

School of Nursing

**A GROUNDED THEORY STUDY OF THE
EXPERIENCE OF DETOXIFICATION
FROM PSYCHOACTIVE DRUGS**

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**This thesis is presented as part of the requirements for the award of the
degree of Doctor of Philosophy
of the
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Declaration

This thesis is my own work and no part of it has been submitted for a degree at this, or any other University.

Signed _____

Date *October 1988*

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ABSTRACT

The main objective of this thesis was to develop a substantive theory that explained the phenomenon of detoxification from psychoactive drugs such as alcohol, tranquillisers, opioids, and amphetamines in a medical treatment unit for licit and illicit drug users. The other objectives were to (a) determine if the differences reported in earlier studies between licit and illicit drug users in terms of socio-demographic and drug use variables remain extant, and (b) assess the extent of minor psychiatric morbidity among the participants. Both grounded theory and quantitative methods of data collection and analysis were used in the study.

The findings of the quantitative component of the study indicated that there were significant differences between licit and illicit drug users in regard to age, drug use characteristics, and completing the treatment program. That is, illicit drug users were younger than licit drug users, more likely to be poly drug users, and drop out of the program. The prevalence of minor psychiatric morbidity among the participants was 93.6%, and was largely independent of socio-demographic and drug use variables. The high prevalence of minor psychiatric morbidity suggests that the majority of participants warranted further follow-up support in the community after they left the treatment unit. The uptake of referrals for follow-up support, however, was 55.9%.

The basic or core social psychological problem identified by the constant comparative method of grounded theory was found to have two parts, both of which were interpreted as forms of disequilibrium. The first part of disequilibrium, which was a precursor to treatment, was conceptualised as Hitting the Wall. The events associated with the symbolic “wall” interrupted the participants’ drug focussed lifestyles and induced them to enter treatment. These events and problems were not resolved whilst in treatment, they lingered with the participants while they were in the unit, and remained to be addressed when they left. Whilst undergoing detoxification the participants encountered the second part of disequilibrium which was categorised as Incompatibility. The problem of Incompatibility was related to the heterogeneity of the participants and the

structure of the treatment program that in many cases was unable to accommodate individual differences and needs.

The core or basic social psychological process was conceptualised as Seeking Balance through Hanging In. The participants engaged in this process to deal with the disequilibrium of the precursor problem of Hitting the Wall and the problem of Incompatibility encountered in the unit. Seeking Balance through Hanging In was found to have four phases. The phases were Making the Break, Submitting to Cleansing, Fitting In, and Moving On. The process was linear in that the phases were sequential, and failure to complete a phase meant dropping out of the detoxification program. The experience of detoxification was modified by several contextual conditions. These were the physical environment, the participants' expectations of withdrawal symptoms, and the workload of the staff.

The substantive theory, Seeking Balance through Hanging In, integrated all emergent categories, and explained the experience of the phenomenon of withdrawal from psychoactive drugs in a particular context. Recommendations for further research include testing the described phases and relationships of the substantive theory in similar environments, exploring the importance of the modifying conditions on client outcomes, and undertaking follow-up studies to determine the outcomes of those who completed the program as compared to the outcomes of those who dropped out. In addition, further studies are recommended to assess the transientness of the level of minor psychiatric morbidity detected among the participants in this study.

The findings of this study make an important contribution to understanding the experience of detoxification from the perspective of the participants. The substantive theory has implications for clinical practice, professional education, management, and further research.

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PART ONE

INTRODUCTION AND BACKGROUND

CHAPTER 1: INTRODUCTION AND PROBLEM STATEMENT

CHAPTER 2: BACKGROUND TO THE STUDY

OVERVIEW

In chapter one the main objective of this study is presented. This was to explore the experience of detoxification from psychoactive drugs from the client's perspective, and develop a substantive theory to explain this phenomenon. The other objectives included comparing licit and illicit drug users in terms of socio-demographic and drug use variables and assessing the prevalence of minor psychiatric morbidity among the participants in the study. The deficits in the existing literature are identified and the need for the study is discussed. The significance of the study is presented and the limitations are acknowledged. An overview of the organisation of the thesis is provided.

In chapter two the main drugs of concern to the Australian population are described. The different patterns of drug use and the concepts of tolerance and dependence are discussed. The historical, organisational, and ideological issues that have shaped the responses of government and the health care system to alcohol and other drug related issues are presented. The evolution of alcohol and other drug treatment services is described, and the impact of the advent of blood borne viruses on the principles guiding treatment services is discussed.

CHAPTER 1

INTRODUCTION AND PROBLEM STATEMENT

1.1: Introduction

This thesis is concerned with the experience of the phenomenon of detoxification from psychoactive, dependency producing drugs in a residential medical treatment unit. According to the World Health Organisation (WHO) (1993), a psychoactive drug is one which, when consumed, has the capacity to modify the perceptions, mood, cognitive behaviour, or motor functions of the user. Sudden abstinence or abrupt reduction in the use of these drugs after prolonged, heavy use leads to a rebound effect that is manifested in withdrawal symptoms that vary according to the drug or drugs used. This is sometimes referred to as the withdrawal syndrome (Frank & Pead, 1995).

Detoxification has been defined as the management of the withdrawal reaction that occurs when a person who has been using psychoactive drugs, at a level that induces neuroadaptation and dependence, ceases use (WHO, 1994). Detoxification, from any drug, is seldom sufficient to achieve long-term lifestyle changes, but it is a first step in the process. In general, the symptoms of withdrawal are opposite to those of the intoxicated state (Frank & Pead, 1995). For example, alcohol and tranquilliser drugs are central nervous system (CNS) depressants, and withdrawal from these drugs is characterised by CNS hyperactivity. In contrast, drugs such as amphetamines stimulate the CNS and the symptoms of withdrawal reflect reduced CNS activity.

There are three main features associated with withdrawal: neuroadaptation reversal, illness, and psychosocial factors (Frank & Pead, 1995). Neurotransmitter adaptation is a process that occurs in response to consuming high levels of a drug or drugs over a relatively long period of time, and withdrawal involves reversal of this process. Withdrawal symptoms have been described for cannabis (Commonwealth Department of Human Services and Health, 1994), alcohol (Foy, 1991), opioids (West & Gossop, 1994), benzodiazepines (West & Gossop, 1994),

and stimulants (Lago & Kosten, 1994). The onset of withdrawal symptoms varies and is related to the duration of a particular drug's action, that is, whether it is long or short acting. Withdrawal symptoms from alcohol and from short acting sedatives may develop within six to eight hours of the last dose, whereas the symptoms from long acting drugs, such as diazepam, may not occur for several days (West & Gossop, 1994). The duration and severity of withdrawal symptoms cannot be predicted precisely because they are dependent on several interacting factors (Foy, 1991). These include the frequency and length of drug use, whether or not the drug has been used in combination with other drugs, the nutritional state of the person concerned, concomitant illness, the environment in which detoxification occurs, and the expectations that the person concerned brings to the detoxification process.

Treatment for individuals with problems related to the use of psychoactive drugs is being increasingly seen as a continuum with prevention at one end and more intense services for those dependent on the drugs at the other end. The intervention or treatment for an individual depends on the nature of their problems, their level of dependency on certain drugs, their co-existing health conditions, and their preferences. Those with few problems and low levels of dependency are likely to benefit from health promotion media campaigns, or brief interventions from primary health care providers or generalists in the health care system. Others with higher levels of dependency will require more intense treatment from specialist alcohol and drug services. Treatment services have been conceived as a system, the components of which have been identified as: assessment and referral; detoxification; case management; outpatient treatment; day treatment; short-term or long-term residential treatment, and aftercare (Ali, Miller, & Cormack, 1992). Most treatment programs for individuals dependent on psychoactive drugs begin with detoxification. Detoxification programs provide a humane way for individuals to undergo the withdrawal process and offer an opportunity for people to break the cycle of dependency on drugs. This study is focussed on the phenomenon of detoxification experienced in a Western Australian residential, medical detoxification unit for both licit and illicit drug users.

1.2: Deficits in Existing Research

There is a considerable body of literature on detoxification. This, however, has mainly focussed on alcohol and opioids. The emphasis has largely been on the effects of the drugs on the body and the medical management of withdrawal symptoms that occur when an individual abruptly ceases their drug use (Foy, 1986; 1988; 1991). Other authors have focussed on the location in which it occurs (Bartu, 1993; Bartu & Saunders, 1994; McGovern, 1983; Stockwell, Bolt, & Hooper, 1986), or whether medication should be used in the management of withdrawal symptoms (Whitfield, Thompson, Lamb, Spencer, Pfeifer, et al., 1978). Moore (1977) identified four types of detoxification: medical, non-medical, ambulatory, and social. Under the medical model, clients are admitted as inpatients to either a hospital or a specialised detoxification unit. Care is provided primarily by doctors and nurses, and the withdrawal symptoms are treated with medication and other clinical interventions. Non medical detoxification, on the other hand, does not require hospitalisation. Clients have medical backup in the form of doctors being available when necessary, but not on site. Care is provided by staff who may not have a nursing or medical background, and medication is used minimally, if at all.

Ambulatory detoxification, as described by Moore, is medically controlled. Clients are assessed at outpatient clinics or doctors' surgeries where medications are prescribed and relevant pathology and other tests ordered. The progress of clients is monitored by the doctor concerned at follow-up appointments with the client. Ambulatory detoxification is not suitable for those without accommodation. Social detoxification involves providing a supportive environment for the person experiencing withdrawal symptoms in which care is provided largely by volunteers or family members.

Sausser, Fishburne, and Everett (1982) have described detoxification as being of three types according to the location in which it occurs. The three types are medical inpatient, residential social setting, and drug-assisted outpatient. In general, these types are similar to those described by Moore (1977). A more

elaborate typology with distinctions between specialist and non-specialist services was developed by Orford and Warman (1986). Specialist services include:

- inpatient medical, designated;
- inpatient medical, non-designated;
- residential social setting, designated;
- residential social setting, non-designated;
- sobering-up shelters;
- medical outpatient;
- day centre;
- home supervised.

The term “designated” refers to those units that were specifically established as detoxification facilities. “Non-designated” refers to those centres and institutions such as general hospitals where detoxification was not the main focus of care, but in which it may occur in concurrence with the condition for which the person is being treated. An example of this is when a person is admitted to hospital because of trauma, or some sudden illness, and exhibits withdrawal symptoms because their accustomed level of drug use has been interrupted. Non-specialist services include those obtained elsewhere, with or without supervision.

None of these types or typologies of detoxification are useful in understanding the detoxification process itself as experienced by the user of the drug or drugs concerned. The typologies refer merely to locations where detoxification has been undertaken. In alcohol and other drug program evaluations the components of detoxification and other treatments have generally been assessed as a “black box” (Moos & Finney, 1985). Treatment tends to be evaluated in terms of gross categories such as completed or not completed, received or not received, combined versus separate treatment, or inpatient versus outpatient treatment. In almost all cases, little mention is made of the type and quality of the treatment obtained, or even if the clients involved actually received what various programs purport to provide as treatment (Moos & Finney, 1985). The assumption has been that clients in treatment receive the same care, and that this care is what the agency concerned intended to be provided.

Many factors, however, may affect how treatment is delivered and experienced. Among these are staffing levels, the prevailing model of treatment espoused, the mix of other clients in the program, the individual characteristics of the clients concerned, the treatment environment, the staff, and the expectations that clients bring to treatment. All of these factors may contribute to how clients perceive and experience treatment provided in any health care setting. This may be particularly important in combined residential detoxification programs because of the vulnerability of the clients at the time of treatment, and the problems associated with treating users of different drugs in the same unit (Pittman, 1967; 1988). According to Pittman, the problems relate to age differences and the lifestyles associated with licit and illicit drug use. The issue of combined treatment is important to this study and is discussed more fully in Chapter 2, Section 2.5.2. This study is designed to address the deficits in the existing literature by illuminating and exploring the experience of psychoactive drugs from the perspectives of the clients concerned.

1.3: Need for the Study

According to WHO (1993), since the early seventies the international drug scene has changed dramatically. The use of illicit substances such as heroin and cocaine has reportedly increased by a factor of ten, and this has been accompanied by an increase in the use of licit substances such as alcohol, especially in developing countries. Alcohol and other drug related problems deplete the human and financial resources of many nations. In both developed and developing countries, alcohol and other drug use reduces life-expectancy, lowers productivity, require substantial expenditure for health and other services and negatively impacts on family and community life (WHO, 1993). The estimated costs of alcohol and other drug use to the Australian community have been estimated to be over \$18 billion per annum (Collins & Lapsley, 1996).

It is acknowledged that not everyone using psychoactive drugs in a problematic way requires formal treatment to resolve their problems and conditions. This has been demonstrated for alcohol (Saunders & Kershaw, 1979; Tuchfield, 1981; Cunningham, Sobell, Sobell, & Kapur, 1995), heroin (Biernacki, 1986), and

cocaine (Waldorf, Reinerman, & Murphy, 1991). Concerning alcohol, however, it has been noted that those who resolved their problems without treatment had less severe problems than those who required formal interventions (Cunningham, et al., 1995). Those people, however, who are heavily dependent on alcohol or other drugs are likely to require professional treatment during the detoxification process (Mattick & Jarvis, 1993).

In relation to detoxification, the need for qualitative analyses and more “listening and looking” to what patients have to say, has been identified (Edwards, 1990).

Research must reach the point where the power of different methods and theories can be brought sharply to bear on shared questions - that has often been the talk, but seldom the reality.

(Edwards, 1990, p. 458)

In addition, the treatment needs of poly drug users have not been researched adequately, and treatment models for this population have not been developed and evaluated (Hubbard, 1990). More recently, in the presence of evidence of increasingly pervasive levels of multiple substance use among treatment populations, the need to improve the effectiveness of detoxification has been noted (Almog, Anglin, & Fisher, 1993).

Research on the process of detoxification from the client’s perspective in either separate or combined treatment units is notably lacking. This is a major hiatus in addiction literature, as both the treatment experience and the client’s perceptions of treatment in five residential programs for “alcoholism” have been found to be strong predictors of outcomes (Cronkite & Moos, 1978). The treatment settings in the study by Cronkite and Moos were a Salvation Army program based on vocational rehabilitation for skid-row alcoholics, a public hospital unit providing group therapy and anti-anxiety medication for low income patients, a half-way house operating as a therapeutic community, a private aversion conditioning program for middle-class and upper-middle-class patients, and a private program emphasising group and family therapy for middle and upper-class patients.

Detoxification is a central component in the acute stage of treatment of clients dependent on psychoactive drugs (Institute of Medicine, 1990). Interventions at this stage are important as detoxification is, for many, a major step in regaining

health and breaking away from a lifestyle focussed on the use of psychoactive drugs. According to the WHO (1993), failure to provide adequate treatment for people with alcohol and other drug problems is likely to prove costly to health services and the community, both in direct and indirect terms.

1.4: Significance of the Study

The findings of a recent national household survey (National Drug Strategy, 1996) indicate that, in 1995, 76% of the Australian population aged fourteen years and over drank alcohol, and more than half of them were regular drinkers. According to the National Health and Medical Research Council (NHMRC) (1987), moderate or hazardous risk for men is drinking from four to six standard drinks per day, or from twenty-eight to forty-two drinks per week. High risk is defined as drinking more than six standard drinks per day or more than forty-two drinks per week. The recommended low risk quantities for men are no more than four standard drinks per day or twenty-eight drinks per week. For women the quantities in each risk category are halved. At least two alcohol free days per week are recommended for both men and women and drinking to intoxication or occasional "binge drinking" is regarded as potentially hazardous. In defining alcohol related health risks in this manner, it has been estimated that approximately one third of the population are drinking at hazardous or harmful levels (National Drug Strategy, 1996).

According to the report of the National Drug Strategy (1996), 39% of the population aged fourteen years and over had tried at least one illicit drug. Cannabis had been used by 31%, and 13% reported current use. Approximately 6% of the population aged fourteen years and over had tried hallucinogens and amphetamines, and 2% reported current use. Heroin, cocaine methylenedioxymethamphetamine (MDMA), and non-prescribed tranquillisers were used by less than 3% of the population, and less than 1% reported current use. Almost all users of cocaine, amphetamines, cannabis, heroin, LSD, cannabis, and tranquillisers reported using alcohol with these drugs in the past year (National Drug Strategy, 1996).

Population surveys do, of course, have major limitations in the reliability of the estimates they provide. Surveys are effective in measuring regular, widespread, patterns of use for licit drugs such as alcohol and tobacco. They are less accurate in measuring the use of drugs that are illicit or other behaviours that are socially unacceptable, irregular, or engaged in by a comparatively small proportion of the population. In these cases, other methodologies are required to obtain more reliable data (Spooner & Flaherty, 1993). There are also the usual problems associated with respondent recall, the way sensitive questions about alcohol and other drug use are asked, and who does the asking. Despite these problems, mass population surveys represent the most effective means of identifying patterns and trends in alcohol and other drug use.

In economic terms, the cost associated with prevention, treatment of alcohol and other drug related illness, loss of productivity in the workplace, property crime, domestic violence, accidents, and law enforcement activities was conservatively estimated at approximately \$18,845 million per annum (Collins & Lapsley, 1996). Of this, 67% was attributable to tobacco, 24% to alcohol, and 9% to illicit drugs. This figure includes tangible costs such as health care services, loss of production, welfare costs, road accidents, law enforcement, and intangible costs such as loss of life. In addition to these economic costs are intangible social consequences of drug misuse, such as family breakdowns or the or the pain and suffering caused by misusers to themselves and others, including victims of crime.

Alcohol is second only to tobacco as a preventable cause of death and hospitalisation for Australians (English, Holman, Milne, Winter, Hulse, et al., 1995). It has been estimated that 3,642 Australians died from alcohol related causes in 1995 and there were 86,137 hospital attendances due to conditions related to alcohol. It has also been estimated that 778 Australians died from conditions associated with illicit drug use in the same year (Australian Institute of Health and Welfare, unpublished data, cited in Single & Rohl, 1997). While the prevalence HIV/AIDS is low, it estimated that approximately 60% of injecting drug users are hepatitis C positive (National Centre in HIV Epidemiology and Clinical Research, 1997). This has important implications for the individuals involved as well as for long-term costs to the community.

According to Collins and Lapsley (1996), only about 53% of the total costs of the drugs mentioned in their review are potentially susceptible to elimination by public policies and education. This is partly because the full effects of any reduction in drug abuse may take years to filter down through the community in the forms of reduced mortality and morbidity. It is also partly because it is probably not possible to eliminate all drug abuse from any community. Hence it is likely that there will be an ongoing demand for detoxification and other forms of treatment for individuals dependent on various psychoactive substances.

Concerning treatment, any analysis of the costs of providing services should be considered against the costs of not providing services. According to Holder (1987), up to three years prior to treatment people with alcohol problems have health care costs that are between 130% and 300% higher than people without alcohol problems. Holder noted that family members of people with alcohol problems also have higher health care costs than members of families in which alcohol is not a problem. In relation to illicit drug treatment programs, it has been shown that the closure of methadone programs results in increases in direct costs for incarceration, legal supervision, and other types of government treatment facilities (Anglin, Speckart, Booth, & Ryan, 1989). The resources of the criminal justice system, hospitals, and other health and welfare services are all used to a greater extent by illicit drug users who are not receiving treatment than those who are receiving treatment. Similar conclusions have been reached regarding treatment for illicit drug users in the United States of America (Hubbard, Marsden, Rachal, Harwood, Cavanaugh, et al., 1989).

In the 1992 Australian national census of Clients of Treatment Service Agencies (COTSA92), 465 agencies that provided treatment for people with alcohol and drug problems were identified (Chen, Mattick, & Baillie, 1993). Of these agencies, 51 provided outpatient detoxification services, and 504 provided inpatient detoxification. Based on the findings from the same survey, it was estimated that the prevalence of people treated for alcohol and other drug-related problems was between 2.1 and 3.2 persons per thousand head of the population over the age of fourteen years. This represented an increase of approximately 0.5

over the 1.6 and 2.7 persons per thousand head of population in the previous survey (Baillie, Mattick & Webster, 1992).

The increased demand for treatment services for people with alcohol and other drug related problems reported in the national statistics was reflected in the facility in which this study was conducted. For example, from 1990 to 1995, the numbers of people on the methadone maintenance program more than trebled, and the numbers in residential detoxification more than doubled (Western Australian Alcohol and Drug Authority, 1995).

Detoxification is acknowledged to be an important component in the treatment of individuals dependent on psychoactive drug use. Understanding the processes and interactions that influence the social construction of the reality of the detoxification experience for individuals is important, both for advancing knowledge of the phenomenon and for developing services that more effectively meet the needs of the drug using population. At a time when there are many competing demands for the health dollar and the number of people seeking help is increasing, the importance of providing treatment that can improve the outcomes of individuals with alcohol and other drug problems cannot be underestimated. Shifting the focus of investigation from detoxification as an event circumscribed only by treatment procedures to the experiences of people who have experienced it has the potential to broaden clinical perspectives on the phenomenon, and enable a better understanding of the experience as a whole. It is essential that the services provided for people with alcohol and other drug problems are based on sound research, if optimal outcomes are to be achieved and the costs to individuals, families, and the community reduced.

1.5: Purpose of the Study

This study was designed to make a substantial contribution to knowledge of the experience of detoxification for licit and illicit drug users in a combined treatment unit. It sought to discover and provide an understanding of the social construction of the experience of detoxification from the client's perspective. A substantive theory was developed in accordance with grounded theory methodology, which is based on symbolic interactionism, to explain this phenomenon. In addition,

quantitative data were obtained to assess what statistical differences, if any, exist between different groups of drug users in terms of the socio-demographic variables that have been reported to be problematic for combined treatment in previous studies.

1.6: Objectives of the Study

In order to achieve the above purpose, the objectives of this study were to:

- explore and describe the client's experience of detoxification in a Western Australian combined treatment facility for licit and illicit drug users;
- discover the shared problems and basic social psychological processes associated with the phenomenon of detoxification;
- generate a substantive theory which explains the clients' experience of detoxification and the conditions influencing this experience;
- compare licit and illicit drug users in terms of socio-demographic variables and drug use history, and
- assess the prevalence of minor psychiatric morbidity among the participants in the study.

1.7: Assumptions Underlying the Study

There are several assumptions that underlie this study. They are:

- detoxification is an important step in lifestyle change for those dependent on alcohol and other drugs;
- clients' perceptions and construction of the social reality of detoxification have a strong influence on how they experience the phenomenon;
- better understanding of the experience of detoxification, and hearing the clients' voices in treatment services has the potential to enhance both detoxification services and clients' outcomes.

1.8: Limitations of the Study

The following limitations have been identified:

- (a) The study was restricted to the experience of detoxification whilst in a combined, medical, residential treatment unit.

Further follow-up research would be required to investigate both short-term and long-term client outcomes.

- (b) The nature of qualitative investigations and the uniqueness of the context indicates that caution should be employed in any attempt to extrapolate the findings to other areas, unless the conditions which applied in this study were replicated.

1.9: Organisation of the Thesis

The organisation of the thesis is as follows: in the introductory section above, definitions of psychoactive drugs and detoxification are provided, and typologies of detoxification are described. The deficits in existing research on detoxification are identified and described, and the need for this study is established. In addition, the purpose, objectives and significance of the thesis is presented, and the underlying assumptions and the limitations of the study are acknowledged.

In qualitative studies it is not customary to present a comprehensive literature review of the phenomenon under investigation in a separate chapter. Literature reviews are conducted on the themes, issues, and categories as they are identified in the data, and they are discussed in the relevant context of the text. This was the approach used in this study. In order to locate the phenomenon of detoxification within a wider context than the immediate environment, however, an overview of the major events and issues that have shaped the current philosophies guiding policies and clinical practices related to the treatment of people with alcohol and other drug-related problems in Australia and other countries is presented in chapter two. Among these events and issues are the main drugs of concern to the Australian community, patterns of drug use, the concepts of tolerance and dependence, and the main historical, organisational and ideological issues that guide service provision for individuals with alcohol and other drug problems.

In chapter three, the research design and the rationale for using grounded theory and the quantitative methods is presented. The setting in which the study was conducted is described, as well as the strategies employed to gain access to the participants and the cooperation and support of the staff of the unit. The

various sampling strategies used and other ways of data collection are described, and a profile of the participants who were interviewed is presented. The instruments and measures utilised for the quantitative component of the study, and the different types of triangulation employed are described. Issues of reliability, validity, and protection of human rights are discussed and the analytical procedures used for the quantitative component and grounded theory are outlined.

The results of the quantitative component of the study are presented in chapter four. The participants who completed the questionnaire are described in terms of socio-demographic and drug use characteristics, and the level of dependency on drugs. Comparisons are made between licit and illicit drug users in regard to socio-demographic and drug use variables. In addition, the prevalence of minor psychiatric morbidity and the influence of socio-demographic and drug use variables on the scores of the measurement instrument is reported. The quantitative findings are presented before the qualitative findings because they are referred to in the text in the following chapters.

The basic social psychological problem that was shared, but not articulated, by the participants was found to be Disequilibrium. Disequilibrium had two forms; the first was categorised as Hitting the Wall and was a precursor to entering treatment. The components of the symbolic “wall” were related to the drug focussed lifestyles of the participants that brought them into a state of disequilibrium with their wider social environment. The events and problems which comprised the wall induced the participants to enter treatment, remained with them whilst they were in the residential environment, and awaited to be addressed when they left the unit. Hitting the Wall is discussed chapter five.

In chapter six, the second part of the basic social psychological problem of Disequilibrium is described. This was categorised as Incompatibility and incorporated the problems encountered during the participants’ detoxification experience in the treatment unit. Incompatibility was related to the heterogeneity of the clients in the combined treatment facility and the structure of the detoxification program.

In chapter seven, the core or basic social-psychological process that was used by the participants to deal with the two-part shared problem of Disequilibrium is

presented. This was conceptualised as Seeking Balance through Hanging In, and was found to have four phases. The phases were categorised as Making the Break, Submitting to Cleansing, Fitting In, and Moving On.

In chapter eight, the conditions identified in the data that modified and influenced the experience of the participants during their stay in the combined medical, treatment unit are discussed. These conditions related mainly to the physical environment, human and material resources, the participants' expectations of detoxification, and the workload of the staff. These factors contributed to the ambiance and context of the treatment setting, and strongly influenced the way the participants perceived combined treatment and the care they received during the experience of detoxification. In the early part of the study, it was evident that the available resources in the unit were inadequate to manage the number of people admitted at any one time. The response of management was to reduce the number of beds, and make additional resources available to the unit. The implications of these modifications to the treatment environment for the participants are described.

In chapter nine, a substantive, grounded theory, Seeking Balance through Hanging In, together with its four phases and links to the other major categories is presented. The contribution of the qualitative and grounded theory components to the findings of the investigation is discussed. Comparisons are made with existing theories that were found to have relevance to some aspects of the substantive theory developed in this study. The findings are discussed in terms of the implications for clinical practice, education and management, and recommendations are made for further research to extend the study.

CHAPTER 2

BACKGROUND TO THE STUDY

2.1: Introduction

In this chapter, the main drugs of concern to the Australian community are identified and their effects on the body are discussed. The different patterns of drug use and the concept of dependence on drugs are presented. The historical, organisational, and ideological issues that have shaped, and continue to shape, the responses to alcohol and other drug problems are examined. Among these is the evolution of treatment services, public concern about the consequences of alcohol and other drug use, the issue of combined treatment, and reforms in the Australian health care system. The ideological models underpinning government and service responses, and the effect on these responses of the advent of blood borne viruses such as hepatitis C and human immunodeficiency virus (HIV) are discussed.

2.2: Drugs of Concern

The use of dependence producing, psychoactive drugs is not a new phenomenon. In a review of the archaeological evidence, Westermeyer (1988) traces the use of psychoactive drugs such as opium, beers, wines, betel-areca stimulants, and cannabis to the prehistoric era. What is new in contemporary society is the range and complexity of licit and illicit drugs available for individuals to use. There are drugs to inhibit or enhance almost all aspects of human behaviour. There are drugs for contraception, drugs to promote fertility, drugs to decrease appetites and drugs to increase appetites. There are drugs for stimulation and for sedation and drugs to enhance performance on sports fields.

Any drug, whether prescribed for medicinal purposes or not, if used inappropriately can have serious consequences for the user. The concern in the community, however, is focussed not on prescribed medications, the use of which is regulated by professional bodies, but on the use of unprescribed, psychoactive, dependency producing drugs. The findings of the fifth National Household Survey conducted in 1995 (National Drug Strategy, 1996) indicate that, apart from

tobacco, the main drugs of concern to the Australian community are cannabis (31%), opioids, particularly heroin (28%), alcohol (13%), cocaine (7%), amphetamines (4%), tranquillisers and sleeping pills (2%), hallucinogens (1%), and ecstasy (1%) (National Drug Strategy, 1996). These drugs account for nearly all the harm produced by drug dependence and misuse in Australia and, with the exception of tobacco, are the main focus of treatment efforts.

In a recent report of the patterns of illicit drug use in Australia and the United States of America (USA), which drew on data from national surveys, school surveys, and surveys of adults and juveniles in prison and detention centres, it was concluded that there were marked similarities between the two countries in this regard (Maxwell & Davies, 1997). In terms of reported lifetime use for marijuana, tranquillisers, sedatives, and amphetamines the findings were similar. In regard to use of drugs over the past year, the only important differences detected were that marijuana, amphetamine, and alcohol use is higher among Australians, while cocaine and tobacco use is higher in the USA. An area of concern is the increasing purity of street heroin in both countries. This has been implicated, at least in Australia, with an increase in the number of heroin related deaths (Task Force on Drug Abuse, 1995) and may result in telescoping the time between first use of heroin to dependent use (Maxwell & Davies, 1997).

2.2.1: Cannabis

Cannabis, otherwise known as marijuana or hash as well as a number of street names such as grass, mull, pot, weed, gunga, and many others, can be inhaled or ingested. Cannabis is obtained from the hemp plant *Cannabis Sativa*. It is thought to have originated from Asia and reached Europe more than a thousand years ago (Hall, Solowiji, & Lemon, 1994). Cannabis is obtained from the flowering portion of the hemp plant, and the major ingredients are the cannabinoids, particularly delta-9-tetrahydrocannabinol (THC) which is said to be the most important psychoactive constituent. It is the most common illicit drug used in Australia and in Western society in general, but rates of cannabis use are not as high as tobacco and alcohol use (Donnelly & Hall, 1994). In two states, South Australia and the Australian Capital Territory, its consumption has been

decriminalised (Donnelly & Hall, 1994). Cannabis induces feelings of well being, self-confidence, heightened perceptions of time, space, smell, hearing, and touch. Other effects include confusion, impaired short-term memory, inability to think critically, and decreased fine motor movement (Hall et al., 1994). The drug has low toxicity and the long-term effects are as yet poorly understood, but it has been suggested that frequent and heavy users of the drug may experience increased risk of bronchitis, lung cancer, and other respiratory problems. They may also experience a loss of motivation, energy and drive, decreased concentration, interference with sexual drive and hormone production, and may also become dependent on the drug. In addition, it may precipitate schizophrenia in those who have a predisposition to this condition (Hall et al., 1994).

A major concern about cannabis has been that its use in adolescence may lead to, or increase the risk of, using other or more dangerous drugs such as heroin or cocaine (Kleiman, 1992). The most often cited evidence for this "gateway" hypothesis is the fact that the majority of heroin and cocaine users used cannabis before using heroin and cocaine. Kandel (1988), for example, found the prevalence of other illicit drug use increased with the current level of cannabis use. Current cannabis users were more likely to have used a large number of different types of illicit drugs. Cross-sectional data on drug use obtained from Australian adults in 1993 have also shown that those who use cannabis are more likely to have used heroin, and the greater the frequency of cannabis use, the higher the probability of their having tried other illicit drugs, including heroin (Donnelly & Hall, 1994). Such findings as these have been interpreted by some as confirming the "gateway drug" hypothesis, or the "stepping stone theory" of drug use (Dupont, 1984).

This interpretation has been contradicted by Kandel (1988), who stressed that the data imply associations, not causal linkages between the use of different classes of drugs. In a review of the available evidence (Donnelly & Hall, 1994), it was concluded that the case for a pharmacological explanation of the role of cannabis in progression to other illicit drug use is weak. Additionally, it was found that a progression from cannabis use to other illicit drug use is more likely to reflect pre-existing attitudinal and personality traits that predispose to

socialisation into an illicit drug culture, where there is encouragement to use other illicit drugs. While cannabis use is common among licit and illicit drug users, individuals are rarely admitted for residential detoxification from this drug (Heather & Tebbutt, 1989). If people do seek treatment because they have been using cannabis, they generally do so because of legal pressures and are managed on an outpatient basis.

The role of cannabis and cannabinoids in modern therapeutics is uncertain. Following a review of the pharmacology and adverse affects of the drugs, it was concluded that individual cannabinoids have a therapeutic potential that has yet to be explored in clinical practice (British Medical Association, 1997). It was recommended that clinical trials be established to investigate the relative usefulness and optimal medication regimes for the drugs for use with a range of medical conditions such as anorexia, anxiety, nausea, and depression.

2.2.2: Opioids

The opioid drugs are derived from a milky white substance produced by the opium poppy that, when dried, is known as opium. The term opioid includes not only the drugs derived directly from the opium poppy, such as morphine, heroin and codeine, but the numerous synthetic drugs, such as methadone and pethidine, that have opiate-like properties (Gossop, 1996). Heroin in its pure form is usually a white crystalline powder. The colour of the drug available on the streets varies according to the contaminants used in dilution. Heroin is considered the most problematic opioid drug in Australia (Premier's Drug Advisory Council, 1996). While it can be consumed orally, smoked, or inhaled, it is frequently injected either intravenously or intramuscularly. In its pure form heroin is relatively nontoxic. Street heroin, however, is of variable quality as it is usually mixed with other substances such as talcum powder, lactose, baking powder, quinine, and others. These additives can cause embolisms, collapsed veins, and various infections. In Australia, the opium poppy is cultivated legally in Tasmania for medicinal purposes. The main areas from which illicit supplies of opium originate are the Golden Triangle (Burma, Laos, Thailand), the Golden Crescent (Pakistan,

Afghanistan, Iran), the Middle East, and the Andean countries of Peru, Columbia, and Bolivia (Premier's Drug Advisory Council, 1996).

Although there are a number of opioid drugs, the usual ones for which people require treatment are heroin, methadone, morphine, pethidine, and codeine. The opioid drugs stimulate the higher centres of the brain resulting in depression of activity in the CNS that subsequently affects balance, concentration, and coordination. The immediate effects include euphoria and relief of pain. Among the longer term effects are constipation, irregular menstrual cycles, impotence, infertility, and the possible suppression of the immune function (Belkin & Gold, 1991). The symptoms associated with opioid withdrawal are similar to those of influenza and include rhinorrhoea, diaphoresis, yawning, restlessness, insomnia, dilated pupils, anorexia, generalised feeling of weakness and fatigue, piloerection, muscle aches, hot and cold flushes, and craving (West & Gossop, 1994). The symptoms associated with withdrawal from short-acting opioids, such as heroin, begin from eight to 12 hours after the last dose. The symptoms related to long acting opioids, such as methadone, usually begin after 18 to 24 hours of dosing. The duration of heroin withdrawal is approximately five to seven days, and from methadone, five to 21 days (Goodman & Gillman, 1991). Apart from the risk of overdose, most of the complications arising from heroin use relate to the injection of contaminated material and the use of unsterile injecting equipment, which can result in bacterial endocarditis, skin abscesses, infective emboli, and viral infections.

2.2.3. Alcohol

Alcohol is obtained from a range of fruits, vegetables, and grains which when subjected to various fermenting and distilling processes produce a variety of different types of beverages. There are six main types of beverage alcohol: beers, ciders, table wine, fortified wine, liquors, and distilled spirits. These differ in their chemical composition and strength, but the main component in all is ethyl alcohol, or ethanol. Alcohol contains calories, but no minerals or vitamins. Consumed in sufficiently large amounts it is a lethal poison (Gossop, 1996).

Alcohol is a CNS depressant that is absorbed directly into the bloodstream through the mucosa of the stomach and the small intestine. More than 90% is metabolised by a healthy liver at a rate of one standard drink (approximately 10 grams of ethanol) per hour. The remainder is excreted in breath, urine, and sweat. Alcohol is metabolised first into acetaldehyde, then into acetate carbon dioxide and water. Alcohol use has been linked to psychomotor and cognitive impairment associated with various types of accidents, as well poor work performance and domestic and other violence (Gossop, 1996). Chronic, heavy use can lead to brain and liver damage, impaired memory, psychoses, seizures, nutritional deficiencies, polyneuritis, cardiomyopathy, hypertension, stroke, haematological disorders, impotence, sterility, diarrhoea, ulcers, pancreatitis, cancers of various types, and a range of psychological and social problems (Gossop, 1996).

Knowledge of the withdrawal symptoms associated with alcohol is not new. It was described by Hippocrates and has been documented in both animal and human studies (Foy, 1986). The withdrawal symptoms from alcohol include tremors, muscle jerks, hyper-reflexia, increased heart rate, elevated temperature and blood pressure, hyperventilation, anorexia, nausea, vomiting, diarrhoea, diaphoresis, insomnia, nightmares, minor and major seizures, delirium tremens, visual and auditory disturbances, peripheral neuritis, anxiety, depression and disorientation (Foy, 1986). Regarding sleep, specific abnormalities such as disturbances in rapid eye movement sleep have been described, which can be long lasting. Though problems with sleep may settle within a few months, abnormal sleep EEGs have been reported for up to 21 months after detoxification (Williams & Rundell, 1981).

Apart from the widely perceived social benefits of alcohol as relaxant and social lubricant, there is now a growing amount of evidence, which has accumulated over the past 15 years, that alcohol use has health enhancing and protecting properties. In developed countries alcohol consumption has been associated with substantial reductions in the risk of coronary heart disease that is a leading cause of death in these countries (Doll, Peto, Hall, Wheatley, & Gray, 1992; Jackson, 1994; Jackson, Scragg, & Beaglehole, 1991; Steinberg, 1991). This benefit accrues at relatively low levels of alcohol consumption and is most

evident in middle aged and older people (Anderson, Cremona, Paton, Turner, & Wallace, 1993) and may also be limited to certain subgroups of the population (Rankin, 1994; Shaper, Wannamethee, & Walker, 1994). Low alcohol use may also be protective against a number of other conditions including ischaemic stroke (Jackson, 1994), increased resistance to the common cold in non-smokers (Cohen, Tyrell, Russell, Jarvis, & Smith, 1993), some gastro-intestinal infections (Poikolainen, 1994), reduced risk of diabetes (Rimm, Chan, Stampfer, Colditz, & Willett, 1995), and cholelithiasis (Thijs, Knipschild, & Leffers, 1991). Some concern has been expressed about the control of potential confounders such as diet, physical activity, smoking, and social factors in these studies (Ferrance & Bondy, 1994), and Pittman (1996) noted that the studies were correlational, hence no causal explanations were available to explain the findings and the issue required further research. The evidence of a protective relationship between low alcohol consumption and the medical conditions mentioned above is now quite strong.

2.2.4. Stimulants

Included in the stimulant group of drugs are amphetamines and cocaine. Amphetamines stimulate the CNS. Their most common oral forms are dexedrine and benzedrine (Premier's Drug Advisory Council, 1996). The drugs can be taken orally, but in Australia, amphetamines are commonly injected. They decrease appetite, increase awareness and self-confidence, and are said to increase energy levels and concentration. Users become hyperactive, excitable, and irritable. Other effects are headaches, dizziness, blurred vision, irregular heart rate, stomach cramps, dehydration, psychoses, violent behaviour, chronic fatigue, and exhaustion. Amphetamines are generally produced locally in clandestine laboratories. Cocaine can also be inhaled, smoked or injected, and its effects are similar to amphetamines. Cocaine reaches Australia by importation from South America via Europe and the USA (Premier's Drug Advisory Council, 1996). Withdrawal from cocaine has been most studied, but empirical data suggest that the abstinence response to amphetamines is similar (Lago & Kosten, 1994). Withdrawal symptoms include a marked "let down" effect with extreme fatigue,

lengthy sleep, unpleasant dreams, increased appetite, abdominal cramps, depression, apathy, and agitation. The withdrawal period lasts from two to four days, but mood disturbances may last for several weeks (West & Gossop, 1994).

2.2.5. Benzodiazepines

Benzodiazepines are a class of drugs known as minor tranquillisers. Among the most commonly prescribed benzodiazepines in Australia are diazepam, oxazepam, nitrazepam, and temazepam. Together these drugs account for 82% of all benzodiazepine prescriptions in Australia (Mant, Whicker, McManus, Birkett, Edmonds, et al., 1993). The symptoms of benzodiazepine withdrawal include anxiety, irritability, muscle pain, nausea, palpitations, panic attacks, perceptual disturbances, loss of concentration, insomnia, diaphoresis, memory impairment, and depression (West & Gossop, 1994). The onset of symptoms varies from two to seven days depending on whether the drug concerned was short or long acting (Smith & Landry, 1991). Duration of withdrawal symptoms is highly variable and may last from ten to fourteen days to several months (Frank & Pead, 1995). While commonly prescribed in oral form, these drugs can also be injected. According to Gossop (1996), since the late 1980s people admitted to drug treatment agencies in London for heroin dependence also required treatment for intravenous benzodiazepine use.

2.2.6: Hallucinogens

Hallucinogens (also known as psychedelic drugs) alter a person's perceptions of the world. Natural hallucinogens are obtained from such plants as peyote cactus (mescaline) and some mushrooms (psilocybin) (CEIDA, 1995). Other hallucinogens are synthetically manufactured in clandestine laboratories. Among these are phencyclidine (PCP) and MDMA or ecstasy, which is the most common of the so-called "designer drugs" used in Australia. MDMA is a semi-synthetic drug that is often mixed with a variety of other substances including heroin, LSD or cocaine (CEIDA, 1995). The chemical composition of MDMA is similar to amphetamines, as are the effects. These include anxiety, fear, tachycardia, hypertension, dehydration, vomiting, hallucinations, and irrational behaviour.

Other effects include hyperthermia, cardiac arrhythmias, and stroke. The findings of a recent survey in Australia indicate that it is not as widely used as amphetamines, and use has been associated with “dance parties” and “raves” (Solowij, Hall, & Lee, 1992). A small number of deaths have been attributed to acute MDMA toxicity. The number of deaths reported is relatively small compared with the likely extent of use in the community, but are of note in that they appear to be unpredictable, and the causes are not well documented.

Another hallucinogen is lysergic acid diethylamide (LSD). While it occurs naturally as a component of ergot, a fungus that grows on rye and other grains, the LSD available on the street is a synthetically produced compound (Weil & Rosen, 1993). The effects include auditory and visual perceptual distortions, euphoria, hypertension, impaired judgement, and tremor. It diminishes the capacity to differentiate between the boundaries of one object and another, and of the self from the environment. For some users, this is a pleasant sensation, but for others it can result in feelings of panic. It can result in psychoses and post hallucinogen perceptual disorders (flashbacks). It is commonly known as “acid”, and street preparations of LSD are often mixed with coloured substances and sold in capsule or tablet form. It can also be consumed on sugar cubes, gelatine, or absorbent paper (Weil & Rosen, 1993).

2.3: Patterns of Drug Use

Drug users can be divided into five major categories according to their patterns of consumption: experimental users, social or occasional users, situational or occupational users, binge users and compulsive, dependent users (Premier’s Drug Advisory Council, 1996). Experimental use is trying out a drug to experience the effect. Such use generally arises out of curiosity, or a desire to experience new moods or feelings. Following the initial experience of an altered state of consciousness, the person concerned may or may not choose to use the drug again. Social or occasional use is when a drug is used as a means of enhancing social interactions or leisure activities. Situational or occupational use occurs when a drug is used to enable people to meet the requirements of their work. Examples of this include the use of stimulants by truck drivers to enable them to keep awake

when driving long distances, and students using the same type of drugs to cram for examinations. Binge use occurs when a person who is usually abstinent, or only uses drugs infrequently, uses large amounts on an occasion. Dependent use is when drugs are used from a sense of compulsion, so that other activities and responsibilities may be neglected. Although dependent users constitute only a small proportion of the population, they consume a disproportionate share of drugs, and make up the bulk of the population in treatment. Most people will use drugs, of whatever kind, in a way that controls the quantity and frequency of consumption to maximise the perceived benefits and minimise any harm that may be associated with use. Others use drugs to the extent that they become dependent on them and, if drug use is ceased or considerably reduced, they are likely to experience withdrawal symptoms from whichever drug or drugs they have been using (Premier's Drug Advisory Council, 1996).

2.4: Tolerance and Dependence

Fundamental to understanding the withdrawal syndromes related to various drugs are the concepts of tolerance and dependence. Tolerance is a reduced sensitivity to a drug following repeated consumption (WHO, 1993). This means that higher doses of a particular drug are required to obtain the effect previously achieved with smaller doses. Dependence has been defined as a state of adaptation to a drug, which may be psychological and/or physical, which includes a compulsion to use the drug to experience its effects and avoid withdrawal symptoms (WHO, 1993).

Alcohol dependence was described as a syndrome by Edwards and Gross (1976). The essential features of this syndrome were: a narrowing of the drinking repertoire, salience of drink-seeking behaviour, increased tolerance to alcohol, withdrawal symptoms when alcohol consumption is ceased or severely curtailed, drinking to relieve or avoid withdrawal symptoms, an awareness of a compulsion to drink, and reinstatement of the syndrome if a person resumes heavy drinking after a period of abstinence. These components of the syndrome exist in degrees, hence the syndrome has a range of severity, from mild to moderate or severe.

The syndrome has attracted criticism on the grounds that prolonged, excessive drinking is not associated with impaired control, craving, or narrowing of the drinking repertoire (Shaw, 1979), and the unidimensionality of the syndrome has been examined (Chick, 1980). It has, however, been encapsulated in the Diagnostic and Statistical Manual of Mental Disorders-IV (American Psychiatric Association, 1994), as well as the International Classification of Diseases-10, and defined as

A cluster of physiological, behavioural, and cognitive phenomena of variable intensity, in which the use of a psychoactive drug (or drugs) takes on a high priority. The necessary descriptive characteristics are preoccupation with a desire to obtain and take the drug and persistent drug-seeking behaviour. Determinants and the problematic consequences of drug dependence may be biological, psychological or social, and usually interact.

(WHO, 1993, p. 5)

It is used in clinical practice to capture the relapsing, repetitive nature of some people's drug use despite the harm associated with this behaviour, and has been applied to substances other than alcohol. Though devised specifically to describe the problems associated with alcohol use, it can readily be applied to other psychoactive drug use. The syndrome can be measured in dimensions of severity, and is said to be "central to helping patients with alcohol and drug problems" (Chick & Cantrell, 1994. p. 15).

2.5: Issues Related to Treatment

As Weisner (1987) noted, when considering responses to alcohol and other drug problems it is important to review the historical, organisational, and ideological issues which influence treatment practices. The historical issues relate to how the current systems of care for individuals with alcohol and other drug problems have evolved. The organisational issues relate to the manner in which care is provided, that is, whether licit and illicit drug users are treated in the same unit, in the same program, or managed in separate facilities. Another factor which influences the way treatment is able to be provided is the reforms occurring in the wider health care system, particularly those related to funding cuts. The

ideological issues are the philosophies and models which guide service providers in working with people with alcohol and other drug problems.

2.5.1: Historical responses

Illicit opioid drug use and injecting drug practices did not become a problem in most English speaking and European countries until the late 1960s and early 1970s (Lewis, 1992). Alcohol, however, has long been a source of major economic, social, and health problems. In Australia, in relation to the early colonists, it has been reported that "The 'transplanted Britons', bonded and free, who colonised Australia, were well practised in the art of heavy drinking. Drunkenness and heavy drinking were common in all classes of British society in the late eighteenth and early nineteenth centuries" (Lewis, 1992, p. 8). Although the early convicts were encouraged to work for wages, the amount of currency available to purchase goods and services was insufficient to meet demand, and a barter system revolving around rum evolved. The term rum was used in a generic sense and included spirits such as gin, whisky, brandy, and illegally distilled products. The control and distribution of rum was largely in the hands of the officers of the New South Wales Corps, commonly known as the Rum Corps (Lewis, 1992).

Several governors attempted to deal with the problems associated with the rum trade (Ward, 1981). For example, Governor Phillip prohibited the practice of substituting rum for food in convicts' rations. Governor Hunter went further and established several formal controls including the suppression of illicit distilling, licensing importers, wholesalers and retailers, and fixing import prices and quotas. Governor King attempted to enforce these measures, but had limited success. The more vigorous efforts of the following incumbent, Governor Bligh, led to the Rum Rebellion and his removal from office. In 1809, Sydney had a population of 6156 and seventy-five hotels (Lewis, 1992). The reported amount of alcohol consumed in the early days of the colony was such that one historian commented that "No people on the face of the earth ever consumed more alcohol per head of population" (Ward, 1981, p. 35).

According to Powell (1988), this statement is more myth than fact. A comparison of per capita consumption in New South Wales (NSW) in the 1830s, a period of peak use, with that of Britain and the USA in the same years, indicated that the inhabitants of NSW were consuming 13.6 litres of pure alcohol per head, in Britain, 7.7 litres, and in the USA, 14.3 litres. At the same time the male female ratio in NSW was 3:1, and children formed 20% of the population. In Britain the proportion of men to women was approximately 1:1, and children made up 30% of the population (Powell, 1988). In the USA, the male female ratio was similar to that of Britain, but children formed 50% of the population. Correcting for the differences in the percentages of women and children in the populations, and assuming that children were non drinkers and that men drank twice as much as women, Powell estimated that the alcohol consumption figures would be 20.3 litres per drinker in NSW, 27.5 litres for the USA, and 14.8 litres for Britain (Powell, 1988, pp. 9-11). Hence the drinkers in NSW were drinking more than those in Britain, but considerably less than those in the USA. While the early colonists may not have been the heaviest drinkers in the world, at least in the English speaking countries, there is no doubt that many consumed a considerable amount of alcohol.

Public drunkenness was a common feature of life in the new colony (Powell, 1988). The legal response to this behaviour was imprisonment, forced labour, or public flogging. By the late nineteenth century, however, the prisons could no longer accommodate the numbers committed for drunkenness. In addition, some members of the clergy, the medical profession, women's groups, and the criminal justice department began to lobby for a more effective way to handle drunkenness than the revolving door of the police courts. The outcome was the passage of an Inebriates Act in 1872 that provided for the establishment of special centres for the care and control of inebriates. This was the first Inebriate Act in the world (Room, 1988). The facilities deemed appropriate for the care of this population were the state mental hospitals.

In a review of public alcoholism treatment in Australia for the period 1859-1939, Lewis (1992) argues that the growing secularisation of society and the growth of a scientific worldview contributed to the decline in a moralistic

approach to drunkenness. According to Lewis, drunkenness, or inebriety, came to be regarded as a disease to be cured, not a crime to be punished. The nineteenth and early twentieth century treatment was based on the disease concept of alcoholism, which in turn was related the growth of modern medicine. According to McCarthy (1988), treatment included total abstinence from alcohol, plenty of rest, and opium was used as a sedative. The doctor was to encourage, in the patient, a sense of responsibility and fear of retribution "beyond the grave". In addition, some manual work and isolation from the community was prescribed. Other methods employed were hypnoses, cures offered by "charlatans and religionists", injections of bichloride of gold for those who could afford them, and morphine (McCarthy, 1988).

Consigning some inebriates to mental institutions, usually in the same ward as psychiatric patients, was considered an improvement over prison. The situation, however, was far from ideal. While state governments were prepared in principle to provide special facilities for the treatment of inebriates, in practice they did little. The modern welfare state was not in existence and, while health care was available on a fee for service basis for the wealthy, the poor and disadvantaged were treated in charitable institutions. In general, no additional resources were made available to the psychiatric services to enable them to deal effectively with the increased workload associated with accepting inebriates for treatment (Lewis, 1992).

The public mental health institutions were overcrowded, understaffed and, in many cases, were unable to provide more than custodial care. Dissatisfaction with conditions led to a national investigation in 1955 (Lewis, 1992). The investigators reported that the standards of Australian services were below those of the United Kingdom, the United States, and Canada. Wards were overcrowded and the buildings were functionally unsuitable. Few comments were made concerning the treatment of inebriates, but these were far from complimentary. The comments made about Claremont Hospital in Western Australia serve to illustrate the findings from other states. Claremont was described as overcrowded, the wards were in poor condition, and it was called on to fulfil too many functions (Lewis, 1992). For example, it was an admission centre for senile females, the criminally

insane, the mentally retarded, and inebriates. The majority of nursing staff were not certificated and the hospital was understaffed medically (Lewis, 1992). The psychiatric institutions in Australia lacked the facilities to implement effective treatment for patients with psychiatric diagnoses, as well as those committed as inebriates (Lewis, 1992). Sentencing inebriates to prison resulted in overcrowding in the gaols; committing them to psychiatric institutions resulted in overcrowding in the asylums. For the individuals concerned, the psychiatric option avoided the stigma of having been imprisoned, but attracted the stigma associated with committal to an asylum.

Lewis (1992) identified two periods in the history of public treatment for inebriates between 1859 and 1939. The first one was optimism due to what was perceived to be more humane and scientific management practices. The second was pessimism when it was realised that the treatment provided did not prove to be very effective, and that on release from psychiatric care many people rapidly relapsed to drinking. The early problems related largely to alcohol, and while alcohol remains the main problem drug in Australia, since the late 1960s there has been increasing concern throughout the community and various State and Federal governments about the use of illicit drugs such as cannabis, amphetamines, heroin, hallucinogens and others (Premier's Drug Advisory Council, 1996).

This concern has resulted in a number of government inquiries and commissions. Between 1970 and 1996 there have been 19 major public inquiries related to alcohol and other drug issues in Australia (Premier's Drug Advisory Council, 1996). The issues investigated ranged from alcohol-related vehicle accidents, liquor licensing laws, drug trafficking, illicit and prescribed drug use, treatment services for alcohol and other drug users, and volatile substances. These Royal Commissions and inquiries reflect the growing public concern about the social, health, and legal consequences of alcohol and drug use, and provision of treatment services for alcohol and other drug users. In 1985, the debates generated by the public inquiries into alcohol and other drug use resulted in a special meeting, usually referred to as the Drug Summit, of the State Premiers and the Prime Minister. At the meeting it was agreed that an integrated approach, involving the health, police, legislation, and welfare sectors, was required to

address all drug problems. It was further resolved that adequate resources should be committed to support this approach, and, as a result the National Campaign Against Drug Abuse (NCADA) was launched in 1985 (Henry-Edwards & Pols, 1991). It involved cooperation between the Commonwealth and all State and Territory governments, and was the first comprehensive national response to alcohol and drug problems in Australia. The principal aim of NCADA was to reduce the harm associated with drug use (Henry-Edwards & Pols, 1991).

Between 1985 and 1988, the Commonwealth and State Governments provided \$110 million through NCADA for new and existing activities, \$77 million for treatment and education in the States and Territories, \$26 million for national education and research projects, and \$7.5 million for drug law enforcement (McDonald et al., 1988, p. 500). Two national centres for research were established. The National Drug and Alcohol Research Centre (NDARC) was located in Sydney; the National Centre for Research in the Prevention of Drug Abuse (NCRPDA) in Perth. NDARC was committed to research on treatment of alcohol and other drug problems; NCRPDA was focussed on prevention of alcohol and other drug related problems. Later, a National Centre for Education and Training in Addictions (NCETA) was established in Adelaide. The policy directions for NCADA were given by the Ministerial Council on Drug Strategy (MCDS) which was comprised of Ministers representing health and law enforcement portfolios from all states. NCADA has had a major impact on the direction and funding of education, research, and treatment programs, in particular in the upgrading and expansion of methadone programs for opioid users (McDonald et al., 1988). NCADA has largely evolved into what is now known as the National Drug Strategy (NDS). At the time of writing this thesis, the NDS continued to attempt to minimise the harms associated with alcohol and other drug use in Australia, albeit with reduced resources and fragmentation of responsibilities across the sectors involved in providing a comprehensive, national response to these problems.

In Australia, and other countries, detoxification and rehabilitation services for individuals with predominantly alcohol and illicit opioid drug problems have largely evolved separately (Room, 1988). This separation was particularly evident

in the USA where each area developed its own experts, professional journals, and conferences. In addition, two federal institutions were established: the National Institute on Drug Abuse (NIDA), which set priorities for research into the drug abuse treatment system, and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) which sponsored research on alcoholism. In contrast, in Australia, the separation of alcohol and drug research was not so marked (Room, 1988). The Foundation for Research and Treatment of Alcoholism and Drug Dependence was established in NSW in 1956. The Victorian Foundation on Alcoholism and Drug Dependence (VFADD) and the South Australian Foundation on Alcoholism and Drug Dependence (SAFADD) came into being in 1959 and 1963 respectively (Room, 1988).

In 1967, these Foundations were combined into a national body, the Foundation for Research and Treatment of Alcoholism (FRATA). In 1971, the name was changed to the Australian Foundation of Alcohol and Drug Dependence (AFADD) in recognition of the increasing problems caused by drugs other than alcohol. By 1975, all states had representation on AFADD, which operated as an umbrella organisation facilitating a range of initiatives involving alcohol related education and treatment. In 1984, AFADD was reconstituted as the Alcohol and Drug Foundation of Australia (ADFA). The Foundations were set up to enable government and non government agencies, professional and interested lay people to have a public voice on matters related to a range of drug issues (Room, 1988).

The two main professional organisations established were the Drug and Alcohol Nurses Association (DANA), and the Australian Medical Society on Alcohol and Drug problems (AMSAD). Over time, the non-medical membership of AMSAD increased and the name was changed to the Australian Medical and Professional Society for Alcohol and Drugs (AMPSAD). More recently, the term “medical” has been dropped, and the association is now known as the Australian Professional Society for Alcohol and Drugs (APSAD). Both DANA and APSAD conduct annual conferences and APSAD publishes the Australian Alcohol and Drug Review journal.

A public system of alcohol treatment services was established long before the need for services for illicit drug users was demonstrated (Henry-Edwards & Pols,

1991). Services for this group, particularly heroin users, were largely provided by non-government agencies, therapeutic communities (TC), and self-help groups. More recently, for heroin users, methadone maintenance programs were established in both the public and private sectors in all Australian states except the Northern Territory. Methadone is a long acting opioid which is administered orally, and if prescribed in high enough doses reduces the craving for heroin, and consequently the use of the drug and the associated risk factors such as injecting drug practices, the spread of blood borne viruses, crime, and overdoses (Mattick & Hall, 1993).

The TC approach began with the establishment of Synanon in 1958 (Glaser, 1981). The model was organised around clients helping clients, confrontational and group therapy, Alcoholics Anonymous (AA) principles, structured lifestyles, drug abstinence, self-reliance, and personal responsibility for decisions about lifestyle. The TC approach was designed to provide structure for individuals whose lives had involved criminal activity, disorganisation, and social rebellion. This is not to imply that voluntary agencies and self-help groups did not and do not provide services and support for alcohol dependents, but that some agencies catered and cater almost exclusively for illicit drug users.

The first self-help group, AA was designed to provide assistance to people with alcohol related problems and originated in the United States in the mid 1930s. It was the forerunner of a number of self-help groups concerned with addictive behaviours such as Gambling Anonymous (GA), Narcotics Anonymous (NA), Alanon, Alateen and others. According to Lewis (1992), AA was introduced to Australia by A.V. McKinnon, a nurse at the Darlinghurst Reception Centre. After obtaining information about AA from a group in the USA, the nurse was instrumental in establishing the first Australian AA group at the Darlinghurst Reception Centre in 1944. From there it spread rapidly to all other states and, for a period in 1960, it was reported that Australia had more AA groups per head of population than the USA (Room, 1988).

Alcoholics Anonymous members identify themselves on the basis of being an alcoholic. This is achieved by open confession where people tell the story of their drinking history, and share their experiences with other members of the group. It

involves self-examination, admitting to character deficits, and restitution of any wrong committed (AA World Series Inc., 1988). Alcoholics Anonymous functions on the premise that alcoholism is a disease which cannot be cured but can be arrested through abstinence. Those attending AA groups are sponsored by a more experienced AA member, offered social support, and work through what are called the Twelve Steps of recovery. The Twelve Steps include admitting that they have no control over alcohol, and placing their recovery in the hands of a Higher Power. They also subject themselves to critical self-examination, make a commitment to honesty and humility, accept the reality of the past and the harm they have caused, and responsibility for restitution of harm done. Frequent attendance at meetings is recommended, and members are welcomed back time and again should they relapse to drinking (AA World Series Inc., 1988).

Active involvement in the organisation of groups is encouraged, and over time an individual's experience of AA can change from initially seeking help for themselves to helping others. When non-government organisations targeted at individuals with alcohol related problems began to develop in the 1960s, many adopted the AA approach in their programs. Many of the helpers in these organisations were either active or former members of AA, and the AA approach proliferated. This approach to alcoholism involves a particular style of group participation and leadership. It also promotes a belief system about drinking and a way of life for some. It is a common practice to introduce lay programs based on the twelve step program promoted by AA or NA as adjuncts to professional, clinically based treatment.

Though the AA program does explain some aspects of the behaviour of heavily alcohol dependent persons, there are a number of limitations to the use of this model. The individual concerned must accept that they are powerless to control the use of a particular substance, and the locus of control for achieving any change is external to the person. There is, moreover, no real problem resolution, only abstinence from the substance concerned. Whatever the limitations of AA may be, however, it offers help to many people with problems related to alcohol and other drugs and is an important and accessible resource throughout Australia and other parts of the world.

2.5.2: Organisational issues

Organisational issues relate to the question of whether or not licit and illicit drug users should be treated in the same program. Licit and illicit drug users are said to be incompatible because of differences in age, lifestyle, legal status, and the negative attitudes that each group has of the other group (Pittman, 1967). People using predominantly illicit drugs such as heroin, cocaine, and amphetamines are generally younger than those who prefer licit drugs such as alcohol, and have experiences in a subculture that frequently includes petty crime, burglary, and trafficking in drugs. People with problems arising mainly from licit drug use are said to be older, more conformist, and have fewer legal problems.

Illicit drug users are reported to consider themselves to be more resourceful and alert than licit drug users, and licit drug users consider illicit drug users to be dangerous and untrustworthy (La Porte, McLellan, & MacGahan, 1980).

According to Fort (1967), a combined approach to treatment for people with problems from alcohol, sedatives, stimulants, hallucinogens, and opioids would assist in avoiding fragmentation and over specialisation of staff and services. In responding to these comments, Pittman (1967) stressed the sociological differences between alcohol and other drug users that he believed made the combined approach untenable. These differences included the legal acceptability of alcohol that is readily available and part of many social and religious customs, whereas obtaining and using drugs such as heroin is surrounded by strict proscriptions. Pittman also pointed out the differences in the time between onset of drug use and dependency between alcohol and opioid users, and concluded that they were separate phenomena.

Others considered that, while the sociological dissimilarities between users of different drugs were real, they were irrelevant (Popham, De Lint, & Schmidt, 1968). The authors cited the successful mixing of varieties of mental health patients for purposes of treatment as a basis for combined treatment for licit and illicit drug users. They argued that combined treatment would be more consistent with the “whole person” approach, which was being introduced in mental health services at that time. Others distinguished sub populations among multiple

substance users, for example, between “streetwise” and “non streetwise” polydrug users. They maintained that each group had special social and drug-use characteristics that necessitated treatment approaches especially tailored to their needs. They also considered that highly structured therapeutic communities were inappropriate for “streetwise” people (Wesson, Smith, Lerner, & Keltner, 1974).

During the 1960s and early 1970s, there was considerable debate about combined treatment. Researchers arguing the case for combined facilities stressed the similarities between people with addictive behaviours regardless of the substance used (Fort, 1967; Popham et al., 1968). Those against combined treatment emphasised the differences and summarised the similarities (Pittman, 1967; Wesson et al., 1974). Neither argument was based on the results of any rigorous research, and the reports of combining treatments produced conflicting results. For example, St Bernard's Hospital in Middlesex was initially established to treat people with alcohol related problems (George & Glatt, 1967). Those admitted, however, were using a variety of drugs including amphetamines, cannabis, heroin, cocaine, barbiturates, and various combinations of these drugs. The problems reported related to attempting to include a younger group of clients in a program designed for older clients. The average age reported for clients with alcohol problems was fifty-three years, for amphetamine users it was nineteen years, and for heroin users, twenty-two years. Problems occurred among the younger age groups from drug-seeking behaviour, boredom, and lack of involvement in group activities. The majority of younger clients did not complete the program. The authors concluded that a combined treatment approach could be effective for middle-aged clients, regardless of the substances used, but questioned the feasibility of combining the different age groups. They also recommended limiting the number of drug users in the unit to no more than five at any one time (George & Glatt, 1967).

Contrasting results were reported from Eaglesville Hospital and Rehabilitation Centre (EHRC) (Aumack, 1980). The EHRC was established in 1966 to treat individuals with alcohol related problems. In 1968, in response to a growing number of illicit drug users in the community, clients with problems arising from a variety of drugs were accepted into what was described as a fully integrated

program. The difficulties experienced related to the antagonistic and negative stereotypical images that each group had of the other group, and the poor motivation of illicit drug users to refrain from drug use. Initially, the proportion of illicit drug users was restricted to 25%; this was later relaxed to 50% (Ottenberg, 1975). The EHRC program consisted of a residential stay of sixty days, during which clients were involved in a variety of physical, social, and psychological activities.

The program was evaluated by Aumack (1980). The research design consisted of randomly assigning clients to either separate or combined treatment and following them up eight months after entry into the program. The results indicated that, on a range of outcome variables, there were no significant differences between clients in the two treatment modalities, and it was concluded that combined treatment was at least as effective as separate treatment. The EHRC continued to expand combined services under a disease model and, in the mid 1980s, was regarded as being one of the largest treatment centres for individuals with alcohol and other drug problems in the US (Hearn, 1986).

It has been reported that the most important element in the success or failure of combined treatment is the attitudes of staff (Cole & Cole, 1979). Provided staff are receptive and willing to provide treatment in a combined manner, it is said to be at least as effective and probably more efficient than separate treatment. In a recent review of seventy-six studies from overseas and thirty-nine studies from Australia, the provision of separate services for licit drugs (mainly alcohol) and illicit drugs (mainly heroin) is evident (McDermott, Hamilton, & Legay, 1991). This separation may be more apparent than real. Some of the reported differences between users of different drugs now may be no longer so marked. There is an aging cohort of heroin users; many individuals are consuming alcohol at hazardous levels in their early teens, and are thereby experiencing problems at an earlier age. Serious crime may be more common among heroin users than alcohol users, but alcohol use is frequently associated with violence and crime (Dunne, Paton, & Waller, 1989). In addition, many individuals are dependent on prescribed drugs such as benzodiazepines and pethidine.

Cannabis is widely used in the community, and the majority of those using this drug would not regard themselves as criminals on the basis of using this particular drug alone. Poly drug use such as alcohol and opiates, sedatives and stimulants, analgesics and stimulants, cannabis and alcohol, and various other combinations of drugs is common (Dunne et al., 1989). It has been pointed out that

. . . all treatment programs may be viewed as serving a mixed population of alcohol abusers and drug abusers, regardless of whether or not the administrators or treatment staff acknowledge the existence of the other problem.

(Carroll, 1986, p. 126)

Carroll distinguishes between three forms of combined treatment: unconscious, covert; conscious, covert; and conscious, overt. Unconscious, covert treatment is when staff working in a substance-specific facility are unaware of, and do not look for, the coexistence of other problem drug use. Though some problems may be addressed, obviously clients will not receive optimal treatment since the use of a range of drugs will not be acknowledged in case management. Conscious, covert combined treatment occurs when staff acknowledge the coexistence of a dual dependency and treat the multiple problems, though the centre does not advertise that clients with multiple substance use problems are admitted to the programs. The conscious, overt type of treatment is said to be present when the treatment centre is presented to the general public as a combined treatment facility (Carroll, 1986).

