "a human approach".

Reputation

Seventeen per cent of participants thought that the reputation of OOPS is one of their key strengths.

- Their name is known, like product recognition.
- They have a good profile, good market presence.
- Don't have to advertise for volunteers anymore – people all over want to be in the program
- The fact that so many people want to do the training shows the market impact
- Well known to the using community, there's good recognition.
- Credibility amongst users is good; the way they cross that fine line between being trusted by users and professionals alike is good
- Have high credibility and have worked hard to get that

Community development and education

Seventeen per cent of people consulted said that community development and education was a strong point for OOPS. It's work with the police and schools were particularly singled out:

- Working with AOD Collaboration Unit of WA Police Service, Forensic display at the Royal Show this year
- Raises awareness of police involvement at ODs
- Work with schools
- OOPS is widespread – it actually reaches clients, agencies and everyday people
- Dispels myths and challenges attitudes in the community
- Encourages the acceptance of drug users - "it's not 'us and them', it's 'us and us'"
- Changes the way the community views overdose

BREATHE

A further 17% of the sample suggested that the BREATHE Project was a strength of OOPS. They had these things to say about the program:

- The program is well structured, professional, has good resource materials, and is comprehensive
- Practical, hands on, getting people to practice with the Annie dummies, and asking them how they would discuss overdose with their friends
- Uses their language, not professional jargon. Makes it very simple, they learn to breath into the mouth, not all the cardio stuff that would be overwhelming

- Was particularly useful amongst that particular target group, i.e. prisons, where there is a large injecting drug use population, a classic group where the minute they get out they have their usual dose and come into the ED blue. BREATHE was a very innovative approach to this.

The project officer for the BREATHE Project was mentioned also:

- What Sam has been doing in the custodial setting has been phenomenal
  They are a high risk group, who can take the info back out there
  It's great to give young people these skills
- Sam has a passion for the area
- Has helped OOPS with PR – Sam got out to agencies

Volunteers
The volunteers themselves were named as a key strength by 11% of respondents, for the following reasons:

- Diversity of the volunteers; gives access to a whole range of drug users and perspectives; they often have their own experiences
- Numbers – the large volume of volunteers trained means:
  They can do many projects eg crossover work with WAAC & WASUA
  They can meet personal needs, and move in and out of the program
  Flexibility is possible
  Rosters are covered
- They are accepted by users and professionals, due to the training
- They are reliable after early teething problems
- Upskilling and supporting volunteers is cost effective

OOPS as a source of information and support for agencies
OOPS was seen as being a valuable resource for agencies by 11% of the sample.

- They are willing to share resources, expertise and give advice.
- They have the capacity to initiate helping other organisations.
- They have been very helpful to us, in a mentoring role, very supportive, always ready to pass on information, very transparent. They offer an organisation like us a lot that we couldn't afford usually.
- OOPS are a trusted source of information for opioids, illicit drug use and overdose
- Always available as a source of information other than the typical sources. Their view is quite different to WASUA, WAAC and HCC and they see a slightly different population, so we get a rounded view of the population.

Expansion
OOPS' potential for expansion was also identified as a key strength by 11% of interviewees, for example:

- The ability to adapt to trends beyond opiates, such as the SCGH pilot project
- Expansion into the prison system, through Breathe, has been well received

"Finger on the pulse"
A further 11% said a strength of OOPS was its ability to keep up to date:

- they have a good knowledge of users, they keep in touch and can verify information about drug trends
- they are working on the frontline, so they see trends in drugs early
- they can stay relevant, and update their skills accordingly

Liaison and links
Eight per cent of participants said that the fact that OOPS are connected and supported by key stakeholders (such as ambulance workers, police, hospitals and prisons as well as users), and their strong links with other agencies such as WAAC and WASUA are a key strength.

Resources
Resource materials such as pamphlets, handouts and stickers were also identified as a strength for OOPS:

- Resources are very creative
- Very funky and user friendly – young people are more likely to read them

Funding
Several people (8%) commented that a strength of the project is that they do a good job with limited resources and budget. A few others (8%) remarked that they are able to do a lot of different activities because they have so many resources.

Other strengths mentioned for OOPS were:

- It's one of a kind;
- It's a world first;
- It's meeting a need that's really important

Weaknesses

The following weaknesses were identified, with twelve major themes emerging. Three respondents (8%) said they could not identify any weaknesses of OOPS.

OOPS is opiate specific
Thirty one per cent said that the fact that OOPS has been opiate specific in the past has been a weakness. The parameters have been narrow, and it has been hard to meet the needs of clients.

The opiate drought has meant that activity has been low for OOPS, leading to an expansion into other areas. Some participants of the review said that although OOPS are aware of changing trends, it has been difficult for them to respond quickly as they are aware of their "opiate mandate".

Some saw limitations and raised questions about OOPS expanding to include drugs other than opiates, such as:

- How knowledgeable are they about other drugs? And,
- Why should OOPs be the one to pick up other drugs?

ED project
Twenty six per cent of the sample identified facets of the ED Project that could be considered weaknesses.

The fact that the service is not 24 hours was seen as a weakness by 8% of participants (there is still a gap between midnight and 9am).

