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A process evaluation of Gorman House detoxification service

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EXECUTIVE SUMMARY

Gorman House is a 20-bed, non-medicated, in-patient detoxification service attached to St. Vincent's Hospital, Sydney, and located in the inner-city suburb of Darlinghurst. Gorman House, which was established in 1982, aims to provide a safe and reassuring environment where persons dependent on alcohol and other drugs can detoxify and have their health and social welfare needs addressed. Gorman House has traditionally cared for the needy inner-city population of men and women with high rates of mental illness and homelessness. The Gorman House service model has never been evaluated and the ability of the service to attend to the needs of the population it serves is largely unknown.

This report describes the findings of a process evaluation conducted to determine the extent to which Gorman House meets its aims and goals and the needs of its residents. The evaluation was based on information derived from interviews held with 80 consecutively recruited residents, 12 months of data of admissions to Gorman House, anonymous staff questionnaires, an audit of clinical notes of a random sample of participants, and telephone interviews with 15 selected key informants.

It is important to note that although Gorman House had traditionally provided a service seven days per week, during the period of this evaluation and throughout the previous twelve months its days of operation were reduced to five per week only. The findings of the evaluation, therefore, relate predominantly to the residents who were admitted during this period of restricted days of service operation.

Based on admissions and interview data, Gorman House residents may be described as predominantly Australian born, alcohol dependent men in their fifth decade who live alone, are homeless or marginally housed, receive disability pensions or temporary benefits, and have had previous residential or in-patient admissions for detoxification. Poly-drug use is the norm rather than the exception.

Two-thirds of residents who consumed alcohol had severe alcohol dependence. Dependence scores for residents who used heroin, cocaine, amphetamines and cannabis were substantially higher than accepted cut-off scores. Over half the sample reported having recently experienced severe withdrawal symptoms. Most participants expressed their intention to reduce or quit their drug of concern or had already made some changes towards this goal.

Physical health was impaired in two-thirds of residents and there was substantial health service utilisation during the previous four weeks for substance-related problems. Most residents had mental health impairment. Rates of anxiety, depression and psychological or psychiatric distress were substantially higher than those found in the general community in Australia. The experience of a range of traumatic events was frequently reported.

Within the constraints of a five day service operation, the median duration of admissions was three days. Two-thirds of residents were assessed by staff to have completed their substance withdrawal during the period of their admission; one-third of residents did not complete withdrawal. Heroin dependent residents, compared with alcohol dependent or methamphetamine dependent residents, were two and a half times more likely to 'leave against advice' before completing treatment. Two-thirds of residents were referred

elsewhere for ongoing treatment. Of these, one-third were sent for treatment of acute medical or psychiatric conditions, and others were sent to residential drug and alcohol treatment and other extended treatment or care.

There was generally high participant satisfaction with Gorman House. Residents revealed that one of the most appealing aspects of Gorman House was the staff and their care. Program characteristics, however, received compliant as well as approval. Restricted opening hours and non-medicated withdrawal were other less appreciated aspects of Gorman House.

All staff believed that withdrawal management was conducted adequately and that residents were satisfied with the services they receive. Some staff, however, would like to see educational or living skills programs introduced. Most praised the medical care provided to residents through clinic access. Treatment planning was generally regarded as being carried out adequately, as was referral to ongoing community care. Some staff saw shortcomings in the provision of psychiatric care. Five day opening was a concern to many staff. Most staff felt their training and skills prepared them well for work at Gorman House, although they noted an absence of ongoing training and supervision.

Interviews with key informants provided independent feedback on many aspects. Key informants viewed Gorman House very favourably, stating that it provides an important role in caring for a very disadvantaged group. There was reasonable consensus on who should or should not be referred to Gorman House. There was also consensus that to operate optimally Gorman House needed to return to its seven-day opening. Members of staff were described as having extensive knowledge of their field and as being well regarded by consumers. The ready access to Gorman House and its basic services were viewed as appealing to its needy consumers. The need for the service to develop further, to keep abreast of the complex needs of its current consumers, was acknowledged; as was the need for clearer delineation of the clinical capacity of Gorman House and for greater integration with existing services.

Conclusion and recommendations

Gorman House is one of few services in Sydney providing detoxification to a group of very disadvantaged individuals, who in many cases do not meet criteria for admission to other detoxification services. It occupies a very important place in a treatment environment in which there are now very few beds for supervised detoxification. Gorman House performs its demanding role with limited resources and a capable staff very committed to their work. The views expressed by residents, staff and key informants in this evaluation broadly converged on several aspects of Gorman House that may need some attention. The areas of improvement and recommendations identified in this evaluation and enumerated below may assist Gorman House to achieve its goals even more successfully.

1. The residents who benefit most, in terms of treatment completion, are those who present with alcohol, methamphetamine or other substance dependence. Heroin dependent residents are more likely to leave without completing withdrawal. This suggests that their needs are not being adequately met. Increasing access to buprenorphine and agonist medication to heroin dependent residents may better facilitate withdrawal completion or maintenance for this group.

2. There is little doubt that Gorman House residents are socially marginalised, mentally and physically unwell, and need residential drug withdrawal. There may be a small group of individuals whose primary needs are respite from homelessness and for whom detoxification may be a less urgent need. Although to exclude these individuals is somewhat at odds with the purpose and goals of Gorman House, improved screening (and referral) may reduce the number of admission-day discharges.

3. Many staff, key informants and residents requested the introduction of some structured activity or program. The exact nature of these activities would need to be explored, tailored to the special needs of residents and tested for relevance and appeal. Examples might include skills training and health education, or more therapeutic activities targeting residents who are interested and well enough to participate.

4. There was a strong consensus among staff, key informants and residents that five-day per week service opening undermined the functioning of Gorman House. The five-day operation was viewed as having an adverse effect on service access and referral patterns (individuals who require a longer period for withdrawal would not be referred), as well as impinging on the staff's ability to organise referral and ongoing treatment for residents. Some key informants voiced the concern that restricted service opening may adversely affect staff morale as staff are expected to discharge clients, including those who are still quite unwell, by the end of the week. A return to seven-day service opening was regarded as necessary for Gorman House to perform its role adequately as a supervised withdrawal service for disadvantaged, homeless alcohol and other drug dependent individuals.

5. Members of staff, who were generally very well regarded by residents and key informants alike, expressed some dissatisfaction that may need prompt attention. Apart from their main concern in relation to five-day service opening, staff perceived a lack of support from management following emergencies or critical incidents. This could be addressed by assessing the staff's need for support following these incidents and developing protocols outlining how support would be implemented following an emergency or critical incident.

6. A further source of dissatisfaction among staff was the absence of ongoing training and supervision. The staff, who felt well-prepared for their roles and were described by key informants as skilled and knowledgeable, would benefit from access to ongoing training and supervision. The provision of, or facilitation of access to, training and supervision may be expected to boost staff morale and perceived self-efficacy.

7. There were concerns voiced by some key informants and staff that at present Gorman House may have a limited ability to detect and manage mental health problems among residents. This could be addressed through staff training, recruitment of professionals with specific mental health experience, and the introduction of more structured assessment and standardised instruments to assess mental health problems (e.g. suicidality). Furthermore, partnerships and referral arrangements with mental health services, especially within St. Vincent's

Hospital, may need to be clarified and strengthened to improve and increase access to psychiatric care.

8. Comments from key informants suggest a need to clarify for other agencies the intended target group of Gorman House and the scope of the service it provides. The development of clearer guidelines and policies in this regard may be a timely undertaking in view of the changing characteristics and needs of Gorman House residents.

9. There were some complaints from residents, key informants and staff about the 'dormitory-style' accommodation. Smaller rooms accommodating three to four residents may be preferable and allow greater flexibility of use (e.g. increasing the number of female admissions).

1. INTRODUCTION

1.1 Drug and alcohol detoxification services

Detoxification is the supervised withdrawal from a drug of dependence to minimise the severity of symptoms and reduce the potential for serious medical complications. It can be conducted on either an in-patient or out-patient basis and the aim is to assist the individual to complete substance withdrawal in a safe and humane way (Mattick and Hall, 1996). Detoxification should be viewed in the larger context of what is known about the treatment of alcohol and drug dependence. It addresses only the initial steps of treatment and should wherever possible be followed with strategies to maintain behaviour change and prevent relapse (Mattick and Hall, 1996; O'Connor, 2005).

The range, location and existence of facilities providing detoxification throughout Australia varies depending on funding, staff capacity, local demand or changes in policy, direction and practice (Miller, 2005). In-patient, fully medicalised detoxification in a specialist unit was previously the standard. Currently, a variety of detoxification approaches, including out-patient and non-medicated programs, are utilised to manage individuals with withdrawal symptoms of varying severity (Mattick and Hall, 1996). However, supply of in-patient, residential, and out-patient detoxification services in Australia is limited and there is little effort to increase the availability of such services.

1.1.1 In-patient and out-patient detoxification

There is a growing movement across Australia to provide community-based health care for people with alcohol and drug problems (Roche et al., 2001). In keeping with this, the provision of out-patient detoxification with a minimum of medication has become more widespread. Since the mid-1980s, there has been a steady decline in the number of in-patient beds for detoxification throughout Australia. The situation in New South Wales reflects the national trend. Less than half (41%) of the 117 alcohol and drug services in New South Wales provide detoxification in in-patient settings (Miller, 2005). Recently, there has been a further reduction in the number of in-patient detoxification beds available in the inner-city area of Sydney (City of Sydney, 2003).

Several factors have contributed to the movement towards community-based detoxification. Studies show that rates of withdrawal completion, health gains and attraction into rehabilitation are as good for out-patient (clinic- or home-based) detoxification as they are for in-patient detoxification (Abbott et al., 1996; Allan et al., 2000; Fleeman, 1997; Hayashida et al., 1989; Klijnsma et al., 1995), if not better in some cases (Roche et al., 2001). In addition, the cost of providing out-patient detoxification is substantially less than that for in-patient detoxification (Annis, 1985; French et al., 2000; Hayashida et al., 1989; Klijnsma et al., 1995). It is also becoming apparent that home-based detoxification is the preferred option for many drug users (Steele et al., 1999). Yet the number of people provided with out-patient detoxification is small and not increasing.

The majority of alcohol and drug dependent individuals do not require supervised detoxification and the majority can be managed safely and effectively as out-patients (Annis, 1985; Degenhardt et al., 2000; Mattick and Hall, 1996; Prater et al., 1999; Sannibale et al., 2005). Despite this, there remains a role for in-patient detoxification services. For a proportion of severely disadvantaged dependent individuals, in-patient detoxification provides more than supervised management of withdrawal; it also affords

temporary respite from drug use and satisfies a need for humanitarian care and shelter (Mattick and Hall, 1996). For homeless or marginally housed alcohol and drug dependent persons, in-patient detoxification can be a vital link to health and other services, such as accommodation providers. Research consistently shows that in-patient detoxification remains essential for severely dependent individuals who are at risk of severe withdrawal symptoms (Degenhardt et al., 2000; Fleeman, 1997; Hall and Zador, 1997; Mattick and Hall, 1996), who have serious psychiatric or medical comorbidities (Asplund et al., 2004; Day et al., 2005), who have high levels of substance-related impairment (Frank and Pead, 1995; NSW Health Department, 1999) or who live in an environment that does not support out-patient detoxification (Mattick and Hall, 1996; NSW Health Department, 2006).

1.1.2 Medicated and non-medicated detoxification

Detoxification from alcohol, while at times extremely uncomfortable for the individual, is generally not life-threatening. A minority of alcohol dependent patients may experience seizures or delirium tremens (DT), which very rarely are fatal (Lee et al., 2005). The provision of benzodiazepines to severely alcohol dependent patients ameliorates this risk (Mayo-Smith, 1997). In any case, however, a request for medicated withdrawal from alcohol should be considered after appropriate assessment. With alcohol dependent individuals, where a medicated detoxification is not indicated, a non-medicated approach can be used (Myrick and Anton, 1998). Clinical experience in Australia, Canada and parts of Asia supports the management of alcohol withdrawal symptoms in a non-medical setting with counselling, social support and without pharmacological intervention (Mattick and Hall, 1996). If non-medicated, out-patient alcohol detoxification is not feasible, specialised units providing non-medical management are cheaper and at least as effective as hospital in-patient detoxification (Proudfoot and Teesson, 2000).

Heroin withdrawal has fewer medical complications than alcohol withdrawal; however, it is associated with low withdrawal completion rates, especially in out-patient settings (Broers et al., 2000; Gossop and Strang, 2000; Mattick and Hall, 1996; Sannibale et al., 2005; Unnithan et al., 1992). Medical intervention, in the form of agonist pharmacotherapy (e.g. buprenorphine) or symptom relief, can improve retention among heroin dependent patients (Raistrick et al., 2005). Evidence that psychosocial strategies alone can alleviate the symptoms of opiate withdrawal is inconclusive (Mayet et al., 2005; Proudfoot and Teesson, 2000) and further research into the non-medical adjuncts which may assist detoxification is required (Mattick and Hall, 1996; Myrick and Anton, 1998; Proudfoot and Teesson, 2000). Moreover, buprenorphine detoxification for heroin dependence often results in entry to treatment with buprenorphine maintenance.

There is generally a lack of pharmacological interventions with proven effectiveness for detoxification from drugs such as cocaine, amphetamines and cannabis (Proudfoot and Teesson, 2000). Nevertheless, medical assistance for withdrawal from these substances can be of benefit in cases where withdrawal symptoms are relatively severe. If pharmacotherapies are needed, then they should be supported by effective psychosocial interventions.

1.2 Gorman House detoxification service

Gorman House is a 20-bed, non-medicated, in-patient detoxification service attached to St. Vincent's Hospital, Sydney. Seventeen beds are allocated to men and three to women.

The service is located in Darlinghurst, an inner-city suburb just a few minutes walk from one of Sydney's major illicit drug markets, Kings Cross.

Since 1982 Gorman House has been providing a non-judgemental, non-discriminatory environment for people to detoxify from substances of dependence. The stated goals of Gorman House are to provide a safe and reassuring environment where people dependent on alcohol and other drugs can detoxify, to provide residents with a negotiated management plan which includes specific health and social welfare solutions, and to assist residents to achieve the targets in their negotiated management plan. In particular, Gorman House caters for the needy inner-city population of men and women with high rates of mental illness and homelessness.

Because of the diverse needs of the population served by Gorman House, the service is not strictly non-medicated. People may obtain medication prior to admission, which is then securely stored and supplied to residents according to the prescriber's instructions. Residents with a history of seizures or DT may use this system to access diazepam. Heroin dependent clients may bring over-the-counter symptom-relieving medications such as anti-diarrhoeals (see Appendix 1).

Changes in the inner-city population in the last two decades have increased the demand for detoxification services in the area. People seeking treatment for alcohol and other drug problems are now more likely to be poly-drug users who present with complex clinical needs (Shand and Mattick, 2001). Services located in the inner-city are more likely to attract and treat people who are socially marginalised and may have mental health problems and legal problems. The Gorman House service model has never been evaluated and the ability of the service to appropriately and effectively attend to the needs of the population it serves is unknown. This report describes the results of a service evaluation that developed from these concerns.

2. AIMS AND METHODS

2.1 Aims

The study aimed to determine the extent to which Gorman House meets its aims and goals, and the needs of residents, by identifying the following: the demographic and clinical characteristics of residents and whether Gorman House serves its intended client group; the route by which residents enter the service; waiting-time; the average length of stay; the proportion of residents that complete detoxification and the characteristics of residents that do not complete detoxification; the experiences of residents during admission; and the extent of referral to the community treatment network. The study also aimed to gauge the views and perceptions of staff and of a selected range of key informants in relation to the services delivered at Gorman House.

2.2 Ethical approvals

The study was approved by the University of New South Wales Human Research Ethics Committee and the St. Vincent's Hospital Human Research Ethics Committee.

2.3 Participants

All residents admitted to Gorman House between 2 December 2005 and 16 March 2006 were approached to participate in the study. Residents who were unable to give informed consent, declined to participate or had participated in the study during a previous admission were excluded from the study. The voluntary nature of participation was emphasised and participants received no remuneration.