Restricting treatment units to accepting either licit or illicit drug users does not match up to the reality of the clientele seeking assistance. The dichotomy probably reflects more the practice in many treatment units of categorising clients on their main problem drug than on their actual drug use. In the USA for instance, in regions where the only available beds were designated for individuals with alcohol problems, cocaine users were advised to report themselves as “alcoholics” (Rawson, 1990-1991). Conversely, in areas where alcohol resources are scarce, alcoholics could gain admission to drug services by reporting use of cocaine, cannabis, or some other drug.

In a more recent study, Weisner (1992) compared the clients in alcohol treatment agencies (n=381) with clients in drug treatment agencies (n=307), in terms of socio-demographic, drinking and drug use, associated problems,

dependence, criminal behaviour, and treatment history variables. The results indicated that, while large numbers of clients reported use of both alcohol and other drugs, there were important differences between the two groups. They differed in regard to age, ethnicity, marital status, education, employment, and criminal behaviour measures. Weisner concluded that there were different socio-cultural meanings and values ascribed to alcohol and drugs that affect treatment strategies and outcomes.

The debate on combining services, which has essentially remained unchanged over more than twenty years, has been referred to as a "giant distraction" (Raistrick, 1988, p. 868). Raistrick considers that grouping clients on the stages of change as described by Prochaska and DiClemente (1986) was more important than divisions on the lines of substance use. The stages of change were described as precontemplation, contemplation, action, maintenance, and relapse. People in the precontemplation phase were classified as "happy users", and were not likely to be seen in treatment settings unless coerced in some manner. A full discussion of these stages of change is provided in chapter nine. The argument is that "addicts" would be more likely to present in the precontemplation stage because of legal pressures, or because their supply of drugs had terminated. "Alcoholics", on the other hand, would be more likely to present later in their drug taking career when the adverse effects of their drinking had occurred, so they may be already at least in the contemplation stage, and more willing to make a commitment to change. Pittman (1988) argued that if services were organised around a generic concept of dependency on substance or behaviour, then those who were obese, sexually promiscuous, smokers, compulsive gamblers, and work or fitness addicts should be included in combined programs. Pittman (1988) reaffirmed his earlier views that the heterogeneous life experiences and age differences between predominantly licit and illicit drug users makes combined treatment problematic.

Despite these reservations, the merging of alcohol and other drug treatment services has continued, particularly in the USA. Of the 7,759 public and private programs analysed in the 1989 National Drug and Treatment Alcoholism Treatment Unit Survey (NDATUS, 1989 cited in Schmidt & Weisner, 1993), 65% reported combined programs. This represents an increase of 234 % compared

with the findings of the survey conducted in 1982 (Schmidt & Weisner, 1993). Comparable Australian data are not available as the COTSA surveys reported on the demographic and drug use characteristics of the clients of the participating treatment agencies, but did not differentiate services on the basis of specific drug use, though it was obvious that methadone programs were designed solely for opioid dependent clients. The phenomenon of multiple drug use continues to be the most common feature among clients in treatment programs (Almog, Anglin, & Fisher, 1993). Many treatment programs, however, have remained ostensibly substance specific for either individuals with problems related to alcohol or illicit drug use, despite the increasing evidence for multiple drug use in the different drug using populations.

In the late 1970s, the agency in which this study was conducted treated opioid and alcohol dependents in the same setting (Western Australian Alcohol and Drug Authority, 1979). Following a period of dissatisfaction and frustration with attempts to treat people dependent on alcohol and people dependent on heroin or other illicit drugs in a combined treatment program, the services were restructured in 1983 to deliver separate residential detoxification services for the two groups of clients. In 1991, faced with economic constraints and an accumulating amount of evidence that outpatient detoxification was, for some individuals, at least as effective as inpatient treatment and moreover was more cost effective, the separate residential services were again combined with a considerable reduction in bed numbers (a full discussion of this is provided in Appendix A). A review of the literature on outpatient detoxification is provided by Bischof, Booker, Dyck, Hamblen, Hittinger, et al., (1991). The authors noted that many clients can be treated as outpatients for half the cost of inpatients, but cautioned that inpatient treatment is necessary for those likely to experience severe withdrawal symptoms. In addition, evidence was gradually accruing that home detoxification was safe, cost effective, readily acceptable to clients and concerned others and, for many, the outcomes were at least as favourable as inpatient care (Bartu, 1991; Bartu & Saunders, 1994; Stockwell, Bolt, & Hooper, 1986). The economic constraints, which impinged on the unit in which this study was conducted, were congruent with the financial cutbacks that were occurring in the wider health care services.

2.5.2.1: Health care system reforms

At the time of this research, in Australia health care was and is largely funded from government sources. The governments, Federal and State, determine the priorities for health care and allocate the funds to ensure that the priorities are met. In addition, the governments own most of the infrastructure necessary to provide the services. In a review of the situation, the State Health Purchasing Authority (SHPA) noted that in 1992-1993, Australia spent over \$34 billion on health services, or nearly \$2,000 for each person (SHPA, 1995). This represented approximately 8% of gross domestic product, and was similar to the average amount spent on health in other developed countries.

The traditional method of funding health care services in the public sector was to give the service concerned what it spent the previous year, topped up with adjustments for inflation, new initiatives, capital works and equipment (SHPA, 1995). The alternative to this would be to pay health care services for what they actually delivered, and to link individual client care with the resources used in delivering that care. This concept led to the introduction of the Casemix system which was an attempt to gain a better understanding of the cost structure of health services in terms of inputs and outputs (SHPA, 1995).

This development resulted in the separation of purchasing of health services from the provision of services, and has come to be referred to as the "funder-provider split". At the time of writing, the government remained the funder, but not the provider of services. Organisations, such as hospitals, agencies and other health care facilities, were required to tender competitively to the appropriate health department for funds to continue delivering the services they customarily provide. In addition, they were required to demonstrate regular monitoring of efficiency and effectiveness measures of the services for which they received funding. In Western Australia, more than \$3 billion a year was spent on health services provided by public, private, and non-profit organisations (SHPA, 1995). Of the public health budget, in 1995, 60% was provided by the state, and the remainder was provided by the Commonwealth government. Over recent years, however, the Commonwealth contribution in terms of real per capita expenditure

has declined steadily (SHPA, 1995). The reforms were achieved in the presence of a decreasing health budget, and an emphasis on accountability and getting value for money, which in turn resulted in the imposition of economic constraints on service providers.

The changes, which occurred in the wider health care system, had a strong influence on how services could be provided in specialist drug treatment facilities. This was due to a large extent to the funding arrangements under which specialist public services operated. For example, the operating funds of the organisation in which this study was undertaken were derived partly from federal sources such as the National Campaign Against Drug Abuse, but mostly from the Health Department of WA (HDWA). The drive towards efficiency and cost containment had resulted in a shift in emphasis from residential to outpatient care in public treatment facilities throughout Australia. Together with the research findings referred to above, it was a major factor in the structural reorganisation which resulted in the amalgamation of the two residential detoxification services of the agency in which this investigation was conducted.

2.5.3: Ideological issues

The ideological issues concerning how treatment is provided relate to the various models or theories that have been developed in attempts to explain alcohol and other drug use. A model consists of certain perspective or orientation towards the aetiology of alcohol and other drug problems that in turn influences the way services are provided and the anticipated outcomes of interventions (Ali et al., 1992). A professional ideology not only includes beliefs about theories of aetiology, but provides perceptual norms for what should be provided in clinical practice, education, and research, as well as what outcomes may be achieved by treatment. The concept of professional ideology has been used to explain variations in psychiatric treatment observed in hospital settings (Strauss, Butcher, Erlich, Schatzman, & Sabshin, 1964). This group of researchers demonstrated how the treatment philosophies held by different health care providers shaped the way services were organised and delivered. This included definitions of what were "proper" treatment, and the division of labour in the hospital. In regard to

alcohol and other drug use, several models have been developed, partly from scientific findings, but also from prevailing social and political values and the interests of competing professional groups. These are (a) the moral model, (b) the disease model, (c) the social learning model, (d) the existential model, (e) the public health model, (f) the neuro-psycho-pharmacological model, and (g) the harm minimisation model. These models are not merely of academic or philosophical interest; they form the basis for determining the form of treatment, including appropriate goals, outcomes, staffing patterns, and treatment duration, that may be adopted by organizations.

2.5.3.1: The moral model

Drunkenness, prior to the late eighteenth century, was viewed as a moral issue (Henry-Edwards & Pols, 1991). The main features of this model were that drunkenness was sinful and that the person exhibiting this behaviour was weak-willed and had a moral weakness. The substance was usually defined as bad or evil, and was seen as inevitably leading to problems. This model was the basis of the temperance movement. In order to overcome the problems related to alcohol, complete abstinence was necessary. The implications of this model were that "excessive" alcohol use was either criminal or sinful, and that this behaviour was appropriately dealt with by legal or religious sanctions.

2.5.3.2: The disease model

At the end of the eighteenth century, a number of physicians in different countries were referring to alcoholism as a disease. Among them was Bergman in Germany, Dragonet in France, Rush in the United States, and Trotter and Halloran in England (Lewis, 1992). The source of the problem was posited to be in the substance alcohol, and the only lasting option available for persons identified as having the disease was, as in the moral model, lifelong abstinence (Levine, 1978). This resulted in it being seen as a condition that should be treated by members of the medical profession. This contrasted with moral views that located the source in the weakness of the person concerned, and the disease concept was adopted in the 1930s by AA (AA World Series Inc., 1988). Adherents of AA believe that the

disease alcoholism is caused by a pre-existing abnormality that prevents some people from drinking normally.

Jellinek (1960) is often considered to be the originator of the concept of "alcoholism" as a disease. In a classic study, Jellinek interviewed over 2,000 alcoholics, described several types of alcoholics (alpha, beta, delta, gamma, and epsilon), and found a characteristic pattern that constituted the "road to alcoholism". Jellinek, in a sense, rediscovered the disease concept. In his 1960 study, Jellinek restricted the disease concept to one where the individual concerned had experienced loss of control, or the inability to abstain, and then only after years of hazardous and harmful alcohol consumption. Of the various types of "alcoholics" that Jellinek described, he regarded only delta (inability to abstain) and gamma (loss of control) as diseases. The process of loss of control and the phases of alcohol addiction described the course of a chronic and progressive disease. Another mechanism related to the disease model is neuroadaptation. Neuroadaptation involves complex phenomena within cells, particularly in the central nervous system (Jaffe, 1990). According to Ghodse (1989), neuroadaptation is not solely a biological process. It is linked to conditioning processes, and withdrawal symptoms have been precipitated by environmental cues in persons who have been drug free at the time of exposure.

Although the disease model has been found to have limited explanatory power in relation to the aetiology of alcohol and other drug problems, the morbidity which results from severe dependence fits well within the concept. The WHO has accepted alcohol and other drug dependence as diseases and incorporated them in the International Classification of Diseases (ICD-10), and they have been operationalised in the American Psychiatric Association (1994) criteria for diagnosis in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV-R). The advantages of the disease model are that it has resulted in improved management of people with all forms of drug dependence, and has assisted health care workers to approach such patients in the same way they approach patients with other diseases. The focus is on the disease, not the individual.

The disease model has, however, serious limitations. When applied simplistically, severe alcohol dependence is often seen as a disease for which there

is no specific medical treatment, except perhaps a series of laboratory and imaging tests to determine the extent of organ damage. The only course is complete abstinence, and the condition is irreversible and lifelong. It also assumes that alcohol dependence is a biological process over which the individual concerned is powerless. In other words, people cannot consistently predict and control when, where, or how much they use alcohol or other drugs. The reason for this is that they are suffering from a disease in which choice, or will, or moral conviction do not, for the main part, make any difference to their use of particular substances.

Associated with the disease model and the emphasis on abstinence are the studies on predisposing, biologically transmitted, and genetic risk factors for alcoholism. Some evidence for this has been reported in studies on twins (Pickins, Suikes, McGee, & Lykken, 1991), adopted children (Goodwin, 1974), and animals. Several investigators have attempted to identify a specific set of genes that may be responsible for alcoholism. For example, a higher rate of the A1 allele or the D2 dopamine receptor has been reported in people with a diagnosis of alcoholism (Blum, Nobel, Shendon, & Finley, 1991). Cloninger (1987) described two types of alcoholism, Type 1 and Type 2. According to Cloninger, Type 1 alcoholism is explained by genetic factors and environmental influences. Type 2, however, is determined solely on genetic factors independent of the environment.

In a series of studies over the last twenty years, the disease model and the emphasis on abstinence has been challenged. Early intervention has been demonstrated to be effective with people who were alcohol dependent (Babor, Ritson, & Hodgson, 1986; Chick, Lloyd, & Crombie, 1985; Kristenson, Ohlin, Hultin-Nosslin, Trelle, & Hood, 1983), and controlled drinking has been found to be possible in many cases (Edwards, 1985; Sobell & Sobell, 1976). A long-term, prospective study of three groups of male subjects (Vaillant, 1983) indicated that the natural course of alcoholism could be described as consisting of three stages: social drinking, alcohol abuse, and alcohol dependence. According to Vaillant, approximately a third of heavy drinkers will continue to drink at that level with no apparent adverse consequences. A third will reduce their drinking to minimal levels, and a third will increase their drinking to levels that result in serious

medical, social, and at times legal problems. Of those considered to be abusing alcohol, approximately 25% progress to alcohol dependence; the others spontaneously become abstinent, or drink intermittently.

Vaillant reported that the rate of spontaneous recovery was lower for those who were dependent on alcohol, and that medical detoxification was usually required for this group of people. The implications of these findings are that many individuals do have control over their drinking behaviour and that total, life long abstinence is in most cases not compulsory or necessary.

2.5.3.3: The social learning model

Social learning theory proposes that individuals model their behaviour after that of people in the immediate environment (Bandura, 1977). Alcohol and other drug use is learned in the same way as other behaviours. As individuals develop in their formative years, their drug use is influenced by drug use in the home and in society as a whole. Peer pressure and role models, such as high profile sporting figures, may be particularly influential in the learning processes. In this model, all drug use is volitional, the locus of control of addictive behaviour is internal, and the assumption is that what is learned can be unlearned. Previously modeled behaviour may serve as a guide for future action provided the opportunity to practice the behaviour exists in the individual's environment. This model is useful for treatment, particularly treatment based on the principles of behavioural psychology and learning theory (Henry-Edwards & Pols, 1991). It places control over decisions about future drug use with the person concerned, and allows for informed choices to be made about different lifestyle options. What the model does not adequately address is that, before a theoretical learning model can be applied as a basis for treatment, the person must make a decision to change (Henry-Edwards & Pols, 1991). The social learning model of addictions was promoted in the unit in which this study was undertaken.

2.5.3.4: The existential model

The existential model was described by Drew (1986). Drew argued that the decision to use any drug involves decisions about competing behaviours. For any

lasting change to occur, people who use drugs in a dependent way have to adopt a new value system, and the new values must take priority over the former drug seeking and using behaviours. This model has clinical application as it subsumes many common elements of practice. These can include the precepts of AA, motivational interviewing, and drug substitution such as methadone for heroin or other opioids.

2.5.3.5: The public health model

The public health model is based on an awareness that the majority of alcohol related harm in a community is caused, not by the relatively few people dependent on alcohol, but by the far greater number of persons drinking at comparatively moderate levels (Kreitman, 1986). The public health model promotes a shift away from an exclusive focus on treatment for highly dependent drinkers and other drug users, towards brief interventions provided by doctors, nurses, and other health and welfare workers in a variety of settings. It recognises that specialist treatment is still essential for persons with severe alcohol and other drug dependence, but since the treatment of this population frequently has limited effect and is unlikely to decrease the amount of alcohol related harm experienced in society, a greater emphasis is placed on early and brief interventions for those with less severe problems. The aim is to promote moderate or low risk drinking (NHMRC, 1987) rather than abstinence, and reduce the problems associated with intoxication and the consequences of regular, excessive drinking (Ali et al., 1992).

2.5.3.6: Neuro-psycho-pharmacological model

A more recent model is based on Cloninger's (1987) tri-dimensional theory of personality and psychopathology. Cloninger proposed that alcohol "abuse" is related to three dimensions of personality: novelty seeking, harm avoidance, and reward dependence. These personality dimensions are assumed to reflect brain systems involved in adaptation to stimuli. Novelty seeking comprises frequent exploratory activity and exhilaration in response to novel stimuli. Harm avoidance refers to a tendency to respond to aversive stimuli or their conditioned signals, and is posited to be related to brain systems involving behavioural

inhibitions. Reward dependency is a dimension involving variation in behavioural maintenance and resistance to extinction, and is related to brain systems activated by onset of reward or punishment. In a review of a number of studies in which the tri-dimensional theory was applied to substance abusing populations, it was concluded that the utility of the theory for prevention and clinical practice is not well established (Howard, Kivlahan, & Walker, 1997).

2.5.3.7: Harm minimisation

The advent of blood born diseases such as HIV and hepatitis C has had a major impact on treatment and prevention services. Although the risk of an explosive spread of HIV among and from injecting drug users in Australia now appears to have abated, slow diffusion of the infection continues (Wodak & Crofts, 1994). The prevalence of HIV infection among Australian injecting drug users remains low, and is reported to be less than 5% in those who have not had male-to-male sexual contact (Kaldor, Elford, Wodak, Crofts, & Kidds, 1993). Among opioid dependent persons and poly drug users, particularly injecting drug users, the medical complications include hepatitis B and C, infective endocarditis, osteomyelitis, septicaemia, pulmonary emboli, cellulitis, thrombophlebitis, and nephrotic syndrome (English, Holman, Milne, Winter, Hulse, et al., 1995). It is estimated that more than 100,000 Australians are now infected with hepatitis C, and 10,000 new infections occur each year largely through injecting drug use (Crofts, Hopper, Bowden, Breschin, 1993). In contrast, there are an estimated 17,000 cases of HIV infection and the annual incidence is 600 (Australian HIV Surveillance Report 10, 1994). The annual incidence rate in Australian injecting drug users of HIV has been estimated as 0.4 % for HIV, and from 19.6% to 41% for hepatitis C (Wodak & Crofts, 1994).

Harm minimisation measures adopted to reduce the spread of HIV and hepatitis C infection include making available supplies of sterile needles and syringes, needle vending machines, condoms, increased access to methadone maintenance treatment programs, and treatment goals which include improvements in physical, social, legal, and psychological status, and may not be abstinence orientated. Initially developed to reduce the harm associated with injecting drug use, the

principles have been extended for the management of alcohol and other drug use. Increasingly, treatment agencies in Australia are adopting a model which takes into account the bio-psycho-social aspects of alcohol and drug use and incorporates the guiding principles of harm minimisation, which is essentially an extension of the public health model (Wodak & Crofts, 1994). This was the case in the newly amalgamated unit of this study in which the principles of harm reduction or harm minimisation were incorporated with a social learning model of addiction in the main treatment responses.

2.6: Summary

At the time this research was undertaken, the main psychoactive drugs of concern to the Australian community were cannabis, opioids (particularly heroin), alcohol, cocaine, amphetamines, tranquillisers, and hallucinogens. People who become dependent on psychoactive drugs are likely to experience withdrawal symptoms when they cease use. Treatment practices are influenced by historical, organisational and ideological factors. In Australia, the initial government response to habitual drunkenness was flogging and imprisonment. It was not until the late nineteenth century that individuals labelled as inebriates were committed to psychiatric institutions and, later still in the latter part of the twentieth century, that specialist facilities were provided for those now referred to as being dependent on alcohol and other drugs. In general, these services evolved separately because those dependent on licit drugs (mainly alcohol) and illicit drugs (mainly heroin and amphetamines) were said to be incompatible in terms of age and lifestyle differences. The current trend is to treat both groups in the same program.

The early treatment systems that developed were disorganised, parochial, and evolved largely as a result of considerations unrelated to theoretical or empirically derived information. Over time, a number of ideological models were developed to assist in understanding the aetiology of alcohol and other drug use which have, in part, influenced the response of governments and service providers to individuals with problems related to alcohol and other drug use. These are the moral model, the disease model, the social learning model, the existential model,

the public health model, the neuro-psycho-pharmacological model, and the harm minimisation model. Apart from the models, the most important factors impinging on how treatment is provided for individuals dependent on alcohol or other drugs are health care reforms and the advent of blood borne viruses.

It should not be assumed that the ideological models described above represent a sequential, historical progression in knowledge and practice. Rather, elements of all these models continue to be represented in the current responses to alcohol and other drug problems in the government and non-government sectors of health care services. Certain groups, such as AA, operate from a fixed model of recovery. This is not to say that the AA approach is not appropriate for many people, but is to emphasise the variety of conceptual models which have been developed to assist in understanding addictive behaviours. In the unit in which this study was undertaken, the disease consequences of alcohol and other drug use were recognised and taken into account. The aetiology of alcohol and other drug use, however, was viewed from the perspective of the social learning model and clinical interventions were strongly influenced by this model and the principles of harm minimisation or harm reduction. In the next chapter, the elements of the research design, the rationale for combining grounded theory and quantitative methods, and other aspects of the methodology of the investigation undertaken to address the objectives presented in chapter one are fully described.

PART TWO

METHODOLOGY AND QUANTITATIVE FINDINGS

CHAPTER 3: METHODOLOGY

CHAPTER 4: QUANTITATIVE FINDINGS

OVERVIEW

The research design, that incorporates grounded theory and quantitative methods, is described in full in chapter three. The various techniques employed for data collection and analyses are presented, and the instruments used in the quantitative component of the study are described. A description of the participants who were interviewed is provided. The quantitative findings are presented in chapter four. Included is a description of the participants who completed a questionnaire in terms of socio-demographic and drug use characteristics, and the uptake of referrals for follow-up care in the community is reported. Comparisons are made between licit and illicit drug users in regard to the above variables, and the prevalence of minor psychiatric morbidity is assessed by the GHQ-28. The influence of socio-demographic and drug use variables on the overall score and the domains of the GHQ-28 is presented. Comparisons are made between the prevalence of minor psychiatric morbidity detected in this study and that reported in other studies.

CHAPTER 3

METHODOLOGY

3.1: Introduction

In this chapter the methods used in the investigation of the participants' experience of the phenomenon of detoxification are reported. The setting in which the investigation was conducted and how access to the participants was negotiated is described. The strategies used to gain the support of the organisation and the staff in the unit in which the research was conducted are related. The research design is illustrated and described, and the rationale for combining grounded theory and quantitative methods is presented. The criteria for inclusion of the participants in the study and the sampling techniques used are described.

The various ways used for qualitative and quantitative data collection are presented. The sources of the qualitative data collection included formal semi-structured interviews with 29 participants and two staff members, focus groups with a further 20 participants, documents and literature, and participant field observation. The way the interviews were conducted and closed is fully described, and a profile of the participants who were interviewed is provided. The quantitative data were obtained by a questionnaire that was completed by 421 participants, and the measures used are clearly described. A limited amount of additional quantitative data on clients who left the unit without completing the treatment program were obtained from the computerised client record system of the organisation. The types of triangulation used in this study are discussed. The strategies used to address the issues of reliability and validity are portrayed, and the pilot study undertaken to test the questionnaire is described and the results presented.

The constant comparative method of grounded theory analysis is described. This includes data coding (open, category, and theoretical), memoing, field notes, identifying the basic social psychological problem, seeking the core category, saturation of categories, identifying the core category or process, and

delineating and describing the emergent substantive theory. The statistical tests used to analyse the quantitative data are presented, and definitions of several key terms are provided. A brief overview of the main findings of the study is presented.

3.2: Setting

Seven months prior to the commencement of the study the unit had been restructured to treat both licit and illicit drug users. An historical overview of the facility is provided in Appendix A. At the beginning of data collection the unit could accommodate 20 clients. This number of clients, however, placed considerable pressure on resources, both human and physical, and approximately six months after data collection commenced the number of beds was reduced to 17. The implications of this are discussed fully in Chapter 8. The facility was staffed by nurses, counsellors, doctors, social workers, a psychologist, and a consultant psychiatrist. In addition, there was a full complement of staff to provide catering and cleaning services. The organisational structure was based on functional unit management lines rather than professional groupings, that is, the unit was managed by a manager who was not a clinician. The manager was responsible for the overall functioning of the unit, and had authority over the operating budget. The latter related to operating the unit within a fixed budget and not to collecting fees, as all services provided to clients were funded by the government. Clinical issues related to client management were dealt with by the clinicians.

The philosophy of the program was based on a social learning model of addiction and the assumption that detoxification is an important initial step in lifestyle change. The residential detoxification service was regarded as a central link in a network of alcohol and drug treatment services, which included health care services in the government and private sectors, as well as a number of non-government agencies and self-help groups.

The program provided a comprehensive bio-psycho-social assessment, detoxification with medications according to the type of drug or drugs concerned, appropriate laboratory tests, pre and post-test counselling for blood borne viruses

such as hepatitis C and HIV, one-to-one counselling, group work, and AA and NA meetings. In addition, education about the physical consequences of drug use was provided and efforts were made to introduce clients to leisure activities as an alternative to alcohol or other drug use. The emphasis was on relapse prevention, motivational interviewing, goal setting, decision making, and linking individuals to aftercare services for ongoing support. Individuals were admitted to the unit if they were eighteen years of age or over, withdrawing from alcohol or other drugs, and required a level of nursing and medical care that would be difficult to provide on an outpatient basis.

3.3: Access to Participants and Liaison with Staff

Permission to undertake this study was provided by the relevant Graduate Studies Committees at Curtin University of Technology. The proposal was then submitted to, and approved by, the Human Research Ethics Committee of Curtin University of Technology. Following this, the proposal was reviewed and approved by the research committee of the organisation in which the study was conducted. The researcher then commenced a period of protracted liaison with all members of the staff in the detoxification facility to ensure that they were aware of the purpose of the study, the role of the researcher, and the data collection methods. A committee consisting of the manager of the unit, the nurse coordinator, the clinical nurse specialist, and a clinical nurse was formed. The purpose of the committee was to:

- a) allow the researcher to address any concerns the members had regarding aspects of the ongoing conduct of the study;
- b) negotiate a time for piloting instruments and data collection which would not inhibit the therapeutic activities in the unit, and
- c) develop a mechanism to provide regular feedback to the staff about the progress of the study.

It was made clear at the beginning that this feedback would not include any information obtained under a guarantee of anonymity and confidentiality to the participants, but would focus on such data as the number of questionnaires

completed, the number of interviews conducted, and the general progress of the study.

One of the ethical issues considered at the early meetings was the researcher's responsibility if a participant provided information about unprofessional behaviour on the part of a member of the staff, or any breaches of the unit regulations by clients. It was agreed that any action would be inappropriate unless a clearly harmful or damaging situation was revealed. Intervening in such circumstances would involve breaching confidentiality. In the event, no information about unprofessional conduct was forthcoming. Information about illicit drug use by another client was, however, revealed during one of the interviews. In this case, the researcher was not obliged to address the issue of breaching confidentiality, as the drug use was detected by the staff and the client involved was discharged from the unit.

The main concern expressed by members of the committee was whether the staff would be asked to act as data collectors. Once assured that the data would be collected by the researcher, or if she was unavoidably absent, by a colleague from outside the unit, the study was enthusiastically supported. It was agreed that the staff members who participated in the initial discussions would continue to meet on a three-monthly basis during the period of data collection. At each meeting, the researcher provided a summary of the status of the study, which was disseminated to the rest of the staff by one of the committee members charged with this responsibility. These procedures were employed to ensure that all staff were familiar with the aims of the investigation, the procedures of data collection, the presence of the researcher in the unit, and the potential relevance of the findings of the study to their clinical practice.

3.4: Research Design

This was an exploratory, interpretative, theory generating study that employed both qualitative and quantitative methods of data collection and analyses. Theory building was undertaken through the constant comparative method of analysis and other techniques of grounded theory. Quantitative methods were used to determine what, if any, statistical differences existed between licit and illicit drug

users in terms of socio-demographic and drug use variables, dropping out of treatment, and minor psychiatric morbidity.

3.5: Grounded Theory

Grounded theory is an inductive approach to studying phenomena to generate theory that ". . . is inherently relevant to the world from which it emerges" (Hutchinson, 1986, p. 113). It is based on Symbolic Interactionism, which is concerned with the study of the experiential aspects of human behaviour, that is, how people define their reality through personal and social interactive processes, and how they respond in relation to their perceptions (Blumer, 1969; Mead, 1934). Symbolic Interactionism is a distinct theoretical perspective within social psychology that views individuals as actively constructing and creating their environment through a process of self-reflective interaction. It rests on three premises: that human beings act towards things on the basis of the meanings that things have for them; that meanings arise from interactions with people; and that meanings are created and modified by an interpretative process used by the person concerned (Blumer, 1969; Mead, 1934). The emphasis is on the connectiveness of individuals to, and interaction with, their social context. Symbolic Interactionism stresses the interactive processes which occur in social relationships, as well as the fact that individuals actively influence, and are influenced by, their physical and social environments. In this process, individuals assign meanings to events and situations that are not static and inflexible but are derived from the changing interactional experiences. Along with other qualitative methodologies, it is associated with rich, indepth data obtained from small samples, and is unlikely to be representative of populations in the statistical sense.

Grounded theory method is a set of strategies for researching phenomena in natural settings, which was originally developed to study the experience of dying patients (Glaser & Strauss, 1967). Grounded theory differs from other qualitative methods, such as phenomenology, in the use of selected literature reviews during analysis and in the assumption of the existence of a process (Omery, 1983). The aims of grounded theory method are to identify and describe the basic social psychological problems and processes together with the context and conditions, to

generate a substantive, middle range theory that explains the phenomena being studied. It is based on the premise that theory is necessary for deeper understanding of social phenomena (Glaser & Strauss, 1967; Glaser, 1978).

The methodological thrust of the grounded theory approach is towards the development of theory, without any particular commitment to specific kinds of data, lines of research, or theoretical interests. So, it is not really a specific method or technique. Rather, it is a style of doing qualitative analysis that includes a number of distinct features, such as theoretical sampling, and certain methodological guidelines, such as the making of constant comparisons and the use of a coding paradigm, to ensure conceptual development and density.

(Strauss, 1987, p. 5)

According to Denzin and Lincoln (1994), grounded theory method is an interpretive style of qualitative research in the postpositivist paradigm, in that the processes and outcomes are judged on the basis of traditional scientific criteria. In a more recent analysis of the evolution of the ontology, epistemology, and methodology of grounded theory, it was argued that while it had traditionally been located within the postpositivist paradigm, it was moving towards the constructivist paradigm (Annells, 1996).

The method of grounded theory has recently been presented in a more formalised, densely codified, structured format (Strauss & Corbin, 1990) than that proposed by the originators (Glaser & Strauss, 1967). This more formalised version has been criticised by Glaser (1992) on the grounds that it deviates from the original method in that it is oriented towards forcing the data into a codified frame, rather than allowing the theory or concepts to emerge from the data.

Another variant of grounded theory methods is what has been termed dimensional analysis (Schatzman, 1991). According to Schatzman, a dimension is an abstract concept and dimensional analysis refers to the process of examining a phenomenon by dimensionalising it into attributes, contexts, processes, and meaning. The key organising schema is dimensionalising or designation, differentiation, and integration or reintegration until a critical mass of dimensions is identified and analysed. In this study, the method as described by Glaser and Strauss (1967), Glaser (1978), and Strauss (1987) was applied to the phenomenon of the experience of detoxification in a combined, medical treatment unit. The use of grounded theory methods to examine phenomena is becoming more

widespread, particularly among nurse researchers. The method has been applied to develop theories about the social psychological processes of people undergoing major life changes, such as infertility, family processes, chronic illness, behaviours in health care settings, as well as nursing interventions (Beneliol, 1996).

3.6: Rationale for Using Grounded Theory and Quantitative Methods

In this study grounded theory method was used to investigate the phenomenon of the experience of detoxification from psychoactive drugs. A quantitative analysis of the characteristics of the heterogenous population was undertaken to provide valuable data on the similarities and dissimilarities between users of different drugs, and the statistical association of independent socio-demographic variables with dependent variables. This was done to provide important information on the characteristics of the participants in the study, a factor that contributed considerably to the context in which the phenomenon being investigated occurred. While necessary to address some of the objectives of this study, the quantitative data alone, however, would not illuminate the detail required to explore the social reality, problems, and processes of the participants' experiences of the phenomenon of detoxification in a combined treatment unit.

When using grounded theory method, all variables relevant to the phenomenon being studied are identified in the data, which are obtained from multiple sources. The focus is on examining phenomena in the complex context of natural settings. This method generates theory from the data, rather than attempting to fit the data into predetermined concepts, theories, or hypotheses. As discussed in chapter one, previous studies of detoxification have neglected to fully delineate both the clients' perceptions of their experience, and their passage through the process of detoxification from psychoactive drugs. The criticism mentioned in the previous chapter of treatment being a "black box" (Moos & Finney, 1985) illustrates this point. Employing grounded theory method was deemed to be appropriate to address this gap in the literature, enabling a substantive theory to be developed from data obtained from participants in a combined detoxification setting. As Glaser and Strauss (1971) point out in reference to theoretical sampling "Different

kinds of data give the analyst different views or vantage points . . . there are no limits to the techniques of data collection, the way they are used, or the type of data required” (pp.183, 184).

Grounded theory method usually excludes any statistical examination of the important variables mentioned above. Hence to obtain a broad, comprehensive description of the heterogeneity of the participants, a combination of both approaches was indicated. In other words, grounded theory method was used to study the phenomenon of the experience of detoxification, and the quantitative data were used to statistically describe the participants in terms of socio-demographic and drug use characteristics and the prevalence of minor psychiatric morbidity. In addition comparisons were made, in terms of the above variables, between licit and illicit drug users.

The research design is illustrated in Figure 1. While the elements of grounded theory are depicted in a somewhat linear manner, in reality, in accordance with the constant comparative method that is integral to this form of analysis, data collection and coding continued in a circular fashion until all categories were saturated and the linkages between categories were apparent. The various components of the design are discussed in the following sections of this chapter.

3.7: Criteria for Inclusion in the Study

Participants were invited to be interviewed and/or complete a questionnaire if they:

- a) were not too cognitively impaired to be involved;
- b) had been residing in the unit for a minimum of three to four days, and their major withdrawal symptoms had subsided;
- c) had sufficient comprehension of English to enable them to understand the purpose of the study, the content of the questionnaire, and to participate in an interview with informed consent.

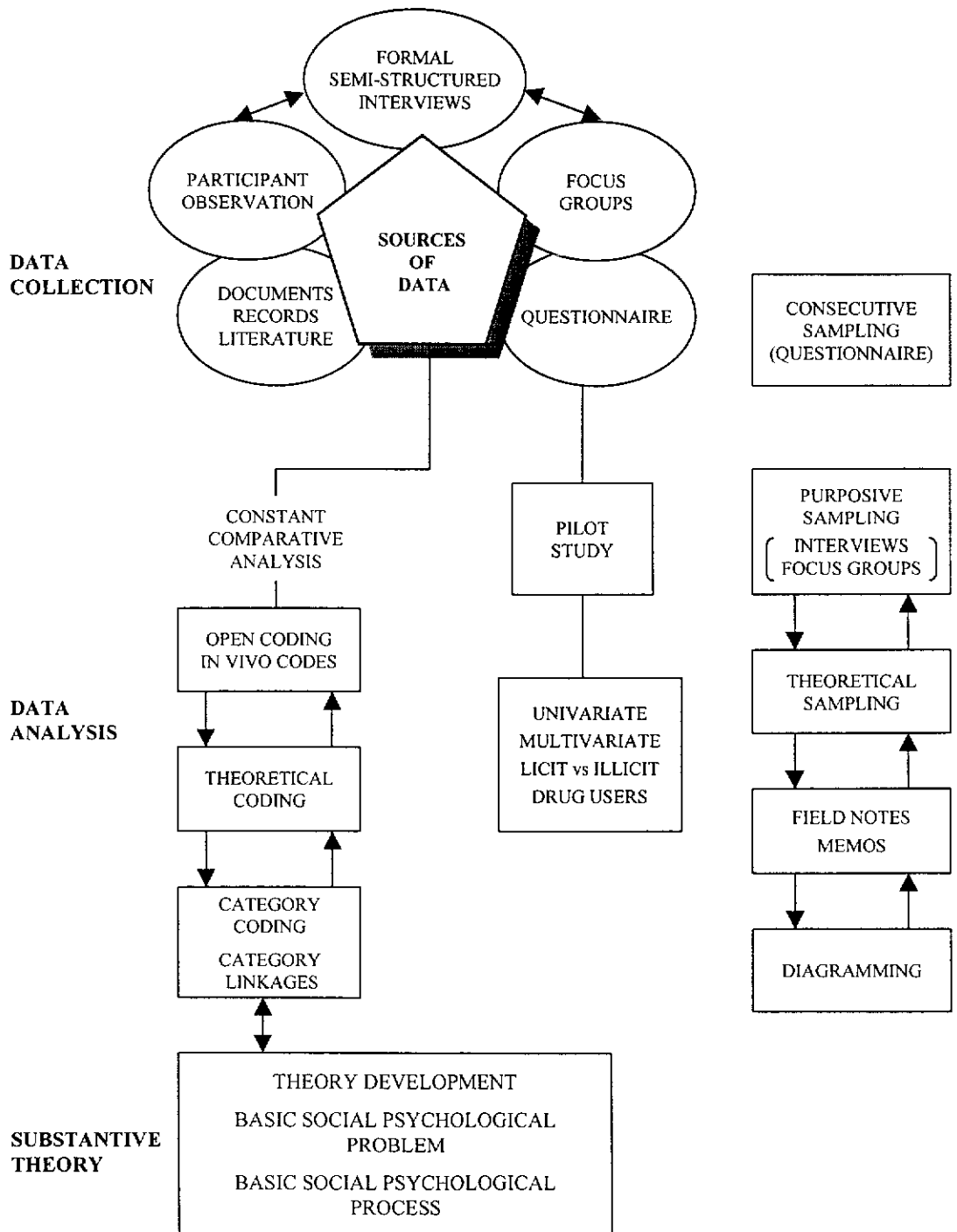


Figure 1: Research Schema

Regarding (a), this was determined indirectly by consultation with the case manager of each participant. If the case manager was not available, then the Clinical Nurse Specialist or the medical officer on the unit was consulted. If the clinical assessment of the case manager, or others, indicated that a client was mentally impaired to a degree that would preclude their full comprehension of the study, the client concerned was not approached (see Appendix B). During the period of data collection, 16 people were diagnosed as having this degree of mental impairment and were transferred to a psychiatric hospital. In addition, seven people were transferred to a general hospital because of various coexisting physical conditions among which were cancer of the larynx, unstable diabetes, oesophageal varices, and AIDS.

In relation to (b), it has been demonstrated that the withdrawal process from all psychoactive drugs is biphasic in severity and time (Foy, 1991). That is, while most of the major physical withdrawal symptoms associated with alcohol and other drugs subside after three or four days of abstinence, changes in central nervous system activity may persist for many months. For example, people withdrawing from stimulants may experience mood disturbances for several weeks or months (Lago & Kosten, 1994), people withdrawing from alcohol may have abnormal sleep patterns for almost two years, and the symptoms of benzodiazepine withdrawal may occur up to one year after the person concerned has ceased using the drug (Foy, 1991). Hence, it was anticipated that after three to four days the majority of clients would be physically well enough to participate in the study with informed consent, although less severe symptoms and mood swings may be experienced for a much longer period. No participant was approached unless one of the staff mentioned above confirmed that they were physically well enough to be involved in the study.

Regarding (c), the involvement of participants with a limited command of English would diminish their ability to discuss and describe events and experiences. Because of the sensitive nature of much of the data, it was not considered appropriate to procure the services of an interpreter if a participant was not sufficiently fluent in English to understand all aspects of the study. In the event, this criteria for inclusion was redundant, as the majority of participants

came from English speaking backgrounds, and those who did not had a good command and understanding of the language. Involvement in the study was not compulsory and participants could refuse to be involved or withdraw at any time. None of those invited to complete a questionnaire or to be interviewed refused and none withdrew their participation in the different components of the study.

3.8: The Sampling Strategies

Three sampling strategies were employed in this study: consecutive, purposive, and theoretical. Consecutive sampling was employed over a period of twelve months for the questionnaire component. Participants (N=421) who met the inclusion criteria were recruited on a consecutive basis from a total of 541 people admitted to the unit over a one year period. This period of data collection was selected to obtain a sample size large enough to provide sufficient power for confidence in the quantitative findings. In addition, it was considered that this period would allow the inclusion of any possible seasonal variations in the number and type of clients admitted to the unit.

A purposive or non-probability sampling technique was used for the selection of the initial clients who were interviewed. The assumption underlying this sampling strategy is that all potential participants are not equally informed about the phenomenon being investigated. Because the main purpose of the study was to seek meaning and understanding of the phenomenon of detoxification, this sampling method was chosen to maximise variability among the participants. The first participant was selected on the basis that (a) he or she met the inclusion criteria, and (b) had a broad knowledge of the phenomenon being studied in that he or she had undergone multiple withdrawals from alcohol in several alcohol specific treatment units. The second participant was selected on the same basis, except that the drug he or she was withdrawing from was heroin, and previous detoxifications were undergone in facilities specific to that drug. Hence, they were well able to provide information on their experiences of previous detoxifications, and to make comparisons with a combined program. In order to achieve a wide range of detoxification experiences, others were selected on the basis of gender, age, multiple drug use, and on the fact that they were undergoing

their first detoxification. This ongoing selection of participants was also part of theoretical sampling.

As the study progressed, theoretical sampling was employed to pursue specific issues as they emerged during the analysis (Glaser, 1978). Theoretical sampling has been described as targeted interviewing (Silverman, Ricci, & Gunter, 1990), or “. . . sampling on the basis of concepts that have proven theoretical relevance to the evolving theory” (Strauss & Corbin, 1990, p. 176). This approach was used to search for variation on developing categories, and to clarify and expand on the properties of categories and processes. In this way, it was used to shed light on issues which appeared controversial or required clarification, and to increase the depth of focus in the original data.

The information from the questionnaires was also regarded as an additional source of data to guide theoretical sampling. For example, when the individual quantitative scores for anxiety and depression were elevated, this was checked in the interviews and in field observations undertaken at corresponding times. In this manner, the information obtained from the questionnaires was used in an iterative way throughout the study.

3.9: Data Collection

Data were obtained from a combination of fixed, forced response questionnaires, formal, semi-structured, ethnographic-type interviews, participant observation, and relevant literature and documents. In addition, a limited amount of data was obtained from the computerised client database of the agency concerned. This was necessary because it became obvious that a number of clients, apart from those who were transferred to a general hospital, failed for various reasons, to complete the program. Information pertaining to these clients was important because if they were omitted from the analysis the findings would be biased in favour of those who completed the program. The matter was discussed with the over-sighting committee and permission was obtained from management and the research committee of the agency to obtain a limited amount of non-name identified information from the agency's computerised client database on those who failed to complete the program. The variables of interest were age, sex,

marital status, employment, principal drug, and poly drug use. As no name-identified data were obtained, client confidentiality remained protected.

Obtaining these data enabled the variable completed/ not completed to be included in the analysis. The principal source of data, however, was the participants who were interviewed, either individually or in focus groups, and those who completed the questionnaires. Throughout the study, however, informal interviews and discussions were held with nurses and doctors to clarify points arising from the data provided by the participants and participant observation. Notes on these informal interviews and discussions were written as soon as possible after the event.

3.9.1: Period of data collection

Data from questionnaires were over a one year period. Formal, semi-structured interviews for qualitative data commenced at the same time of quantitative data collection, and continued for 18 months. As the analysis proceeded, however, and as codes and categories were being refined and clarified, and theory was being developed, data continued to be obtained from unit records, literature, informal interviewing and participant observation for another two years.

3.9.2: Questionnaire data collection

The optimal time for administering the questionnaires, from the staff's perspective, was between 11.00 a.m. and 12 midday each day. In general, by 11.00 a.m. most of the treatment scheduled for the morning was completed and the clients had some free time before lunch was served. The agreed upon procedure was for the researcher to visit the unit at 11.00 a.m. each day and determine, in consultation with the clinical nurse specialist, or the medical officer, which clients met the inclusion criteria mentioned above. Once this was established, the case manager or one of the other clinicians introduced the researcher to the clients. Some days only one client was available; other days there were two or three. The questionnaire took approximately 10 to 15 minutes to complete.

The researcher explained the purpose of the study to the potential participants, answered any questions relating to aspects of the investigation and obtained informed, written consent before administering the questionnaires. With the exception of data obtained by questionnaires from fifteen participants, all data were collected by the researcher. Data collection by a colleague, from the fifteen participants concerned, was necessitated by the fact that the researcher was overseas for a two-week period. To ensure standardisation in the method of data collection, the colleague who assisted in the process was made fully aware of the purpose and objectives of the study, and thoroughly rehearsed in the process of contacting participants, and administering the questionnaires.

A question which was important for this study, and which was assessed from the questionnaires, was whether or not the differences between licit and illicit drug users that were found to be problematic for combined treatment in earlier studies remained extant. In order to address this, data were obtained on the following variables:

- a) Socio-demographic characteristics such as age, sex, type of accommodation, marital status, country of birth, and legal problems.
- b) Alcohol and drug history. This included the primary drug of use, other drugs used, age first used and duration of current drug use episode, level of dependency on drugs, and injecting drug history.
- c) Treatment variables such as source of referral, number of previous admissions, length of stay, and drop-out rates.
- d) The extent of minor psychiatric morbidity among the participants.

A total of 421 participants completed the questionnaire. A copy of the questionnaire and the consent form used with the questionnaire is provided in Appendix C.

3.9.3: Instruments and measures

The extent of MPM was assessed because it is a robust finding in the literature that people with alcohol and other drug problems have higher rates of MPM than the general population (Helzer & Pryzbeck, 1987; Kantzian & Treece, 1985;

Rounsaville & Kleber, 1985). Rates of from 54% to 75% have been reported among “alcoholics” in the community, and data from the Epidemiological Catchment Area (ECA) study (Regier et al., 1984) indicated that psychiatric diagnoses were more likely to occur among “alcoholics” than the general population (Helzer & Pryzbeck, 1987). Among heroin users, rates of from 33% to 61% have been recorded (Corty, Ball, & Myers, 1988; Kantzian & Treece, 1985; Rounsaville, Weissman, Kleber, & Wilbur, 1982; Swift, Williams, Neill, & Grenyer, 1990). In regard to clinical anxiety, rates of from 16% to 38% have been recorded (Marsh, Style, Stoughten, & Trout-Landen, 1988; Rounsaville & Kleber, 1985). The extent of psychopathology and social stability is the two most well documented predictors of treatment outcomes (McLellan, Barr, & Evans, 1986).

Dependence was assessed because it is largely determined by neuroadaptation to certain drugs, which results in withdrawal symptoms when drug use is ceased (WHO, 1993). Poly drug use was assessed because it is not uncommon for people who use drugs in problematic ways to potentiate the effects with other drugs, or to substitute one drug for another (WHO, 1993). The severity of withdrawal symptoms was not assessed quantitatively because participants were not engaged in either the quantitative or qualitative component of the study until their acute physical symptoms had largely diminished (see Section 3.7).

3.9.4: Minor psychiatric morbidity

This was operationalised by the General Health Questionnaire, version 28 (GHQ-28), which is incorporated into the Opiate Treatment Index (Darke, Ward, Hall, Heather, & Wodak, 1991). This is a shortened form of the GHQ-60 (Goldberg & Hillier, 1979), which was developed as a self-rating instrument to identify two phenomena: inability to continue to carry out one's normal functions and the appearance of other conditions, such as anxiety. The instrument was designed to detect recent, transient, psychiatric disorders among respondents in primary care settings, general practice surgeries, and medical outpatient clinics. The GHQ is a widely used measure of psychological health and consequently there is a considerable amount of literature on the reliability and validity of this instrument. The GHQ has been translated into 38 languages and used in diverse

cultural groups. The GHQ-28 contains 28 items consisting of four subscales. These are somatic symptoms, anxiety and insomnia, social dysfunction, and severe depression. Each sub-scale contains seven items which have a choice of responses: “less than usual”, “no more than usual”, “rather more than usual” and “much more than usual”.

In contrast to Likert scales which have discrete weights assigned to each response, the recommended GHQ-28 scoring method forces a bimodal score in that only the responses to “rather more than usual” or “much more than usual” are recorded for analysis. The recommended threshold for case finding is an overall score of four or five (Goldberg & Hillier, 1979). Scoring at or above the threshold is not sufficient for a psychiatric diagnosis, but suggests that further assessment is warranted.

The GHQ has both content and construct validity and good test-retest reliability. There are a large number of studies attesting to this, which have been reviewed extensively by Goldberg and Williams (1988). There are 22 studies in which the correlations between GHQ scores and standardised psychiatric assessments were reported. The median correlation reported between the criterion psychiatric diagnostic interview and the GHQ-28 was .76, the sensitivity was 84% and the specificity was 82% (Goldberg & Williams, 1988). It has concurrent validity in that it has been used recently in substance misusing populations in Australia (Swift, Williams, Neill, & Grenyer, 1990) and is recommended as a reliable screening instrument for minor psychiatric morbidity (Dawe & Mattick, 1997). The GHQ-28 is intended for use when more information on minor psychiatric morbidity is required than that provided by a single severity index. It was selected for this study as it was considered important to determine the extent of morbidity in each of the domains assessed by the instrument.

3.9.5: Dependence

Alcohol dependence was measured by the Short Alcohol Dependence Data questionnaire (SADD). This is a 15 item scale designed to determine the range of present state alcohol dependency as distinct from alcohol-related disability or consumption (Davidson & Raistrick, 1986). It has a fixed choice, four point

frequency scale of “never”, “sometimes”, “often”, “always or nearly always”, which is scored from zero to three. The maximum score is 45, and scores in the range of one to nine indicate a low level of dependence; 10 to 19 indicate medium dependence, and a score of 20 or more indicate a high dependence on beverage alcohol.

The validity of the SADD was assessed by comparing SADD scores with another measure related to aspects of alcohol dependency, the Severity of Alcohol Dependence Questionnaire (SADQ) (Davidson & Raistrick, 1986). The correlations were significant and of high order ($r=0.83$, $p < 0.001$). Split half reliability was reported to be 0.87.

Dependence on other drugs was measured by the Short Dependence Scale (SDS). This is a five item instrument for use with drugs other than alcohol, such as heroin (Gossop, Griffiths, Powis, & Strang, 1992). Each item has four possible responses, which are scored from zero to three. The maximum score is fifteen and scores of five or above are indicative of dependence. All items have been reported to be significantly and positively correlated ($r=0.57$) with the Severity of Opiate Dependence Questionnaire (SODQ) (Sutherland et al., 1986).

3.9.6: Poly drug use

Poly drug use was assessed by reference to the results of urinalysis on samples obtained on admission. The samples were analysed by chromatographic and enzyme multiplied immuno-assay for alcohol, amphetamines, benzodiazepines, cannabinoids, cocaine, methadone, and opiates. The analyses were conducted at the Combined Unit of Clinical Pharmacology and Toxicology at the Queen Elizabeth Medical Centre. Like most tests, this method is subject to error from several sources. Apart from laboratory procedures, these relate to the type of drug being tested for, the dose of the particular drug, frequency of consumption, and the delay between last ingestion and urine sampling. Different drugs are eliminated from the body at different rates, so depending on the drug and the time between ingestion and urine sampling, the results may be affected. For example, metabolites of cocaine can be detected in urine two to three days after use, and chronic, heavy use of cannabinoids can be detected for up to 27 days. Opiates can

be detected up to 48 hours after use, and benzodiazepines up to three days after last dose (American Medical Association, 1987). A negative result does not mean the person concerned has not used the drug. They may have used the drug but not recently enough to be detected in their urine. Alternatively, they may have substituted other urine for their own, or adulterated the sample with some diluent, or drunk excessive amounts of water before providing the sample (Manno, 1986). However, with these reservations, the tests do provide relatively objective measures of drug use in the days prior to testing.

3.9.7: Formal, semi-structured interviews

The process of approaching clients and gaining their consent to be interviewed was similar to that described for questionnaire data collection. The purpose of the study was explained and again, informed, written consent was obtained from the participants. As those interviewed also completed a questionnaire, these participants gave consent twice, once for each aspect of the study. The interviews, which took approximately one and a half hours each, were conducted in a quiet room behind closed doors, at a time convenient to the staff and the participant concerned. Generally, this took place during a rest period in the middle of the afternoon or after the evening meal, though two interviews were conducted in the morning because the scheduled activities for those days had been postponed until after lunch. All interviews were tape recorded and none of the clients approached to be involved in the study refused to be interviewed.

The interviews were formal in the sense that they were arranged, were conducted under the ethical considerations of confidentiality and were undertaken to obtain information about a certain phenomenon, the experience of detoxification. The interviews were semi-structured in the sense that they consisted of open-ended discussions during which participants were asked to describe what encouraged them to seek treatment, their experiences in the unit, and what detoxification meant for them. Each interview was commenced with some social talk such as thanking the individual for agreeing to participate and a general question "How do you feel about being in here?" Other probes and questions were introduced at appropriate points. Spradley's (1979) guide to

ethnographic interviewing which suggests including descriptive, structural, and contextual areas was adopted. In the interviews, the language used by the researcher was kept simple and colloquial, and questions were phrased in neutral terms to avoid any judgmental implications.

There was no fixed order in the discussions; the person being interviewed was free to elaborate on any aspect of their experience of undergoing detoxification. As the interview progressed, however, based on the findings of the ongoing analysis, specific questions were asked about the process and experience of detoxification. Other questions asked included "What are the worst things about being in here?" "How did you deal with that?" "What are the best things about your stay?" "How do you think you will get on when you leave here?". The early interviews generated a voluminous amount of data (up to thirty pages of transcript from each interview). As the study progressed and the focus narrowed (when theoretical sampling commenced), the volume was considerably reduced. No formal interview guides were used in the early interviews. Brief notes were employed in the latter ones, however, to maintain focus on the category or issue being explored.

3.9.8: Closure of interviews

The closure of formal, semi-structured interviews is regarded as an interruption in data collection, not a termination (Swanson, 1986). This is because once the analysis is underway, it may be necessary to contact the participant again to clarify some point that has emerged. At the end of an interview, it is recommended that the person concerned be informed that it may be necessary to seek further information from them at a later date. In this study, because of a concern of management that attempts to follow-up participants after they had been discharged could be viewed by some as harassment, this strategy was not utilised. Instead, the tapes were played back to the participants, either immediately following the interview or the next day. This was to provide them with an opportunity to verify the contents. They were asked to contact the researcher before discharge if they wished to clarify or expand on any aspect or contribute additional information. In all instances the information was validated and only

two participants availed themselves of the opportunity to contact the researcher. In both cases, the supplementary comments added little to the original data.

3.9.9 Focus groups

As the analysis proceeded, it became clear that an important area had not been explored in the early interviews. This was the participants' reasons for seeking treatment. In most studies, when an omission becomes obvious during analysis, the participants are re-interviewed to clarify whatever issue had been overlooked. In this case this was not an option, as the participants concerned had left the unit. Instead, data related to the reasons for entering treatment were sought from focus groups conducted with the residents in the unit at the time when the omission was identified. This aspect was fully explored in all subsequent interviews with individual participants. Three focus groups were conducted on the targeted issue: one with eight participants, one with five, and one with seven. According to Krueger (1988), the number of people in a focus group should not exceed ten because larger numbers encourage partitioning in the group. The numbers in each of the three focus groups conducted in this study were within the recommended size of focus groups. In focus group interviewing, members hear each other's responses, and are able to make additional comments if they so choose. Consensus is not necessary, nor was it sought. Instead participants were encouraged to elaborate on the main question posed to the groups. This was "Thinking back over the last two or three weeks, what made you seek treatment?." All variations in reasons for seeking treatment were identified in the first two groups. The third yielded no additional reasons, and it was assumed that theoretical saturation had been achieved in regard to this issue.

Formal interviewing ceased when theoretical saturation of the categories had been achieved, that is, that no additional data were obtained to develop new categories or properties of categories (Glaser, 1978; Glaser & Strauss, 1967). According to Morse (1995, p. 149), the principles of saturation include selecting a cohesive sample, using theoretical sampling, and sampling all variations in the data until the data are rich, full, and complete. Twenty-nine individual interviews were conducted and a further 20 participants were interviewed in three focus

groups. In addition, extensive participant observation was undertaken over a period of 18 months, and copious field notes were compiled and reviewed before it was judged that theoretical saturation had been achieved. Informal interviews were conducted with staff throughout the study to clarify any points that arose and events that occurred during the study.

3.9.10: Participant observation

Participant observation involves the systematic observing of the environment of the social setting chosen for the study and the events and behaviours which occur there. In qualitative research, it is customary to refer to observations in study settings as participant observation. Morse and Field (1996) note that participant observation has been classified into four types according to the amount and form of involvement of the investigator in the study setting. These are; complete participation, participant-as-observer, observer-as-participant and complete observer.

Complete participation is said to occur when the investigator enters the setting concerned as a member of the group and does not divulge the research role. Participant-as-observer refers to those cases when the researcher has work responsibilities in the setting and has negotiated some time for the purpose of data collection and writing field notes and memos. At the level of observer-as-participant, the researcher's time is overtly devoted to of data collection in the setting. A complete observer is said to be one who has no direct social interaction in the setting. The researcher may observe interactions concealed behind one-way mirrors or otherwise observe without social contact (Morse & Field, 1996). It has been suggested that

The ideal is to negotiate and adopt the degree of participation that will yield the most meaningful data given the characteristics of the participants, the nature of staff-participant interaction and the socio-political context of the program.

(Patton, 1990, p. 209)

In this study, the researcher was observer-as-participant. That is, the researcher had no direct work responsibilities and time in the setting was devoted to direct observations of the clients, interactions, and events taking

place in the unit (field). The nature of the observations shifted from the early to the late stages of the study. Initially the observations were targeted to include the progress of clients through the program. For instance, observations were focussed on initial assessment and admission procedures, the management of withdrawal symptoms, entry into and involvement in the various therapeutic activities, as well as arrangements for discharge at the completion of the program. During the periods of observation when clarification was required about certain aspects of behaviour, informal interviews with participants, doctors, nurses and other staff members were conducted. For example, clarification was sought when it was observed that not all participants attended the AA meetings held in the unit, despite the fact that the staff encouraged attendance. This is discussed fully in chapter seven.

As the study progressed and analysis of the data from interviews and previous observations raised further questions, observations were more focussed to fully uncover the complexities and patterns of behaviours and social interactions. For example, interactions were observed in the lounge room, which was also the television room and a main thoroughfare for staff and clients. Observations were also undertaken during group therapy and in the tea breaks after group therapy, when clients tended to informally debrief themselves. Other observations were undertaken in the meetings that were held to discuss the activities for the next day.

This type of observation was done from one to three hours on a daily basis for one year, then two or three times a week for a further two years. During the time spent in the unit, the researcher's knowledge and clinical experience was used to enhance the observations. It has been suggested that to be a successful participant observer it is necessary to know the general framework, institutions, and values which guide the behaviour of the community being studied (Saville-Troike, 1982). The position the researcher held in the organisation (Principal Research Officer) ensured a thorough, indepth knowledge of these factors and enabled participation in the activities in the unit from a basis of a shared understanding of the philosophy, treatment, and mission of the organisation. It also ensured that the study was kept in perspective.

Field notes were made as soon as possible after each period of observation in the unit. Sometimes they were tape recorded, but mostly they were written in the form of notes or memos. They were used to record the involvement of participants in groups, socialising with other clients, the day-to day running of the program, and to check for consistency with the data provided in the taped interviews. They also served to direct further observation as well as questions in interviews.

3.9.11: Documents and literature

Documents such as minutes of meetings, annual and other reports, working party reports, parliamentary reports, organisational charts and related policies, and professional journals were reviewed and critiqued to provide background information for the study and to locate the investigation in a temporal and spatial context. As the study progressed, case notes were reviewed as necessary and other records such as reports on leisure programs and participation in group therapy were studied. The initial literature review in grounded theory studies is primarily aimed at identifying the scope, range, intent, and type of research that has been conducted in the study area (Chenitz, 1986). The initial literature review is used to establish the purpose and the significance of the study. In this study, as data were coded and conceptual categories were identified, literature reviews related to the concepts were undertaken on an ongoing basis. Throughout the study, the literature was used as a source of data.

Most of the literature reviewed came from the social sciences, addictions, and medicine. Though nurses are frequently confronted with individuals and families affected in some way by alcohol and drug use and there is a growing number of studies undertaken by nurses to investigate aspects of substance use or misuse, nursing research in this area, particularly detoxification, remains sparse (Sullivan, 1995).

3.10: Profile of the Participants who were Interviewed

Twenty-nine clients in the combined detoxification unit were interviewed individually under the conditions of confidentiality described in Section 4.5. The

ages of those interviewed ranged from 18 to 55 years. The average age was 35 years. Eleven of the participants were women; 18 were men. Four were married, one was widowed, seven had never married, eight had a defacto relationship, and nine were either separated or divorced from their spouse. Seventeen of the participants were unemployed. Of the others, six had either full or part-time work, and six described their employment status as “home duties”. Fourteen participants had some secondary school education, and 12 had completed secondary schooling. Three had some tertiary education.

Regarding drug use, 11 of the participants had problems related mainly to one drug. Of these 11, seven had problems associated with alcohol, two had problems with amphetamines, one with benzodiazepines, and one with pethidine. The other 18 had problems associated with combinations of drugs, such as alcohol and benzodiazepines (five participants); amphetamines, alcohol and heroin (five participants); alcohol, amphetamines, heroin and benzodiazepines (four participants); methadone, benzodiazepines, and heroin (three participants), and one had problems associated with heroin, benzodiazepines, and alcohol.

Fourteen of the participants had commenced using drugs from ages 11 to 15 years inclusive. A further 12 commenced using drugs from ages 16 to 20 years, and three commenced using drugs after the age of 26 years. Prior to admission to the unit, the participants had been using drugs on a daily basis from three to 24 months. For nine participants, this was their first detoxification from drug use. Twelve others had experienced two previous detoxifications, and the others had several previous detoxifications. The characteristics of the 20 clients interviewed in focus groups were similar to those described above. That is, the focus groups included people of similar age groups, gender, similar treatment histories and lifestyle characteristics to the participants who were interviewed individually. The profile of the 421 participants who completed a questionnaire is presented in chapter four.

3.11: Triangulation

Triangulation is a metaphor borrowed from navigation and surveying where the term is used to plot positions from several points. It has gained wide acceptance

in qualitative research as a means of validating and confirming findings (Knafl & Breitmayer, 1989). In a review of the use of triangulation in social sciences and nursing, Knafl and Breitmayer (1989) noted that triangulation has been used for two distinct applications: as a means of convergence of findings, and as a means to obtain completeness in a study. They cautioned that triangulation is not a means in itself; it should be undertaken for a specific purpose and the purpose should be specified clearly. They developed a framework for evaluating the completeness of qualitative investigations that incorporates five types of triangulation: investigator, data source, method, unit of analysis, and theory. These are similar to the four main types of triangulation described by Denzin (1978), namely collecting data from different sources, using different researchers to study a problem, employing different theories to interpret data, and using multiple methods to conduct a study. The framework proposed by Knafl and Breitmayer (1989) extend the number of types of triangulation described by Denzin by including unit of analysis, although this could be viewed as being subsumed under collecting data from different sources.

3.11.1: Investigator triangulation

Knafl and Breitmayer (1989) viewed investigator triangulation as having a committee or research team comprised of people from different intellectual backgrounds with diverse areas of expertise and an interest in a common phenomenon. Bringing such a group of people together is said to extend the methodological and theoretical expertise available to the study. Patton (1990) referred to triangulation through “multiple analysts”. This is achieved by using several interviewers or observers for data collection and analysis. Another approach is to have the participants who were interviewed or observed review the data and the findings. This acknowledges the role of the people involved as participants, not subjects or informants, in the research process. As mentioned later in this chapter, Section 3.12.1, investigator triangulation was done by having other researchers experienced in grounded theory method independently analyse sections of the data (Appendix D). The analysis was then compared with that of the researcher, and overall, a high level of congruency was found.

3.11.2: Triangulation of data sources

This involves comparing and cross checking the consistency of information derived by different means from different sources. Within grounded theory methodology used in this study it is an integral part of the constant, comparative approach to data collection and analysis. It included comparing observational data with interview data, checking for consistency with what participants say about the same thing over time, comparing perspectives of people with different views of the same phenomenon, such as staff or others relevant to the investigation. It means cross checking information through multiple sources such as documents, literature, and other written data that may be able to be used to confirm or otherwise illuminate the findings of the study. In reference to a study on the effects of chronic illness on families, it was noted that “The triangulation of multiple data sources is essential to obtaining a complete view of family life” (Knafl & Breitmayer, 1989, p. 215). All the above techniques were used in this study.

3.11.3: Triangulating methods

Quantitative research involves the use of methodologies which aim to test hypotheses, establish causal relations, summarise numerical findings, demonstrate statistical significance according to the laws of probability, and generate findings that are context free and generalisable. The methods are characterised by objectivism, reductionism, and control. Qualitative research is concerned with gaining insight into particular phenomena and understanding the meaning that people assign to their social lives, by exploring the depth, richness, and complexity inherent in the phenomenon being studied. In some instances, such as grounded theory, theory is generated to aid the understanding of the processes of the phenomenon concerned. Combining qualitative and quantitative methods in one study has attracted considerable debate. At times the debate has been conducted at the paradigm level, at others it has been focused on the types of research strategies or techniques employed. In Kuhn’s (1962) original

interpretation, a paradigm is considered to be a world view, a way of looking at things, a framework for particular activities.

Mixing methods across paradigms has been said to violate the intent and philosophical purposes of each paradigm (Leininger, 1994, p. 102). According to Leininger (1994), the first principle of research is that the philosophical and epistemological roots of the paradigms must be understood and maintained. The second is that while methods can be mixed within paradigms, they should not be mixed across paradigms. Leininger qualifies this position by stating that “. . . the two paradigms, if used as philosophically based, tend to complement each other and lead to new and different knowledge” (Leininger, 1994, p. 102). Debating the merits and difficulties of combining qualitative and quantitative methods at the paradigm level has its uses in that it is dichotomous, heuristic, and allows debaters to locate their arguments within one or the other position. The debate, at this level however, has been hindered by the use of overly broad concepts, and doubts have been raised as to whether or not qualitative inquiry can be considered a paradigm.

There is no single set of theoretical or methodological presuppositions to underpin a qualitative paradigm, nor is there an uncontested collection of methods and research exemplars. On the contrary, any remotely comprehensive listing of qualitative studies will reveal at best a collection of assumptions, methods and kind of data that share some broad family resemblances. Together, they do not suggest the kind of coherence and consensus among researchers as to constitute a single paradigm.

(Atkinson, 1995, p. 119-120)

Others support the existence of paradigms, and Guba and Lincoln (1994) have distinguished four: positivism, post positivism, critical theory and related ideological positions, and constructivism. Each has its own ontology (What is reality? What can be known about reality?), epistemology (What is the relationship between the knower and the researcher? What can be known?), and methodology (How does a researcher find out what they believe should be known?). The aims of positivism and post positivism are said to be explanation, prediction, and control. Knowledge is attained by testing hypotheses and generating findings that can be accepted as fact or laws. In the case of post positivism, hypotheses are unfalsifiable, and facts or laws are regarded as probable, not absolute. The aims of critical theory and related ideological

positions are transference, critique, restitution, and emancipation. Knowledge from critical theory is derived from structural and historical insight that can be transferred through dialectical interaction over time. The aims of constructionism are understanding and reconstruction, and the possibility that multiple knowings can exist and are subject to continuous revision is acknowledged (Guba & Lincoln, 1994).

The debate about combining methods and rigour in research is not confined to the paradigm level. Among some researchers, it has occurred over blurring the distinctions between the different qualitative approaches to research. For example, under the banner of qualitative methods, Leininger (1992) has listed ethnography, ethnohistory, grounded theory, phenomenology, critical theory, life history, narrative, audiovisual techniques, constructionism, deconstructionism, metaphoric and philosophical inquiry, ethnology, history, symbolic interaction, and feminist theory. Different lists have been generated by others (Denzin & Lincoln, 1994). In reference to phenomenology and grounded theory, blurring the boundaries has been referred to as "method slurring" (Baker, Wuest, & Stern, 1992, p. 1355).

