

REPORT OF A COLLABORATIVE CARE INITIATIVE: ASSERTIVE OUTREACH TEAM AND HARM REDUCTION SERVICE

Assertive Outreach Team, Harm Reduction Service and Dual Diagnosis Project
Leeds, July 2009

ABSTRACT

Background: A recent survey indicated that a substantial proportion (51%) of clients with a diagnosis of Schizophrenia under the care of AOT present significant substance use problems, and a minimal number of them currently access drugs treatment. A joint-outreach initiative between AOT and HRS was piloted and evaluated as a way to assess and engage clients with harm reduction interventions.

Aims: To engage AOT clients in assessment and harm reduction interventions; to explore evaluation and outcome measurement methods with this client group; to inform future work to meet the needs of this client group.

Methods: Consenting AOT clients known to use alcohol/drugs were engaged in joint-outreach visits over a period of 12 weeks. Base-line and end questionnaires including quantitative outcome measures for patterns and severity of substance use were used. A qualitative interview guide and case notes were also included. Basic descriptive statistics were produced for all quantitative data and thematic analysis was used to process all qualitative data.

Findings: A total of 12 clients were engaged. 36% of contacts resulted in screening and drug related discussions, and there was evidence that 18% of contacts actually resulted in the structured delivery of harm reduction advice and information. Cannabis and amphetamines were the most commonly used drugs. There was evidence that most clients had very little insight into the risks and impact of their substance use and had little or no motivation to change, which was a key barrier to engagement. There was evidence of physical harm (such as infected injecting-site) and psychological problems (such as increased anxiety, paranoia) directly related to substance use.

Conclusion: The evaluation suggests a success ratio of 1 in 6 clients actually engaged in structured harm reduction interventions and health promotion.

1. BACKGROUND

Coordinated joint outreach work between Assertive Outreach Team (AOT) and Harm Reduction Service (HRS) staff in Leeds has taken place since 2008. This partnership was developed following the completion of a cross-sectional survey of Dual Diagnosis cases carried out by AOT in July 2008 (appendix 1). The survey indicated that 51% of AOT clients had a significant substance use problem, and only 9% of patients were currently involved with a drugs treatment service. It was estimated that problematic substance use had a significant and detrimental effect on the mental health of at least 71 clients (42% of cases surveyed). The complexity of this group's mental health problems, their highly risky patterns of drug use and their generally low level of motivation to change encouraged practitioners in these services to pilot a harm reduction oriented outreach approach. Staff involved in joint-outreach in the initial stage of this partnership were nominated Lead Dual Diagnosis Practitioners who had completed a specialist training course, and who were regularly involved in the practice development sessions for members of the Leeds Dual Diagnosis Network.

In 2009 this partnership work was formalised with a joint working protocol (appendix 2) which also included the Street Outreach Team. The aim of this partnership is to offer support to drug users with severe mental illness who are not currently accessing any drug treatment services, and whose circumstances have led on to homelessness or increase the risk of becoming homeless.

2. DESCRIPTION OF PILOT PROJECT

AOT and HRS agreed to conduct a brief pilot project over a period of 12 weeks between April and June 2009.

2.1 Aims

- To engage drug users with severe mental illness under the care of AOT with a harm reduction practitioner via joint outreach work.
- To explore ways in which any outcomes for this client group could be evaluated.
- To identify any benefits and limitations of joint-outreach from the point of view of clients and staff.
- To inform future work to meet the needs of this client group.

2.2 Procedure

A HRS practitioner did outreach work alongside 2 (alternating) AOT practitioners one afternoon per week over the course of 12 weeks. The work targeted AOT clients known to use drugs, whose care was coordinated under the Care Programme Approach. Verbal consent was obtained from clients in order to share information and to engage with the HRS practitioner. Efforts were made to engage with a set cohort of clients over several weeks, although in practice 'one off' contacts with clients also took place. Contact was made at clients' houses and also in hospital settings. As possible, the practitioners endeavoured to: engage clients in a discussion about their drug use and impact on health, assess patterns of use, provide some information about effects - risks - harm reduction, and elicit feedback about joint-visits. More details on confidentiality and collaborative care are found in appendix 2.

