WHO'S WHO?: A REPORT ON THE CHARACTERISTICS OF CLIENTS SEEN AT WE HELP OURSELVES (WHOS), 1985-1991.

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INTRODUCTION[1]

We Help Ourselves (WHOS) was one of the first therapeutic communities established for the treatment of drug-related problems in Australia, commencing operation in 1972. Since that time, a number of changes have occurred in location, program format and emphasis, although its philosophy has always remained the same.

The primary goal of WHOS is to help clients achieve personal growth and a drug-free lifestyle through self-help. It aims to provide a safe, structured environment in which clients may be encouraged to pursue abstinence, by providing opportunities for learning responsibility and empowerment. According to WHOS philosophy, this is best achieved within a community of people who have experienced such problems themselves - people who can provide long-term peer support and appropriate drug-free role models. An introduction to aftercare networks, e.g. Narcotics Anonymous (NA), is an important element of establishing and furthering such peer support, especially upon discharge from WHOS.

The program utilises individual counselling and group work in order to achieve its goals. Clients are considered members of WHOS rather than patients - they run the therapeutic community with the assistance of staff, and the emphasis is on individual and shared responsibility.

Originally established in Sydney, WHOS moved to rural Goulburn in 1978, offering 150 places at any one time in a program of between 18 months and 2 years duration. In 1986, the program was shortened to between 9 and 12 months.

A full service review conducted by the NSW Drug and Alcohol Authority (now called the Drug and Alcohol Directorate) in 1987 recommended a decrease in program size to 100 beds. Subsequently, in 1988 WHOS moved from Goulburn to the Hunter Valley, offering a 70 bed program. This move lasted only 9 months, however, when, with funding provided by the Directorate, a decision was made to move to Redfern, an inner city suburb of Sydney.

On July 1, 1989, a new WHOS program commenced in Redfern, consisting of a 35 bed therapeutic community with a program duration of between 3 and 6 months. Part of the reason for shortening program length stemmed from WHOS' belief that longer programs could foster dependence upon the program, and they wanted to avoid such institutionalisation.

Further, the increase in HIV among injecting drug users prompted a move from a rural abstinence model to an inner city harm reduction model with an aim of abstinence. It was felt that an integrated, short term residential program with a harm reduction emphasis could best achieve educational and prevention aims among clients, while continuing to offer a drug-free lifestyle. Popple and Georl (1992) state their philosophy thus: "WHOS considers that abstinence is one of the options available to a client to achieve the reduction of harm associated with their drug use and to prevent HIV transmission" (p5). Rural isolation had some disadvantages, while an inner city location forced residents to confront their old using environment. In letting go of an

[1] The authors would like to thank Jim Lemon, Caroline Muir, Bruce Flaherty and David Paroissien for their assistance in preparing this report.

abstinence or nothing approach, WHOS made the necessary information and equipment available to all clients, whether or not they chose to adopt a drug-free lifestyle.

A new target client group was also identified at this time, focusing on those at risk of contracting HIV through risky injecting practices or through sex work, those who had been repeatedly disqualified from other drug treatment services, and those with a poor quality of life (low self esteem, social and educational disadvantage, poor self care and general health). Further, there was an increased demand for services from those with non-English-speaking (including Koori) backgrounds.

WHOS is currently an inner city, short to medium term residential treatment service with a structured environment and a harm reduction approach. It is funded by the NSW Drug and Alcohol Directorate and the AIDS Bureau (N.S.W. Department of Health). In 1992, in order to comply with council fire ordinances, it further reduced in size to 30 beds, these being located in separate female (10 beds) and male (20 beds) houses, located only a few doors from each other. The program currently commits clients to a stay of between 30 and 60 days, with a maximum program length of 6 months. Separate men's and women's houses are provided in an environment in which gender issues can be raised, while still allowing for socialisation between the sexes. The occupancy and retention rate in 1992-1993 is high, and there is a waiting list for entry.