All ten Gorman House staff members involved in direct patient care during the study period were approached via a questionnaire left in their in-box, which they were asked to complete and return anonymously.

Key informants were recruited via phone calls from the set of services that refer to and receive referrals from Gorman House. Five key informants were recruited from rehabilitation services; two from hostels/supported accommodation services; two from intoxicated persons units; and one each from a medical detoxification unit, support/counselling service, medical support service and accommodation support service. In addition, one key informant was recruited from St. Vincent's Hospital Emergency Department and St. Vincent's Hospital Mental Health Services.

2.4 Procedures

A process evaluation was deemed to be the most appropriate design for the current purposes. Its methodology is based on World Health Organisation Evaluation approaches (World Health Organization, 2000a; World Health Organization, 2000b) and the work of Sannibale and colleagues (2005). It consists of: an interview with a prospectively recruited sample of consecutive admissions to Gorman House; twelve months of admission data from the Minimum Data Set (MDS) for purposes of comparison; an anonymous questionnaire completed by Gorman House staff; telephone interviews with key informants from organisations within the Gorman House referral network; and an audit of a random sample of clinical notes relating to the assessment and clinical care of residents.

It is important to highlight that the evaluation was conducted when the service operated only five days per week rather than seven days per week as it did prior to evaluation. Consequently, the results may reflect the characteristics of individuals who were referred to a time-limited and hence a possibly less intensive detoxification. Data was collected by contract research officers who were independent of St. Vincent's Hospital.

2.4.1 Service process indicators

Information on process indicators was gathered by examining organisational policies and protocols and discussions with the service manager. Supplemental information was sourced from Minimum Data Set (MDS) information collected during admission and from treatment progress notes entered in the Community Health Information Management Enterprise (CHIME) database. The data allowed a comparison of demographic and clinical characteristics of the residents who were interviewed and those who were not, and helped determine whether the sample was typical of the residents admitted over the rest of the calendar year. The data also helped assess the main process variables including the number of admissions, length of stay, rate of treatment completion and source of referral during a 12 month period.

2.4.2 Resident sample

The resident questionnaire (see Appendix 2) contained items from the following domains: substance use and dependence; history and severity of detoxification; past and current admission/s to Gorman House and residents' perception of the experience; screening for global physical and mental health; screening for current psychopathology, anxiety and depression; exposure to traumatic events; and recent use of health services and accommodation. Most items were self-administered or administered with some assistance if required. The 90 minute questionnaire was completed on-site.

The questionnaire contained the following standardised measures: the Beck Anxiety Inventory (BAI) (Beck and Steer, 1990) and Beck Depression Inventory (BDI) (Beck et al., 1996); the Severity of Dependence Scale (SDS) (Gossop et al., 1995; Swift et al., 1998); the Opiate Treatment Index (OTI) (Darke et al., 1991); the SF-12 (General health survey) (Ware et al., 1995); the Kessler Non-Specific Psychological Distress Scale (K10) (Kessler and Mroczek, 1994); Psychosis Screener (Degenhardt and Hall, 2000); the Severity of Alcohol Dependence Questionnaire (SADQ, ICQ) (Stockwell et al., 1994); the Client Satisfaction Questionnaire (CSQ-8) (Larsen et al., 1979); and a health services utilsation measure (Australian Bureau of Statistics, 2006).

2.4.3 Staff survey

An anonymous twelve item questionnaire (see Appendix 3) was distributed to patient-care staff to elicit their views and opinions about Gorman House; in particular, to learn more about their experiences of and satisfaction with working at Gorman House and perceptions regarding the services delivered to its residents.

2.4.4 Key informant survey

Key informants were selected from rehabilitation, medical, counselling and support organisations that refer to and receive referrals from Gorman House and were interviewed over the telephone. The ten minute interview was semi-structured and inquired about patterns of referral, the perception of Gorman House, and its place in the wider system of services. See Appendix 4 for key informant survey.

2.4.5 Key components of resident care

The clinical notes (entered in CHIME) of a random sample of 20 (25%) residents were reviewed to determine attention to key aspects of assessment and clinical care. A list of key components of care was developed based on discussions with the manager, service policies and protocols.

2.5 Statistical analysis

SPSS 14 was used to conduct descriptive analyses. One-way analysis of variance was used with continuous measures, and chi-square tests and logistic regression were utilised with categorical measures.

3. DESCRIPTION OF SERVICE PRACTICES

3.1 Staffing, training and professional development

Gorman House operates with one manager, five full-time and four part-time detoxification workers. Generally, detoxification workers include alcohol and other drug workers (graduate and non-graduate), psychologists and social welfare officers.

According to protocols, staff at Gorman House are to make four agency visits each year to gain first-hand knowledge of other organisations and methods of service delivery. An in-service is to be provided to other staff after completing the visit. When funds allow, staff attend supplementary training courses and conferences. Staff are also required to attend yearly CPR training sessions and participate in OH&S training in accordance with St. Vincent's Hospital policy and State legislation.

3.2 Admission criteria

Any person who is withdrawing from alcohol or other drugs is eligible for admission to Gorman House, except those who; have a pre-existing medical condition which is likely to be exacerbated by withdrawal; demonstrate uncontrolled psychotic behaviour; cite benzodiazepines or an opiate substitution therapy as their primary drug; were discharged from Gorman House in the last seven days; are pregnant; are brought in against their will; or are aged less than 16 years. Residents must also agree to abide by a formal admission agreement that sets out house rules and expected standards of behaviour. Persons wishing to remain on opiate substitution therapy and withdraw from alcohol or other drugs (selective detoxification) are eligible for admission. As Gorman House caters to individuals with complex needs, admission criteria are regarded as somewhat flexible, with a preference for admission rather than exclusion. In practice, the majority of individuals assessed are eligible for admission.

At the time at which this study was undertaken, Gorman House was open five days a week and admissions were conducted from Monday morning to noon on Tuesday. Previously, during seven-day operation, residents were admitted at any time on any day of the week.

3.3 Assessment

A preliminary assessment is frequently conducted via telephone to assess eligibility. On presentation, all people are assessed by a detoxification worker. According to protocols, this assessment should cover current level of intoxication, drug and alcohol use history, history of and current withdrawal symptoms, pre-existing medical conditions, mental health concerns, prescribed medications and source of referral.

If medical management of withdrawal beyond the capacity of Gorman House is indicated by the assessment, the person is referred to a medical officer or medicated detoxification unit. Persons who present for assessment as highly intoxicated, disclose recently ingesting a dangerous quantity of drugs or alcohol or have a blood alcohol concentration of 0.36 or above are referred to the Emergency Department of St. Vincent's Hospital for further assessment and observation.

3.4 Clinical routine

A staff member approaches each resident within 24 hours of admission to negotiate an individual Management Plan. The Plan addresses the resident's immediate health and welfare needs, listing medical or community agency appointments, and is integrated with Management Plans at other agencies. In addition, the resident is encouraged to formulate short- and long-term goals. Discharge planning is usually incorporated into the Management Plan on the second day after admission. To assist in discharge planning, residents have access to a comprehensive range of information on accommodation, half-way houses, rehabilitation programs, counselling services and support agencies that they are encouraged to consult.

For the safety and well-being of residents, staff note the whereabouts of each resident on a log sheet every half hour. In addition to assisting residents to follow their Management Plan, Gorman House staff work with residents on daily living skills, craving control, hepatitis C prevention, relaxation, aggression management and are available for informal counselling. Staff tend to work on a one-to-one basis with residents. Group-work is not facilitated as currently there are no opportunities for employees to receive appropriate training. Previously, residents were able to attend Self Management and Recovery Training (SMART) groups which were held for the wider community at St. Vincent's Hospital. However, the opportunity for Gorman House residents to participate in these groups ended in January 2006.

Usually, 'Touching Base' meetings are held each morning for those residents who are well enough to attend. This is an opportunity for staff to make any announcements and for residents to raise any general issues they may have. During these meetings, residents are rostered on a voluntary basis to assist with duties around Gorman House such as clearing up after meals and keeping the kitchen, dining and courtyard area tidy.

Residents with medical concerns may visit the Haymarket Foundation Clinic, a nearby healthcare clinic that provides free consultations. Transport to and from the clinic is provided. A spa bath is available for residents to help alleviate symptoms of withdrawal such as muscle aches and cramps. Additional facilities include a payphone, television, DVD/video player and movie library.

3.5 Medical emergencies, psychiatric assessment and critical incidents

In the event of a medical emergency such as seizures, delirium tremens, overdose or loss of consciousness, an ambulance is called to transfer the resident to St. Vincent's Hospital Emergency Department. Supportive care, including CPR if necessary, is provided by staff at Gorman House until ambulance officers arrive.

Residents who display signs of psychiatric disturbance or suicidal ideation and intent are assessed by Darlinghurst Community Health Centre Crisis Team. Gorman House staff contact the crisis team and request a prompt assessment.

Other critical incidents such as physical fights between residents and aggression towards staff occur from time to time. In cases such as these, St. Vincent's Hospital security service is called upon to assist in defusing the situation or removing aggressive residents if necessary. Residents involved in violent or aggressive incidents may face sanctions

against their re-admission to Gorman House, but are rarely banned outright from the service. All staff provide input into deciding sanctions against aggressive residents.

3.6 Discharge policy

Residents may self-discharge at any time without prejudice and without justification. Staff may discharge a resident for transfer to hospital, unauthorised drug use, physical or verbal aggression or for other behaviour not in accordance with the admission agreement. In the event that a resident is suspected of having used drugs or alcohol during their admission, two staff members assess the resident together to establish whether alcohol or drug use has occurred. Once discharged, people cannot be readmitted for seven days, and in some circumstances this length of time may be extended.

As Gorman House is permitted to operate as a secondary needle and syringe program, sterile needles and syringes are provided in the event that a resident expresses an intention to inject drugs after discharge

4. RESULTS

4.1 Minimum Data Set profile of residents admitted 17 March 2005 to 16 March 2006

In order to compare study participants with other residents not interviewed, Minimum Data Set (MDS) information pertaining to all residents admitted to Gorman House over a period of twelve months, including the study period, was obtained from St. Vincent's Hospital. Between 17 March 2005 and 16 March 2006 there were a total of 836 admissions among 392 individuals to Gorman House. This represents approximately half of the yearly admissions during a 12 months period when Gorman House operated seven days per week (e.g. between 1 January and 31 December 2002 there were 1,842 admissions to Gorman House). Overall, Gorman House residents were predominantly Australian born (83%) men (90%) aged in their fifth decade and nominated English as their preferred language (94%). A small (7%) proportion identified as Aboriginal, while the majority (84%) identified as neither Aboriginal nor Torres Strait Islander. Residents predominantly received pensions (e.g. disability support allowance) or temporary benefits (92%), lived alone (76%), came to Gorman House from refuges, hostels, shelters, boarding houses or no fixed abode (53%). The main source of referral was recorded as 'self-referral' (98%).

All residents had previous residential or in-patient admissions for detoxification. Their principal drug of concern was alcohol (66%), opiates (20%) or methamphetamine (12%). Almost half (44%) the sample injected substances within the previous three months. The majority (65%) of the overall sample leave treatment having completed withdrawal, while one-third (31%) do not complete withdrawal (leaving against advice or without notice). The remainder did not complete withdrawal due to transfer to other services. Two-thirds (66%) of all admissions were referred to another agency. Of those who were referred elsewhere, over one-third (38%) were referred to a general practitioner, medical officer, hospital (psychiatric or general) or residential community mental health service. The remainder were referred to residential drug and alcohol treatment (10%), community care unit (13%) or a non-health service agency (5%). No referral was generally associated with treatment non-completion.

A regression analysis was conducted to determine which variables may have been associated with 'leaving against advice'. One predictor emerged - heroin and opioid use - which was significantly associated with leaving against advice (OR 2.4, 95%CI 1.65 – 3.51). Amphetamine or methamphetamine use or other drug use was not significantly associated with treatment non-completion. Injecting drug use was also associated with treatment non-completion (OR 1.74, 95%CI 1.25 – 2.41). However, when both variables were analysed together, only presenting drug use was significant. Compared with alcohol dependent residents, those who presented with heroin (N=152) and other opiate use (12 codeine, 1 buprenorphine, 1 morphine) were two-and-a-half times more likely to leave treatment against advice. The median length of stay of heroin dependent residents was two days (range 0-4) compared with three days (range 0-4) for residents with alcohol or other drug use. There were 33 individuals whose admission lasted zero days. The available information did not reveal any major differences between these and other residents. (Of those who were discharged on the same day of admission: fifteen 'left against advice', seven 'completed treatment', two were 'transferred' to a residential drug and alcohol or community care service , two 'left without notice' and six were classified as 'other').

Table 1: Comparison based on MDS data between study participants and other residents admitted over a 12-month period (17 March 05 to 16 March 2006)

Characteristic	Study sample (N=80) N (%)	All other admissions (N=756) N (%)	Total admissions (N=836) N (%)
Mean age in years* (SD, range)	40.5 (10.2, 17-63)	41.7 (10.6, 17-79)	41.7 (10.5, 17-79)
Male gender	69 (86)	681 (90)	750 (90)
Number of individual cases#	80 (100)	312 (41)	392 (47)
Born in Australia	65 (81)	628 (83)	693 (83)
Neither Aboriginal nor TSI	66 (83)	637 (84)	703 (84)
English preferred language	78 (98)	710 (94)	788 (94)
Employment status#			
Pension	34 (44)	430 (57)	464 (56)
Temporary benefits	32 (41)	298 (36)	298 (36)
Employed (FT / PT)	5 (6)	43 (5)	43 (5)
No income	7 (9)	22 (2)	22 (3)
Living alone	58 (73)	579 (77)	637 (76)
Usual accommodation			
Rented house/flat	41 (51)	279 (37)	320 (38)
Shelter/refuge	12 (15)	200 (27)	212 (25)
Homeless	11 (14)	142 (19)	153 (18)
Boarding house/hostel	7 (9)	74 (10)	81 (10)
Principal drug of concern*			
Alcohol (incl alcohols not elsewhere classified)	54 (69)	504 (68)	558 (66)
Heroin and other opiates (incl codeine)	8 (10)	158 (21)	166 (20)
Methamphetamine and other amphetamines	16 (21)	80 (11)	96 (12)
Other (cocaine, cannabis, methanol)	2 (3)	14 (2)	16 (2)
Injecting drug use			
Never injected	37 (48)	304 (40)	341 (41)
Within last three months	31 (40)	335 (45)	366 (44)
More than three months ago	9 (12)	101 (15)	118 (14)
Method of use of principal drug			
Ingestion	55 (69)	513 (71)	568 (70)
Injection	22 (31)	231 (29)	253 (30)
Source of referral 'self'	77 (96)	745 (99)	822 (98)
Previous treatment			
Residential/in-patient detoxification	80 (100)	756 (100)	836 (100)
Reason for cessation of treatment#			
Treatment completed	69 (90)	470 (67)	539 (69) [2]
Left against advice/without notice	8 (10)	235 (33)	243 (31)
Referral to another service#			
No referral	20 (25)	270 (36)	290 (34)
Other[1]	25 (31)	288 (38)	313 (38)
Other residential community care unit	14 (17)	93 (12)	107 (13)
Residential D&A treatment	7 (9)	75 (10)	82 (10)
Other non-health service	14 (18)	28 (4)	42 (5)
Length of admission			
Median no. of days (range)	3.00 (0-4)	3.00 (0-4)	3.00 (0-4)

$p \leq 0.001$ * $p \leq 0.4$

[1] 'Other' includes: general practitioner, medical officer, psychiatric hospital, other hospital, residential community mental health, non-residential drug and alcohol service and community health centre.

[2] Individuals who were transferred to another service during treatment were excluded from this analysis

A comparison between the characteristics, based on MDS information, of the 80 participants recruited to the study between 2 December 2005 and 16 March 2006 and the 756 other admissions to Gorman House during the 12-month period is presented in Table 1. The two groups differ significantly in few respects. The recruited sample on average is one year younger than all other admissions and includes fewer people who receive a pension. Both samples had alcohol as their principal drug of concern, but more study participants than other admissions used methamphetamines and fewer used opiates. More participants than other admissions completed withdrawal during their stay and were referred to other services, either during their stay or upon discharge.