In a review of the debate about combining qualitative and quantitative methods, Rossman and Wilson (1985) identified three stances that they labelled "purist", "situational" and "pragmatist". Purists maintain that theoretical paradigms are closely linked to methods and that combining methods violates epistemological assumptions (Duffy, 1987; Leininger, 1994; Phillips, 1988). Situationists believe that each method or approach is appropriate for certain purposes. The results obtained, however, are not amenable to synthesis (Long, 1984). Pragmatists are more interested in combining the strengths of both approaches to best address the question being investigated. The most important stance is said to be "pro-meaning" (Patton, 1990, p. 479). Morse (1991) noted that researchers who adhere to one methodology only have overlooked the fact that research methods are tools and instruments to be used to achieve understanding. In particular reference to grounded theory, it has been stated that both approaches (grounded theory and quantitative) can be combined effectively in the one study (Strauss, Bucher, Ehrlich, Schatzman, & Sabshin, 1964; Strauss & Corbin, 1990).

Marshall (1990) used ethnographic and epidemiological data to study substance use in Truck, Micronesia. He concluded that, when used together, the two approaches provide more information than can be obtained by the use of either approach alone. Jenkins and Howard (1992) combined interviews, behavioural observations, and case control methods in a study of diarrhoea among young children in Papua New Guinea. Hundt and Forman (1993) combined ethnography and epidemiology in a longitudinal study of infant feeding practices among Bedouin Arabs. Barnard and Frischer (1995) combined ethnography and data from a large scale, cross sectional survey to assess health risk behaviours of injecting drug users. Mckeganey (1995) notes that using both types of data enables clarification of key relationships that could not be fully explained by quantitative analysis alone. The value of using both methods lay in being better able to explore and interpret the behaviours investigated.

The grounded theory method, though uniquely suited to field work and qualitative data, can be easily used as a general method of analysis with any form of data collection: survey, case study. Further it can combine and integrate them. It transcends specific data collection methods.

(Glaser, 1978, p. 6)

In this study, grounded theory method was used to develop a substantive theory of the experience of detoxification from psychoactive drugs. The quantitative data were used to describe the population experiencing detoxification in terms of socio-demographic and drug use characteristics, and minor psychiatric morbidity. These characteristics illustrated the marked heterogeneity of the participants that contributed to the problem of Incompatibility. In addition comparisons were made between licit and illicit drug users on the above variables. It was also used to theoretically direct aspects of the qualitative data collection and analysis. For example the scores of the GHQ-28 indicated high levels of anxiety and depression among the participants that was checked out in participant observation and interviews.

3.11.4: Triangulating units of analysis

It has been noted that “Triangulation of the units of analysis relates to the person dimension of the triangulation of data sources” (Knafl & Breitmayer 1989,

p. 217). Using a study of family responses to chronic illness as an example, Knafl and Breitmayer discussed how the data were analysed at the individual and family unit level. This type of triangulation, with two levels of analysis, enabled the investigators to conceptualise how individual family members and the family unit as a whole responded to chronic illness. In this study of the experience of the phenomenon of detoxification, the qualitative data were analysed at the individual level as well as the group level, in group therapy and as groups and individuals in social interactions during breaks in the program. Both univariate and multivariate statistics were used to analyse the quantitative data and, in addition, the quantitative and qualitative findings were analysed to determine the degree of divergence and convergence between aspects of the findings of the two methods.

3.11.5: Theory triangulation

Triangulation with a theory or theories can be done for theory testing or theory generating purposes. In the case of studies designed to generate theory (as in the case of this study), it usually occurs towards the end of the investigation (Knafl & Breitmayer, 1989). In this study, no other theory of the experience of detoxification was located in the literature. Several theories, however, which have relevance to some aspects of the substantive theory developed in this investigation were identified. The newly developed theory was compared with the other theories to determine the extent of similarity or congruence with an existing body of theoretical knowledge. This is discussed fully in chapter ten.

3.12: Reliability and Validity

Issues of reliability and validity are of concern to all researchers, regardless of which approach or combination of approaches are adopted for a study. They are of particular concern, though, to researchers utilising qualitative methods, because these methods of inquiry have been criticised as lacking in scientific rigor (Sandelowski, 1986). The strategies proposed to achieve rigor in qualitative research include leaving a clear audit trail on the conduct of a study and the interpretation of the findings, increasing credibility and fittingness by checking for the representativeness of the data as a whole, and triangulating across data sources

and procedures (Sandelowski, 1986). More recently Sandelowski (1993) cautioned that the quest for rigor might result in “rigor mortis” (p.1). She argued that naturalistic, interpretive, qualitative research is as much art as science, and that a relentless search for reliability (repeatability) may be a threat to validity in that it may not be able to accommodate multiple realities.

Other qualitative researchers have suggested that issues of reliability and validity should be considered as issues of credibility, confirmability, dependability, and transferability (Guba & Lincoln, 1982; Le Compte & Goetz, 1982; Leininger, 1994). Credibility refers to whether the findings of the study reflect the reality of the lived experience of the participants in the study. Confirmability means the extent to which the findings were confirmed in the data and not influenced by the biases of the researcher. Dependability means whether or not other researchers would reach similar conclusions from the analysis. Transferability refers to what extent the findings have applicability to other contexts and participants. Because of the design of this investigation, which utilises both qualitative and quantitative methods, in order to maintain consistency, the terms reliability and validity are employed. While the central issues of reliability and validity are similar to both methods, there are certain aspects, such as the use of instruments in quantitative studies and the differing ways of data management and analyses, which are not. Le Compte and Goetz (1982) fully described the issues of external and internal reliability and validity in qualitative and quantitative research, and the following discussion of these issues is based on their framework.

3.12.1: Reliability (qualitative component)

Reliability is the extent to which studies can be replicated. This is problematic in qualitative research because the contexts of the studies are often difficult to reproduce. Reliability has two aspects: external and internal. External reliability refers to whether or not independent researchers would discover the same phenomenon or generate the same constructs in similar research (Le Compte & Goetz, 1982). This can be enhanced by addressing five issues, (a) the position of the researcher, (b) the selection of participants, (c) social situations and

conditions, (d) analytic constructs and premises, and (e) methods of data collection and analyses.

Regarding (a), the researcher held a senior nursing position within the organisation, but was not directly concerned with the day-to-day running of the unit. Because of this, the researcher was accepted by the participants as one knowledgeable in addictions and to whom they could speak freely about their experiences without the information being passed to the clinical staff. The second issue (b) relates to sampling. According to Patton (1990), three kinds of sampling errors can occur in qualitative research: errors in restricting observation to only certain incidents, errors related to the timing of observations, and selection of participants. The procedures used for purposive (non-probability) and theoretical sampling were carefully considered, and are fully described in the relevant section in Section 3.8. In addition, the protracted period of data collection allowed for time sampling to minimise any possible temporal errors. In regard to (c), the background to the study is described, and a full description of the physical, social, and organisational contexts within which the study was conducted has been provided. To address (d), the constructs, definitions, and premises are fully described in the following chapters. Finally (e), the methods of data collection and analyses are clearly delineated. Sufficient information on the background, implementation, management, progression of the study, analyses, and theoretical findings has been provided to facilitate replication of the study.

The question of whether or not other researchers would discover the same constructs or generate the same theory was addressed by having other researchers experienced in grounded theory independently analyse sections of the data and compare the results with those of the researcher (Appendix D). This strategy was adopted as part of the ongoing constant comparative method employed, and overall, consistency in analyses was found to be high.

Internal reliability is the degree to which other researchers utilising a set of similar constructs would arrange them in accordance with the data in the same way as the original researcher (Le Compte & Goetz, 1982). One of the key issues here is inter-rater and inter-observer reliability. This was not a problem in this instance, as with the exception of the administration of fifteen questionnaires out

of a total of 421, all data were collected by the researcher. The colleague who assisted with the questionnaires was thoroughly rehearsed in the procedure, and it is considered that this deviation in data collection did not prejudice the standards adopted for this aspect of the study.

Another strategy adopted to reduce bias and increase reliability, as well as validity, was to have the transcribed interviews, codings, and interpretations reviewed throughout the study by other researchers and other clients experiencing the phenomenon under investigation. The points that emerged during the ongoing review and analysis process were explored further during theoretical sampling. In this manner, the factual and interpretative aspects of the data were verified and the credibility of the findings tested.

3.12.2: Validity (qualitative component)

Internal validity is the extent to which the findings are reflections of some reality. According to Le Compte and Goetz (1982), this is one of the strengths of qualitative enquiries. Internal validity is threatened by several factors: selection and observer effects, maturation and history, instrumentation, mortality or attrition, and spurious conclusions (Cook & Campbell, 1979). Regarding observer effects, it is possible that the researcher's biases may dictate the development of codes and concepts. Silverman et al. (1990) stated that the biases researchers inevitably bring to their work have the potential to influence the results. They suggested that these biases must be acknowledged and efforts should be made to address them at all stages of a project. One way of reducing bias is to avoid using leading questions to direct responses in interviews. This technique was adopted in this study, but was not totally achieved in all cases. When re-editing the transcripts of two of the earlier interviews, it became evident that several leading questions had been posed. The responses to these were not included in the analyses, and care was exercised to avoid this error in later interviews.

The participants appeared to be very open and to have no reservations about talking about their perceptions of their experience, their drug use, their opinions about the program, the staff, and other clients. This may have been an indirect result of the measures described above, which were taken to ensure that the

research was seen to be important for the staff and to the unit. In addition, before data collection commenced, the researcher spent over a month in the unit piloting the survey instruments. Another factor which contributed to minimising observer effects was the extended period of data collection during which the researcher was present in the unit for at least two hours on most days for twelve months, and two or three hours on two to three days a week for another two years. This allowed the researcher to be viewed as part of the background of the unit, but distant to the decision making processes involved in the clinical management of the participants.

Throughout the study, the researcher's theoretical and clinical knowledge of addictions were utilised as "reference points" that were used to assist in formulating questions that were addressed in the data (Glaser, 1978, p. 39). According to Glaser and Strauss (1967), categories must be "grounded" in the data. In this case, grounding was stringently pursued and was verified by other researchers, and participant observations were used as validity checks on data obtained from interviews, and vice versa.

In relation to maturation and history, several strategies were employed to minimise the influence of these factors on the validity of the findings. Participant observation and interviewing were conducted over an extended period, and quantitative data were obtained over one year. This lengthy period of observation and data collection enabled sampling to be done over time. The core process remained constant with variations in the stages dependent on certain intervening conditions. These conditions are fully described in chapter seven. Data related to the events that led the participants to seek residential detoxification were obtained mainly from focus group interviews. The historical factors which contributed to the context in which detoxification took place were retrieved from the organisation's records and relevant literature and are discussed in chapter two.

Another issue is premature closure, that is closing off from further data collection and analysis before the categories have been saturated. Data collection and analysis must continue until all negative cases have found (Lincoln & Guba, 1985; Patton, 1990). Premature closure was avoided by a strict application of the constant comparative method and theoretical sampling which was continued until

saturation of cases and categories was achieved. Researchers are also subject to becoming too immersed in the study to objectively analyse the data (Le Compte & Goetz, 1982). This was avoided by constantly having to locate the study within the wider context of the organisation and having sections of the data analysed by other researchers. These strategies enabled objectivity to be maintained and enhanced internal validity.

Another point emphasised by Cook and Campbell (1979) and relevant to the quantitative component of the study was instrumentation; this is addressed below. In regard to mortality, no deaths occurred on the unit during the study period, though several clients were transferred to a general hospital because their condition had deteriorated. The outcomes of these individuals is unknown. Because of the design of the research, however, participants were only interviewed once and none were engaged in follow-up interviews so this was not a major concern.

The validity of the taped information was reinforced by each participant listening to their own tape before they were discharged from the unit. Transcripts were further checked against tapes by the researcher. Statements about the relationships between categories were confirmed in the data. Hypotheses emerged from, and were tested in, the data. Validity was enhanced by the use of a variety of data sources, and the combination of methods employed in the study. The grounded theory method is clearly described, and was applied rigorously.

3.12.3: External validity (qualitative component)

This refers to the extent to which findings can be compared or generalised to similar groups in other settings. In qualitative studies generalisation is not normally possible because the sample sizes are usually small, and the contexts of the studies cannot be easily replicated. The objective in these cases is not generalisability, but comparability and transferability of findings (Le Compte & Goetz, 1982). This requires a clear description of the characteristics of the participants, the context, and the method of data collection and analysis. This is supplied in this and other chapters.

3.12.4: Reliability (quantitative component)

As noted above, reliability is the extent to which studies can be replicated. Research is considered reliable when the study can be repeated and when the findings can be generalised beyond the particular context of the initial study. The research design, the major constructs, the instruments employed, the data analyses and the findings are fully described. This would enable replication of the study, providing it was attempted with similar participants in a similar environment.

Methods to enhance generalisability in quantitative studies include appropriate sample sizes, random allocation of subjects to certain conditions, and the use of relevant instruments and statistical testing of the results. The sample size ($n=421$) was large enough to provide sufficient power to meet the assumptions of the statistical tests employed. In relation to random allocation, this technique is only appropriate when inferences are to be made about the outcomes of one intervention over another. In this instance, random allocation was not required, as the design was descriptive and no causal effects were sought between the dependent and independent variables.

3.12.5: Validity (quantitative component)

As mentioned above, according to Cook and Campbell (1979), threats to internal validity come largely from (a) selection of participants, (b) observer effects, (c) maturation and history, (d) instrumentation, (e) mortality or attrition, and (f) spurious conclusions. Regarding selection of participants for the quantitative component, all participants who met the criteria for inclusion were recruited, on a consecutive basis, throughout the twelve months period of data collection for this component of the study. As no person refused to be involved in the study, this was not a threat. The issues associated with (b) and (c) are discussed in the section related to the qualitative component, as are the strategies employed to minimise biases in these areas. Regarding (d), instrumentation, a major concern in quantitative studies is that the instruments developed or employed to measure variables or constructs actually do provide reliable and valid

measures of what they purport to measure. The instruments used to measure the variables important to this investigation, such as MPM and dependency, were reported to have good psychometric properties. As they were developed elsewhere, they were rigorously pretested in a pilot study. The findings of the pilot studies and the modifications made to the instruments are fully described in this chapter. Another issue related to instruments is administration. In this study, all questionnaires were administered to the participants at a time and in a place where they could complete the questionnaire free from distractions. The questionnaires were self-administered, and were accompanied by clear instructions. The researcher (or in a few instances, a colleague) was present to answer any questions and clarify any misunderstandings, hence consistency in administration was high, and standardisation of data collection was maximised.

Other problems related to validity of quantitative data are data entry errors, and the validity of the statistical tests employed. To minimise this problem, the data were checked after computer entry for any coding or entry errors. Any anomalies that arose from this editing were checked against the actual questionnaire concerned. Additional editing was undertaken by a colleague on a random sample of records to further check the reliability of data entry. Regarding the statistical tests used, measures of central tendency were computed on all variables, and parametric or nonparametric tests were used as indicated. Univariate and multivariate tests were employed where appropriate. The sample size ($n=421$) was adequate to provide statistical power to detect differences at the selected alpha level, and the assumptions underlying the various tests used were not violated.

In relation to threats posed by mortality or attrition, mortality was not a problem, as no deaths were recorded in the unit. Several clients, however, were transferred to a general hospital whilst data collection was in progress because their condition deteriorated, and the outcomes of these people are unknown. As the investigation progressed, however, it became obvious that a number of people ($n=97$) who would have been well enough to be invited to participate in the study left the study site prematurely for various reasons, usually within two to three days after admission. As described in Section 3.9, this was addressed by obtaining

(with permission from the relevant committees) a limited amount of data from the computerised client management system for inclusion in the analysis. In relation to spurious conclusions, this was a descriptive study and no causal attributes were sought. The findings are fully described and clearly presented.

3.13: Confidentiality and Protection of Human Rights

Prior to administering a questionnaire, or engaging a participant in an interview, the purpose of the study was explained and any questions regarding the investigation were answered in full. In all cases, informed written consent was obtained before proceeding. For some subjects, this meant signing two consent forms, one before they completed the questionnaire and one before they were interviewed (see Appendix B). All participants were advised that, if they chose not to be involved in the study, their treatment would not be prejudiced in any way. They were also advised that if they chose not to respond to any question, or to withdraw at any time, they were free to do so and that this would in no way prejudice their treatment in the unit.

Munhall (1988) suggested that, for qualitative studies, consent forms should be developed with input from participants and should be changed if necessary as the study evolves. In this study, this strategy was not employed as the participants were only interviewed once. The signed consent forms, tapes, and transcribed interviews were stored in a locked cabinet in a separate building, and the questionnaires, tapes, transcriptions, and extracts from interview transcripts were identified by a unique number known only to the researcher. A codebook containing these numbers was kept in a secure place. The computerised data files of both the qualitative and quantitative data were also secured by a password, which, again, was known only to the researcher and only the results of group data from the quantitative component were reported.

After the tapes had been transcribed they were played again and reviewed against the typed copies to ensure that the nuances of the voices such as breaks, inflections, intensity, and emotions were not lost. Following data analysis the tapes were erased. The transcripts and other files will be kept for five years, in accordance with current university requirements.

3.14: The Pilot Study

The questionnaire contained socio-demographic and drug use items and the SADD, SDS and the GHQ-28. It was piloted on thirty clients in the unit in the month prior to commencement of the main component of quantitative data collection to determine the appropriateness of the language used, the time required to complete the questionnaire, whether or not any items were missed or marked not applicable, and whether any items or words were obsolete with regard to the environment and the culture of the participants in the study. The clients found the GHQ-28, the SADD, the SDS and other items easy to interpret and complete. No responses were omitted and there were no apparent inconsistencies in the data. Hence the questionnaire was adopted without modification. The questionnaire was self-administered and took from ten to fifteen minutes to complete. A copy of the questionnaire is provided in Appendix B.

3.15: Data Analysis

In order to meet the objectives of this study both quantitative and grounded theory methods of data analysis were used. The quantitative method was incorporated to determine to what extent licit and illicit drug users differed statistically in terms of socio-demographic and drug use characteristics and minor psychiatric morbidity. The grounded theory method was used to generate a theory grounded in the data to illuminate the experience of the phenomenon of detoxification from psychoactive drugs from the participants' perspective.

3.15.1: Quantitative analysis

The quantitative data were analysed by SAS programs for personal computers (SAS Institute Inc., 1989) and GENSTAT5 (Payne et al., 1994). Following data entry, and before the commencement of analyses, a number of frequencies on all variables were run and all obvious errors and missing data were checked against the participants' questionnaires. In addition, a number of random checks of the

data against the questionnaires were carried out by the researcher and two colleagues experienced in data entry and cleaning.

This was an exploratory, interpretative, theory generating study. Data were obtained over a twelve-month period to detect if there were any statistically significant seasonal variations in the participants admitted to the study unit. A variety of descriptive, univariate, and multivariate analyses were employed. Measures of dispersion and central tendency were computed for all variables. Because of the nature of the data, a generalised linear models approach was used, namely regression, logistic regression models, log-linear models, and proportional odds models.

Comparisons were made between licit and illicit drug users in terms of socio-demographic and drug use variables, treatment variables, and minor psychiatric morbidity. The alpha level was 0.05, two tailed. A power analysis was applied to the data to estimate of the statistical power achieved by the tests employed to detect differences in association with the sample size with the predetermined alpha level. The results are presented in Appendix C.

3.15.2: Qualitative analysis (grounded theory method)

The main aim of this study was to generate a substantive theory of the participants' experience of detoxification. The approach used was the constant comparative method of analysis (Glaser & Strauss, 1967). This method involved coding the data, grouping the codes in categories, comparing the codes, categories and incidents related to each category both "close-in and far-out" (Strauss & Corbin, 1990, p. 95) across interviews. It involved selecting a "heterogeneous sample and observing commonalties in their experiences (Morse, 1994, p. 229). This was accompanied by writing memos and diagramming schemes of ideas about the categories and their relationships. Theoretical sampling was employed to obtain additional data from the participants and other sources to clarify and elaborate the categories and their properties. The analysis conducted throughout the entire process continued through the writing of the report.

3.15.2.1: Data coding

The recorded interviews were transcribed verbatim and entered in the Ethnograph, version 3 (Seidel, Kjolseth, & Seymour, 1988) computer program to facilitate qualitative data management and manipulation. The coding procedures adopted for the analysis were based on the recommendations of Glaser and Strauss (1967) and Strauss (1987) for the development of grounded theory. Among the procedures are open coding (including substantive coding), category coding, theoretical coding and seeking the core category or process. The interview data were complemented by, and triangulated with participant observation, document and literature reviews, and quantitative data from the questionnaire.

3.15.2.2: Open coding

The data were examined line by line, sentence by sentence, and incident by incident. In order to prevent, or minimise, the imposition of preconceived impressions, most of the initial codes were derived from the words and phrases of the informants. These were substantive or "in vivo" codes (Glaser, 1978, p. 70; Strauss, 1987, p. 33) or what Hutchinson (1986) described as level 1 codes. Examples of these codes are "juice freaks", "space cadets", and "cloud cover". Other codes were ascribed as representing the substance of the data, such as "awakening" to refer to how the participants described their feelings after a few days in the unit. These open codes fragmented the data for further analysis. Codes and categories were subsumed under broader categories as the constant comparative method of analysis proceeded.

3.15.2.3: Category coding

The codes obtained from open coding were compared across interviews and further condensed under more abstract categories or level 11 codes (Hutchinson, 1986). The data were compared to determine similarities and differences in the experiences of the participants interviewed and observed. In this procedure, many of the properties and dimensions of the categories were identified. Categories were derived through the constant comparative analysis, as the main processes

underlying the participants' experiences were formed into theoretical constructs. For example, the codes "tremor", "nausea", "sick", "ill", "blurred", "jaggly" and "woozy" were subsumed under the category "unpleasant sensations". Variations in the data were viewed as different experiences that needed to be integrated theoretically to enrich the concepts and developing theory (Glaser & Strauss, 1967). Each incident was compared with other incidents and the other categories to ensure that they were mutually exclusive and covered the behavioural variations.

Selective sampling of the literature began once the categories and concepts were sufficiently developed. For example, when it became evident that certain forms of language were a cause for concern of some participants, the literature pertaining to language was explored.

3.15.2.4: Theoretical coding

Theoretical codes contribute meaning and density to the theory (Glaser, 1978). Theoretical codes conceptualize how substantive codes and categories may relate to each other as hypotheses to be integrated into a theory (Glaser, 1978, p. 72). These are level 111 codes or theoretical constructs (Hutchinson, 1986). Glaser (1978) described a number of families of theoretical codes. Among these families were the Six Cs - causes, contexts, contingencies, consequences, covariances and conditions; process - stages, staging, phases, progressions, etcetera; the Degree Family - limit, range, intensity, extent, amount, level and the like; the Dimension Family - dimensions, elements, divisions, properties of, aspect, section, and other families not used in this study.

These families of theoretical codes directed the types of questions that the researcher asked of the data, for example, "What was this behaviour contingent upon?"; "What was the cause of this behaviour, these actions?"; "What conditions led to certain outcomes?"; "Were there stages in the process?". These questions built on the coding paradigm suggested by Strauss (1987), that is, conditions, interactions, strategies and consequences. As these questions were asked and incidents compared, memos were written to direct further data collection and hypothesis testing. In this way, the categories were elevated to more abstract

levels, the linkages between categories were identified and the relationships between the categories were integrated. During this process the number of major categories, or theoretical constructs, was reduced to a core problem with two parts and a core process with four phases that were shared by the participants. The other categories formed sub-categories of the problem and phases that together made up the framework of the substantive theory.

3.15.2.5: Memos

Memos were written throughout all stages of data analysis and theory development. They were used to summarise interviews, assist with category development, and generate hypotheses for testing. In addition, they were used to direct data collection to other sources, and recording ideas about possible relationships between properties and categories. The following is a memo written after examining the transcript from an early interview.

March 20th, 1992. R3: Over-Crowding

This participant believes the unit is too small and too much attention is given to users of other drugs (alcohol). Believes the withdrawal process is managed efficiently, but "by the book". The staff have been "overworked" and not able to provide adequate individualised care i.e. counselling. She is concerned about the possible negative consequences of having young drug users in with older users experienced in cutting and dealing in drugs. Considers that the changes have pushed the services "down the drain". However, she is attending groups and has described the detoxification as "good".

What is the main problem here? Is it the size of the unit? Is the staff-client ratio inappropriate? Are the staff really too busy to provide individual attention? Is this just a busy phase? What is the current mix of clients?

The questions raised were explored in participant observations, other interviews, and in additional data sources such as rosters and monthly reports.

Memos are considered to be an important part of the analytical process, essential for generating theory and providing direction for further sampling (Glaser, 1978; Strauss, 1987; Strauss & Corbin, 1990).

3.15.2.6: Field notes

As mentioned in section 3.10, field notes were recorded as soon as possible after a period of observation. The following is an example of an extract from a field note written after being an observer-as-participant in a group.

There were twelve people in this group; eight men and four women. There was only one group facilitator. The group started late because some people appeared to be reluctant to participate. The topic under discussion was 'Addiction is Normal'. The facilitator emphasised that everyone is dependent on something and that there were more similarities than differences between licit and illicit substances. Not everyone agreed with this, and two of the older people did not comment. They did not look convinced of this. The group broke up in separate discussions and the facilitator had difficulty getting them back together and keeping them on track. The facilitator appeared to be relieved when the group was brought to a close and hurried out of the room. The participants seemed dissatisfied with the group, and walked away talking among themselves. The facilitator went off to lunch and the participants were drinking coffee and smoking on the patio.

Field notes were an important means of keeping track of the observational data. Together with memos they provided a way of checking back over the events that occurred at the site. They also helped with keeping the flow of data collection in perspective, and provided a temporal framework for the analysis.

3.15.2.7: Identifying the basic social psychological problem

The basic social-psychological problem is a problem that is shared by the group being studied and is not necessarily articulated (Hutchinson, 1986). The participant's unarticulated problem was found to be Disequilibrium. This problem had two parts, the first was related to lifestyle and encompassed the events that led the participants to treatment. This first part of the problem was categorised as

“Hitting the Wall”. Whilst in the treatment unit, the participants encountered another problem that was identified as “Incompatibility”. This was related to the heterogeneous nature of the clients in the combined treatment unit and the structure of the treatment program. The problems associated with Hitting the Wall interrupted the participants’ drug taking career and were a precursor to treatment. These problems remained with the participants whilst they were in the unit and awaited to be addressed when they were discharged. Hence the basic social psychological problem was two pronged in that it incorporated the problems that led them to treatment and the problems they encountered while they were in treatment.

3.15.2.8: Seeking the basic social psychological category

Following identification of the main concern or basic social-psychological problem, the analysis was directed towards discovering the core category, which in this case was a process. According to Strauss (1987), a core category or process must be central, that is related to as many other categories as possible, it must appear frequently in the data, relate easily to other categories, have implications for more general theory and allow for the maximum variation in the data. The questions that were put to the data to determine the core process were “What is going on in the data?”; “What is the basic social-psychological process that allows people to deal with the core problem?”. Questions such as these guided the discovery of the core process. This is discussed in detail in the findings.

3.15.2.9: Identifying the basic social psychological process

The aim of grounded theory is to derive a core category that explains the phenomenon under investigation (Glaser, 1992; Glaser & Strauss, 1967). Fagerhaugh (1986, p. 135) emphasised that most, but not all core categories are social processes. The core process, once identified, was used to guide and selectively code the data and theoretical sampling. A core process or category occurs over time, under different conditions which generate change and has two or more phases or stages (Glaser, 1978). Transition from one stage or phase is

contingent upon one or more things happening. Fagerhaugh (1986) noted that basic or core social process should be expressed as gerunds, which means that they should end in “ing”, and provided examples such as “becoming”, “limiting”, and “routing”. The gerund suggests movement and change over time.

The basic social psychological process in which the participants engaged to deal with Hitting the Wall and Incompatibility was identified as “Seeking Balance through Hanging In”. Seeking Balance through Hanging In was a fundamental, patterned process that occurred irrespective of the type of drug or drugs used by the participants, or the structure of the treatment program. Seeking Balance through Hanging In had four phases, “Making the Break”, “Submitting to Cleansing”, “Fitting In”, and “Moving On”. Though there was some overlap between the phases, they were theoretically distinguishable and sequential.

3.15.2.10: Saturation

Sampling and coding continued until saturation or a sense of closure became apparent. This was evidenced by the fact that no new incidents or behavioural patterns were observed, the data from the interviews became repetitive, predictive and no additional variations were found. The data fitted into established categories, the interactional and organisational patterns were visible, variations in behaviour were described, and behaviour in the context of the investigation could be predicted (Hutchinson, 1986).

3.15.2.11: Development of a model

The development of a model to represent the substantive grounded theory develops along with the progressive theoretical coding of data. Theory was generated around a central, unifying core process with four phases which accounted for the most variation in the patterns of behaviour and to which most of the sub-processes and categories were related. It linked the sub-processes and categories together (Glaser, 1978). The model developed to represent the theoretical constructs of the basic social psychological problem, together with the basic social psychological process, phases, links with major categories, and contextual, modifying conditions is diagrammatically illustrated in chapter nine.

3.16: Comparison with Existing Theories

The final stage of data analysis consisted of comparing the findings with existing theories. This should be done later rather sooner (Glaser, 1978). This approach minimises the risk of the imposition of *a priori* concepts on the data and analysis. Comparing the substantive theory developed in this study involved critically reviewing theories which were identified in the literature as potentially having some bearing on the newly developed theory, and examining them to determine to what extent they were relevant. The theories that clearly did not fit were discarded. Those such as the Health Belief Model (Rosenstock, 1974), Status Passage (Glaser & Strauss, 1971), Stages of Change (Prochaska & DiClemente, 1983), Changing careers: Becoming clean and sober in a therapeutic community (Marcus, 1998), and Stress and Coping (Lazarus, 1966), that were found to be related to some of the theoretical constructs were considered in depth. They were then aligned with data from the newly developed theory to assess the degree of fit. This is fully described in chapter nine.

3.17: Definitions

To avoid ambiguity and enhance conceptual clarity, definitions are provided for the terms “combined treatment”, “licit” and “illicit drugs”, “poly drug use”, “participant” and “staff”.

Combined Treatment

A program in which alcoholics and drug addicts participate together in the same therapy/ rehabilitation process or program with no distinction between patients with respect to substance(s) of abuse.

(Carroll & Malloy, 1977, p. 344)

Licit and Illicit Drugs

The question of which drugs are legal or illegal is historical, cultural, and political. The division separating licit and illicit drugs is a socially constructed phenomenon. There is no universal consensus on what is a drug and which drugs should be given legal status. The status of drugs varies through time within countries and between countries. For example, alcohol was an illegal drug in the United States during Prohibition, and is still prohibited in Muslim countries. In

Australia, the use of cannabis in some states such as WA is illegal, while in South Australia and the Australian Capital Territory it has been decriminalised. The distinctions between licit and illicit drugs are blurred as their legal status is, in the case of alcohol, determined by the age of the user. For some drugs, such as minor tranquillisers, codeine, steroids and others it is determined by how they were obtained. For example, a person may be using alcohol and be prescribed tranquillisers and be considered a licit drug user. Alternatively, they may be obtaining tranquillisers under false pretences from a number of medical prescribers, and though the drug is licit and has been prescribed, the practice of procuring it is not condoned.

A *licit* drug is any drug that is legally available in a community such as alcohol, tobacco, codeine, or minor tranquillisers.

An *illicit* drug is any drug the use of which attracts legal sanctions when used without appropriate authorisation. In Australia, the main drugs regarded as illicit are cannabis, heroin, amphetamines, ecstasy and cocaine.

Poly Drug Use

The use of more than one drug or type of drug by an individual, often at the same time or sequentially, frequently with the intention of enhancing, potentiating, or counteracting the effects of another drug. As the WHO (1994) points out, the term is frequently used in association with illicit drug use, although alcohol, nicotine, and caffeine are the substances most frequently used in combination in industrial societies.

Participant

When undertaking quantitative research it is customary to refer to those involved as "subjects". In qualitative research the term often used is "informant". In this study the word "participant" is employed. As Hutchinson and Wilson (1994, p. 306) note ". . . participants agree to help the researcher by sharing personal information". In order to maintain consistency, and to emphasise the reciprocal role of those involved in the research process, the term participant is used here to refer to those involved in both components of the study.

Staff

The unit was staffed by a multidisciplinary team of health professionals. The majority of the staff, however, were nurses. Nurses made up the largest number of staff on the unit at any one time and had the most contact with the participants. Nevertheless, they were not the sole providers of care and, as the focus of this study was not on health professionals, no distinction is made between the various disciplines. The generic term “staff” is used to refer to care providers, except when the participants specifically used a term to denote a specific discipline, such as “doctor” or “nurse”.

3.18: Overview of Main Findings

The quantitative findings indicated that the participants had long histories of drug use, and were all either moderately or highly dependent on their principal drug of use. The best predictors of being an illicit drug user were being aged 35 years or less, poly drug use, and dropping out of treatment. The most salient finding in regard to minor psychiatric morbidity was the high prevalence rate detected (93.6%) that was largely independent of socio-demographic and drug use variables.

The shared basic social psychological problem identified in the data was Disequilibrium. This problem had two parts that were separate but inter-related. The first part was conceptualised as Hitting the Wall. This category, Hitting the Wall, was the precursor to entering treatment and subsumed the events and problems that interrupted the participants’ unbalanced, drug focussed lifestyles. Whilst in the treatment unit the participants encountered the second part which was categorised as Incompatibility. Incompatibility incorporated the problems related to the heterogeneous nature of the client population in the combined unit, and the structure of the treatment program. The core, social psychological process adopted by the participants to deal with these problems was categorised as Seeking Balance through Hanging In. This process, Seeking Balance through Hanging In, was central to the study, and was found to have four phases, Making the Break, Submitting to Cleansing, Fitting In, and Moving On.

Several contextual, intervening conditions that modified the participants' experience during their time in the treatment unit were identified in the data. These were the physical environment (space, physical resources, privacy and personal territory), control, the participants' expectations of detoxification, and staff workload. These conditions were important as they strongly interacted with the problems of Incompatibility, and influenced how the participants perceived the care they received in the unit. The findings are presented in detail in the following chapters.

3.19: Summary

An exploratory, theory generating research design was adopted for this investigation. The approach used combined grounded theory and quantitative methods. The rationale for combining the two methods has been provided. The setting in which the study was undertaken was a residential, medical detoxification unit in which licit and illicit drug users were treated in the same program. Careful attention was given to obtaining access to the participants and gaining the support of the staff in the investigation. Consecutive, purposive, and theoretical sampling techniques were used. Data were obtained from various sources such as questionnaires, individual interviews, focus group interviews, participant observation, unit records, and other documents and literature.

A total of 49 people were interviewed. Twenty-nine were interviewed individually and a further 20 were interviewed in focus groups. Among the participants interviewed were individuals from different age groups, different gender, different marital status, problems with different drugs and different drug use histories. In addition, 421 participants completed the questionnaire.

The instruments used in the study have been fully described, and definitions of key terms have been provided. The types of triangulation used, and the ways in which issues of reliability, validity, and confidentiality were addressed are clearly presented. The methods used for analysis of both the qualitative and quantitative data are fully portrayed, and a broad overview of the major findings of this study has been provided. In the next chapter the findings on the quantitative component of the study are presented.

CHAPTER FOUR

QUANTITATIVE FINDINGS

4.1 Introduction

As discussed in chapter one, the main objectives of the quantitative component of this study were to:

- a) determine what statistically significant differences, if any, exist between licit and illicit drug users in terms of socio-demographic and drug use characteristics, and
- b) assess the prevalence of minor psychiatric morbidity (MPM) among the participants in the detoxification unit.

In this chapter the findings of the quantitative analyses are presented. The participants are fully described in terms of the relevant variables. These are age, sex, referral source, type of accommodation, marital status, employment, education, legal problems, previous admissions for detoxification, length of stay, characteristics of drug use (main drug, poly drug use, dependency, frequency of use, age first used, age first used regularly, duration of current use, and injecting use), and uptake of referrals after discharge. The findings of the analyses performed to compare licit and illicit drug users in the unit in regard to age, sex, employment, poly drug use, program drop-out, and time are presented. Time was a grouping variable with four levels, each of three months, which was used to assess any variation that may have occurred in the type of client admitted during the twelve months of quantitative data collection. The prevalence of MPM, as determined by the GHQ-28, among the participants is presented. The influence of socio-demographic, drug use and time on the overall scores of the GHQ-28, as well as the domains of the GHQ-28 is discussed.

4.2. Response Rate

During the year of data collection from questionnaires, 541 people were admitted to the unit for detoxification. As discussed in Chapter 3, Section 3.7, 16 people were transferred to a psychiatric hospital and seven to a general hospital for conditions that could not be appropriately managed in the unit. A

further 97 people left before their major withdrawal symptoms had subsided and failed to complete the program. Of these, 90 people left against advice within approximately 72 hours after admission, and seven were discharged (usually within 48 hours of admission), for using unprescribed drugs on the premises. Of the 421 people who met the inclusion criteria (Chapter 3, Section 3.7), none refused to complete a questionnaire and the response rate was 100%.

4.3. Socio-demographic Characteristics

The socio-demographic characteristics of those who completed a questionnaire (n=421) are presented in Table 1. The majority (n=315, 74.8%) were male. A small proportion (n=48, 11.4%) were aged from 16 to 25 years. A larger proportion (n=181, 43%) were aged from 26 to 35 years, and 45.6% (n=192) were aged 36 years or over. The average age was 35 years (SD=10.9 years, range=17-55 years). Most of the respondents (n=313, 74.4%) were born in Australia or New Zealand. A small proportion (n=78, 18.5%) were born in the United Kingdom, and 7.1% (n=28) were born in countries in South East Asia or Europe. The majority of respondents (n=250, 59.4%) referred themselves for treatment. Others were referred from health and welfare agencies (n=143, 34%), and other sources (n=28, 6.6%). Included in the “other” category were a small number referred from legal services and employers.

The majority of these participants (n=257, 61.1%) lived in rented accommodation, and 23.5% (n=99) either lived with their parents or in their own homes. A small proportion (n=65, 15.4%) were either living in a refuge or had no fixed place of abode. The majority (n=339, 80.5%) were without a spouse or defacto partner, and slightly over half (n=235, 55.8%) were unemployed. Most of the respondents (n=308, 73.2%) had some secondary education, and 26.8% (n=113) had completed secondary schooling, had a trade qualification, or had some tertiary education. Only a small proportion (n=9, 2.1%) had current legal problems. For over a third (n=150, 35.6%) this was their first admission for detoxification. The majority (n=214, 50.8%) had one or two previous admissions, and a relatively small proportion (n=57, 13.6%) had three or more previous admissions for detoxification. The average length of stay in the unit was 9 days (SD=4.8 days, range=4-15days).

Table 1: Socio-demographic characteristics (N=421)

| Characteristics | f | % |
|---|-----|------|
| <i>Age</i> | | |
| 17-25 years | 48 | 11.4 |
| 26-35 years | 181 | 43.0 |
| 36 years and over | 192 | 45.6 |
| Mean age=35 years, SD=10.9 years, range=17-55 years | | |
| <i>Sex</i> | | |
| Male | 315 | 74.8 |
| Female | 106 | 25.2 |
| <i>Country of birth</i> | | |
| Australia/New Zealand | 313 | 74.4 |
| United Kingdom | 78 | 18.5 |
| Other | 30 | 7.1 |
| <i>Referral source</i> | | |
| Self | 250 | 59.4 |
| Health & Welfare agencies | 143 | 34.0 |
| Other | 28 | 6.6 |
| <i>Accommodation</i> | | |
| Rented | 257 | 61.1 |
| Parents/Own home | 99 | 23.5 |
| Refuge/NFPA* | 65 | 15.4 |
| <i>Marital status</i> | | |
| No partner | 339 | 80.5 |
| With partner | 82 | 19.5 |
| <i>Employment</i> | | |
| Unemployed | 235 | 55.8 |
| Full/part time employment | 171 | 40.6 |
| Student | 15 | 3.6 |
| <i>Education</i> | | |
| Some secondary | 308 | 73.2 |
| Secondary/ trade/ some tertiary | 113 | 26.8 |
| <i>Legal problems</i> | | |
| No | 412 | 97.9 |
| Yes | 9 | 2.1 |
| <i>Number of previous admissions</i> | | |
| Nil | 150 | 35.6 |
| 1 - 2 | 214 | 50.8 |
| 3 or more | 57 | 13.6 |
| <i>Length of stay</i> | | |
| Mean = 9 days SD=4.8 days range=4-15 days | | |

* No fixed place of abode.

4.4. Drug use characteristics

The majority (n=266, 63.2%), were poly drug users, as assessed by the routine urinalyses tests performed on admission. The drugs detected included alcohol, benzodiazepines, cannabis, heroin, other opioids, amphetamines, cocaine, and hallucinogens. The most common combination of drugs used were:

- alcohol and benzodiazepines;
- alcohol, cannabis and benzodiazepines;
- benzodiazepines and alcohol;
- benzodiazepines, alcohol and cannabis;
- heroin, cannabis, benzodiazepines and amphetamines;
- amphetamines, cannabis, ecstasy, LSD;
- amphetamines, benzodiazepines and cannabis.

While multiple drug use was common, participants were undergoing detoxification from what they considered to be their principal problem drug (Figure 2).

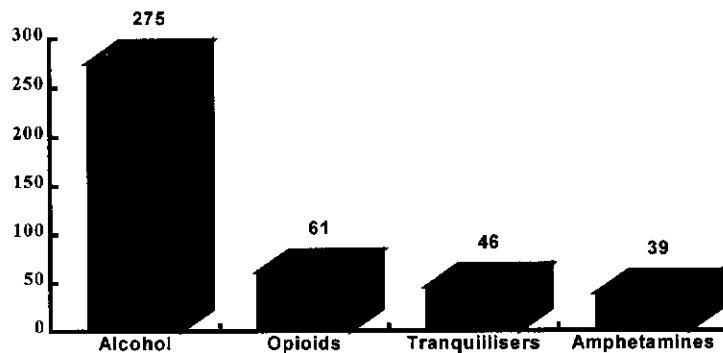


Figure 2: Principal drugs (n=421)

The majority (65.3%, n=275) were undergoing detoxification from alcohol. Others were undergoing detoxification from opioids (heroin, methadone, and pethedine) (11.5%, n=61), tranquilizers (10.9%, n=46), and amphetamines (9.3%, n=39).

As shown in Table 2, the majority (94.8%, n=399) had been using the drug from which they were undergoing detoxification on a daily basis, and a small proportion (5.2%, n=22) reported using it on most days. The median age of

first use of main drug was 17 years (mode=16 years, range=7-48 years). The median age of regular use was 20 years (mode=18 years, range=7-56 years). The duration of current use of the drug ranged from 1 to 240 months (median=8 months, mode=6 months).

Table 2: Frequency of use, age first used, age first used regularly, and duration of current use of main drug (n=421)

| Variable | f | % | |
|--------------------------|---------------|-------------|----------------|
| <i>Frequency of use</i> | | | |
| Daily | 399 | 94.8 | |
| Most days | 22 | 5.2 | |
| | <i>Median</i> | <i>Mode</i> | <i>Range</i> |
| Age first used | 17 years | 16 years | 7 - 48 years |
| Age first used regularly | 20 years | 18 years | 7 - 56 years |
| Duration of current use | 8 months | 6 months | 1 - 240 months |

4.5. Dependency (principal drug)

The findings in regard to dependency on alcohol and other drugs are presented in Table 3. Dependence on alcohol was assessed by the SADD that allows for low (1-9), medium (10-19), and high (20 or more) levels of dependence to be detected. Based on these criteria, no person whose main drug was alcohol had a low level of dependency. The majority (89.5%, n=246) had a high level of dependence, and (10.5%, n=29) had a medium level of dependence on alcohol. The median score on the SADD was 28 (mode=32, range=12-38).

Dependence on other main drugs was assessed by the SDS. The medians, modes, and ranges were similar (Table 3). The highest score attainable on this measure is 15, and the scores ranged from 6-14, hence all assessed by the SDS could be regarded as dependent on their principal drug. In view of these findings, no comparisons were made between users of different drugs in terms of dependency, as all were dependent on their main drug of use.

Table 3: Alcohol and other drug dependency (n=421)

| Drug | n | f | % | |
|-----------------------|-----|---------------|-------------|--------------|
| * <i>Alcohol</i> | 275 | | | |
| Low | | 0 | 0.0 | |
| Medium | | 29 | 10.5 | |
| High | | 246 | 89.5 | |
| | | <i>Median</i> | <i>Mode</i> | <i>Range</i> |
| | | 28 | 32 | 12 - 38 |
| ** <i>Other Drugs</i> | | | | |
| Tranquilizers | 46 | 12 | 12 | 8 - 14 |
| Amphetamines | 39 | 12 | 12 | 6 - 14 |
| Opioids | 61 | 12 | 14 | 10 - 14 |

* SADD

** SDS

4.6. Injecting drug use

Data were obtained on whether or not participants had ever injected drugs, the age they first injected, when they last injected, and the last time they shared injecting equipment. The results are presented in Table 4.

Table 4: Injecting drug use (n=421)

| Response | f | % |
|--|-------------------|---------------------|
| <i>Ever injected (N=421)</i> | | |
| Yes | 165 | 39.2 |
| No | 256 | 60.8 |
| <i>Last injected (N=165)</i> | | |
| Less than a week ago | 100 | 60.6 |
| 1 week - less than 4 | 25 | 15.1 |
| 1 month - less than 3 | 23 | 13.9 |
| 3 months - less than 12 | 12 | 7.3 |
| More than a year ago | 5 | 3.1 |
| <i>Last shared injecting equipment (N=164)</i> | | |
| Never | 52 | 31.8 |
| Less than a week ago | 55 | 33.5 |
| 1 week - less than 4 | 11 | 6.7 |
| 1 month - less than 3 | 8 | 4.9 |
| 3 months - less than 12 | 8 | 4.9 |
| More then a year ago | 30 | 18.2 |
| <i>Age first injected (N=165)</i> | | |
| Mode = 16 years | Median = 18 years | Range = 14-34 years |

Numbers vary because of missing data.

Almost 40% (n=165) of the participants had injected drugs at some time. Of those who had injected drugs, 60.6% (n=100) had injected less than a week

before admission. A further 15.1% (n=25) had injected more than a week but less than a month before admission. Others had not injected for some months, and a small proportion (3.1%, n=5) had not injected drugs for more than a year. Only 31.8% (n=52) of those who had injected drugs at some time recorded that they never shared injecting equipment such as needles and syringes. Approximately a third (33.5%, n=55) had shared injecting equipment less than a week before admission, and 18.2% (n=30) had not shared for more than a year. The median age of first injecting was 18 years (mode =16 years, range=14-34 years). As mentioned in Chapter 2, Section 2.5.3.7, injecting drug users are a high risk group for contacting a number of infectious blood borne viruses, including HIV/AIDS, hepatitis B and C, and one of the modes of transmission is sharing injecting equipment. Approximately two thirds of the sample had engaged in behavior that placed them at risk of exposure to these diseases.

4.7. Uptake of referrals

The need for ongoing support once the withdrawal process has been completed is widely acknowledged, and all participants, where possible, were offered a referral to aftercare services. Referrals were regarded by the staff as an integral part of discharge procedures, and it was the responsibility of one of the nurses to maintain a data base on the referrals made, as well as whether or not the clients concerned took up this option. The latter was determined by the nurse contacting the relevant agency, by phone, approximately two weeks after discharge, to ascertain if the client who had been referred had actually presented for their appointment. The data for the following table were obtained from unit records.

Table 5: Number of referrals made, and uptake of referrals (N=421)

| Referrals | f | % |
|--------------------------|-----|------|
| Number of referrals made | 379 | 90.0 |
| Uptake of referrals | 212 | 55.9 |
| Refused referral | 42 | 9.9 |

Not all participants accepted the offer of a referral, and not all who

received a referral actually attended for the follow-up appointment. Almost a third ($n=125$, 29.7%) were referred to the outpatient services of the organization in which this study was conducted, and slightly over 50% ($n=215$) were referred to other drug/alcohol agencies. A small proportion ($n=20$, 4.8%) were referred to general practitioners. Others ($n=19$, 4.5%) were referred to welfare agencies. Some participants, ($n=42$, 9.9%) refused the referral option. Overall, although 90% (375) of the clients were provided with referrals, the uptake of this option was 55.9% ($n=212$). Formal referrals were not made to NA or AA as representatives of these groups visited the unit regularly, and conducted groups on the premises. Hence all participants had been exposed to contact with these self-help groups. It is possible that at least some of those who refused a formal referral, or did not take up this option, attended either or both of these self-help groups after they left the unit.

4.8. Licit versus illicit drug users

One of the arguments put forward to promote combined treatment was that the differences noted previously in regard to socio-demographic characteristics of users of mainly licit or mainly illicit drugs may no longer be so marked (Dunne et al., 1989). The principal drugs regarded as licit in this study were alcohol and tranquilizers; those considered as illicit were opioids (mainly heroin) and amphetamines. The research question was “What are the differences between licit and illicit drug users in terms of *age, sex, marital status, employment, poly drug use, program drop-out, and time?*”. *Time* was included in the analysis as a grouping variable with four levels (each level corresponded to three months) to assess what influence it had on the type of client admitted to the unit during the twelve months of data collection. Included in the analyses were data from those who failed to complete the program ($n=97$).

Since all responses were categorical in nature, general linear models (GLM) were used for the analyses. GLMs are natural generalizations of ordinary regression models. GLM assumes the response variates y_i are independent and follow a distribution which is a member of the exponential family. This family includes such distributions as normal, binomial, Poisson, gamma etc. The mean of y_i is functionally related to a linear predictor through

a monotone differentiable function known as the link function. For example, for the binomial distribution the logit or probit or complementary -log-log link function is usually chosen. For the Poisson distribution the log link function is often appropriate. The usual link function for the normal distribution is the identity. In this study logistic regression models (binomial distribution with logit link) and log-linear models (Poisson distribution with log link) were employed. For a detailed explanation of GLMs see McCullagh and Nelder (1989).

The influence of *age*, *sex*, *marital status*, *employment*, *poly drug use*, *drop-out*, and *time* on *licit/illicit* drug use was investigated by fitting a logistic regression model. Interactions of *age*, *sex* and between *age* and *sex* with *poly drug use* and *program drop-out* were also included. A summary of the analysis and estimates of the regression coefficients and accumulated analysis of deviance is presented in Appendix E, Table E1. The main effects of *sex*, *time*, and *marital status* were not statistically significant, nor were the interaction effects. All non-significant variables were excluded from the model. The importance of the variables was assessed by their contribution to the deviance of the logistic regression model. Namely, the greater the contribution the more important the variable. The contribution of an additional variable, moreover, depends on which variables have already been included in the model, because of the existing correlations and associations between them. In this manner, the contribution of each of the variables was obtained. The final model and the estimates of the regression coefficients are presented in Appendix E, Table E2.

The scaled deviance (minus twice the log-likelihood ratio between the fitted model and the full model) was used to assess the quality of the fit. The scaled deviance has approximately a Chi-square distribution, with degrees of freedom equal to the residual degrees of freedom, that is, it is not significant. Hence the binomial distribution is credible for these data and the model provides an acceptable fit (Table 6). A summary of the significance of the above mentioned variables is presented in Table 6. The predictions of being an illicit drug user for combinations of those levels with significant effect are presented in Appendix E, Table E2.

Table 6: Logistic regression with licit/illicit as response variate and constant, poly, drop-out, age, employment as fitted variables (summary)

| | Df | deviance | mean deviance | deviance ratio |
|---|-----|-----------|------------------|-------------------|
| Regression | 5 | 167.3 | 33.4592 | 33.46 |
| Residual | 512 | 450.7 | 0.8802 | |
| Total | 517 | 618.0 | 1.1953 | |
| Change | -1 | -6.8 | 6.8323 | 6.83 |
| Ratios are based on dispersion parameter with value 1 | | | | |
| *** Accumulated analysis of deviance *** | | | | |
| Change | df | deviance* | mean deviance | deviance ratio |
| + poly | 1 | 56.0465 | 56.0465 | 56.05 |
| + drop-out | 1 | 40.7663 | 40.7663 | 40.77 |
| + age | 2 | 63.6508 | 31.8254 | 31.83 |
| + employment | 1 | 6.8323 | 6.8323 | 6.83 |
| Residual | 512 | 450.6693 | 0.8802 | |
| Total | 517 | 617.9652 | 1.1953 | |
| Ratios are based on dispersion parameter with value 1 | | | | |

* Critical value of Chi-square (df = 1, p = 0.05) = 3.84.
Critical value of Chi-square (df = 2, p = 0.05) = 5.99.

The only significant main effects observed were *poly*, *drop-out*, *age*, and *employment*. As illustrated in Table 6, the deviance ratio of *poly drug*, *dropout*, *age*, and *employment* was 56.05, 40.77, 31.83, and 6.83 respectively. A fitted logistic model allows estimation of the odds of an event occurring, that is, the ratio of the probability that it will occur to the probability that it will not. In this case, the odds of being an illicit drug user for different combinations of the factor levels were predicted. When the odds ratios of the combinations of the factor levels is considered (Appendix E, Table E3), those who were poly drug users, who were in the younger age groups (17-25 years, 26-35 years), unemployed, and dropped out of the program were more likely to be illicit drug users than licit drug users.

A further analysis was performed to examine the difference in drop-out rates between each principal drug type (alcohol, opioids, amphetamines, and tranquillisers). To simplify interpretation, a bivariate test was used to explore the comparisons. The results are presented in Table 7. The drop-out rate for the participants whose principal drug was alcohol or tranquillisers was similar, 13.53% and 13.21% respectively. The drop-out rate for the participants whose

main drug was opioids or amphetamines was 27.78% and 34.41% respectively. The drop-out rate for the participants whose main drug was opioids was approximately twice that of those whose main drug was alcohol or tranquillisers.

Table 7: Drop-out by principal drug

| Drop-out | Alcohol | | Opioids | | Amphetamines | | Tranquillisers | |
|----------|---------|---------|---------|---------|--------------|---------|----------------|---------|
| | n | % | n | % | n | % | n | % |
| No | 275 | (86.48) | 39 | (72.22) | 61 | (65.59) | 46 | (86.79) |
| Yes | 43 | (13.52) | 15 | (27.78) | 32 | (34.41) | 7 | (13.21) |
| Total | 318 | (100) | 54 | (100) | 93 | (100) | 53 | (100) |

Chi-square 24.56, df = 3, p = 0.001

The drop-out rate for those whose main drug was amphetamines was somewhat higher than opioid users, and almost three times that of the licit (alcohol and tranquillisers) drug users.

One of the reasons the quantitative data were obtained over a twelve month period was to determine if there were any significant seasonal variations in the type of client admitted to the unit. As shown in Appendix E, Table E4, no significant differences were detected over time in regard to *age, sex, marital status, principal drug, and poly drug*.

In summary, the best predictors for illicit drug use were poly drug use, being aged from 17 to 36 years inclusive, being unemployed, and dropping out of the program. Amphetamine users were more likely to drop-out than heroin users, and heroin users were more likely to drop out than those participants whose main drug was alcohol or tranquillisers. No significant seasonal variations were detected in the type of client admitted to the unit, at least in regard to the variables examined, and during the period of data collection.

4.9. Minor Psychiatric Morbidity (MPM)

The research questions were:

What is the prevalence rate of MPM among participants?

What is the influence of socio-demographic and drug use variables on overall MPM scores?

What is the influence of socio-demographic and drug use variables on MPM domain scores?

These questions were investigated by firstly establishing the extent of overall MPM as assessed by the recommended cut-off point of 4/5 (Goldberg & Williams, 1988). Secondly, by determining the influence of socio-demographic and drug use characteristics on overall GHQ-28 scores. Thirdly, by determining the influence of these characteristics on the domain scores of the GHQ-28.

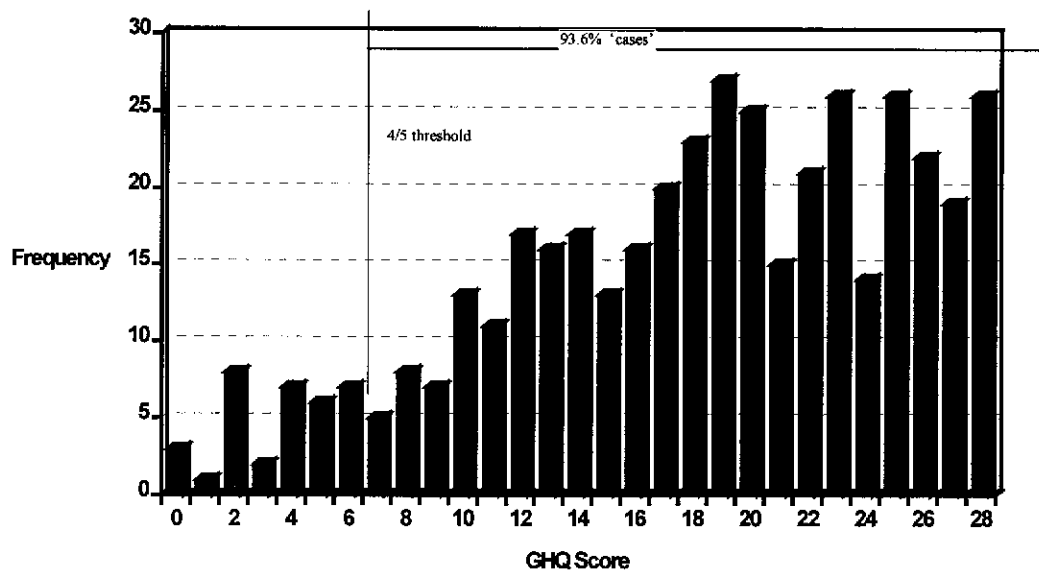


Figure 3: Distribution of overall GHQ-28 Scores (N=421)

The distribution was negatively skewed in favour of high scores (skewness=-0.50) (Figure 5). The mean score was 18 (SD=6.66, range=0-28, mode=19). At the 4/5 threshold 93.6% of the sample could be viewed as 'cases'. The mean score of 18, and the modal score of 19 suggests that the overall symptoms recorded by the majority could be relatively severe.

4.10: Influence of socio-demographic, time, and drug use on overall GHQ-28 scores

To assess the prevalence of overall MPM among the participants a regression model was fitted for the total score (*ghqtot*). The categories in this model were considered on an interval scale and the response variable was analysed as a continuous variable, logarithmically transformed (see Table E5, Appendix E). For this model the only significant effects were for *time*. The

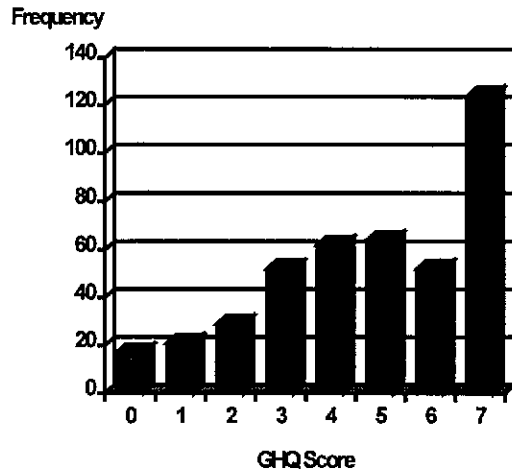


Figure 4: Somatic Symptoms

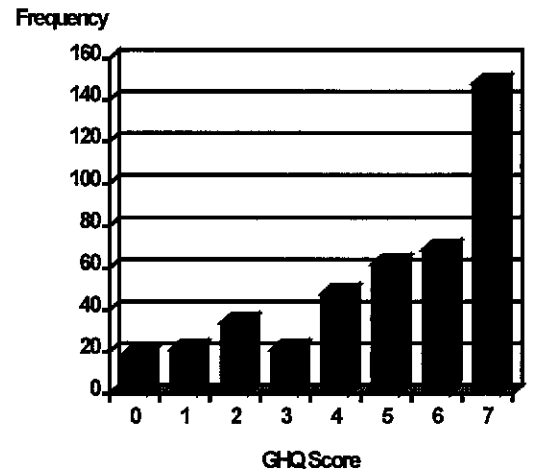


Figure 5: Anxiety and Insomnia

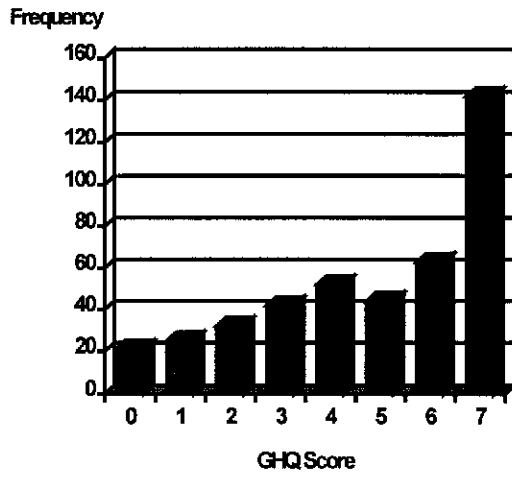


Figure 6: Social Dysfunction

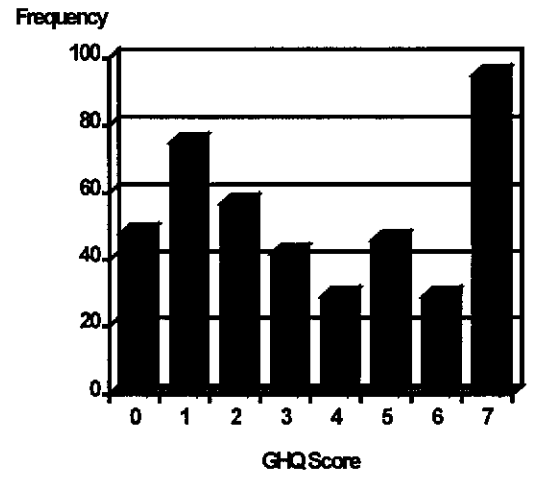


Figure 7: Depression

other variables entered, namely *age*, *sex*, *poly drug use* and *prindrug* (principal drug) had no significant influence on the overall scores of MPM.

4.11: Distribution of GHQ-28 domain scores

The distributions of the scores for each domain are shown in Figures 4, 5, 6, and 7. With the exception of depression, which has a bimodal distribution, the scores reflect the negative skewness in favour of high values evident in the overall scores (Figure 3). This suggests a high degree of severity in each domain.

4.12: Influence of socio-demographic, time, and drug use on GHQ-28 domains

To assess the influence of *age*, *sex*, *marital status*, *prindrug*, *poly*, and *time* on the domains of somatic symptoms (*ghqa*), anxiety and insomnia (*ghqb*), social dysfunction (*ghqc*), and depression (*ghqd*) four tests were performed. The response variables (*ghqa*, *ghqb*, *ghqc*, *ghqd*) were polytomous and the response categories were ordinal. That is, there is an ordering of the categories but no concept of distance between them. Proportional-odds models with logit as the link function were fitted for the response variates. A proportional-odds model is a cumulative model which describes the relation between the numbers of observations up to a particular category, and the explanatory values using cut-off points in order to provide a quantification of the difference between successive categories in the logit scale (McCullagh & Nelder, 1989).

The response variables were created by counting the number of individuals for each category for all possible combinations of the variables included in the model, namely *age*, *sex*, *poly*, *prindrug* and *time*. The interactions of *age* and *sex* with *poly* and *prindrug* were also considered. Detailed descriptions of the results of the analyses are presented in Tables E6, E7, E8, and E9, Appendix E, and summarized below in Table 8.

Table 8: Summary of influence of sex, time, age, and drug use on GHQ-28 scores

| GHQ28 | Sex | Time | Age | Poly Drug Use | Prindrug |
|-------------|-----|------|-----|---------------|----------|
| GHQa | * | * | NS | NS | NS |
| GHQb | NS | NS | NS | NS | NS |
| GHQc | NS | * | NS | NS | NS |
| GHQd | * | NS | NS | NS | NS |
| Total Score | NS | * | NS | NS | NS |

None of the interactive effects were significant. Among the main effects *sex* was significant for somatic symptoms (*ghqa*) and depression (*ghqd*). That is, women had higher scores than men on these domains. Women in treatment services have been found to have more psychiatric symptoms than men (Davis & Morse, 1987) and more depression and anxiety (Blume, 1986; Thom, 1987). The findings of the present study give some support to these earlier results in that women had higher scores in regard to somatic symptoms and depression than men, but not in terms of anxiety. *Time* was significant for somatic symptoms (*ghqa*), social dysfunction (*ghqc*) and total scores. The most notable finding from these analyses was the extremely high prevalence rate (93.6%) of MPM detected by the GHQ-28 among the participants, which was not influenced by *age*, *poly drug*, or *prindrug*.

4.13: Prevalence of MPM compared with other studies

The prevalence rates of MPM obtained using different versions of the GHQ in different settings are presented in Table 9. Despite the problems associated with attempts to make direct comparisons between the findings from different versions of the GHQ, and different cut-off points used in different samples, the results are noteworthy. The rate obtained in the present study is far higher than that found in earlier investigations conducted in Western Australia, where the rate among people in a community study was 18% (Finlay-Jones & Burvill, 1977), and among general practice patients, 29% (Finlay-Jones & Burvill, 1978). It is higher than the 56% reported among young, unemployed people in Canberra (Finlay-Jones & Eckhardt, 1981), and that reported from a sample in an addiction treatment centre (Ross & Glaser, 1989). It exceeds the 61% reported in a more recent study among opioid users in an outpatient clinic in Sydney (Swift, Williams, Neill & Grenyer, 1990).

Table 9: Prevalence of MPM versus other studies

| Researchers | GHQ Version | Location | Rate % |
|--------------------------------|-------------|---|--------|
| Finlay-Jones & Burvill (1977) | 60 | Community (WA) | 18 |
| Finlay-Jones & Burvill (1978) | 60 | GP Patients (WA) | 29 |
| Finlay-Jones & Eckhardt (1981) | 30 | Young unemployed (ACT) | 56 |
| Ross & Glaser (1989) | 60 | Addiction Treatment Foundation (Canada) | 56 |
| Swift et al. (1990) | 28 | Methadone Clinic (NSW) | 61 |
| Present study | 28 | Detoxification Unit (WA) | 93.6 |

There are two possible explanations for this. One relates to the cut-off point used here, and the other to the timing of data collection. Goldberg and Williams (1988) recommend a threshold of 4/5, but emphasize that other cut-off points may be more appropriate for different populations. One example of this for the GHQ-60 is the suggested use of 23/24 instead of 11/12 for a sample from an addiction treatment centre (Ross & Glaser, 1989). If it is intended to detect only the most severe cases the threshold could be raised. If, however, all cases are to be detected then the threshold should be lowered. Raising the threshold improves specificity, but reduces sensitivity, while lowering the threshold improves sensitivity but reduces specificity. Another issue is whether cut-off points should be normed by sex. The differences between women and men, particularly in regard to alcohol use, are well documented, and the possibility that it may be more appropriate to establish a different cut-off point for women than men warrants consideration.

In regard to the timing of administering the GHQ-28, data for this study were obtained approximately six days after those concerned were admitted to the unit. As all versions of the GHQ seek information on recent symptoms, the participants were reporting on their functioning and feelings both prior to admission and during most of the period of withdrawal. Many of the symptoms of MPM mimic withdrawal and the possibility that the scores, to some extent, reflect this cannot be discounted, though one of the criteria for completing a questionnaire or being interviewed was that the participants' acute withdrawal symptoms largely subsided. It is also possible that, as the time for discharge from the unit approached, levels of MPM became elevated as the participants considered whatever problems required addressing on their return to the community.

The GHQ was constructed to detect transient disorders, which may not require

treatment (Goldberg & Williams, 1988). This may not be the case for the participants in this study, who sought treatment because their lifestyle was problematic. Though it was customary to arrange appointments for ongoing support for participants after they had left the unit, a small number ($n=42$, 9.9%) refused this option, and of those who accepted a referral the uptake was 55.9%. Hence a considerable number of the participants did not have the benefit of follow-up care in the community when they left the treatment unit.

