BEFORE DURING AFTER: A NEW HARM REDUCTION TOOL

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ABSTRACT
***Background**: In a Community Care Unit (CCU) in Melbourne, providing medium to long term clinical care and rehabilitation/recovery services to consumers with serious mental illness and associated psychosocial disabilities, a review of admissions identified an increase in the number of consumers with alcohol and/or other drug (AOD) issues. Concerns were regarding the impact of AOD use on the individual's recovery journey, the recovery journey of other consumers, the CCU environment, and the development of risk management strategies to reduce harm for all. **Method**: The dual diagnosis service for the region was consulted. A trial of the Before During After (BDA) Harm Reduction Tool, and associated capacity building package, was commenced as a collaborative quality improvement (QI) activity. **Results**: The service increased clinicians' knowledge about harm reduction and impacted on service culture. **Conclusions**: Use of a tool like the BDA can provide a structure to conversations with consumers about harm reduction.*

INTRODUCTION

The partners

Footbridge

The Footbridge Community Care Units (CCU), of St Vincent's Hospital (Melbourne), a 20 bed facility that provides medium to long term clinical care and recovery services to adult consumers with serious mental illness and associated psychosocial disabilities. In the program, 79% of consumers self-report dual diagnosis issues.

Nexus

Auspiced by St Vincent's Hospital (Melbourne). Nexus is part of the Victorian Dual Diagnosis Initiative. Nexus is one of four Metro teams with rural partners established 2001 to assist dual diagnosis capacity building in clinical mental health (MH), mental health community support services (MHCSS) and alcohol and other drug (AOD) services. Nexus works across local government areas including Banyule, Boroondara, Nillumbik, Yarra, and Darebin. It also covers Bendigo and Mildura.

An innovative approach to harm reduction in a clinical mental health residential service

There were a number of reasons for wanting to improve clinical practice when working with consumers with dual diagnosis. A review of admissions (2014-2015) was completed which identified a 21% increase in consumers entering the Footbridge program with AOD issues. Multiple clinicians working at Footbridge expressed ongoing concerns related to working with consumers who were using AOD. Concerns were related to the impact of AOD use on the individual's recovery journey, other consumers' recovery journeys, the Footbridge environment, and the development of risk management strategies to reduce harm for all. Clinicians identified a lack of knowledge, skills, and confidence when addressing AOD use with consumers.

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Consumer feedback was obtained. Eight consumers from Footbridge completed a Drug and Alcohol survey in April 2016. One consumer believed there was a problem with drug use at Footbridge. Two consumers identified that they have been offered, and also observed the use of alcohol and other drugs at Footbridge, and found this upsetting. Of those who responded 75% identified having knowledge of the AOD policy, and felt that AOD issues were dealt with appropriately by Footbridge staff, and 88% felt comfortable discussing AOD use with clinicians.

The CCU planned to change the way of working with consumers with alcohol and/or other drug issues to fit with the model of care, which is strengths and recovery-orientated practice. The service also wanted to build clinician capacity to provide harm reduction responses to the residents of Footbridge.

> *Harm reduction considers the health, social and economic consequences of alcohol and other drug use on both the individual and the community as a whole. Harm reduction aims to address alcohol and other drugs issues by reducing their harmful effects on individuals and society*
>
> (Department of Health, 2004)

In consultation with Nexus we developed a trial of the Before During After (BDA) harm reduction package as a Quality Improvement (QI) Activity.

METHOD

The BDA Package

Through work with numerous health and welfare agencies over the years, and a comprehensive literature review, it is apparent there is a lack of consistent, evidence based tools for clinicians to use with consumers when trying to plan harm reduction strategies to increase the safety and quality of life of the consumer. In addition, clinicians often focus most of their attention on the administration and intoxication phase of the drug and less on the acquisition and withdrawal phases. Each phase offers multiple opportunities to explore realistic ways that the consumer can reduce harm and improve their quality of life, provided this is done in a consistent evidence-based manner. This can be a complex conversation and there is a void when it comes to having a tool to assist.

The Before During After harm reduction package is an attempt to fill this void. The BDA Package is a systematised dual diagnosis capacity building product designed by Simon Kroes, a senior dual diagnosis clinical specialist.

The BDA Package contains a number of other elements including, but not limited to:

- 2 hours training,
- 2 follow up group mentoring sessions,
- sample posters and
- letters to inform consumers about the BDA and that staff are being trained in its use,
- questions and other information and resources to assist staff to explore harm reduction with consumers.

At the core of the BDA Package is the BDA Harm Reduction Tool. The aim of the BDA Harm Reduction Tool is to provide a practical, structured approach to assist staff when having conversations with consumers about harm reduction. It is a low threshold tool that can be applied by a range of staff in numerous service settings. The BDA tool takes a practical timeline approach where the clinician discusses with the consumer ways of keeping safe and healthy before, during and after drug use. A key aspect of the tool is that dual diagnosis,

mental health and AOD issues are considered in an integrated manner through an exploratory and consumer-centred approach that is covered in training.