4.2 Study participants

4.2.1 Sample demographics

The characteristics of the study sample are presented below. The inevitable discrepancies between research interview information and MDS data, attributable to different methods of eliciting and recording information and variations in self-report, have been retained in this Report.

The study sample consisted of 80 residents admitted to Gorman House between 2 December 2005 and 16 March 2006. This represents 38% of the total number of residents (N=211) admitted over this time. The mean age of the sample was 40.5 years (SD 10.19), considerably older than the national sample accessed in the Clients of Treatment Service Agencies (COTSA) census (Shand and Mattick, 2001). The majority (86%) of the sample was male, and this was anticipated as fewer beds are allocated for females than males. Female participants were slightly older than males (44.3 years vs. 39.5 years).

With regards to relationship status, 16% of participants were separated, 26% were divorced and 45% reported having never been married (see Table 2). This compares with a third of the adult population in NSW who have never married (Australian Bureau of Statistics, 2006).

Table 2: Relationship status

Relationship status	N (%)
Married	1 (1)
Widowed	2 (3)
De-facto	7 (9)
Separated	13 (16)
Divorced	21 (26)
Never married	36 (45)

All but one participant reported some formal education. Thirty per cent had completed Year 10 or equivalent and 13% had completed Year 12 or equivalent (see Table 3).

Table 3: Highest level of education achieved

Education	N (%)
Never attended school	1 (1)
Attended primary school	1 (1)
Attended secondary school	23 (29)
Completed Year 10 or equivalent	24 (30)
Completed Year 12 or equivalent	10 (13)
TAFE	12 (15)
University degree	7 (9)
Other	2 (3)

The majority (85%) of residents were unemployed. The mean duration of unemployment was 4.7 years and ranged from just a few days to 20 years. Just over one-fifth (23%) reported being currently involved with the legal system - for example, were on parole or awaiting hearing. Only 15% of residents stated that they felt pressured to attend a detoxification service. Sources of pressure included family members, health professionals and legal concerns.

In the week prior to admission, 39% of the sample had resided in rented accommodation, while 8% lived in privately owned homes. One person reported that they had been in a residential drug treatment service, and one person in a psychiatric hospital, in the week prior to admission. The remainder (51%) were homeless or marginally housed (e.g. resided in a hostel or shelter) (see Table 4). In the week before admission, one-quarter (26%) reported living in more than one type of accommodation.

Table 4: Accommodation in the week prior to admission

In the week before you came to Gorman House where did you mostly stay?	N (%)
Rented house (public or private)	31 (39)
Privately owned house or flat	6 (8)
Boarding house	3 (4)
Hostel/supported accommodation service	11 (14)
Psychiatric home/hospital	1 (1)
Alcohol/other drug treatment residence	1 (1)
Shelter/refuge	4 (5)
Prison/detention centre	1 (1)
No usual residence/homeless	8 (10)
Other	14 (18)

4.2.2 Drug and alcohol use

Tobacco and alcohol were used in very similar proportions, 89% and 86% respectively, and were the two most commonly used substances. Among illicit drugs, the most commonly used was cannabis (50%), followed by amphetamines (30%) and heroin (15%). Table 5 shows the proportion of the sample who reported using each drug type in the previous month. Poly-drug use was common, with 91% reporting use of more than one substance.

Table 5: Drug and alcohol use in the previous month

Drug	N (%)
Tobacco	71 (89)
Alcohol	69 (86)
Cannabis	40 (50)
Amphetamines	24 (30)
Tranquilisers (benzodiazepines)	13 (16)
Heroin	12 (15)
Cocaine	8 (10)
Other opiates	2 (3)
Hallucinogens (ecstasy)	2 (3)
Other (Gamma-hydroxybutyrate, GHB)	1 (1)

All participants reported they were concerned about their use of alcohol or other drugs. The majority (70%) reported they were most concerned about their use of alcohol. Other drugs nominated included amphetamines and heroin (see Table 6).

Table 6: Drug of 'most concern'

Drug	N (%)
Alcohol	56 (70)
Amphetamines	15 (19)
Heroin	6 (8)
Cocaine	1 (1)
Cannabis	1 (1)
Gamma-hydroxybutyrate (GHB)	1 (1)

When asked how participants felt about their current use of their main drug of concern, 43% reported that they had 'made real plans to quit or cut down' (see Table 7).

Table 7: Participants' descriptions of feelings about drug use

'Which of the following statements best describes how you feel about your current use of [drug of most concern]?'	N (%)
I am happy with my drug use, I don't feel the need to quit or cut down	0
I think I might need to quit or cut down but I am not sure I want to	16 (20)
I have made real plans to quit or cut down	34 (43)
I have recently started to quit or cut down	28 (35)
I have already cut down or quit some time ago	2 (3)

The Opiate Treatment Index (OTI) was used to assess daily consumption of drug and alcohol use. The number of participants drinking alcohol or using substances and their median OTI quantity/frequency (Q) scores are reported in Table 8. The majority of participants (91%) reported using several substances. There was a wide range of consumption with daily or more frequency being reported by most participants who drank alcohol (98%), used cannabis (70%), amphetamines (68%), cocaine (86%) and cigarette smokers (96%).

Table 8: Quantity and frequency of substance use in the previous 4 weeks (OTI)

	Residents who used in the last month N (%)	OTI Q[1] Quantity/frequency Median (range)	Unit of measurement
Alcohol	69 (86)	26.0 (0.0-156)	Standard drinks
Amphetamine[3]	24 (30)	2.0 (0.4-22.5)	Tablets/snorts/hits
Heroin	12 (15)	0.7 (0.07- 2.5)	Hits/smokes/snorts
Other opiates[2]	2 (3)	0.5 (0.5-0.54)	Hits/snorts/doses
Cannabis	40 (50)	4.1 (0.14-52.5)	Joints/bongs
Cocaine	8 (10)	2.0 (0.9-5)	Snorts/hits/smokes
Tranquilisers[4]	13 (16)	1.4 (0-9)	Pills
Hallucinogens	2 (3)	0.2 (0-0.4)	Tabs/trips
Tobacco	71 (89)	18.0 (0-60)	Cigarettes

[1] Interpreting quantity/frequency: Abstinent (Q = 0), once a week or less (Q=0.01-0.13), more than once a week (Q= 0.14-0.99), daily (Q=1.00-1.99), more than daily (Q=2.00 or more).
[2] Including street methadone, morphine, pethidine, codeine
[3] Including methamphetamine
[4] Including oxazepam, flunitrazepam, nitrazepam, diazepam

Participants who consumed alcohol in the previous month, and answered two Alcohol Use Disorders Identification Test (AUDIT) screening items affirmatively were assessed for alcohol dependence. Participants who reported drinking two to three times a week or more and drinking five or more drinks per drinking day were administered the Severity of Alcohol Dependence questionnaire (SADQ). The mean SADQ score was 39.7 (SD 13.63; range 14-69), indicating extremely severe dependence (the cut-off score for severe dependence is 30, and 73% of participants scored 30 or more).

The level of dependence on other substances, for participants who had consumed those substances in the previous four weeks, was assessed using the Severity of Dependence Scale (SDS). The validity and reliability of the SDS has been established only for heroin, cannabis, amphetamines and cocaine.

SDS scores range from zero to 15, with higher scores indicating greater dependence. The cut-off score for heroin dependence is four or more (Ross and Darke, 1997), cocaine dependence is three or more (Kaye and Darke, 2002), amphetamine dependence is four or more (Dawe et al., 2002) and cannabis dependence is three or more (Dawe et al., 2002). Median SDS scores for heroin, cocaine, amphetamines and cannabis are presented in Table 9.

Table 9: Drug dependence (SDS) median scores

	N (%)	Median (range)	SDS cut-off score for dependence
Heroin	12 (15)	7 (0-15)	4 or greater
Cocaine	8 (10)	9.5 (1-15)	3 or greater
Amphetamine	24 (30)	10 (0-15)	4 or greater
Cannabis	40 (50)	8 (0-15)	3 or greater

4.2.3 Detoxification experiences

The majority (85%) of residents reported at least one previous detoxification episode, with a median of eight previous detoxification episodes, and one-quarter of participants reported 20 or more previous episodes.

Among participants who had previously been admitted for detoxification, 58% reported severe withdrawal symptoms such as delirium tremens or seizures; the majority (85%) of this group reported experiencing these symptoms in the last 12 months.

Two-thirds (64%) of residents had been admitted to Gorman House previously, with one-fifth of the total sample reporting 15 or more prior admissions. The median number of prior admissions was four (estimated range one to 100 or more). Three-quarters (77%) of the participants who had been to Gorman House before were admitted within the previous 12 months.

Of participants who had previously attended Gorman House (N = 51), the mean length of the last admission was 4.7 days (range 2-7). The majority (59%) of these participants reported staying long enough to complete their withdrawal. Those who did not complete withdrawal provided a range of reasons for non-completion, including transfer to rehabilitation or another detoxification service and relapse. Just under one-third of residents who reported not completing their withdrawal the last time they stayed at Gorman House stated this was because the service did not remain open over the weekend.

Nineteen per cent of participants with previous admissions to Gorman House reported discharging to a residential alcohol or other drug treatment service following their last admission. About one-third reported discharging to rented housing; 13% reported they had no usual residence or were homeless at the time they were discharged. Table 10 shows the destinations of residents following their last admission to Gorman House.

Table 10: Destinations of participants following last discharge

Where did you go the last time you left Gorman House?	N (%)
Rented house (public or private)	17 (32)
Privately owned house or flat	2 (4)
Boarding house	2 (4)
Hostel/supported accommodation service	7 (13)
Alcohol/other drug treatment residence	10 (19)
Shelter/refuge	1 (2)
No usual residence/homeless	7 (13)
Other	8 (15)

More than half (57%) of participants with previous admissions to Gorman House reported that in the past there had been times when they could not secure a bed at Gorman House when they wanted one, because the service was full or closed for the weekend. A majority (61%) reported that on these occasions they continued to drink or use drugs until a bed became available. A minority (26%) reported contact with an alternate detoxification unit or health service.

In terms of the present admission, just over half (55%) of residents were admitted on the same day that they asked for a bed. Most residents (56%) who could not get a bed on the same day that they asked for one reported that the reason for this was associated with the weekend closure of Gorman House (e.g. people were told no admissions were accepted from Wednesday to Friday). One-third (33%) of residents had voluntarily postponed admission at their own request.

Participants were asked to nominate their main reason for coming to Gorman House (see Table 11 below). The majority (53%) nominated 'to get into treatment' as their main reason for presentation.

Table 11: Reasons for seeking detoxification

Main reason for coming to Gorman House	N (%)
To get a bed/decent meal	2 (3)
To sober up/get straight for something special	13 (16)
To have a break from drinking/using drugs for a while	15 (19)
To get in to treatment like rehab or counselling	42 (53)
Other reason	8 (10)

Participants were asked an open-ended question regarding their reason for choosing Gorman House rather than another service. The most frequently reported reasons residents chose Gorman House rather than another detoxification service was because they liked it, it had been recommended by another person or agency and that the resident had been at least once before. The reasons for choosing Gorman House are shown in Table 12.

Table 12: Reasons for choosing Gorman House

Why did you come to Gorman House (and not another service)?	No. of times mentioned*
Resident liked GH	25
Recommended by another (including other services)	19
Resident has been before	14
It's a local service	13
Usually can get in quickly	10
Only service with a bed available	9
Only service known to resident	3
Other reason	6

*Residents could report more than one reason for choosing Gorman House

Residents were asked where they would have gone if they were not able to get a bed at Gorman House. Almost one-third (31%) would have tried to access another detoxification service or health care facility, 16% reported they would have tried an accommodation service, and 13% stated that they would have gone home if they were not able to get a bed at Gorman House this time. A proportion (13%) would have returned to the street and 20% did not know what they would have done.

The majority of participants (91%) stated that they felt 'safe' or 'very safe' while staying at Gorman House. Five per cent of participants reported feeling 'neither unsafe or safe' and 4% felt 'unsafe'. Most commonly, participants who felt unsafe stated that they were concerned about other residents becoming agitated or violent. Concerns were also expressed about property being stolen and lockable drawers were suggested as a solution to this problem.

A majority (30%) of participants reported that they would be discharging from Gorman House to rented accommodation. Nineteen per cent reported that they would be discharging to a residential alcohol or other drug treatment service. Table 13 shows the expected destination of participants upon discharge from Gorman House.

Table 13: Expected destinations following discharge

Where will you go when you leave Gorman House at the end of this week?	N (%)
Rented house (public or private)	24 (30)
Privately owned house or flat	7 (9)
Boarding house	3 (4)
Hostel/supported accommodation service	6 (8)
Alcohol/other drug treatment residence	15 (19)
Shelter/refuge	1 (1)
No usual residence/homeless	3 (4)
Other	13 (16)
Don't know	8 (10)

Most (89%) residents would return to Gorman House if they had to detoxify again. A minority (11%) would not return or were unsure about returning. Participants were also asked if they had any plans or thoughts about where they might be in the next three months. Responses, some of which contained more than one theme, were categorised thematically. The most common theme, referred to by 45% of participants, related to seeking treatment for alcohol or other drug problems. Other common themes are summarised below in Table 14.

Table 14: Participants' plans for the next three months

Theme	N (%)
Seek treatment for alcohol and other drug use	36 (45)
Abstain from alcohol and other drug use	18 (23)
Obtain employment or begin a course	20 (25)
Obtain stable housing	12 (15)
Resume alcohol or drug use	2 (3)
Don't know	4 (5)
Other	11 (14)

Open-ended questions about the things participants 'liked most' and 'liked least' about Gorman House elicited varied responses. The majority of participants (54%) nominated Gorman House patient care staff as one of the things they liked most. Sample comments included:

Staff are friendly and kind.

Staff are approachable and genuinely interested in helping.

Staff are very non-judgmental about your drug use.

Many residents (45%) nominated the unstructured approach of Gorman House as one of the things they liked most. Sample comments included:

You're supervised but they leave you alone; there's no pressure.

Not too many routines so you can recuperate.

Easy-going atmosphere.

Other commonly mentioned positives of Gorman House are summarised in Table 15.

Interestingly, 29% of participants nominated the behaviour of other residents as one of the things they liked least about Gorman House. Sample comments included:

Some people use it not for a detox, just for a place to eat and sleep.

Guys talking about drinking and drug use, it's a bad influence on others.

Sixteen per cent of participants made comments referring to boredom while at Gorman House. Sample comments included:

Not much to do during the day.

Need more optional activities like cards and games.

While patient care staff and the unstructured approach of Gorman House were mentioned most frequently as the things participants liked most, some participants nominated these as things they liked least. Sample comments included:

No structure; at other detoxes they take you to [AA/NA] meetings.

Staff are too busy when you want to talk to them.

Other commonly reported themes are summarised below in Table 15.

Table 15: Aspects of Gorman House participants like most and least

Things residents like MOST	N (%)	Things residents like LEAST	N (%)
Patient care staff	44 (55)	Behaviour of other residents	23 (29)
Unstructured approach	36 (45)	Boredom	15 (19)
Physical environment	22 (28)	Physical environment	12 (15)
Food	10 (13)	Restricted opening hours	9 (11)
Social aspects	6 (8)	Unstructured approach	9 (11)
Facilities (e.g. videos, barbeque)	5 (6)	Non-medicated	8 (10)
		Patient care staff	7 (9)

Participants were given an opportunity to describe what they would change about Gorman House if they could. Eighteen per cent made suggestions relating to improving the physical environment of Gorman House. Sample comments included:

Have less people per dorm.

This is a very small unit for the number of people using it.

Put in curtains around beds for privacy.

Other common themes are summarised in Table 16.

Table 16: Changes participants would make to Gorman House

What would you change about Gorman House?	N (%)
Improve physical environment	14 (18)
Improve recreational facilities	13 (16)
Add structure or a program	9 (11)
Open twenty-four hours a day, seven days a week	8 (10)

All residents were asked to comment on Gorman House being a five day detoxification service and closed over the weekend. Six percent of responses supported the five day per week operation in place at the time of the evaluation. The majority (54%) of responses were in support of seven day operation. Some sample comments included:

It's good that it's open only five days, everyone knows they have to go, it helps set limits.