2.3 Outcome measures (appendix 3)

CLIENT OUTCOMES FORM: DRUG USE

Patterns and severity of drug use were captured using a form with 2 sections:

Section 1 included an inventory of substances used, frequency, route and quantity. The form also contains a section to include any notes about current harm / risk related issues. This inventory was adapted from the triage assessment form routinely used by the HRS, and it was chosen due to its familiarity to staff and compatibility with the service's assessment procedure.

Section 2 included a severity rating scale known as the *Clinician Drug Use Scale (CDUS)*, developed by Drake et al¹. This scale provides operational definitions to rate clients' severity of drug use according to the following categories: abstinence, use without impairment, abuse, dependence, and dependence with institutionalization. The CDUS tool was developed in reference to DSM-III-R (APA 1987) criteria for drug dependence, and the validity and reliability of this instrument was confirmed by a series of studies involving clients with severe mental illness (Drake et al 1989, Drake et al 1990, Mueser et al 1995).

CLIENT OUTCOMES FORM: HEALTH, COPING & WELL-BEING

Section 3 - A semi-structured qualitative interview guide containing open questions and rating scales was designed to enable staff to elicit information about: Perceptions about the impact of substance use; perceptions about overall health; self-rating of physical and mental health; perceptions about current problems / difficulties; coping strategies and self-rating about ability to cope. The questionnaire also contained a question to elicit feedback about joint-outreach visits

STAFF QUESTIONNAIRES: ATTITUDES, PERCEPTIONS AND FEEDBACK

Practitioners taking part in the pilot were asked to complete baseline and end questionnaires based on the *Co-morbidity and Co-morbidity Clients' problems perceptions questionnaire (CMPPQ)*, commissioned by

¹ Drake, R.E., Osher, F.C., Wallach, M.A. (1989) Alcohol use and abuse in schizophrenia: a prospective community study. *Journal of Nervous and Mental Disease* 177:408-414.

the Scottish Executive and developed by Watson et al². This tool was developed to assess the views and attitudes of practitioners in relation to clients who have co-existing mental health and substance use problems. The tool is designed to measure 6 domains: role adequacy, legitimacy, support, motivation, professional self-esteem and satisfaction. The CMPPQ was derived from the *Drug and Drug Problems Perceptions Questionnaire*, which has undergone psychometric testing with regards to factor analysis, validity and reliability (Watson et al 2003). Comparing baseline and end questionnaires was intended to assess if taking part in joint-outreach had any effect on practitioners' attitudes and perceptions about working with dual diagnosis clients.

Additionally, open questions were added to this questionnaire in order to elicit feedback about the impact of joint-outreach, and to obtain suggestions about how care for this client group could be improved.

2.4 Data Analysis Methods

The data analysis was performed by a reviewer independent of the AOT and HRS teams to minimise bias. A draft report was shared with the above services and a final version was produced in discussion with all staff involved in the pilot project. Descriptive statistics were provided for: number of clients seen, patterns of drug use and engagement patterns. CDUS scores were compared between baseline and end questionnaires in order to assess if there had been any change in severity of drug use. CMPPQ questionnaires were scored with a view to compare overall scores for all 6 CMPPQ domains between base-line and end questionnaires to assess any changes. Any further statistical analyses were not possible due to small sample size. All qualitative data was submitted to thematic analysis, this included client outcome forms, case notes and staff feedback questionnaires.

3. OUTCOMES

3.1 Data collection and outcomes monitoring

A total of 12 clients were seen via joint-outreach during a period of 12 weeks. The table below describes the type of information collected during the pilot:

Table 1

		N	%	
Data Collection	TOTAL clients seen →	12	100	
	Case notes kept	12	100	
	Base-line client outcomes form:			
	Drug inventory completed	5	42	
	CDUS score completed	3	25	
	Health & coping info gathered	5	42	
	End client outcomes form:			
	Drug inventory completed	0	0	
	CDUS score completed	0	0	
	Health & coping info gathered	1	8	
	Feedback obtained re: joint-outreach	2	17	
	Base-line staff questionnaires completed	1 out of 3 staff		
End staff questionnaires completed	1 out of 3 staff			

² Watson, H., Maclaren, W., Shaw, F. and Nolan, A. (2003) Effective Interventions Unit: Measuring staff attitudes to people with drug problems: The development of a tool. Scottish Executive Drug Misuse Research Programme. Available at: <http://www.scotland.gov.uk/Publications/2003/08/17735/23438>