To aid implementation, a number of meetings are held with management and senior clinicians of the service to work out the best way to implement the package, taking account of rosters, competing priorities, etc.

Clinicians from various disciplines such as Social Work, Nursing and Occupational Therapy have used the BDA Harm Reduction Tool and found it to be easy to learn and useful when working with dual diagnosis consumers.

Procedure

Nexus met with Footbridge management and practice leaders to plan and implement the Quality Improvement (QI) activity. A needs analysis survey was completed by all Footbridge clinicians prior to commencing the QI activity.

Posters and letters for consumers were presented to the Consumer Reference Committee of St Vincent's Hospital (Melbourne). The organisation approved their use prior to the QI activity being implemented.

An initial cohort of 6 clinicians was identified to be a part of the QI activity to use the Before During After Harm Reduction Tool over a 3-month timeframe. The CCU planned to measure clinicians' knowledge and confidence in using harm reduction strategies with consumers with mental health issues who use alcohol and/or other drugs. The Footbridge manager and practice leaders determined which clinicians to invite into the cohort based on availability during the QI activity time period. However training in and use of the package was extended out to the whole Footbridge clinician group for expressions of interest to participate.

Practice leaders completed a documentation audit for quantitative and qualitative data to measure clinical practices of using harm reduction strategies as part of treatment planning, pre QI activity and at 6 months post, to measure changes in practice and sustainability of the BDA package.

Clinicians actively informed consumers of the QI activity through direct conversations, a personal letter; and an information poster and other posters with results of the QI on a consumer-accessible noticeboard.

Likert scale questionnaires pre and post training were recorded to measure (cohort) clinicians' knowledge and confidence using Harm Reduction strategies, and the Before During After Harm Reduction Tool.

Nexus provided 2 hours of training which covered the type of approach to use, information and resources on harm reduction and how to apply it and then clinicians used the BDA Tool with each other to gain experiential insight as to how best to use the BDA Tool. In the following two weeks the cohort were then expected to utilize the BDA Tool with consumers who identified using alcohol and other drugs. Clinicians were informed that this information would be the focus of the mentoring sessions.

Nexus provided group mentoring to the cohort during the QI activity (Group mentoring sessions were booked at week 2 and week 6 post training). Extra mentoring was also offered if the situation arose where clinicians couldn't make the initial planned sessions. Mentoring was structured using a proforma to record staff observations and reflections.

An audit of consumer files (including progress notes, treatment plans, case reviews, risk assessments, medical and case manager sessions) was completed Pre and Post the QI activity.

RESULTS

The clinicians reported that they gained both knowledge and confidence in exploring and developing harm reduction strategies through training, mentoring and using the BDA tool. Having a more specific process the BDA Tool, rather than a generic concept, enabled the cohort to feel more prepared and able to have conversations with consumers about the use of alcohol and other drugs, and ways to stay safe and physically and mentally well.

The wider Footbridge clinicians showed interest and support with the QI activity focus and supported the cohort in this activity. They also maintained consistent approaches with harm reduction strategies that the consumer identified. In this way the capacity of the workforce at Footbridge was assessed to have been increased.

Significantly the QI activity prompted changes to the residency agreement at Footbridge, to identify clinicians' acceptance and willingness to work with consumers on an individual basis, to plan for their safety and wellbeing around alcohol and other drug use. Excerpt from the new residency agreement:

> *'We understand some people use drugs and alcohol for various reasons. Being at Footbridge provides an opportunity to explore how and why you use drugs and alcohol, and ways to keep safe and healthy'.*

From the pre and post self-rating surveys of knowledge and confidence in the BDA Tool, and harm reduction package, the results indicated that:

- Only 1 clinician felt a level of confidence using the BDA Tool pre training.
- Half of the cohort started the process being unaware of the BDA Tool, and through the process all clinicians (100%) gained knowledge of BDA Tool.
- All clinicians in the cohort (100%) reported that they had gained knowledge of harm reductions strategies.
- All clinicians in the cohort (100%) reported that they felt their confidence in harm reduction strategies increased through the process.
- Post results show that half of the cohort felt strongly that they had developed/improved in their confidence.
- 1 clinician 'disagreed' on the item of confidence in BDA Tool and provided comments to supplement – they felt they needed more opportunity to use the package with consumers as they had taken unexpected leave during the QI activity timeframe.

Feedback from clinicians suggests consumers readily engage in the BDA Tool and associated conversations. It seems that the BDA Tool helps open the door to harm reduction conversations that might otherwise not happen.
Quotes from clinicians who have used the BDA Package:

> *"…this is such a practical and easy to use tool …"*
>
> *"Extremely useful – I feel that it increased my understanding of harm reduction approaches significantly."*
>
> *"The BDA (package) helped provide a structure to work with consumers with alcohol, drug and gambling addictions. The mentoring sessions really helped in developing more*

confidence in using the BDA (package) and also building on my knowledge of harm reduction strategies"

"The response from consumers, when using BDA and harm reduction focus, was more engaging, with consumers readily talking about their use, and it promoted empowerment, with consumers feeling more in control of decisions about their life."