Better when it was open seven days, it was easier to get in.

It affects a lot of people, they desperately need a seven day a week service.

The worst thing you can do is put someone out on the street on the weekend when they are an alcoholic.

The eight item CSQ-8 questionnaire was used to provide a standardised measure of participant satisfaction with Gorman House. Possible total scores could range from a minimum of eight (strongly negative dissatisfaction) to a maximum of 32 (strongly positive satisfaction). Therefore, the higher the score, the greater the participant satisfaction. The mean score was 26.5 (SD 4.5, range 14-32), indicating (on average) high participant satisfaction (see Appendix 5 for more detailed CSQ-8 results).

4.2.4 Blood-borne viruses

Participants were asked about their experience of testing for blood-borne viruses such as hepatitis C and HIV. Two participants declined to answer these questions; results presented here are based on a sample of 78. The majority of the sample (82%) had been tested for hepatitis C, and, of these, 34% reported that they were hepatitis C positive. The majority (85%) had also been tested for HIV. Of these, 2% were HIV positive. In a small number of cases, participants had been tested for blood-borne viruses and were awaiting results.

4.2.5 Physical and mental health

Quality of life

Quality of life in terms of physical and mental health was measured using the SF12. Participants rated their level of physical and mental health and the extent to which their physical and mental health limited their ability to perform certain tasks or social activities. The scores range between zero and 100, with a higher score indicating better health. It is conventional to regard people with scores 40-49 as mildly impaired, 30-39 as moderately impaired and below 30 as severely impaired (Ware et al., 1995).

The mean score for physical health was 43.9 (SD 12.1, range 21-64). The physical health of a majority (61%) of participants was impaired. Of these, one-quarter (25%) were mildly impaired, 16% were moderately impaired and 20% were severely impaired.

The mean score for mental health was 33.7 (SD 11.2, range 15-66). The mental health of a substantial majority (89%) of participants was impaired. Just under half (45%) of these participants were severely impaired, one-quarter (28%) were moderately impaired and the remainder (16%) were mildly impaired.

General psychological distress
The Kessler Psychological Distress Scale (K10) was administered as a measure of psychological distress. Participant scores were grouped as low (10-15), medium (16-29) or high (30-50) risk of an anxiety or depressive disorder. The mean score was 28.4 (SD 8.1, range 12-47). Only three (4%) participants had K10 scores indicating no or low psychological distress. Forty-one, or just over half (53%) of participants, had scores indicating moderate psychological distress and 34 (44%) participants scored in the high psychological distress range.

On the other hand, K10 scores from the National Health Survey show 63% of the general community were at low or no risk, 24% were at moderate risk and 13% were at high risk (Australian Bureau of Statistics, 2006). This suggests most Gorman House residents interviewed were at substantially greater risk of anxiety or depressive disorder than the general community.

Anxiety symptoms
The Beck Anxiety Inventory (BAI) was used to score the severity of anxiety-related symptoms among participants. A score of 0-21 indicates no or low levels of anxiety, 22-35 indicates moderate levels of anxiety and a score of 36 or more indicates high levels of anxiety. The mean BAI score was 23.1 (range 3-54, SD 12.5). The majority (53%) reported low or no anxiety; however, moderate or high anxiety was reported by significant minorities of participants (see Table 17)

Depressive symptoms
The Beck Depression Inventory (BDI) was administered as a measure of the severity of depressive symptoms among participants. The mean BDI score was 22.8 (range 0-49, SD 11.3). About one in five participants (18%) had scores of 31 or higher indicating high levels of depressive symptoms. The majority (55%) had scores between 17 and 30 indicating moderate levels of depressive symptoms. The remaining one-quarter (26%) of participants had scores of below 17 indicating low levels of depressive symptoms (Table 17).

In responses to the BDI item on suicidal ideation (Q. 9), forty-one (51%) participants endorsed the statement 'I don't have any thoughts of killing myself'; thirty-five (43%) endorsed the statement 'I have thoughts of killing myself, but I wouldn't carry them out'. Three participants (4%) endorsed 'I would like to kill myself' and one, 'I would kill myself if I had the chance' (these four participants consented for the research staff to alert the Gorman House staff who provided counselling and support and liaised with Mental Health staff as per service procedure). Thus, just under half of participants experience current suicidal ideation and one in twenty of these have active suicidal ideas.

Table 17: Proportion of participants with low, moderate and high BAI and BDI scores

	BAI N (%)	**BDI N (%)**
Low	41 (53)	20 (26)
Moderate	22 (29)	42 (55)
High	14 (18)	14 (18)

Psychotic symptoms

A psychosis screener developed by Degenhardt and Hall (2000) was used to assess the presence of characteristic psychotic symptoms. A score of three or more out of a possible maximum of seven has been demonstrated to discriminate between cases and non-cases of schizophrenia or schizoaffective disorder. There was an absence of psychotic symptoms in the majority (59%) of participants. Twenty-three (30%) participants scored one or two when screened, which suggests that psychotic symptoms were present in these participants to some extent. Psychotic symptoms sufficient to suggest the presence of schizophrenia or schizoaffective disorder were reported in one in ten (11%) participants.

Traumatic or stressful experiences

This study explored experiences of trauma in the lives of participants. Nine specific events of extreme trauma were assessed. Participants were also asked if they had ever experienced any other stressful or upsetting event, or ever experienced a great shock because any of these events had happened to someone close. These events are typically associated with post-traumatic stress disorder; however, whether or not the participant met diagnostic criteria for post-traumatic stress disorder was not assessed in the present study.

Multiple experiences of extreme trauma were common amongst males and females. Participants had experienced a mean of 4.3 (SD 2.1, range 0-8) different types of stressful or upsetting events. Participants were asked whether they had ever experienced any of the listed events (listed in Table 18). There were similar mean numbers of events and types of stressful events experienced by males and females (M 4.3, SD 1.9 vs. F 4.4, SD 3.1). Five participants, or 6.6% of the sample, had experienced eight different types of traumatic event, the maximum number reported. Four (5%) participants stated that they had not experienced any of the types of traumatic events asked about, nor had they experienced any other type of stressful or upsetting event.

A substantial proportion of males (73%) and females (80%) reported experiencing serious physical attack or assault. More than half (60%) of the female participants reported having been raped, compared to 11% of male participants. More males than females reported having been sexually molested. Males were also more likely than females to have witnessed someone being badly injured or killed, to have been involved in a life-threatening accident, to have been threatened with a weapon and to have had combat experience in war (see Table 18).

Table 18: Lifetime experience of traumatic or stressful event

Traumatic or stressful event	Male N=69 N (%)	Female N=11 N (%)	Total N=80 N (%)
Direct combat experience in war	6 (9)	0	6 (8)
Life-threatening accident	45 (68)	5 (50)	50 (66)
Involvement in fire, flood or other natural disaster	24 (36)	2 (20)	26 (34)
Witness to someone being badly injured or killed	52 (79)	5 (50)	57 (75)
Experience of being raped	7 (11)	6 (60)	13 (17)
Experience of being sexually molested	17 (26)	2 (20)	19 (25)
Seriously physically attacked or assaulted	48 (73)	8 (80)	56 (73)
Threatened with a weapon, held captive or kidnapped	45 (68)	7 (70)	52 (68)
Tortured or the victim of terrorists	7 (11)	1 (10)	8 (11)
Any other extremely stressful or upsetting event	16 (24)	3 (30)	19 (25)
Shock due to event(s) above happening to someone close	19 (29)	5 (50)	24 (32)

4.2.6 Health service utilisation

The extent of use of health care services, as reported by participants, in the four weeks prior to interview was ascertained using questions from the National Survey of Mental Health and Wellbeing (ABS, 1999). This included use of ambulance, hospital and other health services including psychological and social services.

One-fifth (20%) of participants had received help from ambulance officers on one or more occasions. Almost two-thirds (64%) of these occasions were related to the participants' alcohol or drug use and had resulted in ambulance transfer to hospital.

A minority (25%) of participants were treated on at least one occasion as a patient in a hospital emergency or casualty ward. One participant had been treated on three occasions, and this was the maximum reported.

Six (8%) participants had attended an out-patient clinic of a hospital for treatment at least once. This included one participant involved in a clinical drug trial who reported attending on five occasions.

Fourteen (18%) participants had been admitted to hospital for a day-only procedure or had stayed for at least one night. One participant had been admitted to hospital on four separate occasions, the maximum reported. The length of hospital stay among those participants admitted ranged from one day up to six nights. Examples of reasons given for admission included colonoscopy, drug overdose, head injury, detoxification, methamphetamine psychosis and mental illness.

Almost three-quarters (73%) of participants had visited a general practitioner at least once. Of these, one-quarter (23%) had made between three to six visits. Thirteen percent of participants had visited a medical specialist (excluding visits to a psychiatrist). A minority (9%) of participants had visited a dentist. Eleven (14%) participants had visited a psychiatrist and nine (12%) had visited a psychologist on at least one occasion.

Just under one-third (30%) had visited a social or welfare worker and nineteen percent had visited other therapists or counsellors at least once. The majority (95%) had not

visited a health professional such as a chiropractor, naturopath, physiotherapist or podiatrist.

Twenty-two percent of participants had at least one urine test, 30% of participants had at least one blood test and 12 (16%) participants reported having at least one x-ray or scan. A majority (58%) had received medications on prescription (this included methadone and other heroin treatment medication).

4.3 Staff interview data

All ten staff members of Gorman House completed and returned the anonymous questionnaire. Their responses are summarised under each topic below.

4.3.1 Aims and objectives of Gorman House

Staff were asked to report what they believed the aims and objectives of Gorman House to be. Responses were categorised by themes (see Table 19). All staff answered this question and most responses included multiple themes. The most common themes, each mentioned by eight staff members, concerned providing a safe environment for detoxification and providing harm minimisation services such as education around drug use and safer injecting. Other aims reported included providing general health and living skills education and acting as a conduit to physical and mental health care. Two staff members highlighted the role of Gorman House in catering for marginalised groups such as the homeless and people with dual diagnosis.

Table 19: Staff perception of the aims and objectives of Gorman House

Theme	N (%)
To provide a safe environment for detoxification/withdrawal	8 (80)
To provide harm minimisation services/drug use education	8 (80)
To provide health and living skills education	3 (30)
To help residents access physical and mental health care	3 (30)
To provide services to marginalised populations	2 (20)
To provide drug and alcohol interventions (e.g. motivational interviewing)	2 (20)
To encourage residents to explore drug and alcohol treatment options	2 (20)

Staff were also asked if they believed Gorman House was achieving its aims and objectives. Seven staff answered this question: four stated that Gorman House was 'definitely' achieving its aims and objectives, two believed that Gorman House was achieving its aims 'to some extent' and one was 'unsure'.

4.3.2 Resident services

Staff were asked to rank a list of possible reasons that might prompt people to seek admission to Gorman House. Nine staff members nominated 'to have a break from drinking and/or using drugs for a while' as the main reason most people present to Gorman House. One staff member thought the main reason most people attended Gorman House was 'to get into treatment like rehab or counselling'.

Staff were then asked to use a five point Likert scale ranging from 'very adequately' to 'very inadequately' to rate the extent to which they believed various needs of residents

were met during admission to Gorman House. Comments on each issue were encouraged.

In relation to shelter and food, most (eight out of ten) staff reported that the quality of these services was 'adequate' or 'very adequate'. Of staff who commented, four agreed that the food provided was of acceptable quality. However, one person believed the food could be improved, particularly given the poor health and diet of most residents. Although three staff commented positively on the quality of shelter provided, three raised concerns about the dormitory-style rooms shared by residents. Smaller rooms accommodating 3-4 people each was suggested as an alternative.

All ten staff felt assessment on admission was conducted 'adequately' or 'very adequately'. However, one staff member expressed concern that regular residents 'are not always comprehensively assessed'. Another suggested that mental health assessment should be incorporated into the admission assessment. The introduction of standardised measures for conducting assessment was also suggested.

While seven staff believed treatment planning was adequately carried out, two stated that treatment planning was 'neither adequate nor inadequate' and one believed treatment planning to be inadequate. Comments focused on the difficulties of adequate treatment planning given that residents are only in Gorman House for five days. Two staff reported that Gorman House treatment plans tended to focus only on immediate needs.

All staff believed withdrawal management at Gorman House was 'adequate' or 'very adequate'. Two staff provided additional comments: one of these stated that most residents do not require medication; the other believed a longer period of admission was required as many residents did not complete withdrawal within five days.

With regards to general medical care for residents, nine staff believed it to be adequate or very adequate. Only one staff member rated general medical care as inadequate. Two staff mentioned the ability to refer to external medical services such as Haymarket Clinic, Rankin Court Treatment Centre and St. Vincent's Hospital as an advantage of Gorman House. One raised the concern that Haymarket Clinic can be 'chaotic and off-putting for some'. One criticised access to general medical care from Gorman House, stating that dental problems were not addressed adequately and access to Haymarket Clinic was limited to morning hours.

While six staff believed psychiatric care for residents was 'adequate', one said it was 'neither adequate nor inadequate' and three 'inadequate' or 'very inadequate'. Two staff noted that, while referral to mental health and crisis team services was possible, these services were poorly resourced and not available at all times. One commented that there was sometimes 'a reluctance on the part of Mental Health to treat people with a dual diagnosis'. One noted that St. Vincent's Hospital has recently opened a psychiatric emergency ward, but this had made the situation more confusing as it was unclear which cases should be referred to which mental health services.

With regards to duration of admissions, three staff felt that five day admissions were adequate. Two nominated neither adequate nor inadequate, and five rated duration of admission as inadequate or very inadequate. Five staff expressed concern with current opening hours (Monday-Friday). Some commented that while a five day stay was adequate for most residents, some require longer to complete withdrawal and others

need a longer stay to facilitate referral to rehabilitation services. Concern was expressed that sometimes residents had to be discharged even though they were still unwell.

Five staff felt that discharge planning was adequate, four that it was 'neither adequate nor inadequate' and one 'inadequate'. While one staff member commented that 'all assistance is given as required', another noted that discharge plans for many residents, particularly homeless ones, are 'in disarray'. Two staff expressed concern that the current limited opening hours restricted the ability of staff to implement comprehensive discharge plans.

The majority of staff (8) rated referral to ongoing community care as being adequately carried out. Two rated it as 'neither adequate nor inadequate'. One staff member commented that referral to community care 'is not always easy – especially for the homeless'. Another remarked that referral to community care is 'only as effective as the resident wants it to be'.

Staff were also asked whether there were any other resident needs that were not being adequately addressed. Eight had suggestions in this regard. Responses were summarised thematically and most responses contained multiple themes. Six response categories emerged (see Table 20). Three staff nominated the current restricted opening hours as a concern, explaining that restricted opening hours affected the ability of the service to meet resident needs both by limiting the days on which admissions could be accepted and limiting the duration of admissions. Other unmet needs raised by the staff were the lack of group education and individual counselling sessions. One staff member suggested at least one single room was needed for transgender residents, for whom placement in either male or female dormitories was problematic.

Table 20: Resident needs not currently being addressed, as nominated by staff

Theme	N (%)
Restrictions on opening hours	3 (38)
Lack of group/health education sessions	2 (25)
Mental health concerns	2 (25)
Lack of individual counselling sessions	2 (25)
Lack of single rooms for accommodating particular residents (e.g. transgender residents, residents with mental health problems)	1 (13)
Lack of attention to dental care	1 (13)

Staff were asked to nominate what they thought the main reasons for residents discharging from Gorman House before completing withdrawal were. Nine completed this question. Seven staff thought that cravings or 'wanting to get on' were the main reason residents discharged early. Two suggested that some residents appear to make use of Gorman House for accommodation and are not concerned with completing withdrawal. Other reasons nominated included 'conflict with others', 'feeling good physically and wanting to go back to own accommodation for comfort' and the lack of pharmacotherapies such as buprenorphine for heroin dependent residents.

All ten staff reported that they believed residents to be 'satisfied' with the services provided by Gorman House. No staff nominated aspects of Gorman House they thought residents might be dissatisfied with.