WHOS utilises various half-way houses, including its own six bed house upon client discharge. WHOS provides a number of outpatient services, including a HIV/AIDS outreach service for previous clients who may or may not be drug free. WHOS is also a registered needle exchange. The HIV/AIDS education worker also provides education to inpatient clients, and networks with other AIDS services. Among other services, WHOS provides outpatient groups for ex-clients and soon- to-complete clients and an outpatient relapse group for ex-clients who have lapsed.

The aim of this report is to provide a profile of admissions and discharges at WHOS from January, 1985 to August, 1991, a period within which much transition occurred, most notably the move from a rural to an inner-city setting, and the adoption of a harm-reduction approach.

METHOD

The data on which this report is based were obtained from the Clients at Residential Agencies (CARA) database already established at the NSW Drug and Alcohol Directorate. They consisted of information gathered on forms which were completed on all clients on admission to, and discharge from, WHOS. These forms are used in all NSW non-government residential treatment agencies funded by the Directorate, and cover a number of areas ranging from demographic details to current drug use and treatment history, providing a profile of each client upon treatment entry and exit. In order to track multiple admissions and discharges, but still retain confidentiality, the forms contain a unique client identifier, consisting of components of clients' names, sex and birth date. This is more fully described in Didcott, Flaherty and Muir (1988).

In this report, five databases spanning the period January, 1985 to August, 1991, were examined. Copies of the relevant admission and discharge forms can be found in **Appendix 1**.

Analysis and missing data

Due to the number of changes in the CARA forms over the period studied, it was not feasible to merge the data from each year into a single database. Analyses were performed separately on each year or set of years for which a common form was used. In the case of age, gender and length of stay analyses were conducted for each year, as these variables were coded the same way across the different forms.

Descriptive statistics were generated for each variable of interest. In the case of categorical variables, percentages responding to each category were calculated. Due to the large number of categorical variables which could potentially have been analysed for differences, and the subsequent corrections which would have been required, no formal statistical tests were performed on these data. Sex differences were calculated for continuous variables and are noted where relevant.

Missing data was generally minimal (<10%). All percentages reported refer to the data after the exclusion of missing values.

Admissions 1985 to 1991

Data are described from CARA admission forms completed during the following periods:

Form 1985(1) - January, 1985 to June 30, 1985

Form 1985(2) - July, 1985 to June 30, 1986

Form 1986 - July, 1986 to June 30, 1987

Form 1987 - July, 1987 to July 31, 1988

Forms 1988/91 - August, 1988 to July 31, 1991

Details of admissions for each period are presented in Table 1.

Table 1

Admissions to WHOS, January 1985-July 1991

FORM	No. Admissions	No. Persons	No.Readmissions
1985(1)	680	474	206
1985(2)	1127	661	466
1986	1206	659	547
1987	868	625	243
1988-91	911	697	214

Discharges 1985 to 1991

Data are described from CARA discharge forms completed during the following periods:

Form 1985(1) - January, 1985 to June 30, 1985

Form 1985(2) - July, 1985 to June 30, 1986

Form 1986 - July, 1986 to June 30, 1987

Form 1987 - July, 1987 to July 31, 1988

Forms 1988/91 - August, 1988 to August, 1991

Details of discharges for each period are presented in Table 2. It should be noted that while the majority of discharges would probably correspond with admissions for the same time period, this may not necessarily be the case. This is because some clients admitted during a period may have been discharged in the following period. Similarly, some clients discharged during the period may have been admitted prior to it.

Table 2

Discharges from WHOS, January 1985-August 1991

FORM	No. Discharges	No. Persons	No. Multiple Discharges
1985(1)	664	475	189
1985(2)	1097	681	416
1986	1172	686	486
1987	823	602	221
1988-91	878	691	187

RESULTS

Results are presented on admission data, followed by that for discharge. For each set of data, results are grouped under various headings (such as demographics and treatment history). As the forms vary, some results may be reported in some years and not others, or may be reported in slightly different ways.