It was noted that there have been problems getting the project fully operational at RPH. Possible explanations for this were: the busyness of RPH due to the location in the CBD; high staff turnover; physical layout of the ED at RPH; and staff attitudes.

Another weakness is the lack of callout mentors in the ED volunteers, which could be due to:

- The heroin drought – volunteers haven't been able to get the experience that is required to take on this role
- Volunteers move out of the program to finish degrees and get jobs

Some respondents felt that the service is open to abuse from patients ("some see it as a free source of cigarettes and taxi vouchers"). Some had concerns that there were multiple presentations of the same people, and the lack of follow up post-callout was identified as a major gap:

- We don't know if the callout has been effective or not
- Has the referral been effective?
- How can we get feedback? Who are we reaching? How do hospital staff get feedback?
- "Sometimes volunteers need to be more pushy giving their feedback to staff" (an ED worker, who also acknowledged that this can be hard for the volunteers)
- What results are OOPS having with patients? We (ED staff) don't get any evaluation results on the overall effectiveness – this would be useful, and it may encourage more staff involvement

There was an acknowledgement by some participants that follow up could prove difficult with this population, as they are often transient, and there are confidentiality issues to be considered.

One participant said that a weakness of the ED project was that there is no theoretical framework for the interactions volunteers have with users, and suggested that a Motivational Intervention would be a useful way to talk to people about overdose.

Another proposed that the model could be improved upon by using a social worker in the hospital instead of volunteers, who could pick up not just overdose issues, but also work with hospital staff to change attitudes towards users.

Roles

The lack of clarity around the role of OOPS and its' staff was raised as a weakness of the program by 26% of those interviewed.

- Parameters and roles are badly defined and constantly shifting
- Often the aims and objectives aren't clear for different projects
- OOPS needs to be clearer about their job roles, their contract and the role of other agencies
  Need to identify a specific role for each agency and work out how they can work together
  There is alot of overlap with St Johns, WASUA and other agencies and services at the moment
  Need a clearer idea of their role and how OOPS works with Next Step, WASUA etc so they can establish what only OOPS can do
  Carve out their own niche of what only they can do without overlap with other agencies

Linked to the problem of role identification was the issue of the isolation of OOPS:

- They are operating too much in isolation
- They tend to go it alone, and don't realise the similar roles of other agencies
- Consultation with the user group is limited and inconsistent, it is a very loose partnership

Also connected to this issue, as a few people suggested, is that fact that OOPS are very generous with their time (perhaps in part due to the lack of role identification) which could put them under pressure to achieve their outputs.

Volunteers

Operating a program with volunteers was seen to be a weakness by 23% of interviewees.

Some claim there is too much concentration on training volunteers:

- There is a big focus on the volunteer program and its importance. There seems to be enormous energy and resources put into volunteers and their training and support. It's not clear what the outcome of this is for the OOPS/ED Project and its relation to the objectives of the program.
- Too many volunteers are being trained with no callouts
- "it's a bit tragic when you have volunteers complaining because there are no overdoses to attend"
- A volunteer program is labour intensive
- "it's not easy organising rosters, and when it gets down to it, volunteers don't have to do it"

There is also the issue of ongoing turnover and attrition:

- "OK they're back in the community spreading the word even if they are not on the roster, but it puts a strain on the organisation"

The role of the volunteer was also raised:

- Need to be clear about the role of the volunteer – they can be out of control and need close organising

"Having volunteers is a double edged sword, on one hand they are enthusiastic and don't expect to be paid, and on the other hand they can be unreliable, and when they stuff up it is hard to discipline them."

Database management, evidence and evaluation

The current system of database management was seen to be lacking by 23% of participants. A lack of evidence for the effectiveness of what OOPS do and a lack of evaluation was also linked to this issue.

- Data is collected, but it is hard to retrieve and analyse
- The data that is collected is not that fantastic
- Need data to promote and improve what they are doing, but can't expect OOPS staff to be good peer educators and good researchers and evaluators
- It's hard to produce research, they don't have clear evidence
- "Being evidence based is very hard – this is not a criticism of OOPS, they are going into new territory, uncharted, and it takes a long time. They don't have to suspend the rules, but they do need to be flexible, as they are doing community development with a hidden population. They don't have an evidence base to guide them – so they make decisions based on what? They may save 20 deaths, but this may not show up in any statistics."
- Monitoring and evaluation of activities could be better – this is due to a lack of resources, and it's also not necessarily up to them (the research team at Next Step could help)
- It is frustrating that they're not documenting or publishing what they do

Issue of being located within a government agency doing peer education

Seventeen per cent raised the issue of OOPS being located in a government agency and doing peer education as a possible weakness. Some noted that this issue has caused conflict in the past. Some agencies and users may be concerned that OOPS are from a government agency. It was perceived as difficult by some for a community based program to flourish in a government environment, making it hard to gain trust from users. Being part of a government agency can restrict what OOPS can do and say. It can also be difficult sometimes for the project to fit in with bureaucratic systems. One participant claimed that "outreach from Next Step is doomed to fail".

Staffing

There were several points raised by the 17% of people who said that staffing issues were a weakness for OOPS. Some reflected on the past:

- Initially the staff were overworked when there were no volunteers, which led to burnout

- The problems of two years ago have been ironed out. The team has only been a team for the past 12 months, it was all over the place before that, it was damaged goods.