The file audit discovered how many consumers identified as having dual diagnosis issues, what tools or interventions were being used, if there was any evidence to show the use of harm reduction strategies around their AOD use, and examples of these. The findings were as follows in Table 1:

Table 1 Dual diagnosis profile in Community Care Unit residents

	# Pre QI	# Post QI
Total Consumer files audited	14	11
Consumers who identified as Dual Diagnosis (DD)	11	10
Consumers who identified as DD where there was evidence of Harm Reduction Strategies in the files	4	7
Consumers who identified as DD where there was **no** evidence of Harm Reduction Strategies in the files	7	3

There wasn't a specific tool used when discussing harm reduction strategies pre-QI activity. The BDA gave clinicians a specific tool that they used with consumers.

With clinicians using the BDA Tool, consumers were able to identify numerous strategies focusing on harm reduction. Examples of Harm Reduction Strategies:

- The use of Nicotine Replacement Therapies
- Exploration of the interactions/relationship between physical health?, mental health?, medications, and AOD use
- Developing strategies to reduce risk, including towards sexual health, and general health
- Trying alternative self-soothing strategies to reduce the need to smoke when feeling anxious

Based on the data collected (above), including evidence from the wider Footbridge team, staff felt more accepting and prepared to work with consumers with a harm reduction focus. They reported they were more confident in accessing the BDA Tool in planning strategies to minimize harm and promote wellbeing.

DISCUSSION

The Before During After Tool focuses on partnering with consumers in the management of their treatment, care and recovery planning pertaining to exploring ways to reduce harm from alcohol and other drug use; with the consumer and clinician working together to improve the consumer's quality of life. The BDA package complements the existing Strengths model of care and recovery practices of the service.

The specific changes the CCU QI team wanted to accomplish were to increase knowledge and build clinician confidence in exploring and developing harm reduction strategies with consumers through using the BDA Harm Reduction Tool and associated capacity building package. This approach is better preparing clinicians in helping consumers to build their own self-efficacy and access community resources and information, empowering their learning, growth and changes, and the attaining of their recovery goals.

The QI team also wanted to build confidence and capacity for the cohort to be able to provide mentoring, for other Footbridge clinicians to develop confidence in harm reduction strategies post the QI activity. They are continuing the work in this area.

A harm reduction focus is now integrated with consumers' care and treatment planning. BDA plans and harm reduction strategies are incorporated into consumer treatment plans, case reviews and risk assessment documents.

There is a wider acceptance of the occurrence of alcohol and other drug use in the mental health consumer population, and a willingness to work with consumers to reduce risks associated with substance use. This is due to increased confidence as a result of having a process to direct the work. Clinicians are able to identify current harm reduction practices and further build their knowledge and confidence.

Limitations

Dual diagnosis can be a complex area in which to implement changes.
Initiating a cultural change within mental health services and maintaining fidelity to this change are challenging tasks. Clinicians' own attitudes toward change, and support from all organizational levels, impacts on the success of implementing and promoting a positive change (Aarons & Sawitzky, 2006).

Complexity in systems such as rosters, competing demands for time when arranging training and mentoring, posed barriers that required proactive thinking through and then ongoing problem solving with good will and commitment from all involved.

The QI activity had a small cohort and, while good outcomes were achieved, the authors acknowledge this limitation.

CONCLUSION

Implementing the BDA Package at Footbridge has brought about positive outcomes for clinicians, consumers and the organisation. It has assisted in a cultural change toward more integrated and holistic harm reduction practice with a dual diagnosis focus. This takes more than just a session of training, and requires the service to be ready and able to change and to have the necessary support to do this. Fortunately these elements came together in this instance through the efforts of the management and senior staff at Footbridge in collaboration with Nexus.

Future Directions

Discussions between the improvement leads and NEXUS have identified a need to:

- Review the need for refresher training, and training opportunities for new employees.
- Explore how to maintain fidelity of the BDA tool and having a harm reduction focus post NEXUS involvement, such as mentoring being provided by local clinicians who were a part of the QI activity cohort.
- Where BDA is rolled out to the wider programs, have consideration for maintaining fidelity at the local level.
- The BDA contributes to addressing Section 11, Principle (f) of the Victorian Mental Health Act 2014 which states:

  'persons receiving mental health services should have their medical and other health needs, including any alcohol and other drug problems, recognised and responded to.'

In light of this, providing a practical structure for both doing and evaluating practice is important in this area.

Footbridge is currently rolling out training to all clinicians and setting up mentoring support from clinicians in the cohort to offer support peer-to-peer.

Footbridge will utilize a Dual Diagnosis Medical Records Online barcode, moving forward, to scan BDA plans and other harm reduction documents into consumer files.

NEXUS will continue to develop, refine and systematize the BDA package and associated materials.

ACKNOWLEDGEMENTS

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