Admissions

Demographics

Sex and Age

Throughout the years 1985-1991, the majority of admissions to WHOS were male. As can be seen from Figure 1, there was, in fact, an increase in the proportion of male admissions, rising from 68.4% in 1985 (1) to 79.5% in the 1988-1991 period.

The mean age of admissions rose from 24.8 years in 1985 (1) to 26.7 years in 1988- 1991. Males were significantly older than females in all years except 1988-1991. The trend in admissions over the years 1985-1991 would thus appear to be towards a higher proportion of older males.

Ethnic Origin

The ethnic profiles of admissions are presented in Table 3. The profile of admissions was stable throughout the study period, with approximately 80% being born in Australia. With the exception of 1985 (2), a significant minority of Australian born admissions were Aboriginal/Torres Strait Islanders. Females were consistently more likely to be of Aboriginal/Torres Strait Islander origin than males. In each year, less than 1% of admissions were not fluent in English.

Table 3

Ethnic profiles of WHOS admissions, January 1985-July 1991

FORM	Australian Born (%)	ATSI* (%)	New Zealand (%)	Other (%)
1985(1)	81.6	7.9	1.9	16.5
1985(2)	84.5	1.2	3.5	12.0
1986	81.8	4.5	2.5	15.7
1987	83.8	4.1	1.6	14.6
1988-91	79.5	7.6	3.6	16.9

* Aboriginal/Torres Strait Islander as percentage of Australian born.

Place of Residence

Between 1985 and 1991 the majority of admissions claimed their usual place of residence to be New South Wales, with a small percentage reporting that they lived interstate. A sizeable minority of admissions claimed to have no fixed address.

Table 4

Usual place of residence of WHOS admissions, January 1985-July 1991

FORM	NSW (%)	Interstate (%)	No fixed address (%)
1985(1)	76.1	1.8	6.1
1985(2)	89.9	2.9	3.2
1986	81.7	3.5	6.6
1987	77.1	2.5	6.4
1988-91	76.7	3.5	7.5

Employment Status

The overwhelming majority of admissions throughout the study period were unemployed or on sickness benefits/pensions at admission. It should be noted that the 1985-1986 CARA forms asked whether the client had been in employment in the preceding month, whereas the later forms inquired about the number of months in the preceding six months that clients had been employed.

Table 4

Employment of WHOS admissions, January 1985-July 1991

FORM	Unemployed (%)	Sickness Benefits (%)	Pension (%)
1985(1)	57.4	18.7	7.1
1985(2)	61.0	21.0	4.7
1986	60.5	24.5	4.3
1987*	60.5	14.6	3.7
1988-91*	45.1	31.3	2.5

* Had spent at least some of the previous 6 months unemployed, on sickness benefits or on a pension.

Treatment History

The majority of admissions had previously been admitted on more than one occasion to an agency for treatment of drug or alcohol dependence. A large proportion of admissions, ranging from 45% to 66%, had previously been admitted to WHOS.

Table 5

Drug treatment history of WHOS admissions, January 1985-July 1991

FORM	Previous Drug Treatment (%)	Previous WHOS (%)	Methadone (%)
1985(1)	67.9	50.2	-
1985(2)	68.5	58.7	11.9
1986	83.4	65.9	27.8
1987*	detox 76.2 rehab 73.2	53.0	-
1988-91	detox 71.6 rehab 56.8	44.9	37.9

* From 1987 onwards, forms inquired about admissions to residential agencies for detoxification and rehabilitation separately.

There is a clear trend towards larger proportions of admissions having been previously in methadone maintenance treatment, increasing from 12% of admissions in 1985 (1) to 38% in 1988-1991. As can be seen, females were more likely to have previously been in methadone maintenance treatment than males. It should be noted that the 1988-1991 figure is based upon discharge data, as the question was moved to the discharge form in this period.