4.3.3 Staff satisfaction

A variety of aspects of staff satisfaction were explored. Staff were asked to rate their own level of satisfaction on a five point Likert scale ranging from 'very satisfied' to 'very dissatisfied'.

With regards to the physical environment of Gorman House, three staff reported being 'satisfied', four were 'neither satisfied nor dissatisfied' and two were 'dissatisfied'. Four people commented on the physical work environment. One noted that 'surroundings are clean and freshly painted', although 'we could do with more space in the reception area'. One other staff member commented that more room was needed in reception. Two staff commented on the lack of staff room.

Five staff members were satisfied or very satisfied with safety in the workplace. Two were neither satisfied not dissatisfied and two were dissatisfied. The ability to call on St. Vincent's Hospital security service in an emergency was mentioned as a positive by two staff. The lack of escape route should an aggressive resident block the reception area exit was mentioned as a concern by two staff. One staff member suggested clinical supervision would improve staff safety.

Satisfaction with support received in the event of an emergency or critical incident was assessed. While three staff were satisfied or very satisfied with support received following a critical incident, two were neither satisfied nor dissatisfied and five were dissatisfied. Four staff members commented on a lack of support. All four who commented noted that there was a lack of support from middle management following incidents.

Four staff reported that they were satisfied with the range of services provided at Gorman House. Four were neither satisfied not dissatisfied and two were dissatisfied. Two staff suggested that groups addressing health education and living skills should be implemented. Another suggested that residents would benefit from more room to move and exercise and from access to a computer for searching for employment or housing. One staff member commented that the range of services on offer was limited by low funding levels and restricted opening hours.

Only one staff member was satisfied with training and supervision provided. Four were neither satisfied nor dissatisfied and five were dissatisfied or very dissatisfied. Six staff commented that training and supervision were limited or non-existent, with one of these stating that it seemed as if training was 'actively discouraged'. One staff member noted that while there was no clinical supervision, access to training courses had recently improved.

Staff were also asked to nominate any other concerns they had relating to satisfaction with their role. Four staff raised concerns. These included poor management and lack of support for staff, low staff morale, restricted opening hours and being asked to perform duties outside one's training and skills.

Staff felt well prepared to perform their job. When asked to rate, on a five point Likert scale, their agreement with the statement 'I think my training, skills and competencies have prepared me well for my work at Gorman House', seven agreed or strongly agreed. Two neither agreed nor disagreed and one person did not answer the question.

Staff were asked if there were any changes they would make to Gorman House to improve services for residents. Six people commented and seven themes were identified (see Table 21). Five commented that they would return the service to seven-day-a-week operation. Three suggested improving support and training for staff. Other issues identified included improving the physical environment, providing groups and improving access to withdrawal medication (including buprenorphine for opiate dependent residents).

Table 21: Changes to Gorman House that staff would make

Theme	N (%)
Open seven days a week	5 (63)
Improve support and training for staff	3 (38)
Improve physical environment	2 (25)
Change management	2 (25)
Provide groups	2 (25)
Improve access to medication for withdrawal symptoms	2 (25)
Improve access to medical care	1 (13)

Finally, staff were asked if they had any other comments to make about Gorman House. Four people provided responses. Three raised concerns with the way Gorman House is currently managed at all levels. Two noted that returning to seven day operations was necessary in order for Gorman House to truly cater to the needs of its residents.

4.4 Key informant interview data

Key informants from 13 organisations that refer to and receive referrals from Gorman House were interviewed. The organisations included a range of rehabilitation, medical, counselling and support services. In addition, key informants were interviewed from two departments within St. Vincent's Hospital. The interview inquired about patterns of referral, the perception of Gorman House and its place in the wider system of services. Where possible, responses were categorised into various themes, and a summary follows. Frequently, key informants provided responses corresponding to more than one theme.

Key informants were asked who they refer to Gorman House and why. Six key informants commented they refer people who would benefit from a supervised detoxification. Four mentioned they would refer people who did not need a medicated service and an additional four commented that they frequently refer to Gorman House at the client's request. Three key informants responded in very general terms that they refer people who require detoxification. Two key informants refer people in instances where they do not expect a complicated withdrawal. An additional two key informants refer on occasions that people live in the catchment area for Gorman House. One key informant mentioned that people who have recently detoxified, but relapsed in a short space of time, are referred to Gorman House to 'sort themselves out'. Other people who key informants refer are methadone users (for selective detoxification), heroin users, couples (because Gorman House admits males and females), people who don't have health insurance, the 'skid-row population' and people who don't want lots of group work or structured activities. Typical comments included:

Anyone who needs a supervised detox, but not medicated.

We mainly refer to Gorman House at the client's request, most know it well, and it's the easiest to get in to.

Three key informants made mention that in some cases - although this was not stated as such - the reason for seeking admission to Gorman House was respite from homelessness. Sample comments included:

I feel a number of clients we refer are just waiting for their next cheque.

We accept that some people choose Gorman House only for a bed and a meal and we do our best to differentiate between patients who need this, and those who need a detox, and refer them to crisis accommodation.

Key informants were also asked who they do *not* refer to Gorman House. Six key informants stated they would not refer people who require medicated detoxification and four mentioned that neither would they refer people who would be expected to have a complicated withdrawal (such as benzodiazepine withdrawal, alcohol withdrawal accompanied by seizures or multiple substance withdrawal). Two key informants would not refer those who needed a longer detoxification and a further two would not refer heroin users. One reason given for this was that heroin users frequently request a detoxification with buprenorphine which is not available at Gorman House. Two key informants mentioned they would not refer people with complex or acute mental health problems. Persons suitable for out-patient detoxification were also less likely to be referred, and this was mentioned by two key informants. One key informant commented that females were less likely to be referred. The reason given for this was that the majority of residents at Gorman House are male and this may be intimidating to some females. Other people who key informants would not refer were more functional people and young people, and the reason given was that the population of Gorman House tends to be comprised of the older, more entrenched user.

Key informants were asked about their perception of the role of Gorman House. Four key informants commented that supervised detoxification was the role of Gorman House. Four key informants also mentioned the role of Gorman House to be the provision of respite from homelessness. Of these, two key informants acknowledged a dual role of detoxification and respite from homelessness. Four key informants mentioned that it was the role of Gorman House to provide referral to rehabilitation, counselling or mental health services. Two key informants commented that the role of Gorman House is to provide, specifically, 'short-term' detoxification. A further two key informants recognised that Gorman House provides a service to a substantially disadvantaged and severely drug or alcohol dependent population. One key informant saw the role of Gorman House as somewhere between providing in-patient and home detoxification. Another recognised the critical role Gorman House plays in taking the pressure off other services in the network. Other perceptions key informants held were that Gorman House has a role as a harm minimisation measure (providing respite from alcohol use) and provides residents with information about rehabilitation in a non-judgemental way. Typical comments included:

Gorman House provides detox, but also a bit of time-out.

Staff work hard to refer clients on to rehab or follow-up.

Gorman House deals with a lot of hard cases, the skid-row alcoholic goes to Gorman House.

Two key informants mentioned that they did not have a good understanding of the role of Gorman House. One reason given for this was a deterioration in what used to be more open lines of communication. Further to this, another key informant thought the role of Gorman House was not clearly defined. The reason given was that the service tries to be too flexible, 'over-extending its reach', and admitting people who are more dependent than it can manage.

When key informants were asked what services they would like to see offered at Gorman House, the vast majority (12) mentioned restoring operation to seven days per week. Better discharge planning and more follow-up was recommended by four key informants. Three key informants wanted to see Gorman House offer a medicated in-patient detoxification. Three key informants also nominated an expansion in the number of available beds, and one of these suggested specifically increasing the number of female beds. Two key informants would like to see case-workers become involved in the management of Gorman House residents. Two key informants also suggested providing detoxification that was more structured. One key informant saw a benefit in Gorman House increasing its capacity to admit people with behavioural problems (aggression, absconding, and sexual interaction with other residents were provided as examples by the key informant) or mental illness such as depression or suicidality (but not necessarily schizophrenia). Two key informants thought Gorman House generally fulfilled its role, and therefore they did not mention any services they wanted to see offered. Sample comments included:

People in this catchment area need a medicated, in-patient service which is open seven days.

Clients need more follow-up. Otherwise they just end up where they started and the cycle starts again.

Key informants were asked what they think of the service provided by Gorman House. The service was generally held in very high regard by six key informants. Typical comments included:

Gorman House has the reputation that for the clients they do look after, they look after well.

The service is highly regarded and professional.

One key informant mentioned that it was good that you can usually get someone a bed quickly on Monday and Tuesday (these are the days when Gorman House accepts admissions). Whereas another mentioned that it was hard to work with Gorman House because they only admitted on Monday and Tuesday. One key informant thought there was sometimes a long delay between requesting that Gorman House assess someone and when the telephone assessment is conducted. The key informant added that this decreased the likelihood of the person beginning detoxification as they are often reluctant to wait. One key informant described Gorman House as a fairly basic detoxification service. Another mentioned Gorman House seemed very insular and didn't have any definitive links with other agencies.

Key informants were asked about the feedback they receive from their clients about Gorman House. The majority (10) of key informants mentioned that had generally

received positive feedback or no real complaints about Gorman House. Two key informants had received positive comments about the staff, one had heard clients liked the food and another said some clients thought the BBQ and videos were good. Sample comments included:

> *Gorman House has an excellent reputation. Those clients who are motivated to change almost always have positive reports.*
>
> *Older alcoholics like the staff at Gorman House, and it's familiar.*

One key informant had received feedback that there was not enough group work to keep residents occupied. A degree of anxiety was associated with the mandatory Friday discharge, and another key informant reported this as the reason some people were less inclined to go to Gorman House. One key informant mentioned that it was very easy to get in to Gorman House again and again, and this suited some people. Another commented that some clients thought it was too easy to leave Gorman House (e.g. residents can leave on the second day) which made recidivism more likely. In relation to this, one key informant also reported that some people thought Gorman House was too close to areas where they could be tempted to use. One key informant commented that they hear different things about Gorman House, usually negative, but added that most people's experiences of detoxification are not positive anyway. Another key informant said some people, especially those detoxifying for the first time, say Gorman House is a bit of a 'wake-up call', due to the large number of 'hardcore' users.

Key informants were asked if they think Gorman House occupies a unique niche among detoxification services. Almost half (7) of the key informants mentioned that the service was definitely unique or unique in some respects. Of these, one key informant commented it was one of the longest running units and the staff have a wealth of knowledge. Another thought what made the service unique was that it operated only five days per week. Three key informants described Gorman House as an essential service, rather than as a unique one. Four key informants commented that the detoxification provided by Gorman House was a duplication of services and not especially unique. Sample comments included:

> *It's unique in the way it's not confronting for clients like some other detoxes.*
>
> *It's a special place. Not too many places for the alcoholic or druggie to go when they are sick and tired of being sick and tired.*
>
> *There are not a lot of services in the East, therefore it is essential.*
>
> *Gorman House has a similar role to other detoxes. It takes on some people other detoxes don't, but I wouldn't say it occupies a niche.*

Key informants were asked to state their views in relation to the current model of service at Gorman House which provides a detoxification of five days duration. Seven key informants described the current model of service as limiting to some extent and five held strong, negative views about it. Typical comments included:

> *Admission to Gorman House on Monday is the optimal day for the detox process, which is very limiting.*

It's a formula for failure. You're not going to get people detoxed.

One of the key informants who thought the detoxification was too short commented that the staff must be operating under a 'pressure-cooker' situation. Another mentioned that as Gorman House residents need to be well enough for discharge by Friday, the service can only admit very low threshold people. The current model of service was seen to put pressure on other services in the network by one key informant. This key informant mentioned that it was not uncommon to receive calls from Gorman House on Friday about the referral of a resident still in detoxification. One key informant commented that they were not really aware of the current model of service, and stated that the reason for this was not having made many referrals.

Key informants were asked to remark on how Gorman House deals with people who have special needs, such as those with acute mental illness or medical conditions. A majority (7) of key informants said they could not comment on this, and not having much contact with these types of people was frequently given as the reason. One of these key informants mentioned, however, that these kinds of people challenge any drug and alcohol service. This key informant also added that it would be useful to know what protocols Gorman House has developed to manage these people. Three key informants commented positively on the work Gorman House does with residents with dual diagnosis. One key informant would refer these types of people to Gorman House only if alcohol or drug dependence was their primary problem. Two key informants mentioned they would refer elsewhere if mental illness was the person's primary problem. One key informant remarked that many people like this are seen by mental health services, even though their primary problem is alcohol or drug dependence. Another key informant commented that Gorman House needs to address the assessment of their residents' mental health needs (e.g. suicide assessment) in a structured way, and added that, at present, Gorman House only 'catch' the mentally unwell when there is a crisis. Typical comments included:

I am aware of some of the work they do, psych reviews for example, which is really sound.

We don't refer people with complications to Gorman House, we would try somewhere where there is nursing staff first.

Key informants were asked whether they thought there were any areas of improvement for Gorman House and what changes, if any, they would like to see. Once again, almost all (13) key informants mentioned they wanted to see the service restored to seven day operation. Four key informants thought that medical or nursing staff should be provided, and, in relation to this, it was suggested that maybe a medical officer present for half an hour a day would give the service more flexibility. Three key informants commented that detoxification should be fully medicated. One key informant thought that Gorman House should provide some mental health workers, and also suggested operating four beds for challenging residents staffed by nurses. Two key informants commented on the need for better discharge planning with more follow-up. The need for more clarity about how Gorman House prioritises admissions was identified by another key informant. One key informant remarked that the services provided by Gorman House should be expanded in general. Providing benzodiazepine withdrawal was one suggestion. The provision of more education, group work or courses was suggested by two key informants, and health information sessions, yoga, meditation and internet classes were

given as examples. Two key informants recommended that facilities be improved, and suggestions included extending the premises, providing more beds and creating a 'time-out' space. In addition, it was mentioned that the small size of the staff area made it difficult to maintain confidentiality when interviewing or assessing people. Sample comments included:

> *Just increase operation to seven days, otherwise the standard of service is very professional.*
>
> *Non-medicated services don't really work. Clients have to be at the very low end of dependence, and even then there are problems.*
>
> *Better discharge planning …Actually move them on to rehab; detox is a waste of time if they can't get straight in to rehab.*
>
> *More focus on positive living courses …Gorman House needs to be more holistic, not just BBQs and videos, they're just band-aid solutions.*

One key informant thought Gorman House had a reputation for being a bit of a 'drunk tank', and that it should try and 'pitch itself higher' to raise its profile. A suggestion included providing more consistent service from staff when interacting with other agencies. Two key informants commented that they would like to develop a better working relationship with Gorman House. Some strategies suggested included increasing communication between agencies and establishing service agreements.

At the end of the interview, key informants were given an opportunity to make any other comments about Gorman House. Five key informants made comments which were generally quite positive about the value they placed on the service. Two key informants specifically stated they would not want to see Gorman House closed. Two key informants mentioned that the closure of Gorman House over Christmas impacted dramatically on their own service, and one commented that it was like 'the tap was turned off'. Five key informants remarked that there was scope for improvement in the service. One suggestion included more clearly defining the guidelines on who Gorman House can, and can not, admit. Some typical comments included:

> *We appreciate the cooperation of Gorman House; staff are very willing to help.*
>
> *Our relationship with Gorman House over the years is consistent and valued, but could be far more valuable.*
>
> *I don't want to see Gorman House closed, I want to see it fully functional.*
>
> *Gorman House needs to move on …The days of the old drunk are over, it's about poly-drug use now.*

4.5 Key components of resident care

The clinical notes (entered in CHIME) of 20 randomly selected participants (25% of residents) were reviewed in relation to key components of care. This was done not only to determine the extent to which these areas of care were regularly attended to, but to identify incidents, emergencies, or other patterns of activity not recorded elsewhere.

A list of key components was developed after discussion with the service manager and examining organisational policies and protocols. These included: a comprehensive admission interview, an individual management plan, referral to Haymarket Clinic (and other drug and alcohol services as necessary), resident safety and the monitoring of withdrawal symptoms. The review of clinical notes undertaken in this evaluation determined if particular aspects of care had been 'noted' or 'not noted' by the attending staff member. It is likely that in some instances, due to variations in clinical workload at times, aspects of care were provided by staff but may not have been documented. Findings are presented in Table 22.