- The HRS practitioner took a lead in keeping records of all contacts with clients during the 12 week pilot. AOT practitioners also had an input into the information that was recorded in standard client outcome forms through discussion following client contacts. In addition to the forms, the HRS practitioner kept (anonymised) case notes of all client contacts, which were also provided to the reviewer for data analysis.
- In practice, it was difficult to use client outcome forms in the format of client interviews due to the circumstances in which outreach work was conducted (e.g. at hospital settings, in brief home-visits, etc.) and also due to the state of mind of some clients (not willing to engage, not well enough to follow a structured interview, etc). Therefore, only 5 'base-line' client outcome forms were completed based on information recalled by both practitioners after seeing clients. Only one 'end' client outcome form was completed; therefore it was only possible to assess 'before and after' outcomes for one client (see details in point 3.4).
- Sections 1 and 3 of the client outcome forms were found easier to complete by staff, and were more informative from the point of view of evaluation. Practitioners felt that the operational definitions of Section 2 (CDUS) were not always adequate or accurate as a way to rate the substance use of clients, therefore this was only completed for 3 clients.
- Qualitative client case notes were much more informative from the point of view of evaluation, and enabled the reviewer to describe outcomes and challenges presented in points 3.2 – 3.4 below.
- One practitioner completed base-line and end staff questionnaires (CMPPQ); outcomes are described in point 3.4.

3.2 Mental Health & Substance Use

Table 2

		N	%
	TOTAL clients seen →	12	100
Gender	Male	9	75
	Female	3	25
Psychiatric Diagnosis	Schizophrenia	12	100
Substances Used	Cannabis	6	50
	Amphetamines	4	33
	Heroin	2	17
	Alcohol	2	17
	Medication misuse*	1	8
	Crack	1	8
	Ecstasy	1	8
	Unknown*	2	17
	of which:		
poly-substance users	4	33	
intra-venous use	3	25	

* One client known to 'misplace' medication and ask for more.

*3 clients seen either did not disclose or did not admit to using drugs.

Sources and accuracy of data: Table 2 above illustrates drug using trends identified from information gathered via joint-outreach contacts and also from information known to AOT from historical contact, given that not all clients openly discussed their drug use. A common characteristic among the clients that did openly discuss their drug use was 'poly-substance use'. It is reasonable to infer from this that there may be more poly-substance users than shown in table 2 above, as the 'true' prevalence of poly-substance use can only be known if all clients openly admit and discuss their drug use.

Trends: Cannabis was found to be the most commonly used drug, followed by amphetamines, heroin and alcohol.

Qualitative data gathered in client outcomes forms and case notes suggests the following:

Impact of drug use on physical health: 2 clients were clearly putting their physical health at risk through poor injecting practices (e.g. blood loss, infected injecting site, needle-stick injury, poor injecting hygiene).

Impact of drug use on mental health: 2 clients were becoming more paranoid due to drug use, both were poly-substance users (cannabis & amphetamine were drugs in common). 2 clients' drug use was having an impact on inadequate compliance with medication regime (both used cannabis, one was poly-substance user). Cannabis use was having a detrimental impact on 2 clients regarding anxiety, mood and poor engagement with staff.

Self-reported reasons for drug use: 3 clients were using drugs specifically to cope better by: regulating mood, 'increasing confidence', enhancing sociability and helping to 'calm down' and sleep. 2 cannabis users were preoccupied with a lack of routine and structure in their lives and admitted that cannabis use was a habit developed to pass time and relieve boredom; case notes indicate low level of motivation for these 2 clients.

3.3 Engagement patterns

Table 3

		N	%
	TOTAL clients seen →	12	100
Engagement Patterns	Seen once	6	50
	Seen twice	4	33
	Seen three times	2	17
Success Rate	TOTAL <u>actual</u> client contacts (excludes unsuccessful attempts or visits) →	22	100
	Contacts leading to drug-related discussion	8	36
	Contacts with evident delivery of harm reduction / risk awareness	4	18

Clients engaging with intervention: Only 5 out of 12 clients (42%) openly discussed their drug use and provided detailed information about their past and current use. Two of these clients were aware of St Anne's Harm Reduction Service and one of them had current contact with this service. Case notes indicated that all of these clients did discuss their drug use during the first joint-outreach contact (2 of them were only seen once), so the number of contacts doesn't appear to correlate with willingness to discuss drug use. Case notes indicate that 4 out of 5 of the above clients were stable in relation to their mental health and references are made about being in an amiable mood when contact was made.