4.14. Summary

In summary, 11.4% of participants were in the 16-25 year old age group, 43% were in the 26-35 year old group, and 45.6% were aged thirty-six years or older. The majority were either born in Australia or New Zealand, and had referred themselves for treatment. Most of them lived in rented accommodation, had some secondary education, and were without a spouse or defacto partner. A small proportion had current legal problems. Over a third were experiencing their first detoxification. Over half, however, had from one to two previous detoxifications, and some had experienced three or more. The average length of stay in the unit for those who completed the program was nine days. Of those who accepted a referral for follow-up care, only 55.9% ($n=212$) actually took up this option.

While the majority were poly drug users, all were ostensibly being withdrawn from one drug, their designated principal drug, that is, alcohol, opioids (heroin, methadone, pethidine), tranquilizers (mainly benzodiazepines) or amphetamines. All had lengthy histories of drug use and all were assessed as being either moderately or heavily dependent on their principal drug. Almost 40% reported injecting drugs, generally in the week preceding admission and only approximately 30% of those who had injected drugs had never shared injecting equipment. Sharing injecting equipment is one of the main risk factors in the transmission of blood borne viruses, such as hepatitis C and HIV. While the prevalence of HIV among injecting drug users in Australia is relatively low (1.6%), the prevalence of hepatitis C is 69% (National Centre in HIV Epidemiology and Clinical Research, 1997). Hence the likelihood that those who had shared equipment had been exposed to, and perhaps were positive for hepatitis C is high.

Significant differences were detected between licit and illicit drug users in

terms of age, employment, poly drug use, and completing the program. Illicit drug users were younger than licit drug users, were more likely to be unemployed, poly drug users, and to drop out of treatment than licit drug users. The influence of time on the characteristics of the clients admitted to the unit over the year of data collection was insignificant. This is not to claim that there were no differences in the number and type of clients admitted as this varied on a day-to-day basis. Over an extended period of time, however, the differences were not statistically significant, at least in regard to the variables examined. While there were significant differences over time in regard to somatic symptoms and anxiety, this could not be explained in terms of the socio-demographic and drug use variables included in the models. It is possible that this finding is a reflection of variation in the severity of some of the withdrawal symptoms experienced by the participants. However the possibility that the differences detected in regard to time are an artifact of the number of tests performed on the data cannot be discounted. The most salient finding in regard to MPM was the very high prevalence rate detected and the largely insignificant influence of socio-demographic and drug use variables on overall scores of the GHQ-28, or the scores of the domains of the GHQ-28. The qualitative findings from the grounded theory method of analysis are presented in the following chapters.

PART THREE

THE BASIC SOCIAL PSYCHOLOGICAL PROBLEM: DISEQUILIBRIUM

CHAPTER 5: HITTING THE WALL: PRECURSOR TO TREATMENT

CHAPTER 6: INCOMPATIBILITY

Overview

The data indicated that the basic social psychological problem that was shared by the participants had two parts. The first part was related to the participant's drug focussed lifestyles, and consisted of the events and problems that induced them to enter the combined, medical detoxification unit. The second part was related to the problems encountered whilst the participants were in the treatment unit. The first part was categorised as "Hitting the Wall". The second part was categorised as "Incompatibility".

The first part of the problem, Hitting the Wall, was significant as it was antecedent to entering the unit, lingered with the participants whilst they were in treatment and, in general, remained to be addressed when the participants left the residential facility. The second part, Incompatibility, was associated with the heterogeneity of the clients in the unit and the structure of the treatment program. At a higher level of abstraction, both parts represented different forms of disequilibrium that the participants had to deal with. Disequilibrium means "a loss or absence of equilibrium" (Collins English Dictionary, 1993). Hitting the Wall brought the participants into a state of disequilibrium in which they could no longer sustain their drug focussed lifestyles. The second part, Incompatibility, that was encountered whilst the participants were in the treatment unit, created a further problem of disequilibrium that had to be dealt with.

The first part was long standing and not resolved by detoxification alone. In contrast, the second part of the problem and another form of disequilibrium, Incompatibility, was transient and time limited in that it was confined to the participants' stay in the unit. The first part of the basic social psychological problem Hitting the Wall is presented in chapter five. The second part, Incompatibility, is described in chapter six.

CHAPTER 5

HITTING THE WALL: PRECURSOR TO TREATMENT

5.1: Introduction

The problems and events that created disequilibrium and led the participants to seek treatment were conceptualised as “Hitting the Wall”. This symbolic wall encompassed the causal factors that interrupted the participants’ drug using behaviours. The problems associated with the symbolic wall were a precursor to treatment and were not resolved by entering the treatment program. They lingered with the participants whilst they were in the unit, contributed to the problems associated with Incompatibility encountered in the unit and remained to be addressed when the participants left the unit.

The factors involved in Hitting the Wall were important as they influenced the participants’ decision to seek treatment, permeated their involvement in the detoxification program, as well as their progress through the basic social-psychological process of Seeking Balance through Hanging In. In other words, the circumstances and events that culminated in Hitting the Wall led the participants to treatment. In this chapter the elements of the symbolic wall are described. Some of the data presented were obtained from focus groups and are identified as (FG) following the extract concerned. Data obtained from formal, individual interviews are indicated by a code number such as R1. Italics are used to give emphasis to parts of the extracts.

5.2: Hitting the Wall

Hitting the Wall was conceptualised symbolically as a point where the consequences of continuing drug use had led to a state of severe disequilibrium that had become unacceptable to the participants and/or others. For the participants in this study, Hitting the Wall was antecedent to seeking treatment for their drug use, and the problems associated with their particular walls persisted with them whilst they were in treatment, and remained to be addressed

when they left the unit. Often this symbolic point occurred after an accumulation of negative experiences was combined with some particularly significant and disturbing personal event. Experiences which alter and shape the meanings that people assign to themselves and their lives have been referred to as epiphanies (Denzin, 1992). Epiphanies occur when a person confronts and experiences some interactional crisis. Four types of epiphanies have been identified: a major event which changes life forever; the cumulative, which is a crisis bought on over time by a series of events; the illuminative moment in which underlying structures of a relationship are revealed, and the relived moment in which an event is defined consequentially (Denzin, 1992).

In this study, all forms of epiphany were evident in *Hitting the Wall*. There was evidence of major upheavals, such as causing the death of a friend in a car crash and striking relatives whilst under the influence of drugs. There was evidence of cumulative epiphanies, for example when a spouse eventually walked out of a relationship after many threats to do so, or when work supervisors finally confronted an employee regarding their alcohol-inhibited work performance. An example of the illuminative moment was when a mother gained insight about how her drug using behaviour could eventually be perceived by her daughter. Examples of a relived moment was when a person looked back over the events which led to their dependence on pethidine, or the previous experience of severe withdrawal symptoms.

The significant personal experiences, or epiphanies, that comprised *Hitting the Wall* varied considerably from one individual to another. Some experiences, such as causing the death of a friend, were quite dramatic. Other experiences, such as the possibility of a child coming to view her mother as a drug user or a spouse threatening to walk out of a marriage, appeared relatively trivial in comparison. The events were similar, however, in that they were significant to the individual concerned and served as catalysts to interrupt what, for some, was a comparatively complacent drug using lifestyle. The events created a state of disequilibrium that was intolerable for the participants. The decisions to seek treatment originated in a range of problems associated with drug use that led to *Hitting the Wall*.

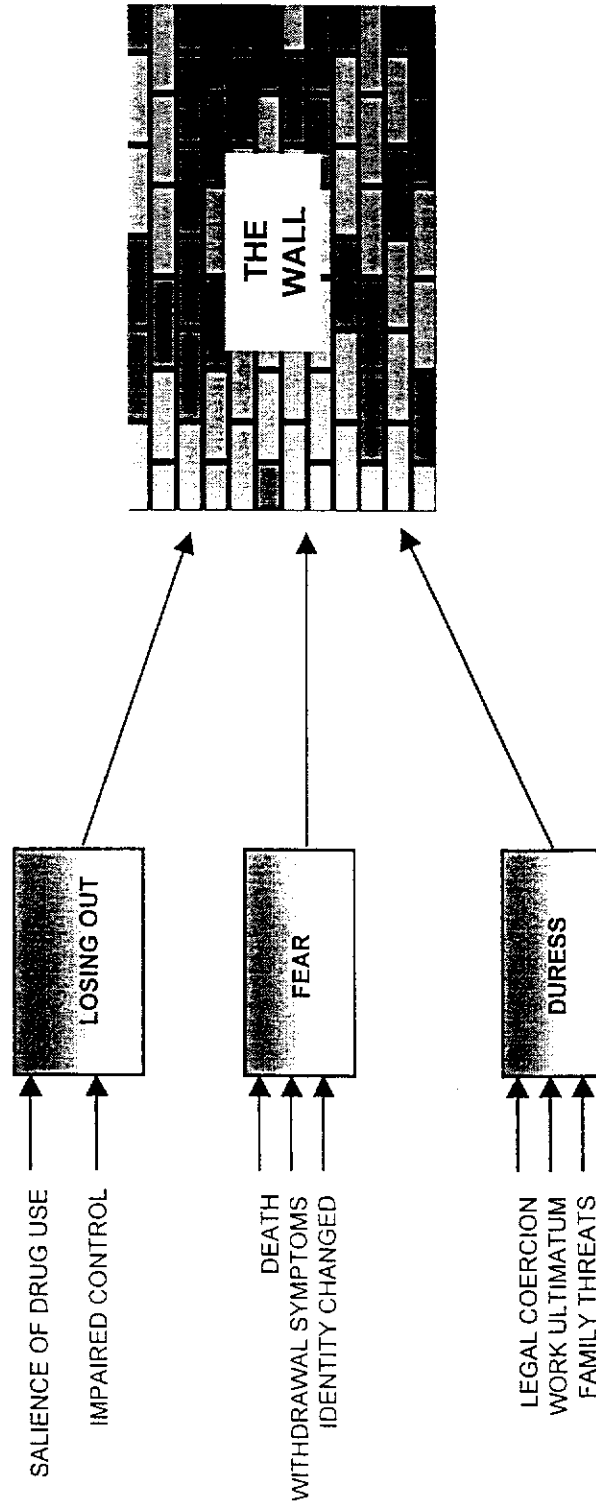


Figure 8: Hitting the Wall

The sub-categories of Hitting the Wall identified in the data were Losing out, Fear (of death, withdrawal symptoms and identity change) and Duress. These are illustrated in Figure 2 and are described below. Though presented as discrete entities for the purpose of discussion, in reality there was considerable overlap between them as there were elements of losing out, fear, and duress in all sub-categories and the distinctions between them were largely a matter of degree.

5.3: Losing Out

Losing Out was a category which encompassed the participants' growing awareness of the adverse consequences of their drug-focussed lifestyles. For some participants this was manifested in a sense of deprivation and marginalisation of other social and daily living activities, and a realisation that their lives had become focussed around obtaining and using drugs. Other participants experienced it as impaired control over their senses or actions. The sub-categories of Losing Out were Salience of Drug use and Impaired Control.

5.3.1: Salience of Drug Use

Several participants had sought treatment because their drug use had increased to the point that their lives were dominated by activities related to drugs. That is, most of their day was devoted to obtaining drugs, using drugs and dealing in drugs. The salience of these activities was such that these participants had little time for anything else and perceived themselves to be losing out on other aspects of their lives. This is well illustrated in the following excerpt from the transcripts of a participant whose main drug was heroin:

R3: *It was taking up most of the day. I used to meet the suppliers and get the dope [heroin]. Then I would cream off enough for my hits [injections], then cut [adulterate] it to sell to others. That's all I did. Nothing else. I had no money, no clothes and no job. Everything I did was focussed on drugs. I had nothing else. The only friends I had were people like me who were doing the same things.*

Another way that some other participants, usually those whose main drug was one of the tranquillisers, obtained their drugs was by “doctor-shopping”. The term refers to the practice of viewing general practitioners as outlets for certain drugs and shopping around to determine which doctor would prescribe the desired drugs, generally one of the tranquilliser group. That meant presenting to a number of doctors at different surgeries complaining of symptoms which would induce the doctor concerned to prescribe them the drug they sought. According to one participant:

R10: *I would go to this one [doctor] and that one, probably three or four different ones each day. I had to have my bathroom cupboard full of pills, or I would get really uptight. If I was down to one packet I would go out and get some more. But then I would be running out of doctors. I was going back too soon. They would say “I just prescribed for you last week”.*

When asked what would happen then, the participant continued:

I would just say “Yes, but I left them in someone’s car, and they have gone away on holiday”. They would just look at me, but they would write out the script. They probably thought I was just a silly woman.

Doctor-shopping was a common practice and those involved appeared to have little time for anything else. The participants who engaged in this practice seemed to have little respect for the doctors who provided them with prescriptions for the drugs they were seeking. This is illustrated in the following extract:

R12: *I got hooked on sleeping pills. I don't like them much because they have a real hangover effect. But as I got more addicted the pills seemed to lose their effect, and you have to take about five to get the same effect as one. I changed brands and found that the rohypnol and normison are really brothers. I got so bad I was seeing about six doctors, six different doctors a day. I was doing the rounds. One doctor asked “Are you under a therapist?” I said “Yes”. The doctor said “You can have twenty valium, but you must see the therapist”. I don't know what they think a therapist will do. They [doctors] don't know nothing.*

When asked how she managed to visit so many different doctors in one day she added:

It was up to the phone box, get an appointment, surgery, chemist, next appointment, surgery, chemist. It was a continuous hassle. *There was no time for anything else. That's all I did, every day.*

Another participant, who was an epileptic, blamed her problems on the doctors for prescribing tranquillisers as part of her medication regime:

R14: They [doctors] put me on valium with my epilepsy tablets. That started me on pill taking. After a while I couldn't take just one pill. It grew to ten, twenty and more. Up to four or five full boxes a day. All different sorts like serepax, rohypnol, panadeine forte, and a drug called rivotril, or something.

When asked how the medications were obtained, she replied:

Well, you just have to keep going to different doctors; you can't keep going to the same one. And they all prescribe different pills. You have to tell them you got anxiety or something, that you can't sleep. Or that you are depressed. That's all I say. I don't say anything else, and they give the prescriptions.

Not all participants did their own doctor shopping; some managed, by various strategies, to involve their partners in the practice. The following excerpt from transcripts serves to illustrate how these partners were manipulated into the role of a procuror of drugs:

R23: Every week he [partner] would say "I'm not going to get them [tranquillisers] again for you, so you will have to get them on your own". So I would say "Okay, don't bother". Then he would *get the silent treatment* and after a bit he would go out and get some. I got so lazy I just lay back in bed thinking I'm going, I'm going to have a fit if I don't get the tablets. I sort of imagined him in the surgery, you know, and how long he would be. *I made him tell the doctors he was an epileptic.* They sent him letters to have tests and things. It's quite funny to look back on it. Half the time he must have felt what a horrible woman I was, and I sort

of thought what a dumb man. He doesn't even know what to say [to doctors].

Others acknowledged that they, the participants who were doctor shopping, were responsible for placing the general practitioners concerned in difficult situations. The following comments illustrate how they viewed the doctor's position:

You know, you can get almost anything you want out of doctors. *They are really in a difficult situation*, and most don't know how to deal with us. I think they know when we are lying to them, but they can't really prove it. Some of them don't want to [prescribe], they just want to get us out of their surgeries, because we might have a disease or something, or might cause them some trouble. *I suppose it's not really fair on them, you know, because once you have been doing it [doctor shopping] for a while you know what to say, and all they can do is write out the script.* I suppose that's what they do for a living, and it works for people who are straight with them. For people like us who are forever on the scam for their drugs, they just don't know what to do. (FG)

It was obvious that, while the participants who engaged in doctor-shopping were aware of the difficult situation in which the doctors were placed, they were prepared to take advantage of this to support their drug habit.

I suppose they ought to have better training or something. You know, drugs are all over the place, and the doctors should be right up there with it. But they don't seem to be somehow, and if you're a woman and you go to see them and tell them you have premenstrual pain or can't sleep or can't cope with the kids or something, well, they just reach for the scripts. *They don't want any emotional women around to have to deal with. I suppose that would take up too much time, and they have to earn a living just like everyone else.* (FG)

It was apparent that these participants had a low opinion of general practitioners' knowledge and ability to deal with drug related issues. The doctors concerned were also perceived to be disinclined to be involved with women's

emotional problems. One of the reasons postulated for this was that these issues took up too much time and had the potential to negatively impact on a doctor's income, which under the current Australian system of remuneration is dependent on the number of patients seen. Doctors were, however, held in high regard in their ability to manage trauma or disease and the vulnerability of doctors to manipulation in certain situations was acknowledged.

I don't want you to think that doctors are bad. It's just that pill users are a lying bunch, and they [doctors] rely on people telling the truth. If there is really anything wrong with you, like you break an arm or a leg or something, they are great. Even if you get the flu or hepatitis they will try and help you. But it is not hard to get drugs if you just keep telling the right story. (FG)

I can certainly blame the doctor who gave me the drug [pethidine] but I put it into my arm. I didn't ask him to do it, and he wasn't there to hold my hand. It's a problem with society and the medical services. Just handing out drugs willy nilly, without thinking about the people. *But I was the one who used the stuff. So I have to bear most of the responsibility. (FG)*

On occasions, drugs were also sought from Emergency Departments in public hospitals. This did not appear to be a common practice and those who had attempted it were apparently unsuccessful in obtaining drugs. The experience of the participants who had sought drugs from this source is well illustrated in the following extract:

The GPs are alright to scam, but *the hospitals are something else*. I was really strung out one night and I went up to an emergency section to try to get something. They took one look at me and said, "You are not sick. Go and see your GP in the morning". They wouldn't give me anything, and I really told them to get off. I suppose they did the right thing, you know. *I mean they are really there for accidents and heart attacks, and don't want people like us taking up their time*. But at the time I was really annoyed, but *I never went back there. I never had such a bad experience with a GP. (FG)*

It was apparent that the participants seeking drugs from this source were well aware of the main functions of Emergency Departments. In one sense, however, this extract points to the inadequacies of main stream health services in dealing with people with drug related problems. These people require patient, competent assessments which are generally unable to be provided in busy Emergency Departments designed and staffed to deal with quite different problems. From the data it appeared that the only intervention offered to the above participant was a suggestion to see a general practitioner the following day.

In a recent study undertaken elsewhere in Australia, it was reported that tranquillisers, particularly diazepam and oxazepam, were easy to obtain from doctors (Ross, Darke, & Hall, 1995). One third of the subjects in that study had acquired the drug(s) solely through a doctor. Others had acquired them illicitly or from friends. Over half reported that they had either sold or given the drug to others on occasions. The majority of those who sought the drug(s) from a doctor reported being successful in obtaining it most of the time. If they were denied a prescription from a doctor, they would simply go to another doctor. Drugs of this type are frequently used in conjunction with others, such as heroin, cannabis, and alcohol. Of concern is the practice of injecting the drug(s) that was reportedly widespread. The authors noted that, in regard to drugs such as benzodiazepines, doctors could be regarded as ". . . part of the chain of supply" to drug users (Ross et al., 1995, p. 27).

Obtaining sufficient drugs to satisfy the needs of the participants in this study required considerable commitment, dedication, and manipulation on their part. For those who were engaging in this behaviour, the outcome was a form of disequilibrium in that they were losing out in regard to fulfilling basic home duties, as well as losing contact and discourse with other social stimuli in their lives.

5.3.2: Impaired Control

Impaired control was experienced in several ways, for example, in relapse to drug use, loss of memory, and aggressive behaviour. In regard to relapse to drug use, in some instances this had occurred when an individual left an environment

in which they had been abstinent and returned to an environment in which they had previously used drugs and the associates with whom they had engaged in this behaviour. The following extract illustrates how this eventuated:

R17: Heroin is my drug. I have used speed and other drugs at times, but never very regularly, but I've been using heroin for years. I don't mean all the time you know. Sometimes I can give it away for months. Like last year I was in xxxx [another town] for most of the time and I never touched it. *I came back here to sort out a relationship, and I couldn't get a job, and I started using again sort of socially with a group I used to know before.* Then I moved to xxxx [another suburb] to get away from the scene, but two houses up there were people I used to know dealing. I started visiting them and it became more regular, and the next thing I know I'm right back there you know. *I started hocking things and borrowing money. It was getting messy, and towards the end I was right back where I'd been before.*

For one participant, the impaired control experience appeared to have been a consequence of the loss of a spouse. The participant concerned had a long standing problem with alcohol, but had been successful in achieving abstinence for eight years. He ascribed his ability to refrain from drinking to the support he had received from his wife. After her sudden death as a result of head injuries sustained from a bicycle accident, he relapsed to heavy drinking. The couple had been married for twelve years, and his wife had apparently been very understanding and supportive throughout their relationship, particularly in his resolve to abstain from drinking. According to him, "She was always there for me, even in the bad times when I was really knocking it [alcohol] back. She was always there" (R5). The following comments illustrate his experience:

R5: *I busted because my wife died. The reason I busted was because my wife became sort of like my sobriety, and without that I had nothing. I didn't want to drink because I had promised her I would not touch it again. But when she died, well, I thought it's not fair. Why her? I had one or two drinks, and just kept going. I drank all day and most of the nights for two or three weeks. I just couldn't seem to stop once I had started*

again. Some people may be able to control their drinking, but I know now I can't. It's all or nothing for me. But I promised her, and once I'm through here, I won't touch it [alcohol] again.

In some cases the impaired control over drinking was related to loss of work and a perceived exclusion from job opportunities. This contributed to financial difficulties, broken relationships, and heavy drinking. This experience is summarised in the following extract:

R16: I am a builder. I have been self-employed but there is *not much work out there*. There is not much building going on. *I maybe applied for fifty regular jobs, and maybe prepared 1500 quotes over the past three months, but I just missed out. I tried to do the best I could, but it doesn't seem to be my day any day*. So then you just sit home and wait for a call, and it's easy to pick up a drink. The bills kept coming in and my wife left me. When I work I am a very active sort of person, and *I was just home and waiting for the phone to ring, and sick of doing quotes all the time*. Yeah it's easy to pick up the drink, especially when all the people that you apply to for work, *they never answer you back*, and someone always undercuts you on the quote because they work for nothing just to keep going.

These people felt powerless over their ability to obtain work and were trapped in a situation in which they had to remain by the phone in case someone called in relation to work. This situation, together with financial problems and loss of support from their partners, contributed to feelings of low self-esteem and heavy alcohol consumption. There is some evidence that individuals may use tobacco and alcohol as a means of stress reduction (Leventhal & Cleary, 1980). It is suggested that the use of these drugs for this purpose promotes relaxation by reducing negative affect and increasing positive affect. More recently it has been suggested that, as stress increases, people who feel vulnerable and lack confidence in themselves are more likely to rely on drinking and other drug use to cope than people who are confident about themselves and less vulnerable (Timmer, Veroff, & Colten, 1985).

In the cases mentioned above the suggestions of these authors can be readily applied. Both the above participants were vulnerable and lacked confidence in themselves, albeit for different reasons. One because he had lost his wife who had supported him in his sobriety and the other because he had lost his job, then consequently his wife. It is reasonable to speculate that one participant had used alcohol as a coping strategy to deal with his feelings of grief and loss associated with a sudden bereavement. In a similar way, the other participant had used alcohol to help deal with loss of work, separation from his spouse, and financial problems.

Another example of impaired control, which was not uncommon, was described as “blacking out”. This involved loss of memory of the events that occurred following an episode of drug use. According to one participant, he blacked out after using a variety of drugs at a Friday night party. He recalled using cannabis, ecstasy, and alcohol early in the evening but had no recollection of any events that occurred later in the night or over the weekend. He woke up on the following Monday morning in a motel room with three other friends at a town approximately 200 kilometers from where the party was held. According to him, his friends were able to recall the events that took place during the weekend but he had no memory of what had occurred. Apparently, it was the first time he had lost his memory and he was deeply concerned about the experience. As he put it “It’s time to get out of this scene. Anything could happen to you when you get stuck into that mess of stuff [drugs]. You never know what could happen”. (FG)

Another participant described how he had been driving under the influence of a variety of drugs when he lost control of the vehicle and crashed it into a tree. He was unhurt, but two of the passengers were slightly injured and his best friend was killed. As illustrated in the following comment, he appeared to be profoundly shaken by the event, blamed himself for the death of his friend, and was determined to cease using drugs:

I didn't mean to hurt anyone. I know I shouldn't have been driving, but I had driven like that many times, and once you have the dope you just don't think. It's my fault. It's too late for him [friend], but it won't happen again. I'm giving up the drugs. When you are using

you have no control over things. Sometimes you think you have, but you really haven't. (FG)

Another participant, whilst under the influence of amphetamines, became involved in an argument with his wife and mother-in-law because they were attempting to remove his two young children from his house. He physically struck his mother-in-law, knocking her to the ground, and punched his father. He blamed his loss of control over his behaviour on the drugs he had been using. According to him:

R18: My wife had left the kids [one aged six years and one aged one year] with me in the morning. By the time she got back *I was totally out of it, and I didn't know what I was doing.* She [his wife] went away and came back with her mother and my father to try and get the kids off me. Well there was a lot of drama. I didn't want to lose the kids, I just wanted to keep them, to hang on. *I was totally out of it, and ended up pushing her mum on her arse, and things like that. My dad tried to intervene, and I shoved him and punched him on the mouth.* I didn't even know what I'd done until a week later, when I spoke to my wife, and she told me all about it, you know, what I'd done. I thought you're kidding, you know. That was it. I would never do such a thing if not on drugs. The stuff [amphetamines] does things to you, you know.

When asked "What things does it do to you?" he continued:

Well you know, you don't like someone arguing with you. Depending on whether you use speed [amphetamines] or heroin. If they try it on [argue] when you are on speed you are likely to hit them. On the other hand, if you're up on heroin, well you may just get annoyed, and hope it will all go away, but you won't hit anyone.

The aggressive behaviour associated with amphetamine use is well documented (West & Gossop, 1994). In this instance, it resulted in the participant losing control over his behaviour and losing out as a parent and a member of a family. His aggressive behaviour under the influence of drugs led to domestic violence, which resulted in his wife taking the children and going to live with her parents.

Others who had jobs had experienced impaired control in regard to their ability to abstain from drinking whilst at work. This is well illustrated in the following comments:

R7: I was drinking three cans of stout and three cans of beer a night, and some vodka. *That would get me through the night, and mostly through the next day.* By 5.30 though, as I was driving home from work, I would start to dry retch because I wanted a drink. I would then go through it again and I'm saying to myself "See I'm not really an alcoholic". On the weekend I would buy a bottle of vodka and completely iron myself out. Then try to sober up on Sunday night, and go to work next morning pale, sweating, with diarrhoea, saying I had a wog [illness] over the weekend. *But then it got so that I had to have something at work, just to keep going.*

The phrase "iron myself out" was used by many who were dependent on alcohol. Ironing out meant drinking to intoxication and commonly occurred at the weekends. Apparently, absence from work on the Monday following such behaviour was not unusual, nor for some was drinking whilst at work.

In summary, the use of psychoactive drugs had long occupied a central place in the life of these participants. This drug-related behaviour had been pursued to the extent that some of the participants had largely divested themselves of involvement in many other activities. Drug use was a contributing factor in some of the participants being unable to fulfil their roles at work or within their family structures. In one instance, it contributed to the death of a friend and in other cases to aggression towards members of their families. Losing out reflected disequilibrium associated with feelings of guilt, marginalisation, isolation and alienation from families, friends, and work places.

5.4: Fear of Death, Withdrawal Symptoms or Identity Change

A common aspect of Hitting the Wall was fear. There was strong evidence that most of the participants were fearful about aspects of their lives and about what might be likely to happen in the future if they persisted in their drug using

lifestyles. The main fears expressed in the data were of death, withdrawal symptoms, and identity change.

5.4.1: Fear of Death and Withdrawal Symptoms

Most of the participants who were injecting drug users knew of someone who had died from a drug overdose and some had friends who had died in that fashion. The following comments describe how some participants became involved in the death of a friend:

Well, one Friday night we scored some smack [heroin], and three of us went to a friend's place to hit up [inject]. We all had kits [injecting equipment], but we usually share the stuff, because we have been friends for years. (FG)

When asked if he was aware of the risks associated with such behaviour, he said:

Yeah, we all know. But we started using together, and if we were going to get anything like AIDS or the hepatitis thing, we would have it by now. Perhaps we already do. I've been tested for all those things since I've been in here, but the results are not back yet. Anyway, we usually only score from xxxx [dealer]. He's usually been straight with us, and the shit [heroin] has been OK, but I wouldn't share with anyone else. Anyway, after hitting up, we all sat around in the lounge for a while, and then we went to bed. That is all except xxxx who stayed up watching TV. She was still there *when we woke up in the morning, and when we looked at her she was dead*. We don't know when she died. It was like, God, what do we do now? We can't just leave her, so we called the ambulance and they called the police, and it was just awful. They [the ambulance crew] took her away, but the cops were all over the place and us, wanting to know if we had killed her, or whether she had suicided. But it was an accident, I don't know how it happened, because we all had the same amount of shit. Maybe she had some more and topped herself up after we went to bed, I just don't know. It could have been me. *I'm scared that more of us will die like that.* (FG)

The feelings of those who had been closely associated with these types of deaths are summarised in the following comment: "There's no fun in it any more.

It's a one-way street, and I don't want to end up [dead] down that track. There has to be something better for me". (FG)

The findings of a recent study undertaken in a methadone clinic indicated that overdosing, whether accidental or otherwise, among heroin users is not uncommon (Bartu, 1996). Of the 375 clients in the study, over 50% had overdosed at least once, and some had overdosed more than eleven times. In addition, over 90% knew someone who had overdosed, over 80% knew of someone who had died from an overdose, and approximately one third had been present when someone had overdosed on various drugs.

Other participants had actually attempted suicide, and were afraid that they would make another attempt if they did not make changes to their lifestyles. The following extract illustrates how this was experienced by some heroin users:

R27: *I ended up hating myself, and I tried to kill myself. I thought people don't need me around and I don't need myself. I couldn't see a future for me. I wasn't crying for help, you know, it was serious. I didn't telephone anybody, I did it on my own. I didn't ring people and threaten I was going to commit suicide, I just did it. I took enough drugs to probably kill someone else, but for some reason I just blacked out for a few hours, and then I woke up. I was really pissed off I woke up you know. I thought, "Oh shit this didn't work and I've blown \$500 because I didn't think I would wake up". I thought then, that maybe I shouldn't die, but in the state I was in I thought next time I will probably really do it. It's funny, I really wanted to die, but when I woke up I was afraid that I would kill myself, and I would never have another chance to straighten out my life.*

Overdosing on drugs was not restricted to heroin users and some participants were afraid that their drug use was leading to feelings of self-destruction, social isolation, and perhaps death. This is illustrated in the following comments:

R13: *I've actually died twice in the last twenty-one months. The first was accidental, as I forgot how many rohies [rohypnol] I had taken. The second time was quite intentional. I got a supply of rohies and serries [serepax] and took the lot. One of my neighbours sensed there was something wrong, and came and*

busted the door down. I didn't know anything about it. All I knew was I was in my flat one minute, and the next minute I woke up in an emergency section in a hospital. *I was so crazy at the time I abused the doctor for bringing me back to life, because I thought I didn't want to live anymore. I said "Go and attend to someone else".* I could see my tracksuit pants and my belongings in a nice little stack on a chair, so I just pulled out the drips and got up out of there and walked out. Just like that. *They said, "Let her go".* It was about 2 a.m. and I didn't see anyone. I just found the exit and walked home. The reason I came in here is I realise that I was becoming a very self-destructive person, and very isolated from other people. When I'm on drugs I just shut myself away, and drink and drink and take pills. The only time I go out is to get more drink and more pills. I don't eat, I just get depressed. I'm glad I didn't kill myself that time, but you know *if I don't get myself straightened out this time I'm scared I really could kill myself. Maybe that would be the best thing in the long run.*

Other participants with problems associated with alcohol use sought treatment because recollections of previous severe withdrawal symptoms made them fearful of the consequences of attempting to stop drinking without help. The comments of one serve to illustrate their experiences:

I knew I had to stop. I just couldn't go on drinking the way I was. I had to stop, but I couldn't do it alone. Last time I tried to detox myself at home. I didn't sleep for two nights because *I was scared my heart would stop beating.* I thought I was going to stop breathing because my throat was closing up. Then the sweats and the vomiting and diarrhoea started. I had the shakes and the hot and cold sweats. I didn't fit last time, but I have done before, and that's scary. *When you have been knocking it [alcohol] off as long as I have, you really need help when you try to stop.* (FG)

5.4.2: Fear of Identity Change

Some of the participants sought treatment because they were fearful their identity was changing or being threatened. A social identity represents an image that individuals have of themselves, as well as how others perceive them

(Biernacki, 1986). A social identity encompasses the past, but also contains a sense of the future in what people hope to be or are concerned about becoming. For example, one participant sought treatment because he had become dependent on pethidine. The drug had been prescribed for pain relief after major surgery for injuries sustained in a motor vehicle accident. A chronic pain victim, he had been injecting himself with pethidine four or five times a day for some months. As he described it:

R20: Every day you got up *you felt you were going to die*. You were just pushing that needle into parts of your body that couldn't accept it. My muscles were completely gone after that much medication went into it. But I was still pushing it into raw places, and the blood was pouring out of me, and I was disgusted with myself. I would look into the mirror and wonder what the hell had happened to me. I'm not a junkie. *I don't want to be identified in this way. I'm scared I will be though if I can't stop using.*

Some unemployed women who were single parents had been using amphetamine as a means of coping with parenting and financial and other problems. The functional benefits they obtained from amphetamine use is summarised in the following comments:

R21: It gives you the energy to keep going you know. You can do things real quick, and nothing is too much trouble. You can get everything done in a day and have time for the kids. I have three kids and they really keep me busy. I would never take the stuff [amphetamine] in front of them, but they are growing up and I don't want them to think of me as a drug user. I need to get off it.

R26: Speed [amphetamine] keeps you awake. I have a baby nine months old and the stuff has really kept me going all through the nights when she didn't sleep, when I had to be awake to see how she was and then keep awake when she woke up. It's getting easier now because she is mostly sleeping through the night and I can also get some sleep. I think now is a good time to get off the stuff, before I get really hooked on it. I've seen some people who

have stayed on the stuff for too long and they have changed completely. I don't want that to happen to me.

Another single mother, who thought that her drug use went unnoticed by her three-year-old child, came to the realisation that her behaviour could no longer be concealed from her daughter. As she described it, one day when she was "hanging out" (starting to withdraw) and her partner was out attempting to obtain supplies of amphetamines, the child went to the cupboard where she usually kept the drug and the injecting equipment, and said "Mummy, do you want your medicine?" The woman concerned said, "I felt ashamed. Then I got *scared* when I thought one day she would know what the stuff was. There is no way I want my child to see me as a junkie, I'm a good mother, so here I am" (R24).

It has been proposed that the psychological salience of role identities influences whether people appraise a stressor as a threat or a challenge (Thoits, 1995). According to Thoits, undesirable threats or stressors in the domain of salient identity are more likely than those in nonsalient domains to be appraised as threatening or psychologically harmful because they disrupt a valued aspect of the self. This participant (R24) obviously valued her role as a "good" mother. She viewed her daughter's awareness of the link between her condition when she was "hanging out" and her need for the drug as a stressor and potential threat to her salient identity of being a good mother. She was prepared to undergo detoxification to protect and validate this valued identity.

Some participants were fearful that the use of drugs was changing their personalities. Their perceptions of this change is summarised in the following extract:

R21: It's like different personalities. When the urge to have some takes over, you'd go to any extreme or do anything so you can have some, and that *turns you into a monster*. Then you have your other personality that is like your normal self. You look at what you're doing and you think it's disgusting. *I have seen what happens to people who have been using for years and it's frightening*. They really change, and I don't want to be like that. It's already starting to ruin my life, financially and otherwise, but I don't want it to change

me. I can maybe sort out the finances and stuff, but I don't want me to change.

For these individuals, the activities associated with their drug using lifestyle resulted in feelings of fear and disgust with their behaviour, as well as concern about potential changes to their personalities. They perceived this not solely as a threat to their identity, but to their integrity as a person.

Another example of fear was related to an episode of apparent inappropriate pain management following surgery. This was described as follows:

R13: I was in hospital for six weeks. I had three lots of pretty serious surgery and I lost a lot of internal bits and pieces. I was on pethidine in drip form for pain for six weeks. At the end of that, he [the doctor] just took out the drips. "You're cured", he said. "Just go home". I couldn't understand why after a couple of days I was really starting to feel dreadful. I just seemed to be out of it. *I was really scared. It was weird. I honestly thought I was going crazy because I was having these strange thought patterns.* I was shaking and I was feeling ill. Physically, I couldn't eat. I didn't know, I didn't make the connection [with the pethidine].

As described, this participant had undergone a series of major abdominal operations and had been administered pethidine for pain relief, on a regular basis, over a period of six weeks. Based on the evidence provided in the interview, there appeared to have been no attempt made by the medical or nursing staff to slowly decrease the use of the drug or to substitute a less addictive, non-narcotic drug for pethidine, or to provide any other means of pain relief. Nor was the participant informed of the possible outcome of abruptly ceasing a drug such as pethidine after prolonged use. She had not understood that the withdrawal symptoms she had obviously experienced were related to the pethidine she had been prescribed and had become fearful that she was losing her sanity.

5.5: Duress

Duress has been defined as "compulsion by use of force or threats" or "coercion" (Collins English Dictionary and Thesaurus, 1993). Duress was identified in the data as pressure brought by others on the participants concerned

to reduce or cease their drug use. The participants experienced duress from several sources: from the legal system, employers, and from partners or spouses.

5.5.1: Legal Duress

Several participants, for example, were undergoing detoxification because they had been directed to do so by local magistrates. This formed part of their pre-trial requirements before appearing in court on charges of drug-related crimes, such as possession of an illegal drug, dealing, or breaking and entering. The experience of one participant who was a user of heroin and amphetamines and who had been apprehended for dealing is illustrated in the following excerpt:

R24: I was doing really well. I had a job, earning \$700 a week, plus I was dealing. I could make up to maybe \$20,000 a week from that. I was using too, but I was still working and I had no problem with using the stuff [heroin]. In the end I got busted. The cops raided me one night when I had five packs of heroin sitting on the table, plus some coke [cocaine], and some LSD trips. I was narked [informed on]. I have a pretty good idea who did it, and I won't forget. I have heard that he has left the state, but if he comes back and I am out [of jail] we will have some settling to do. Mind you, I think he has narked on others and he may be attended to before I get an opportunity. *I wouldn't be here if I hadn't been busted.* I mean I was really doing OK.

Another who had been apprehended for unlawfully breaking and entering commented:

R25: I got to the stage where I was doing anything to get money for drugs. I have been using stuff [pills, speed, smack, coke, trips] for about eight years, and like it's a real expensive way to go. I would do anything, like stealing cars, safes, houses, and chemists, but *I only got caught for house breaking.* The fact that I had some stuff [cannabis and amphetamines] on me when the cops picked me up and searched me didn't help. *I might have come into a place like this eventually, you know, but I was not considering it before I got busted.*

If these participants had not been detained because of illegal, drug-related activities it is extremely unlikely that they would have voluntarily sought

treatment. Drug and alcohol offenders may be coerced into drug treatment in a variety of ways. This may occur after detection of an offence but before a person has been charged if police exercise their discretion not to charge an offender provided he or she agrees to enter treatment. This form of coercion is not usually favoured because it is not under judicial oversight and is open to abuse and corruption. Coercion into treatment may also occur after an offender has been charged and is being processed by the court. A court, for example, may look favourably upon enrolment in treatment as evidence of a desire to achieve abstinence and it may postpone adjudication until treatment has been completed, as happens in some American "drug courts" (General Accounting Office, 1995). This was the case for several of the participants in this study.

Concern has been expressed over the ethical issues of coercing offenders into treatment. These issues have been debated by members of the WHO (Porter, Arif, & Curran, 1986) and the consensus was that it was legally and ethically justified only if effective and human treatment was provided and the rights of the individuals were protected by "due process". One of the main justifications for drug treatment under duress or coercion is that the alcohol and drug dependence of some offenders contributes to the commission of the offences with which they had been charged or convicted. Treatment under coercion is said to be an effective way of treating their drug dependence and thereby reducing the likelihood of their re-offending (Inciardi & McBride, 1991). It is also less costly to treat them in the community than to incarcerate them (Gerstein & Harwood, 1990).

The causal connection between drug dependence and criminal offences is least contentious in the case of drink driving offences (Hall, Bell, & Carless, 1993). In these cases, driving with a blood alcohol level above the prescribed limit is defined as an offence. The causal connection between dependent heroin use and property crime is more tenuous. In comparison with estimates of heroin dependents in the Australian population of 0.4% to 0.7% (Hall, 1996), offenders who are heroin dependent make up from 18% to 23% of the prison population and hence are over represented in that environment (Stathis, Bertram, & Eyland, 1991). Heroin dependence, however, is not a direct cause of criminal activity

since it has been reported that most Australian heroin users commit criminal offences before they begin to use heroin (Hall et al., 1993). The most plausible argument for applying legal duress to drug offenders to enter treatment would appear to be

. . . . not that coercion may improve the results of treatment, but that treatment may improve the rather dismal record of plain coercion - particularly imprisonment - in reducing the level and intensity of criminal behaviour that ensues when the coercive grip is released.

(Gerstein & Harwood, 1990, p.11)

5.5.2: Employer Duress

Another example of duress was the ultimatums which were delivered by employers to participants whose loss of control over alcohol led to drinking whilst at work and deterioration in work performance. Some had been called to disciplinary interviews with their supervisors and instructed to "Get themselves sorted out" (FG). It had been made clear to them that if they did not enter treatment they could lose their jobs. The comments of R7 presented in the section on Impaired Control (6.3.2) serves to illustrate how drinking can come to pervade the workplace.

The participants who were in treatment because of duress from employers or the legal system had had their particular "wall" erected following a collision with other social worlds. Society divides into social worlds by virtue of people's definitions of who they are and what they do (Weiner, 1981). According to Strauss (1987), a social world is a community, which has activities, and organisations that support and further the activities of the particular world. Examples of social worlds include professional groups, ethnic and religious groups, sports teams, families, criminals, and the world of dependent drug users (particularly users of illicit drugs). The worlds vary in size, but each has common activities, understandings, and means of communication.

Individuals are not restricted to one social world, for example, as Strauss has pointed out, a woman can be a mother as well as a doctor or a judge. A policeman can be an active member of a sports club in his off-duty time, or an artist could be an active member of an environmental group. A person who

devotes a considerable amount of time to drinking or drugging, and shares in a world of drug users, may still be a part of the regular workforce. When the worlds overlap, however, and the activities which take place in one world commence to occur in another, such as drinking alcohol at work or committing a crime, the boundaries become blurred and the worlds collide. In these instances, as evidenced in the data obtained in this study, pressure to conform can be applied by such institutions as the legal system, as well as employers.

5.5.3: Partner Duress

Other participants entered treatment because their partners were threatening to end their relationships. According to one participant:

R9: *My life got harder to manage. The pressures, just silly things like cooking a meal. They became huge, enormous things. The man I live with said to me "You're killing yourself. I can't sit around any longer watching this. Its [drug use] got to stop or I'm leaving". I knew he meant it. He said, "You can't reduce yourself". So I had to come here. I knew once I got here I'd be alright, because you got the support you need with people [staff] that know what they are doing.*

This participant appeared to have little faith in mainstream health services being able to provide the care and support she believed she needed. As she described it:

I mean you could go to a hospital saying "Help me I'm a pill addict". They would probably put you to bed and say you've got a disease or something. They are not dispassionate but *they don't understand even though they might try to help you.* People like me [drug dependents] need the help you get in places like this.

Another participant described his partner's response to his continued drug use and drug seeking behaviour in the following comments:

R18: I was out of pills, and I said "Well I'm off to the doctors to get some more". She said "*You go and I'm leaving*". She had said that many times before and I brushed it off. But when I got back she was gone, with the kids and all the clothes and stuff. So I came in

here. I'm going to call her in a day or so and see if she will talk to me. She might have cooled down by then. When she hears I am really serious about getting off the stuff she might be ready to talk. I really hope so, because I don't want to lose them. I know this time she means it [leaving him]. This time I will really have to get off the stuff [drugs].

It has been suggested that few people come to treatment without being pressured by family, friends, or others (Hingston, Mangione, Meyers & Scotch, 1982; Room, 1987). This was supported in part in this study, as some of the participants sought treatment because of pressure from external sources, both formal and informal.

The formal sources of duress experienced by the participants originated from the world of the criminal justice system, as well as that of the workplace. Informal sources of duress came from non-drug using spouses or partners.

5.6: Summary

As a consequence of Hitting the Wall, the participants disengaged from the environments in which drug acquisition and drug use occurred, and an unacceptable level of disequilibrium was experienced, and sought professional assistance in a residential, combined medical detoxification unit. The sub-categories of Hitting the Wall were losing out; fear of discomfort, harm, death, or identity change, and duress.

The majority of the participants in this study had been using drugs for many years, and the problems associated with their particular drug use were generally long standing and cumulative. Most had become accustomed to dealing with these problems in their own way and did not see them as more than the normal inconveniences associated with maintaining a lifestyle focussed on the use of a variety of drugs. These problems were not perceived as a serious barrier to continued drug use, nor as reasons to change behaviour, until some event or experience (Hitting the Wall) stimulated thoughts of a need to seek treatment. In other words, disequilibrium had become intolerable.

Actions that once were considered appropriate or at least necessary to obtain drugs, such as doctor-shopping, dealing in drugs, or using drugs in a functional

manner to assist with parenting, became viewed as undesirable, as did the consequences of continuing to use drugs in the way to which they had become accustomed. One assumption that was rejected early in the analysis was that women drug users were dominated by their partners. It soon became evident that this was not the case. There was strong evidence that women actively sought drugs on their own account and in some cases directed their partners into procuring drugs for them. The majority of women (and men) actively pursued their drug using behaviour on their own account. They were concerned about the path their drug use was taking but did not lay the blame for this on their partner.

In some cases the “wall” was erected slowly and cumulatively, as when the effort required to obtain drugs and maintain drug use eventually became too great. Biernacki (1986) compares this to the phenomenon of burnout experienced by individuals working in high stress situations. If such individuals continue in the same work situation they may meet their obligations, but do so at less than optimal levels and with little enthusiasm. This was the case described by those who were spending most of their time obtaining drugs from dealers or doctors. For other participants, Hitting the Wall appeared to occur as a result of what, in reference to chronic illness, has been termed a “cumulative mess trajectory” (Strauss, Corbin, Fagerhaugh, et al., 1984, p. 141). This was evidenced by those who had lost their jobs and accumulated problems with relationships, finances, and work.

Some participants appeared to erect the wall themselves; others had the wall erected for them. In some cases, the wall arose from feelings of disgust at their behaviour and their opinion of the self underwent changes. This was well evidenced by the comments of the participant who became dependent on pethidine and had been injecting himself several times a day. In other instances, the wall was constructed quickly from an existential crisis that caused the participants to question their lifestyle. Examples of this were when one of the participants struck his mother-in-law, or for others, the threat of being abandoned by a significant other if changes in drug use were not made. For another participant, the crisis was being an intoxicated driver in a car crash that resulted in the death of a friend. In the case of the woman with a three-year-old daughter, the

realisation that the child was aware of her drug use led to her reappraising her role as a mother and the way she wished to be perceived by her daughter. Another example of an existential crisis on which the wall was erected was a participant experiencing severe, unanticipated, withdrawal symptoms from a medically prescribed opioid.

The sub-categories of Hitting the Wall provide indications of the lifestyles of the participants and the social worlds in which they interacted, and in some cases collided, before seeking treatment and which led them to treatment. In no instance did any of the participants interviewed seek treatment without Hitting the Wall. In other words, treatment was not sought until some factors, events, or epiphanies indicated that change was required. In each instance, an epiphanic moment of major, cumulative, illuminative, or relived variety was experienced. There was considerable variation in the type of wall described in the data. The experience of hitting it, however, was consistent and led the participants to engage in the process of Seeking Balance through Hanging In. During this process they entered into a treatment program designed to treat licit and illicit drug users which generated further problems which had to be dealt with. These were categorised as Incompatibility and are discussed in the next chapter.

CHAPTER 6

THE PROBLEM OF INCOMPATIBILITY

6.1: Introduction

As described in the previous chapter, in order to deal with the problems associated with Hitting the Wall and start to regain more balance in their lives, the participants in this study sought detoxification in a residential, medical, combined treatment unit for licit and illicit drug users. Whilst in the treatment unit the participants were confronted with more problems of disequilibrium that were subsumed under the category Incompatibility. The components of Incompatibility that were found to be problematic for the participants were related to the heterogeneity of the clients in the unit in terms of age, gender, the perceptions that users of certain drugs had of users of other drugs, perceptions of combined treatment, the language used by some of the illicit drug users, and the variation in the unpleasant sensations experienced by licit and illicit drug users. In addition, for many of the participants, the structure of the treatment program was incompatible with their individual needs and differences. This was particularly evident in the daily routine of the program and group therapy. The shared problem of Incompatibility and its components is described in this chapter.

6.2: Incompatibility

The most salient problem shared by the participants in this study, which was identified during the investigation of the interactions that occurred between the participants in the treatment unit, and the participants and staff, was conceptualised as Incompatibility. According to the Collins English Dictionary and Thesaurus (1993), incompatibility means “incapable of living or existing together harmoniously”, “apposed in nature or quality: inconsistent”. Incompatibility captured the sense of disequilibrium and the difficulties experienced by the participants undergoing detoxification in a combined treatment unit in close proximity to users of different drugs, with different agendas, and with different reasons for ceasing or suspending their drug use. The presence of clients who emphasised the positive effects of using drugs (mainly heroin) was unsettling

for the participants who appeared committed to changing their lifestyles. There was a notable lack of harmony among the participants that is reflected in the following extract:

R20: There are some that like to drug rave. They talk about how great it [heroin] is, how they are going to buy it, and different ways of giving it to themselves. I can't relate to that. I'm here to get myself sorted out, and I can do without that constant talk. *I'm different from them*, and I'm going to get myself straight. I'm here to get help to straighten myself up, not rave on about the stuff. I want to put that behind me and get on with life. *I don't want to mix with that lot, and I don't want them around me.* They're different and I'm going to have enough trouble without them in my face all day.

While some of the participants felt incompatible with other clients in the unit, others considered that they were incompatible with some of the components of the treatment program. One, which appeared to be problematic for many of the participants, was attending the self-help groups such as AA or NA. While attendance at these groups was not compulsory, it was strongly encouraged by the staff. The feelings of many of the participants about attending these groups is expressed in the following comments:

R6: *It's not for me.* You have to stand up and say that you're an alcoholic even if you haven't had a drink for years. Apart from your family, the only friends you end up having are people from AA. The only outings you go on are with those people, and you are always talking about this and that, or how many groups did you attend today. But if people are happy with that, I suppose it's OK. But you know *in many ways it's no different from the continual drug raves those junkies in here carry on with.*

The components of Incompatibility that the participants had to contend with during their stay in the detoxification unit were found to come from two main sources: the heterogeneous mix of clients in the combined treatment unit, and the structure of the treatment program. These are illustrated in Figure 8 and discussed below. Not all the participants had problems with all the components of Incompatibility discussed below. All the participants, however, experienced

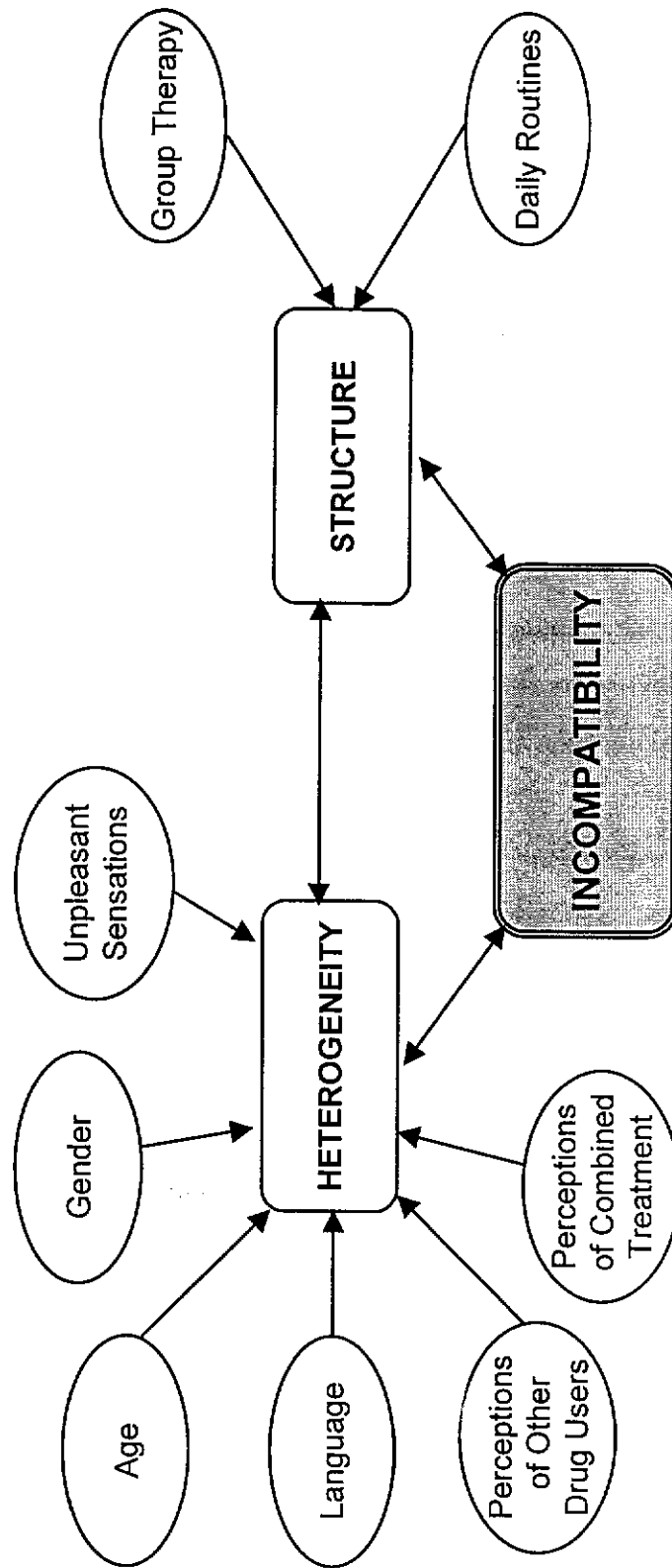


Figure 9: Components of Incompatibility

problems of Incompatibility with one or more of the characteristics of the clients or other components of the program.

6.3: Heterogeneity

The participants in the study were all dependent on, and had problems related to, the use of psychoactive drugs. Apart from this, there were considerable differences between them in terms of the type and patterns of drug use, lifestyles and other socio-demographic variables, as well as the type of wall they had collided with before they commenced the detoxification program, and these contributed to their experiences of Incompatibility. The characteristics of heterogeneity that were found to be particularly problematic for the participants during their stay in the unit were identified in the data as age, gender, the perceptions that users of certain drugs had of users of different drugs, their perceptions of combined treatment, language, and the variation in the unpleasant sensations experienced by the participants.

6.3.1: Age

One of the arguments against providing combined treatment services for licit and illicit drug users was based on the reported age differences between the two groups (George & Glatt, 1967; Pittman, 1967). That is, that illicit drug users are younger than licit drug users. According to Pittman (1988), it is difficult to provide programs that are therapeutic for both young, illicit drug users and older, licit drug users, because of age-grading and life experiences. The quantitative results presented in Chapter 4, Section 4.8 support the findings of the earlier studies in that one of the significant predictors of being an illicit drug users was being aged thirty-five years of age or younger. The reservations expressed by the above authors (George & Glatt, 1967; Pittman, 1967; 1988) about combined treatment, reflected the concerns of service providers. In this study, however, both licit and illicit drug users were concerned about the variation in the ages and drug-related experiences of the people in the unit. The concerns expressed were not related to service provision, however, but on the potential negative effect that exposure to older, more experienced drug users in a combined unit could have on

younger people, regardless of what drug or drugs they had been using. Hence the concerns expressed crossed the boundary between licit and illicit drug users. The concern of licit drug users regarding the exposure of a young person who was dependent on legally prescribed drugs to older, illicit drug users is well expressed in the following extract:

R2: There is one young lad in here at the moment. He became dependent on prescription drugs through a back injury. There are things that kid is learning here through listening to other drug addicts. He says, "Oh gosh, I didn't know you could do that". "Is that how it feels?" *It's a bad environment for him.* I sit here and I hear this kid listening to all these things, and I'm thinking he is going to get out of here and he will know it all [how to cut drugs, how to administer them, where to get them, and how to deal]. *Being in here is doing that kid more harm than good.*

As illustrated in the following comments, this concern was shared by other licit drug users about young illicit drug users:

R4: I mean those young heroin users might *pick up new tricks* they have never heard of. The type of people you have in this place could teach them any thing. What they didn't know about drugs when they came in here they would know before they go out. *It's not good for them.*

The possibility that experiencing detoxification in a combined unit could result in increased knowledge and skills regarding the use of drugs was acknowledged by the older, illicit drug users:

R11: If a 17-year-old came in here *I could teach him things he probably has never heard of like how to cut drugs.* When I say cut, I mean if I had an ounce of heroin I could make that into five ounces, and still make it seem alright. I don't say I would do that, but I could.

These participants were aware that exposing young drug users to older or more experienced drug users could expand their knowledge of drugs. It could also encourage their experimentation with different drugs and combinations of drugs, and increase their knowledge of the drug market. Some of the licit drug users

thought that young people used the differences in age as an excuse for leaving the unit before completing the program:

R12: I've noticed several young people [illicit drug users] who have come in here and said that they are leaving because the people are all geriatrics. Uh . . . but I don't know how much of that's *just an excuse or rationalisation to go back out again*.

The quantitative findings presented in Chapter 4, Table 6 indicates that illicit drug users were younger and more likely to drop-out out of treatment than licit drug users. Age differences appear to have been a contributing factor in some of the younger illicit drugs failing to complete the program.

One participant appeared to believe that, because of her age, she was perceived negatively by the others in the unit at that time. “You know I'm the oldest female here [43 years]. A lot of the clients think, sort of, well she's so much older, you know, *she should know better*” (R8). In contrast to the views presented above, a mixture of different age groups was seen by some as providing a sense of security. The following extract illustrated how this was perceived by some young amphetamine users: “The older people, the alcoholics, they give you that *sense of security* that like you are in a safe environment” (R15).

In summary, older clients in the unit, regardless of whether they were licit or illicit drug users, were concerned that the presence of younger drug users in the unit was potentially harmful. That is, the younger drug users could become more knowledgeable about procuring and using a variety of drugs. Some of the older drug users considered that younger drug users used the age differences as a pretext to leave the unit. Alternatively, some of the younger drug users found the presence of older drug users gave them a sense of security.

6.3.2: Gender

According to the National Institute on Drug Abuse (NIDA, 1989), approximately 75% of clients in substance abuse treatment programs in the United States were men. The predominance of men in comparison to women in alcohol treatment programs is even more marked in Australia. For example, in 1991,

women made up approximately 17% of the population in alcohol and other drug treatment programs (Webster & Jarvis, 1991). It was reported that, in Australian treatment services, women were significantly younger than men and more likely to receive outpatient care than men. They were also more likely to be treated for opioids or benzodiazepines than men (Webster & Jarvis, 1991). In the present study, of the 421 participants who completed the questionnaires, 25% were women. It has been suggested that women are under-represented in alcohol treatment programs (Vannicelli & Nash, 1984). In a review of the subjects of published alcohol treatment research between 1970 and 1984, it was reported that only 8% were women (Harrison & Belille, 1987). It has been noted that most alcohol and drug treatment programs have largely been developed by men, for men and continue to evolve, in part, on the findings of research studies done on male subjects (Copeland & Hall, 1995). The consequences for women entering substance abuse treatment services have been found to be more negative than for men (Beckman, 1984). The consequences include disruption of family relations, loneliness, lack of money, loss of job, avoidance by friends, and anger of spouse.

It has been suggested that women respond differently to group therapy (Cronkite & Moos, 1984; Jarvis, 1992). The explanations for this include: (a) groups are almost always composed largely of men; (b) the dynamics in such groups may be more favourable to men, and (c) women may respond more to individual social interaction than group involvement. In this study, women were at all times in the minority in group sessions. From data from participant observation and field notes, this did not appear to be major problem for the younger women. The older women, however, felt that some issues that were important to them could not be addressed in such forums, and their needs were incompatible with mixed group sessions. Their views about mixed gender groups are encapsulated in the following extract:

R2: We should have a group session for women, because *there are certain problems that a woman can't bring up in front of a man through embarrassment*. Well I know that is my case. Because of drug use there are certain problems you have. Part of my problem is that I'm going through menopause at the moment. Now I'm interested in that, but

you can't bring that up in a group session. So I think they should have a look at having *women only* group sessions, and men only sessions as well. Say just one session a week where it's just women, and they could talk about women's issues. I mean because menopause does affect a lot of things. There are so many issues that women go through that men don't. While you could talk to your own man about these issues, you certainly couldn't talk about them to strangers. *You want to talk about it, you know. About what your body is doing, what your hormones are doing.* How it [menopause] stops your periods, how it brings about depression, and how it turns you off sexually. *It's something that's not discussed, you know.* It's just like, the staff they don't know about things like that, because they don't ask. So people just think well, I can't say that, or they'll think I'm a weirdo.

According to Reed (1987), mixed gender treatment services should at least incorporate an approach that is oriented towards women. This would involve taking into consideration women's need to be responsive to social relationships, women's socialisation and role in society, suppression of sexual harassment, and addressing the specific treatment issues of women. Among these issues are reproductive health and sexual problems (Gomberg, 1993). For example, alcohol use during pregnancy can contribute to the Foetal Alcohol Syndrome or foetal alcohol effects. The use of other drugs such as heroin during pregnancy may induce neonatal withdrawal symptoms after birth. The social stigma ascribed to women with drinking problems also has been commented on by several researchers (Cronkite & Moos, 1984; Gomberg, 1988; Pemberton, 1967).

The general perceptions of mothers who use illicit drugs, such as heroin or cocaine, are even more negative (Taylor, 1993). These mothers have been portrayed as sexually promiscuous, lacking maternal instincts, uncontrollable, and a risk to their children. The women who use these drugs are stigmatized, not only because they use heroin or other illicit drugs, but also because they are regarded as lacking socially proscribed feminine characteristics in regard to children and childcare. According to Goffman (1963), a person considered to be stigmatized is regarded as blemished and may be disqualified from full social acceptance. During the study period, several single parent mothers with young children were

admitted to the unit. The following extract summarises some of the comments that other participants made to these mothers:

R22 They [other participants] say to me, "How could you use those drugs? *You have young children. What are you doing to them?*" I don't say anything, but I'm here to really get off the stuff [heroin] this time. I know it's no good. I don't want my kids to suffer because of my drug use. I want them to be straight, and enjoy their life and get a good education. They are really very bright.

This mother appeared to hold her children in high regard. She wanted them to avoid using drugs, and was attempting to change her lifestyle to prevent her children being exposed to any negative consequences from her drug using behaviour. While most of the male participants disapproved of women using drugs, particularly if they had young children, they appeared to be reassured by the presence of women in the unit. The following extracts illustrate how the presence of women was viewed by some of the men:

R5: I believe men and women should be mixed, because *it gives us that balance*. Because a lot of us have huge problems with relations. Addicts with problems relating to alcoholics, alcoholics with problems related to females, and females relating to males. *So putting us together helps keep the pressure down. It's like a pressure cooker effect*, it's sort of puts the lid on feelings, whereas if they're all men together you can end up having a fight. Because the women are there, well sort of, there is enough respect left in us to say we won't do that because there are women here. It just has a balancing effect.

R11: It's good to have the girls to talk to, because they know more about aspects of life, like parenting and self-control. *Women have a lot more self-control than men have.*

When asked to elaborate, the above participant continued:

Well, how often do you see women fighting? How often do you see men fighting? Women can usually come up with an answer that you'll want to listen to. *I think it's good to have women in here.*

Most of the male participants had strong positive views about the benefits of women being in the unit. They appeared to believe that women had more control over their behaviour than men, and that their presence had a modifying effect on men's behaviour, that is, that the presence of women would minimize the possibility of physical violence between men. On the other hand, they strongly disapproved of women who used alcohol or other drugs, at least to the extent that they required treatment in a detoxification unit.

6.3.3: Perceptions of Users of Different Drugs

As discussed in Chapter Three, grounded theory is based on symbolic interactionism. One of the main premises of symbolic interactionism is that the worlds of human beings are made up of objects (Blumer, 1969). An object can be physical (a tree or a chair), social (a person, a group), or it can be abstract (a philosophical doctrine, moral principles). The meanings given to objects are social creations that are formed in the process of definition and interpretation that takes place during interaction with people. These meanings guide the way people interact with the objects concerned (Blumer, 1969). In the world of the combined medical detoxification unit in which this study was conducted, some of the most important "objects" with whom the participants interacted were the other clients in treatment at the time. From the data it was evident that users of licit drugs had negative views about users of illicit drugs, and users of illicit drugs had strong views about users of licit drugs. These perceptions contributed to the lack of harmony that was so evident in the unit in the early part of the study.

Some of the participants whose main drug was alcohol clearly viewed those whose main drug was either heroin or amphetamines as considerably different from themselves. The comment of one participant serves to summarise how the licit drug users perceived the illicit drug users in the unit. "We call the others [illicit drug users] '*space cadets*' because 99% of the druggies are not on the planet anyway" (R1). Other licit drug users believed that heroin and amphetamine users were thieves who had to steal to obtain money to sustain their drug use, and that they could not be trusted. As one participant expressed it: "I would *never trust a drug addict*. From what the guys [heroin users] themselves

tell me they steal to get their money” (R3). Some of the participants whose main drug was alcohol had strong views about what sanctions should be applied to those who used illicit drugs, particularly those who marketed these substances. This is well illustrated in the following comments:

R9: Now I never had anything to do with drugs in my life. I am an alcoholic. I am talking about drugs as I know them, which is needles and so forth. What I am saying is that *they [illicit drug users] should be shot or drowned, especially the pushers. That's hypocritical but that's just how I feel.* They shouldn't be out in the community pushing the drugs. At the least they should be locked up for good.

Other licit drug users questioned the motivation of illicit drug users to abstain from drugs, as well as the reason they were in treatment. They appeared to think that illicit drug users lacked credibility in regard to their commitment to change their lifestyles. These perceptions are illustrated by the comments expressed by the following participant:

R14: I just couldn't sort of accept the drug addicts. They all seem to be only interested in how much they are spending on their dope. *I don't believe they want to stop using. I don't know why they are in here.* And I don't believe that they were spending the money they claim to have. *They seem to think that the more they spend on dope the smarter they are.*

Users of heroin had alternative views of themselves. Tajfel (1974) described a theory of intergroup relations and suggested that when members of a group interact with members of another group they compare themselves on a number of valued dimensions with the other group. The theory is based on a proposed sequence that involves social categorisation, social identity, social comparison, and psychological distinctiveness. People's membership in various social categories or groups of people and the value they attach to that membership, whether in positive or negative terms, is defined as their social identity and forms part of their self-concept. Social identity, however, acquires meaning by comparison with other groups. Intergroup social comparisons encourage members

to view their own group as psychologically distinct and more favourable than other groups. In other words, group members search for certain characteristics or qualities of their own group, which allow them to assume a positive social identity and differentiate themselves favourably from another group. This appeared to be the case for heroin users in this study. Contrary to the perception held by licit drug users, they perceived themselves to be intelligent, sensitive, caring and supportive towards each other:

R2: Among ourselves we know we are *very sensitive people*. I've never met a junkie [heroin user] that wasn't *intelligent*. You know junkies just don't have the energy to be violent. Most of them use drugs for a numbness process. To blot out the world and forget their problems.

R22: We [heroin users] are fairly placid people. We hurt easily, and *we are very caring people*. When we come in here we tend to sort of feel for each other, and support each other. We don't try to knock each other down.