Others (8%) said there are not enough full time staff, given the workload.
Some claimed the problem lies in the fact that the management hierarchy has grown, which can lead to "the message getting diluted".

The possible perception was also raised that workers who are ex-users are non-business minded. Another weakness was identified for OOPS when there are no current users on staff.

Funding
A lack of funding was considered a weakness by 17% of the sample. This meant that current services cannot expand (for example to the rural areas). Some raised the concern that funding was not just an issue in terms of service delivery, but also for staff job security.

However, several respondents (8%) said that OOPS did not represent value for money.

Peer based issue
Fourteen per cent said that OOPS are not a peer based organisation. Some said there is a lack of direct day to day contact with users, and others said that OOPS hasn't worked in terms of its' outreach activities:

- This is where it hasn't worked. The only people likely to be effective in outreach to users are WASUA. Perth is a different using culture to Sydney or Melbourne. There are no public scenes or foot patrols out of agencies here. In WA we are talking about the suburbs and people's homes
- Outreach to users has been a dead loss

This reaction was pre-empted by some OOPS staff members who said:

- People's perception of us as peer based is skewed, they see that we are supposed to be peer based and we're not. The reality is that we are peer facilitators. Their definition of peers is very narrow.
- The original concept of using peers changed somewhat after the second intake. It is still strong, the emphasis is on drug experience. We changed because it was difficult for peers to be put back into a using context. It was hard to support some peers, some had ongoing personal stuff. We were almost setting them up to fail. Distance is needed. Now we have volunteers who are ex-users, non-users and users. We haven't moved away from the peer education model – we are reworking it to become peer facilitation. It's very open to individual interpretation.

BREATHE finishing
There were 11% of participants who said they were disappointed when the BREATHE project finished.

"OOPS has been diluted since it was taken out".

One participant suggested that a way to achieve sustainability for the BREATHE program would have been to implement a Train the Trainer program.

Lack of marketing
Marketing was identified as an area for improvement by 8% of respondents.

- We haven't heard a lot lately what OOPs have been doing, maybe they could send a flyer to all AOD agencies to let them know?
- Their profile is improving, but there is still a limited knowledge of OOPs

Steering committee

Six per cent of the interviewees said that the OOPS Steering Committee could be better utilised:

- Didn't seem to achieve anything, it was just talk, with no action
- Could have been better utilised, with more input from WASUA and NDRI. It wasn't always used as a resource for the project, often seen as something to try and avoid

Opportunities and Future Directions

The answers for these two separate questions were very similar, so the results have been amalgamated in this section. Two (6%) participants did not have any ideas for the future directions or possible opportunities for OOPS.

Nine themes emerged from those who did have ideas.

Expansion
The expansion of OOPS was discussed by many of those interviewed. Ten main areas were discussed in terms of expansion.

Drugs other than heroin
Two thirds of all participants (66%) said that OOPS should expand the service to include drugs other than heroin, with 23% particularly mentioning amphetamines.

- Don't just evolve to all drug use, OOPS should reconceptualise and have an ED strategy for speed, benzodiazepines, MS Contin and other drugs
- "Trends come and go, and with the amount of work put into setting up a program like OOPs, it's a shame to just limit it to opiate issues. Should use the structure and supports for different substances"
- They need to adapt to changing drug trends, to be responsive to the population they service
- They should develop similar resources for other drugs like they did with opiates
- They have quite a good set up, the volunteer training is very good, and with the heroin drought it is sensible to try and expand. Heroin will be back on the streets, and we could be in the same situation we were 5 years ago with 80 deaths and no-one doing anything
- It's appropriate to move beyond opioid overdose, but OOPS should still maintain a profile with opioids for when the drought is over
- With the trial at SCGH looking at overdoses from benzodiazepines etc – at the end of the day, these are the same people being seen for opioid overdose
- It's time for the field as a whole to broaden from opioids to psychostimulants. OOPS is well placed for this. If they don't, someone else will and they will have missed the opportunity

Increased community development
Twenty per cent of participants said that OOPS should be doing more community development.

More training
There was an opportunity for OOPS to do more training, with hospital staff, agencies and St John Ambulance staff, according to 20% of the sample.

Hospitals
Seventeen per cent said that OOPS should expand to other hospitals, such as Swan Districts, Armadale, Joondalup and King Edward Memorial Hospital, as well as building on the relationships they already have with SCGH, RPH and Fremantle Hospital. It was also suggested that the ED project could also extend to wards other than ED.

- More needs to be done about getting it into the hospitals, but that takes time. SCGH is a very good model and ideally we would like to see that in other hospitals

- Need to build on the relationship with SCGH – you've got a very strange service embraced in a teaching hospital's ED, that sort of thing takes years

Prisons
A further 17% of participants said that further expansion should occur into the prisons, including BREATHE as well as addressing other drugs. Follow up with prison populations was also seen as an opportunity for OOPS.

Schools
Expansion into other schools as well as universities was seen as an opportunity for OOPS by 14% of the sample. Training teachers was also mentioned.