Clients not engaging with intervention: 7 out of 12 clients (58%) did not openly discuss substance use, even where they were known by AOT staff to be drug users. There didn't appear to be a correlation between the number of joint-outreach contacts and willingness to discuss drug use, as these 7 clients were approached between 1 and 3 times without success. 2 of the above clients avoided a follow-up appointment after initial joint-outreach contact. 2 of these cases were not known to use drugs. Case notes indicated that 3 of the above clients were stable in regards to mental health but did not wish to discuss drug use, although they were openly discussing other issues such as medication, housing, benefits, etc. Case notes indicated that 2 clients denied using drugs, despite evidence to the contrary (e.g. blood stains from injecting drug use, smell of cannabis, etc.). Case notes indicate that one of these

clients was floridly psychotic and hence unable to have a focused discussion around drug use. The evidence would appear to indicate that lack of engagement was most likely related to *pre-contemplative* drug use, poor motivation or lack of insight into the impact of substance use, and not exclusively due to unstable mental health at the time of contact.

Success rate: A total of 22 joint-outreach contacts were made during the 12 week pilot; this includes repeated contacts with clients seen more than once. 8 out of 22 contacts resulted in drug-specific discussions (with 5 clients); this includes brief screening of drug use patterns as well as more extensive sessions covering harm reduction and risk-related advice. Evidence was found in outcome forms and case notes for 4 contacts that specifically involved delivery of harm reduction advice and discussion of drug-related risks, effects and consequences. These 4 contacts were made with 2 clients (1 client seen 3 times, 1 client seen twice). If the actual delivery of harm reduction and risk-related advice to a client is taken as a successful case, then success was achieved for 17% of cases.

Estimated engagement rates: Based on the patterns observed during the 12 week pilot, roughly 1 out of 3 joint-outreach contacts will result in screening & discussions about drug use. 1 in 6 (17%) clients seen via joint-outreach will engage with harm reduction advice and information.

3.4 Impact of joint-outreach

Impact on drug use: As described in point 3.1, base-line and end drug use inventories were not completed for any clients; therefore it is not possible to assess any effect of interventions on patterns of drug use. Similarly, standardised CDUS base-line and end outcome measures were not completed for any of the clients; therefore it is not possible to assess the effect of joint-outreach on severity of substance use.

Impact on overall health and coping: Base-line and end qualitative health & coping data was only completed for 1 client. An analysis of this data is presented below in the form of a case study:

- **Case vignette:** Client V has a diagnosis of Schizophrenia and admits to using cannabis, ecstasy and amphetamines. V was seen twice via joint-outreach, engaged well and spoke openly about his drug use. His perception is that drug use (cannabis) helps him to socialise, feels more confident, relax and sleep better. These perceived 'benefits' and attitude towards drug use didn't seem to change after 2 joint-outreach contacts. There appears to be some discrepancy expressed during the second visit, where on the one hand V doesn't consider that he is 'addicted to cannabis', but on the other hand he admits that he uses cannabis to cope with feelings of unhappiness and sleeping problems. V is interested in fitness, he wants to find a job, and he would like to have some routine and structure in his life but feels unmotivated.
- **Discussion:** The above appears to be a case of *pre-contemplative* drug use. V might not realise that regular cannabis use may have an impact on his motivation levels and it might actually be worsening his sleeping patterns. He has expressed some contradictory thoughts about his drug use; this might be an opportunity to '*develop discrepancy*' and promote change following the motivational interviewing model. V clearly has some interests in leisure and work activities, so it may be possible to employ a '*decisional balance*' technique to get him to explore the pros and cons of drug use and how this might relate to his goals and ambitions.

Despite the lack of base-line and end data, there is also evidence found in case notes suggesting that thorough harm reduction advice was provided to a client over 3 contacts and that this resulted in enhanced injecting-hygiene.