Apart from the legal status of illicit drugs, the mode of administration appeared to be a matter of concern for licit drug users. While alcohol is almost invariably ingested orally, other drugs can be consumed in a variety of ways such as snorting, smoking, sniffing, and injecting. Smoking heroin appears to be a recent phenomenon in Australia (Maher, 1996), and has been associated mainly with Indo-Chinese heroin users. Anglo-Australians, when they do smoke heroin, often combine the drug with cannabis (Maher & Swift, 1997). In this study, all the participants whose main drug was heroin or amphetamines were injecting drug users. These participants generally felt that those whose main drug was alcohol were uncomfortable about being in the same unit with them. The following extract reflects their feelings:

R21: When they [alcoholics] hear what you lived like with all the heavy stuff [stealing, dealing etc.] and shooting up, they say, "*Ooh, how could you do it?*" I suppose it's *like when you go into prison or something and you're just a thief and you're mixing with murderers. Maybe that's how they feel about us.*

Some of the participants who were heroin users considered that the licit drug users did not understand the problems and health risks associated with injecting drugs. “Alcoholics *don't seem to understand the problems of junkies sharing needles* and that sort of thing” (R15). They, the illicit drug users, appeared to believe that licit drug users were wary about having contact with them. They ascribed this to the illegal status of heroin and amphetamines and the criminal behaviour frequently associated with the use of these drugs, particularly heroin. According to Frieberg (1997), between two and three billion dollars worth of property is stolen from homes, shops, cars, factories and other places in Australia each year. It is difficult to determine how much of this is attributable to heroin users. Research undertaken in Australia (Dobinson & Ward, 1985) and overseas (Grapendaal, Leuw, & Nelen, 1995), however, suggests that most dependent heroin users engage in theft and resale of stolen property to support their drug use. For example, in a recent study conducted in Sydney it was reported that 70% of the sample derived a portion of their income from property crime, 70% had income from dealing in drugs, 59% had some form of legitimate income, and 9% had income from prostitution (Maher, Dixon, Lynskey, & Hall, 1998).

Heroin users also thought that many of the licit drug users were concerned that they could be exposed to blood borne viruses, such as AIDS or hepatitis C, through contact with illicit drug users. As reported in Chapter 4, Section 4.6, almost 40% of those who had completed a questionnaire had injected drugs, and of these approximately 30% had never shared injecting equipment. Sharing injecting equipment is one of the main risk factors in the transmission of blood borne viruses. While the prevalence of HIV among injecting drug users is relatively low (1.6%), the prevalence of hepatitis C is 60% (National Centre in HIV Epidemiology and Clinical research, 1997). Hence the likelihood that those who had shared injecting equipment had been exposed to, and were perhaps positive for, hepatitis C was high. How heroin users perceived the way licit drug users viewed them is summarised in the comments below:

R2: *They think we are all criminals because you know its [heroin] an illegal drug and we have to steal to get our drugs. They are scared they will get AIDS from us. You know, they think that we're just dirty junkies. They think*

that drug addicts are people who sit in toilets injecting needles and different sorts of drugs. We are not all like that, anymore than alcoholics are homeless drunks.

There was a common perception among the participants who were heroin users that those whose main drug was alcohol had sustained a considerable amount of brain damage as a result of their drinking. As one participant commented: "They don't seem to want to grasp the problem. A lot of *their brains seem to be more destroyed than ours are*" (R10). There was considerable support for this view of alcohol dependents among heroin users, many of whom considered that the brain damage was irreversible. "Some I've met in here now, the alcohol addicts or alcoholics, they seem irreparable. *Their brains are too far gone to recover*" (R22).

Some of the participants whose main drug was amphetamines were apprehensive about communicating with other amphetamine users. They also had negative views of heroin users. These views added to the lack of harmony and incompatibility between users of different drug types. The amphetamine users were concerned about possible violence if they entered into discussions with other amphetamine users. They also appeared to have a low opinion of heroin users and preferred to avoid interacting with them. They preferred to interact with people whose main drug was alcohol because they thought that such people would be willing to listen to them. They also appeared to believe that people whose main drug was alcohol had short-term memory impairment, hence they would be unable to recall their conversations. These perceptions are well encapsulated in the following extract:

R11: *Heroin users, they are really low people. I don't talk to them. When you need someone to talk to you can't go and talk to another speedhead [amphetamine user] because they end up arguing schizophrenic gutter to each other and killing each other practically. But if I go and talk to an alcoholic they will sit down and listen to me, whereas a speedhead would keep butting in. Like they would just keep annoying me and it would get to the point where we would end up fighting. Like with say alcoholics, some of these people's bones are still floating from it, they take that much of it. The speedheads take that into consideration*

too, and that's why they go and talk to them because they will sit there and listen. Even though they are not really listening. *You have got to talk to someone, and you talk to these people who are going to forget it two minutes later.* It's out in the open, you have told your story, and you feel better for yourself. *What's more you can tell them again the next day because they don't remember and they still listen.*

Chronic, heavy alcohol use has been reported to increase the likelihood of brain injury by increasing capillary fragility, altering blood clotting mechanisms, and reducing blood pressure thereby reducing the oxygen supply to the brain (Fals-Stewart, Schafer, Lucente, Rustine, & Brown, 1994). The result can be diffuse cortical damage, particularly in the frontal lobes (Goldman, 1990; Fals-Stewart et al., 1994). The incidence of brain damage, that is diffuse cerebral and cerebellar atrophy and ventricular enlargement, has been estimated to be approximately 50-60% (Wilkinson, 1982). The Wernicke-Korsakoff syndrome associated with thiamine (vitamin B1) deficiency has been detected in 12.5% of alcoholics at post-mortem (Torvic, Lindboe, & Rogde, 1982).

According to Grant (1987), although alcoholics process single, simple perceptual elements normally, they have difficulty organizing such elements into a meaningful whole and logical memory visual reproduction is adversely affected. Profound memory deficits have been detected among alcoholics suffering from Korsakoff's psychosis (Walsh, 1985). The symptoms related to this condition include difficulty in learning new things, poor spontaneous recall, and the timing of remembered events might be lost. That is, individuals may remember what happened, but they may not know when it happened. These individuals may have no difficulty with speech, language, and activities of daily living unless in an unfamiliar environment. Individuals are generally unaware of their condition and are more likely to deny that they had been given information than acknowledge that the material had been forgotten (Walsh, 1985). It has been suggested that the above memory problems represent the far end of a continuum of memory deficits which may not be independent of other types of intellectual functioning (Bowden, 1990).

To what extent the individuals referred to by the above participant, R11, were suffering from the Wernike-Korsakoff syndrome is unknown. From conversations with the staff it was established that no person in the unit at that particular time had been diagnosed as such and the memory deficits which were viewed so favourably by this participant may have been due to other factors.

The perceptions of different drugs and drug users expressed by the participants appeared to reflect, to a large extent, those of the wider population towards alcohol and narcotic users. These have been traced to the attitudes towards drinking which emerged from the role that alcohol filled in colonial times in Australia (Powell, 1988). For example, the "work and bust" tradition of itinerant bush workers: the shearers, drovers, stockmen, miners, and others who worked in the outback. The bust refers to a drunken binge, usually in a town, at the end of a period of hard, physical work in the bush. During the bust, the payment received for labour was spent on alcohol. Once the money was expended, the individuals concerned usually returned to work in the bush. This type of behaviour was seen largely as a male activity and masculinity was directly related to an individual's capacity to drink large quantities of alcohol (NHMRC, 1987).

Traditionally, drinking has been viewed as being done by "real men" who were strong, capable, and able to hold their liquor. Drinking together reinforced the idea of mateship, which was viewed as a commitment to mutual, egalitarian relationships among groups drawn together by work, sports, or other activities such as the wars of the twentieth century (Lewis, 1992). Alcohol is used ritually in religious ceremonies, in national, community and family celebrations, on sporting occasions, and other social functions. With the exception of caffeine, it is regarded as the main social drug in Australia (Henry-Edwards & Pols, 1991).

In contrast to alcohol, views of narcotics have changed considerably in the past 150 years. In the first half of the nineteenth century, opiates and opiate derivatives were widely available and used. Most of the use was in the form of quasi-medicinal patent medications to treat a range of conditions from headaches, abdominal pain, joint pain, and insomnia to consumption. By the beginning of the twentieth century, this availability was restricted. According to McCoy (1980), the reduction in the availability of patent medicines containing opiates, and in

many cases alcohol, must be viewed against the growing professional power of doctors and pharmacists in the latter part of the nineteenth century. The services offered by doctors and pharmacists were in competition with a variety of accepted ways of treating illnesses. These included traditional "folk remedies" for many conditions and the use of patent medicine for self-medication. The attacks on the patent medicine industry, particularly for the use of dangerous ingredients, secrecy, and dishonest advertising, were long and involved. The outcome was that pharmacists acquired the right to dispense and doctors the monopoly of prescribing narcotic and other drugs (McCoy, 1980).

Manderson (1987) argued that the prohibitions imposed on opium and opium derivatives were economic and racist in origin. In the latter part of the last century the consumption of opium in the form of medicinal preparations was widely accepted in the community. Opium smoking as a social problem was, however, associated with the Chinese immigrants who provided a source of cheap labour in the settlements. These immigrants were initially attracted to the country by the gold rushes of the nineteenth century, and when the industry slumped the Chinese miners and fossickers sought alternative employment on the labour market. Chinese workers began to compete with white labour and, as they were prepared to work for lower wages than their white counterparts, were undermining white labour rates. The Chinese community was a minority and opium smoking was regarded as a deviant behaviour practiced by a small proportion of the population. Their drug taking was formally defined as criminal and perceived by many as immoral (Manderson, 1987).

A number of myths influenced the debate on drugs other than alcohol. These myths were that drugs destroy personal control, that all heroin users are addicts, that drug use leads to violent crime, that drugs are only used by deviants, and that the laws prohibiting use are sufficient to prevent the non-medical use of drugs (Manderson, 1987). Society was, and is, much more tolerant about the use of licit drugs such as alcohol, than the use of heroin, amphetamines, or other illicit drugs. The use of illicit drugs, particularly those which are commonly injected, has been identified as a major risk factor in the transmission of blood borne viruses such as HIV and hepatitis C, which have far-reaching health consequences (Kaldor et al.,

1993). Today, not only are illicit drug users regarded as deviant, they are viewed as a threat to public health. The perceptions of the wider society in regard to licit and illicit drug users were reflected among the participants in the study. This is well illustrated in the following comments:

R13: We have *preconceived ideas about junkies*, like they all shoot up, and they are all criminals. The same as the addicts think about alcoholics: the park bench drunk. Just generally what society believes about the two different groups.

6.3.4: Perceptions of Combined Treatment

The participants' perceptions of combined treatment varied considerably. Many of the participants interviewed in the early part of the study had strong, negative opinions about being in a combined program. These views appeared to be based on the perceptions that users of licit drugs had very different lifestyles to users of illicit drugs, had different personalities, and consequently had little in common. These views were expressed by both licit and illicit drug users, and are well portrayed in the following extract:

R2: The fact that alcoholics and opiate users are in here together is *not a good concept*. For a start they tend to lead different lifestyles. They tend to be totally different personalities. I mean both groups are dependent on substances, but there is a hell of a difference. Alcoholics and drug addicts *don't have a lot in common*, they don't identify. It [combined treatment] is not a good mixture. They should have different counsellors that have experience with drug users and experience with alcoholics. Because, as I've said, *they are two different personality types*.

Some of the participants who were heroin users considered that combined treatment could be effective for users of different drugs, provided that those dependent on amphetamines and cocaine were excluded from the program.

R4: *The two definitely don't mix together*. If someone is an alcoholic as well as an injecting drug user then he would be able to relate to both parties. That would be the only way they could mix, in my opinion. I think the

heroin addicts and alcohol and benzo addicts would probably be okay together. But I'd definitely *segregate the cocaine users and the speed users*. Because if it was just the speedheads here there would be *schizophrenic paranoia*. *A bunch of speedos would be at each others throats most of the time*. *Aggression would be on the menu every day, all day*.

While separation by drug type was suggested by some participants, others thought that clients in the unit should be segregated according to the severity of their withdrawal symptoms. Their views are summarised in the following extract:

R10: I saw very, very sick people coming in here. You know, people with alcohol problems that have lost control of their bowels, and can barely speak or walk. I looked around and thought to myself, this is sort of like a hospital now, not a specialist drug unit. If it is to be a unit for alcoholics and drug addicts it should be *two separate wings, like in a hospital, you know*. *Like a ward where they put very sick people and one where they put the not so sick*. I think it's too much to have all these people in together. *Both lots miss out in many ways*. *The ones who are not really too sick miss out because the nurses are having to look after the sick ones, and the sick ones miss out too, because the nurses are having to give some attention to the others*. *You should definitely put the sick ones in a ward by themselves*.

Other participants, mainly alcohol dependents, had alternative views on combined treatment. They appeared to believe that it had benefits for the participants, but was difficult for the staff to deliver because of the demands made on them by those dependent on heroin and amphetamines. "It's a *good idea* to have them all in. But it's hard on the staff. *The junkies are always at them for something*" (R7). As the study progressed, the views of the participants regarding combined treatment became much more positive. The differences between licit and illicit drug users in terms of lifestyles and personalities that were evident in the early data were minimised, and the similarities between users of different drug types was emphasised. This is illustrated in the following comments:

R6: It is not all alcoholics in here now. There are some who are speed freaks, and two of the girls are on heroin. The ones on alcohol, you know, I can talk to them more than the speed freaks, they are not with it. The girls are alright. I find it very comfortable, and all the people have much the same problem, only with different drugs. People with alcohol problems, people who have been using intravenous drugs, people on pills and some who say they have taken everything. But *they all have much the same problems*, and they have much the same treatment.

R20: So maybe it's good for people with different problems to be in together. It doesn't matter where we come from, *we are all offenders, we have all stuffed up. We have all done things we shouldn't, and have all hurt people we care about.* None of us would be in here if we hadn't. We've all got problems and in many ways they are not so different. *I think it is good to have everyone in together.*

The other benefits attributed by licit drug users to combined treatment were that it minimised the focus on drugs in conversations, and exposed illicit drug users to the duration and severity of the withdrawal symptoms experienced by many of the licit drug users. This is illustrated in the following comments:

R17: I think the mix here is good, because you know, both alcoholics and drug addicts are not always talking about drugs. When you have both lots *it breaks it up a bit because the druggies can see that they're not the only ones with problems. We all have problems and we [licit drug users] are a lot sicker than them, and it takes a lot longer for us to get well.*

In general, most of the negative opinions of combined treatment were obtained from participants interviewed in the early part of the study. At that time, the workload of the staff was perceived by the participants, and observed by the researcher, to be particularly heavy. The participants interviewed in the latter part, when the conditions of overcrowding and lack of resources had been somewhat addressed, appeared to be much more tolerant of combined treatment. The majority interviewed at that time considered that the benefits outweighed any

negative aspects of providing the same treatment to both licit and illicit drug users.

6.3.5: Language

The language used by illicit drug users was, at times, a cause of concern for licit drug users. According to Atkinson (1992), language describes the boundaries and perspectives of a cultural system and reflects how social life is represented within that system. Language acts as a filter on perceptions that largely acquire meaning through being rooted in specific verbal networks. It has been suggested that the majority of meanings are conveyed nonverbally and the meanings from actual words account for only a relatively small proportion of communications. According to Leach (1976), body language and distance between the people involved in the communication are organised in patterned sets, similar to how words are organised in language. The type of language used by illicit drug users was, at times, a source of irritation to the licit drug users. “The drug talk . . . it goes on and on. It’s all street talk and I can’t relate to that. They all talk gibberish” (R9). The following extracts illustrate the effect that this had on some of the participants:

- R1: The *constant moaning* about it [drugs], well, that becomes an irritant. That’s all the junkies can talk about. They have no other conversation. It’s all drugs, drugs, drugs. I don’t know what they do in their lives, but *it doesn’t seem as if they have anything else to do but get stuck into drugs*. When there is a bunch of them together, that’s all they talk about. At least with us [alcohol dependents] we can talk about the football, the weather or some other thing. We don’t go around saying, “The beer or the wine is good in this or that pub”. We don’t go on about how much we spend on wine or such, or how we can water it down and sell it off. *The junkies just never shut up about it*.
- R8: *They talk about how much money they spend on drugs, and what drugs they use*. There seems to be gains in how much they can take, and how much they can spend on drugs. I don’t want to be involved in that but you hear it all the time. Heroin users seem to want to *talk about drugs, or talk unintelligent*.

The unintelligent talk included words such as "blap" (injecting), "quick" and "zip" for amphetamines, and "hammer" for heroin. Other words used were "snow cones" (heroin mixed with cannabis in a foil and smoked), "caps" (a measure of heroin), "half weights" (half a measure of heroin), "the white" (heroin), "fits" (injecting equipment), "scoring" (obtaining heroin), "hanging out" (starting to withdraw from heroin), and "shooting or taste galleries" (places or spaces where people gather to inject drugs), "breaks" (burglaries), "smashed" (high on heroin), and "drop" (overdose). It has been reported that drug users converse in "metaphoric language and coin words that do not mean anything to people who do not belong to their culture" (Manwar, Johnson & Dunlap, 1994, p. 291). It has been suggested that ". . . words are not maps of reality. Rather, words gain their meaning in social exchange within the language games of the culture" (Gerber, 1991, p. 102). The language used by illicit drug users emphasized the different lifestyles of licit and illicit drug users and also highlighted the salience of drug use in their lives. In reference to two clients who had left the unit prematurely against advice, one participant commented:

R12: We all feel it's better they went because they *talked incessantly about drugs*, mainly heroin and speed [amphetamines] you know. They never talked of anything else. It was all they cared about. They never talked about things like their family, or things like the weather, you know. Just drugs, drugs, and more drugs.

In response to a query about what it feels like to have to listen to such talk, this participant said:

I feel it is a waste. You spend your whole time sitting out on the verandah listening to long tales of death, drugging, and destruction, hour after hour. They call them *drug raves or drugathons*. You know, all about drugs, where you can buy them, how you can use them and who is using what drug. *I don't need that in my life.*

Others commented that when illicit drug users were engaging in "drug raves" they only discussed the benefits of using drugs. They associated this behaviour with a

lack of motivation to stop using drugs, and this was unsettling for those who genuinely wished to change their behaviour.

R15: They [illicit drug users] *don't want to give up*. They just keep talking about it, and talking about the good sides of drugs. If it's so good I don't know why they have come in here. This place should be for those who really want to get their act together. Not those who can't stop talking about how good it is.

Some participants were of the opinion that illicit drug users were so involved in using drugs that they had no other topic of conversation. They also questioned their reason for being in the unit. This is summarised in the following comment:

R17: The bad thing with all [illicit] drug users is that they start talking about drugs. It's like they have nothing else to talk about. *They might as well not come in here. They should stay with their mates and just keep talking about drugs. It's all they want to do, anyway.*

Other participants considered that the conversations related to illicit drug use (particularly heroin) were used to emphasize that illicit drug users, when compared with licit drug users, were clever and enterprising. The following extract illustrates this opinion:

R20: There are some that like to drug rave. They talk about how great it is, how they are going to buy it, and different ways of giving it to themselves. I can't relate to that. I'm here to get myself sorted out, and I can do without that constant talk. *It's like they talk like that to show how smart they are.* How they can get drugs anywhere. They're not smart, if they were they wouldn't be in here. They would have got their act together and not need to be in here. Just listening to them, though they don't really want to stop using drugs. They just want to keep on with it. If these people come in, they should have a separate place. They don't belong with people who are really trying to do something about their problems. *That drug talk, it's not smart, it's just weird, but it's all that lot [heroin users] think about.*

According to the theory of speech accommodation (Giles, Bourhis, & Taylor, 1977), people are motivated to adjust their speech styles as a means of expressing

values, attitudes, and intentions towards others. People will reduce language dissimilarities between themselves and others if they desire their approval and wish to mix with them. If they wish to increase communicative distance they will maintain their speech style and emphasize it in interactions with others. The use of words that had no meaning, except in communication with current users of similar drugs, served to emphasize the separateness of heroin and amphetamine users from those whose main drug was alcohol or tranquilizers. According to one participant, "They [illicit drug users] segregated themselves in one corner, and they wouldn't say hello to anybody else" (R14).

This was supported by observation in the unit. When four or five (or more) illicit drug users were in the unit at any one time, they tended to group together during breaks in the program. This was particularly evident during morning and afternoon tea. They generally separated themselves at one end of the activity area, and the conversation inevitably became focussed on some form of acquiring, dealing, and using drugs, mainly heroin or amphetamines. They discussed who had been busted (arrested by the police), who had a good, reliable supply of drugs, which nightclub was under surveillance by the police, and whether the stuff (usually heroin) on the streets was "good" or "bad". The definition of "good" or "bad" was apparently related to the relative purity of the heroin, that is, to what extent it had been adulterated with other substances.

Other drug-related topics discussed included who had gone interstate seeking better drug deals and who was contemplating visiting South East Asia in the near future. In regard to the latter, it was speculated if the person concerned did go, whether or not they would try to bring a quantity of heroin with them when they returned to Australia. On one occasion, the conversation was focussed on a person who was known to two of the heroin dependents and who had been arrested in Thailand for possession of heroin. On contemplating the future of this person, one of them commented, "It's tough shit getting caught there. They don't stuff around. You could go down [imprisoned] for a long time if the Thais get their hands on you".

The problems with language and separateness discussed above were not observed when there were less than four or five illicit drug users in the unit. At

these times, the illicit drug users appeared to mix fairly well with users of other drugs and the division between the groups was not so apparent. If illicit drug users had conversations between themselves about aspects of drug use, they did so in a manner that could not be perceived as a “rave” and did not appear to be a source of concern to the other participants. It was notable that the language used by licit drug users in relation to their particular drug or mode of use did not appear to be a problem for illicit drug users.

Language was a source of reinforcement for illicit drug users and a source of irritation and concern for licit drug users. The use of the type of language used by illicit drug users was viewed by licit drug users as a means of emphasizing the differences between the two groups. Licit drug users considered that the use of language in this way, by illicit drug users, had a negative influence on the participants who were making a serious attempt to change their lifestyles. It was one of the main reasons that the licit drug users strongly supported separate programs for the two groups.

The heterogeneity of the participants was evident in the variation in ages, gender differences, and the type of drug(s) used. The differences in drug use were reinforced by the stereotypical views that users of certain drugs had of users of other drugs, and the language used by illicit drug users. These factors contributed to the disequilibrium among the participants and were major components of the problem of Incompatibility.

6.3.6: Unpleasant Sensations

The unpleasant sensations were the withdrawal symptoms experienced when the participants, who were all dependent on alcohol or other drugs, suddenly ceased or dramatically reduced the use of the substance or substances concerned. The participants who were withdrawing from drugs such as heroin, amphetamines, alcohol, or LSD completely ceased the use of their particular drug or drugs once they were admitted to the unit. The withdrawal symptoms associated with these drugs were ameliorated by the use of medications such as benzodiazepines, clonidine, and others. For those dependent on benzodiazepines, however, the medication regime was the continued use of benzodiazepines, albeit on reduced

doses titrated to the severity of the symptoms experienced by the individual concerned. The sensations associated with withdrawal from alcohol and other drug use were not wholly physical. While the physical sensations were relatively severe for some, many considered that the emotional and mental sensations they experienced were worse than the physical ones. There was a wide range in the intensity of the sensations experienced that emphasised the heterogeneity of the participants and contributed to the overall problem of disequilibrium, as well as aspects of Incompatibility.

6.3.6.1: Physical and Emotional Sensations

The most common physical symptoms experienced were elevated blood pressure, vomiting and diarrhoea, muscular cramps, hot and cold flushes, and fatigue. The elevated blood pressure frequently associated with withdrawal from alcohol was of particular concern to the staff and required frequent observations and monitoring by the nurses for the first forty-eight hours. The experience of those with elevated blood pressure is summarised in the following excerpt:

R5: The nurses came around every two hours to check my blood pressure. They were really concerned because *my blood pressure was sky high*. So was my heart rate. I was nauseated, vomiting and had diarrhoea. I don't know what would have happened if I hadn't got in here. *I was really sick*.

Nausea and vomiting was a common experience described by participants withdrawing from alcohol, many of whom had sustained a considerable amount of physical damage as a result of their drinking behaviour. Differences were observed between the symptoms experienced by the users of different types of drugs. For instance, the unpleasant, physical symptoms experienced by heroin users are described in the following comments:

R17: *You get cramps. You get leg and stomach pains, hot and cold flushes. You get really cold. It's what they call cold turkey. But it's like a cold from the inside, you know what I mean. No matter what you do you can't get warm. It's like having a fever or*

something. You get a runny nose and diarrhoea like the 'flu. Yeah, it's quite painful.

R23: I was just so restless. I couldn't read, couldn't concentrate. *The first two days were just hell.* I was so *depressed* I just cried and cried. My eyes were all swollen, and my nose was running constantly. *Every nerve hurt.* Even my skin hurt and all my joints, and I had goose flesh all over. Every bit of me was cold. I was so out of it *I couldn't walk straight.* They give you clonidine here and some valium, but it doesn't help much.

The symptoms associated with withdrawal from heroin are often dismissed as being no more than a rather bad attack of influenza. Up to a point, the comparison is a useful one as the external symptoms are similar in both conditions. People who use heroin regularly, however, have diminished bowel activity and chronic constipation. When heroin use is ceased the bowel activity will start to return to normal functioning. This is an uncomfortable experience that ranges from a general abdominal ache to severe abdominal cramping. This is usually followed by diarrhoea that may last for two or three days.

The symptoms experienced by participants withdrawing from methadone appeared to be more intense than those experienced by people withdrawing from heroin. Though both drugs are opioids, heroin has a relatively short half-life of four to five hours. In contrast, methadone is a long acting synthetic opioid with a half-life of approximately 24-26 hours (Ward, Mattick, & Hall, 1992), and the unpleasant sensations associated with withdrawing from this drug appeared to be more protracted and severe than those related to heroin. The following comments serve to illustrate the symptoms experienced by several participants whose main drug was methadone:

R6: *I had these bad stomach cramps, and I couldn't sleep. When I did I had nightmares, really horrible ones. After six nights of this I was really sick. Tired out and fed up and aching all over. With heroin it's quick. It's all over in a few days. But with methadone it just keeps going on and on.*

In a recent study which compared the withdrawal responses from two groups, one undergoing withdrawal from heroin and one from methadone, the results indicated that, while there were no statistically significant differences between the two groups in regard to the onset and duration of withdrawal symptoms, the methadone group had more severe symptoms (Gossop & Strang, 1991).

The unpleasant physical sensations associated with benzodiazepine withdrawal included deficits in sleep, taste, and appetite. The following comments demonstrate how these sensations were experienced:

R10: *I got this funny taste in my mouth, like nothing tasted right, not even water. I couldn't sleep, and it's not much better now. I don't know what it is, but it's like everything tastes like cotton wool, and I just can't eat.*

Not all the participants withdrawing from benzodiazepines experienced these sensations. For some, the main sensations were being emotionally labile and having feelings of disequilibrium and disembodiment, or being disconnected to body parts. These feelings are well illustrated in the following extracts:

R8: *I am constantly emotional. I feel like I am swaying all the time. Even my voice sounds different to me. I started to speak the other night and I looked around and thought who was that? It was me. It was really weird.*

R9: *I feel I have been chopped around in little pieces and they haven't come back together yet. My stomach is not right. I still don't know if anything will stay down or not. I'm not really hungry, but I know I need something, but I don't know what. It's like not quite being all-together yet.*

Fatigue was a common complaint from participants who had been using amphetamines. This was described as follows:

R21: *I was tired mainly. Really washed out. All I could do was sleep all day and night. I was very lethargic, and no get up and go. It [amphetamines]*

makes you stay awake and not eat. So towards the end [before Hitting the Wall] I was going with, like two nights sleep a week. Sleeping and eating, that's all I do now.

6.3.6.2: Psychological Sensations

Paranoia was mentioned consistently as being one of the main psychological feelings related to withdrawing from amphetamines, and was frequently associated with anger and depression. This combination of sensations was summed up as “You feel *jaggly*, you know” (R11). When asked what this meant, the participant continued:

It's not a word, it's a feeling, real paranoia. You feel real angry, real agitated, you hate everything, and you want to kill everyone. I would go to bed and I'd wake up, and still feel tired, and then I'd become agitated, and really angry, and then I'd get depressed.

Depression was a major factor for users of all drugs, but the association with paranoia was particularly evident in those who had been using amphetamines. As another participant described it “It's the depression. I just cry through it. I do that and think everyone is talking about me. It's just complete and utter paranoia” (R19).

Other participants were more distressed about memory deficits and thought processes than depression and paranoia, and talked of being in a mental fog. As illustrated in the following comments, these mental deficits were a cause for considerable concern:

R2: *My memory is shot. I mean I keep losing things. I put all my gear away when I came in here, but I went to change my clothes and didn't know where I'd put anything. It just seems all fogged out, you know. It's an awful feeling.*

R18: *You're thinking, but your thinking is all muddled. That means you can't even get to a point to sort things out. It's a horrible feeling. You don't know what you're doing from one minute to the next.*

For some participants, the inability to think clearly appeared to interfere with their ability to obtain assistance when needed. It was observed that the staff frequently engaged in conversation with the participants, socialised with them in coffee breaks, and asked how they felt and if there was anything they required. The thought deficits experienced by some, however, prevented them from making their needs known. This is well illustrated in the following comment:

R19: I knew people were here to help me, and I wanted that help, but *I couldn't get my head together to think*. I couldn't say what I wanted. *My thoughts were a mess*. It's a terrible feeling. They [staff] would come and talk to me, and ask me if I was alright, or if I needed anything, but I couldn't tell them, even though I knew I needed something.

Among the symptoms reported in the literature as features of withdrawal from amphetamines are fatigue, irritability, restlessness, lack of energy, apathy, depression, difficulty concentrating, anxiety, weakness, muscle cramps, increased appetite, tremors, and hallucinations (Topp, Mattick, & Lovibond, 1995). Most of these symptoms were experienced by the participants in this study. The main exception was auditory and/or visual hallucinations. None of the participants in this study experienced these sensations, though from conversations with the nursing staff it was revealed that hallucinations, while not common, were not rare. Most of the nurses could recall caring for people experiencing hallucinations, and were willing to discuss the interventions they employed. These consisted of constant observation, reassurance, and sedation with medications to control for violent movements.

The most common symptoms experienced by the participants in this study who were withdrawing from amphetamines were fatigue, depression, irritability, and problems with memory and concentration. All participants, regardless of which drugs they had been using, experienced some degree of unpleasant physical sensations as well as a considerable amount of psychological distress that many considered to be worse than the physical symptoms. The following comment serves as an example of how the mental symptoms were perceived: "Physically

it's really bad, but the mental pain is the worst. That can drive some people to suicide" (R25).

6.3.6.3: Variations in unpleasant sensations

There were considerable variations in the severity of the withdrawal sensations observed and described by the participants. Those whose main drug was alcohol had the most intense physical symptoms; those whose main drug was heroin had least intense physical symptoms. Alternatively, those whose main drug was amphetamines or heroin appeared to have more intense mental symptoms than those experiencing detoxification from other drugs. Intensity of unpleasant sensations varied within users of the same drugs and between users of different drug types. In other words, while alcohol dependents appeared to experience the most intense unpleasant sensations, not all alcohol dependent individuals experienced the same degree of intensity of symptomatology. The same situation was evident with users of other types of psychoactive drugs. Though a number of medications were used to ameliorate the symptoms of withdrawal, some participants were clearly more ill and uncomfortable than others. As illustrated in the following comments, the variations in the unpleasant sensations experienced by users of different drugs were obvious to the participants:

R6: *Some of the alcohol people, they are really sick, you know.* They had one on his bed for three days with a drip in his arm. Then they sent him off to hospital and we didn't see him again. He was just too sick to be in here, and the nurses had to help him with everything, even to the toilet.

Many illicit drug users, who had no real problem with alcohol, appeared to have little knowledge of the effects of alcohol on the body, and observing people withdrawing from alcohol had increased their awareness of the physical harm associated with the use of this drug. The following extracts show how they perceived the physical consequences of alcohol related withdrawal symptoms:

R10: *The people who drink, they are sick.* At least when you are coming off pills you can still wash and dress

and organise yourself. But some people on alcohol, they just can't do things for themselves, you know.

R12: *It's a real eye-opener for people who have only used speed or something. The other drugs, like alcohol, they really make you sick for days. The nurses really have to look after them. You know, the alcoholics just can't even walk properly.*

The difference in the duration of the withdrawal symptoms associated with different drugs was also noticed, and many of the illicit drug users appeared to think that some of the people dependent on alcohol were likely to have poor outcomes. This is well portrayed in the following comment:

R8: *With booze and tablets it's a longer recovery. When I was on other things [heroin] it wasn't as long. With heroin, and also speed, it takes only a few days. Well, mentally not, but physically yes. After a few days, you're alright. With pills it can take up to six weeks before they are out of your system. Heroin doesn't stay in the body so long so physically you can get better quicker. With alcohol, well some of them will never get it all back together, not their brains as well.*

As presented in Chapter 4, Table 3, the level of dependence on various drugs was assessed as being either moderate or high. Despite this finding, not all the withdrawal symptoms reported in the literature as being associated with sudden abstinence from various drugs were experienced by the participants in this study. It is relevant to note, however, that several people were transferred to a general hospital because their condition had deteriorated to a level that could not be managed with the resources in the unit. It is possible that at least some of these clients had manifestations of extremely severe withdrawal symptoms that were not observed in this study.

6.3.6.4: Clicking Back

Analysis of the data revealed that the worst of the unpleasant feelings experienced as a consequence of suddenly abstaining from drugs in the main

usually diminished within a few days. While some sensations, such as sleep deficits, and in some cases flash backs, were likely to be experienced for weeks or months, in general, by the third or fourth day it was obvious that most of the participants were much improved physically. This, however, varied considerably from individual to individual according to what variety of drug(s) they had been using, the frequency of use, and their general physical health. Once they had experienced a few days of abstinence, their basic dietary deficits had been addressed, and their blood pressure and other physical symptoms had subsided, they became more able to be involved in other aspects of the program.

Clicking Back was an “in vivo” term used by some participants to describe the feelings experienced when the more acute unpleasant sensations they had been exposed to had subsided. The term was used by the researcher as it encapsulated the feelings expressed by the participants as their general condition improved. Clicking Back was conceptualised as a time of increasing physical wellness and alertness. Almost all of the participants had been using alcohol or other drugs on a daily basis for weeks or months (see Chapter 4, Table 2), and Clicking Back to a relatively drug-free state was a novel experience. Not all recovered at the same rate, however, and the heterogeneity of the participants in regard to Clicking Back was marked. The feelings expressed by many of the participants in reference to this are expressed in the following comments:

R10: *I'm feeling much more alive. It's like I have just come out of a deep sleep. You know, I'm waking up, I've seen my daughter in here, and I've looked at her and thought "Wow!" You know it's like I've seen her for the first time and she is three years old. I think, "Where was I for the last eighteen months?"*

Other participants related their experience to their cognitive and physical sensations. This is well described in the following extracts:

R6: *I'm coming out of it slowly. I'm not vomiting or sick. At the moment I am feeling fairly comfortable and am starting to eat. I am getting on fairly well with most people, and can talk to most of them. But I still feel really shaky inside, you know.*

R12: For me *its like a cloud cover lifting from the back of my eyes*. Well the chemicals you use, they distort your thoughts and you can't think clearly. Because you need your drug so bad that's the only thing you think about, and other thoughts are clouded over. These thoughts are now coming back, and I am starting to really think again.

R13: *I feel every day things are clicking back into place*. I'm feeling much better, but I still have trouble walking, and the doctor said that would get better eventually. I've never had that before, you know. Apart from that, I don't feel too bad. I can eat and I'm sleeping better and I feel that my strength is slowly coming back.

This participant (R13) had a considerable amount of physical damage, including peripheral neuropathy, which was a direct result of heavy alcohol consumption over many years. Consequently, walking was a difficult and uncomfortable exercise for him at this time. While most of the more severe physical symptoms passed relatively quickly, many of the participants remained relatively unwell in this phase. For some, even the act of actually looking at themselves in a mirror without being affected by various drugs was uncomfortable. As the following extract illustrates, some even found regarding their reflected image frightening.

R14: Before I would look in the mirror to shave, but I wouldn't really be looking for the real me. *Now I see myself and it's frightening. I can't believe that I really look like this*. I used to be well, you know, fairly well groomed. Now I look like one of those ads you see of park bench bums.

Other participants felt depressed and scared during this phase. These feelings are well captured in the comments below:

R15: All those feelings that were hidden through the drugs *they all come back to you in one big Ker-bang. It's frightening*. I don't know what's going to happen to me, but I've just about stuffed up my life. I don't know if I can get it back together. *I feel*

depressed and scared. It's going to be a long, hard slog, and there's not much light at the end of the tunnel. Those problems that made me come in here are still with me, you know. They're with you all the time. They just don't go away because you come into a place like this. Don't get me wrong, this place is OK. I really needed to come in here. But I've got a lot of work to do, and this is just a start.

R16: I'm halfway there. I don't laugh at the moment. I'm starting to hurt a little. *I think it is the program that makes you think, and it's quite horrifying.* You start to think about the things you've done, the people you've let down and hurt. I've got nothing to laugh about yet. . . . it's going to be a long time before I can laugh again.

When their acute withdrawal sensations had subsided, the participants were becoming more aware of the physical and emotional consequences of their drug focused lifestyles. For the majority, Clicking Back was not a comfortable or pleasurable experience. The participants were emotionally unstable and depressed about their recent drug related behaviours, and in a sense were confronting again aspects of the "wall" that had led them to treatment.

While the participants were experiencing their more acute withdrawal sensations, they were in a relatively subordinate relationship with the health professionals in the unit. Once they began Clicking Back, however, the relationship shifted to a more horizontal plane and they began to take a more active part in the other therapeutic activities of the treatment program, such as group therapy.

In summary, the aspects of heterogeneity that were problematic for the participants were age, gender, perceptions of users of different drugs, perceptions of combined treatment, and unpleasant sensations. The heterogeneity of the participants was further emphasised by the variation in the unpleasant sensations and the timing and extent of Clicking Back. All of these aspects of heterogeneity contributed to the problem of Incompatibility as it influenced the participants ability to become fully engaged in counselling and group therapy.

6.4: Structural Incompatibility

All health care programs function under organisational routines or structures that determine how they can operate. These dictate to a large extent what clients and staff should be doing at different times during the day, as well as on different days throughout their stay in the program. These routines are designed by the staff to facilitate and expedite the smooth functioning of programs. In other words, programs are designed and clients are fitted into the various therapeutic activities and routines. Clients enter established programs and are expected to comply with the routines, rules, time schedules, and other activities associated with existing programs.

Structural Incompatibility refers to the degree of divergence many of the participants experienced with the regime of the treatment program of the combined detoxification unit in which this study was undertaken. One aspect of the program that some participants had difficulty with was the daily schedule that in many instances was incongruent with the participants' accustomed patterns of daily living. Another aspect that was found to contribute to incompatibility was involvement in group therapy. In many cases this was required of them before the participants had recovered sufficiently to benefit from any of the sessions. The way these problems were experienced is discussed below.

6.4.1: Daily routine

The daily patterns and routines of any health care program are designed to deal with, and care for, relatively large numbers of clients. People's daily living patterns, however, are very individualistic. Some people are "morning people" who rise early and accomplish their most productive work before noon. These people often retire to bed early in the evening. Others can be perceived as "night people" and retire to bed relatively late and rise late. They achieve their most productive output in the afternoon or evening, and often work late into the night. With reference to hospitals, it has been stated that

Diagnostic and treatment activities, along with nursing care and food service, are woven into an intense program for each patient, geared to the efficiency of the system, with little consideration of the temporal pattern of the person who is the recipient of these services.

(Newman, 1994, p. 53)

This applied equally well to the situation in the unit. The majority of participants were “night people” and were accustomed to rising late in the morning. The detoxification program was organised around a fairly strict timetable to which clients were expected to adhere once their physical withdrawal symptoms had subsided. A typical day in the unit involved showering at around 7 a.m., followed by a walk and breakfast around 8 a.m. After this, the clients were expected to tidy their rooms and attend their medical or counselling appointments. The first group session of the day was held from 10 a.m. to 11.30 a.m., following which lunch was served at approximately 12 m.d. During the afternoons there were more counselling sessions and, where possible, outings were organised to introduce people to leisure activities. Dinner was served at 6 p.m., after which there was another group session, usually AA or NA. Following this, the participants were expected to complete their homework and retire by about 10.30 p.m. Medications were administered at set times, and laboratory tests were performed as ordered by the medical officer.

Participants took part in this routine according to how the staff assessed their functional abilities. For example, those with severe withdrawal symptoms were often cared for in bed for one to three days. This was frequently the case for those who were experiencing detoxification from alcohol as the withdrawal symptoms from this drug appeared to be more acute than those associated with other drugs. As the participants' physical condition improved, generally by the third day, they were expected to be involved in other activities such as group therapy and outings. The daily routine of the unit commenced at approximately 7 a. m. This schedule was quite acceptable to clients with morning rhythms of living; for others it presented problems. The following example illustrates what can happen when an individual's rhythm of living conflicts with that imposed by the routine on the unit.

James (pseudonym) had been a polydrug user for several years, though his preferred drug was heroin. For several months, he had been working as a waiter in a nightclub. He enjoyed the work as it afforded him a regular income and provided him with an avenue for profitable, opportunistic dealing in heroin and other drugs with the club's patrons. As the club did not close until 2 a.m., he was seldom in bed before 3 a.m., and was accustomed to rise sometime in the mid afternoon. For the first two to three days after admission he was allowed to remain resting in bed and his behaviour was considered unproblematic. Following this, he was expected to rise early and conform to the other aspects of the routine in the unit.

When this occurred, he became very uncooperative. He was reluctant to get out of bed, and the staff were obliged to personally ensure that he did get up, shower, and take part in the daily early morning walk. He was verbally abusive and frequently threatened to discharge himself. The staff objected to the abuse and to having to take time to enforce conformity at the busy period of change of shift and handover from night staff to day staff. In addition, he was observed dozing in group sessions, not contributing to any of the discussions, and was unwilling to retire at night at the designated time. The staff rapidly became exasperated with his behaviour, and he was labeled "disruptive" and "uncommitted to change". The question of whether or not he should be prematurely discharged was raised at clinical meetings and seriously debated. He did complete the program, but refused the option of an appointment at the outpatient clinic for follow-up support.

The above incidents can be viewed as an example of the negative interactions that can occur between staff and participants when individualistic rhythms of daily living come in conflict with the logistic demands of service delivery. Participants were expected to be compliant with established practices, and when someone did not comply, staff would attempt to ensure that the person concerned adhered to the routine. If the person concerned persisted in non-compliant behaviour, they could acquire a reputation for non-participation, which could be passed on through informal and formal channels to other staff members. The inability of the program to accommodate individual differences in regard to accustomed patterns

of daily living was evident and formed part of the problem with which the participant had to deal.

6.4.2: Group Therapy

Group therapy, like many other caring techniques, has evolved as a way of helping, supporting, teaching, or ameliorating the condition of those who, for whatever reasons, find difficulty in coping with themselves or those parts of society with which they are in contact (Douglas, 1993). One of the main ways they work is by providing opportunities for disseminating stories of experiences that have the benefit of being relevant and based on real life events. There is some comfort to be derived from the realisation that others are equally in need of help to deal with problems or difficulties in their lives (Douglas, 1993). Group therapy has been said to be appropriate for the population in short-stay detoxification facilities provided it is non-confrontational (Powell, 1992).

In this setting, after the participants had been in the unit for two or three days they were expected to attend a variety of groups. Among these were self-help groups and the groups run by the staff in the unit. Attendance at the self-help groups was strongly recommended but voluntary; attendance at the latter groups was compulsory. Nevertheless, not all the participants were fully recovered or comfortable participating in the groups, and this exacerbated the problem of Incompatibility with which they had to deal.

6.4.2.1: Self-help Groups

Attendance at self-help groups such as AA and NA was encouraged by the staff on the unit. The groups were held each morning, on alternate days, from 9 a.m. to 10 a.m. Though the groups were ostensibly designed for either alcoholics or narcotic users, it was observed that it was not uncommon for people coming off a range of drugs to attend either or both groups. As evidenced in the data presented below, there was considerable variation in the way the participants viewed these self-help groups, and some found them incompatible with their philosophy and needs:

- R1: *AA works for some people, but not others. I don't think a lot of people go for that higher power stuff. If it's one thing most of us have learnt it's that we have to help ourselves.*
- R4: *I don't agree with AA or NA. I agree with their program, the Twelve Steps, I certainly do. But I believe AA and NA both together replace one addiction with another. Now I believe an addict or an alcoholic, whichever way you want to put it, needs to find a balance in their life. I don't see how you can find a balance if your whole life centers on AA or NA. To me that is not a balanced lifestyle.*

Others found attendance at AA meetings beneficial. They liked the accessibility of the meetings that not only took place in the unit, but were widely available throughout the metropolitan area, and the fact that they could share their problems with people who had “ . . . been there and done that” (R22). Others saw it as a source of insurance, which they could invest time in, and would be able to draw on if the need arose in the future. Several participants saw attendance as a way of socialising after discharge. As one participant expressed it: “It will give me something to do. I will meet people with much the same problems as me, people who will understand” (R19). Several others commented on the support they could find in AA. They viewed the meetings as forums at which they could discuss issues related to drinking and their lifestyle issues in an emotionally supportive, non-judgmental environment. Others found comfort in the structure of the “12 steps” and reliance on a “higher power”. As one participant put it: “I know I have no control over drinking. If I am ever to get away from the drink, I will need God’s help. There is no way I can do it alone” (R9).

Despite the reservations expressed by some participants, attendance at the self-help groups was encouraged by staff as they served as an introduction to follow-up support. In many parts of the state, professional expertise in addictions is not available, and AA is the only form of support readily accessible to any drug user who resides rural and remote areas.

6.4.2.2: Staff Groups

Though all groups were part of the overall program, those run by the nurses on the morning shift were specifically designed to support the treatment philosophy

espoused by the unit. They were scheduled to commence at 10.30 a.m. and ran for an hour or an hour and a half. Because of the transitory nature of the population, the membership of the groups changed constantly, with some members ceasing to attend because they had completed the program, and others joining as they were assessed as being well enough to be involved. Group relationships were fleeting, and members seemed to be important to each other only in so far as they helped individuals to learn about themselves through sharing experiences and feelings in the group discussions.

The role of the group leaders in the nurse therapist groups appeared to be to facilitate discussion and provide brief interpretive or directive input, usually towards the end of each group session. In addition, they were required to provide specialist information, particularly in the alcohol and drug education groups, and the groups related to harm minimization. These groups were concerned with such topics as drug interactions, the effects of drugs on the body, the consequences of risk-taking behaviour such as unsafe sex and sharing injecting equipment, and relapse prevention.

The expertise of the group leader needed to be firmly based on knowledge of the adaptation of groups and group processes, and a critical awareness of the condition of the group members. In addition, the group leader had to be skilled in managing the interactions within the group and holding together appropriate group structures. Hence, the way the group was designed, conducted, and the discussion targeted was obviously very important. It was also evident that frequently the participants were not well enough to fully comprehend the material presented. According to one participant, "What is being taught or lectured on is not being absorbed" (R9). The effect on some participants when the information presented was at an inappropriate level for their level of recovery is summarised in the following extract:

R10: You go into group and you get some sort of basic exercise that involves using your brain. When it hasn't been exercised for so long it is very threatening and very hard. It can be a negative experience. I am not ready for that yet. I didn't want to go to the group, but they [staff] insisted. *I knew I wasn't ready, but I had to go.*

From participant observation it appeared that, at times, the material presented was mainly derived from the literature, and assumed a degree of basic literacy and knowledge on the part of the participants. For some members of the group it was, at times, obviously too theoretically orientated. It also appeared that the group leaders assumed that all participants in a particular group were cognitively well enough to take advantage of the content presented. In many instances this did not appear to be the case, and some of participants were involved in complex group therapy before they were able to be fully engaged. It was not uncommon for the routine of the program to take precedence over individual differences. This negatively affected the participant's experience in the unit, and added to the problem of Incompatibility.

Congruent with the social learning model of addictive behaviour adopted in the unit, there was an emphasis on education, social coping, and problem solving. Discussions in the group often focussed on relapse prevention, particularly on identifying situations of high risk of alcohol or other drug use, strategies for avoidance or minimizing these risks and other related harms, and the costs and benefits of continuing to use alcohol and/or other drugs at hazardous or harmful levels. An example of the latter is illustrated in the following extract:

R11: In today's group we all wrote on a piece of paper about *what's going to happen when we get out of here if we use again, and what will happen if we don't use again*. Like we wrote down all the negatives and the positives. We came up with some beauties. Most people went from, you know, as soon as they get out they will have a blap [injection of heroin], and they will feel good immediately. Like Wow! I needed that. Then soon it would be Oh shit! I'm getting back into my old habits again, a vicious circle. *Then they wrote they would get depressed and paranoid and eventually most people wrote death*. On the positive side we wrote what we thought would happen if we stopped using. Like our health would come back, and we would be able to get our lives together and really do something.

6.4.2.3: Verbal Skills

Group work is fundamentally a verbal process. Members of a group are expected to share their experiences and feelings with other members, and this is

done largely through verbal communication. As illustrated in the following extracts, not all the participants were comfortable about this component of the program:

R9: It's very hard for me. A lot of people find it very easy. They talk their life away, and they just love it. But I feel *intimidated*. *I'm going over it and I'm very nervous* and I don't usually get nervous over how I feel.

R12: In groups, the first thing is that *I will definitely withdraw*. *I will definitely not say things* that I would say if I was familiar with the people I was with. I just don't like talking about things that are very personal to me with all those other people.

Individuals who have difficulty articulating their opinions and thoughts are not as likely to profit from groups as those who can express their views fluently. If a person is not verbally oriented or inclined, or is shy or withdrawn, interaction in groups can be uncomfortable or painful. Many of the participants had difficulty expressing their views and feelings, and were nervous and anxious about having to be involved in group interactions. Attendance at these groups was compulsory, but the involvement of those with poor verbal or interpersonal skills appeared to be very limited.

6.4.2.4: Size of Groups

Another factor which was found to affect the interactions in groups was the size of the groups. The number of people in a group has a strong influence on how a group will function, and how it will benefit members (Douglas, 1993). For facilitators or group leaders, small groups may be easier to work with, but members miss the stimulation that larger numbers can provide. While it is recognized that size is important to optimize the potential of groups, there is no agreement on what are ideal numbers. In reference to focus groups, Patton (1990) recommends no more than eight members at any one time. Whether the same limitation is applicable to other groups is not clear, but the number of participants in the groups, particularly those conducted by the nurses, frequently exceeded this

recommendation. The following extracts serve to illustrate some of the problems experienced by the participants in a large group:

R5: Sometimes it tends to develop into a *bit of a riot* where everybody's talking over the top of each other and *tensions go up, and anxiety levels go up*. Then anger sets in and people storm off and you can see them stomping round the backyard for half an hour till they cool down.

R10: The groups are a lot bigger than before. There are too many aspects for the staff to cover. They do their best, but it's *just too much*. *The staff just can't get around it all*.

R12: The groups- well they're *hard on everyone*. The staff have their work cut out to keep them on track. It's hard on us too, when there are too many (in group). Like the last three days there have been fifteen or sixteen of us in group. If everyone gets to talk it takes too long, and people go off on a tangent, and *we never finish what was started*.

A large group has more resources in the form of members than a small group, but is more difficult to guide, and there is more scope for individuals to avoid participation if they so choose (Douglas, 1993). When asked if everyone actually got to talk in the large groups the above participant (R12) continued:

Well I don't, and many of the others don't either. *When it's like that [with too many in the group] it is no use whatsoever*. Before there were only eight or ten in a group and that was much better. Now there are too many.

It was evident from data obtained from interviews and participant observation in the groups, that large groups posed problems for the group facilitator and did not meet the needs of many of the participants. Moreover, it appeared to be difficult to control or predict group sizes as the mix of clients and their progress through detoxification varied considerably.

6.4.2.5: Combined Groups

One of the underlying assumptions of group composition is that as a starting point, members share a common problem (Douglas, 1993). Membership removes the sense of uniqueness that any individual may possess about their situation and problem. The discovery that others have the same problem or similar problems has the potential to generate a sense of relief that they are not alone. It may also help in considering possible coping strategies based on first hand, personal experiences of others who have dealt with similar and even worse situations.

One of the main aims of therapy in the combined unit was to stress the similarity of alcohol and other drug-related problems, and to normalize the concept of addiction. In the groups, addiction was presented as something that a person depended on, and could not do without. The examples used to illustrate this were breathing or eating, both of which are essential to sustain life. It was emphasized that everyone is addicted to something, and that while the substance or activity that a person was addicted to might be different, the similarities in the types of problems experienced when giving up an addiction were greater than the differences. From observational and interview data it was evident that not all the participants agreed with this view. As reflected in the following extracts, many commented on aspects of incompatibility between the sub-groups:

R2: There are an *awful lot of conflicting issues* that arise when we have group therapy that don't apply to alcoholics and drug addicts together.

When asked what these were, this participant continued:

Well, most of *their [heroin users] issues relate to crime*. They are forever going on about what they did, how much money they spent on getting the stuff [heroin], and what a lot of it they had been using. *Alcoholics now, they don't have these problems*, and I for one don't want to listen to them.

R3: In group, one minute you're talking about a drug addiction, and next about an alcohol addiction. Even though it's all an addiction, *they are not the same*. I think the groups should be taken separately.

While prepared to acknowledge that alcoholics and other drug users were all addicted to substances, the participants were well aware that the problems associated with the use of licit and illicit drugs differed considerably. These differences related to a large extent to the legal status of the drugs, the lifestyles of the two groups, and were such that some participants considered that licit and illicit drug users should attend separate groups. The participants who had experienced detoxification before the units had been amalgamated frequently made comparisons between the groups they had been involved with previously and the ones they were attending now. The following extract summarises their views:

R10: In some groups, *when it gets on to an alcohol problem, well I can't relate to that*. I sort of miss a lot, and it goes over my head. I learnt this time it's basically all an addiction, but *I really do think that drug addicts have different problems*. The groups we had before [before amalgamation] were more effective and easier to relax with, because we all had basically the same problems.

Other participants questioned the value of combined groups on the basis of what they perceived to be a lack of motivation to change on the part of illicit drug users. This was a belief held by many licit drug users, and is well expressed in the following comment:

R17: *I think it's pointless, alcoholics and drug addicts attending the same groups*. I mean even though they are both addictions, the motives of people are different. The drug addicts, they really don't want to stop using.

When asked to elaborate this participant said:

Well take the drug addicts. You must agree that most of them do not want to give up. You've only got to listen to them going on about how marvelous the stuff [heroin] is. Now some of the alcoholics, they have to stop because if they don't they will kill themselves, and at least they are making an effort. That's more than you can say about the others [illicit drug users].

Some participants, however, appeared to enjoy the combined groups and gained considerable benefit from the presentation of addiction as a generic occurrence, that is, that all people are addicted to something. The following extracts illustrate their views of some positive aspects of combined groups:

R5: There's some very good groups here. What happens is that they [group leaders] don't talk about addiction, they don't talk about drugs, *they talk about the basic, underlying reasons why we do what we do to ourselves.* Like we had a group the other day which talked about learnt behaviour in childhood and adolescence that would influence how we are as adults.

R6: *I get a lot out of groups.* You all get a say and no one tries to put you down. It's good to know that we all [users of different drugs] have a lot of the same problems. It somehow makes you feel better.

R15: I feel we *all have the same problems* whatever drug is used. We are all looking for a chemical security for some chemical to deal with our problems. We just try to find it in different drugs. Alcohol, heroin, amphetamines, or all those pills some people use. We all have problems that stem from abusing drugs. I don't know whether this is good or bad. But I for one *don't feel good about being regarded the same as some of the people you have in here.*

Promoting the similarities and de-emphasizing the variation in problems associated with the use of different drugs appeared to reduce any uniqueness that can be attributed to a particular drug using lifestyle. The consequences for some individuals, however, seemed to be fundamentally negative and depressing rather than positive and relieving.

Attendance at self-help groups was encouraged, but was not compulsory. Attendance at the staff groups was compulsory, and the effect on the participants was strongly influenced by several conditions. These were: the expertise of the facilitators or group leaders, the level of cognitive and physical well being of the participants, their ability to communicate verbally, the number of people in the group, and the presence of licit and illicit drug users in the same group. Large groups presented problems for the facilitators, appeared to have little therapeutic

value for the participants, and exacerbated the problem of Incompatibility experienced by the participants. When involved in large groups, both licit and illicit drug users considered that their needs were not adequately addressed, and were of the opinion that there should be separate groups for users of different drugs. When group numbers were less than ten, combined groups were viewed more favorably by the participants. In these instances the facilitators were able to provide more direction, and all members had more opportunities to become involved in the discussions and exercises. Participants in the smaller groups appeared to be more prepared to accept the view put forth by the staff that the similarities between the problems associated with addiction to either licit or illicit drugs were greater than the differences, albeit with some reservations.

6.5: Summary

During their stay in the combined, medical detoxification unit the participants encountered the second part of the basic social psychological problem of Disequilibrium that was conceptualised as Incompatibility. The components of Incompatibility were related to the heterogeneity of the clients and the structure of the treatment program. The heterogeneity of the clients was manifested in differences in age, gender, perceptions of users of different drugs, perceptions of combined treatment, language, and variations in the unpleasant sensations associated with detoxification from psychoactive drugs. In regard to age, many of the older participants were concerned that having young drug users in close contact with older, more experienced drug users would expose them to a wider knowledge of ways of procuring, using, and dealing in drugs. There was also a perception expressed by older drug users that some of the younger drug users used age differences as a pretext to leave the unit. In contrast, many of the younger drug users considered that the presence of older drug users in the unit gave them a sense of security.

In regard to gender, treating men and women in the same program excluded any group discussion of gender sensitive issues such as hormonal changes during menopause. In addition, many of the participants, both male and female, viewed women with young children negatively. Paradoxically, most of the male

participants viewed the presence of the women in the unit positively. A common theme in the data was the stereotypical images that users of licit drugs had of users of illicit drugs and vice versa. In addition, it was clear from the data obtained from the participants interviewed in the early part of data collection that there was little support for combined treatment. It was considered that it failed to meet the needs of both licit and illicit drug users. In the latter part of the study, however, the participants appeared to be more tolerant of combined treatment, and perceived that, in some ways, it was beneficial.

The way language was used by illicit drug users was, at times, a cause of concern for licit drug users. This was particularly evident when there were sufficient illicit drug users in at any time to form a group. On the other hand, the language used by licit drug users did not appear to be a problem for illicit drug users. The heterogeneity of the participants was further highlighted by the variations in the intensity of the unpleasant sensations experienced, with those dependent on alcohol experiencing the most severe symptoms.

The other areas of Incompatibility related to the structure of the program. The regimented time schedules of the unit were incongruent with the accustomed patterns of daily living of some of the participants. Another aspect of structural incompatibility concerned compulsory attendance at group therapy. It was obvious that not all the participants were able to be involved in groups to the same extent. The inhibiting factors were found to be the verbal and interpersonal skills of the participants, the extent to which they had recovered from the unpleasant sensations associated with their particular drug or drugs, and the size of the groups.

The logistics of operating a program requires the implementation of rules to enable the "smooth" operation of services to a constantly changing treatment population. These rules may serve the needs of a proportion of the clients as well as the staff; however, the same approach for all clients is inconsistent with contemporary perspectives of individualizing treatment services to meet the needs of the client.

It is relevant to note that not all the participants had problems with the mix of clients they came in contact with whilst in the unit, nor did they all experience

incompatibility with all aspects of the program. The majority, however, encountered problems in at least one of these areas, and some had problems with several. The two parts of the basic shared problem of Disequilibrium that were categorised as Hitting the Wall and Incompatibility were dealt with by the core process of Seeking Balance through Hanging In. This process is discussed in the next chapter.

PART FOUR

BASIC SOCIAL PSYCHOLOGICAL PROCESS AND MODIFYING CONDITIONS

CHAPTER 7: SEEKING BALANCE THROUGH HANGING IN

CHAPTER 8: MODIFYING CONDITIONS

OVERVIEW

In order to deal with the two-part problem of Disequilibrium, Hitting the Wall and Incompatibility, the participants engaged in a common, shared process that was conceptualised as Seeking Balance through Hanging In. The core process was found to have four phases. These were: Making the Break, Submitting to Cleansing, Fitting In, and Moving On. The phases were sequential, relational, but not mutually exclusive. That is, the borders between each of the phases were porous and there was some overlap between the phases.

A number of contextual conditions were identified that combined with the problems described in chapters five and six to influence the way the participants experienced the phenomenon of detoxification, and the way they perceived the care they received. The conditions were the physical environment, including space, privacy and personal territory, control in the unit, the expectations the participants had of treatment, and staff workload. The influence of some of these conditions, such as space and staff workload, changed over time in response to managerial decisions to reduce bed numbers and allocate additional resources to the unit.

CHAPTER 7

SEEKING BALANCE THROUGH HANGING IN

7.1: Introduction

The basic social psychological process engaged in by the participants to deal with the problems of Hitting the Wall and Incompatibility was identified as Seeking Balance through Hanging In. The core process was found to have four sequential phases. The phases were categorised as Making the Break, Submitting to Cleansing, Fitting In, and Moving On. Making the Break subsumed two minor categories, Seeking Admission and Dealing with Delays. Submitting to Cleansing encapsulated the category of Enduring Unpleasant Sensations. The third phase, Fitting In, incorporated the categories of Complying with the Program and Avoiding Conflict and Confrontation. The final phase, Moving On, included the categories of Reviewing and Previewing. In this chapter, the basic social psychological process, Seeking Balance through Hanging In is described, together with its four phases.

7.2: Seeking Balance through Hanging In

Seeking Balance through Hanging In was engaged in as a consequence and part solution to the problems of disequilibrium inherent in Hitting the Wall and Incompatibility. The terms "Seeking Balance" and "Hanging In" are processual in nature. They interact with each other in a way in which one promotes and sustains the other, and together they make up the core process identified in this study. It is necessary to distinguish them analytically, however, to demonstrate this process. Seeking is defined by the Collins English Dictionary (1993) as "to try to find by searching", "to seek a solution" or "to try to obtain or acquire". According to the same source, balance is defined as "a state of equilibrium, something that brings about such a state". This aptly captures part of the basic social psychological process that participants entered into in response to hitting a symbolic wall and being confronted with the problem of incompatibility, both representing states of disequilibrium. It was evident in the data that the participants were engaged in a

process of seeking, not regaining balance. This is illustrated in the following extract:

R12: *My life had become completely unbalanced. It was just chaos at times. Every thing was just too much. I couldn't get up in the morning without having a hit [injection of heroin] or a pill or something. I have to try and get it sorted out. I have tried once or twice to cut down and get off [drugs] but I couldn't do it on my own. I know it's not going to be easy, but I'm here to start getting some balance back in my life. I want to get straight and live again, not just the way I have been going.*

Hanging In was an "in vivo" code that was used because it encompassed the second aspect of the core process. According to Strauss (1987, p. 33), "in vivo" codes are those taken from the informants in the substantive field of inquiry. Hanging In is summarised in the following comment: "I haven't walked out, I haven't left or climbed over the wall. I am just *hanging in* here" (R15). Hanging In was an integral part of all phases of the core process and dealt with the problems of Incompatibility; it meant persevering and persisting with the resolve to regain a more balanced lifestyle free from drugs. It involved making efforts to comply with, and complete the components of the program, adhering to rules and regulations, and avoiding confrontations and conflict with other clients in the unit.

For the participants, Seeking Balance through Hanging In entailed Making the Break from problematic drug use, achieving admission to a combined, residential, medical detoxification unit, and dealing with any delays that occurred during this phase. It meant Submitting to Cleansing and enduring the unpleasant sensations associated with withdrawal from psychoactive drug use. It involved Fitting In by complying with the treatment program, and avoiding conflict and confrontation with other clients and staff. It also involved re-examining the antecedent events that induced the participants to enter treatment and anticipating scenarios that possibly awaited them and Moving On to attempt to achieve a more balanced lifestyle. The unit and the program provided the structural conditions that facilitated, and at times inhibited, the detoxification experience of the participants.

Seeking Balance through Hanging In was identified in the data as the core category or process. A core category integrates the relationships between

categories and their properties. It must occur frequently in the data, relate well to other categories, and account for the maximum variation in the phenomenon concerned (Strauss, 1987). Seeking Balance through Hanging In met these criteria. It occurred over time, under different conditions in the context of the study and with users of different drugs, hence it was identified as a process (Glaser, 1978). Seeking Balance through Hanging In explained the most variation in the data, and linked the disequilibrium problems of Hitting the Wall and Incompatibility with the theoretical constructs of the four sequential phases which were conceptualized as Making the Break, Submitting to Cleansing, Fitting In, and Moving On. These phases were sequential, relational, but not necessarily mutually exclusive. That is, some of the participants were already enduring unpleasant sensations while they were waiting to be admitted to the unit. The unpleasant sensations persisted throughout the other phases, although with diminishing intensity. Efforts to “fit in” with the program were evident in all phases. These phases are illustrated in Figure 10 and are described in the following sections.

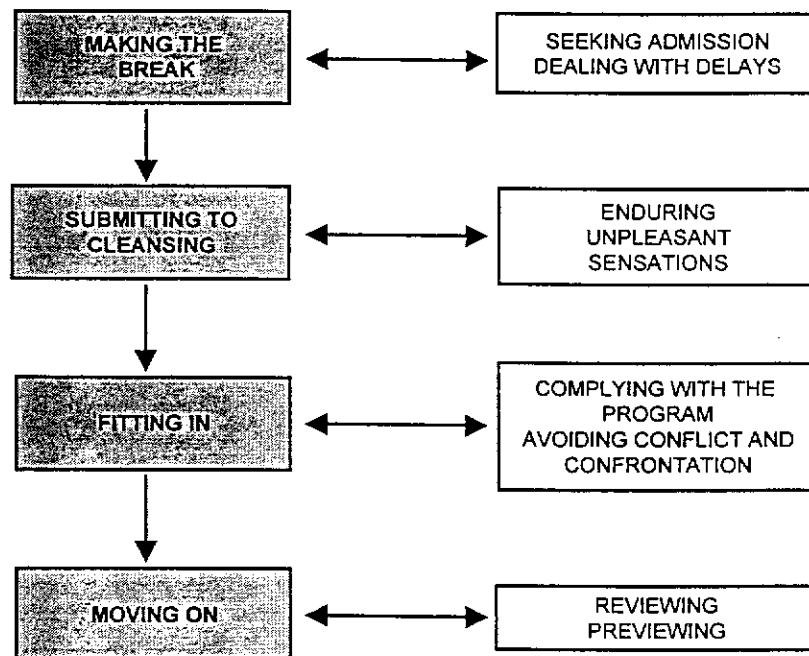


Figure 10: Phases of Seeking Balance through Hanging In

7.3: Phase 1: Making the Break

The first phase of the core process was conceptualized as Making the Break, that is, seeking admission to the combined, medical detoxification unit. Making the Break meant disengaging from normal social networks and entering the treatment unit. It also meant exchanging one lifestyle for another, that is, one set of daily routines for another, one set of social interactions for another, and a radical shift to abstinence from the use of accustomed drugs.

R7: I've been doing drugs for years. Sometimes I've given it away for a time, but I've always gone back to the shit. You name it [drugs] and I've done it. I don't know anyone who doesn't do drugs. Everyone I know is into the stuff. I don't know anyone else. These people, they're not friends you know, not like friends that would help you if you needed it. The ones I know would just as likely steal my rent money if they found it, or clean me out of my fits [injecting equipment]. *I have to break away from all this. I have to make a break and get my shit together. I am in here to get away from it all and get my head straight.*

Making the Break was contingent on three factors: the events associated with Hitting the Wall which were discussed in Chapter 6, meeting the criteria for admission established by the unit, and the availability of a bed at the time that access to the unit was sought. It also entailed persevering with attempts to gain admission. In regard to the criteria for admission, individuals were accepted into the unit provided there was a bed available, they were withdrawing from psychoactive drugs, and were unable to be managed on an outpatient basis.