Research
Research was also seen as an area for expansion by 14% of participants:

- The ED project provides valuable access to illicit drug users who aren't involved in treatment. There are remarkable opportunities for research, and OOPS need to capitalise on this
- What excited me about OOPS is that they can offer Next Step an opportunity to access a non-treatment population. Next Step could be the only treatment service in Australia that could get reliable non-treatment control groups
- The Lollipop survey (surveying users about their awareness and knowledge of OOPS) needs to be replicated. It was cheap and the volunteers helped
- A fundamental research question for OOPS would be to look at how many OOPS clients end up at Next Step Treatment Services in East Perth
- It would be a substantial research project to find out if OOPS were effective - should do a large scale, more formal evaluation that is funded

Rural and regional areas
Eleven per cent said that OOPS should expand to regional areas, especially to mining and fishing communities, where drug use is more prevalent. It was suggested by one participant that perhaps this could be achieved by working with the Community Drug Service Teams throughout the state.

Expand ED Project to 24hrs
Expansion of the ED Project to cover 24 hours was identified as an opportunity for OOPS by 6% of participants.

Prevention
A further 6% said that there were opportunities for OOPS to become more involved in early intervention and primary prevention.

Other opportunities for expansion mentioned were:

- OOPS could take a larger role as an early warning indicator – what drugs are out there, how is the heroin out there, risks etc. Could be more formal, and could feed into the treatment services
- To retain BREATHE and charge for this training
- Could do more work with police – to assist with other drug related callouts (this would require more training)
- Provide support and information for naltrexone patients
- Provide consultancy in the Aboriginal area

Liaison and linking
Over a third (34%) of those interviewed said that OOPS needed to develop stronger links with some stakeholders.

There is a need to develop stronger relationships with hospitals, especially RPH and Fremantle
Need to make these more formal relationships, e.g. with hospital social workers.

The OOPS project could be used as a conduit for better relationships between hospitals and other Next Step services.

An opportunity for more collaboration with other services at Next Step was identified, such as:

- The rest of the Information Strategy (ADIS, PDIS, Library, Education and Training, GP Project)
- Research (although two people pointed out that OOPS are already working on database management and publishing issues with the Research team)

More collaboration, links and strategic alliances should be made with external agencies, such as:

- Family & Children's Services, TAFE, Phoenix, Women's Refuges, JSDU, WASUA, DOH, WADASO, NDRI, St Johns Ambulance, Fire Brigade, Police, local government, CDSTs, LDAGs, pharmacists, Yirra
  This will be useful for cross referral
  Opportunity for cross agency placement of volunteers (some volunteers are already doing this with WAAC and WASUA)
  OOPS can't work in isolation, they need to be involved in the wider process
  OOPS should spend a lot of time supporting WASUA, to build bridges there, they should give time and resources

It was also identified that OOPS should utilise their reference groups more:

- Use Opiate Overdose Strategy Group and it's broad membership more for it's expertise, information sharing, and PR
- Use steering committee more

Location
26% of the sample said the location of OOPS should be examined in the future. Several models for the most appropriate location for OOPS were suggested, with the debate centring on having it in a government vs a non-government location.

Leave it within Next Step (9%)
Some people acknowledged that this could be isolating in some ways. Others thought it was the best case scenario:

- OOPS is better located at Next Step rather than WASUA – they would find it difficult to get in the door, or have access, to prisons and hospitals. Being in a government organisation makes a difference.
- Would rather see OOPs in government to maintain an evidence based approach, which you can't have in a user group. We couldn't have a direct say in their approach.

Move it to WASUA or other NGO (17%)
- Relocate in WASUA with salaries paid from Next Step
- After the new AOD organisation is formed, reconstitute OOPS as a partnership between the new organisation and WASUA, to be run jointly. It's logical to put OOPs with WASUA.
- OOPS may need to be an NGO. Messages can be sanitised from government agency.

Move to a hospital base (8%)
- Make OOPS a more instrinsic part of hospital structure
- Perhaps a Nurse or a social worker in ED could take up the role

- Move OOPS to within the hospital system, but keep it independent of them, to maintain rapport and trust with users

St Johns Ambulance was also raised as a possible location for the OOPS Project (6%).

Volunteer Training Program
Twenty per cent of participants saw opportunities to do with the VTP for OOPS.

- 11% thought that the VTP should be Nationally Accredited
  become a centre for excellence in peer facilitation and training;
  establish an accredited peer education program; and
  provide more PD for peer based workers.
- Improvements to the VTP could be made by:
  including more on NSPs, BBVs and other drugs;
  including training on motivational interventions and other theoretical frameworks and more counselling skills, so volunteers can do a good intervention. Should ook at what works with people at risk;
  using the Education and Training team at Next Step to assist with the training; and
  focusing on the workforce development aspect of the VTP.

Some participants felt that OOPS should cut back from training so many volunteers, as this was seen to hamper the flexibility of the program. Others felt that the volunteers could be better utilised in other projects.

Better marketing
Fourteen per cent said that better marketing was required for OOPS, to gain a better community recognition of what they do.

Strategic planning
A few participants (11%) felt that more strategic planning was required by OOPS, to help them focus on the future of the service.

"Just because they are attending in times of crisis doesn't mean they have to be an organisation in crisis themselves"

The Review
Several people (11%) saw the Review process as an opportunity for OOPS.