Table 22: Key components of resident care, as noted by staff

Key components of resident care noted	N (%)
Admission interview	
Source of referral	8 (40)
Primary drug of concern	20 (100)
Other drugs of concern	11 (55)
Level of intoxication	12 (60)
Usual daily consumption	18 (90)
Usual daily consumption accurately quantified	14 (70)
Amount consumed on day of admission	10 (50)
Length of substance use	18 (90)
Any medical problems	18 (90)
Any mental health problems	6 (30)
Resident's own medications stored	19 (95)
Current withdrawal symptoms	14 (70)
Previous withdrawal symptoms (including severe symptoms)	2 (10)
General observations	19 (95)
Management plan	
Management plan negotiated with resident	19 (95)
Management plan negotiated within 24 hours of admission	17 (85)
Immediate issues of care	14 (70)
Short-term goals	16 (80)
Long-term goals	13 (65)
Personal care/nutrition issues	7 (35)
Discharge plan	17 (85)
Referral	
Referral to Haymarket Clinic	15 (75)
Attendance at Haymarket Clinic	11 (55)
Referral to any other agency	16 (80)
Referral to drug and alcohol treatment agency	11 (55)
Resident safety and withdrawal symptom monitoring	
Safety check completed half hourly	20 (100)
Withdrawal symptoms described	18 (90)
Medical complication as a result of withdrawal described	5 (25)

Most (85%) clinical notes in the random sample had been updated at least once per shift (e.g. morning, afternoon and night). It was documented that one resident had been involved in a medical emergency, and in this case it was noted that the resident had been referred to St. Vincent's Hospital Emergency Department. It was documented that one

resident had expressed suicidal ideation; however, it was not noted if the crisis team had been contacted. Documentation of history of withdrawal symptoms (especially severe symptoms), 'triggers' for drug and alcohol use, discussion of daily living skills, hepatitis C education, and instruction on relaxation techniques were noted in only a small minority of the clinical notes reviewed. In the sample, two out of five female admissions were completed by female members of clinical staff. It had not been documented in the selection of notes reviewed that female residents were screened for domestic violence.
It must be reiterated, however, that absence of documentation of these aspects of care does not imply absence of activity in the relevant area.

5. DISCUSSION

This study aimed to determine the extent to which Gorman House meets its aims and goals, and the needs of the residents. All relevant information from the evaluation is summarised under each aim of the evaluation.

5.1 Who attends Gorman House?

The characteristics of the 392 individuals who constituted 828 admissions to Gorman House over the twelve month period reveal that residents are predominantly Australian born, alcohol dependent men in their fifth decade who are alone, are homeless or live in shelters and refuges, receive pensions or temporary benefits, and have had previous residential or in-patient admissions for detoxification. One-third inject their main drug of concern (heroin or methamphetamine), but more than that (44%) have injected substances within the last three months. Poly-drug use in this sample is the norm rather than the exception.

Interviews with the 80 study participants, who closely resembled other admissions, provided a greater depth of information regarding Gorman House residents. Approximately half the sample had never been married; two-thirds had completed 10 or more years of education. About three-quarters of those who consumed alcohol (73%) had severe alcohol dependence. Median dependence scores for those residents who used heroin, cocaine, amphetamines and cannabis were substantially higher than the accepted cut-off scores. Over half the sample reported having experienced severe withdrawal symptoms (e.g. seizures, delirium tremens, hallucinations), and mostly during the previous 12 months.

Physical health was impaired in two-thirds of residents, and one-fifth of residents had severe physical impairment. Over one-quarter of the sample was hepatitis C positive. There was substantial health service utilisation during the previous four weeks which included contact with ambulance officers, emergency department visits and overnight admissions for substance-related problems.

Nine out of ten residents had mental health impairment; in half the cases this was in the severe range. One out of ten residents was screened as having sufficient psychotic symptoms to suspect schizophrenia or schizoaffective disorder. Psychological or psychiatric distress, measured using the K10, was present in all but three residents; about half the residents had moderate distress and the other half had high psychological distress. These rates are substantially higher than the rates of distress found in the general community in Australia. A similar pattern was found using the Beck measures of depression and anxiety. Just under one-half the residents have moderate to high anxiety symptoms and two-thirds have moderate to high depression symptoms. Suicidal ideation, but no intention to carry out suicide, was present in four out of ten residents and active suicidal intent was identified in four residents. Although, based on brief screening, one in ten residents may have had serious mental illness, the majority of residents most probably experienced more transient anxiety, depression and general distress, possibly related to recent personal crises and the discomfort associated with withdrawal from alcohol and other drugs.

The experience of trauma (having ever experienced one or more stressful or upsetting events) was reported by four in ten individuals. In most cases, they reported experiencing between one and three types of traumatic events. Predominantly, these were witnessing someone being badly injured or killed, being seriously physically attacked or assaulted, being threatened with a weapon, held captive or kidnapped, or having a life-threatening accident. One in ten men and six out of ten women also reported being raped. These events are generally associated with post-traumatic stress disorder (PTSD). A full diagnosis of PTSD, which would have required eliciting additional information, was not made in this study.

Two-thirds of residents had been admitted to Gorman House before with a median of four previous admissions. Following their last admission, one-fifth had gone on to residential alcohol and other drug treatment, one-third went on to rented accommodation and about one-third were homeless (13%) or went on to shelters and hostels (19%).

Four-fifths of participants expressed their intention to reduce or quit their drug of concern or had already made some changes towards this goal. One-fifth expressed recognition, albeit not readiness, to change their substance use but no one expressed satisfaction with their current drug use. Consistent with these figures, half the sample endorsed their main reason for seeking admission to Gorman House as wishing 'to enter ongoing treatment (such as rehabilitation or counselling)' for their substance use; whereas one-third wanted mainly to 'sober up' or 'take a break from substance use'. When asked about their plans within the three months of discharge from Gorman House, nearly half the sample described seeking treatment for their alcohol and other drug use; two-thirds envisaged abstinence from alcohol and other drug use, training or employment and stable accommodation.

5.2 Who is referred to Gorman House and who is not?

Some key informants described referring to Gorman House those individuals who do not require a medicated detoxification, are not expected to have a complicated withdrawal, or those who request a referral to Gorman House. Some key informants acknowledge that it may be difficult at times to differentiate those individuals who may use Gorman House as respite from homelessness - for whom crisis accommodation would be a more appropriate choice - from individuals who genuinely need detoxification.

Among the individuals who are not referred to Gorman House are those who require medicated detoxification or are likely to have a more complicated withdrawal, such as individuals withdrawing from alcohol with a history of seizures or those withdrawing from multiple substances. Key informants tend to not refer those who require a longer period of supervised withdrawal or heroin users, as they may need withdrawal facilitated by buprenorphine. Individuals with complex or acute mental health problems are similarly not referred by key informants. Individuals with a higher level of functioning, female substance users, and young people are also not referred to Gorman House because of the view that residents are predominantly older, more debilitated men.

5.3 Waiting time prior to admission

In terms of waiting time for admission, just over half the sample was admitted on the same day they sought admission. Half of those who were not admitted reported being told that admissions to Gorman House had closed for the week (due to five-day per week opening). Participants with previous admissions to Gorman House were asked about the ease of access to Gorman House on previous attempts to seek admission. More than half said there had been times when Gorman House was full and a bed was unavailable. At such times, the majority would continue to use substances until a bed became available, while about one-fifth sought help elsewhere.

Participants were asked where else they could have gone should an admission to Gorman House have been impossible on this occasion. About half stated they would have sought assistance elsewhere (either treatment or accommodation); the other half reported either going home and waiting or remaining on the streets until a bed was available, or not knowing what they would do.

5.4 Completion of withdrawal and length of stay

Within the delineated five-day per week operation of Gorman House, the median duration of admissions was three days (ranging between zero and four). Based on clinician assessment (MDS), two-thirds of residents were deemed to have completed their substance withdrawal within the stipulated five days; one-third of residents did not complete withdrawal from their presenting substance, leaving 'against advice', 'without notice' or, more rarely, 'involuntarily'. Participants who completed treatment were more likely to be dependent on alcohol than heroin or other opioids. Residents presenting for alcohol withdrawal or methamphetamine remained at Gorman House a median of one day longer than heroin dependent residents. Heroin dependent residents, compared with other residents, were two and a half times more likely to 'leave against advice', leaving a median of one day earlier, before completing treatment. Based on the criterion of treatment completion, it would appear that Gorman House meets the withdrawal needs of individuals whose principal drug of concern is alcohol or methamphetamine but is less likely to meet the needs of individuals with heroin or other opioid dependence.

5.5 Referral to treatment network

Two-thirds of residents were referred elsewhere for ongoing treatment. Of these, one-third appear to have been sent for treatment of acute medical or psychiatric conditions, others were sent to residential drug and alcohol treatment and other more extended treatment or care. Those who were not referred were more likely to have left without notice or against advice.

5.6 Perception of the service

5.6.1 Residents

When asked about their reasons for seeking admission to Gorman House, over half the sample reported liking the service or having it recommended to them by other services or individuals; the other half reported reasons of familiarity with the service and easy access. Consistent with the fact that two-thirds of residents had been admitted to Gorman

House before, nine out of ten participants would return to Gorman House should they require detoxification in the future.

There was high participant satisfaction with Gorman House. Residents' responses to open-ended questions revealed that one of the most appealing aspects of Gorman House are the staff and their care. Program characteristics were a source of appeal as well as complaint. The unstructured and un-pressured approach was also associated with boredom and the disruptive behaviour of other residents. Restricted opening hours and non-medicated withdrawal were other disliked aspects of Gorman House. One in ten residents would like to see a program or greater structure introduced and seven-days per week opening; half of all residents would prefer a seven day service operation.

When asked about their perception of how safe they felt at Gorman House, nine out of ten participants reported feeling 'safe' or 'very safe'. Three participants felt 'unsafe', stating that they were concerned about other residents becoming agitated or violent, and about their property being stolen.

5.6.2 Staff

Consistent with the residents' own accounts, all staff believed residents to be satisfied with the services they receive at Gorman House. Most staff perceived the main reason most residents sought admission to Gorman House was 'to have a break from drinking and /or substance use for a while'. This differs somewhat from the residents' reports that their primary reason for seeking treatment is 'to enter ongoing treatment (such as rehabilitation or counselling)'. All staff believed that withdrawal management at Gorman House was conducted 'adequately' and 'very adequately' and nine believed the general medical care provided to residents, through access to Haymarket Clinic, Rankin Court Treatment Centre and St. Vincent's, is 'adequate' or 'very adequate'. Treatment planning was regarded by most as being carried out adequately, as was referral to ongoing community care.

Psychiatric care was viewed by six staff as being adequate; some staff saw shortcomings in the provision of psychiatric care, which was seen as not always available.

Most staff rated the quality of the shelter and food as 'adequate' or 'very adequate', although, in agreement with assertions made by residents themselves, some staff were concerned about the 'dormitory style rooms'. All staff viewed the quality of the admission process as 'adequate' or 'very adequate'.

Seven out of nine staff thought early discharge from Gorman House was usually related to drug craving. This is consistent with the finding, based on the MDS data, that leaving treatment prior to completion of withdrawal was more strongly associated with heroin dependence than dependence on any other drug. Withdrawal from heroin without opioid replacement (methadone or buprenorphine) has been found to be associated with withdrawal treatment attrition before (Sannibale et al., 2005).

Five day opening was a concern to many staff. The main view was that it excessively restricted resident access to treatment, by limiting admission to only one or two days, and hindered arrangements of discharge planning. Staff were concerned that a proportion of residents were being discharged when still unwell, which in their view impeded treatment planning and undermined successful referral to residential treatment.

With regard to the staff's own satisfaction with Gorman House, there was some dissatisfaction with the physical work environment, specifically the crowded office space. There was a general perception of lack of support received by staff following an emergency or critical incident. Although most staff felt their training and skills prepared them well for work at Gorman House, they noted an absence of ongoing training and supervision, a low morale, and sometimes being asked to perform duties outside their skill base.

Staff were not very satisfied with the range of services delivered at Gorman House. Some staff would like to see educational or living skills programs introduced.

5.6.3 Key informants

The key informants component of the evaluation provided valuable independent feedback on many aspects of the functioning of Gorman House. Key informants viewed Gorman House very favourably, stating that it provides an important, if not unique, role in caring for a difficult and very disadvantaged group. There was reasonable consensus and understanding on who should or should not be referred to Gorman House. Individuals appropriate for admission were described as those substance users who needed supervision during withdrawal as well as respite from homelessness; those with predominantly uncomplicated detoxification needs, who did not require medication (thus excluding heroin users who need opioid maintenance or buprenorphine); and those who did not have acute or serious mental health concerns.

In agreement with the views expressed by staff, there was consensus among key informants that to operate optimally Gorman House needed to return to its seven day opening. The current five day operation was seen as detracting from its ability to provide the necessary care to a proportion of its residents, which, in turn, would impact on staff morale.

Key informants described the staff as having extensive knowledge of their field and being well regarded by consumers. The ready access to Gorman House and its basic services were viewed as appealing to its needy consumers. The corollary of this was that perhaps Gorman House needed to develop further to keep abreast of the more complex needs of its current consumers, including needs for medication, and to ensure that its services are delivered to the appropriate target group.

Some key informants saw a need for a better integration of Gorman House within the wider network of services, especially to improve links with services that provide ongoing treatment. They expressed a desire to have stronger and clearer lines of communication with Gorman House and a clearer definition and statement of its scope and the limits to its clinical capacity. Some wanted to see: improved discharge plans and follow-up; protocols to deal with complex cases; a structured assessment for acute mental health needs, especially suicidality; and the recruitment of nursing and mental health staff to facilitate the capacity to manage more complex presentations (medical and psychiatric). Others would like to see an increase in beds, especially for women, and the introduction of a more structured program (e.g. group work for residents).

5.7 Does Gorman House cater to its intended client group?

These demographic and clinical descriptors reveal a group of socially marginalised individuals who are mentally and physically impaired. These heavily substance-involved and affected individuals, who present to health services on a frequent basis, express a desire to change their alcohol and other substance use but are clearly struggling to do so. Two-thirds of these individuals appear to complete withdrawal during their brief admission at Gorman House and are referred for further treatment. About one-third of individuals, those whose primary drug of concern is heroin, appear to not benefit from an admission to Gorman House as it currently operates. Another, smaller, group of residents, who may need further scrutiny, comprises individuals who are discharged the same day of admission (some of whom are described as having 'completed treatment', while others leave without notice or are transferred).

5.8 Summary and recommendations

Gorman House is one of few services in Sydney providing detoxification to a group of very disadvantaged individuals, who in many cases do not meet criteria for admission to other detoxification services. It occupies a very important place in a treatment environment in which there are now very few beds for supervised detoxification. Gorman House performs its demanding role with limited resources and a capable staff very committed to their work. The views expressed by residents, staff and key informants in this evaluation broadly converged on several aspects of Gorman House that may need some attention. The areas of improvement and recommendations identified in this evaluation and enumerated below may assist Gorman House to achieve its goals even more successfully.

1. The residents who benefit most, in terms of treatment completion, are those who present with alcohol, methamphetamine or 'other drug' dependence. Heroin dependent residents are more likely to leave without completing withdrawal. This suggests that their needs are not being adequately met. Increasing access to buprenorphine and agonist medication to heroin dependent residents may better facilitate withdrawal completion or maintenance for this group.

2. There is little doubt that Gorman House residents are socially marginalised, mentally and physically unwell, and need residential drug withdrawal. There may be a small group of individuals whose primary needs are respite from homelessness and for whom detoxification may be a less urgent need. Although to exclude these individuals is somewhat at odds with the purpose and goals of Gorman House, improved screening (and referral) may reduce the number of admission-day discharges.

3. Many staff, key informants and residents requested the introduction of some structured activity or program. The exact nature of these activities would need to be explored, tailored to the special needs of residents and tested for relevance and appeal. Examples might include skills training and health education, or more therapeutic activities targeting residents who are interested and well enough to participate.