7.3.1: Seeking admission to the unit

As evidenced in the quantitative findings in Chapter 4, Table 1, the majority of clients (59.4%) were self-referred, over a third (34%) were referred by health and welfare agencies, and a small proportion (6.6%) were referred from "other" sources such as employers and the legal system. The qualitative data related to the first prong of the shared problem of disequilibrium, Hitting the Wall, indicates that, of the participants interviewed, three were in the treatment unit because of

legal duress; the others were there because of personal, family, health, or job related pressures which caused intolerable disequilibrium in their lives.

In this study, almost all the participants were seeking balance because the disequilibrium in their lives had reached an unsustainable level resulting in Hitting the Wall. These pathways to treatment strongly influenced the extent to which the participants actually engaged in the core process, or whether they merely joined in the treatment program. The various paths to treatment were important, as they brought different types of people, with different agendas, to the same treatment program, and strongly influenced how they contemplated their future after leaving the unit. In the early part of the study, most people who sought admission appeared to have entered treatment relatively promptly. As one participant commented:

R3: I knew I had to come in. I hadn't had a drink for two days and I was starting to shake. Once I had decided to detox I rang up asked if I could be detoxed. They said "Come in and we will assess you". I packed a few things on the chance that I would get in and got a taxi here. I saw the doctor and he said *OK, you are withdrawing and we will admit you now*. It was just in time, if I had had to wait I know I would have been vomiting and all.

7.3.2: Dealing with delays

Not all participants were successful in gaining entry to the unit on their first request. As mentioned above, provided a person was withdrawing from a psychoactive drug(s) and was not suitable for outpatient care, they would be admitted if there was a bed available. In the latter part of the study, when the number of beds had been reduced, some people could not be admitted so readily and many had to "hang in" until the unit could accommodate them. The experiences of those who were not admitted promptly is well illustrated in the following comments:

R13: *I was very sick by the time I got here. Because there were no beds I had two days of withdrawal before I got in. I was violently ill as soon as I arrived, vomiting and shaking and diarrhoea. They*

[nurses] gave me medication which they said I needed, and I was put to bed immediately. I was on the verge of fitting when I came in. I have a lot of liver damage and kidney damage.

The above participant had a long history of alcohol misuse and had obviously commenced withdrawing from the drug whilst waiting for admission. This was not his first experience of detoxification and he was well aware of the physical damage he had incurred as a result of his alcohol consumption. He was convinced that he would have commenced fitting if access to the unit had been delayed further. Some of the illicit drug users considered that being refused prompt admission could result in criminal activity. This is illustrated in the following comments:

R15: If people could get in here when they needed to, they wouldn't have to go out and do something silly, do you know what I mean? They wouldn't go out and rob a bank or something, because people do that when they get desperate. *If people could come in here when they needed to, they wouldn't have to go and rob a bloody liquor store or a house or something.* If you let people in here when they need to get in you are stopping someone getting hurt. Like innocent people get hurt out of that person's desperation.

The participants had different ways of dealing with delays and persevering with their resolve to make the break whilst awaiting admission to the unit. Some participants abstained from drug use, whereas others continued using during this interim period.

R17: When I needed help, when I rang up I needed help then and there. I couldn't get in for a week later. Yeah, in that week that could be a life or death situation for a lot of people. That whole week, *waiting to get in here cost me a lot of money just to keep myself maintained* [on heroin] until I got in. I pulled myself together a bit, but I should imagine that having to wait a week could be a matter of life or death for some people. When you are dependent on heroin, you just can't stop you know. If you do,

you have real hell for a few days. So you just have to keep using until you can get help.

Some participants attempted to expedite the admission process by getting their general practitioner to contact the Principal Medical Officer of the unit and request admission on urgent medical grounds. The following comments demonstrate how this was achieved:

R7: I tried to get in but they [staff] said there was no beds. I went home and within four hours I was vomiting and starting to shake. I rang them up again, but they said they still did not have any beds. *So I rang my GP and he said "I'll get on to the doctor and see what I can do"*. I don't know what happened, but they rang me the next morning and said come in. I don't know if my GP did any good, but I got in. I had a very bad night though. I didn't sleep and I was very worried about what could happen. I nearly started to drink again, but I didn't. *I hung in all night*, but I was really glad when they rang in the morning.

Other participants resorted to telephoning the unit every two or three hours in order to gain admission. As illustrated in the following comments, this was successful at times:

R11: When I couldn't get in I didn't know what to do. I just went home and thought I'll keep ringing and they might let me in. Well I rang about 11 p.m. and they said "Sorry, you will just have to call again in the morning". Well I didn't sleep and I called again about 2 a.m. and talked to the girls [night staff]. I had a good talk to them and eventually they said, "Some one has just walked out. If you can get yourself here we will assess you". Well I got a taxi in and they examined me and put me to bed. I was very glad to get in.

Some of the participants whose main problem drug was heroin thought that, in the admission process, they were discriminated against in favour of alcoholics. As one participant commented:

R6: I tried several times to come in, but they couldn't take me. There were too many alcoholics and they [staff] said there *was no room*. *I just had to wait it out. They have closed down most of the accommodation, and what there is seems to go to alcoholics. It was really tough, you know.*

At times, when demands for admission exceeded the capacity of the unit to accommodate all the people seeking inpatient care, beds became a scarce resource. This increased the waiting time for admission to the unit, and became a source of additional stress on those who had encountered the problems associated with Hitting the Wall, and who had engaged in the process of seeking Balance through Hanging In. Some heroin users appeared to believe that they had been denied admission to the unit on the basis of their particular drug of use.

The resolve to hang in was particularly evident when a participant was unable to be accommodated on request. Among the examples of this were the strategies used to gain admission, such as frequent telephone calls, and the use of a general practitioner as an advocate for priority for a bed. When having to wait for admission, those whose main drug was alcohol were prepared to stop drinking, but “hung in” despite being concerned about experiencing the consequences of sudden abstinence in the form of alcohol related withdrawal symptoms. In contrast, illicit drug users appeared not to contemplate ceasing their drug use [usually heroin]. They dealt with delays in gaining access to the unit by continuing to use drugs, and some believed that they would be forced to commit a crime or crimes to obtain money to maintain their habit during the waiting period. They believed that being denied prompt access to the unit placed innocent people in the community at risk of becoming victims of crime.

In summary, Making the Break involved seeking admission to the combined treatment unit. Not all the participants could be admitted promptly. In some instances, when a bed was not available at the time admission was requested, participants had to deal with delays and many were already enduring the unpleasant sensations of withdrawal symptoms before they were admitted. Dealing with delays involved hanging in and maintaining their resolve to enter treatment. Some illicit drug users appeared to believe that delays in admission to

the unit increased the likelihood of crimes being committed to obtain money for drugs. The strategies used by some of the participants to expedite their admission were telephoning the unit frequently, and persuading their general practitioner to act as an advocate on their behalf.

7.4: Phase 2: Submitting to Cleansing

The second phase of the core process was conceptualized as Submitting to Cleansing. This involved participants enduring the unpleasant symptoms that occurred as a consequence of ceasing use of their particular drug(s). The variation in these symptoms, and the way they were experienced is fully described in Chapter 6, Section 6.4.1.2. As evidenced in the data presented on the phase of Making the Break, some participants whose admission was delayed were already enduring the unpleasant sensations before they gained entrance to the unit. In these instances there was some overlap with the two phases. This did not apply to all, however, as some participants continued with their drug use until they were accepted into the program.

After they were admitted to the unit Submitting to Cleansing meant that the participants placed themselves in the hands of the staff, accepted the care provided and the medications administered to ameliorate their withdrawal symptoms, and endured the unpleasant sensations associated with their particular drug or drugs of use. As discussed in Chapter 6, there were variations in the intensity of these symptoms, and those whose main drug was alcohol appeared to experience more severe physical symptoms than those whose main drug was either heroin or amphetamines. The following extract serves to illustrate how the participants were involved in this phase:

R26: They [staff] took me in and cleaned me up. They put me to bed and gave me an injection and some medication and said 'You will be alright now. *Just you rest in bed and we will be around to keep an eye on you. You are OK now*'. *I just did as they said. They know what they are doing, and I just lay back and did what they said. In here you are in their hands.*

In the Submitting to Cleansing phase, little active involvement in the treatment program was required from the participants. Their main focus was on receiving the care provided, enduring the unpleasant sensations, and hanging in. They were examined, assessed, had their vital signs measured and monitored, laboratory tests performed and medications were prescribed and administered. Attention was given by the staff to providing comfort and reassurance to the participants and reducing the unpleasant sensations they were experiencing. In addition, deficits in sleep, nutrition, and hydration were addressed as they were cared for during the unpleasant sensations related to this phase.

7.4.1: Enduring unpleasant sensations

Enduring Unpleasant Sensations meant tolerating the experience of withdrawal symptoms and hanging in during this phase. While medication was prescribed and administered to alleviate the withdrawal symptoms, in many instances this appeared only to modify, and not completely alleviate, the sensations. The experience of heroin users hanging in and enduring withdrawal symptoms is well described in the following comments:

R6: They give you clonidine here, and some valium, but it doesn't help much. *I think the only thing is time, it all does wear off after a few days, but it is hard. It's not just like the 'flu. I have had the 'flu and coming off shit is nothing like it. With 'flu you don't get the abdominal cramps and the diarrhoea. The cramps are really painful, and you can spend all night in the bathroom. The cramps just go on and on. The hot packs help a little, but the pain and the cold is on the inside and you can't get warm. You just have to hang in with it.*

Those participants who were withdrawing from long acting opioids such as methadone appeared to have to endure more intense, protracted sensations. These are summarised in the following comments:

R6: It was really difficult. I was coming off methadone. It's not like heroin you know. *It goes on and on. If you haven't experienced it you wouldn't know what it's like, but it goes on and on. You get all the pain*

that you get from heroin, but it doesn't stop. It's much harder and much longer than heroin. The medications they give you help a little, but *it is up to you to put up with it until it passes*, and that doesn't happen over night. *It goes on for days and days.*

The difficulty of enduring unpleasant sensations undergone by the participants whose main problem drug had been amphetamines is well described in the extract below:

R24: On speed [amphetamines] you just keep going. Like I would go maybe two or three days without sleep. When you stop taking the drug *everything takes so long you're just tired out. It's all too much, and it's just not worth the effort.* I am tired, but I can't sleep despite the medication they give me. When I do get to sleep I wake up in maybe two hours and can't get back. I know that it will pass, but it is not easy going through this.

Hanging in and enduring unpleasant sensations was an essential component of the core process that was experienced by the participants in their search for a more balanced lifestyle.

Not everyone who entered treatment completed the program. As reported in Chapter 4, seven of the 541 people admitted during the period of quantitative data collection were discharged for disciplinary reasons, mainly for using illicit drugs that had been smuggled into the unit. A further 90 left the unit against advice before completing the program. Those who dropped-out (either discharged or left against advice) generally did so within a two to three days of admission, and for those who engaged in the core process of Seeking Balance through Hanging In, this would have occurred during the phase of Submitting to Cleansing. As one participant commented in reference to a number of individuals who did not complete this phase: "They were here for a couple of days and then they're gone. They *couldn't hang in here*" (R23). In reference to a heroin user who had been sharing his room and was either unwilling or unable to hang in and endure the discomfort of the unpleasant sensations, another participant commented:

R25: He was up all night. Pacing up and down. I said to him 'What's wrong?' He said '*I don't think I can stand this*'. He went and saw the nurses and *signed himself out at around 3a.m.* Next day we were betting on how long it took him to score [obtain heroin] after he left. Most thought about one hour if he had any money.

Those participants who left in this manner did not meet the criteria for inclusion in the study, hence were not interviewed. The reasons they chose to enter treatment and then depart two or three days later can only be postulated. This matter was, however, explored with the nursing staff and several explanations were proposed. While the nurses believed that the majority who left in this fashion did so to obtain drugs, it was considered that this was only one reason for not completing the program. According to the nurses, it was not uncommon for individuals to leave in response to calls from spouses who were experiencing difficulties in managing children, or to deal with other domestic and financial problems. It was also reported that, in two cases, clients had left the unit suddenly because they had received a telephone call from friends informing them that some drug dealer had become aware of where they were and was waiting for them when they were discharged. All those interviewed, however, completed the detoxification program.

The deleterious effects that those who dropped out of the program had on those who completed the program is well illustrated in the following comment:

R16: Those people who come in here one day and are gone the next should not be allowed in. They take up a bed, take up the nurse's time and they are gone the next day. *They are just a drain on the resources here and you should be more careful who you let in.* These people are not committed to making any changes and they are just using the place. There are plenty of people out there that really want to get in here and do something for themselves, but these people are taking up the beds. *It is not a good thing to have them in here because they distract those of us who are really trying to do the right thing.*

The clients who dropped out were perceived by those who completed the program to be utilizing the resources of the unit inappropriately, lacking commitment to change their lifestyles and denying other, possibly more motivated individuals, access to the unit. Those who dropped out were viewed unfavourably by those who hung in because their departure was a distraction for those who were committed to the process of Seeking Balance through Hanging In, or at least completing the detoxification program. The number of individuals who dropped out also raised questions about the adequacy of the assessments for admission to the unit, as well as other aspects of the structure of the program.

In summary, there was considerable variation in the way that the participants experienced the second phase of the core process, which was apparently related to the type of drug, or drugs they had been using. During this phase it would appear that a number of clients, mainly illicit drug users, were unable to hang in and dropped out of the program. While the majority of those who dropped out apparently did so to avoid unpleasant sensations associated with abstinence and to resume drug use, others dropped out because of family reasons, or because they believed their whereabouts had become known to drug dealers. In general, by the third or fourth day of Submitting to Cleansing most of the acute physical symptoms had subsided, and there was a marked improvement in the wellbeing of the participants. This was a necessary prelude that led directly to the next phase that was identified as Fitting In.

7.5: Phase 3: Fitting In

Fitting In was the term used by the researcher to describe the participants' attempts to take a more interactive role in the therapeutic program of the unit, and to overcome some of the issues of Incompatibility. It involved the participants taking steps to avoid conflict and confrontation with other clients and complying with the rules and treatment regime of the unit, even when these conflicted with their own patterns of daily living and preferences. How the participants perceived Fitting In is well summarised in the extract below:

R19: I came here to get myself sorted out. Now I don't see eye-to-eye with all the clients you have in here, or all the talk

therapies [group therapy] you have, but you people didn't ask me or anyone else to come in here. We all came in because we needed to. Some people here [other clients] seem to think that they have to like everything that goes on. But this place is not a holiday camp, and you get all sorts here. I think if you really want to do something for yourself, *you have to fit in with what's on offer*. After all, nobody has to stay. Anyone can leave any time they like, but if you want to stay you *have to be prepared to fit in* with what's going. You can't please all the people all the time, and that's not what should happen. When we are in here we should go along with what's on, and use the opportunity to start to get straight.

The activities in which they were encouraged to be involved included group therapy and more in-depth, individual counseling sessions with their nominated counselor, who in some instances was a doctor but was generally a nurse. In the event that the staff considered that additional input into case management was required, the participant concerned could be referred to a psychologist, a psychiatrist, or a social worker as was deemed appropriate. In addition, they were expected to take an active part in socialising with other clients and recreational outings. During this phase many were Clicking Back to a reality relatively unclouded by the use of their accustomed drugs and were endeavouring to comply with some of the most important components of the program, that is, group work and individual counselling. The integral components of Fitting In were complying with the program and avoiding conflict with other clients.

7.5.1: Complying with the program

Compliance means “acquiescence” or “conformity” (Collins English Dictionary and Thesaurus, 1993). In regard to the program this meant keeping to the daily timetable and participating in the therapeutic and other activities, even when this was incompatible with their individual needs. As discussed in the previous chapter, many of the participants appeared to have problems with various aspects of the program. Despite these problems the majority of the participants complied with the daily routine and the various components of the program. This is summarised in the following comments:

R13: Yeah I found it hard at times. There were many times I did not want to get up and I certainly did not want to go to the groups. Left to me I wouldn't have gone to any of them and would probably have stayed in bed until lunch time. Coming into the program, well you have got to want to do it. When they said get up I got up and there is no use complaining too much about it. They [staff] have got to have rules and such just to manage the place. They have to have specific times for meals and things and they have to run the groups. If people don't want to do these things there is no point in being in here. I did find it hard but I'm serious about myself and want to change. I think it is good and have done what they say. It puts structure into the day and we all know what we should be doing. *If you don't comply with the program you are silly, because that is why we all came in here.*

A different form of compliance was evident in the data. This was the compliance exhibited by those participants who were in the unit because of legal pressures. These participants complied with all components of the treatment program, but the type of balance they were seeking was different to that of the participants who were engaged in the core process. The behaviour of the participants who were in the unit because of legal pressures was better described as obedience. This situation carried with it a need to convince significant others, in this case relevant representatives of the legal system, that they had undergone detoxification. That is, they obeyed the rules and conformed to the program. In other words, they exhibited temporary public compliance with the program, and had outcome goals that included a return to the use of their particular drug(s). While they completed the prescribed treatment program, it cannot be claimed that they engaged in the core process of Seeking Balance through Hanging In. The balance these participants sought was a return to their former drug using lifestyles free of legal complications.

Seeking Balance through Hanging In was a social process. Although the participants were physically separated from their usual social networks and relationships, regardless of whether they were merely complying with the

treatment program or engaging in the core process, they did so in the company of others. This cannot, however, be regarded as a group exercise. At any one time in the unit there were people in the different phases of Seeking Balance through Hanging In: Making the Break, Submitting to Cleansing, Fitting In, and Moving On. There were people of different ages and gender, with different drug use histories, different experiences of Hitting the Wall and different reasons for entering treatment, and different expectations of outcomes.

All participants, however, were experiencing a common phenomenon, detoxification, within a collective environment, yet their experience was uniquely their own. Each participant's experience was influenced strongly by the events that led them to treatment, and the problems and conditions that applied whilst they were in the unit. As illustrated in Chapter 6, the problem of Incompatibility and disequilibrium encountered in the treatment unit related to the heterogeneity of the treatment population and the structure of the program.

Socialising involved engaging in conversation with the other clients and staff members, and not isolating themselves away from the others in the unit. Socialising was inhibited by the problems of Incompatibility. In particular, the stereotypical views that users of certain drugs had of users of other drugs created problems; hence many of the participants had difficulty socialising with other clients. They viewed the other clients with suspicion and appeared to have no desire to interact with them. The comments of the following participant serve to demonstrate their reservations about socialising with other clients:

R15: I'm feeling much better now and they [staff] keep telling me to sit out in the lounge and talk to everybody. I would rather be in the lounge room than sitting here by myself, but I don't really want to talk to them. *I don't want to get involved. I don't know what to talk to them about and I don't want to get involved with any of them.* I mean I wouldn't normally meet with these people and I don't want to spend time with them here. I wouldn't be rude to anybody, but I prefer not to be involved.

Other participants found that some aspects of socialising were enjoyable and stimulating, for example, being escorted on recreational outings. While the

average length of stay in the unit was relatively short, most of the participants had the opportunity to go on at least one outing and some went on several. Those who went appeared to have enjoyed the experience. The following comments reflect how they felt about outings:

R28: Six of us went in the bus to Kings Park. You know I live here, but I haven't been to the park for about 10 years. It's very well kept, and the views are spectacular. It gives you a great feeling just to get out and look down on the city. *It was nice to go in the group, you know. Six people were just enough and we all enjoyed it and the company, and I for one will try to get there more often when I leave here.*

Another area of compliance, which was difficult for some, was partaking of communal meals. All clients, except those who were ill, were expected to have their meals together in the dining room. For many this was not a problem, but some participants found the table manners of others offensive, and were very selective about their companions at meal times. The following comment illustrates how some of the participants viewed the company of others at meals:

R24: I don't mind sitting with most of them, but I draw the line at xxxx. He always tries to sit with me at meal times and I can't stand watching him eat. He talks with his mouth full and he talks all the time, and drops his food all over the table. I don't want you to think that I'm critical, but there's a right and a wrong way to eat, and if you are accustomed to good table manners it's hard to take. I know I can't be too particular in here, but I try to avoid him. He's not the only one though. In fact, most of them have very poor eating manners. *It's very off-putting to have to try and eat with them and I try to avoid them, but it's generally not possible, and you are obliged to go to meals here.*

The other main activity that individuals were expected to comply with was group therapy. The participants' perceptions of group therapy have been presented fully in Chapter 6, Section 6.4.2. There was strong evidence that while some of the participants felt able to fully fit in with this form of therapy and found

it beneficial, many were not able to be optimally involved, and appeared to be uncomfortable when in groups.

R8: The groups, they can be very intense and for the new people that have just come in *who are feeling wobbly and sick it is just too much for them*. Even after a week you're still very fuzzy, worried, and sick, and sometimes *you don't feel like going to a group, but you have to go*. A lot of people try, and they walk in and sit there, and then they start to feel bad. I'm not saying the groups are wrong, I think they are good. *But you have to be well enough to join in and get any benefit from them*.

R13: The groups are well structured, and usually very informative. Ummm, *they are sometimes embarrassing though because we have to get up and actually join in and participate*, and there are things that I for one am not comfortable with discussing with people I barely know.

Others who were more physically and mentally alert were able to fully join in all group discussions and exercises. For these people, involvement in group work appeared to have considerable therapeutic benefits. The following comment reflects the positive view of groups held by some of the participants:

R23: *They [groups] are good. We are all being stimulated and once that starts to happen people feel stimulated and alive, and start to feel good about themselves. I like the groups, I like talking and starting to think about things. When you have been on drugs for as long as I have, you virtually stop thinking about many things. Yeah, they're stimulating. It's good to go to groups and start to get thinking again.*

The social aspect of Seeking Balance through Hanging In was not always comfortable for the participants, and many had difficulty handling the close contact with individuals with whom they would not otherwise associate, and hanging in with the program. Exposure to social contact with the heterogeneous population in the unit was beneficial for some participants in that it challenged the stereotypical views that many licit drug users held of illicit drug users and vice

versa. It also served to minimize the insidious belief held by some of the participants that their problems related to alcohol and/or other drug use were unique, and enabled them to view their situations within the constellation of difficulties with lifestyles and relationships experienced by others.

7.5.2: Avoiding conflict and confrontation

Because of the problems of Incompatibility described previously, participants often experienced discomfort, or in some cases conflict, when in the company of other clients in the unit. The main strategy used by the participants to diminish conflict and confrontation with other clients was avoidance. As illustrated in the following extract, some participants achieved avoidance by a strategy of “tuning out”:

R8: I just go quiet, I just shut up. It is not much use talking to them [illicit drug users]. I think well, if I was outside I would say “Excuse me, I don’t like that sort of language” and I wouldn’t have to put up with it. In here I have tried it a couple of times and it has worked for a while. But then they start again.
I just shut up now and try to tune out.

Other participants avoided problems with offensive language by walking away and distancing themselves from such conversations, and focussing on improving their own situations. The way this was accomplished is reflected in the comment below:

R12: *I just do a couple of rounds of the courtyard and go and listen to music or watch TV. I can’t stand listening to them [illicit drug users] raving on. It’s no help for anyone. It certainly doesn’t help me. It is the last thing I need in here. I want to get my mind off drugs, not have them talked about incessantly. I want to concentrate on getting better and getting on with my life.*

Some of the other participants dealt with certain types of language, which were found to be problematical, by refusing to own the problem. The way they dealt with this is well portrayed in the comment below:

R26: I can put up with most things, but I grit my teeth when somebody swears in front of a woman. Then I think I've got to accept it. *Like well, it's not my problem, it's theirs if they want to sit there using that language [swearing]. If they've got a problem it's theirs not mine. . . . I have learnt that I've got to help people as much as I can, but not take their burden on my shoulders. I feel the language is other people's problems, not mine.* I know this sounds selfish, but it is a selfish program because ultimately you are here for yourself. So I just grit my teeth and say nothing.

Despite the apparent discomfort associated with Fitting In, very few people dropped out in this phase. The majority hung in and persevered with Fitting In, avoided conflict and confrontation, socialised in varying degrees with other clients, and complied with all aspects of the therapeutic program. Fitting In was the third phase of the core process, and was antecedent to the next phase, Moving On.

7.6: Phase 4: Moving On

In the second phase of the core process, Submitting to Cleansing, the needs of those withdrawing from a range of different drugs were similar. That is, to progress to the next phase, they had to endure unpleasant sensations of varying intensity. They all required medical and nursing interventions to minimize the unpleasant sensations associated with suddenly abstaining from the problematic use of psychoactive drugs. Once the worst of the unpleasant sensations had subsided, the participants entered the third phase of Fitting In. At this time their individual problems and special needs, which were largely a consequence of Hitting the Wall, became more apparent and the participants explored them, to some extent, through sharing experiences in the groups, counselling and with other clients.

Submitting to Cleansing was followed by Fitting In, which in turn led to the participants dealing with the prospect of leaving the unit. This last phase was conceptualized as "Moving On". This was the fourth phase of the core process, Seeking Balance through Hanging In. During this time, the participants reflected

on their personal resources and social networks and considered options for community support with their counsellor. As evidenced in the following extract, this term adequately described what was occurring in this phase during which the participants were preparing, with the assistance of the staff, to leave residential care.

R23: Being in here has given me a chance to get away from drugs. It's been hard, but I had to come, the stuff [heroin] was just killing me. But I can't stay, if I am to get myself together I have to *move on*. It's been hard in here, but I'm getting ready to *move on* and I know that it is *time to go*.

It was evident that Moving On encompassed two sub-categories that were identified in the data as Reviewing and Previewing. Reviewing refers to recalling and examining the experiences associated with Hitting the Wall. Previewing refers to projecting situations and conditions with which they were likely to have to deal when they left the unit. Previewing included attempting to devise some means to enable them to maintain the gains that they had achieved and further sustain their search for balance in their lives. Previewing was intimately linked with Reviewing, and the scenarios they recalled and anticipated were a product of the multiple problems associated with their lifestyles which had led them to Hitting the Wall. Both Reviewing and Previewing were essential for determining reasonable, achievable, goals and strategies to enable them to maintain the progress they had made and to continue their quest for a more balanced lifestyle. Engaging in Reviewing and Previewing assisted the participants to evaluate their existing psychosocial resources and develop strategies likely to assist them in meeting their goals. Reviewing and Previewing were central parts of Moving On and had a considerable influence on how the participants viewed the prospect of leaving the unit. On one hand, the experience and process of Seeking Balance through Hanging In seemed to give confidence to some participants. On the other hand, for many, the prospect of leaving the residential, treatment program was a cause of apprehension and ambivalence. This appeared to undermine their recently achieved sense of relative physical wellbeing gained through abstinence

from drugs, taking an adequate diet, having sound sleep, and the care they had received whilst being in a sheltered environment.

7.6.1: Reviewing

As the time for leaving the unit approached, participants reflected on the meaning of their experiences in the unit, as well as those leading to their decision to seek a better balance in their lives. Whilst in the unit they had been separated from physical contact with friends, relatives, and significant others, and their physical and mental needs had been attended to by a multidisciplinary team of health professionals. As illustrated in the following extracts from transcripts, experiencing feelings of gratitude was a common theme:

R2: *I feel grateful. Grateful that there is a unit like this for someone like me. I don't know what I would have done if I hadn't got in. I couldn't have gone on much longer the way I was and there was no way I could stop drinking by myself.*

R13: *It's the difference between life and death, I would say, and I mean that literally. I think I would have died out there. I'm thankful that I got in. It's given me a chance to change my life. It won't be easy I know, but at least I have another chance to straighten up.*

Another aspect associated with residential care, which was identified in this phase of Reviewing, was the concept of protection and security, of being in a safe environment. The following extracts capture the comments of many:

R12: *Being here gives you security. You know nobody is going to call you and say "Have you paid this bill or that bill". Or say "you need to do this or that". When I first came in I resented the fact that you couldn't have visitors, but now I understand why not, and it's a good thing that visitors are not allowed. The place is a cocoon, a sort of womb, where I feel secure enough to work through some things [problems]. I think that's important to people.*

R14: *It's a safe environment. A safe place to get your head straight, to start thinking straight. Nobody knows where I am. It's given me space to take a breather, so to speak. To get a chance to get off the stuff [heroin]. This place, it's been like a protection for me. Even mentally it helps you because you know you're in here to try and help yourself. It has given me time to think about things. I feel very fortunate to have been given the opportunity to be here.*

For some participants, the experience improved their perceptions of self. The following comment reflects how these participants perceived themselves:

R15: *It's made me feel like I am a better person. I am actually starting to like myself. Like if I hurt myself I hurt from the pain, I don't like it because I cut myself. It's the counselling that has helped me. It has helped me see why I didn't like myself, why I had no self-esteem. I don't claim that I am well yet, but I'm a lot better than when I came in.*

Not everyone viewed their experiences in the unit so positively. For some, it lowered their opinion of self, and increased their awareness of the negative aspects of their lifestyle. These feelings are encapsulated in the following comments:

R20 *I am disgusted. I feel absolutely disgusted, not at the place, at myself, how low I'd stooped. I was like a drug junkie. I suddenly realized that I'd gone down so low to have let myself end up in a place like this. What I thought was a place for bums, to put it politely. They [staff] treated me with respect and they weren't nasty when they could have been. But it's been a terrible experience.*

Another aspect reflected on by many during the phase of Reviewing their situation was the limitations of the relatively brief treatment intervention episode, when compared to the events and circumstances that contributed to the participants Hitting the Wall. The time in residential care was deemed to be inadequate by many participants. The following comments illustrate how the length of stay was perceived:

R1: *You spend all your time in here getting well. Then five minutes later you're out the door and back on the street. You're not actually getting anywhere and there is a lot of fear in a lot of cases about how you can manage once you get out. They [staff] have arranged an appointment for me to come back to outpatients next week, but it's not the same and, for me, it's just going back to the same old place to where I was before. I think the time in here is definitely too short.*

The approaching point of discharge had created self-doubts for many regarding their ability to continue on the path they started in the detoxification unit. This is well encapsulated in the following comment:

R15: *I realize I have to leave. I also know that, hell, two weeks of detox aren't going to do much. Not when you've been doing what I have. I know it will be a long road for me and I don't really feel strong enough to face it yet. But I know I can't stay much longer. You can't keep people like me forever and there are others trying to get in.*

This realization of the limitations of residential care appeared to be associated with a growing awareness that ultimately the responsibility to make and sustain any meaningful changes to their lifestyle was theirs. The following comments show how many perceived this:

R8: *You get the best care in here, but they can't keep you. You got to walk out the door and say "I'll be Ok". I know I won't have all those people [staff] running around after me. I have got to do it myself. I have got to face it. I'm the only one who can pick up the pieces. The staff you have here, the doctors and nurses, well they can help just so much, but you have to live your own life. They can't do it for you.*

R20: *If you want to change, you can. That is what this place is for. If you want to detox it's here for you. If you don't want to change, you're wasting the country's and the government's money. You really are the one to do it [change]. You can't expect to*

have someone forever at your side. It's your life and your responsibility to try and get it right. The drugs [heroin] have to go and I for one will give it my best shot to keep off when I leave.

Reviewing encompassed a perusal of the immediate past experiences in the unit. Strong, consistent themes in the data were gratitude for the care received and the limitations of the brevity of the length of stay in the treatment unit. The majority of the participants were also aware that, while follow-up appointments for further support would be negotiated, they themselves were responsible for maintaining any lasting changes in their lifestyles.

7.6.2: Previewing

As the limitations of the residential stay became increasingly evident to the participants, more time was devoted to Previewing the future. Previewing involved looking forward to the situations which awaited them once they left the unit. Associated with Previewing were feelings of exclusion, apprehension and uncertainty, and in a few cases, confidence and hope (Figure 11).

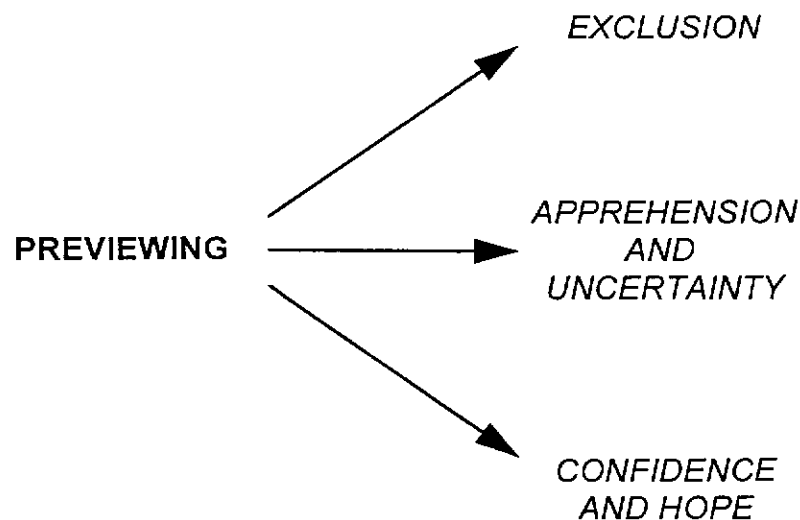


Figure 11: Previewing

Exclusion was not an uncommon theme as the participants viewed the prospect of Moving On. The past reality of Hitting the Wall was no longer obscured by drugs, and the future was viewed as insecure and fluid. For the participants, the past would, to a large extent, define the possibilities of the future. As illustrated in the following comments, some of the participants felt excluded from access to follow-up care from community services:

R12: There are a lot of places [other agencies, other programs], but they all seem to be unsuitable for me. All the programs, all the set-ups, *but I don't seem to fit somehow*, and neither do a lot of others for some unknown reason.

R11: *I think that there should be a place where I can go for a while. You know, where there are people [staff] like you got here, who know what they are doing. Just so they can put you back together properly. I have done OK here but there is a long way to go for me. There is one place I believe I could go, but my counselor said it's full up and there's no where else so I am going home in a couple of days. I have an appointment to see the doctor here in about a week, but I'll have to manage in the meantime.*

Other participants felt excluded from the employment market. Exclusion was associated with an awareness of the lasting effects that their previous lifestyles could have on their future life prospects. The following comment illustrates how some of the young poly drug users viewed their futures:

R11: I was living on the streets before I come in here. That's all I know. *I got no place to go. They [staff] say they can fix me up with some rehab place for a couple of months, but what then? They can't get me a job, can they?* I know what the streets are like, the hustle, the deals, the cops, you know. That's all I know. *What is there for someone like me?*

Having a job appeared to be fundamental to achieving and maintaining changes away from a lifestyle focussed on drug use. Many of these participants, however, had criminal records and no skills likely to be sought after in the legitimate

employment market. Some were, moreover, heavily and visibly tattooed and had most of the pinna of their ears decorated with earrings. After years of moving in circles where tattoos and multiple body piercing were an accepted part of their body image, their appearance, clothing and language skills were likely to be impediments in many job interviews. Their view of the future was bleak and their fears to some extent were justified, as it would take considerable strength of resolve on their part and a great deal of community support to prepare them to be successful in entering a shrinking, very competitive job market.

The multiple problems encompassed in Hitting the Wall that led the participants to Seeking Balance through Hanging In permeated their stay in the unit and remained to be addressed when they left. The prospect of dealing with them seemed almost overwhelming. The following comment reflects how many felt about the situations that they would face when they left the unit:

R14: *It's going to be chaos when I go out. I've hurt so many people, I don't know where to start. I know I can have a referral to xxxx but I have to start with the people [spouse], start to make things right somehow. But it's not going to be easy. My wife has been disappointed in me too often and it's not going to be easy for her to trust me again. There are many other things I have to do to get on track again, but she's the most important and I really don't know if I will be able to sort out our relationship.*

Another common finding in the data related to Previewing was apprehension and uncertainty. Many of the participants had doubts about their ability to cope with life without the use of drugs. They were also unsure how they would be able to abstain if people around them were using drugs. The following extracts from transcripts illustrate these feelings.

R8: *It's funny, you know. I feel ready one minute and not the next. But you can't stay here forever and be safe. I don't want to become institutionalized which is easy to do. You got to go. But if they [friends] come around and start passing pills out, I don't know, it will be very hard. But I wish I could stay a*

little longer, maybe just over the weekend, because that's the time they usually come around.

R6: It's hard to go straight back out again. They [staff] say I can go and I've already got an appointment to see xxxx [another agency], but it's not for another week. I would like to stay a few more days, at least until the appointment. But it's not possible. I guess I'm on my own until then. *I hope I can hang on, but if someone comes around with stuff [heroin], I don't know how I will cope.* I don't want to start using again, but when someone puts the stuff in front of you and hits up it's really very difficult not to have a taste [hit].

Several of the participants who were going back to relationships with partners who were still using drugs wished to prolong their time in the unit. While they wished to maintain the state of abstinence they had achieved in the unit they felt vulnerable to the possibility of relapsing to drug use when they returned to their partners. Such relationships were likely to bombard them with cues that would not be congruent with their new needs. As illustrated in the following comments, these participants had little confidence in their ability to abstain from drugs in the presence of someone who was using drugs, nor did they appear to have any firm strategies for coping with the situation if it arose:

R2: I know he's [partner] still using it [heroin]. I tried to get him to come in here when I get out, and get off the stuff. He said he might, but I don't think he will. *If he starts hitting up [injecting] in front of me, I don't know what I'll do. It's just too much of a temptation.*

R21: Yeah, he's [partner] the one who started me off. He used to get it [heroin] and we would use together so to speak and I just kept having it. I don't know. I'll just have to see how it goes. *It's hard enough for yourself to get it out of your life, but when you get someone doing it in front of you, no way, I don't think I could do it [abstain]* You know like someone comes around with a drug you used to use, it's like having a stroke to say no.

The above participant (R21) was a single parent of a two-year-old daughter. She was unemployed and was dependent on a government pension for financial support. Living with the person she was referring to had a number of functional advantages for her in that he used to provide her with companionship, financial assistance with food and rent, as well as transport for shopping and attending social events. Without his support, she would be considerably disadvantaged, both financially and socially. Nevertheless, she was contemplating trading off the advantages of cohabitation in an attempt to refrain from relapsing to drug use. As she put it "He will probably have to go. *But it will be hard to manage by myself*" (R21).

When Previewing their future, others appeared to be confident and hopeful that they would be able to manage their situations and deal with their problems. The projection of confidence and hope was not a common theme and was exhibited by few. The following comments illustrate how the feeling was conveyed in the data:

R12: I have had enough [of drugs]. *I am not going to use again.* I know I will need ongoing counseling, but I have an appointment, *and I will go.* This time I will get my shit together.

R21: *I feel optimistic.* I feel when I come out of here *I will be back to my normal self and will be able, I hope, to cope with day to day things.* I will stick with the counseling and hopefully will maybe get my job back.

Confidence and hope for the future was evident in the above extracts. Hope has been referred to as a process that involves determination and planning to meet one's own goals (Averill, Catlin, & Chon, 1990). It should be realistically attainable and accompanied by a willingness to take action to achieve one's goals. Hope assists patients to endure and overcome disabilities and crises (Miller, 1989). Both of the above participants expressed a sense of confidence and hope that they could attain their desired goals, as well as the intention to work towards achieving these goals. Another participant's confidence was based on anticipated support from a general practitioner who he apparently held in high esteem:

R13: *I will be alright. I'm not just being pushed out the door. My counselor has been just great. She's arranged for me to be have an outpatient appointment within a couple of days to get my blood results. I've seen the doctor here and he has talked to my GP, who has agreed to counsel me. I have known him for years and he has been very helpful. He is someone I really respect and admire, so I think I will really be alright.*

Other participants appeared to have gained confidence and hope from the fact that their partners were divorcing them. For these participants, their marriage had been a source of stress, which they felt contributed to their drug-use problems. The following comment demonstrates this view:

R24: *I have been basically relieved of obligations towards marriage and family. My children are more or less self-sufficient now and my wife is organizing the divorce. I won't have the same stress of trying to cope with a marriage and without that pressure I think I can get by [without drugs]. You know, I think one of the reasons I used so much was just to cope with my wife. Without that stress I think I will have a good chance of getting straight. I know I can't blame it all on her, but she certainly accounted for a good deal of the stress in my life.*

Reissman (1990) examined the meaning of the significance of divorce from the point of view of men and women who had experienced this event. Her study of divorce illustrated how a culturally "negative" event can, at times, be perceived positively by those involved. The findings indicated that divorce is less distressing for those people for whom the perceived benefits of marriage are less than the perceived costs. Similarly, Wheaton (1990) found that stressful life events such as divorce can have positive effects for people when prior stress in the marriage was high because it is viewed as stress relief. The response of the above participant (R: 24), which served to summarise how he and several other participants felt about divorce, was consistent with the findings from these previous studies. They appeared to perceive the approaching divorce as an

enabling event that would assist them to abstain from, or at least considerably reduce, their reliance on and use of drugs.

The participants who had been apprehended for committing drug-related crimes and were undergoing detoxification because of legal duress appeared resigned to the possibility of a prison sentence, or at least a community service order. These participants appeared to have no commitment to either reducing their drug use or abstaining from drug use in the future. Though they had complied with the legal order to enter the treatment program and attain a drug free state, for various reasons the balance they sought was to return to using their particular drug or drugs and avoid being caught breaking the law. In other words, their lives had become unbalanced because of their confrontation with the legal system. Regaining balance, in their view, meant returning to their habitual use of drugs. As one expressed it "I've been in [jail] before. It's not too bad, and once you know your way around it's not hard to get stuff [drugs]" (R22). Another had attempted suicide on several occasions and saw jail as just another mark of a wasted life. According to him "I have wasted my life. The things I have done, you wouldn't want to know. Why should I stop using? Drugs are all I've got" (R25). Another was expecting a court order for community service because it was the first time he had been apprehended for a drug-related offence. His future intentions were clear and were expressed as follows:

R26: Yeah, I'll do as they [the court] say. But then I'm out of here [the state]. Now I'm known to the cops they will not let me alone. *Besides, most drugs are easier to get in Sydney. Why should I stop?* I make more money out of drugs than I could with just a job. I will be much more careful in future and you don't have to stuff up just because you are using something or dealing a bit. Plenty of people do it and don't get caught. I don't know, but for me I think maybe somebody dobbed me in [to the police].

This participant's intention was to fully comply with the requirements of the treatment program and the court order when it eventuated. Following this, he was planning to move to another state, where presumably he would resume his drug

use and drug dealing lifestyle free from the pressures he anticipated from the police if he remained in this state.

Most of the participants were in treatment because of the disequilibrium in their lives due to problems associated with Hitting the Wall. The reasons that induced the participants to enter treatment had implications for their projected post-treatment outcomes. There were marked differences in terms of outcome goals between the participants who completed the treatment program because of legal leverage, and those who had engaged in the core process of Seeking Balance through Hanging In. The former were there merely to fulfill a legal requirement. For these participants, detoxification was no more than a forced period of abstinence from drug use. These participants appeared to be fully committed to reversing the physical gains achieved by completing the program (and being drug free) as soon as they could gain access to more drugs. In contrast, the other participants, albeit with differing levels of confidence, appeared to be committed to the core process of Seeking Balance through Hanging In identified in this study.

Clearly, the majority of the participants viewed the transition from the security and care provided in the unit with considerable trepidation and anxiety. This is well supported in the quantitative findings in Chapter 4, Section 4.9, which demonstrated, as determined by the GHQ-28, that 93% of the 421 individuals who completed a questionnaire had levels of minor psychiatric morbidity (anxiety, somatic problems, social dysfunction, and depression) which warranted further investigation.

7.6.2.1: Previewing coping strategies

As the time of leaving the unit approached, the participants contemplated strategies to enable them to continue their search for balance in their lives and to deal with the problems they anticipated facing once they returned to their original environments. One of the most common strategies mentioned was that promoted by AA: living one day at a time. In other words, they resolved to focus on the immediate problems and address them on a daily basis. This was a strategy that even those who had not attended the AA meetings conducted in the unit indicated they were going to employ. Others were intending to prioritize their problems and

address them sequentially. The following excerpt from transcripts illustrates how this was to be achieved:

R14: This time it's going to be different. *I know I can't do everything at once. I know what I have to do first, though.* I am trying not to think of everything that has to be done. Just one thing at a time. My counselor has helped me with this and I have a list of priorities that I will use as a guide to help me sort things out. Just doing one thing at a time should be manageable.

Another common strategy considered by participants at this time was to focus solely on maintaining abstinence from the drug(s) they had been using. The following comment summarises their intentions in regard to drug use: "I will never use again. I will just be terribly clean, and get on with my life" (R24). This was probably an unrealistic goal as relapse to drug use following treatment is a common outcome in the addiction literature. In addition, it is rare that drug use alone is the sole cause of many relational and lifestyle problems. Yet many saw the drug or drugs they had been using as the source of all their problems and assumed that if they ceased using drugs their problems would be resolved. Another strategy contemplated by some participants was trading off, that is, giving up something in order to gain something of greater value. For example, giving up some of the benefits associated with a lifestyle in which drug use featured prominently and which involved companionship and support in an attempt to achieve a drug-free existence. Other participants, however, appeared to have no strategies to deal with high risk situations, such as people using drugs in their presence, and were uncertain how they would react to such exposure. Some participants, such as those who were facing legal proceedings, appeared resigned to a possible jail term and were intending to resume drug use as soon as possible.

7.6.2.2: Follow-up arrangements

As the participants were preparing to move on and leave the unit, it was apparent that the staff, in consultation with the participants, endeavoured to ensure that those leaving had access to ongoing, formal support. This took the form of

arranging transfers and referrals. Transfer meant negotiating a direct relocation of the participant concerned to another residential facility. Referral meant negotiating an appointment to the out-patient clinics of the organisation concerned in this study, or to services provided at other relevant agencies. For those participants assessed as most likely to benefit from further residential care, attempts were made to negotiate transfers to other agencies that provided this service. For those who were considered likely to benefit from other forms of support, appointments were made with the most appropriate service. In other words, efforts were made to match the participants to their preferred choice of support.

According to Miller and Hester (1986), the reason for the frequent failure of outcome studies of alcohol and other drug interventions to show that one treatment is superior to another treatment is that subjects have not been matched appropriately. To receive optimal treatment, clients should be matched to interventions that address their specific problems and lifestyles (Lindstrom, 1992). This implies that certain treatments would be better for certain types of clients.

Recently a large national, multisite, randomized clinical trial of alcoholism treatment matching entitled Matching Alcoholism Treatments to Client Heterogeneity (Project MATCH) was completed in the United States of America (Project MATCH Research Group, 1997). This eight-year project was the largest alcohol related study ever undertaken, both in terms of funding (\$23 million) and the number of personnel involved. The aims of the project were to assess the benefits of matching alcohol dependent clients to three different treatments with reference to a variety of client outcomes. The three treatments were Cognitive Behavioural Coping Skills Therapy, Motivational Enhancement Therapy, and Twelve Step Facilitation Therapy. Two independent clinical trials were conducted, one with alcohol dependent clients receiving outpatient therapy, and one with clients receiving aftercare therapy following inpatient or day hospital treatment. Clients were monitored over a one-year post-treatment period and evaluated on a number of matching variables.

The primary outcome measures were percent days abstinent and drinks per drinking day. The results did not support the matching hypothesis, and indicated

that only psychiatric severity demonstrated a significant treatment interaction, and no single treatment showed an overall superiority in terms of post-treatment success regardless of what outcome measure was employed. Whether the results of Project MATCH can be extrapolated to users of drugs other than alcohol, or to the participants in this study who were dependent on alcohol, is unclear. What became evident in the data was that attempting to match the participants in this study to aftercare services was problematic, and highlighted the deficiencies in the availability of services for individuals with alcohol and other drug-related problems.

In reference to hospices, it has been noted that staff become negotiators with external agencies (Levy, 1987). This was found to be the case in this study undertaken in the combined detoxification unit. A large component of staff time in discharge planning was devoted to negotiating with external agencies to ensure that those leaving the unit were integrated into a suitable after-care network. While further residential care was an option in theory, in practice it was available to few, as only two agencies were able to offer this service, and both were restricted in regard to the type of client they would accept and the number of clients they were able to accommodate. Overall, only six of the 29 participants interviewed individually moved on to another buffer zone. That is, they were transferred to further residential care provided by another agency.

The others were offered appointments with different sources of community support such as other alcohol and drug agencies, outpatient clinics, marriage guidance counseling, financial counseling, and general practitioners. Of these participants, two refused this option for follow-up support. It is relevant to note that, of the two who refused the offer of an appointment for further support, one was a mother who had been using amphetamines with her partner and was concerned that she would be identified by her young child as a drug user. The other was a heroin user who had entered treatment after being involved in an episode of domestic violence with his mother-in-law.

In some cases, the appointments were unable to be negotiated until one or two weeks after discharge. This meant that most of the participants would be reliant on their own resources and strategies during this period. As demonstrated in the

quantitative findings, the uptake of the negotiated referrals of those who completed a questionnaire was 59%. This suggests that 41% were not formally engaged in any follow-up care or support. Formal referrals were not made to NA or AA as representatives of these groups visited the unit regularly and conducted groups on the premises. Hence all participants who wished to do so were able to make contact with these self-help groups. It is possible that at least some of those who either refused a formal referral, or did not take up this option, attended either or both of these groups. It is not known how many of the participants actually became engaged with these groups, though it was evident in the data that at least some had reservations about becoming involved in this type of support.

7.7: Summary

The basic social-psychological or core process of the experience of detoxification from psychoactive drugs was identified by the constant comparative method of grounded theory as Seeking Balance through Hanging In. This process was engaged in to deal with the problems and events of disequilibrium associated with Hitting the Wall and Incompatibility. The core process was found to have four sequential, relational, and overlapping phases that were conceptualized as Making the Break, Submitting to Cleansing, Fitting In, and Moving On. The first phase, Making the Break involved disengaging from social networks, ceasing drug use, and gaining admission to a combined, medical detoxification unit. Making the Break had two sub-categories, Seeking Admission and Dealing with Delays. Gaining prompt admission was contingent to a large extent on whether or not a bed was available at the time entrance to the facility was sought. While many of the participants were successful when they first sought admission, in some instances when the unit was full, some participants had to wait until a bed became available. Dealing with Delays subsumed the strategies used by the participants during this waiting period. Some of the participants ceased using drugs during this period, and the delay meant that the person concerned was already experiencing the unpleasant sensations associated with the second phase of the core process before they were admitted. Illicit drug (heroin) users, however, persisted with using drugs, and appeared to believe that delays in admission could

induce some drug users to commit crimes to obtain money to maintain their drug use. Other strategies used by the participants to expedite their access to the unit were telephoning the unit frequently and imploring their general practitioner to act as an advocate on their behalf.

Submitting to Cleansing was the second phase of the core process. There was considerable variation in the intensity of the unpleasant sensations experienced by the participants that were related to the type of drug or drugs that they had been using. In general, the participants whose main drug was alcohol appeared to experience more severe symptoms than those whose main drug was heroin or amphetamines. The participants dealt with the sensations by hanging in and enduring the discomfort. It was in this phase, Submitting to Cleansing, that the majority of those who left the unit without completing the program dropped out. Those who dropped out were almost all illicit drug users. They were viewed negatively by the participants who hung in and endured the unpleasant sensations because they were regarded as a distraction and drain on resources. That is, during their brief stay they occupied a bed that could have been allocated to someone who may have been more motivated, and they occupied valuable staff time in admission and discharge procedures.

The third phase of the core process was categorized as Fitting In. It involved complying with the treatment regime, socialising with other clients, and avoiding conflict and confrontation. There was wide variation in the way the participants experienced this phase, and not all were able to be involved in the therapeutic activities, particularly group therapy, to the same extent. For many of the participants the problems of Incompatibility that are discussed in Chapter 6 strongly influenced the way they socialised with other clients in the unit.

During the critical fourth phase of the core process, Moving On, when the time for leaving the unit approached, the participants reviewed their recent experiences, previewed the conditions that they considered they were likely to face, and attempted to develop strategies for coping once they left the unit. Residential treatment was viewed as an episode, a period of protective factors nestled among periods of risk and conflict, and one aspect in a participant's life. For the majority, the prospect of leaving was associated with feelings of apprehension or

uncertainty. Only a few exhibited confidence in their ability to achieve and sustain any lasting balance in their lives.

The participants who had undergone detoxification because of legal duress did not appear to engage in the core process of Seeking Balance through Hanging In. They did admit that there was a possibility that the experience of detoxification could have a permanent effect on their drug using behaviour. They appeared to regard their time in the unit as no more than an interim period of abstinence from drugs, a temporary loss that had to be endured. It cannot be assumed that these participants were engaged in anything other than compliance with the legal requirements that had brought them to the unit.

Individual strategies contemplated by some of the participants to sustain their search for balance by hanging in included living one day at a time, prioritizing problems, and addressing them one at a time with the one perceived to be the most serious dealt with first, and trading off relationships and associations with individuals who were drug users. Other participants appeared to have developed no clear strategies to deal with high-risk situations, such as those in which partners were likely to be using drugs in their presence, and were preparing to detach from the unit unshaped by any clear purpose or identification with any formal support. The main strategies negotiated by the staff, in conjunction with the participants, to enable access to after care services were referral and transfer, both of which were subject to structural limitations from other agencies in regard to time and available accommodation.

It was clear that there was considerable variation in how the participants experienced and progressed through the four phases of Seeking Balance through Hanging In. It was equally clear, that not all who completed the program engaged in all phases of the core process. For example, the participants who attended the unit under legal leverage endured the unpleasant sensations associated with their various drugs, complied with the treatment program and avoided conflict and confrontation with the staff and other clients. While they completed the detoxification program they were not committed to the same outcomes as those engaged in the process of Seeking Balance through Hanging In. The balance they were seeking was a reinstatement of their former drug focussed lifestyles as

apposed to attempting to achieve a drug free lifestyle. Several conditions were identified in the data that contributed to the context and ambience of the unit. These are discussed in the next chapter.

CHAPTER EIGHT

CONTEXTUAL AND MODIFYING CONDITIONS

8.1: Introduction

The way in which the core process, Seeking Balance through Hanging In, was experienced was strongly influenced by a number of conditions which existed in the treatment unit. These conditions largely made up the context of the unit and modified and shaped the progress of the participants during their stay. These conditions were the physical environment (space, privacy and personal territory, and material resources), control, expectations of treatment, and perceived staff workload. The conditions were not static; they changed over time in response to structural changes to the unit. These conditions interacted with the problems encountered with Incompatibility and strongly influenced the participant's perceptions of the care they received. In this chapter, the contextual and modifying conditions and their interactive effects on the participants are described.

8.2: Context

Context has been referred to as the ambience of the setting in which a phenomenon is found (Glaser, 1978), and the environment in which behaviour occurs (Hutchinson, 1986). Others have defined it more specifically as "Context represents the particular set of conditions within which the action/interactional strategies are taken" (Strauss & Corbin, 1990, p. 96). Van Maanen (1988) views meaning as coming from the interaction of self with the context and phenomenon concerned. It has been noted by others that

Regularities or patterns that can contribute to prediction and explanation may be found not in the phenomenon itself but in its context.

(Hinds, Chaves & Cypess, 1992, p. 72)

Despite these varied interpretations of the term context, there is general agreement in the literature that a phenomenon cannot be understood apart from the context in which it occurs.

The participants in this study were experiencing detoxification in the context of a combined medical detoxification unit. There was strong evidence in the data obtained during the first six months of data collection that the unit was too small and under-resourced to adequately manage 22 clients at any one time. In response to this, the management closed the unit to admissions for a period of three days, reduced the number of beds from 22 to 17, and purchased additional material resources for the program. The reduction in bed numbers, and the additional resources had a dramatic effect on how the participants viewed the care they received. The conditions that contributed to the context of the detoxification program, and which contributed to the problem of Incompatibility, are illustrated in Figure 11.

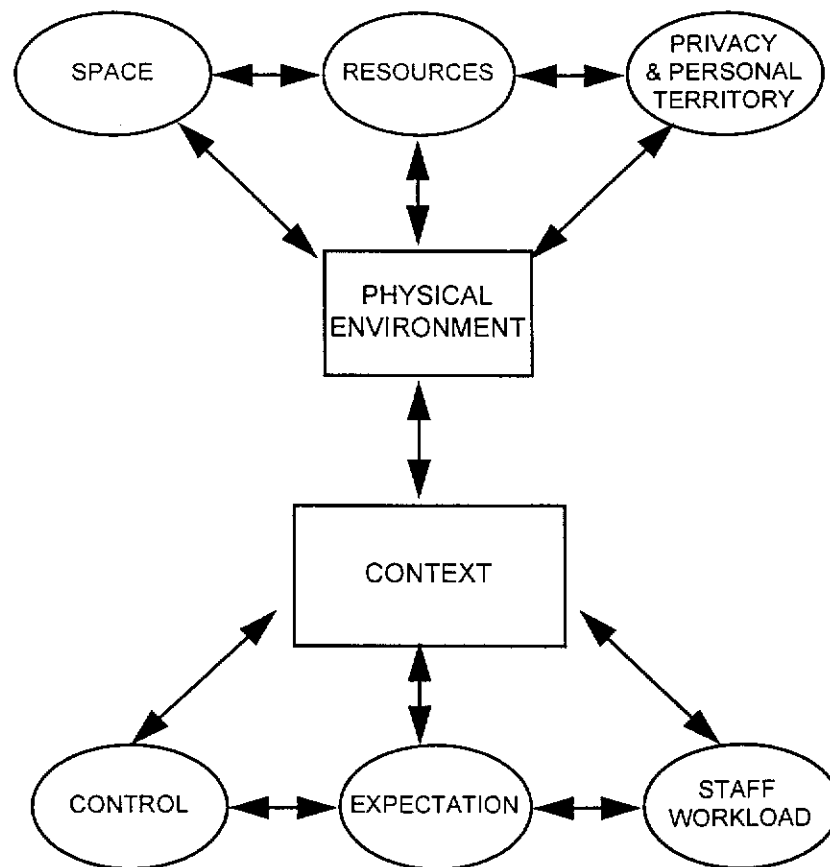


Figure 11: Contextual, modifying conditions

These relate mainly to the physical environment, resources, and the staff. These conditions were not stable over time, but changed in response to the reduction in

bed numbers and the acquisition of additional resources. More specifically, these conditions which are discussed in full below, were space, privacy and personal territory, material resources, control, the participant's expectations of detoxification, and perceived staff workload.

8.2.1: Physical Environment

The design of the interior of a facility is a constant and important component of treatment, and can facilitate or hinder the interactions of clients and the work of health care personnel. The effect of environments on the patients/clients and staff who live and function in them is well documented. In reference to psychiatric hospitals, Goffman (1961) noted that all aspects of residents' lives are conducted in the company of unselected others, who are required to do the same things on a fixed schedule, and residents and staff interact with one another in restricted, formally prescribed ways.

According to Shumaker and Reizenstone (1982), the social and physical environments in acute care hospitals depersonalise patients by treating them as homogeneous beings within diagnostic categories. In these environments, patients are vulnerable because of the illness that necessitated their admission and the fact that they are in unfamiliar surroundings. According to Rapaport (1982), physical spaces have meaning for people, which extends beyond inhibiting and facilitating actions to guiding the responses of those inhabiting the space concerned.

There was strong evidence that the physical environment considerably influenced the participant's experience of the detoxification program and the core process of Seeking Balance through Hanging In. It also aggravated the problems of Incompatibility. The aspects of the physical environment that were identified in the data as exerting the most influence on the participants in the unit were space, privacy and personal territory, and material resources.

8.2.2: Space

In the newly amalgamated unit, clients were accommodated three to a room and a bathroom was attached to each bedroom. There was a television/lounge room, a dining room, laundry facilities, a room for group work, offices for staff,

and examination and treatment rooms. The interior furnishings were in soft muted colours and there was ample outdoor space for recreation. The major architectural limitations were that the television/lounge room was a major thoroughfare for staff and clients and there were insufficient counselling rooms. The outdoor spaces, while pleasant in spring and autumn, were too hot in summer, and too cold and wet in winter. Hence for several months of the year they were not used to any great extent, and the clients spent a considerable proportion of their time indoors, generally in the television room. The following extract from the transcribed interviews conducted in the early part of the study represents frequently cited comments about the amount of space in the unit:

R3: It's *cramped* from a room point of view. That gives a feeling of being *confined*. It is sort of a situation where there doesn't seem to be enough *space* so to speak. The whole thing, you know, the actual building itself is not built for the *amount of people* they receive here.

The lack of space, and the number of clients in the unit, was particularly problematic for the participants in the phase of Fitting In. In that phase the participants were strongly encouraged by the staff to become actively involved with the full range of the therapeutic activities provided in the unit and socialise with other clients. As described in the previous chapter, during this phase the participants dealt with this and the problems of Incompatibility by complying with the demands of the program and avoiding confrontation and conflict with other clients. In addition, as has been noted in reference to acute care hospitals, patients have work to do during their illness episode (Strauss et al., 1985). This work goes largely unacknowledged by health care professionals, but is part of the division of labour in managing their illness. In the detoxification unit, participants were expected to take an active part, in collaboration with staff, in the organisation and management of their care. As an adjunct to counselling, group work, and other activities, each person, once they were well enough, was required to complete written exercises on problem identification, problem solving, goal setting, identifying situations likely to be high risk for drug taking, and strategies for relapse prevention. These exercises were referred to as "homework" and were

designed to assist the participants to assess their situation and to clarify what they hoped to achieve from detoxification. To do this properly they needed privacy and quiet for reflection and writing. As illustrated in the following comment, this was difficult to achieve under the physical conditions that existed in the early period of data collection.

R1: There is *not enough room* to write up your homework or something. You should be working on plans for more room, for another storey to add to the top of this one. *There is no place to think things through.*

The outcome was that at that time most of the participants made no more than cursory attempts to write up their homework. The lack of space made it difficult for the participants to fully comply with this requirement of the program. The workload of the staff at that period, moreover, was such that they were unable to find the time to encourage the participants in this exercise, or to attempt to organise some suitable space for people to withdraw to and reflect on their problems associated with Hitting the Walls. After the reduction in beds, however, this was not seen as a problem. The room in which the beds had been located was refurnished and made available to the participants to use for reflective homework and other purposes. As illustrated in the following comment, this appeared to be of considerable benefit to the participants in the latter part of the study:

R 21: *I spent quite a bit of time working on homework. It helps me think about why I'm in here. It makes me look at the problems I've got, and what I can do about them. It gives me something to talk about when I see my counsellor, something to work on. It keeps my thoughts focussed on what I've done and what I have to do. It clarifies my situation and helps me sort out the most important things I need to address when I leave here.*

8.2.3: Privacy and Personal Territory

Other aspects of the physical environment that contributed to the problem of Incompatibility were issues of privacy and personal territory. When people enter treatment in any public residential health care facility, they usually eat, sleep, and

meet in group situations, and give up some of their personal freedom. This can be difficult for alcohol and other drug users, who have often become socially isolated. Group living can present challenges for these people, as they may long have ignored even the simplest routines for sharing living space, such as keeping a room clean, getting to meetings and meals on time, and doing their share of whatever needs to be done in a family or group situation.

The participants in this study were experiencing the unpleasant sensations associated with the phase of Submitting to Cleansing, and were physically uncomfortable for some of the time, at least in the early part of their detoxification. They were also concerned about their condition and the problems of Hitting the Wall that led them to treatment and they were confronted with the problems of Incompatibility. At the same time, they had to comply with the requirements of the program, and interact with a number of people of different ages, gender, and from different drug subcultures. There were times when the participants preferred not to mix with others, but were unable to shut out social interaction. The following comment illustrates how some participants perceived the lack of privacy: "There is just *no room to get away*. Nowhere you could go for *time out on your own*" (R2).

Altman (1975) classified territory into three distinct groups on a continuum from high to low control. These were primary territory, such as their own home where individuals have high control; secondary territories such as areas that are semi public, in which people have some control; and areas that are public territories such as buses, trains, concert venues and others, which are places of low control. In each of these types of territories, there are expectations about how people should dress and act. The type of territory provided to individuals in public detoxification units, and many other health care facilities, does not fit into these categories. While those admitted were assigned a room and cupboard space for a limited amount of personal belongings, such as clothing and toiletries, they had no choice in which room they would be allocated, who would share the room with them, or who could enter it and when. This exacerbated the problems of Incompatibility, and added to the difficulties of avoiding confrontation and

conflict with other clients. As the following excerpts illustrate, in some cases, this appeared to lead to feelings of insecurity and vulnerability.

R11: XXXX was a little on the funny side. He got a kitchen knife and tried to slash his wrist with it. Because that didn't work he ended up getting a biro and doing it with a biro. That to me was a bit of a *shock*. After they carted him out they said to me you're moving. I ended up in his bed and I thought to myself *I hope I don't have any funny dreams*.

Other participants found that threats to security came from invasion of personal privacy. The following comment serves as an illustration of how this occurred:

R14: I had an experience yesterday. A girl in my room was leaving. She had been found with drugs on her, and before she left she *destroyed my knitting*. She pulled my knitting needles off. When I went to bed last night I put my head on my pillow and felt a lump. She had put a glass inside my pillowcase. I then searched my belongings because she had *placed pills on me*. *I didn't tell the staff because what's the use. They probably wouldn't believe me*.

The rules of the unit were quite specific: if any client was found to have drugs in their possession they were discharged. The above participant was very anxious to comply with the rules and regulations and successfully complete the program, as a report on her progress was to be used in a forthcoming court case regarding the custody of her daughter. She appeared to believe that if she reported this incident to the staff they would assume that she had obtained the drugs for her own use. Her feeling of anxiety was heightened because the outcome of her pending custody case could be seriously prejudiced if she was discharged for possession of drugs whilst in treatment.

Other events that contributed to feelings of insecurity in the unit were associated with the aggressive behaviour exhibited by some participants. This added to the difficulties experienced with fitting in and avoiding confrontation and conflict with other clients. Displays of aggression often took the form of

punching the walls or other objects. This behaviour is illustrated in the following comments:

R1: XXXX wanted to get into a *fight and hit someone*. He went out and slipped into a punching bag. He just thrashed himself to death literally. And then he came back to the table and sat there exhausted. His hands were virtually ripped to pieces. The nurses took him away and cleaned him up and he came back all bandaged up. He just sat there then and wouldn't talk to anyone. We wondered when he would start in on any of us.

Additional threats to privacy and personal territory, which contributed to feelings of insecurity and difficulties with fitting in and hanging in came from outside the unit. In a few instances, people who had been discharged broke in to the unit at night. These occasions were rare, but they had a considerable effect on the participants' experience in the unit. Their feelings about this are captured in the following extract:

R3: The other night XXXX came back over the fence and two of the blokes that were in the same room as he was must have been storing medication. He *came back to get whatever he could* out of them, then he disappeared. Last night there was another one trying to get into the place. The security guard got hold of him, but it doesn't take much to get through those bars. You have got *no real security here; if they get in they could do a lot of damage*. There is a lot of *fear* in this place because there are a lot of hard cases around who will do anything to get drugs.

Drug use on the premises was a cause of concern and unease for many participants. The drug that was most commonly used was heroin, which was smuggled in from outside the unit. Apparently, if a client wished to obtain drugs, he or she would contact one of their friends by telephone and arrange for them to throw a quantity of the drug concerned over the wall at a designated time and place. If any person was detected using unprescribed drugs they were discharged, and in some cases it was observed that they discharged themselves before being

asked to leave. Drug use in this context had a particularly upsetting effect on the participants, who questioned the admitting practices that allowed people who were not committed to abstaining from drugs into the program. Drug use in the unit generated feelings of resentment among those who were committed to the core process of Seeking Balance through Hanging In. Their feelings about this behaviour are illustrated in the extract below:

R17: There were a couple of young kids here on speed or something. They were injecting drugs in their room and it was quite messy. *There was blood all over the room and so on. It looked as if they had been shooting it all over the walls and bed.* They stayed a day and a night and took off you know, because they couldn't handle it. *People like that shouldn't be allowed in here.* This place should be for those who are genuinely trying to get off the stuff, not those who have no intention of giving up. It's hard enough for us in here without them throwing drugs all over the place in our faces so to speak.