Client feedback on joint-outreach: As described in point 3.1, two clients provided feedback on their experience of joint-outreach work. This feedback suggests that these clients felt able to talk in detail about their own perspectives on drug use and were keen to discuss this in future contacts.

Impact on staff confidence and attitudes: As described in point 3.1, only one practitioner completed base-line and end staff questionnaires (CMPPQ). This limits any useful analysis and interpretation of CMPPQ scores, as it is not possible to make any comparisons between practitioners across teams. It would not be informative to analyse base-line and end scores for one practitioner, as this would not be representative of all of the staff involved in the pilot.

Feedback from staff:

Benefits of joint-outreach	Challenges	Proposed improvements
<ul style="list-style-type: none"> • Provides both mental health and substance use interventions to clients via single contact. • Increases options for clients to access services and tailored interventions to explore their drug use. • Good way to initiate discussions around drug use with clients. • Improves inter-agency relations. • Enables practitioners to gain experience in each other’s area of expertise. • Improves practitioners’ confidence in working with dual diagnosis clients. 	<ul style="list-style-type: none"> • Measuring outcomes and conducting qualitative interviews with this client group has proven difficult. This is partly due to tools used but also circumstances in which joint-outreach was carried out. • Utilising structured questionnaires was a barrier to engaging with clients in some instances, and became an obstacle to developing a rapport. • It has been difficult to engage unmotivated and resistant clients in discussions about drug use, despite reasonably stable mental health in some cases. 	<ul style="list-style-type: none"> • Targeting specific clients more effectively to ensure continuity of contact from week to week. • Improve structure, organisation of outreach visits to minimise unsuccessful attempts. • Arrange and prioritise follow-up appointments with clients engaged via joint-outreach. Protect time for follow-up appointments to ensure continuity. • Have necessary resources (e.g. injecting equipment) and leaflets / information on various drugs to maximise ‘one-off’ contact with clients.

4. CONCLUSIONS

The serious mental health problems and the circumstances in which outreach work with this client group is conducted present challenges to harm reduction work, health promotion and outcome measurement. Despite these challenges, this pilot project highlighted some of the typical drug using trends in this client group, the impact on physical and mental health, and some of the self-reported beliefs and reasons for substance use. Cannabis and amphetamine use was particularly common in this group, and it is likely that the prevalence of poly-substance use is still greater than currently known. Although some clients’ reasons for using drugs seemed to indicate ‘self-medication’ and mood enhancement, it was clear that drug use was having a detrimental effect on their physical health (e.g. injecting-site infection, injury) and mental health (e.g. increased anxiety, paranoia, poor motivation, poor compliance with medication). It was evident that even in cases where clients spoke openly about their drug use, little insight into the adverse impact of drug use and low motivation to change were very common features in this client group. These latter issues pose the greatest challenges for engagement with drug treatment and it is

therefore unlikely that standard referral on to specialist treatment services would be any more successful than pro-active, opportunistic outreach work.

Collaborative care in the way of joint-outreach work is resource intensive and requires careful organisation and planning. Despite efforts to pro-actively target and engage clients in drug-related discussions, success was modest: 8 out of 22 contacts (36%) resulted in screening and drug related discussions, 4 out of 22 contacts (18%) actually resulted in the delivery of harm reduction advice and information, 5 out of 12 clients (42%) openly discussed their drug use, 2 out of 12 clients (17%) actually engaged with targeted harm reduction information and advice.

Doing joint-outreach work was perceived to be useful for practitioners who have gained experience in each other's area of expertise and gained confidence in working with people with a dual diagnosis. Joint-outreach also was seen to strengthen collaboration between services.

6. ACKNOWLEDGEMENTS

The following staff contributed to the development of this pilot project at various stages:

Dual Diagnosis Project	Assertive Outreach Team	Harm Reduction Service
Jaime Delgadillo	Andy Aitchison Sue McCartney Christina Morton Charlie Place	Asna Ahmed Karen Buckland Don Cantrell Margaret Lee

6. APPENDICES

APPENDIX 1:

ASSERTIVE OUTREACH TEAM DUAL DIAGNOSIS SURVEY

Survey Lead: Charlie Place, Assertive Outreach Team

Survey Date: July 2008

SAMPLE

Total number of service users asked about – 168
(brackets = percentage of ALL AOT service users)

No of males – 102 (60%) No of females – 66 (40%)