- It is time for a review, OOPS has evolved over time, so it's time to look at where it should be
- Should do a more formalised review of the effectiveness of the OOPS program. It should be properly documented.
- Should review the program and build on success

ED Project
Improvements to the ED Project were suggested by 8%, particularly to increase mechanisms for follow up and referral. Evaluation of the project was also seen as necessary:

- to continue the ED Project it needs more evidence of success, an evaluation to see if it is preventing overdose in the long term

Continue the work they are doing
A further 8% said that OOPS should continue "the valuable work they are doing", including "retaining staff with historical resources".

Better data management

Eight per cent called for improvements in data collection, management, recording and reporting.

Other comments on opportunities and future directions for OOPS:

- "the whole OOPS package is an opportunity"
- "could have great scope"
- "huge opportunities really"
- "huge future"

Threats

Funding (15)

Reduced funding was identified as a major threat for the OOPS Project by 37% of the sample.

- If there's less in the kitty, what do you stop doing? Need for prioritising.
- You can't run projects like OOPs with short term funding

Losing staff as a result of reduced funding was also considered to be a threat.

- If staff were lost and they moved into other areas, there is a risk that expertise will go with them, and the next person may not have their passion, they may see it as just a job

Another comment was about funding issues within Next Step:

- I would like to see OOPS get it's full budget and for Next Step to acknowledge OOPS for what it does

Relationship with the user group

OOPS' relationship with the WA user group (WASUA) was clearly identified as an issue by 31% of people consulted. The following comments were made about a lack of collaboration between OOPS and WASUA:

- On face value, work is done to promote collaborative relationships, but when it comes down to competing for a limited pool of funding, there's a perception that knives are drawn and backs are wounded
- OOPS should not lose touch with the user group and the needs of that community

Other comments were to do with people perceiving WASUA having concerns with where OOPS is located:

- Certain user based organisations having difficulty with where OOPs is placed
- The user group is constantly complaining about how appropriate it is for OOPs to be there (at Next Step)
- OOPs is the rich brother because it is a government organisation, it sets them up as an easy target

This participant felt that the relationship could improve:

- The relationship with the user group could be better – they have their own needs and desires, and they see OOPS as a competitor, whereas they are really complementary services;

Whereas this respondent says:

- The tension between OOPs and WASUA, sometimes there is nothing you can do about it, they can still get things done. There will always be an element of tension, with OOPs in a government agency and others seeing them as being advantaged.

Volunteers
Utilising a volunteer force was seen to be a potential threat by 17% of participants.

Eight per cent were concerned with how to keep volunteers motivated in periods of low activity:

- You have volunteers that have been trained chafing at the bit, sitting around waiting for calls that never come, losing momentum, enthusiasm, skills and confidence, and possibly feeling inadequate when they do get a callout. Should give them other projects to do.

A further 8% were concerned with recruitment and retention issues:

- You don't want the numbers of volunteers to be too big, as adequate support becomes an issue
- Maintaining the quality of the volunteers recruited is important
- If a lot of the volunteers were doing it to support their ongoing education and were less user/peer based there would be a problem, if people were just doing it for work experience
- For some of the volunteers ti just seems to be value adding to their studies

Some were concerned about the effect accredited training may have on a "unique volunteer training program".

Heroin drought
Eleven per cent saw the heroin drought as a potential threat, concerned that "people may forget about overdose".

End of Breathe
A further 11% saw the BREATHE project finishing as a threat to OOPS.

- BREATHE is a complementary component of OOPS
- Still receive enquiries for BREATHE
- It should be re-funded or included in core Next Step funding
- BREATHE should be taken up by another agency (e.g. St John's)
- "a couple of patients have been brought into ED by mates who had actually attended BREATHE and kept their mates alive"

Community attitudes
Some people (11%) thought OOPS may be perceived as condoning drug use by those who come from an abstinence based model. The attitudes of the community were seen as a potential threat to OOPS.

- "Society is becoming less tolerant"

Unable to prove effectiveness
Eight per cent thought that OOPS' inability to prove its effectiveness was a threat.

- What is good effect? How do you measure it?
- Are we perceived as effective in other agencies eyes?
- There is no evidence base for what they do

Lack of understanding of what OOPS does
A few respondents (8%) felt that the OOPS Project isn't fully understood:

- The "full bodied" version is not understood

- "Our work has been defined by an outside definition without understanding what we do"
- Not promoting what a great service it is
- Need more marketing

Peer issue
The peer issue was seen as a threat by 8% of those interviewed.

- There is an assumption that we're not effective – "you're not peers, you don't use". There is an "either/or" mentality around the peer issue, instead of seeing us as a complementary service
- I don't care if you call it peer education or peer facilitation, there are different approaches and it is not helpful to argue over this. Common ground should be found, and then work on that.

Being located in a government organisation
Being part of Next Step, and in the DOH, was seen as a threat by 8% of the sample.

- The ongoing conflict of being placed in a government agency

Complacency
Eight per cent of people interviewed felt that there may be a danger of OOPS becoming complacent, or stagnant. They said that simply focusing on training volunteers and doing the ED Project without considering other strategies could be a threat for OOPS.