The two individuals involved in this episode had been admitted for detoxification from amphetamines. They had procured some drug, possibly heroin or perhaps an amphetamine, from external sources and had injected themselves with the drug in their room. Following this, they had sprayed the mirror, walls and ceiling of the room with blood stained fluid. The amount of blood actually sprayed around was probably quite small, but the effect on all the participants in the unit at that time was considerable. In particular, it appeared to confirm the views of licit drug users, that illicit, injecting drug users should not be admitted to the unit. Illicit drug use in the unit appeared to be more of a problem for the participants interviewed in the early part of data collection than those interviewed after the structural modifications to the unit had been implemented. In the latter part of data collection there was little mention of it in the data, though from informal conversations with the staff it was obvious that some illicit drug use did take place, but at infrequent intervals.

8.2.4: Material Resources

It was evident that, before the number of beds was reduced, the unit was under-resourced in other areas and participants were in competition, not only for space, but also for other resources. This was a particular problem for the participants when they were enduring the unpleasant sensations of the phase of Submitting to Cleansing. For example:

R19: I'm suffering from muscle spasm and I have a medical condition [migraine and urinary tract infection]. I haven't had a hot pack because there are *too many coming off smack [heroin] and no hot packs left*. I know hot packs are not a cure all, but they do help, at least for a while. I haven't been able to get one for two days, and my room does not have a bath so I can't even have that. If I could only have a hot pack or something it would help.

This participant was a poly drug user who was withdrawing from heroin. Individuals withdrawing from opioids frequently experience severe abdominal cramps that are often alleviated without medication, by the application of heat. This was done in the form of applying hot packs to the abdomen, or taking hot baths. Only two bathrooms contained baths; the others had shower facilities attached to them. At the time this participant (R19) was interviewed, there were eight other people in the unit enduring the unpleasant sensations related to withdrawing from heroin, none of whom were in a room with a bath, and the demand for hot packs exceeded the available supply.

Another area in which resources were inadequate was sporting facilities. In general, after a participant had been in the unit three days they were expected to become more involved in physical activities, and a room with various pieces of gymnastic equipment was available for this purpose. Though it existed, in reality it was little used because the room was too small to accommodate the number of people who were eligible to avail themselves of it at any one time, and for long periods the room was closed. This did not appear to be a major problem for the majority of participants, as they appeared not to be interested in working out in a gymnasium. Some of the other participants, however, would have welcomed the

opportunity to engage in this type of exercise. The following comment serves to illustrate their feelings:

R16: *There is an exercise room, you know, but we are not allowed to use it because the room is too small. It is small, but not everyone wants to use it. So I think it should be opened up for those who do. I mean what is the point of having it if we are not allowed to use it?*

Another important aspect of the program was participation in outings. These were organised by a community coordinator and were aimed at (a) introducing people to a range of low cost activities which could be engaged in as alternatives to alcohol and other drug use, and (b) decreasing the social isolation experienced by many alcohol and other drug users. As noted in Chapter 7, Section 7.2, the core process engaged in by the participants in this study was one of seeking, not regaining, balance in their lives. The outings could potentially provide opportunities for the participants to increase their social contacts, improve their self-esteem, encourage new interests, and improve their overall well being. They could also encourage the participants who were engaged in the core process to continue their search for balance and a lifestyle free from drugs after they left the unit. The activities took the form of taking the participants, in buses, to sporting facilities such as bowling alleys, public swimming pools, the beach, and picnic areas. In addition, when possible, they were introduced to such things as bush walking clubs, craft centres, and many other indoor and outdoor activities. For obvious reasons, the activities were largely dependent on the season and the weather. For instance, the beach was not a very attractive venue in winter or when it was raining, neither was bush walking or other outdoor sports in the middle of the intense heat of a Western Australian summer.

Introduction to leisure pursuits was contingent on having access to sufficient resources to transport people to the relevant areas. This was not always possible, particularly in the early part of the study. The amount of transport available at that time was inadequate for the number of clients who were assessed as being well enough to take part in whatever had been arranged for the day, and consequently, at times, not all were able to be accommodated. The following

comment serves to demonstrate how participants viewed being unable to take advantage of this option:

R3: There is not enough room in the van for everyone. We *have to take turns* on who goes [on outings]. *Some have not managed to go at all.* I don't mind really, but some of the people here would like to get out. I think if you offer this sort of thing it should be able to be used by everyone.

Not going on outings or having to take turns was not viewed as a problem by some participants who gave up their place to allow those they thought might benefit more to attend. As one participant commented "I would like to go out. But if I go somebody else misses out. So I just stay here and let the others go" (R5). It is possible that giving up a place on an outing was a strategy used to avoid company with other clients, at least for a short period.

The acquisition of additional resources that occurred after the reduction in beds did not include the purchase of a new van or bus. The problems associated with the lack of sufficient hot packs and sporting equipment were resolved, but those related to the lack of room in the van which limited the number able to take part in the planned outings remained.

8.3: Control

Control refers to the organisation of the detoxification program. This includes the selection process, that is, who will be admitted and when, who will be discharged and when, the rules that govern day-to-day behaviour in the unit and the therapeutic program. In regard to the selection process, the criteria for admission was that the person concerned should be either exhibiting withdrawal symptoms from some drug or combination of drugs, and unable to be managed on an outpatient basis. As described in Chapter 7, Section 7.3.2, in the early part of the study, people who met these criteria could generally be admitted when they presented for assessment. As the study progressed and the number of beds in the unit was reduced to a level that was more consistent with the available resources, many participants who sought admission could not be admitted so readily and had to wait until a bed became available. While this reduced the stress in the unit, it

placed additional stress on those who had to deal with the delay in being admitted. This is well illustrated in the first phase of the core process, Making the Break (Chapter 7, Section 7.3.2). The strategies used by the participants to deal with the delays included telephoning the unit frequently, getting their general practitioner to act as an advocate to expedite their admission, and in some cases continuing their drug use to avoid the onset of withdrawal symptoms.

A typical day in the unit has been described in Chapter 6, Section 6.4.1. (Daily routines). The regimen included proscribed times for rising and retiring, showering, meals, therapeutic activities such as group therapy and recreational outings, medical and counselling appointments and medications. In other words, there was a sequential ordering of activities and an organisational base on which the daily routine and overall program was conducted, and clients were required to comply with an established program.

Control in the unit was exercised by both the staff and the participants. Staff controlled the entrance to and, to a large extent, exit from the program. They also controlled the participants' movement through the program, and could discharge a participant in the event of disruptive incidents such as non-compliance with the rules and regulations. Staff also controlled transfers to general hospitals and, in negotiation with participants and other agencies, referrals for after-care.

The participants had limited control over the program in that they were aware that they could not be confined against their will and they could leave anytime they chose. This was the case even for those who were present under legal duress. These participants could leave at any time, though the legal consequences of such an action would likely be unfavourable. The majority of participants, however, persevered with "hanging in" through the phases of the core process and the treatment program.

8.4: Expectations of Detoxification

It is almost impossible to enter any social situation in a state of *tabula rasa*. The assumptions of *tabula rasa* are that the past has no effect on the present and that the present is a blank sheet (Douglas, 1993). People have expectations of how they should behave in most situations, including encounters, for whatever reasons, with health care services. Expectations can operate as a filter of

experience, a framework to lend meaning to experiences, or a guide to decision making about certain actions. Expectations influence how a situation or event will be judged, and what value a person will place on the experience.

Hence it is reasonable to postulate that people develop expectations of treatment episodes based on previous experiences and the information they possess or acquire, regardless of the accuracy or quality of the information. The fit of expectations in relation to actual situations can range from poor to good depending on circumstances. If the fit becomes too incongruent it can become a cause of conflict. Some participants in this study were undergoing their first experience of detoxification; the majority, however, had experienced at least two or three previous episodes. Previous experience exerted a considerable influence on their expectations of the current episode, particularly if this had occurred before the units were amalgamated.

Whether the previous experiences of detoxification were synonymous with the process of Seeking Balance through Hanging In described in this study is unknown, and it cannot be assumed that the two were identical. As the following excerpts from transcripts illustrate, some participants who had experienced detoxification in what had been the illicit drug unit appeared to think that the care they were currently receiving was different to that which they had received previously. They also considered that the care they received was inferior to that given to people with alcohol-related symptoms. This is illustrated in the following extract:

R2: The other detox I was in was mainly for narcotic users. This place is *all different now, and we don't get the same care as we did in the other place. It's much more like a hospital, you know, and all the attention goes to the alcoholics.* I guess they are sicker than us [heroin users], *but we need care too.* The nurses are always with them, checking how they are and helping them to shower and things, and they don't seem to have the same time for us.

Other participants who were accustomed to the routine of the unit that had been mainly for alcohol users found some of the rules of the combined unit restrictive.

Of particular note was the rule related to visitors, and the regulation that no client was allowed out of the unit on their own.

Regulations related to visitors vary from one health care facility to another. Some facilities have few restrictions on visitors; others limit visitors to certain times and certain days. In some instances there are also restrictions on the number of people who are allowed to visit at any one time. These regulations can change through time in response to the views of the organisation concerned regarding visiting privileges. This was the case in the unit in which this study was conducted. Each detoxification unit, prior to the amalgamation, had specific rules related to visitors. In the unit for licit drug users, the visiting hours had been generous and few restrictions had been imposed on either the number of people who could visit, or the time they spent with the person they had come to see. In contrast, in the illicit drug unit, no visitors had been allowed because of the risk that drugs would be brought in for the clients.

After the amalgamation, there were several changes in relation to visiting privileges. Initially, visitors were permitted on two afternoons a week and there were no regulations governing the number allowed in to see each client. After a number of incidents, in which young children had been disruptive in the unit, no child under the age of twelve was permitted in the unit. Later, this was amended to permit young children in provided the person they were visiting was well enough to supervise them. Following other incidents that involved visitors supplying clients with illicit drugs, the rule was again changed to permit children under twelve to visit and prohibit all over this age.

Eventually, in response to complaints about the inconsistencies regarding visiting privileges, a “no visitors” rule was enforced. The effect of these changes on the participants had a negative, unsettling impact of some of the participants, and contributed to the sense of incompatibility with the rules.

R3: Things change. When I was here last time visitors could come in to see you on Tuesdays and Thursdays between the hours of 5.30 and 7.00 p.m. and everyone could come. Fathers and mothers, husbands, sisters, brothers, everyone. Now the rules have changed and no person over the age of twelve is allowed in the building. I

realize the rules and I mentioned to my counselor that my boys were coming in. They are thirteen and fifteen and my thirteen-year-old had made some cookies at school and was going to bring them in to me. I had to ring and say "Look you can't come in because you are over twelve". *It was a big disappointment for me. They would be no trouble and I can't see why they are not allowed in.*

This participant had obviously been looking forward to seeing her sons and sampling the cookies one of them had baked for her. She could see no reason for the change in the rule and was disappointed that her sons were denied access to the unit on the basis of being over twelve years of age. This rule was also a problem for those who had no children.

R9: Now you are not allowed any visitors apart from children under twelve. I mean, I'm nineteen years old and I don't get on well with twelve or nine year olds. I can't have my cousins come and see me and close friends and family are not allowed in. *I don't think that's fair.* I mean they can't tell me that it's because people will bring drugs in for me. I wouldn't be here if I was going to use drugs. I would just jump the fence and go and use. I came in here to stop using drugs.

Shortly after this participant was interviewed the rule was changed again and only people over the age of twelve were permitted to visit. As evidenced in the following comments, refusing access to children under the age of twelve was also problematic for some participants:

R11: It's something new [no children allowed] and it's a very sore point. There is a female in here who might as well be non-existent as far as cooperation goes. She wants to do the right thing, but she's that depressed. The problem is that she's got a twenty-month-old daughter. *Now the daughter is not allowed in, but the husband can't come in without the daughter and it's got her in a completely depressed state.* So of course she doesn't want to do anything. It's a bad case for her, it's not doing her any good. They should make allowances for these cases.

R10: There's a chap in my room who has three children. One of them is fourteen, one is thirteen and the other is fifteen months old. The other day the two older kids came in to see him, but the fifteen months old one was too small. It just happened that we were going on an outing in the bus and there was the mother sitting out there on the kerb with the baby for the duration of the time the other kids were in here with their father. You know, *everyone in the bus was completely irate about that*. It's a ridiculous rule for any place. *The whole concept of visiting rights needs to be reviewed*.

The inconsistencies in the changing regulations related to visiting privileges had a negative impact, not only on those participants with young children, but also on those to whom it did not apply. Eventually a "no visitors" rule was introduced and rigidly enforced. As the following extract shows, some of the participants were relieved that visitors were not allowed in the unit.

R15: Well you know there has to be rules. When I first came in here I resented the fact that there are no visitors. Now I totally understand why not and it is a good thing that visitors are not allowed. You are in here for one thing, to get detoxed. That the reason we are all here. We need time out, time to get straight. *It is a good thing that visitors are not allowed*.

Other participants had alternative views on the issue, and felt deprived by the lack of contact with visitors. They felt that the rule had been introduced because of the possibility that visitors would bring drugs into the unit. They thought that this could be avoided if the staff routinely "checked out" all visitors for possession of drugs. They considered that they needed social contact with visitors because they were unable to converse with the other clients. Their sense of deprivation is summarised in the following comments:

R19: All the rules have changed now and no visitors are allowed. Visitors are what keep me sane. Most people around here, you know, you can only talk to them occasionally because once they get their medication they are drugged out or they are in counselling or something, or they are too depressed to talk. We ought to be allowed visitors. If the staff checked the visitors out they wouldn't bring in drugs. Some people don't

mind about not having visitors, but it's not fair on the rest of us.

Throughout the period of data collection, the various rules related to visitors remained a source of irritation for many of the participants. From observation in the unit it was obvious that they were also a concern for staff who were confronted with the task of enforcing whatever variant of the rule was in place at the time. In the early part of the study it was not uncommon for the staff on duty to have to take time to conciliate disappointed and irritated clients complaining about the visiting rules. Though the majority of participants accepted the policy regarding no visitors that was eventually introduced, some felt deprived and considered that the rule was unjust.

No client was allowed out of the unit unescorted. Clients were encouraged to go on arranged outings, but at all times they were accompanied by a member of the staff. In comparison with their previous experience in the unit for licit drugs in which solitary walks had been permitted, some of the participants considered the amalgamated unit to be more regimented, and were disappointed that the staff appeared to be less accessible. The following comments demonstrate how amalgamated unit was perceived in comparison with the unit that had been solely for licit drug users:

R1: The other place was *much more open and you could go for a walk if you wanted to*. It was more homely somehow. You could talk to the staff about things, and if you weren't satisfied they would try to help. This time, I have to say *I'm disappointed*. It's very hard to get to talk to the staff now, they are too busy. It's not what I expected and it's much more *regimented and confined*.

There was a strong sense of being confined, of not being able to have some time out by themselves. This added to the problems of incompatibility, creating difficulties in avoiding conflict and confrontation with others. This feeling is well depicted in the extract below:

R6: This is my second detox. The first was in the other unit for alcoholics. Now that was different. We could go

for walks and have visitors, and all that sort of thing. *Now we're locked up. I wasn't prepared for this.* I have never been locked up before. I know I can leave at any time and I am here of my own free will, but we definitely can't even go for a walk around the block by ourselves here. We can't get away without actually leaving the program. I would like to go for a walk by myself, but that is definitely not allowed. The only way that can be done is if a nurse can go with you. But they are too busy to take just one person for a walk. They might agree to take two or three people but that defeats the purpose because then I would not be by myself.

Some of the participants attributed the restriction on solitary walks to the presence of heroin users in the unit. The following comment serves to depict this attribution:

R12: This place is all different now. Nobody told me this is a completely locked unit. You're not allowed out at all except with an escort. I find this very heavy, as I have never been locked up in my life before, and I resent it. But I suppose you have to *keep the other lot [heroin users] in.*

Other participants, who were experiencing their second episode in the combined unit, were more prepared to adapt to the routine and accept the prevailing conditions. The following comment describes the conditioning effect of a previous admission to the amalgamated unit:

R3: I'm doing alright here now. I was in here three months ago, that was my first experience of any of this. *I didn't know what to expect then.* Now I know what to do, like about the groups and what you can expect to get out of them. *I'm better prepared to be involved.* Possibly this time I have more direction. I don't know, but I'm managing much better and am getting more out of it. I know how the place works and what I'm supposed to do.

Those participants who were experiencing their first episode of detoxification had no baseline experiences with which to make comparisons. For some

participants this resulted in a "wait and see" attitude that is summarised in the following comment:

R23: This is my first time for detox. *I didn't know what to expect.* I hate the thought of being in here, but the nurses treat me with respect, and *I'll just wait and see.* I know it is not the whole answer, that I have a lot of problems to deal with, but I'll see what happens in here.

The expectations that other participants had on entry to the unit appeared to be related to their stereotypical views of the type of person who uses illicit drugs. The perceptions that users of licit drugs had of users of illicit drugs has been described in Chapter 6, Section 6.3.3. Being in close proximity to a number of illicit drug users, however, caused many of the participants to reconsider their views. This shift in perspective is well portrayed in the following comments:

R25: I have never been in a place like this before. I thought it would be a place full of junkies you know. Real awful people, covered with tattoos and things. People who hold up chemists and break into houses and things. *But it's not like that,* most of them just seem sick and miserable somehow, and are just trying to get off their drugs, same as I am. Most of them have tattoos but they are not covered with them and some of them [tattoos] are quite small. Some of them have even tried to have them removed, but they say that's expensive and not very successful. In fact most of them are more miserable than us [alcohol dependents] in their own way. At least we don't have the problems that they have with the law and that.

In summary, people who had been exposed to previous detoxifications in other units had developed expectations based on their earlier experience, which in some cases resulted in feelings of resentment and disappointment with the current situation. These feelings contributed the problems of incompatibility and the difficulties of fitting in and avoiding confrontation and conflict in the unit. In contrast, other participants who were undergoing their second detoxification in the combined unit considered that their previous experience had better prepared them to be able to fully participate in the combined program. Other participants

undergoing their first detoxification were prepared to suspend judgement of the program and some had their pre-existing perceptions of illicit drug users challenged.

8.5: Staff Workload

Seeking Balance through Hanging In was not experienced as part of the normal process of the participants' lives. It was engaged in at a particular time in a participant's life to deal with the problem of Hitting the Wall and the problem of Incompatibility encountered in the combined treatment unit. In the early part of the study, before the bed numbers and material resources were adjusted, the participants perceived the workload of the staff to be heavy, and believed the staff to be under considerable stress. The participants relied on the staff to provide them with care, guidelines, support, and encouragement whilst they were in the unit. Hence during this period the staff were their most important resource, and when the workload was stressful it exacerbated the problem of Incompatibility, and modified the way the participants viewed the care they received. It was obvious from the early data that the participants perceived that the staff at that time were highly stressed by the workload in the unit.

There is a substantial body of research on work stress in health care settings. Initially, much of the research was concentrated on the stressors experienced in Intensive Care Units (Caldwell & Weiner, 1981). Since then, researchers have studied the stressors encountered by nurses in other acute care settings (Chiriboga & Bailey, 1986; Dewe, 1988). In a recent review of studies of work stressors in health care environments, it was noted that among the most salient were those related to unit management, understaffing, and heavy workload (Foxall, Zimmerman, Standley & Bene, 1990). The research cited above was conducted in settings other than a detoxification unit, the findings however, in regard to workload, were of particular relevance to this study in the early part of data collection. The way the participants perceived the staff's workload at that time is portrayed in the following comments:

R1: The staff are definitely *overworked, flat out in most cases, their work is cut out*. Recreation is a problem. We were told we were going on an outing, but nothing

happened. When we asked about it, it was because of *shortage of staff*. So there was this matter of hanging around, with nothing to do.

During the early part of the study it was not uncommon for staff to be called on to work double shifts. As one participant commented “The workload here is on the increase. I’ve seen a lot of *double shifts* worked. This adds to stress” (R3).

R9: The staff are *very busy*, what with clients coming through the door one after another, just like a mob of sheep. They [staff] are flat out just getting them organised. *It’s hard to get a word with them*, they are all busy with all the people who are coming in here. They are just flat out, and have to work very long hours. *Some are here all day, they just don’t get a break*. It’s really not fair on the nurses. They try their best, *but they have no time for us who have been in here a while*. The new ones take up all their time.

While the participants appeared to be sympathetic towards the staff who were working long hours, they felt marginalised in terms of the care they were receiving at this time, as most of the attention was directed to new clients. The participants who had been in the unit for a few days felt they had unequal access to the staff and were unable to communicate with them. Some of the participants attributed this perceived lack of attention to the demands made on staff by illicit drug users. This is well illustrated in the following extract:

R5: They [staff] work hard. The *druggies [heroin and amphetamine dependents]* are always hassling them for something, like more drugs. They never seem to let up. They never give them [staff] a break. They keep at them about what medication they’re on, nagging them for more and always complaining about how they are not getting enough [medication]. They don’t seem to grasp that they are supposed to be coming off drugs and that it is not easy.

These comments were supported from observation in the unit. The participants who were experiencing detoxification from heroin and amphetamines were particularly demanding on the staff at medication times. They frequently questioned the amount and type of medication they were receiving, and made

requests to see their doctor. They appeared to expect that a doctor would see them immediately, even after hours, and some became abusive to the staff when their demands was not met. Attending to these illicit drug users frequently took up a considerable amount of the staff's time, and other participants had to wait to have their needs addressed. Paradoxically, in the data presented in Chapter 6, Section 6.3.6.3, illicit drug users appeared to believe that the staff spent too much time caring for licit drug users, particularly those whose main drug was alcohol.

The workload appeared to dictate to a large extent how the participants could interact with the staff, and vice versa. It also appeared to influence the type and amount of care able to be provided to the participants. Work stressors in any form tend to lower staff efficiency (Foxall et al., 1990). What occurred during this period was that the staff's ability to provide professional care, and address the individual needs of all the participants, was inhibited by the necessity to attend to the basic tasks required to maintain the safe passage of participants in and through the unit. In addition, the demands made on staff by the number of admissions to the unit at this time contributed to work related stress, at least as perceived by the participants.

It was clear from participant observation that the staff gave priority to caring for those who had acute withdrawal symptoms, and the tasks associated with admitting and discharging clients. These activities had priority over such things as organising outings for those who were relatively well and which could only be undertaken if the staff were not engaged with other work. The participants who were eligible to go on an outing were advised of this the day before the event and, in general, most appeared to look forward to these activities. When the planned event had to be abandoned or postponed because of pressure of work or lack of staff, the participants were left with free time until sufficient staff were available to attend to the less pressing aspects of the program. The consequences of this are summarised in the following excerpts:

R9: There are *some things not done*. Meditation would help, but that seems to be non-existent these days. They [staff] have been too busy with new cases coming in all the time. Nobody has the time to organise any thing

like meditation. Relaxation would help and more counselling, but the nurses just don't have the time.

R11: Every time there is no group or outing or something, *everyone just sits around smoking and drinking coffee.* They have a cigarette, walk around, have another cup of coffee, and then another cigarette. *The coffee makers and cigarette manufacturers are making a fortune out of this place.*

It was obvious from observations in the unit that cigarette smoking and coffee drinking were common behaviours. In fact, no exceptions to this were identified. As evidenced in the above comments (R9), when certain aspects of the program were unable to be provided by the staff, most of the participants filled in the time smoking cigarettes and drinking coffee. Another consequence of the heavy workload of staff was that, at times, some participants were not adequately introduced into the program, and contact with their counsellor was limited. This is demonstrated in the following comments:

R12: I had been here five days before I had an interview with my counsellor. I think the staff were very busy with all the clients coming and going. *They didn't seem to have time to see if people understood how the place worked.* I didn't know I had a resource person I could approach at any time. I didn't know I was supposed to be doing homework, I just didn't know what I should have been doing during that time.

The above participant (R12) appeared to have spent five days without being fully aware of "how the place worked". When clients were admitted to the unit they were provided with a comprehensive package of information on the routine of the unit, the general rules, meal times, group times, access to telephones, access to doctors, counsellors, welfare workers, outings, leisure activities and other items pertaining to the therapeutic program. In addition, they were introduced to a staff member who would be their primary case manager and resource person. Information about events has been shown to increase people's feelings of control, confidence, and adaptation to situations (Paulus & Matthews, 1980). The stress associated with surgery and medical procedures has been reported to be reduced

by providing patients with information about what to expect (Johnson & Leventhal, 1974).

Information on the likely course of withdrawal, the likely intensity of the symptoms, the medications that would be used, the plan for care, and orientation to the setting and the rights of the individual has been demonstrated to have a substantial effect on the withdrawal syndrome. In a randomised controlled trial of information versus no information, significantly lower withdrawal scores were found for those given information compared to those who received no information (Green & Gossop, 1988). The issue was explored informally with staff and it was established that the admission procedures had been followed. The participant concerned, however, appeared to have no recollection of this, and was unaware of certain aspects of the program. Providing such comprehensive information at the point of admission may be something of an overload for people entering a detoxification unit. Information should be controlled, time spaced, and transmitted in a style that a client is able to comprehend, so that it fulfils the purpose for which it was produced and works to the client's advantage.

In summary, in the early part of the study the participants perceived the workload of the staff to be stressful. This was confirmed by participant observation and informal interviews with the staff. The consequences for the participants were that aspects of the program were omitted, and some did not receive information that would have helped them with fitting into the unit. Many of the participants felt marginalised from care as the staff devoted most of their time to dealing with new clients. Licit drug users appeared resentful of what they perceived to be a lack of contact with staff, but attributed this to the demands made on staff by illicit drug users. In contrast, illicit drug users appeared to believe that it was due to the amount of care provided to licit drug users. The factors related to the workload of the staff contributed to the participants' problem of Incompatibility and fitting in with the program. It is relevant to note, however, that these data were obtained from interviews and participant observation done prior to the reduction in bed numbers and the acquisition of additional resources for the unit. Staff workload did not appear to be a problem for the participants interviewed after the structural modifications to the unit had been implemented.

8.6: Perceptions of Care

The contextual conditions combined with the problem of Incompatibility to exert a strong modifying effect on how the participants viewed the care they received. One of the major conclusions from alcohol and other drug treatment research is that, while there are a range of interventions and approaches to treatment available, there is no single one that is fully effective for all clients (Lindstrom, 1992). Uniform approaches, moreover, may disguise significant interactions between particular subgroups and the treatment provided, and may have less than optimal outcomes. In certain cases, this may require separate programs for subgroups of individuals such as women, Aboriginal people, or for those dependent on different drugs such as alcohol and opioids. In regard to the latter, this was essentially what was provided by the agency concerned in this study before the amalgamation of the residential services mentioned above. In general, though, individualised care plans can be developed within general programs to address the specific needs of each client. In the information package provided to clients on admission there was a strong emphasis on treating clients as individuals and providing individualised care. That this was notably lacking in the early part of the study was evident from data obtained at that time from participant observation and interviews. The following extract summarises how the participants viewed the care provided before the bed numbers were reduced and the unit was better resourced.

R2: They [staff] are inexperienced. I mean they are more used to dealing with alcoholics than drug addicts like myself. They just *don't make allowances for individual cases. So now to tell the truth I think the place is run very badly, and they have no concept of people's feelings.* I don't think they have the knowledge, or the understanding or the caring that's needed for these types of drugs [heroin]. Everyone receives the same sort of counselling. You tend to be *cloned*.

The combined effect of the cramped physical environment, the heavy workload of the staff, and the problem of Incompatibility contributed to creating a particularly stressful environment at that period, for both participants and staff.

The brief closure of the unit to admissions and the reduction in beds was a distinct disjunction point. The positive effect of this event on the participants' view of staff, as evidenced in the data obtained after this episode, was dramatic. Their views of the night staff are summarised in the following extract:

R15: They [nurses] are pretty *good at night*. *They are always there*, they come around every hour to see if you are alright. They are always there if you can't sleep and want to talk. They really look after us.

R16: The nurses here are *very understanding*. *Always ready to listen*. They all try to help. I haven't met one that wouldn't try their best to help you out. They seem to know just what to do to get you through the night.

In contrast to the views expressed earlier, the participants now regarded the staff as highly professional, able to increase their levels of confidence and self-esteem, and provide individualised care to enable them to better address their problems. The way they expressed these perceptions is captured in the extract below:

R19: The counsellors here are *brilliant*. *They seem to know what I've been through, and they are very helpful*. They are all very professional and won't take any bull. They know what they are doing, and really help you work through your problems.

R21: The staff give you the *confidence and self-esteem* you need to survive without drugs. *I couldn't get that on my own*. They have helped me believe that I will be able to get my shit together again. There is no way I could do it by myself.

Coupled with the belief in the professionalism of the staff was a strong theme of appreciation for the care received whilst in the unit. This is well expressed in the comments below:

R23: I really appreciate what the people who work here do. *They are marvelous*. *The nurses are very good*. *The one I have has never once looked down on me, and she is helping me get the strength to change my life*. She is

giving me the confidence to believe in myself again. I don't think I could have done it by myself.

R25: The nurses are tremendous, they have *helped me tremendously*. They are always ready to listen, and they are very competent. They are good nurses. *They treat me as a person, with respect*, and are always there when I've needed to talk. I am very grateful to them all.

The positive attributes of the staff that, in participants' views, appeared to be markers of professionalism, and which resulted in appreciation and gratitude for the care provided are listed below. They are:

- Being “good” at night. This meant monitoring the condition of the participants on an hourly basis, and being prepared to spend time and talk to them if they (the participants) were unable to sleep.
- Being available, understanding and willing to listen to the participants.
- Being competent and helpful.
- Able to increase the participant's confidence and self-esteem.
- Being non-judgmental in their attitudes towards the participants.
- Treating the participants with respect.

Prior to the brief closure of the unit to admissions and the reduction in beds, the staff had been working to ensure that the participants were admitted appropriately, their withdrawal symptoms were monitored, the essential groups were conducted, discharges were planned, and referrals for aftercare were negotiated. These tasks were necessary to maintain the flow of clients through the unit. It is not that the staff were indifferent to the individual needs of the participants at that time. Rather, they had little time to spend with participants on the individual level, and organisational procedures took priority over individual needs. What was delivered in the program prior to the structural adjustments was far short of what was stated in the documents on the policies, procedures, and goals of the unit. The differences between the participants' perceptions of care in the early part of the study as compared to the latter part are illustrated in Figure 12.

The type of care provided was perceived by the participants to be highly professional and individualised when the fit between available resources, both human and material, and the number of clients in the unit was congruent. This meant that the physical and human resources available were adequate for the number of participants in the unit at any one time.

| | | | |
|------------------------|-------------------------|---------------------------|------------------------------|
| | OVER CROWDING | NO CROWDING | |
| CLONED CARE | INADEQUATE RESOURCES | ADEQUATE RESOURCES | PERSONALISED CARE |
| | HEAVY WORK LOAD | EQUITABLE WORK LOAD | |

Figure 12: Perceptions of care

When the fit was incongruent, that is, when the pressure on space and other resources was considerable, interactions with staff became problematic, and prejudiced the participants' views of the care they received. In the early part of the study, care was viewed as "cloned" and it was considered that individual needs were not addressed. When conditions changed and bed numbers were adjusted to be more in line with the physical constraints of the unit, care was perceived by the participants to be of high quality and personalised.

Although busy periods were observed later in the study, at no time was the degree of stress on staff and participants, so obvious in the early part of the study, evidenced. The reduction in the number of beds reduced the number of clients in the unit at any one time. This relieved the pressure on both physical and human resources, and appeared to be sufficient to prevent subsequent busy periods becoming stressful, at least as perceived by the participants and observed in the unit.

The detoxification program did not change, nor was there any increase in staffing levels. What transpired was that the staff had more time for ongoing assessment and spending time listening and interacting with the participants. This

had a strong, positive effect on the participants, and to a large extent, appeared to prevent illicit drug users forming small groups and engaging in the “drug raves” referred to in Chapter 6, Section 6.3.5, which had been such a source of concern for licit drug users. The structure of the program did not change, and the problems associated with the conflict between some individual’s patterns of daily living and the routine of the program remained, as did the issues related to involvement in the groups. These appeared to be ongoing problems. The changes resulted in a better fit between resources and the number of participants in the unit at any one time, and the staff had more time for individual counselling. The immediate outcome was that the participants rated the staff more highly and the care they received as more personalised.

Despite this, the participants continued to be slotted into the existing program and there were no major changes to the groups or other activities. The problems of Incompatibility remained and the participants continued to deal with them by complying with the program and avoiding conflict and confrontation with staff and other clients.

8.7: Summary

Participants experienced the four phases of Seeking Balance through Hanging In within the confines of a structured, combined medical detoxification program. Their experience was influenced by several modifying conditions that overlapped considerably, strongly interacted with each other, and contributed to the overall ambience and context of the unit. The main conditions were found to be those related to the physical environment, particularly the lack of space, which led to feelings of being confined and cramped, the inadequate human and material resources, and issues of privacy and personal territory. In some instances, threats to privacy and personal territory came from other participants, in other cases they came from external sources when people attempted to break into the unit.

Other modifying conditions were found to be the participant’s expectations of detoxification, and the staff workload. These conditions contributed to the social and therapeutic environment of the detoxification program and shaped the experience of the participants during their time in the unit, as well as their

perceptions of combined treatment and care. In the early part of the study the participants' views of combined treatment were negative and care was perceived to be cloned. Following the reduction in bed numbers and the addition of some additional material resources, combined treatment was viewed more favourably by the participants, and the care was perceived to be more personalised. The structure of the program remained unchanged, however, and as described in Chapter 6, some of the participants continued to be moved through it in a way that did not take into account their individual differences and needs. The findings indicate that combined treatment can be perceived favourably by participants provided there is a good match between human and material resources. The problem of Incompatibility remained, and the participants continued to deal with various aspects by complying with the program and avoiding conflict and confrontation with staff and other clients in the unit.

PART 5

DISCUSSION AND CONCLUSION

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9.1: Introduction and Chapter Overview

In this chapter an overview of the proposed substantive theory of the phenomenon of detoxification from psychoactive drugs, Seeking Balance through Hanging In, together with the two-part basic social psychological problem, phases, elements, and modifying conditions is presented. The linkages between major categories are portrayed. The contribution of the grounded theory and quantitative components to the findings of the study is discussed. Comparisons are made with existing theories such as the Health Belief Model, Status Passage, Stages of Change, Changing Careers: Becoming clean and sober in a therapeutic community, and Stress and Coping, that were found to have relevance for some aspects of the newly developed substantive theory Seeking Balance through Hanging In. The implications of the findings are discussed in terms of their application for clinical practice, professional education, management, and research, and the limitations of the study are reiterated.

9.2: Elements of the Proposed Theory of Detoxification

The aim of grounded theory is to generate a substantive or middle range theory about a phenomenon. In this case, the phenomenon was the experience of detoxification from psychoactive drugs. Detoxification was studied from the perspective of people undergoing the experience in a combined, medical detoxification unit. An assumption underlying grounded theory methodology is that groups experiencing the phenomenon being studied share a basic social-psychological problem that may not necessarily be articulated and which is addressed by means of a basic, or core social-psychological process. A significant feature of the substantive theory developed in this study was that the findings supported a four phase core process that was conceptualised as Seeking Balance through Hanging In. This was

the process engaged in by the participants to deal with the two-part basic social psychological problem of Disequilibrium. The first aspect of this problem was Hitting the Wall, the second aspect was Incompatibility. It was also integrally linked to the contextual and modifying conditions encountered whilst in the combined, medical detoxification unit. The elements of the proposed model, therefore, are the problem(s) encountered both prior to and in treatment, the phases of the core process and the conditions that modified the participants' experience of the phenomenon.

9.3: The Proposed Theory of the Experience of Detoxification

The proposed theory of the experience of detoxification Seeking Balance through Hanging In, consists of the basic social psychological, two part problem, the core process and its four phases, and the contextual, modifying conditions. The model is presented schematically in Figure 14. Both Hitting the Wall and Incompatibility were different forms of Disequilibrium. The disequilibrium associated with Hitting the Wall was a consequence of an unbalanced lifestyle focussed on drug use. The problems associated with this caused the participants to enter treatment, and were not resolved whilst in the unit. They remained to be addressed after the participants had been discharged. The problem of Incompatibility was time limited, and a consequence being in the combined residential unit. It was transient, however, in that it remained located and circumscribed in the treatment environment.

Hitting the Wall encompassed the categories of Losing Out (salience of drug use, impaired control), Fear (of death, withdrawal symptoms, identity change), and Duress (legal coercion, work ultimatums, family threats). Losing out incorporated the participants' awareness of the negative consequences of their lifestyles, and a sense of marginalisation from a wider range of social interactions. It subsumed the lower level categories of Salience of Drug Use and Impaired Control. The salience of drug use was manifested in the extent to which drug seeking and drug using activities had replaced other forms of social activities and discourses in the participants' lives. This included doctor shopping and dealing in drugs. Impaired control was evidenced in several ways, such as relapse to drug use after a period of abstinence, loss of memory

or blacking out after drug use, and loss of control over a motor vehicle when under the influence of drugs. Other ways that impaired control related to drug use was experienced by the participants were aggressive behaviour towards relatives and friends and drinking at a level that impaired their performance at work.

Fear was a strong theme in Hitting the Wall, and most of the participants were fearful of the consequences of their drug related behaviours. One of the main fears evident in the data was the possibility of premature death. Another was the possibility of experiencing severe withdrawal symptoms in the event that drug use was ceased. Other participants were fearful that their social identity could be spoiled if their drug use became known to their children or friends. For these participants the fear of a spoiled identity was a motivator to action to preserve their integrity and valued identity.

Duress was a common component of Hitting the Wall. Many of the participants, even those who reportedly referred themselves to treatment, did so in response to an external form of duress exerted by family members, spouses, employers, and in some instances, the legal system. The strength of the duress applied to the participants ranged from informal pressure from spouses to formal ultimatums from employers and the law.

The second part of the problem of disequilibrium, that was conceptualised as Incompatibility, was encountered by the participants when they were in the treatment unit. This second prong was related to the heterogeneity of the client population, and the structure of the treatment program. The heterogeneity of the participants was evidenced in the differences in age, gender, the stereotypical views that users of certain drugs had of users of other drugs, the participants' perceptions of combined treatment, and the language used by some of the clients. It also included the differences in patterns of accustomed daily living, and the wide variation in the type and intensity of unpleasant sensations experienced by the participants.

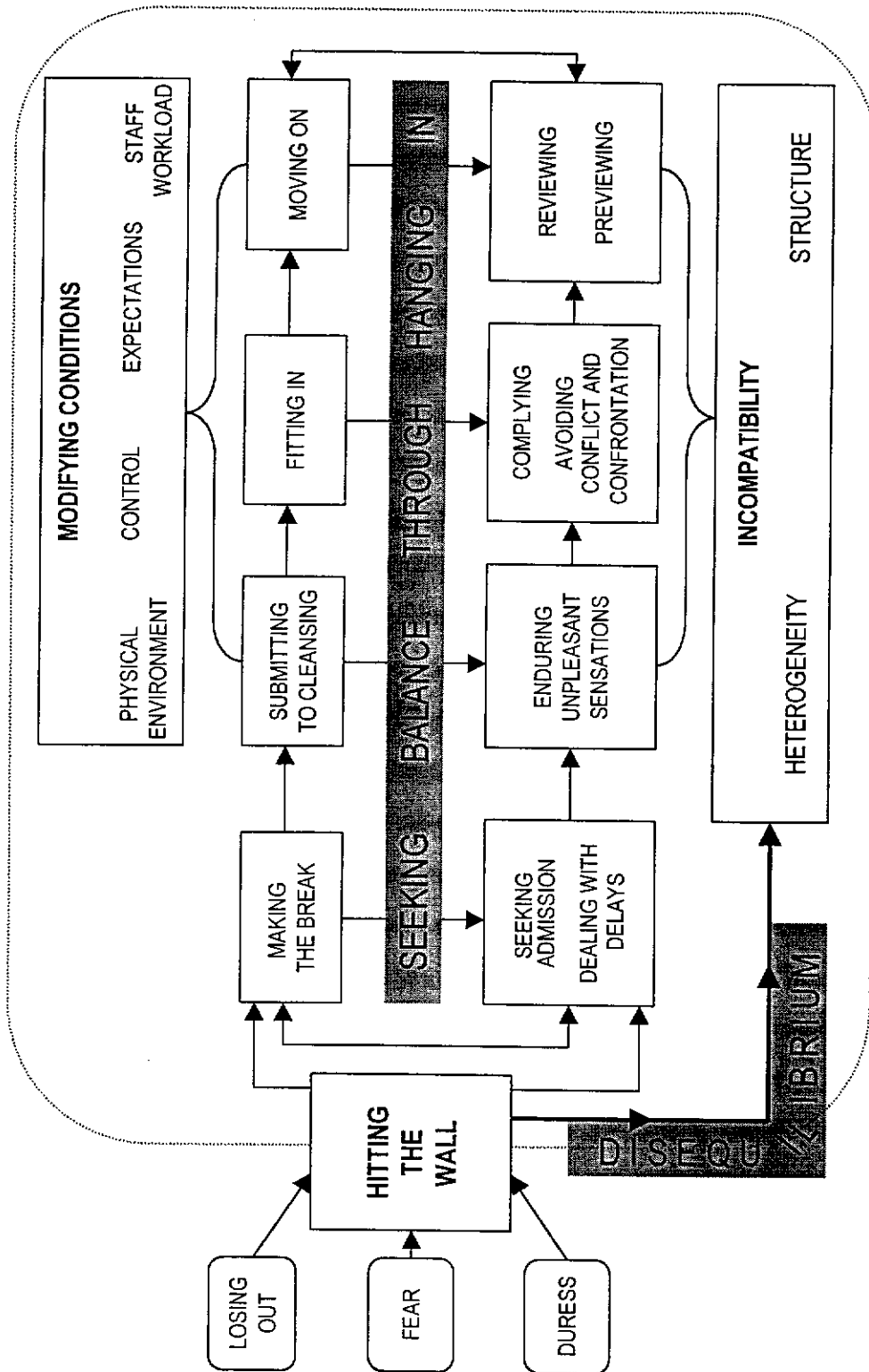


Figure 14: Seeking Balance Through Hanging In

The structure of the program was another source of Incompatibility. This was particularly evident when the participants were required to attend group therapy, and in the inconsistencies related to the rules concerning visitors. Many of the participants appeared unable, for various reasons, to become fully involved in group therapy when they were required to do so by the program, and many remained resentful about certain rules, particularly those related to visiting. Not all the participants had problems with all the components of Incompatibility, but the majority had problems with at least one, and some had problems with several.

The core, or basic social-psychological process engaged in by the participants to overcome the two-part problem of disequilibrium was conceptualised as Seeking Balance through Hanging In. This theoretical construct had four phases; Making the Break, Submitting to Cleansing, Fitting In, and Moving On. Making the Break was the most fundamental phase of Seeking Balance through Hanging In. Engaging in this phase meant responding to the pressures that were associated with Hitting the Wall and deciding, for whatever reason or reasons, to enter treatment. It involved seeking admission to the combined unit and dealing with delays in gaining entry. Making the Break meant disengaging from customary social interactions and exchanging one lifestyle for another. That is, it meant replacing one set of social interactions with another, and making a dramatic shift to abstinence from the use of drugs. It involved being in close proximity to, and having to interact with, people from different sub-cultures whom the participants might not otherwise encounter.

Submitting to Cleansing entailed enduring the unpleasant sensations that arise when the use of psychoactive drugs at a level to engender dependency is ceased. These sensations were physical, emotional, and cognitive. Most of the acute physical sensations subsided within a few days, but sub-acute sensations lingered in diminishing severity for much longer. While most of the participants were physically uncomfortable during this phase, many found the mental sensations to be worse than the physical sensations. The third phase, Fitting In, involved hanging in and

complying with the program and avoiding conflict and confrontation with other clients.

Moving On, the fourth phase, included the processes of Reviewing and Previewing. Reviewing and Previewing involved an important mental temporal juggling back and forth over the past and projected future. It included reviewing the experience of the core process and the limitations of the stay in the program. It also included (a) reassessing the problems of Hitting the Wall that led the participants to their present situation, and (b) attempting to develop coping strategies to enable them to deal effectively with the problems concerned when they left the unit. It was clear that the process was one of seeking, not achieving, balance, and that a brief stay in a detoxification unit was but one step in a more protracted process to be undertaken if the participants were to achieve any sustained improvement in their situations.

The process of Seeking Balance through Hanging In had a trajectory which moved from a phase of physiologically based self-centredness related largely to withdrawal symptoms, to one of more contextual and social concerns, and thence to one of future orientations as the participants prepared to leave the unit. Appraising the future entailed re-appraising the past and was related strongly to the problems of Hitting the Wall that had induced the participants to enter the process of Seeking Balance through Hanging In. The precursor problems associated with the "wall" permeated the participants experience in the treatment program, and together with the problems and conditions encountered during their stay in the unit influenced the way they perceived other participants, the care they received, and the extent to which they were involved in the therapeutic activities of the treatment program.

9.4: Interactions of the Components of the Model

The basic social psychological problem was conceptualised as disequilibrium, the first aspect being hitting a symbolic "wall". This wall was at times constructed slowly and incrementally, at other times it was erected suddenly by some epiphanic event such as causing the death of a friend. The wall was a barrier that prevented the participants from continuing with their customary drug using behaviour. The strategy

used by participants to deal with the problem of the wall was to enter residential, medical detoxification facility for alcohol and other drug users. Here they encountered the second aspect of the problem of disequilibrium that was conceptualised as Incompatibility. The participants who completed the program passed through the four phases of the core process in a sequential manner. These phases functioned as an integrating theme with which to tie together the various categories and sub-categories identified in the data. The phases allowed for a tracing of, and accounting for, change over time and were built into the theoretical structure of the theory. While sequential and distinguishable, they could not be considered as discrete, separate entities, as there was considerable overlap between each phase and the boundaries between were permeable and blurred.

The phases were sequential, however, in that participants did not progress through the four phases without hanging in, and Making the Break led to Submitting to Cleansing which was followed by Fitting In, and Moving On. Not all the participants completed these phases. Some dropped out, usually within a few days of admission, and it is not known to what extent they had been engaged in, or remained committed to the core process. Other participants, such as those who were in the unit under legal duress, completed the program but cannot be considered to have engaged in the core process in the same way as the other participants. While they encountered the two-part core problem of disequilibrium and progressed through the four phases of Seeking Admission, Submitting to Cleansing, Fitting In, and Moving On, they did so in response to strong legal duress. The balance they were seeking was a resumption of former drug use and a return to their previous lifestyles free of legal problems. The others who were engaged in the core process progressed through the four phases and moved on, albeit with varying degrees of apprehension, ambivalence and confidence in their search for a more balanced, drug-free lifestyle.

9.5: Contextual and Modifying Conditions

The contextual and modifying conditions that made up the immediate context were found to have a strong influence of how the participants experienced the

phenomenon of detoxification. These conditions were the physical environment (space, material resources, privacy, and personal territory), control, expectations of combined treatment, and staff workload. Initially, the resources of the unit were inadequate to equitably meet the needs of the participants. The participants, at that time, were in competition with each other for space, access to such things as hot packs to relieve abdominal cramps, places on the bus to enable them to go on outings, and individual time with staff. Because of the closed nature of the unit, the cramped conditions were of particular concern as the participants were unable to avoid social interaction with individuals whom they might otherwise avoid.

Associated with this was the issue of personal territory. Many of the participants felt insecure and threatened by sharing accommodation and being in close proximity with users of certain drugs. These feelings of insecurity and vulnerability were heightened by the fact that the staff detected some clients using illicit drugs on the premises, and other clients, who had been discharged, apparently had no difficulty breaking back into the unit at night.

Both staff and participants exercised control in the unit. That is, staff controlled the selection process for admission and the components of the treatment program. They were also largely in control of discharges from the program and obtaining referrals for follow-up care. The participants could exercise limited control in the sense that, if they choose they could leave at any time, and a number exercised this option by leaving without completing the program. The expectations that the participants had of detoxification were found to be a strong influence on their perceptions of the unit. That is, those who had experienced a previous episode of detoxification in the combined treatment unit were better prepared to be able to optimise on the potential benefits of the program. Those who had experienced previous detoxifications in separate programs were likely to make unfavourable comparisons with the combined program. Those who were experiencing their first episode of detoxification were unable to make comparison and were inclined to adopt a "wait and see" attitude. The attribute of the staff which was of particular importance to the way the participants perceived the care they received was workload.

At times this was at a level that was perceived by the participants to be stressful and resulted in the inability of staff to deliver individual, personalised care.

The context in the early part of the study appeared to be non-therapeutic. That is, the workload of the staff was particularly demanding, the physical environment was less than ideal, and the available physical and human resources were inadequate to meet the individual needs of the participants in the unit during this period. The participants perceived the staff to be stressed by the heterogeneity of the treatment population, the number of clients being admitted to the program, and the demands made by some of the clients on their time. The high workload of the staff became a stressor for the participants in that their individual needs were not being met. As the study progressed, however, and the number of beds in the unit was reduced, additional resources were acquired, and the staff had more time to interact with the participants and allay fears about threats to security. Consequently, the context became less problematic and the program was viewed more favourably by the participants.

The reduction in beds had a dramatic, positive effect on the contextual conditions in the unit in that it reduced the pressure on resources, both physical and human. The reduced availability of beds, however, meant that not all who sought admission could be accommodated promptly, and some had to wait several days before they were able to be admitted. It is relevant to emphasise that throughout the study the treatment program remained the same and there were no changes in staff. All that changed was the number of clients in the unit at any one time, and some additional resources were allocated to the program. The decrease in bed numbers and increase in resources contributed to a dramatic shift in the way the participants viewed the care they received.

9.6: Contribution of Quantitative and Grounded Theory Findings

Quantitative findings

The findings of the quantitative component of this study are presented in Chapter 4. They indicate that 11.4% of participants were in the 16-25 year old age group,

43% were in the 26-35 year old group, and 45.6% were aged 35 years or older. The majority were either born in Australia or New Zealand, and had referred themselves for treatment. Most of them lived in rented accommodation, had some secondary education, and were without a spouse or defacto partner. A small proportion had current legal problems. Over a third were experiencing their first detoxification. Over half, however, had undergone one or two previous detoxifications, and some had experienced three or more. The average length of stay in the unit for those who completed the program was nine days (SD=4.8 days, range=4-15 days).

While the majority were poly drug users, all were ostensibly being withdrawn from one drug, their designated principal drug, that is, alcohol, opioids (heroin, methadone, pethidine), tranquillisers (mainly benzodiazepines), or amphetamines. All had lengthy histories of drug use and all were assessed as being either moderately or heavily dependent on their principal or main drug. Almost 40% reported injecting drugs, generally in the week preceding admission, and only approximately 30% of those who had injected drugs had never shared injecting equipment. Sharing injecting equipment is one of the main risk factors in the transmission of blood borne viruses, such as hepatitis C and HIV. Hence the likelihood that those who had shared equipment had acquired hepatitis C is high. The presence of injecting drug users in the unit was a source of concern for the participants who used drugs by other routes.

Significant differences were detected between licit and illicit drug users in terms of age, employment, poly drug use, and completing the program. Illicit drug users were younger than licit drug users, were more likely to be unemployed, poly drug users, and to drop out of treatment than licit drug users. Hence the differences observed in earlier studies remain significant. The most salient finding in regard to MPM was the very high prevalence rate detected (93.6%) and the largely insignificant influence of socio-demographic and drug use variables on overall scores of the GHQ-28, or the scores of the domains of the GHQ-28. These data were obtained close to the point of discharge from the unit, and indicate the vulnerability of the participants at this time in that the majority had levels of MPM that warranted further investigation. While most of the participants were provided with referrals for follow-up care, a

considerable proportion did not take up this option, and were returning to the environments from which they came, in which the cues to drug use abounded, without formalised support.

The main findings of the quantitative component of the study demonstrate that:

- The differences in age between users of licit and illicit drugs identified in other studies remain extant and statistically significant. That is, users of illicit drugs are likely to be younger than users of licit drugs.
- Illicit drug users were more likely than licit drug users to be poly drug users and not complete the treatment program. Opioid users were more likely to drop-out of the program than licit drug users, and amphetamine users were more likely to drop-out than opioid users.
- There was a high prevalence (93.6%) of minor psychiatric morbidity (MPM) among the participants that was largely independent of age, sex and principal drug of use.
- A high proportion of the participants did not take up referrals for aftercare.
- No significant differences were detected in the type of client admitted to the unit in terms of socio-demographic and drug use characteristics over the 12 month period of data collection.

Grounded theory findings

No set of quantitative scales can fully reflect all the dynamic interactions of people experiencing a phenomenon; hence they are necessarily limited in the richness and diversity they can tap. The qualitative data obtained from the constant comparative method of grounded theory, however, were rich and wide ranging in scope. The method and the findings allowed a substantive theory to be generated that was grounded in the data. The theory provides insight into the experience of detoxification in a specific context and enables a better understanding of the phenomenon from the perspective of the participants. The qualitative data illuminated and expanded the findings of the quantitative component in regard to

differences between users of different drug types. They illustrated how and why these differences were problematic in a combined treatment unit.

In regard to age, older participants were concerned that through association with older, more experienced drug users, younger drug users would become more knowledgeable about procuring and using different drugs. In other words, their time in the unit would expose them to a wider knowledge of drug-using networks and ways of using drugs. Some of the younger participants appeared to use the presence of older participants as an excuse to leave the unit against advice. Other young participants, however, found security in the presence of older participants and sought a therapeutic relationship with them. These concerns about exposing young drug users to more experienced, older drug users were not confined to one type of drug user. In other words, these concerns crossed drug barriers, and older participants, regardless of whether they were licit or illicit drug users, were concerned about the presence of younger drug users in the unit.

Regarding gender differences, men generally disapproved of women using drugs and undergoing detoxification. This was particularly evident if the woman concerned had small children. Older women were perceived more negatively than younger women because “they should know better”. Paradoxically, men took confidence from the presence of women in the program and there was no evidence that male participants favoured separate treatment programs for men. While some women considered that there should be a separate gender-sensitive group for women, there was no support from the women participants for a unit specifically for women.

The qualitative findings derived by the use of grounded theory methods revealed that the basic social-psychological problem Disequilibrium had two parts, Hitting the Wall and Incompatibility. The core social-psychological process was Seeking Balance through Hanging In. The problems associated with Hitting the Wall were antecedent to entering treatment and engaging in the core process. The problems of Hitting the Wall pervaded all phases of Seeking Balance through Hanging In and, to a large extent awaited the participants when they left the unit. During their time in the unit the participants encountered additional problems related to Incompatibility with

the structure of the program and the heterogeneous nature of the client population. These data provide a much wider lens to view the events that led the participants to treatment, and the problems that they were confronted with whilst they were in the unit. It also highlighted the strong negative views that those whose main drug was alcohol, tranquillisers, or amphetamines had of heroin users and the perceptions of amphetamine and heroin users of alcohol users.

Applying grounded theory method and quantitative methods in this study enabled a wider understanding of the experience of individuals undergoing detoxification in a combined medical detoxification unit. The findings of the two approaches complemented each other in that statistical differences between licit and illicit drug users were detected by the quantitative method, and the important influences of these differences were able to be contextualised and described qualitatively. In other words, the advantage of combining qualitative and quantitative methods in this study lay in being able to (a) develop a substantive theory of the phenomenon of detoxification from psychoactive drugs, (b) determine the statistical, numerical significance of the differences between licit and illicit drug users and the prevalence of MPM, (c) qualitatively analyse the ways in which these differences affected the participants and (c), enabled the variations between age groups and users of different drugs use to be analysed by both approaches. In particular, the qualitative findings highlighted the variation that exists both between and within groups of licit and illicit drug users. The qualitative method of grounded theory enabled contextualisation of the findings beyond the specification of a set of relationships in a statistical model, and provided a means of interpretation that transcended the findings from the quantitative, reductionist approach. The advantage in combining grounded theory method and quantitative methods lay in being able to better explain the factors which impacted on individuals engaged in the core process of Seeking Balance through Hanging In within the context of a combined treatment unit. In other words, the qualitative findings opened up the "black box" of treatment in a specific context. This is important for understanding the social dynamism of combined treatment programs.

9.7: Comparisons with Related Theories

No theories of detoxification were located in the literature, either prior to this study or during the constant comparative analysis of the data from which the substantive theory of Seeking Balance through Hanging In was developed. Several theories, however, were identified which had aspects that appeared to be relevant to certain elements of the substantive theory developed in this study. These were the Health Belief Model (Rosenstock, 1974), Status Passage (Glaser & Strauss, 1971), Stages of Change (Prochaska & DiClemente, 1983; Prochaska, DiClemente, & Norcross, 1992), Changing careers: Becoming clean and sober in a therapeutic community (Marcus, 1998), and Stress and Coping (Lazarus, 1966).

9.7.1: Health Belief Model

The Health Belief Model (HBM) was developed in the 1950s when a group of social psychologists influenced by the work of Kurt Lewin, attempted to develop a theoretical model which would explain preventative health behaviour, specifically in relation to the use of health services (Rosenstock, 1974). The theory proposed that for an individual to take action to avoid a disease he/she would need to feel (a) personally susceptible, (b) believe that contacting the disease would have at least a moderately severe impact on some component of their life, and (c) believe that the benefits of taking action outweighed the costs and barriers of taking action. Under this model, perceived susceptibility and severity provided the force to act, and the perceptions of outcomes provided the benefits of taking action. Another dimension was added later; this was that overt action would only occur in the presence of either internal or external cues (Janz & Becker, 1984). The model has been used to explain and predict sick role and compliance behaviour, as well as a conceptual framework for health education programs (Eilsen & Zellman, 1986).

The HBM has had limited use in the addictions area. Beck (1981) used it together with the Theory of Reasoned Action (Ajzen & Fishbein, 1980) to explain and predict drink-driving behaviour of a group of health education students. Rees (1985) used the

model to predict compliance with an alcohol treatment program. The HBM has been used to study entry into alcohol treatment programs (Bardsley & Beckman, 1988). The researchers concluded that only two of the components of the HBM, perceived severity of drinking problems and cues to action influenced decisions to seek treatment. The most frequently cited cues were "hitting bottom emotionally", increased conflict with family and friends, and heightened physical symptoms of drinking.

In a more recent study of help seeking by problem drinkers it was concluded that the best predictors were psychosocial problems, especially interpersonal relationships (Tucker, 1995). A belief that individuals could solve their own problems was found to deter help seeking, whereas relationship problems and being unable to stop drinking on one's own facilitated help seeking. In regard to help seeking behaviour by users of drugs other than alcohol, Hartnoll (1992) has identified three hypotheses. These are (a) seeking help is a function of the severity of drug use, (b) it is influenced by a range of environmental and socio-cultural characteristics, and (c) it is influenced by the type and availability of services. To some extent, the reasons the participants in this study sought help were similar to those reported by both Bardsley and Beckman (1988) and Hartnoll (1992). The findings of the present study are more specific, however, and add more detail in regard to both the causal condition and the aspects of that condition, but are not entirely inconsistent with those reported in the earlier, quantitative studies mentioned above and the cost/benefit component of the HBM. They confirm that participants wait until their lifestyles are unbalanced and their drug use has become increasingly problematic before seeking treatment. The findings are congruent with the suggestion put forward by Weisner (1990) that, at least in regard to individuals dependent on alcohol, the treatment seeking process is best viewed as a response to problems.

9.7.2: Status Passage

According to Glaser and Strauss (1971) a status passage is a transition between statuses. Those most commonly studied are age linked statuses, such as childhood,

adolescence, and adulthood. Others are transitions through educational programs, occupations, marriage or marriages, and death. Movement through different passages may involve shifts into different social groups, increases or decreases in prestige and influence, as well as changes in identity and behaviour. As described by Glaser and Strauss (1971) status passages have certain properties. Among these are that a passage may be desirable or undesirable, inevitable or not inevitable, reversible or not reversible, repeatable or not repeatable, voluntary or involuntary, taken alone or in the company of others, and is taken over time.

Passages can be chartered, that is, the passage can be established by authorised persons, or groups. These types of passages are shaped by a validated set of rules and require legitimation by significant others. Though presented as a passage by the authors, no phases in the passage were identified. The authors concentrated, instead, on the properties which could give shape to a passage. There was support for several of these properties in the data. For example, Seeking Balance through Hanging In could be regarded as a chartered passage operating under a specific set of rules that, in part, controlled the movement of the participants through the process. In the case of undergoing detoxification in a combined medical unit entry to the process was by meeting the criteria for admission, and a successful passage required adhering to the rules and regulations governing the behaviour of people in the unit. It was undergone in the company of others; for some it was voluntary, for others it was involuntary. It had a temporal dimension, and could be repeated again if necessary. It involved a brief shift into a different social arena, changes in behaviour, and for some, a reappraisal of self and identity. In this respect, the proposed model shares some commonality with Status Passage, but goes beyond this. Glaser and Strauss focussed on describing the properties that have the potential to shape the path of a “passagee” through the status passage. In the model proposed in this study, the theoretical constructs are defined in detail, and the core process which links the phases together is identified and clearly presented.

9.7.3: Stages of Change

The change model considered during this study was that developed by Prochaska and DiClemente (1983), and elaborated on by Prochaska, DiClemente, and Norcross (1992). The model is claimed to provide a comprehensive account of how and when people change their behaviours. It was developed largely from data obtained from a study of smokers and ex-smokers. The model has five stages of change, through which there is a cyclical pattern of movement that is said to allow understanding of when a person's changes in attitudes, intentions, and behaviour occur. According to Prochaska et al. (1992), the five stages of change are precontemplation, contemplation, preparation, action, and maintenance. Precontemplation is the stage when individuals are relatively happy with their behaviour, and see little need to change. Contemplation is the stage when there is a growing awareness of the costs and benefits of some behaviour, and a feeling of ambivalence about the behaviour concerned. Preparation is said to be present when there has been an unsuccessful attempt to change within the past year, and there is an intention to make a further attempt in the near future. Action is the stage when a determined attempt is made to change a behaviour. Maintenance is said to occur when behaviour change has been sustained for six months.

Progression through the stages rarely occurs in a linear manner, and individuals will generally relapse, that is fail to maintain a change of behaviour, a number of times. Following each relapse, individuals appear to revert back, in a spiral fashion, to an earlier stage of change. They are said to learn from the experience, and begin moving through the stages once more (Prochaska et al., 1992). Prochaska et al. also suggested that integrated within the stages are certain processes that individuals use to facilitate or sustain their decision to change. Cognitive processes appear to be more effective in the beginning stages, and existential and behavioural processes of more benefit to the change process in the latter stages. Success in making and sustaining change may depend on matching the appropriate processes to the appropriate stage. The processes most commonly employed across the stages of change are consciousness raising, self-evaluation, self-liberation, helping relationships,

reinforcement management, counter conditioning, stimulus control, dramatic relief, social liberation, and environmental re-evaluation (Prochaska et al., 1992).

Some aspects of the change theory proposed by Prochaska et al. (1992) were supported in the findings of the present study. For example, the events that contributed to the basic psycho-social problem, Hitting the Wall, can readily be considered as inducing the participants to contemplate changing some aspects of their lifestyles. Entry into the process of Seeking Balance through Hanging In can be viewed as the action stage of the model. What followed after separation from the unit was not a component of this study; hence it is not possible to determine in what manner participants may have moved through the stages of maintenance and relapse. Many of them had, however, undergone detoxification from various drugs more than once, and viewed from the perspective of change provided by Prochaska and DiClemente may have recycled through the stages as described in that model.

There was some support for the processes which Prochaska et al. (1992) relate to the stages of change. For instance, there was evidence of consciousness raising, cognitive restructuring, and education and feedback from participation in group therapy. Viewed from a broad perspective, the change model has some heuristic value, though Prochaska et al. (1992) provide little information on what moves a person through the stages. Nor is it clear to what extent it could be applied to those who were in treatment because of legal duress. In contrast, in this study, the main focus was on what could be regarded as the action stage of the model, that is Seeking Balance through Hanging In. The core process and phases related to this are clearly identified and articulated, and movement through the four phases of Seeking Balance through Hanging In is described together with the associated problems and processes and modifying conditions.

9.7.4: Changing careers: Becoming clean and sober in a therapeutic community

This grounded theory study of recovery from substance abuse, Changing careers: Becoming clean and sober in a therapeutic community (Marcus, 1998), was conducted in three therapeutic communities (TC). The researcher found that recovery

from substance abuse was analogous to changing a career from one of an addict to one of an ex-addict. This was described as occurring in four stages, Entering the Program, Learning the Program, Working the Program, and Gaining Control. The properties of Entering the Program were experiencing a crisis and deciding on a TC as a means of treatment. The properties of Learning the Program were resisting, going along, and letting go of the self. Those of Working the Program included confronting the self, remembering when, learning to communicate, and keeping busy. The properties of Gaining Control were extracting a self, redirecting the self, remaining vigilant, giving back, and planning a life. Some aspects of the four-stage theory of Changing Careers proposed by Marcus (1998) were found to have relevance for the findings of the present study. For example, the events that induced the participants to enter treatment in a TC or the detoxification unit were similar. That is, participants in both studies did so in response to some form of crisis such as a motor vehicle accident, loss of employment, pressure from spouses or the legal system, and overdosing on drugs. In the Changing Careers theory experiencing a crisis was described as a property of the first stage, Entering the Program. In the present study, it was conceptualised as the first part of the basic social psychological problem Hitting the Wall.

The time frame for the stages or phases of the two theories differed considerably. Completion of the TC program described by Marcus took two and a half years. In contrast, the average length of stay in the detoxification unit in which the present study was conducted was nine days, and the range was four to 15 days (chapter 4, Table 1). The focus of treatment in the detoxification unit was on the management of withdrawal symptoms, counselling, group therapy, some exposure to leisure activities, and referral to follow-up support in the community. The TC described by Marcus provided a much more extended program that included educational and vocational training and rigorous behavioural modification therapy.

In the Changing Careers theory, no basic social psychological problem was identified, and little mention was made of any conditions that could have modified the process. In the present study, Seeking Balance through Hanging In, the basic shared

problem is identified, the basic social psychological process engaged in by the participants to deal with the problem is fully described and presented, and the contextual conditions that modified the experience under investigation are discussed.

9.7.5: Stress and Coping

The theory bearing most relevance to that presented in this study is Stress and Coping (Lazarus, 1966). The literature on stress is voluminous and growing. According to Lazarus, stress is best viewed as a relational construct and coping as a complex process, not a single act. Stress is said to occur as a consequence of an imbalance between the demands on an individual and the individual's assessment of their ability to meet these demands. If the demands are met or circumscribed, then little or no stress is experienced. If in the person's view the demands must be met, and the person lacks the ability to meet them, then stress is likely to occur. From this perspective, stress is not a property of the person or the environment, but is a consequence of the relationship between them (Lazarus, 1966). Coping mechanisms to deal with stress are attempts to change the self or the environment, as well as maintaining personal equilibrium and balance. According to Marlatt and Gordon (1985), stress and coping theory is consistent with factors such as deficits in interpersonal and behaviour skills, and maladaptive cognitive and self regulatory processes.

In a more recent summary focussing on alcohol use, stress and coping theory was said to be based on the premise that an individual's equilibrium and adaptation to life is influenced by environmental factors which may or may not be perceived as stressors (Moos, Finney & Cronkite, 1990). Equilibrium depends on the personal and other resources available to a person to manage stressors which may be risk factors for alcohol abuse, and coping responses are conceptualised as situation specific ways of managing stress. According to these authors,

Stress and coping theory is a dynamic perspective that emphasises ongoing change and maturation in personal and environmental factors and the current forces that affect an individual's adaptation.

(Moos et al., 1990, p.12)

This is similar to the phenomenological perspective on stress and coping provided by other authors who have defined stress as:

The disruption of meanings, understandings, and smooth functioning so that harm, loss, or challenge are experienced, and sorrow, interpretation and new skill acquisition are required.

(Benner & Wruble, 1989, p.412)

Their definition for coping is:

What people do when personal meanings are disrupted, and smooth functioning breaks down. Since the goal of coping is restoration of meaning, coping is not a series of strategies that people choose from a list of unlimited options. Coping is always bounded by the meanings.

(Benner & Wruble, 1989, p. 408)

The descriptions of stress provided by Moos et al. (1990) and Benner and Wruble (1989) appear to be congruent with the experiences of the participants in this study of Hitting the Wall. That is, they encompass environmental and personal factors and the meanings that the participants ascribed to these factors. Coping, for the participants in this study, was a way of dealing with disruptions and the disequilibrium of a life that was out of balance and focussed around the use of various drugs. The coping strategy adopted by the participants to deal with their particular stressors was to engage in the process of Seeking Balance through Hanging In.