4. There was a strong consensus among staff, key informants and residents that five-day per week service opening undermined the functioning of Gorman House. The five-day operation was viewed as having an adverse effect on service

access and referral patterns (individuals who require a longer period for withdrawal would not be referred), as well as impinging on the staff's ability to organise referral and ongoing treatment for residents. Some key informants voiced the concern that restricted service opening may adversely affect staff morale as staff are expected to discharge clients including those who are still quite unwell. A return to seven-day service opening was regarded as necessary for Gorman House to perform its role adequately as a supervised withdrawal service for disadvantaged, homeless alcohol and other drug dependent individuals.

5. The staff, who were generally very well regarded by residents and key informants alike, expressed some dissatisfaction that may need prompt attention. Apart from their main concern in relation to five-day service opening, staff perceived a lack of support from management following emergencies or critical incidents. This could be addressed by assessing the staff's need for support following these incidents and developing protocols outlining how support would be implemented following an emergency or critical incident.

6. A further source of dissatisfaction among staff was the absence of ongoing training and supervision. The staff, who felt well-prepared for their roles and were described by key informants as skilled and knowledgeable, would benefit from access to ongoing training and supervision. The provision of, or facilitation of access to, training and supervision may be expected to boost staff morale and feelings of self-efficacy.

7. There were concerns voiced by some key informants and staff that at present Gorman House may have a limited ability to detect and manage mental health problems among residents. This could be addressed through staff training, recruitment of professionals with specific mental health experience, as well as the introduction of more structured assessment and standardised instruments to assess mental health problems (e.g. suicidality). Furthermore, partnerships and referral arrangements with mental health services, especially within St. Vincent's Hospital, may need to be clarified and strengthened to improve and increase access to psychiatric care.

8. Comments from key informants suggest a need to clarify for other agencies the intended target group of Gorman House and the scope of the service it provides. The development of clearer guidelines and policies in this regard may be a timely undertaking in view of the changing characteristics and needs of Gorman House residents.

9. There were some complaints from residents, key informants and staff about the 'dormitory-style' accommodation. Smaller rooms accommodating three to four residents may be preferable and allow greater flexibility of use (e.g. increasing the number of female admissions).

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APPENDIX 1: PERMITTED WITHDRAWAL MEDICATIONS

Alcohol dependent residents with a history of severe withdrawal symptoms, seizures or delirium tremens are requested to obtain diazepam prior to their admission, according to the following regime:

Day 1: 20mg twice daily
Day 2: 15mg twice daily
Day 3: 10mg twice daily
Day 4: 5mg twice daily
Day 5: nil

Heroin dependent residents may obtain symptom-relieving medications prior to admission. However, heroin dependent residents are not permitted to take diazepam or other benzodiazepines specifically for withdrawal purposes.

APPENDIX 2: RESIDENT QUESTIONNAIRE

Process evaluation of Gorman House non-medicated detoxification unit

Client questionnaire

Participant _____
CHIMES_____

Date of interview _____
Day _____
Start time _____ End time _____

Interviewer _____

I would like to ask you some information about yourself and your time at Gorman House.

During this interview I will ask questions about your drug use, treatment history and emotional and physical well-being. I will also ask about your experiences while you have been at Gorman House. Your participation in this interview will not affect your treatment at Gorman House in any way.

It is important that you know that any information you give me will be kept **confidential**. None of the treatment staff at Gorman House will have access to this information.

The interview will take about 1.5 hours. We will take a break half way through. If you need other breaks or have any questions at any stage please feel free to stop me. If there are any questions that you do not want to answer let me know. As I mentioned, any information you give me **will be kept confidential**.

DEMOGRAPHICS

Firstly, I'd like to begin the interview by asking you some general questions.

1. *[Note: gender]:*

   Male ____
   Female ____
   Transgender ____

2. How old are you? _____

3. What is your relationship status?

   De-facto ____
   Married ____
   Widowed ____
   Separated ____
   Divorced ____
   Never married ____

4. What is the highest level of education you have attained?

   Never attended school ____
   Attended primary school ____
   Attended secondary school ____
   Completed School Certificate ____
   Completed Higher School Certificate____
   TAFE ____
   Teachers' college ___
   University degree ____
   Other _____

5. Are you currently employed?

   Yes ____ [go to q6]
   No ____

   5a. If NO, how long ago has it been since you had paid employment (if ever)?

   ____ weeks, or
   ____ months, or
   ____ years.

6. What has been your main occupation? _____

7. At the moment, are you involved with the legal system in any way? (i.e. on parole, court case, solicitors, etc)

   Yes ____
   No ____ [go to q8]

   7a. If YES, in what way? _____

8. Are you concerned about your use of alcohol or other drugs?

   Yes ____
   No (go to q10) ____

   8a. If YES, which drug concerns you **the most**?

   _____

   8b. Apart from *[main drug of concern],* are you concerned about your use of any other drugs (or alcohol)? *[List other substances of concern.]*

   _____

9. For this question I'm going to show you a card with five statements. Which statement best describes how you feel about your current use of *[main drug of concern]*? *[Give participant card with response options.]*

1. I am happy with my drug use, I don't feel the need to quit or cut down ____

2. I think I might need to quit or cut down but I am not sure I want to ____

3. I have made real plans to quit or cut down ____

4. I have recently started to quit or cut down ____

5. I have already cut down or quit some time ago ____

10. Have you ever detox'ed from alcohol or drugs before?
Yes _____
No (go to q12) _____

10a. If YES, [excluding this time] how many times? No. of times _____

10b. How many times have you detox'ed in residential settings like Gorman House [exclude this admission]. _____

11. Have you ever had severe withdrawal symptoms (eg DTs, seizures)?
Yes _____
No (go to q12) _____

11a. If YES, how long ago did you last have severe withdrawal symptoms?
___ days ago OR ___ weeks ago OR ___ months ago OR ___ years ago

The next few questions are about your admission to Gorman House this time.

12. On which day of the week did you 'phone for a place at Gorman House? _____

12a. On which day of the week did you <u>actually</u> get a place at Gorman House?_____

12b. If you didn't get a place on the day you 'phoned, why not? _____

13. How many days have you been at Gorman House so far? _____ days.

14. In the **week before** you came to Gorman House?

	(a) Where did you stay MOST of the time? *[Tick only ONE]*	(b) Where ELSE did you stay? *[Tick all that apply]*
Rented house (public or private)		
Privately owned house or flat		
Boarding house		
Hostel/supported accommodation service		
Psychiatric home/hospital		
Alcohol/other drug treatment residence		
Shelter/refuge		
Prison/detention centre		
Caravan on a serviced site		
No usual residence/homeless		
Other *[Please state]*		
Don't know (or can't remember)		
Name of service, if known		

15. If you hadn't been able to get a bed at Gorman House this time, where would you have gone?
_____

16. I would like to ask you about your **main** reasons for coming to Gorman House. Which of the statements on this card *[hand participant the card]* best describes **your** reason for coming to Gorman House?

I came to Gorman House ….

1. mainly to get a bed and/or a decent meal _____

2. mainly to sober up / get straight for something important
(eg going to court, visiting kids, medical appointment) _____

3. mainly to have a break from drinking and/or using drugs for a while ____

4. mainly to get into treatment like rehab or counselling _____

5. other reasons _____

17. Why did you choose Gorman House and not another detox service?
_____

18. Are you under any pressure to come to GH, for example, from the courts, your employer, family, etc?

Yes _____ (Specify _____)
No _____

19. Have you ever been to Gorman House before?

Yes _____
No _____ (go to q21)
Can't remember _____ (go to q21)

19a. If YES, how many times (*excluding this admission*)? No. of times _____

19b. If YES, have you been to Gorman House when it was operating as a 7 day service?

YES ____
NO _____

19c. When was the **last time** you came to Gorman House?
[If "unsure", say "approximately"]

Month: _____ Year: _____

19d. How many days did you stay? No. of days _____

19e. Did you remain long enough to complete your withdrawal?

Yes (go to q19g) _____
No _____

19f. If you DIDN'T remain at Gorman House long enough to complete your withdrawal, please describe what happened.
_____

19g. The **last time** you were at Gorman House, *[state when that was],* where did you go when you left?

Rented house (public or private) _____
Privately owned house or flat _____
Boarding house _____
Hostel/supported accommodation service _____
Psychiatric home/hospital _____
Alcohol/other drug treatment residence _____
Shelter/refuge _____

Prison/detention centre _____
Caravan on a serviced site _____
No usual residence/homeless _____
Other _____
Don't know (can't remember) _____

Name of service, if known _____

20. In the past, have there been times when you could not get a bed at Gorman House when you wanted to?

Yes _____
No (go to q21) _____

20a. The last time you couldn't get a bed, what did you do?
_____

21. Where will go when you leave Gorman House at the end of this week?

Rented house (public or private) ___
Privately owned house or flat ___
Boarding house ___
Hostel/supported accommodation service ___
Psychiatric home/hospital ___
Alcohol/other drug treatment residence ___
Shelter/refuge ___
Prison/detention centre ___
Caravan on a serviced site ___
No usual residence/homeless ___
Other _____
Don't know (or can't remember) ___

Name of service, if known _____

22. After you leave Gorman House, do you have any thoughts or plans about what you might do and where you might be in the **next three months**? ***[If "don't know", ask:*** What do you think is most likely to happen.]
_____

The next few questions are about your experiences at Gorman House.

23. What are the things you like **most** about Gorman House?
_____
_____

24. What are the things you like **least** about Gorman House?
_____
_____

25. If you could change anything about Gorman House, what would it be?
_____
_____

26. Would you come back to Gorman House if you had to detox again?

Yes ___ [go to q27]
No ___
Not sure ___

26a. If NO or NOT SURE, why? _____

27. How safe or unsafe have you felt during your stay at Gorman House?

[Show card]

1	2	3	4	5
Very unsafe	Somewhat unsafe	Neither unsafe or safe	Somewhat safe	Very safe

27a. If you didn't feel safe, can you describe what makes/made you feel unsafe?

_____

28. Is there anything else you would like to say about Gorman House?

_____

_____

29. Do you have any comments about Gorman house being a 5 day service and closed over the weekend?

_____

_____

CSQ-8

[Self administered with assistance]

The following section asks more about your experiences of Gorman House. For these questions, indicate which response best applies to you [Show questions to participant]

1. How would you rate the quality of service you received?

4	*3*	*2*	*1*
Excellent	*Good*	*Fair*	*Poor*

2. Did you get the kind of service you wanted?

1	*2*	*3*	*4*
No, definitively not	*No, not really*	*Yes, generally*	*Yes, definitively*

3. To what extent has our program met your needs?

4	*3*	*2*	*1*
Almost all of my needs have been met	*Most of my needs have been met*	*Only a few of my needs have been met*	*None of my needs have been met*

4. If a friend were in need of similar help, would you recommend our program to him or her?

1	*2*	*3*	*4*
No, definitively not	*No, not really*	*Yes, generally*	*Yes, definitively*

5. How satisfied are you with the amount of help you have received?

1	*2*	*3*	*4*
Quite dissatisfied	*Indifferent or mildly dissatisfied*	*Mostly satisfied*	*Very satisfied*

6. Have the services you received helped you to deal more effectively with your problems?

4	*3*	*2*	*1*
Yes, they helped a great deal	*Yes, they helped somewhat*	*No, they really didn't help*	*No, they seemed to make things worse*

7. In an overall, general sense, how satisfied are you with the service you have received?

4	*3*	*2*	*1*
Very satisfied	*Mostly satisfied*	*Indifferent or mildly dissatisfied*	*Quite dissatisfied*

8. If you were to seek help again, would you come back to our program?

1	*2*	*3*	*4*
No, definitively not	*No, not really*	*Yes, generally*	*Yes, definitively*

The following questions ask about your use of alcohol and other drugs in the last 30 days.

OTI

***[Note**: for all categories, if the participant responds that their last use of the drug was **more than 30 days ago, score zero** for that category. Do not include use on day of interview.]*

1. Thinking about your use of **alcohol**

a. On what day did you last drink alcohol?

b. How much alcohol did you drink on that day?

Wine (13%)	**Spirits (40%)**	**Light beer (2.5%)**	**Reg. beer (4.8%)**	**Fortified wine (17.5%)**
Glass (100ml) [1.3]	Nips (30ml) [1.2]	Middies (285ml) [0.7]	Middies (285ml) [1.0]	Port glass (60ml) [1]
Bottles (750ml) [9.8]	Doubles [2.4]	Schooner (425ml) [1.1]	Schooners (425ml) [2]	Bottles (750ml) [13.1]
Flagons (2 lt) [26]	Bottles (750ml) [30]	Cans/stubbies (375ml) [0.9]	Cans/stubbies (375ml) [1.8]	Flagons (2 lt) [35]
Casks (__litre) [13 per lt]		Bottles (750ml) [1.9]	Bottles (750ml) [3.6]	
Number of standard drinks				
Total number of standard drinks =				

[Figures in square brackets are numbers of standard drinks in one unit]

c. On which day before that did you drink alcohol?

d. How much did you drink on that day?

Wine (13%)	**Spirits (40%)**	**Light beer (2.5%)**	**Reg. beer (4.8%)**	**Fortified wine (17.5%)**
Glass (100ml) [1.3]	Nips (30ml) [1.2]	Middies (285ml) [0.7]	Middies (285ml) [1.0]	Port glass (60ml) [1]
Bottles (750ml) [9.8]	Doubles [2.4]	Schooner (425ml) [1.1]	Schooners (425ml) [2]	Bottles (750ml) [13.1]
Flagons (2 lt) [26]	Bottles (750ml) [30]	Cans/stubbies (375ml) [0.9]	Cans/stubbies (375ml) [1.8]	Flagons (2 lt) [35]
Casks (__litre) [13 per lt]		Bottles (750ml) [1.9]	Bottles (750ml) [3.6]	
Number of standard drinks				
Total number of standard drinks =				

[Figures in square brackets are numbers of standard drinks in one unit]

e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

2. Thinking about your use of **heroin** (eg gear, smack)

a. On what day did you last use heroin?

b. How many hits/smokes/snorts did you have on that day?

c. On which day before that did you use heroin?

d. How many hits/smokes/snorts did you have on that day?

e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

3. Thinking about your use of **other opiates** (eg street methadone/done, morphine, pethidine, codeine)

a. On what day did you last use opiates other than heroin?
b. How many pills, doses etc did you have on that day?
c. On which day before that did you use opiates other than heroin?
d. How many pills, doses etc did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

4. Thinking about your use of **cannabis** (dope, grass, pot, hash).

a. On what day did you last use marijuana?
b. How many joints, bongs etc did you have on that day?
c. On which day before that did you use marijuana?
d. How many joints, bongs etc did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

5. Thinking about your use of **amphetamines** (speed etc).

a. On what day did you last use amphetamines?
b. How many tablets, snorts, hits etc did you have on that day?
c. On which day before that did you use amphetamines?
d. How many tablets, snorts, hits etc did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

6. Thinking about your use of **cocaine** (coke, crack etc).

a. On what day did you last use cocaine?
b. How many snorts, hits, smokes etc did you have on that day?
c. On which day before that did you use cocaine?
d. How many snorts, hits, smokes etc did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

7. Thinking about your use of **tranquilisers** (eg Serapax, Rohypnol, Mogadon, Valium).

a. On what day did you last use tranquilisers?
b. How many pills did you have on that day?
c. On which day before that did you use tranquilisers?
d. How many pills did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

8. Thinking about your use of **hallucinogens** (eg LSD, magic mushrooms, ecstasy)

a. On what day did you last use hallucinogens?
b. How many tabs, pills etc did you have on that day?
c. On which day before that did you use hallucinogens?
d. How many tabs, pills etc did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

9. Thinking about your use of **inhalants** (eg amyl nitrate, rush, glue, aerosols, petrol etc).

a. On what day did you last use inhalants?
b. How many sniffs did you have on that day?
c. On which day before that did you use inhalants?
d. How many sniffs did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

10. Thinking about your use of **tobacco**

a. On what day did you last use tobacco?
b. How many cigarettes did you have on that day?
c. On which day before that did you use tobacco?
d. How many cigarettes did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

11. Thinking about your use of any **other drug** not mentioned so far (eg Rivotril)

a. On what day did you last use _____?
b. How many pills did you have on that day?
c. On which day before that did you use _____?
d. How many pills did you have on that day?
e. When was the day before that?

q1=	q2=	t1=	t2=	**Q**

SDS

[Suitable for users of heroin, cocaine, amphetamine, cannabis.]