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Drug Use

Between 1985-1987, clients were asked which drugs they had problems with upon admission, whereas the 1988-1991 forms asked subjects to nominate which one drug they considered to be their primary problem. Drug use problems at admission are presented in Table 6.

Table 6

Drug Problems of WHOS admissions, January 1985-July 1991

	FORM				
Drug Class	1985(1) (%)	1985(2) (%)	1986 (%)	1987# (%)	1988-91* (%)
Alcohol	59.1	62.3	54.7	68.8	8.0
Tobacco	59.7	65.0	77.6	71.1	-
Opiates (heroin, morphine)	86.5	80.7	78.9	83.7	72.1
Methadone	24.3	11.9	24.5	19.2	-
Other synthetic opioids	29.0	16.2	22.0	20.4	-
Barbiturates	33.4	25.3	24.6	19.0	-
Benzodiazepines	48.7	38.7	46.7	43.9	1.0
Other sedative hypnotics	21.5	10.4	16.1	14.6	-
Analgesics	9.3	3.6	6.0	4.5	-
Stimulants (speed)	35.4	30.0	42.5	43.0	11.2
Cocaine	29.6	16.4	24.5	22.7	2.6
Cannabis	69.3	64.7	61.8	61.4	2.0
Hallucinogens	27.5	18.4	24.3	26.6	-
Cough & cold preparations	22.7	9.1	12.4	11.7	-
Inhalants	12.4	4.8	7.6	5.6	-
Mean Primary Drug Problems	3.6	3.3	3.2	2.7	N/A

Based upon discharge data; requested staff's opinion of client's drug problem on the corresponding admission.
* Nominated primary drug problem.

Opiates, tobacco, cannabis and alcohol were the drugs most commonly cited by admissions as

problem drugs, with opiates such as heroin most likely to have been their primary problem drug. Males were more likely to endorse alcohol and stimulants as their primary problem drugs, while females more frequently cited opiates such as heroin, barbiturates and sedative-hypnotics. For the entire study period, poly-drug use problems were the norm.

In the period studied drug use histories appeared to become more chronic (see Table 7). There was an increase in the percentage of the sample claiming a drug problem of at least 2 years duration (68.5% of the sample in 1985(1) to 91.7% in 1988-91) and 10 years duration (15.8% of the sample in 1985(1) to 39.6% in 1988-1991).

Similarly, there was a general increase in the percentage of the sample with an alcohol problem of at least 2 years duration (38.2% of the sample in 1985(1) to 56.9% in 1988-91), and 10 years duration (29.3% of the sample in 1985(1) to 42.5% in 1988-91).

Table 7

Chronicity of drug and alcohol problems of WHOS admissions, January 1985-July 1991

	FORM				
Length of Drug Problem	1985(1) (%)	1985(2) (%)	1986 (%)	1987 (%)	1988-91 (%)
> 2 years	68.5	72.4	80.1	87.9	91.7
> 5 years	42.2	42.7	50.7	64.7	71.6
Length of Alcohol Problem					
> 2 years	38.2	45.4	39.7	60.1	56.9
> 5 years	27.4	32.3	28.9	48.2	46.0

Source of Referral

The predominant means of referral over the study period was self-referral or by friends/family. Over time there was, however, a general decrease in the number of self-referred admissions, and a concomitant increase in those referred from specialist drug and alcohol agencies.

Table 8

Source of Referral of WHOS admissions, January 1985-July 1991

FORM	Self/Family/ Friends (%)	D&A Agencies (%)	Hospital (%)	Legal* (%)
1985(1)	80.1	2.2	3.8	5.3
1985(2)	83.2	3.5	1.2	3.4
1986	75.0	6.1	2.0	6.1
1987	78.6	7.7	4.2	4.0
1988-91	60.4	16.1	7.7	7.5

* Excludes those referred from the Drug and Alcohol Court Assessment Program (DACAP).