The coping strategy was an initial reaction to the first part of the problem of disequilibrium, Hitting the Wall. Engaging in the process of Seeking Balance through Hanging In involved entering a combined medical detoxification unit which exposed the participants to other stressors related to Incompatibility. At each stage of the core process of Seeking Balance through Hanging In, Making the Break, Submitting to Cleansing, Fitting In, and Moving On new stressors were encountered and coping strategies were required to manage the evolving situation. Hence movement through the phases was similar to the notion of ongoing change proposed by Moos et al. (1990) and provides support for Benner and Wrubel (1989) in that the

participants were reviewing and previewing their circumstances and the meanings they derived from this.

While there are a number of similarities between the model of Seeking Balance through Hanging In and the theories of stress and coping, there are clear differences. The proposed model of Seeking Balance through Hanging In has a context. It has a precursor problem, Hitting the Wall, the problem of Incompatibility, contextual conditions and a clear core process with four phases, Making the Break, Submitting to Cleansing, Fitting In, and Moving On. Hence it goes beyond existing theories of stress and coping whilst incorporating some of the elements found in the other theories. The proposed model is dynamic, includes environmental and interpersonal factors, and participants move through the phases of the core process in a manner that is facilitated or inhibited by a number of problems and contextual conditions. The conditions that modify the progress of the participants through the core process relate to the heterogeneity of the client population, the workload of the staff, expectations of detoxification, and the physical environment of the treatment facility. These factors exerted considerable influence on the participants in this study, yet have received little attention in the research on detoxification.

9.8: Implications of the Findings

The findings of this study create awareness that detoxification is not merely about managing drug related withdrawal symptoms and arranging referrals for aftercare. It is not concerned solely with drugs and their effects on the body, though this is an important component of the phenomenon of detoxification. The findings illustrate the complexity and inter-relatedness of human lives, which should not be compartmentalised into treatment episodes bounded by admission and discharge points. Delimiting a phenomenon such as detoxification in this manner overlooks fundamental aspects of peoples lives that determine to a large extent when they will seek help, how they will respond to care, and the likely outcomes of the treatment episode. The findings have implications for enhancing the care provided for

individuals withdrawing from psychoactive substances by informing clinical practice, professional education, management, and further research.

9.8.1: Clinical practice

Though there is a considerable volume of literature related to detoxification from various psychoactive drugs, it is atheoretical, and care has been delivered from a basis of responding to presenting withdrawal symptoms. Identification of the substantive theory, Seeking Balance through Hanging In, enhances clinical insight into physiological symptoms experienced by the participants. The delineation of the four phases provides staff with guidance to enable them to better tailor care to the needs of clients in each phase. For example, the description provided of the experience of clients in the phase of Submitting to Cleansing emphasises the endurance of the physical discomfort manifested at this time.

The description of the Fitting In phase provides insight into how the participants' hung in by complying with the program and avoiding any possible conflict and confrontation with other clients. This has considerable implications for therapeutic activities such as one-to-one counselling and group work. Data from the phase of Moving On demonstrates the importance of the events that comprised the symbolic "wall" that induced the participants to enter treatment. The evidence provided in the discussion of the problem of Incompatibility illustrates the difficulties inherent in providing care for the heterogeneous population in a combined treatment unit.

The data from both the qualitative and quantitative components of the study clearly indicate the vulnerability of the participants as they approach the time of leaving the unit. The data also indicated the lack of adequate community support services available. While self-help groups existed, it was clear from the data that they were not an acceptable option for many in this study. In addition, when referrals could be made to various support services, there was often a lag time of from two to three weeks before an appointment could be obtained. In the interim, most of the participants in this study returned to the environments from which they had come.

Awareness of these issues can assist staff to make better informed decisions regarding the time of discharge, and the actual referral negotiated.

The findings of this study demonstrate that, in many cases, participants were moved through the detoxification program at a pace that was incongruent with their physiological status. This caused problems that had to be dealt with by the core process. When this occurred the participants concerned were unable to optimise on the opportunities provided in the detoxification program. This finding highlighted the need for on-going, skilled assessment of the participant's condition to ensure that their needs, not the needs of the program, were being adequately addressed. The findings also highlighted the changing nature of care required by the participants during their stay in the unit. This ranged from physical bedside nursing, to high level counselling and small group work skills, to a thorough knowledge of community resources and referral pathways.

The descriptions of the various factors that made up the contextual and intervening conditions demonstrate the effect of environment on the participants. The discussion on Incompatibility illustrates the complexity of providing care in such an environment. The importance of fully taking into account the events of Hitting the Wall that led the participants to treatment, and influenced their participation in the detoxification program and their motivation to change their lifestyles, was emphasised. The findings of this study have provided clinicians with a substantive, middle range theory to better target care for individuals in combined, medical detoxification units.

The findings of the high level of MPM among the participants, which is supported in the qualitative data, indicates the vulnerability of the participants close to the point of separation from the unit. This appeared to be largely independent of age, sex, or type of drug use. Currently there is increasing pressure on alcohol and drug treatment agencies to shorten length of stay in residential facilities, and to expand the use of out-patient treatment. Recognition of the vulnerability of people with alcohol and other drug problems could assist in informing clinical decisions in regard to discharge planning and the type and level of outpatient care indicated for various clients.

9.8.2: Professional education

The findings of this study provide educators with a description of the experience of clients in a combined medical detoxification unit. This can be utilised to develop more precise educational material and strategies that reflect what is happening for clients in the clinical environment. Currently teaching in regard to detoxification is usually focussed on the types of withdrawal symptoms associated with different drug types, the scales commonly used to measure these symptoms, and referral options. It is rare that education is provided that attempts to address the dynamic nature of the treatment environment, or the significance of the heterogeneity of the client population, in involvement in therapeutic activities or outcome goals.

Identification of the differences of withdrawal manifestations between users of different drugs, as well as the variation between withdrawal symptoms experienced by users of the same drug type could be used to raise the awareness of clinicians about the need for on-going assessment of clients. The description of heterogeneity of the participants in terms of unpleasant sensations in Chapter 6 provides educators with information on this. The descriptions of the problem of Incompatibility and the phase of Fitting In provide important information on the social, interactive aspect of the residential experience of detoxification. These are areas overlooked in most educational programs, yet are equally, if not more important than the phase of Submitting to Cleansing. The information could be presented in the form of case studies, to complement and extend what is taught about withdrawal symptoms. An understanding of these factors would allow educators to teach about these factors from a more credible stance.

9.8.3: Management

The findings of this study have important implications for management. The data from the early part of the study clearly demonstrate that, at that time, the unit was overcrowded and under resourced, and that this had a negative impact on the participants and the ability of staff to provide adequate care. When restructuring

services, for whatever reasons or imperatives, management must be alert to the clinical implications. Identification of the effects of restructuring can be used by managers to ensure that resources are sufficient to meet the needs of a new unit. It would also be useful to include clinicians in the proposed reorganisation and to make the changes known to the consumer population. This could be done through various media outlets and representatives of the consumers could be invited onto the management committee.

During the change process consideration should be given to providing additional staff to cover any unplanned eventualities. Involving the key stakeholders in the change process and ensuring that sufficient resources are available to meet the needs of the anticipated clientele would assist in minimising any negatives effects resulting from the restructure.

9.8.4: Research

The substantive theory of Seeking Balance through Hanging In proposed in this study provides a basis for further research to test the described phases and relationships. The contextual and intervening variables identified as being important in this study should be examined in studies undertaken in other similar settings. The attitudes of users of licit drugs regarding users of illicit drugs and vice versa should be further studied and the issue of gender should be further explored in combined units. The outcomes of those engaged in the process of Seeking Balance through Hanging In warrant investigation. For example, what are the difference in outcomes between those who engaged in the core process and those who appeared to merely complete the detoxification program? What differences accrue to those who experienced what can only be described as minimal, or cloned care compared to those who received more individualised care? What differences in outcomes occur between those who take up referral options and those who don't? What are the differences in outcomes between those who dropped out of treatment and those who hung in through the core process or stayed in the program?

Assessment of the prevalence and degrees of MPM among clients in alcohol and drug treatment programs is important as the results can guide clinical decision making in case management whilst in treatment, and in referring clients to appropriate follow-up services. While those clients with an acute psychiatric diagnosis are unlikely to go undetected in a clinical setting, this may not be the case with MPM that in detoxification settings that may be masked by withdrawal symptoms.

The question of appropriate cut-off points for the GHQ-28 when administered towards the end of a detoxification episode should be investigated. Optimum cut-off points can be established by a Receiver Operating Curve analysis (ROC). The instrument is administered to a sample, and from those scoring one and above a random sample is selected for a structured diagnostic interview using the Diagnostic Interview Schedule (DIS) or the Clinical Interview Schedule (CIS). The results are used to construct a ROC curve to determine the most discriminatory performance of the GHQ-28 for a specific population. It is relevant to note that in a study undertaken in an addiction research setting that DIS findings were equivalent to GHQ-60 findings (Ross, Glaser & Germanson, 1988). Whether or not this is the case for the GHQ-28 is unclear.

It is not suggested that clients should be kept in residential facilities when they are physically well enough to be discharged. Rather, screening for MPM should be considered on a regular basis. Though there are a variety of comprehensive diagnostic instruments available, many are time consuming and may not be possible to be administered on a routine basis given the number of clients admitted and the short length of stay. There is an obvious need for a brief screening instrument to identify those clients in need of more indepth assessment. Because of its ease of administration, interpretation, and division into domains, the GHQ-28 is probably the most cost-effective instrument currently available. Until the questions of transience in the symptoms of MPM and appropriateness of cut-off points for this population is resolved, its utility for discriminate case finding remains uncertain and should be investigated further.

In regard to the GHQ-28, two additional questions arise from the findings of this study which have implications for research and treatment. These are "To what extent does the level of MPM detected reflect withdrawal symptoms?" and "To what extent is the level of MPM transient in this population?" One way to determine to what extent MPM scores reflect withdrawal symptoms would be to administer the GHQ-28 to individuals when they are admitted to a detoxification unit, and repeat the procedure six or seven days later when most of the more severe features had subsided. This would provide information on the condition of clients at the time of admission, at least in relation to MPM, and provide some indication of shifts in scores. In regard to the question concerning transientness, according to Davidson and Ritson (1993), most depressive features found in alcohol dependents subside after a period of two to three weeks following detoxification, providing the individual concerned remains abstinent. Whether this applies to some of the other symptoms assessed by the GHQ-28, such as anxiety, is unknown, or whether or not it applies to individuals undergoing detoxification from drugs other than alcohol is equally unclear. The extent of the temporary nature of the symptoms could be determined by administering the GHQ-28 to a sample of clients prior to discharge, and repeat it perhaps two to four weeks later. This would provide some evidence of change in scores, at least in those people who were able to be followed-up. Another question related to MPM is "What clinical interventions could be implemented to best address this issue whilst clients are in residential care?".

Further studies are necessary to determine the outcomes of those who drop out of treatment and those who complete treatment. In view of the changes occurring in health care services, the increased demand for services and the fact that residential care is becoming increasingly expensive, the most effective model of treatment for individuals dependent on psychoactive drugs needs to be determined. For example, to what extent would individuals heavily dependent on drugs benefit from perhaps a two to three day residential stay if after discharge they were supported by a home nursing service? Or would it be more effective to provide this population with more

residential care, and increase outpatient services for those less heavily dependent on drugs? Decisions on these issues need to be based on clinical research.

Questions were raised in the data about assessment for entry into the treatment program. Research in this area has predominantly focussed on individual psychological factors, but more recent work has included factors related to external pressures (Weisner, 1990). Others have examined motivational and readiness to change factors in terms of stages (Prochaska & DiClemente, 1986). As mentioned above in Section 9.7.3 these stages have been labelled precontemplation, contemplation, preparation, action, and maintenance. Research could be undertaken to determine the value of Prochaska and DiClemente's model in regard to entry into a program in terms of motivation and readiness to change. If these factors were taken into account they could influence who is admitted to a treatment program and assist in tailoring interventions to where a person is at in terms of readiness of the person concerned to change their problematic behaviour.

9.9: Limitations of the Study

The limitations of the study have been acknowledged in Chapter 1, Section 1.8, and are reiterated here. The limitations are that the study is focussed on the participant's experience of detoxification, or neuroadaptation reversal from psychoactive drugs (alcohol, opioids, tranquillisers, and amphetamines) in a combined medical detoxification unit. As such it is intimately linked to the context and times in which it was conducted. The uniqueness of the context indicates that caution should be employed in any attempt to extrapolate the findings to other areas, unless the conditions that applied in this study were replicated. Before this substantive theory can be considered as a formal theory with generalisability, further studies are required in similar, substantive areas (Glaser & Strauss, 1967). In other words, it requires replication in similar contexts and further critical analysis before it can be elevated to a formal theory.

9.10: Conclusion

The main objective of this study was to generate a substantive theory of the experience of detoxification from psychoactive drugs in a combined, medical detoxification unit. Another objective was to determine if the differences between licit and illicit drug users remain extant and statistically significant. Both these objectives have been achieved. A substantive, middle range theory has been developed that is based on interconnected concepts. It has integration, coherence, structure, scope, and pragmatic utility for practice, management, professional education, and research. Combining grounded theory and quantitative methods has enabled a broader understanding of the differences between and within the users of these different drug types that would not have been available if one or the other method had been used in isolation. The substantive theory focuses attention on the complexities of different participants experiencing the same phenomenon, and the influence of the environment and other clients on the individuals in treatment. The findings alert health care professionals to the complexities of providing care to individuals dependent on, and withdrawing from, psychoactive drugs in a particular setting. They also demonstrate that combined treatment can be perceived favourably by some clients, regardless of the heterogeneity of the clients, provided that there are adequate resources available to accommodate their needs.

It is not claimed that the substantive theory of Seeking Balance through Hanging In was the only aspect of detoxification of theoretical importance. The only claim is that Seeking Balance through Hanging In explained much of the variation in the actions, interactions, and perceptions of the participants found in the data collected at a particular time in a particular treatment facility. The process of Seeking Balance through Hanging In illuminates the importance of antecedent factors and interactive patterns between users of different drugs, and between participants and staff as well as a wide range of other variables and conditions which had bearing on the experience of the phenomenon under study.

Despite the variations in experience identified in the qualitative findings, there was a basic uniformity in the process of Seeking Balance through Hanging In. This

uniformity cut across the boundaries of neuroadaptation reversal, or the withdrawal syndromes described for specific drug types. For the participants, the prime function of Seeking Balance through Hanging In was to commence to resolve, at least in part, the problems and events of Disequilibrium related to Hitting the Wall and Incompatibility. It was integrally related to the conditions that led the participants to the detoxification program and the stressors they encountered whilst in the unit.

This was the case regardless of whatever reason or reasons led the participants to treatment. All participants shared the perception that residential detoxification was necessary for them to attempt to address the problems associated with their particular experiences of the first part of the basic social psychological problem, Hitting the Wall. Nor did all participants seek the same sort of balance in their lives. Some participants appeared to view it as an interlude of compulsory abstinence that had to be endured before they could return to their accustomed drug use. The substantive theory developed in this study offers an explanation of the social process of individuals living through a particular health related situation, that is detoxification from psychoactive drugs in a combined medical treatment unit. As such it provides a useful contribution to theory based practice in an important component of the field of alcohol and drug treatment.

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APPENDIX A

HISTORICAL REVIEW OF THE AGENCY

The Western Australian Alcohol and Drug Authority (WAADA) was established by the Alcohol and Drug Authority Act 32 of 1974 with a mandate to:

- provide treatment and rehabilitation for individuals with alcohol and other drug problems;
- develop preventative and professional education programs;
- promote research into the effectiveness of treatment and educational programs;
- provide strategic information to government on legislation, policy, and services involving alcohol and other drug related issues.

The main clinical services were established in Perth, Western Australia. The initial services included a 29 bed residential detoxification hospital, a 26 bed hospital for a behavioural modification program; a 40 bed rehabilitation hospital, and a clinic for outpatient services (WAADA, 1976). In 1979 the Authority established offices in Geraldton and Kalgoorlie and by 1984 had expanded to all regional centres in the state. Each regional centre was staffed by a Field Officer and an Aboriginal Liaison officer. The role of the regional staff included counselling, education, monitoring local needs and issues related to alcohol and other drug use, liaison with health services, and providing a link between the Authority and the community throughout the state (WAADA, 1984).

The debate which preceded the formation of the Authority was particularly concerned with the provision of services for "alcoholics" who had poor social supports and who were often in trouble with the police. Hence initially, a considerable amount of the resources of the Authority were diverted to services for this population, many of whom had poor prognoses and little hope of achieving any lasting lifestyle changes. In 1983 the Authority shifted the focus of treatment from long term care to early detection, minimal intervention and prevention of alcohol and other drug related problems. This was in response to a series of reports which demonstrated that for some individuals brief interventions were at least as effective as long term, intensive therapy (Chick, 1985; Whitfield et al., 1978), and an external service review (Ritson, 1983). This resulted in the

closure of the hospitals involved in behavioural modification and rehabilitation programs, and relocation of the detoxification and outpatient clinic to a new facility. Originally the Authority had 108 beds available for a continuum of residential care from detoxification to long term rehabilitation. With the closure of these facilities the beds were reduced to 22, and were reserved for detoxification of individuals with problems associated with alcohol and tranquilliser use. Shortly afterwards, in response to the growing demand for residential detoxification for individuals with illicit drug problems, a small, 10 bed unit was opened to address the needs of this clientele.

From 1984 to 1991 there was considerable expansion of the Authority's activities in professional education, research, community development and in major teaching hospitals in the metropolitan area, and regional hospitals throughout the state. For example:

- A community nursing service was established to undertake detoxification of problem drinkers in the home.
- Clinical Nurse Specialists were seconded to the major teaching hospitals. Their role included screening, minimal interventions, referrals, and professional education.
- Multidisciplinary community teams were established in the metropolitan regions.
- Development and implementation of a "Key Worker" course for registered nurses. This was a certificated, post basic nursing course of six months duration. During this time nurses were seconded to the Authority from their various places of employment, and underwent training to prepare them to function as Key Workers in addictions. At the completion of the course they returned to their original place of employment.
- The introduction of Addiction Studies courses in universities, technical, and continuing professional education programs.

(WAADA, 1984, 1991a)

The main illicit problem drug at the time was heroin, which was, and is treated with methadone. Methadone had been prescribed for opioid dependents in Perth by private medical practitioners since 1973. In 1976, however, in the face of growing concern over the prescribing practices of these practitioners, the Health Department of WA restricted prescribing rights to the Authority. In July 1976 there were 16 people on the Authority's methadone program, by the end of August the number had increased ninefold to 141, and by December to 206 (WAADA, 1978). Since then the numbers have continued to increase, and in 1995 there were over 900 on the program, and the waiting period for an appointment for assessment for admission was five months (Manager, William Street Clinic, personal communication).

Initially, opioid dependents and individuals with alcohol problems were treated in the same facilities, albeit with increasing reservations. After several years of frustration regarding the congestion and the inadequacies at the combined outpatient clinic a separate, specialist clinic was established in 1980 for the benefit of individuals with drug (mainly heroin) related problems. The move was seen as a means of overcoming the management problems associated with providing treatment for both "the alcoholic and drug affected persons" in the same physical setting (WAADA, 1979, p. 5). In regard to treating opioid and alcohol dependents in the detoxification hospital it was reported that opioid dependent patients pose different, frequently more difficult management problems than alcohol dependents (WAADA, 1979).

In the report following the 1983 review of services it was noted that "Young drug addicts seem to do quite well in Aston (the detoxification hospital) provided their numbers are kept to one or two at a time. With larger numbers they become a distinctly disruptive influence" (Ritson, 1983, p. 5).

A separate outpatient methadone clinic for opioid dependents was opened in 1980. In 1986 a residential, ten bed detoxification facility was established at the Central Drug Unit (CDU) catering solely for illicit drug users. This restructuring completed the separation of services for the two client populations (WAADA, 1986). A court diversion program and a twenty-four hour telephone information and counselling service was also established on the site. By 1990, however, confronted with increasing economic constraints and a consequent need to rationalise services, a decision was made to abolish one residential unit and

integrate inpatient detoxification treatment for all drug users at one site (WAADA, 1991). A Service Integration and Site Development committee was formed to review the facilities and make recommendations on the planned change. Two models were proposed: (a) integrating illicit drug services at the site of the licit facility, and (b) integrating licit services at the site of the existing facility for illicit drug treatment. The reported disadvantages of adopting option (b) were that:

- there were insufficient clinical, group, individual, and recreational facilities;
- observation and clinical management of acute alcohol detoxification would be impossible;
- there were inadequate interview, counselling, and note writing areas;
- existing catering services could not provide for an increase in client numbers.

The committee members main concern was expressed as follows:

In the residential management of detoxification of clients our service would be compromised to an unacceptable degree for both the community and the Authority, unless substantial capital works were conducted prior to integration.

(WAADA, 1991b, p. 7)

It was recommended that integration occur at the site of existing licit drug services. When this unit was established, however, the WAADA had given a commitment to local residents that “drug addicts” would not be treated at that facility. Consequently, despite the recommendations of the committee, a program of capital works was initiated and integration occurred at the site of illicit drug treatment on the 24th June, 1991. Amalgamating the two services resulted in a reduction of inpatient beds from 30 to 20, and a corresponding loss of approximately 12 staff positions. Through informal discussions with staff it was apparent that this restructuring was viewed as particularly disruptive because it was implemented relatively soon after the two services had been separated. The provision of separate services for licit and illicit drug users was considered to be based on clinical merit; that to combine was seen to be driven by economic rationalism.

APPENDIX B

ASSESSMENT OF COGNITIVE FUNCTION

If a client has pronounced organic brain damage, such as the Wernicke-Korsakoff disorder, where memory is severely deficit, cognitive deficits are usually obvious. The amnesic syndrome associated with this disorder leaves short-term memory and memory for long-term events intact, but interferes with the ability to learn new information (Mattick, et al., 1993). A person suffering from the amnesic syndrome might not recognise a staff member even though they had been recently introduced. One way of detecting this form of memory deficit involves giving a client a string of digits to remember and then distracting them with some unrelated activity so they are unable to rehearse the digit string. The amnesic client will be unable to recall the digits after the distraction.

A variety of other tests have been shown to be sensitive to drug induced brain damage and are described in detail elsewhere (Lezak, 1983). These tests include the Rey Complex Figure Test (designed to test perceptual organisation and visual memory), the Rey Auditory-Verbal Learning Test (this measures verbal memory recall and recognition), and the Trail Making Test (designed to test visual concepts and visuomotor tracking). Some tests, such as the Weschler Memory Scale (revised) should only be administered by a psychologist trained in their interpretation.

In the unit in which this study was conducted it was customary to administer the Mini Mental State examination (Folstein, Folstein, & McHugh, 1975) to all clients. This is quick and easy to administer and can be used by non-psychologists. In the event that memory deficits were detected, the client concerned was referred to a psychologist for further testing.

APPENDIX C

CONSENT FORMS & QUESTIONNAIRE

NOTE: The Short Alcohol Dependence Scale (SADD), the Short Dependence Scale (SDS) and the General Health Questionnaire (GHQ-28) is contained in the questionnaire in Appendix C.

The author of this thesis, Dr Anne Bartu, has indicated that SADD, SDS and the GHQ-28, are in the “public domain” and “may be used as long as appropriate acknowledgement is made”, and that this information has been derived from:

Dawe, Sharon and Richard P. Mattick (1997) Review of diagnostic screening instruments for alcohol and other drug use and other psychiatric disorders. National Drug Strategy. Australian Government Publishing Service. pp 29, 47, 52.

(Co-ordinator, ADT Project (Retrospective), Curtin University of Technology, 9.12.02)

APPENDIX C

CONSENT FORMS & QUESTIONNAIRE

FORM OF DISCLOSURE AND INFORMED CONSENT

(Questionnaires)

Dear Client

The Western Australian Alcohol and Drug Authority has recently amalgamated the residential services for people with problems with alcohol and other drugs. I am carrying out a study to find out how clients in the unit feel about the services they receive and how they view users of different drugs. This study is being undertaken as part of my studies at Curtin University. The results will also be used by the Western Australian Alcohol and Drug Authority to improve the services provided.

Participation is voluntary, and if you decide not to be involved this will in no way prejudice your treatment. Participation will involve completing a questionnaire which should take no more than fifteen to twenty minutes. All information will be treated as confidential, and all completed forms will be identified only by a number different to the registration number of the unit.

You are free to refuse to answer any question and may withdraw from the study at any time. Only group data will be analysed and no individual will be identified by name in the reports.

If you are willing to assist would you sign the following:

I have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate and realise that I may withdraw at any time.

.....
Participant

.....
Date

.....
Researcher

.....
Date

**FORM OF DISCLOSURE AND INFORMED CONSENT
(Interviews)**

Dear Client

The Western Australian Alcohol and Drug Authority has recently amalgamated the residential services for people with problems with alcohol and other drugs. I am carrying out a study to find out how clients in the unit feel about the services they receive and how they view users of different drugs. This study is being undertaken as part of my studies at Curtin University. The results will also be used by the Western Australian Alcohol and Drug Authority to improve the services provided.

Participation is voluntary, and if you decide not to be involved this will in no way prejudice your treatment. Participation will involve taking part in a tape-recorded interview which should take approximately one hour.

You are free to refuse to answer any question and may withdraw from the study at any time. All information will be treated as confidential and no individual will be identified by name in the reports.

If you are willing to assist would you sign the following:

I have read the information above and any questions I have asked have been answered to my satisfaction. I agree to participate and realise that I may withdraw at any time.

.....
Participant

.....
Date

.....
Researcher

.....
Date

QUESTIONNAIRE

Demographic, Life Events and Drug Use

| CODE | | | | <input type="text"/> |
|------|--------------------------------|-----------------------------|---|----------------------|
| 1 | NUMBER OF DAYS SINCE ADMISSION | | | <input type="text"/> |
| 2 | AGE | | | <input type="text"/> |
| 3 | SEX | Male | 1 | <input type="text"/> |
| | | Female | 2 | |
| 4 | COUNTRY OF BIRTH (Specify) | | | |
| 5 | REFERRAL SOURCE | Self | 1 | <input type="text"/> |
| | | Family/friend/employer | 2 | |
| | | General Practitioner | 3 | |
| | | Alcohol/drug Agency | 4 | |
| | | Legal Services | 5 | |
| | | Welfare department | 6 | |
| | | Non-government organisation | 7 | |
| | | Hospital | 8 | |
| | | Other | 9 | |
| 6 | ACCOMMODATION | Parent's home | 1 | <input type="text"/> |
| | | Own home | 2 | |
| | | Rental | 3 | |
| | | Refuge | 4 | |
| | | No fixed place of abode | 5 | |
| 7 | PENSION | Yes | 1 | <input type="text"/> |
| | | No | 2 | |
| 8 | EMPLOYMENT | Student | 1 | <input type="text"/> |
| | | Full-time | 2 | |
| | | Part-time | 3 | |
| | | Unemployed | 4 | |
| 9 | EDUCATION | Primary | 1 | <input type="text"/> |
| | | Some secondary | 2 | |
| | | Completed secondary | 3 | |
| | | Trade/Technical | 4 | |
| | | Tertiary | 5 | |

| | | | | |
|----|--|---|----------------------------|--|
| 10 | PREVIOUS ADMISSIONS | Nil 1 – 2 3 or more | 0 1 2 | <input type="checkbox"/> |
| 11 | LEGAL PROBLEMS | Yes No | 1 2 | <input type="checkbox"/> |
| 12 | MAIN DRUG (Specify) | _____ | | <input type="checkbox"/> <input type="checkbox"/> |
| 13 | OTHER DRUG USE (Specify) | _____ | | <input type="checkbox"/> <input type="checkbox"/> |
| | | _____ | | <input type="checkbox"/> <input type="checkbox"/> |
| | | _____ | | <input type="checkbox"/> <input type="checkbox"/> |
| 14 | POLY DRUG USE | Yes No | 1 2 | <input type="checkbox"/> |
| 15 | AGE FIRST USED DRUGS REGULARLY (Specify) | _____ | | <input type="checkbox"/> <input type="checkbox"/> |
| 16 | FREQUENCY OF DRUG USE | Daily Most days Once a week | 1 2 3 | <input type="checkbox"/> |
| 17 | DURATION OF CURRENT USE (Months) | _____ | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 18 | HAVE YOU EVER INJECTED ANY DRUG? | Yes No | 1 2 | <input type="checkbox"/> |
| 19 | AGE FIRST INJECTED (Specify) | _____ | | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> |
| 20 | LAST INJECTED | Less than a week ago 1 week – less than 4 1 month – less than 3 3 months – less than 12 More than a year ago | 1 2 3 4 5 | <input type="checkbox"/> |
| 21 | LAST SHARED INJECTING EQUIPMENT | Never Less than a week ago 1 week – less than 4 1 month – less than 3 3 months – less than 12 More than a year ago | 1 2 3 4 5 6 | <input type="checkbox"/> |

SHORT ALCOHOL DEPENDENCE SCALE (SADD)

Davidson and Raistrick (1986)

Questions 19-33 are for those whose main drug is **alcohol**. If your main drug is other than alcohol, go to Question 34.

The following questions are about your drinking. *Please circle the correct letter.*

| | | 0 Never | 1 Some- times | 2 Often | 3 Nearly always |
|----|---|------------|---------------------|------------|-----------------------|
| 19 | Do you find difficulty in getting the thought of drink out of your mind? | N | S | O | NA |
| 20 | Is getting drunk more important than your next meal? | N | S | O | NA |
| 21 | Do you plan your day around when and where you can drink? | N | S | O | NA |
| 22 | Do you drink in the morning, afternoon and evening? | N | S | O | NA |
| 23 | Do you drink for the effect of alcohol without caring what the drink is? | N | S | O | NA |
| 24 | Do you drink as much as you want irrespective of what you are doing the next day? | N | S | O | NA |
| 25 | Given that many problems might be caused by alcohol do you still drink too much? | N | S | O | NA |
| 26 | Do you know that you won't be able to stop drinking once you start? | N | S | O | NA |
| 27 | Do you try to control your drinking by giving it up completely for days or weeks at a time? | N | S | O | NA |
| 28 | The morning after a heavy drinking session do you need your first drink to get yourself going? | N | S | O | NA |
| 29 | The morning after a heavy drinking session do you wake up with a definite shakiness of your hands? | N | S | O | NA |
| 30 | After a heavy drinking session do you wake up and retch or vomit? | N | S | O | NA |
| 31 | The morning after a heavy drinking session do you go out of your way to avoid people? | N | S | O | NA |
| 32 | After a heavy drinking session do you see frightening things that later you realise were imaginary? | N | S | O | NA |
| 33 | Do you go drinking and the next day find you have forgotten what happened the night before? | N | | O | NA |

SHORT DEPENDENCE SCALE (SDS)

Gossop et al. (1992).

Questions 34 to 38 are for those whose main drug is **other than alcohol**. If your main drug is alcohol go to Question 39.

Please circle the best fitting response.

34 Did you ever think your drug use was out of control?

| | |
|-------------------------|---|
| Never or almost never | 0 |
| Sometimes | 1 |
| Often | 2 |
| Always or nearly always | 3 |

35 Did the prospect of missing your drug make you very anxious or worried?

| | |
|-------------------------|---|
| Never or almost never | 0 |
| Sometimes | 1 |
| Often | 2 |
| Always or nearly always | 3 |

36 Do you worry about your drug use?

| | |
|--------------|---|
| Not at all | 0 |
| A little | 1 |
| Quite a lot | 2 |
| A great deal | 3 |

37 Did you wish you could stop?

| | |
|-------------------------|---|
| Never or almost never | 0 |
| Sometimes | 1 |
| Often | 2 |
| Always or nearly always | 3 |

38 How difficult would you find it to stop or go without?

| | |
|-----------------|---|
| Not difficult | 0 |
| Quite difficult | 1 |
| Very difficult | 2 |
| Impossible | 3 |

GENERAL HEALTH QUESTIONNAIRE (GHQ-28)

Goldberg and Hillier (1979)

I should like to know if you have had any medical complaints, and how your health has been in general over the past few weeks. Please answer **ALL** the questions on the following pages simply by circling the answer that you think most nearly applies to you. Remember that we want to know about present and recent complaints, not those that you had in the past

HAVE YOU RECENTLY:

| | | | | | |
|----|---|--------------------|--------------------|------------------------|-----------------------|
| 39 | Been feeling well and in good health? | Better than usual | Same as usual | Worse than usual | Much worse than usual |
| 40 | Been feeling in need of a pick me up? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 41 | Been feeling run down and out of sorts? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 42 | Felt that you are ill? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 43 | Been getting any pains in your head? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 44 | Been getting a feeling of tightness or pressure in your head? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 45 | Been having hot or cold spells? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 46 | Lost much sleep over worry? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 47 | Had difficulty in staying asleep once you are off? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 48 | Felt constantly under strain? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 49 | Been getting edgy and bad tempered? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 50 | Been getting scared or panicky for no good reason? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 51 | Found everything getting on top of you? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 52 | Been feeling nervous and strung up all the time? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 53 | Been managing to keep busy and occupied? | More so than usual | Same as usual | Rather less than usual | Much less than usual |

| | | | | | |
|----|---|--------------------|--------------------|------------------------|------------------------|
| 54 | Been taking longer over the things you do? | Quicker than usual | Same as usual | Longer than usual | Much longer than usual |
| 55 | Felt on the whole you were doing things well? | Better than usual | About the same | Less well than usual | Much less well |
| 56 | Been satisfied with the way you've carried out your task? | More satisfied | About the same | Less than usual | Much less satisfied |
| 57 | Felt that you are playing a useful part in things? | More so than usual | Same as usual | Less useful than usual | Much less useful |
| 58 | Felt capable of making decisions about things? | More so than usual | Same as usual | Less so than usual | Much less capable |
| 59 | Been able to enjoy your normal day to day activities? | More so than usual | Same as usual | Less so than usual | Much less than usual |
| 60 | Been thinking of yourself as a worthless person? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 61 | Felt that life is entirely hopeless? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 62 | Felt that life is not worth living? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 63 | Thought of the possibility that you might do away with yourself? | Definitely not | I don't think so | Has crossed my mind | Definitely have |
| 64 | Found at times that you couldn't do anything because your nerves were so bad? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 65 | Found yourself wishing you were dead and away from it all? | Not at all | No more than usual | Rather more than usual | Much more than usual |
| 66 | Found that the idea of taking your own life kept coming into your mind? | Definitely not | I don't think so | Has crossed my mind | Definitely has |

APPENDIX D

Investigator Triangulation

One of the strategies to enhance external reliability in qualitative research, particularly grounded theory, is to have other investigators analyse sections of the data and compare their findings with those of the researcher. The investigators should not be involved in the study, and their analysis is grounded in the data contained in the segment they are given. This was accomplished by the researcher in this study taking sections of the transcripts of interviews to the post graduate meetings for grounded theory held at Curtin University of Technology. The participants in these meetings came from a variety of disciplines, and all were conducting post-graduate research using grounded theory as the approach to their investigations. Sections of the data were supplied to these researchers who at times analysed the segments during the meeting; at other times the segments were taken away to be analysed in private and the findings brought back to the following meeting. This was a strategy used by the late Emeritus Professor Anselm Strauss with students at the University of California, San Francisco, to ensure in part that the issue of external reliability in grounded theory research was enhanced, and was adopted in this study.

APPENDIX E

Summary of Statistical Models

Key to Variables

| Variable Name | Meaning |
|---------------|---|
| AGE | 1=17-25 years, 2=26-35 years 3=36 and over |
| SEX | 1=Male, 2=Female |
| MARSTAT | 1=With partner, 2=Without partner |
| EMPLOYME | 1=Employed*, 2=Unemployed |
| PRINDRUG | 1=Alcohol, 2=Opioids, 11=Amphetamines, 12=Tranquillisers |
| LICIT | 0=Alcohol and tranquillisers (legal) 1=Amphetamines and heroin (illegal) |
| POLY | 1=Poly Drug Yes 2=Poly Drug No |
| GHQA | GHQ-28 Somatic scores |
| GHQB | GHQ-28 Anxiety scores |
| GHQC | GHQ-28 Social dysfunction scores |
| GHQD | GHQ-28 Depression scores |
| GHQTOT | Overall GHQ-28 scores |
| DROP_OUT | 0=Completed program, 1=Dropped out |
| TIME | 1=1 st quarter, 2=2 nd quarter, 3=3 rd quarter, 4=4 th quarter |

*includes students

POWER ANALYSIS

The power of a statistical test with a fixed level of significance (in this instance $\alpha=0.05$) is the probability of rejecting a false null hypothesis, Type II error (Cohen, 1977). Power is a function of the alpha level, effect size, and sample size.

Power was calculated according to Cohen (1997) as .76 for the response variable GHQTOT. This variable was the response variable (with logarithmic transformation) in a regression model.

Because of the complexity and specificity of the other models fitted (log-linear, logistic and proportional odds) power was not calculated for the other response variables.

The sample size of 421 provides reasonable grounds to expect that the power of the other tests, though not calculated, was reasonably high.

TABLE E1

Logistic Regression Analysis with licit as response variate and constant, poly, drop-out, age, employme, marstat, time, age.drop-out, age.sex, sex.drop-out, sex.poly and age.poly as fitted terms.

Response variate: licit
 Binomial totals: 1
 Distribution: Binomial
 Link function: Logit
 Fitted terms: Constant + poly + drop-out + age + employme + marstat + time + age.drop-out + age.sex + sex.drop-out + sex.poly + age.poly

*** Summary of analysis ***

| | d.f. | deviance | mean deviance | deviance ratio |
|------------|------|----------|---------------|----------------|
| Regression | 18 | 180.5 | 10.0252 | 10.03 |
| Residual | 499 | 437.5 | 0.8768 | |
| Total | 517 | 618.0 | 1.1953 | |

| | | | | |
|--------|----|------|--------|------|
| Change | -2 | -1.3 | 0.6463 | 0.65 |
|--------|----|------|--------|------|

*MESSAGE: ratios are based on dispersion parameter with value 1

*MESSAGE: The following units have large standardized residuals:

| | |
|-----|------|
| 163 | 3.16 |
|-----|------|

*MESSAGE: The following units have high leverage:

| | |
|-----|-------|
| 189 | 0.188 |
| 430 | 0.139 |
| 432 | 0.116 |
| 472 | 0.113 |
| 477 | 0.118 |
| 489 | 0.122 |
| 510 | 0.141 |
| 512 | 0.129 |
| 514 | 0.228 |
| 515 | 0.141 |
| 517 | 0.128 |

*** Estimates of regression coefficients ***

| | estimate | s.e. | t (*) |
|-------------------|----------|-------|-------|
| Constant | 0.939 | 0.496 | 1.89 |
| poly 2 | -1.684 | 0.625 | -2.69 |
| drop-out 2 | 1.175 | 0.674 | 1.74 |
| age 2 | -0.868 | 0.436 | -1.99 |
| age 3 | -3.066 | 0.581 | -5.27 |
| employme 2 | -0.661 | 0.266 | -2.48 |
| marstat 2 | 0.527 | 0.308 | 1.71 |
| time 2 | -0.070 | 0.349 | -0.20 |
| time 3 | 0.012 | 0.377 | 0.03 |
| time 4 | -0.479 | 0.367 | -1.31 |
| sex 2 | 0.733 | 0.631 | 1.16 |
| age 2 .drop-out 2 | 0.760 | 0.776 | 0.98 |
| age 3 .drop-out 3 | 1.971 | 0.943 | 2.09 |
| age 2 .sex 2 | -0.767 | 0.677 | -1.13 |
| age 3 .sex 2 | 0.001 | 0.821 | 0.00 |
| sex 2 .drop-out 2 | -0.816 | 0.680 | -1.20 |
| sex 2 .poly 2 | 0.716 | 0.748 | 0.96 |
| age 2 .poly 2 | -0.458 | 0.770 | -0.59 |
| age 3 .poly 2 | -1.072 | 0.954 | -1.12 |

*MESSAGE: s.e.s are based on dispersion parameter with value 1

* Critical value of $t_{(19), p = 0.05} = 1.96$

• *** Accumulated analysis of deviance ***

| Change | d.f. | deviance* | mean deviance | deviance ratio |
|----------------|------|-----------|------------------|-------------------|
| + poly | 1 | 56.0465 | 56.0465 | 56.05 |
| + drop-out | 1 | 40.7663 | 40.7663 | 40.77 |
| + age | 2 | 63.6508 | 31.8254 | 31.83 |
| + employme | 1 | 6.8323 | 6.8323 | 6.83 |
| + marstat | 1 | 1.8507 | 1.8507 | 1.85 |
| + time | 3 | 2.7423 | 0.9141 | 0.91 |
| + sex | 1 | 0.3438 | 0.3438 | 0.34 |
| + age.drop-out | 2 | 3.0644 | 1.5322 | 1.53 |
| + age.sex | 2 | 2.3238 | 1.1619 | 1.16 |
| + sex.drop-out | 1 | 0.6590 | 0.6590 | 0.66 |
| + sex.poly | 1 | 0.8809 | 0.8809 | 0.88 |
| + age.poly | 2 | 1.2929 | 0.6463 | 0.65 |
| Residual | 499 | 437.5117 | 0.8768 | |
| Total | 517 | 617.9652 | 1.1953 | |

* MESSAGE: ratios are based on dispersion parameter with value 1

* Critical value of Chi-square (df = 1, p = 0.05) = 3.84.

Critical value of Chi-square (df = 2, p = 0.05) = 5.99.

TABLE E2

Logistic Regression Analysis with licit as response variate and constant, poly, drop-out, age and employme as fitted terms.

Response variate: licit
 Binomial totals: 1
 Distribution: Binomial
 Link function: Logit
 Fitted terms: Constant + poly + drop-out + age + employme

*** Summary of analysis ***

| | d.f. | deviance | mean deviance | deviance ratio |
|------------|---|----------|------------------|-------------------|
| Regression | 5 | 167.3 | 33.4592 | 33.46 |
| Residual | 512 | 450.7 | 0.8802 | |
| Total | 517 | 618.0 | 1.1953 | |
| Change | -1 | -6.8 | 6.8323 | 6.83 |
| *MESSAGE: | ratios are based on dispersion parameter with value 1 | | | |
| *MESSAGE: | The following units have high leverage: | | | |
| | 459 | 0.044 | | |
| | 487 | 0.044 | | |

*** Estimates of regression coefficients ***

| | estimate | s.e. | t (*) |
|------------|--|-------|-------|
| Constant | 0.991 | 0.323 | 3.07 |
| poly 2 | -1.909 | 0.316 | -6.04 |
| drop-out 2 | 1.726 | 0.318 | 5.43 |
| age 2 | -1.014 | 0.312 | -3.25 |
| age 3 | -2.649 | 0.371 | -7.14 |
| employme 2 | -0.630 | 0.241 | -2.61 |
| *MESSAGE: | s.e.s are based on dispersion parameter with value 1 | | |

*** Accumulated analysis of deviance ***

| Change | d.f. | deviance** | mean deviance | deviance ratio |
|------------|------|------------|------------------|-------------------|
| + poly | 1 | 56.0465 | 56.0465 | 56.05 |
| + drop-out | 1 | 40.7663 | 40.7663 | 40.77 |
| + age | 2 | 63.6508 | 31.8254 | 31.83 |
| + employme | 1 | 6.8323 | 6.8323 | 6.83 |
| Residual | 512 | 450.6693 | 0.8802 | |
| Total | 517 | 617.9652 | 1.1953 | |

* MESSAGE: ratios are based on dispersion parameter with value 1

* Critical value of t_{512} , $p = 0.05$ = 1.96.

** Critical value of Chi-square (d.f. = 1, $p = 0.05$) = 3.84

Critical value of Chi-square (d.f. = 2, $p = 0.05$) = 5.99

TABLE E3

Licit/Illicit by poly, drop-out, employment and age (odds ratio)

| Poly Drug Use | Drop-out | Employment | Age | Odds Ratio | SE* |
|---------------|----------|------------|-----|------------|-------|
| 1 | 0 | 1 | 1 | 0.729 | 0.064 |
| | | | 2 | 0.494 | 0.053 |
| | | | 3 | 0.160 | 0.040 |
| | 1 | | 1 | 0.938 | 0.026 |
| | | | 2 | 0.846 | 0.049 |
| | | | 3 | 0.517 | 0.104 |
| 2 | 0 | 2 | 1 | 0.285 | 0.077 |
| | | | 2 | 0.127 | 0.038 |
| | | | 3 | 0.027 | 0.010 |
| | 1 | | 1 | 0.692 | 0.084 |
| | | | 2 | 0.449 | 0.091 |
| | | | 3 | 0.137 | 0.046 |
| 1 | 0 | 2 | 1 | 0.589 | 0.074 |
| | | | 2 | 0.343 | 0.042 |
| | | | 3 | 0.092 | 0.025 |
| | 1 | | 1 | 0.890 | 0.039 |
| | | | 2 | 0.745 | 0.061 |
| | | | 3 | 0.363 | 0.088 |
| 2 | 0 | 2 | 1 | 0.175 | 0.056 |
| | | | 2 | 0.072 | 0.024 |
| | | | 3 | 0.015 | 0.006 |
| | 1 | | 1 | 0.545 | 0.090 |
| | | | 2 | 0.303 | 0.070 |
| | | | 3 | 0.078 | 0.024 |

Poly 1 = Yes 2 = No
Drop-out 0 = Completed program, 1=Dropped-out
Employment 1 = Employed, 2 = Unemployed
Age 1 = 15-25 years, 2 = 26-35 years, 3 = 36 and over

TABLE E4

Age, sex, marstat, prindrug, poly by time (N=518)

| Variable | Time | | Time | | Time | | Time | | Chi Sq | d.f. | P |
|-----------------|------|---------|------|---------|------|---------|------|---------|--------|------|-------|
| | 1 | % | 2 | % | 3 | % | 4 | % | | | |
| Age | | | | | | | | | | | |
| 17-25 | 14 | (2.70) | 27 | (5.21) | 21 | (4.05) | 24 | (4.63) | 4.03 | 6 | 0.672 |
| 26-35 | 49 | (9.46) | 54 | (10.42) | 47 | (9.07) | 54 | (10.42) | | | |
| 36 and over | 56 | (10.81) | 67 | (12.93) | 55 | (10.62) | 50 | (9.65) | | | |
| Sex | | | | | | | | | | | |
| Male | 88 | (16.99) | 107 | (20.66) | 97 | (18.73) | 87 | (16.80) | 3.88 | 3 | 0.274 |
| Female | 31 | (5.98) | 41 | (7.92) | 26 | (5.02) | 41 | (7.92) | | | |
| Marstat | | | | | | | | | | | |
| With partner | 96 | (80.67) | 121 | (81.76) | 102 | (82.93) | 97 | (75.78) | 2.39 | 3 | 0.494 |
| Without-partner | 23 | (9.33) | 27 | (18.24) | 21 | (17.07) | 31 | (24.22) | | | |
| Prindrug | | | | | | | | | | | |
| Alcohol | 80 | (15.44) | 87 | (16.80) | 76 | (14.67) | 75 | (14.48) | 10.52 | 9 | 0.309 |
| Amphetamines | 22 | (4.25) | 31 | (5.98) | 23 | (4.44) | 17 | (3.28) | | | |
| Tranquillisers | 8 | (1.54) | 15 | (2.90) | 10 | (1.93) | 20 | (3.86) | | | |
| Opioids | 9 | (1.74) | 15 | (2.90) | 14 | (2.70) | 16 | (3.09) | | | |
| Poly | | | | | | | | | | | |
| Yes | 69 | (57.98) | 90 | (60.81) | 78 | (63.41) | 73 | (57.03) | 1.30 | 3 | 0.728 |
| No | 50 | (42.02) | 58 | (39.19) | 45 | (36.59) | 55 | (42.97) | | | |

TABLE E5

Logistic Regression Analysis with ghqtot as response variate and constant, and time as fitted terms.

Response variate: ghqtot
Fitted terms: Constant + time

*** Summary of analysis ***

| | d.f. | s.s. | m.s. | v.r. | F pr. |
|------------|------|-------|--------|------|-------|
| Regression | 3 | 399 | 132.94 | 2.78 | 0.041 |
| Residual | 417 | 19920 | 47.77 | | |
| Total | 420 | 20319 | 48.38 | | |

Change 1 0 0.04 0.00 0.976

Percentage variance accounted for 1.3

Standard error of observations is estimated to be 6.91

*** Estimates of regression coefficients ***

| | estimate | s.e. | t(417) | t pr. |
|----------|----------|-------|--------|---------|
| Constant | 17.779 | 0.678 | 26.23 | < 0.001 |
| time 2 | -1.237 | 0.952 | -1.30 | 0.194 |
| time 3 | 1.193 | 0.950 | 1.26 | 0.210 |
| time 4 | 1.015 | 0.963 | 1.05 | 0.292 |

*** Accumulated analysis of variance ***

| Change | d.f. | s.s. | mean m.s. | v.r. | F pr. |
|-----------------|------|----------|--------------|------|-------|
| + time | 3 | 398.82 | 132.94 | 2.70 | 0.045 |
| + sex | 1 | 101.69 | 101.69 | 2.07 | 0.151 |
| + marstat | 1 | 6.96 | 6.96 | 0.14 | 0.707 |
| + employme | 1 | 41.03 | 41.03 | 0.83 | 0.362 |
| + poly | 1 | 6.92 | 6.92 | 0.14 | 0.708 |
| + age | 2 | 96.31 | 48.16 | 0.98 | 0.377 |
| + prindrug | 3 | 55.25 | 18.42 | 0.37 | 0.772 |
| + age.poly | 2 | 41.57 | 20.78 | 0.42 | 0.656 |
| + sex.poly | 1 | 3.44 | 3.44 | 0.07 | 0.792 |
| + age.sex | 2 | 38.51 | 19.26 | 0.39 | 0.676 |
| + age.prindrug | 6 | 88.28 | 14.71 | 0.30 | 0.937 |
| + sex.prindrug | 3 | 125.10 | 41.70 | 0.85 | 0.469 |
| + poly.prindrug | 2 | 28.71 | 14.35 | 0.29 | 0.747 |
| Residual | 392 | 19286.30 | 49.20 | | |
| - age.poly | -2 | -50.25 | 25.12 | 0.51 | 0.601 |
| - sex.poly | -1 | -14.70 | 14.70 | 0.30 | 0.585 |
| - sex.prindrug | -3 | -110.46 | 36.82 | 0.75 | 0.524 |
| - age.prindrug | -6 | -37.39 | 6.23 | 0.13 | 0.993 |
| - poly.prindrug | -2 | -91.89 | 45.95 | 0.93 | 0.394 |
| - age.sex | -2 | -20.91 | 10.46 | 0.21 | 0.809 |
| - prindrug | -3 | -55.25 | 18.42 | 0.37 | 0.772 |
| - marstat | -1 | -16.76 | 16.76 | 0.34 | 0.560 |
| - employme | -1 | -36.91 | 36.91 | 0.75 | 0.387 |
| - age | -2 | -91.74 | 45.87 | 0.93 | 0.394 |
| - sex | -1 | -107.45 | 107.45 | 2.18 | 0.140 |
| - poly | -1 | -0.04 | 0.04 | 0.00 | 0.976 |
| Total | 420 | 20318.88 | 48.38 | | |

TABLE E6

Proportional-odds model with GHQ-A as response variate and age, sex, poly, prindrug, time, age.poly, sex.poly, age.prindrug and sex.prindrug as fitted terms.

Response variates: ordinal model for categories defined by
a[1], a[2], a[3], a[4], a[5], a[6], a[7], a[8]
Distribution: Multinomial
Link function: Logit
Fitted terms: age + sex + poly + prindrug + time + age.poly + sex.poly + age.prindrug
+ sex.prindrug

*** Summary of analysis ***

| | d.f. | deviance | mean deviance | deviance ratio |
|------------|------|----------|------------------|-------------------|
| Regression | 22 | 33.4 | 1.520 | 1.52 |
| Residual | 286 | 542.0 | 1.895 | |
| Total | 308 | 575.5 | 1.868 | |
| Change | -3 | -0.3 | 0.093 | 0.09 |

*MESSAGE: ratios are based on dispersion parameter with value 1

*** Estimates of regression coefficients ***

| | estimate | s.e. | t (*) |
|--------------------|----------|-------|-------|
| Cut-point 0 / 1 | --3.604 | 0.567 | -6.36 |
| Cut-point 1 / 2 | -2.728 | 0.536 | -5.09 |
| Cut-point 2 / 3 | -2.065 | 0.524 | -3.94 |
| Cut-point 3 / 4 | -1.307 | 0.516 | -2.53 |
| Cut-point 4 / 5 | -0.624 | 0.513 | -1.22 |
| Cut-point 5 / 6 | 0.027 | 0.512 | 0.05 |
| Cut-point 6 / 7 | 0.604 | 0.513 | 1.18 |
| age 2 | -0.426 | 0.545 | -0.78 |
| age 3 | -0.081 | 0.543 | -0.15 |
| sex 2 | 0.579 | 0.345 | 1.68 |
| poly 2 | -0.493 | 0.647 | -0.76 |
| prindrug 11 | 0.48 | 1.96 | 0.25 |
| prindrug 12 | -1.435 | 0.770 | -1.86 |
| prindrug 2 | -0.852 | 0.639 | -1.33 |
| time 2 | -0.641 | 0.252 | -2.54 |
| time 3 | -0.238 | 0.251 | -0.95 |
| time 4 | 0.266 | 0.256 | 1.04 |
| age 2 .poly 2 | 0.933 | 0.747 | 1.25 |
| age 3 .poly 2 | 0.362 | 0.707 | 0.51 |
| sex 2 .poly 2 | -0.209 | 0.528 | -0.40 |
| age 2 .prindrug 12 | -0.35 | 13.97 | -0.18 |
| age 2 .prindrug 11 | 1.715 | 0.826 | 2.08 |
| age 2 .prindrug 2 | 1.198 | 0.757 | 1.58 |
| age 3 .prindrug 12 | -0.33 | 1.95 | -0.17 |
| age 3 .prindrug 11 | 0.954 | 0.997 | 0.96 |
| age 3 .prindrug 2 | -1.11 | 1.43 | -0.78 |
| sex 2 .prindrug 12 | -0.085 | 0.628 | -0.14 |
| sex 2 .prindrug 11 | -0.305 | 0.590 | -0.52 |
| sex 2 .prindrug 2 | -0.026 | 0.739 | -0.04 |

*MESSAGE: s.e.s are based on dispersion parameter with value 1

*** Accumulated analysis of deviance ***

| Change | d.f. | deviance | mean deviance | deviance ratio |
|------------|------|----------|------------------|-------------------|
| + age | 2 | 3.869 | 1.934 | 1.93 |
| + sex | 1 | 5.597 | 5.597 | 5.60 |
| + poly | 1 | 0.228 | 0.228 | 0.23 |
| + prindrug | 3 | 1.124 | 0.375 | 0.37 |
| + time | 3 | 1.556 | 0.519 | 0.52 |
| + age.poly | 2 | 1.292 | 0.646 | 0.65 |
| + sex.poly | 1 | 0.405 | 0.405 | 0.41 |

| | | | | |
|----------------|-----|---------|-------|------|
| + age.prindrug | 6 | 4.165 | 0.694 | 0.69 |
| + sex.prindrug | 3 | 1.630 | 0.543 | 0.54 |
| Residual | 286 | 541.746 | 1.894 | |
| Total | 308 | 557.847 | 1.811 | |

* MESSAGE: ratios are based on dispersion parameter with value 1

TABLE E7

Proportional-odds model with GHQ-B as response variate and age, sex, poly, prindrug, time, age.poly, sex.poly, age.prindrug and sex.prindrug as fitted terms.

Response variate: ordinal model for categories defined by
b[1], b[2], b[3], b[4], b[5], b[6], b[7], b[8]
Distribution: Multinomial
Link function: Logit
Fitted terms: age + sex + poly + prindrug + time + age.poly + sex.poly + age.prindrug +
sex.prindrug

*** Summary of analysis ***

| | d.f. | deviance | mean deviance | deviance ratio |
|------------|---|----------|------------------|-------------------|
| Regression | 22 | 19.9 | 0.905 | 0.90 |
| Residual | 286 | 522.3 | 1.826 | |
| Total | 308 | 542.2 | 1.760 | |
| Change | -3 | -1.7 | 0.569 | 0.57 |
| *MESSAGE: | ratios are based on dispersion parameter with value 1 | | | |

*** Estimates of regression coefficients ***

| | estimate | s.e. | t (*) |
|--------------------|----------|-------|-------|
| cut-point 0 / 1 | -3.392 | 0.564 | -6.01 |
| cut-point 1 / 2 | -2.559 | 0.536 | -4.77 |
| cut-point 2 / 3 | -1.826 | 0.524 | -3.48 |
| cut-point 3 / 4 | -1.502 | 0.521 | -2.88 |
| cut-point 4 / 5 | -0.909 | 0.517 | -1.76 |
| cut-point 5 / 6 | -0.267 | 0.515 | -0.52 |
| cut-point 6 / 7 | 0.436 | 0.516 | 0.85 |
| age 2 | -0.155 | 0.549 | -0.28 |
| age 3 | -0.126 | 0.547 | -0.23 |
| sex 2 | -0.026 | 0.346 | -0.08 |
| poly 2 | -1.291 | 0.650 | -1.99 |
| prindrug 12 | -0.95 | 1.91 | -0.49 |
| prindrug 11 | -0.981 | 0.772 | -1.27 |
| prindrug 2 | -0.603 | 0.641 | -0.94 |
| time 2 | -0.200 | 0.252 | -0.79 |
| time 3 | 0.465 | 0.255 | 1.82 |
| time 4 | 0.336 | 0.256 | 1.31 |
| age 2 .poly 2 | 1.109 | 0.750 | 1.48 |
| age 3 .poly 2 | 1.098 | 0.711 | 1.54 |
| sex 2 .poly 2 | 0.027 | 0.526 | 0.05 |
| age 2 .prindrug 12 | 0.31 | 1.92 | 0.16 |
| age 2 .prindrug 11 | 0.818 | 0.827 | 0.99 |
| age 2 .prindrug 2 | 0.178 | 0.757 | 0.23 |
| age 3 .prindrug 12 | 0.43 | 1.90 | 0.23 |
| age 3 .prindrug 11 | 1.73 | 1.03 | 1.67 |
| age 3 .prindrug 2 | 1.54 | 1.49 | 1.03 |
| sex 2 .prindrug 12 | 0.593 | 0.626 | 0.95 |
| sex 2 .prindrug 11 | -0.363 | 0.593 | -0.61 |
| sex 2 .prindrug 2 | 0.054 | 0.736 | 0.07 |

*MESSAGE: s.e.s are based on dispersion parameter with value 1

*** Accumulated analysis of deviance ***

| Change | d.f. | deviance | mean deviance | deviance ratio |
|----------------|------|----------|------------------|-------------------|
| + age | 2 | 3.384 | 1.692 | 1.69 |
| + sex | 1 | 0.053 | 0.053 | 0.05 |
| + poly | 1 | 1.238 | 1.238 | 1.24 |
| + prindrug | 3 | 1.426 | 0.475 | 0.48 |
| + time | 3 | 6.687 | 2.229 | 2.23 |
| + age.poly | 2 | 1.906 | 0.953 | 0.95 |
| + sex.poly | 1 | 0.027 | 0.027 | 0.03 |
| + age.prindrug | 6 | 3.476 | 0.579 | 0.58 |
| + sex.prindrug | 3 | 1.708 | 0.569 | 0.57 |
| Residual | 286 | 522.254 | 1.826 | |
| Total | 308 | 542.160 | 1.760 | |

* MESSAGE: ratios are based on dispersion parameter with value 1

TABLE E8

Proportional-odds model with GHQ-C as response variate and age, sex, poly, prindrug, time, age.poly, sex.poly, age.prindrug and sex.prindrug as fitted terms.

Response variate: ordinal model for categories defined by
c[1], c[2], c[3], c[4], c[5], c[6], c[7], c[8]
Distribution: Multinomial
Link function: Logit
Fitted terms: age + sex + poly + prindrug + time + age.poly + sex.poly + age.prindrug +
sex.prindrug

*** Summary of analysis ***

| | d.f. | deviance | mean deviance | deviance ratio |
|------------|------|----------|------------------|-------------------|
| Regression | 22 | 18.8 | 0.855 | 0.86 |
| Residual | 286 | 522.4 | 1.827 | |
| Total | 308 | 541.2 | 1.757 | |
| Change | -3 | -2.7 | 0.912 | 0.91 |

*MESSAGE: ratios are based on dispersion parameter with value 1

*** Estimates of regression coefficients ***

| | estimate | s.e. | t (*) |
|--------------------|----------|-------|-------|
| cut-point 0 / 1 | -3.077 | 0.556 | -5.54 |
| cut-point 1 / 2 | -2.195 | 0.530 | -4.14 |
| cut-point 2 / 3 | -1.544 | 0.521 | -2.96 |
| cut-point 3 / 4 | -0.969 | 0.517 | -1.87 |
| cut-point 4 / 5 | -0.399 | 0.515 | -0.77 |
| cut-point 5 / 6 | 0.043 | 0.515 | 0.08 |
| cut-point 6 / 7 | 0.689 | 0.516 | 1.34 |
| age 2 | -0.338 | 0.548 | -0.62 |
| age 3 | -0.198 | 0.546 | -0.36 |
| sex 2 | 0.482 | 0.349 | 1.38 |
| poly 2 | -0.622 | 0.651 | -0.96 |
| prindrug 12 | -1.92 | 1.91 | -1.01 |
| prindrug 11 | -0.378 | 0.773 | -0.49 |
| prindrug 2 | -0.204 | 0.643 | -0.32 |
| time 2 | 0.071 | 0.251 | 0.28 |
| time 3 | 0.572 | 0.254 | 2.25 |
| time 4 | 0.471 | 0.255 | 1.85 |
| age 2 .poly 2 | 0.261 | 0.748 | 0.35 |
| age 3 .poly 2 | 0.654 | 0.712 | 0.92 |
| sex 2 .poly 2 | -0.397 | 0.525 | -0.75 |
| age 2 .prindrug 12 | 1.57 | 1.91 | 0.82 |
| age 2 .prindrug 11 | 0.592 | 0.828 | 0.72 |
| age 2 .prindrug 2 | 0.060 | 0.759 | 0.08 |
| age 3 .prindrug 12 | 1.02 | 1.89 | 0.54 |
| age 3 .prindrug 11 | 0.48 | 1.00 | 0.48 |
| age 3 .prindrug 2 | -0.17 | 1.42 | -0.12 |
| sex 2 .prindrug 12 | 0.153 | 0.623 | 0.25 |
| sex 2 .prindrug 11 | -0.896 | 0.593 | -1.51 |
| sex 2 .prindrug 2 | -0.351 | 0.740 | -0.47 |

*MESSAGE: s.e.s are based on dispersion parameter with value 1

*** Accumulated analysis of deviance ***

| Change | d.f. | deviance | mean deviance | deviance ratio |
|----------------|---|----------|------------------|-------------------|
| + age | 2 | 0.837 | 0.419 | 0.42 |
| + sex | 1 | 0.458 | 0.458 | 0.46 |
| + poly | 1 | 0.920 | 0.920 | 0.92 |
| + prindrug | 3 | 2.204 | 0.735 | 0.73 |
| + time | 3 | 8.829 | 2.943 | 2.94 |
| + age.poly | 2 | 1.388 | 0.694 | 0.69 |
| + sex.poly | 1 | 0.091 | 0.091 | 0.09 |
| + age.prindrug | 6 | 1.349 | 0.225 | 0.22 |
| + sex.prindrug | 3 | 2.737 | 0.912 | 0.91 |
| Residual | 286 | 522.431 | 1.827 | |
| Total | 308 | 541.244 | 1.757 | |
| * MESSAGE: | ratios are based on dispersion parameter with value 1 | | | |

TABLE E9

Proportional-odds model with GHQ-D as response variate and age, sex, poly, prindrug, time, age.poly, sex.poly, age.prindrug and sex.prindrug as fitted terms.

Response variate: ordinal model for categories defined by
d[1], d[2], d[3], d[4], d[5], d[6], d[7], d[8]
Distribution: Multinomial
Link function: Logit
Fitted terms: age + sex + poly + prindrug + time + age.poly + sex.poly + age.prindrug + sex.prindrug

*** Summary of analysis ***

| | d.f. | deviance | mean deviance | deviance ratio |
|------------|------|----------|------------------|-------------------|
| Regression | 22 | 16.1 | 0.732 | 0.73 |
| Residual | 286 | 541.7 | 1.894 | |
| Total | 308 | 557.8 | 1.811 | |
| Change | -3 | -1.6 | 0.543 | 0.54 |

*MESSAGE: ratios are based on dispersion parameter with value 1

*** Estimates of regression coefficients ***

| | estimate | s.e. | t (*) |
|--------------------|----------|-------|-------|
| cut-point 0 / 1 | -2.349 | 0.523 | -4.49 |
| cut-point 1 / 2 | -1.163 | 0.511 | -2.28 |
| cut-point 2 / 3 | -0.554 | 0.508 | -1.09 |
| cut-point 3 / 4 | -0.142 | 0.508 | -0.28 |
| cut-point 4 / 5 | 0.146 | 0.508 | 0.29 |
| cut-point 5 / 6 | 0.643 | 0.509 | 1.26 |
| cut-point 6 / 7 | 1.012 | 0.511 | 1.98 |
| age 2 | -0.549 | 0.540 | -1.02 |
| age 3 | -0.636 | 0.538 | -1.18 |
| sex 2 | 0.598 | 0.338 | 1.77 |
| poly 2 | -0.428 | 0.644 | -0.66 |
| prindrug 12 | -2.22 | 1.95 | -1.14 |
| prindrug 11 | 0.167 | 0.769 | 0.22 |
| prindrug 2 | -0.242 | 0.636 | -0.38 |
| time 2 | 0.006 | 0.249 | 0.02 |
| time 3 | 0.280 | 0.249 | 1.12 |
| time 4 | 0.031 | 0.251 | 0.12 |
| age 2 .poly 2 | 0.716 | 0.742 | 0.96 |
| age 3 .poly 2 | 0.833 | 0.705 | 1.18 |
| sex 2 .poly 2 | -0.373 | 0.517 | -0.72 |
| age 2 .prindrug 12 | 2.14 | 1.96 | 1.10 |
| age 2 .prindrug 11 | -0.100 | 0.822 | -0.12 |
| age 2 .prindrug 2 | -0.065 | 0.753 | -0.09 |
| age 3 .prindrug 12 | 1.89 | 1.94 | 0.97 |
| age 3 .prindrug 11 | 0.74 | 1.00 | 0.74 |
| age 3 .prindrug 2 | -1.06 | 1.45 | -0.73 |
| sex 2 .prindrug 12 | -0.110 | 0.615 | -0.18 |
| sex 2 .prindrug 11 | -0.472 | 0.583 | -0.81 |
| sex 2 .prindrug 2 | 0.537 | 0.738 | 0.73 |

*MESSAGE: s.e.s are based on dispersion parameter with value 1

*** Accumulated analysis of deviance ***

| Change | d.f. | deviance | mean deviance | deviance ratio |
|----------------|------|----------|------------------|-------------------|
| + age | 2 | 1.331 | 0.666 | 0.67 |
| + sex | 1 | 3.562 | 3.562 | 3.56 |
| + poly | 1 | 1.034 | 1.034 | 1.03 |
| + prindrug | 3 | 1.124 | 0.375 | 0.37 |
| + time | 3 | 1.556 | 0.519 | 0.52 |
| + age.poly | 2 | 1.292 | 0.646 | 0.65 |
| + sex.poly | 1 | 0.405 | 0.405 | 0.41 |
| + age.prindrug | 6 | 4.165 | 0.694 | 0.69 |
| + sex.prindrug | 3 | 1.630 | 0.543 | 0.54 |
| Residual | 286 | 541.746 | 1.894 | |
| Total | 308 | 557.847 | 1.811 | |

* MESSAGE: ratios are based on dispersion parameter with value 1