Restructure of the AOD area

Some respondents (8%) thought that the restructure of the AOD field may pose a threat to OOPS in the following ways:

- How does OOPS fit into the new model?
- Divide and conquer when scrapping for funding
- Will Possibly need to educate "naïve funders"

Other threats to the OOPS Project raised by the interviews were:

- Partnerships – not having strong partnerships with other agencies, and being closed about what they're doing
- Hospital politics
- Government policy – "the right swing is a worry"

Discussion

There were some issues in particular that were raised during this Review process that need further consideration and discussion.

The Volunteer Training Program

There is an over emphasis on the Volunteer Training Program. Is this the right target group? Does training students, who make up a quarter of the volunteer force, meet the objectives of the project? Is the purpose to value add to people's studies? What about it's role in workforce development? Is it an expensive workforce development project?

There also seems to be overlap with the other VTPs at Next Step, such as the Volunteer Addiction Studies Program and the Parent Drug Information Service.

The resources and expertise of Clinical Education and Training at Next Step also appear to be underutilised.

The content of the VTP needs to be reviewed to include theoretically based interventions such as motivational interviewing. The use of guest speakers also needs to be reviewed. For example, using WASUA to talk about home detoxification does not seem the best use of their time and expertise.

Peer Based Issue

OOPS seems to come from a peer development model, where the personal development of the peer educators is the focus of the intervention, more so than a peer delivery model. This issue needs clarification – what is the desired outcome for the project? Is it:

- to modify peer norms in the area of overdose? (peer influence)
- to have 'expert' peers teaching information and skills about overdose? (peer teaching/counselling)
- to develop peers through involvement in the planning, decision making and implementation of the overdose project? (peer participation)

Peer facilitation as a model was not found in the review of the literature. A definition of peer facilitation provided by the current coordinator of OOPS: "The distinction needs to be made between on the street, one to one peer outreach (such as that which WASUA are funded to do for BBVs, etc) and the more general peer facilitation. This is where users are provided with the opportunity to access information, referral and assistance from people who may or may not be users, but who are well trained in providing specific and appropriate information, from a peer focus. Users may or may not wish to 'out' themselves as users and sometimes prefer methods where their use is not made explicit. (i.e. workshops at their workplace, etc)"

Rather than trying to reach an agreement on the definition of a peer and peer education/facilitation, those involved in this area should focus on the role of their service and how to best meet the needs of their target group.

Relationship with the user group

When the OOPS Project was initiated, WA did not have a funded user group. This is not the case now, with WASUA in operation.

It should be noted that during the first focus group held with staff, WASUA were not even mentioned. There was no discussion of collaboration or of their relationship with the user group.

This relationship will always be competitive, but needs to be more complementary.

Working with hospitals

Working with a number of hospitals has posed some difficulties for the project. Each of the participating hospitals have their own structures, workloads and policies with varying consequences for the ED Project. For example RPH has one of the busiest Emergency Departments in Australia. It's catchment area includes the CBD where many homeless people tend to congregate, and it had a relatively high level of overdose presentations. Security procedures are rigorous and include a visitor's policy (which allows only one visitor per patient, and applies to all visitors including family, police and OOPS volunteers) which has made it difficult for OOPS staff and volunteers to gain access to clients in the ED. Initially OOPS was not called out until the point of discharge, which meant that many clients were missed as most people tend to leave the hospital soon after discharge. However, this issue has been addressed over time and has been largely overcome as ED staff began to see the advantage of involving OOPS in overdose patients discharge planning.

The ED Project has a better response rate from SCGH taking into consideration the total number of overdoses they see and how many callouts occur, however, information from RPH and Fremantle on the total number of overdoses they see is not received by OOPS.

OOPS appears to work well at SCGH because there is:

- A sound understanding of OOPS principles and practices
- Overt support from hospital hierarchy
- Overt support at a worker level
- A non-judgemental attitude by the majority of staff working in ED
- A high profile within the hospital
- Consistent attempts by ED staff to retain clients long enough for OOPS attendance
- Active involvement and support from the Alcohol and Drug Liaison Officer and the Brief Intervention Officer

There is a need for continued liaison with the hospitals to improve the ED Project operations.

Follow Up for the ED Project

Follow up has dropped considerably since the ED Project began, for example 44 clients received follow up for 1998/99, compared to 5 in 2000/01. Barriers to follow up with clients taking place were discussed with the current Coordinator who cited the following issues:

- We are dealing with an illicit activity, with social stigmas. Users don't trust people easily.
- Users were suspicious of the ED Project initially. The project has been working so well because we don't ask for identifying information. They now trust and accept us more, and if we asked them to provide information to allow for follow up, that trust would change
- Not appropriate to actively seek out people in their homes
- Only get very rare follow up episodes, and these mostly occur over the phone

Possible ways to overcome barriers to following up clients were also discussed:

- Its' useful to not emphasis that OOPS is a government service
- Would be useful to crosslink the ED database
- Continue to make linkages with other agencies who have high contact with clients at risk of overdose to identify repeated overdose clients

Research

It is difficult to prove if the program is having an effect. There is no evidence to show that there has been a reduction in overdose, or that the target group is learning about overdose as a result of the program.

This could be partially overcome by improving OOPS' data collection and management. It could also be addressed by OOPS having more involvement with research in the overdose area.