SEVERITY OF SUBSTANCE USE

No of “significant substance use problem” – 87 (51%)

No of “significant effect of substance use on mental health” – 71 (42%)

No of “serious effect on mental health” – 42 (25%)

No whose case manager feels they are dependent in some way – 51 (30%)

DRUG USE TRENDS

Cannabis significant use – 42 (25%)

Alcohol significant use - 37 (22%)

Amphetamine – 17 (20%) (12 out of 17 rated “serious effect on mental health”)

Cocaine (including crack) – 15 (9%)

Heroin – 13 (8%)

No of intravenous users – 7 (4%)

No with drug/alcohol agency involved – 15 (9%)

DISCUSSION AND SUMMARY

Over 80% of people with a significant substance use problem are seen as this significantly affecting their mental health, and nearly 50% of those are assessed to be seriously affected by it.

Overall – about 50% have significant problem, 40% have significant effect on mental health, 25% serious effect on mental health.

30% of AOT service users appear to be dependent in some way. Only a small number of intravenous users. Only 9 out of 87 with a significant problem have drug/alcohol agency involved.

APPENDIX 2:

JOINT WORKING PROTOCOL

1. BACKGROUND

This protocol is following on from the pilot work undertaken by Don Cantrell and Charlie Place, where they worked collaboratively, looking at the needs of service users with mental health and injecting drug issues. After evaluating this work, it is now time to draw up an agreement and look at the further development of collaborative working to meet the needs of people that services can find particularly difficult to engage with.

This protocol will cover all non-injecting and injecting drug users including amphetamine and cannabis users.

Future development will be on information gathering around the needs of predominately alcohol users with mental health issues.

2. PARTNER SERVICES

This partnership is between Assertive Outreach Team (AOT), Leeds Street Outreach Team and the City-wide Harm Reduction Service.

Assertive Outreach Team

St Mary's hospital
Greenhill Road
Leeds LS12 3QE

- Works with people who are reluctant to accept assistance from community mental health teams.
- Encourages independence and ordinary life style in a collaborative approach following a case management model .
- Offers individualised long term care in a flexible sensitive manner.

Leeds Street Outreach Team

6 Blenheim Terr.
Leeds, LS2 9HZ

- Works with people that sleep rough on the streets, people who drink alcohol or use drugs on the street, people who beg for money from the general public, and sex workers on the street.
- It enables people to address issues which have led to street based activities by providing advice and information covering primary health needs, substance misuse, housing and benefits.

City-wide Harm Reduction Service.

BARCA Leeds and St. Anne's Drugs Project partnership.

- Works with people affected by their own or someone else's drug use.
- Empowers people to take a more managed and controlled approach to their drug use

- The service offers holistic support covering the health and social needs of the service users
- Works from a variety of settings offering a flexible confidential service providing advocacy and referrals into health and social care agencies

3. TARGET GROUP

Service users might present with the following characteristics:

- A diagnosis of severe mental health illness; or signs and symptoms of mental ill health in people who are homeless and have no contact with health services.
- Severe and frequent relapse of mental illness.
- Drug use.
- Complex social needs and/or chaotic lifestyle.
- History of very poor engagement with services.
- Not engaged with or difficult to retain in drug services.
- Likely to be at high risk of harm from drug use.
- Homelessness or at risk of becoming homeless.

4. AIMS

- To meet the needs of service users identified by AOT / SOT in need of additional harm reduction information and support.
- To create pathways for identified Harm Reduction service users with severe mental health problems into mental health services through the Street Outreach Team.
- For practitioners to gain knowledge and skills around each other's work.
- To deliver a collaborative outreach intervention model to meet the needs of those people who require intensive and pro-active support around mental health, drug use, housing and other related needs. To work towards stabilisation and entry into mainstream mental health and drug treatment services as a long term goal.

5. HOW IT WILL WORK

The Harm Reduction Service will provide a practitioner with a high level of skills and competences. This practitioner will be available for a 4 hour session on a fortnightly basis, on a day to be agreed by the practitioners from both services. She/he will be flexible to the location of the joint visits (home, hospital day care settings, etc).

In addition to the 4 hour session, the practitioner will be available for informal discussion of service users' needs during the week. Appropriate time will be made available, with notice (2 weeks), for the practitioner to attend further service development and/or care planning meetings.