Criminal Convictions

Clients were asked at admission in 1985 and 1987 about their criminal records. As can be seen from Table 9, about half of admissions claimed prior drug convictions, and just over a half non-drug convictions. Males were consistently more likely to report having drug and non-drug convictions than females.

Table 9

Criminal convictions of WHOS admissions, January 1985-July 1991

FORM	Drug Convictions (%)	Non-Drug Convictions (%)
1985(1)	43.5	28.6
1985(2)	46.2	52.3
1986	-	-
1987	40.8	64.3
1988-91	-	-

Discharges

Demographics

Sex and Age

As with admissions, there was an increase in the percentage of males discharged between 1985 and 1991 (68.4% in 1985(1) to 79.7% in 1988-1991), and similarly, a
an increase in the ages of those discharged. Males were significantly older than females in all years studied.

Treatment Variables

Program Completion

A number of caveats apply to the interpretation of data on program completion. Clients were not necessarily expected to complete the program at WHOS (e.g., they may have been admitted for detoxification only). Thus, they may have been referred elsewhere before program completion for a number of reasons. The percentages of discharges who were reported as having completed the program at WHOS are listed below.

1985(1):	0.9%
1985(2):	1.8%
1986:	4.4%
1987:	1.2% rehabilitation, 3.6% detoxification
1988-1991:	11.5% rehabilitation, 0.2% detoxification

Length of Stay

The median lengths of stay for discharges (broken down by gender) are presented in Figure 4. The median length of stay at WHOS remained constant (4 days) until 1988-91, when there was a large increase to a median stay of 17 days. Except for the period covered on form 1985(1), males remained at WHOS for slightly longer than females.

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As can be seen from Table 10, significant numbers of clients were discharged within a period of one week of program commencement, although this may reflect the fact that a proportion of people were admitted for detoxification only, or were referred elsewhere. Consistent with the increased median length of stay in 1988-91, it can be seen that program retention had improved markedly in the latter stages of the study period.

Table 10

Lengths of stay of discharges from WHOS, January 1985-July 1991

	FORM				
Length of Stay	1985(1) (%)	1985(2) (%)	1986 (%)	1987 (%)	1988-91 (%)*
< 1 day	9.2	8.3	6.3	6.8	3.2
1 day	21.4	24.2	21.9	24.1	7.9
< 1 week	58.9	59.8	60.8	58.0	32.0
1-2 weeks	9.3	9.8	8.0	6.8	11.6
< 4 weeks	79.7	79.1	77.0	72.5	60.1
< 6 weeks	83.4	83.0	80.5	77.1	68.8

* When those admitted for detoxification only were excluded, figures for length of stay remain much the same.

Reasons for Discharge

Between 1985 and 1991 there was a general decrease in the number of discharges who left WHOS against advice or gave no reason, and an increase in the number discharged due to disciplinary breaches, or because the program was unsuitable. Upon discharge, the majority of clients were referred to NA or AA.

Table 11

Reasons for discharge from WHOS, January 1985-August 1991

	FORM				
Reason	1985(1) (%)	1985(2) (%)	1986 (%)	1987 (%)+	1988-91 (%)+
Completed Program	0.9	1.8	4.4	1.2* 3.6#	11.5* 0.2#
Left against advice	92.3	92.9	56.4	66.1	39.7
Disciplinary	2.6	0.4	4.9	10.1	25.4
Program unsuitable	0.9	0.6	2.4	3.1	9.1

+ One or more reasons could be given
* Rehabilitation
# Detoxification

Other Areas

Main Reason for Admission

From 1987 onwards, the main reason for admission to WHOS was recorded at discharge. Just under half of the **1987** sample (46.0%) were admitted to WHOS for treatment/rehabilitation, 52.8% were admitted for detoxification and only 0.6% on a court order.