The National Heroin Overdose Strategy

The National Heroin Overdose Strategy (NHOS) has implications for the OOPS Project. In particular, the work BREATHE has done in prisons has the potential to meet some of the strategies outlined. The opportunity to undertake research to improve the evidence base around both overdose and peer education is also a possibility, as is the potential for OOPS to increase the timeliness and reliability of data in respect to overdose. OOPS has already come some way in addressing some of the key strategy areas outlined in the NHOS, including: assisting drug users to reduce their risk of overdose and increase awareness regarding the consequences of overdose; increasing the confidence of drug users, family and friends in respect to identifying and managing overdose and; increasing the confidence of opioid users, family and friends in contacting emergency services in the event of an overdose.

Where to from here?

There needs to be a refocus on what is required from the project at this point in time when circumstances have changed, both from a financial and an 'on the street' point of view, without losing all of the good things the project has achieved.

The program has failed to be flexible in the last 12mths, when circumstances have changed. It hasn't had the rapid response an action research model requires. Until recently, with the SCGH pilot project, the program continued to operate as if nothing had changed.

OOPs is an expensive program to run. In a time of limited resources, it needs to be examined and perhaps refocused to see what the best use of these resources are. This may include:

- The redistribution of resources to other stakeholders, to meet the current needs of the population. Perhaps a redistribution of funds to WASUA for some aspects of the project?
- Perhaps a focus on EAR train the trainer would be the best use of resources, or the "best buy"
- Less investment on infrastructure and permanent staff, and more use of contractors or casual staff
- Running only one intake of volunteers a year instead of the proposed two. There are currently 46 volunteers on the books for OOPS, which should provide a good base for the ED Project to draw from. The resources saved on this measure could be utilised elsewhere (marginal analysis – prioritisation process)
- Looking at levels of bureaucracy within the project, including levels of management and amounts of meetings etc
- A large amount of money has been spent on the development and distribution of resources by OOPS. This may not be necessary in the future.

Overall the OOPS Project is well regarded in the field. It has had some achievements, but requires a refocusing to meet the needs of the target group in the future.

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Appendices

Appendix One: Volunteer Training Program

Week One: A Walk Through the Project
Defining ground rules
History of the project
History of heroin
Role of the volunteer worker
Poly drug use
Volunteer feedback form

Week Two: Being There
Drug culture dynamics
Peer education
Safe injecting
Tips for self care
Evaluation

Week Three: Walk a Mile in My Shoes
Management of overdose video workshop
Perspective from an Ambulance Officer
Perspective from an Emergency Department nurse
Overdose, the comedy from tradgey

Week Four: Watch it, Viruses Everywhere!
Blood Borne Viruses – hepatitis, HIV and AIDS
Living with HIV – personal perspective

Week Five: Where's Wayne?
Discrimination
Workshop "Queer as a two bob watch"
Sex work
Aboriginality

Week Six: Alternative Rides
Medical management of problematic heroin use
Alternative therapies
Personal perspective of home detox
Legal implications of illicit drug use
Starting the referral process

Week Seven: Pass the Buck and Draw the Line!
Detailed information on referral
Boundaries and confidentiality
"Helping"
"Listening"

Week Eight: That's All Folks
volunteer policy and procedures
brief counselling skills
paperwork, paperwork and more paperwork!
Brief intervention
Course review

Appendix Two: OOPS ED callouts broken down by hospital from 22 May 1998 to 22 November 2001

1998

Hospital → Month ↓	SCGH	RPH	Freo	Totals
May	1	2	n/a	3
June	5	3	n/a	8
July	11	6	n/a	17
August	10	5	n/a	15
September	4	0	n/a	4
October	3	0	n/a	3
November	10	13	n/a	23
December	4	5	n/a	9
Totals	**48**	**34**	—	**82**

1999

Hospital → Month ↓	SCGH	RPH	Freo	Totals
January	9	2	n/a	11
February	12	14	n/a	26
March	12	6	n/a	18
April	9	5	n/a	14
May	4	10	n/a	14
June	6	6	n/a	12
July	9	13	3	25
August	6	11	0	17
September	1	3	0	4
October	9	9	0	18
November	4	8	1	13
December	6	11	0	17
Totals	**87**	**98**	**4**	**189**

2000

Hospital → Month ↓	SCGH	RPH	Freo	Totals
January	9	5	1	15
February	7	5	0	12
March	4	7	2	13
April	9	2	1	12
May	3	9	2	14
June	7	2	2	11
July	6	1	1	8
August	13	3	0	16
September	5	10	3	18
October	7	6	1	14
November	5	1	0	6
December	7	3	1	11
Totals	**82**	**54**	**14**	**150**

2001

Hospital → Month ↓	SCGH	RPH	Freo	Totals
January	3	3	0	6
February	1	0	0	1
March	0	0	1	1
April	2	0	0	2
May	2	1	0	3
June	0	0	1	1
July	4	1	0	5
August	0	0	1	1
September	1	0	0	1
October	2	0	0	2
November *(to date – 22/11/01)*	0	1	0	1
December	n/a	n/a	n/a	n/a
Totals	**15**	**6**	**3**	**24**