AOT will provide a practitioner with a high level of skills and competences. Co-ordination of the service user's care will rest with the AOT team under CPA framework. The AOT practitioner will inform colleagues from SOT and from the Harm Reduction Service of any areas of risk that are pertinent to working with specific service users.

SOT will make a member of the team available and responsive to work with cases identified by the other 2 partner services. SOT may have to make different staff members available depending on staffing / shifts.

6. CONFIDENTIALITY AND INFORMATION SHARING

The first organisation coming into contact with a particular service user who may benefit from collaborative care will obtain verbal consent to share information and to involve the other partner services as appropriate. Wherever possible, written consent will be sought.

Practitioners will work within the confidentiality policies of their organisations; copies of the service's policies are attached. Any breach of confidentiality will be seen as a disciplinary issue.

The Harm Reduction Service will record minimum personal information for reporting purposes. The information will be gender, ethnicity, name or initial, ward of residence, date of birth and any exchange of clean injecting equipment. The Practitioner will only share anonymous information about their case-work with their team when this is in the context of a de-briefing or supervision with their line-manager or to support learning within their team.

SOT practitioners will share information re: service users with their whole team to enable different practitioners to respond to joint-outreach requirements as appropriate and according to staffing levels and capacity.

Protocol Drafted: November 2008

Amended: March 2009

To be Reviewed: July 2009

**APPENDIX 3:
CLIENT OUTCOMES FORM**

Client Outcomes Record – Client ID: _____
Date: _____

1. Patterns of substance use and related harm

SUBSTANCE(S)	Frequency of use [n° times per day / week]	Quantity used in last week [e.g. units, grams, ££, etc.]	Route [iv, smoking, drinking, snorting, etc.]	Combining with other drugs? [name drug]

Notes: Describe current problems / harm / risk related issues concerning drug use.

2. Practitioner Assessment of Drug Use (Derived from CDUS tool)

GUIDANCE: Rate your client’s use of drugs over the past week according to the following scale. You should weigh evidence from self-report, interviews, behavioural observations, and collateral reports (family, day center, community, etc.) in making this rating.

SCORE: _____

1	ABSTINENT: Client has not used drugs during this time interval.
2	USE WITHOUT IMPAIRMENT: Client has used drugs during this time interval, but there is no evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use and no evidence of recurrent dangerous use.
3	MISUSE: Client has used drugs during this time interval and there is evidence of persistent or recurrent social, occupational, psychological, or physical problems related to use or evidence of recurrent dangerous use. For example, recurrent drug use leads to disruptive behavior and housing problems. Problems have persisted for at least one month.
4	DEPENDENCE: Meets criteria for moderate plus at least three of the following: greater amounts or intervals of use than intended, much of time used obtaining or using substance, frequent intoxication or withdrawal interferes with other activities, important activities given up because of drug use, continued use despite knowledge of substance-related problems, marked tolerance, characteristic withdrawal symptoms. For example, drinking binges and preoccupation with drugs have caused client to drop out of job training and non-drug social activities.
5	DEPENDENCE WITH INSTITUTIONALIZATION: Meets criteria for severe plus related problems are so severe that they make non-institutional living difficult. For example, constant drug use leads to disruptive behavior and inability to pay rent so that client is frequently reported to police and seeking hospitalization.

3. Mental Health, Coping & Well-being

Do you think your drug / alcohol use has affected your health or well-being in any way this week? How?

How would you describe your general health during the last week?

How would you rate your physical health in a scale form 1 to 10:

1 2 3 4 5 6 7 8 9 10
very bad bad ok good very good

How would you rate your mental health in a scale form 1 to 10:

1 2 3 4 5 6 7 8 9 10
very bad bad ok good very good

Have you been bothered by any problems or difficulties during the last week?

What have you done to cope or deal with these problems?

How well do you think you have coped with any problems or difficulties during the last week, on a scale from 1 to 10:

1 2 3 4 5 6 7 8 9 10
very bad bad ok good very good

BELOW QUESTION ONLY FOR FINAL INTERVIEW – END OF EVALUATION PERIOD

How have you found the joint visits of [names two members of staff]? Do you think that this has helped in any way or changed anything for you? Please give examples.