The majority of the **1988-1991** sample were admitted to WHOS for treatment/rehabilitation (86.9%), while the remainder were admitted primarily for detoxification (8.8%) or because of a current court order (1.9%).

Noticeable here is the large decrease in the percentage of those admitted for detoxification (52.8% to 8.8%). This was due to official detoxification services ceasing in 1987.

AA/NA

In the 1985(2) and 1986 discharge forms, clients were asked whether they had attended AA/NA prior to their current admission. Over one third (36.6%) of **1985(2)** discharges had attended AA or NA meetings prior to their current admission. Over two thirds of **1986** discharges (69.0%) had previously attended AA or NA meetings. This question was not asked on subsequent forms.

Similarly, these forms inquired as to AA/NA attendance during each discharge's corresponding admission at WHOS. In 1985(2) 32.2% of discharges had attended such meetings while in the program, with this figure rising to 47.7% of discharges in 1986.

DISCUSSION

This report has provided a profile of clientele admitted to and discharged from WHOS over a seven year period. The data describe a fairly young population among whom polydrug use is the norm. While opiates such as heroin appear to constitute the main problem drug, alcohol problems were also common, while tobacco and cannabis were used by the majority of the sample. The majority of those admitted to WHOS were unemployed or in receipt of sickness benefits/pensions, while approximately half have had criminal convictions.

A number of trends emerge from the data presented above. Firstly, there is a noticeable trend to older, male admissions, with more chronic alcohol and other drug problems. It is possible that this trend represents not only the aging of the opioid using population, but the accumulation of "hard" cases at WHOS, as those who find it difficult to gain acceptance into, or remain on other programs, return to this program. This is reflected in the high proportion of admissions who have been previously admitted to numerous agencies for drug-related problems, and in the high percentage who were readmissions to WHOS. Since, it is just such a population that WHOS was seeking to attract when it reoriented its program and client profile in 1989 it has been successful in attracting the clientele that it aimed to attract.

Second, there has been an increase in the percentage of admissions with prior enrolment in methadone maintenance programs. This would appear to be consistent with the expansion of the NSW methadone maintenance program in the late 1980s, and once again reflects the fact that WHOS is attracting those with a previous treatment history.

Third, an important trend has been the increase in the median length of client stay on the program, rising from a median of four days between 1985 and 1987 to a median stay of 17 days in 1988-91. This increase in stay is accompanied by a slowing down of the attrition rate from the program, such that program retention in the period 1988-91 doubled within the first week of admission in comparison to that of previous years. This may reflect the decrease in the proportion of admissions attending WHOS for detoxification. Alternatively, the shift to a harm reduction model and decreased program duration may have had an effect by increasing client motivation or attracting clients who were more motivated to stay in the program. Regardless, WHOS is having greater success in retaining what has become an older, male population with long-standing drug use problems.

Fourth, what is apparent from this report are the similarities between the population characteristics of drug-free residential treatment and MM treatment programs. In terms of age, gender, employment status, polydrug use and criminality, WHOS admissions look remarkably similar to MM admissions (Ward, Mattick & Hall, 1992). Thus, MM clients tend to be older, male polydrug users who are unemployed and have criminal histories. Given the overlap between the two populations, as larger percentages of WHOS admissions are reporting having previously been on MM, this is not entirely surprising. It would appear that the two forms of treatment are tried by most opioid dependent persons and, as such, they are not separate treatment systems.

In summary, retention at WHOS has increased, despite the fact that admissions have become older and more drug entrenched. One implication of these findings may be that the shorter

program at WHOS has significantly improved retention. It could also be argued that the new changes incorporated in the philosophy of WHOS has also contributed to the increased length of program stay. From this report, it can be seen that WHOS is an important arm of the overall drug treatment approach in NSW. WHOS aims to focus on more problematic drug users. It is meeting this aim, and having increasing success in retaining this group in treatment.

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APPENDIX