Appendix Three: List of stakeholders consulted for the review

Christine Lethlean, Volunteer Coordinator, OOPS
Mel Robson, ED Project Coordinator, OOPS
Sam Nicholson, Peer Education (BREATHE) Worker, OOPS
Shane Moore, Coordinator, OOPS
Monique Berkhout, Manager, Information Services, Next Step
Deb McEvoy, Community Health Nurse, Rockingham SHS
Terry Murphy and Melanie Hands, WADASO
Gill Wilson, Alcohol and Drug Coordination Unit, WA Police Service
Tamara Speed, Justin Woodruff and Siobhan Delgardo, WASUA
Damon Joseph, Manager, Clinical Support, St John Ambulance
Kaz Hannelly, Clinical Supervisor, SURU
Anne Bartu, Research, Next Step
Myra Browne, Manger Professional and Organisational Development, Next Step
Nigel Smith, Assistant Superintendent, Rangeview
Dave Paterson, Acting Manger, programs, Banksia Hill
Etza Peers, Penny Richmond and Sandy Clarke, SCGH
Tania Lamond, WAAC
Mary Hinds, WA Pharmacy Needle and Syringe Support Program
Pam Rosenbaum, Community Health Nurse, Mt Lawley SHS
Catherine Montigny, ex-OOPS employee
Gretta Little, ex-OOPS employee
Damien Roper, ex-OOPS employee
James Featherstone and Kim Hargreaves, NDRI
Janelle Fawkes, Phoenix
Siobhan Foley, Yirra
Dave Louden, RPH
Steve Allsop, Director, Clinical Education, Training and Research, Next Step
Kyle Dyer, Research, Next Step

Appendix Four: Service Specifications – BREATHE

1. Training and support of OOPS volunteers and agency staff in 'BREATHE'.

Number of agencies engaged
Number of agency staff engaged and which agency they came from
Number and dates of training sessions for volunteers
Number of workers, OOPS and WASUA volunteers trained
Descriptive report of support activities undertaken by OOPS volunteers for agencies

2. Peer Based EAR training and support.

Number and dates of peer training sessions
Numbers of peers/clients trained in 'BREATHE'
Descriptive report of support activities undertaken by WASUA outreach workers

Coordination and administration of 'BREATHE' project.

Membership list of people on the Reference Group
Descriptive report of coordination and administration activities

Evaluation of the 'BREATHE' project.

Descriptive report of feedback from relevant protocols
Report on the evaluation of the competence of those trained in 'BREATHE'

Appendix Five: Service specifications 1997/98, 1998/99

1997/98

OPIATE OVERDOSE PROJECT (OOPS)

The outputs are difficult to determine without an established baseline and will be developed through the first year. The indicators to be determined relate to:
Number of peer-based education strategies.
Number of peer-based education and training events.
Number of peer-based outreach consultations provided.
Number of education and training events for drug workers and other professionals.
Distribution of appropriate resource materials through networks.
Number of joint programs conducted with other key agencies.

EMERGENCY OVERDOSE FOLLOW UP PROJECT

The development of a fatal and non fatal opiate overdose database
The development of protocols and procedures for the prevention, management and follow-up of non fatal opiate overdoses in Perth A&E Departments.
The introduction of a user focused opiate overdose information package (in conjunction with OOPS).
The development of a referral and follow-up network.
The number of clinical contacts with clients post overdose.
The development of demonstration projects in best practice in opiate overdose prevention, management and follow-up

1998/99

OPIATE OVERDOSE PROJECT (OOPS)

Number and type of peer-based education strategies
Number of peer-based education and training events
Number of peer-based outreach consultations provided
Number of education and training events for drug workers and other professionals
Distribution of appropriate resource materials through networks, including opiate users
Number of collaborative programs conducted with other key agencies

EMERGENCY OVERDOSE FOLLOW UP PROJECT

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

1999/2000

Component 1: Emergency department intervention

The following outputs will be reported on as indicated:
Number of brief interventions (monthly)
Number of volunteers recruited (monthly)
Number of volunteers completing emergency department training program (monthly)
Descriptive report of activity, including, location, type and current issues (quarterly)

Component 2: Opiate Overdose Project (OOPS)

The following outputs will be reported on as indicated:
Number of peer-based education and training events (monthly)
Number of education and training events for drug workers and other professionals (monthly)
Descriptive report of activity, including type, target group, peer-based strategies and resources developed and distributed (quarterly).

2000/2001

Component 1: Emergency department intervention
The following outputs will be reported on as indicated:
Number of brief interventions by Hospital (monthly)
Number and type of follow up interventions (monthly)
Descriptive report of activity, including, location, type and current issues,
number of volunteers recruited and number of volunteers completing program

Component 2: Opiate Overdose Project (OOPS)
The following outputs will be reported on as indicated:
Number of peer-based education and training events (monthly)
Number of education and training events for drug workers and other professionals (monthly)
Descriptive report of activity, including type, target group, peer-based strategies and resources developed and distributed (quarterly).

DESCRIPTIVE REPORTS

ED Project
Descriptive report of activity, including location, type and current issues (quarterly)
OOPS Project
Descriptive report of activity, including type, target group, peer-based strategies and resources developed and distributed (quarterly).