The next part of the interview asks more specific questions about how you feel about your use of certain drugs.
[Only ask for the categories of drug the participant has <u>used in the last 30 days</u>]

The following questions are about your drug use in the <u>30 days before</u> coming to Gorman House

Listen to the question, and from the listed responses, give the one which best applies to you.

Heroin	Never/almost never	Sometimes	Often	Always/nearly always
Do you think your use of heroin was out of control?	0	1	2	3
Did the prospect of missing a fix make you anxious or worried?	0	1	2	3
Did you worry about your use of heroin?	0	1	2	3
Did you wish you could stop?	0	1	2	3

	Not difficult	Quite difficult	Very difficult	Impossible
How difficult did you find it to stop or go without heroin?	0	1	2	3

SDS (heroin) Total: _____

Cocaine	Never/almost never	Sometimes	Often	Always/nearly always
Do you think your use of cocaine was out of control?	0	1	2	3
Did the prospect of missing a fix make you anxious or worried?	0	1	2	3
Did you worry about your use of cocaine?	0	1	2	3
Did you wish you could stop?	0	1	2	3

	Not difficult	Quite difficult	Very difficult	Impossible
How difficult did you find it to stop or go without cocaine?	0	1	2	3

SDS (cocaine) Total: _____

Amphetamine	Never/almost never	Sometimes	Often	Always/nearly always
Do you think your use of amphetamines was out of control?	0	1	2	3
Did the prospect of missing a fix make you anxious or worried?	0	1	2	3
Did you worry about your use of amphetamines?	0	1	2	3
Did you wish you could stop?	0	1	2	3

	Not difficult	Quite difficult	Very difficult	Impossible
How difficult did you find it to stop or go without amphetamines?	0	1	2	3

SDS (amphetamine) Total: _____

Cannabis	Never/almost never	Sometimes	Often	Always/nearly always
Do you think your use of cannabis was out of control?	0	1	2	3
Did the prospect of missing a fix make you anxious or worried?	0	1	2	3
Did you worry about your use of cannabis?	0	1	2	3
Did you wish you could stop?	0	1	2	3

	Not difficult	Quite difficult	Very difficult	Impossible
How difficult did you find it to stop or go without cannabis?	0	1	2	3

SDS (cannabis) Total: _____

Other drug _____	Never/almost never	Sometimes	Often	Always/nearly always
Do you think your use of _____ was out of control?	0	1	2	3
Did the prospect of missing a fix/dose make you anxious or worried?	0	1	2	3
Did you worry about your use of _____?	0	1	2	3
Did you wish you could stop?	0	1	2	3

	Not difficult	Quite difficult	Very difficult	Impossible
How difficult did you find it to stop or go without _____?	0	1	2	3

SDS (_____) Total: _____

For the following questions, you will need to think specifically about your use of alcohol in the past <u>six months</u>.

Read the following statements and select the response which best applies to you.

AUDIT

1. How often do you have a drink containing alcohol?

Never	Monthly or less	Two to four times a month	Two to three times a week	Four or more times a week

2. How many drinks containing alcohol do you have on a typical day when you are drinking?

1 or 2	3 or 4	5 or 6	7 to 9	10 or more

If participant answers *'Two to three times a week'* or more in question 1 AND *'5 or 6'* or more in question 2, then go to proceed to ICQ and SADQ. Otherwise, skip ICQ and SADQ and go to SF12 (p21).

ICQ [<u>SELF ADMINISTERED</u>]

During the past <u>SIX months</u>:

1. After having just one or two drinks, I felt like having a few more.

Never or almost never	Sometimes	Often	Nearly always

2. After having two or three drinks, I could stop drinking if I had other things to do.

Never or almost never	Sometimes	Often	Nearly always

3. When I started drinking alcohol, I found it hard to stop until I was fairly drunk.

Never or almost never	Sometimes	Often	Nearly always

4. When I went drinking, I planned to have at least six drinks.

Never or almost never	Sometimes	Often	Nearly always

5. When I started drinking, I planned to have no more than two or three drinks.

Never or almost never	Sometimes	Often	Nearly always

SADQ

During the past SIX months:

1. The day after drinking alcohol, I woke up feeling sweaty.

Almost never	Sometimes	Often	Nearly always

2. The day after drinking alcohol, my hands shook first thing in the morning.

Never or almost never	Sometimes	Often	Nearly always

3. The day after drinking alcohol, my whole body shook violently first thing in the morning if I didn't have a drink.

Never or almost never	Sometimes	Often	Nearly always

4. The day after drinking alcohol, I woke up absolutely drenched in sweat.

Never or almost never	Sometimes	Often	Nearly always

5. The day after drinking alcohol, I dread waking up in the morning.

Never or almost never	Sometimes	Often	Nearly always

6. The day after drinking alcohol, I was frightened of meeting people first thing in the morning.

Never or almost never	Sometimes	Often	Nearly always

7. The day after drinking alcohol, I felt at the edge of despair when I woke.

Never or almost never	Sometimes	Often	Nearly always

8. The day after drinking alcohol, I felt very frightened when I woke up.

Never or almost never	Sometimes	Often	Nearly always

9. The day after drinking alcohol, I liked to have an alcohol drink in the morning.

Never or almost never	Sometimes	Often	Nearly always

10. The day after drinking alcohol, I always gulped my first few alcoholic drinks down as quickly as possible.

Never or almost never	Sometimes	Often	Nearly always

11. The day after drinking alcohol, I drank more alcohol in the morning to get rid of the shakes.

Never or almost never	Sometimes	Often	Nearly always

12. The day after drinking alcohol, I had a very strong craving for a drink when I woke up.

Never or almost never	Sometimes	Often	Nearly always

13. I drank more than a quarter of a bottle of spirits (OR 1 bottle of wine OR 7 beers) in a day.

Never or almost never	Sometimes	Often	Nearly always

14. I drank more than half a bottle of spirits (OR 2 bottles of wine OR 15 beers) in a day.

Never or almost never	Sometimes	Often	Nearly always

15. I drank more than one bottle of spirits (OR 4 bottles of wine OR 30 beers) in a day.

Never or almost never	Sometimes	Often	Nearly always

16. I drank more than two bottles of spirits (OR 8 bottles of wine OR 60 beers) in a day.

Never or almost never	Sometimes	Often	Nearly always

For the next few questions, imagine the following situation:

> You have hardly drunk any alcohol for a few weeks.
> THEN, you drink **very heavily for two days.**

How would you feel the **morning after** those two days of heavy drinking?

17. I would start to sweat.

Not at all	Slightly	Moderately	Quite a lot

18. My hands would shake.

Not at all	Slightly	Moderately	Quite a lot

19. My body would shake.

Not at all	Slightly	Moderately	Quite a lot

20. I would be craving for a drink.

Not at all	Slightly	Moderately	Quite a lot

SF-12

The following questions ask about your health and how well you are able to do your usual activities. [Interviewer administered].

1. In general, would you say your health is:

Excellent	Very good	Good	Fair	Poor

The following questions are about activities you might do during a typical day. Does your health now limit the way you do these activities? If so, how much?

		Yes, limited a lot	**Yes**, limited a little	**No**, not limited at all
2.	Moderate activities, such as moving a table.	☐	☐	☐
3.	Climbing several flights of stairs.	☐	☐	☐

During the past week, have you had any of the following problems with your work or other regular daily activities as a result of your physical health?

		YES	**NO**
4.	Accomplished less than you would like.	☐	☐
5.	Were limited in the kind of work or other activities.	☐	☐

During the past week, have you had any of the following problems with your work or other regular daily activities as a result of any emotional problems (such as feeling depressed or anxious)?

		YES	**NO**
6.	Accomplished less than you would like.	☐	☐
7.	Didn't do work or other activities as carefully as usual.	☐	☐

8. During the past week, how much did pain interfere with your normal work or daily activities?

Not at all	A little bit	Moderately	Quite a bit	Extremely

These questions are about how you feel and how things have been with you during the past week. For each question, please give the one answer which is closet to the way you have been feeling.

How much of the time during the past week:

		All of the time	Most of the time	A good bit of the time	Some of the time	A little of the time	None of the time
9.	Have you felt calm and peaceful?	☐	☐	☐	☐	☐	☐
10.	Did you have a lot of energy?	☐	☐	☐	☐	☐	☐
11.	Have you felt downhearted and blue?	☐	☐	☐	☐	☐	☐

12. During the past week, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc)?

All of the time	Most of the time	Some of the time	A little of the time	None of the time

Blood-borne viruses

1. This first question is about blood-borne viruses, like hepatitis C and HIV. If you feel uncomfortable about answering any of the questions below, please tell me and we can skip to the next question.

1a. Have you been tested for hepatitis C?

No ____ (Skip to 1d.)
Yes ____

1b. If Yes, how long ago did you have a test?

No. of years ____ **or** no. of months ____

1c. What was the test result? _____

1d. Have you been tested for HIV?

No ____ (Skip to next section, K10)
Yes ____

1e. If Yes, how long ago did you have a test?

No. of years ____ **or** no. of months ____

1f. What was the result? _____

The following questions ask about your mental health and the way you have been feeling. Read the questions below and select the response most appropriate to you.

K10 [SELF ADMINISTERED]

The next questions are about how you have been feeling during the **last 30 days.**

During the last 30 days about how often did you feel…

During the last 30 days, about how often did you feel……	**None of the time**	**A little of the time**	**Some of the time**	**Most of the time**	**All of the time**
Tired out for no good reason?	**1**	**2**	**3**	**4**	**5**
Nervous?	**1**	**2**	**3**	**4**	**5**
So nervous that nothing could calm you down?	**1**	**2**	**3**	**4**	**5**
Hopeless?	**1**	**2**	**3**	**4**	**5**
Restless or fidgety?	**1**	**2**	**3**	**4**	**5**
So restless that you could not sit still?	**1**	**2**	**3**	**4**	**5**
Depressed?	**1**	**2**	**3**	**4**	**5**
That everything was an effort?	**1**	**2**	**3**	**4**	**5**
So sad that nothing could cheer you up?	**1**	**2**	**3**	**4**	**5**
Worthless?	**1**	**2**	**3**	**4**	**5**

Total K-10 score: _____

Beck Anxiety Inventory
Beck, A.T. & Steer, R.A. (1990) *Beck Anxiety Inventory Manual.* San Antonio, TX: Psychological Corporation.

Beck Depression Inventory
Beck, A.T., Steer, A. & Brown, G.K. (1996) *Beck Depression Inventory Manual (2nd edition).* San Antonio, TX: Psychological Corporation.

Psychosis Screener
[Interviewer administered.]

In the next section, I will ask you some specific questions about the kinds of thoughts you have been having.

1. In the past 12 months, have you felt that your thoughts were being directly interfered with or controlled by another person?

   YES NO

   1a. If YES, did it come about in a way that many people would find hard to believe, for instance, through telepathy?

   YES NO

2. In the past 12 months, have you had the feeling that people were too interested in you?

   YES NO

   2a. If YES, in the past 12 months, have you had the feeling that things were arranged so as to have a special meaning for you or even that harm might come to you?

   YES NO

3. Do you have any special powers that most people lack?

   YES NO

   3a. If YES, do you belong to a group of people who also have these special powers?

   YES NO

4. In the past, when you have visited a doctor, have you ever been told that you might have schizophrenia?

   YES NO

PTSD (CIDI K22)
[Interviewer administered.]

Now I would like to ask you about some extremely stressful or upsetting events that sometimes occur to people (HAND CARD K1 TO RESPONDENT). Examples of these events are listed on Card K1.

		No	Yes
1	Did you ever have direct combat experience in war?	1	5
2	Were you ever involved in a life-threatening accident?	1	5
3	Were you ever involved in a fire, flood or other natural disaster?	1	5
4	Did you ever witness someone being badly injured or killed?	1	5
5	Were you ever raped, that is someone had sexual intercourse with you when you did not want to, by threatening you, or using some degree of force?	1	5
6	Were you ever sexually molested, that is someone touched or felt your genitals when you did not want them to?	1	5
7	Were you ever seriously physically attacked or assaulted?	1	5
8	Have you ever been threatened with a weapon, held captive or kidnapped?	1	5
9	Have you ever been tortured or the victim of terrorists?	1	5
10	Have you ever experienced any other extremely stressful or upsetting event? IF YES, ASK: Briefly, what was the most stressful or upsetting experience of this sort that ever happened to you? DESCRIPTION:_____ IF OTHER EVENTS IN 10 ARE ONLY BEREAVEMENT, CHRONIC ILLNESS, BUSINESS LOSS, MARITAL OR FAMILY CONFLICT, BOOK, MOVIE OR TELEVISION, CODE 1. OTHERS CODE 5.	1	5
11	Have you ever suffered a great shock because one of the events on the list happened to someone close to you? IF YES, ASK: Briefly, what was the event that you found most stressful or upsetting when it happened to someone close to you? DESCRIPTION:_____ IF EVENTS IN 11 ARE ONLY BEREAVEMENT, CHRONIC ILLNESS, BUSINESS LOSS, MARITAL OR FAMILY CONFLICT, BOOK, MOVIE OR TELEVISION, CODE 1. OTHERS CODE 5	1	5

Use of health services and medications (HSU)

The following section asks about your use of health services and medications in the past month:

Ambulance services

1a. In the last 4 weeks, how many times did you receive help from ambulance officers? 1b. How many of these times were related to your alcohol or drug use (eg a drug overdose)?	**total times** times
2. How many of these times resulted in you being taken to a hospital in the ambulance?	**total times**

Hospital services

3. In the last 4 weeks, how many times were you treated in a hospital **emergency or casualty ward** but did **NOT** stay overnight?	**total times**
4a. In the last 4 weeks, how many times did you go to the **out-patient clinic** of a hospital for treatment? (exclude visits to drug and alcohol services) 4b. What was the medical reason/ diagnosis/ condition for these visits and how many times were you treated at the **out-patient clinic** for each of these medical reasons/ diagnoses/ conditions? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	**total times** times times times times times
5a. In the last 4 weeks, how many times were you admitted to a **hospital**? (Include overnight stays AND day-only procedures). 5b. What was the medical reason/ diagnosis/ condition/ for you being admitted and the number of nights you spent in the hospital as an in-patient for each of these medical reasons/ diagnoses/ conditions? 1. _____ 2. _____ 3. _____ 4. _____ 5. _____	**total times** nights nights nights nights nights

Other health services

6. In the last 4 weeks, how many times did you visit a **GP**?	**total times**
7. In the last 4 weeks, how many times did you visit a **specialist doctor**? (This is a community based doctor who you can't see without a GP's referral. **Do not include psychologists, psychiatrists, or the medical officer you see as part of your current treatment)**.	**total times**
8. In the last 4 weeks, how many times did you have a blood or urine test?	**total urine tests** **total blood tests**
9. In the last 4 weeks, how many times did you have an x-ray or scan?	**total tests**
10. In the last 4 weeks, how many times did you visit a **dentist**?	**total times**
11. In the last 4 weeks, how many times did you visit other health professionals (eg chiropractor, naturopath, physiotherapist, podiatrist)?	**total times**

Other psychological and social services
In addition to services counted above

12. In the last 4 weeks, how many times did you visit a **psychiatrist**?	**total times**
13. In the last 4 weeks, how many times did you visit a **psychologist**?	**total times**
14. In the last 4 weeks, how many times did you visit a **social/ welfare worker**?	**total times**
15. In the last 4 weeks, how many times did you visit other **therapists/ counsellors**?	**total times**

Prescription medication

1a. In the last 4 weeks, did you get any medications on **prescription**? NOTE: include all prescription medications including **<u>methadone and other heroin treatment medication.</u>**	NO
1b. If YES, please list the brand names of the medications, number of packs you bought, pack size and unit strength.	YES

Brand name	No. of packs bought in the last 4 weeks (If less than one, write '0')	Pack size or quantity	Unit strength as shown on the pack (mg)
Example: Valium	*2*	*50*	*5mg*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

2. Have you been using medication to assist you with withdrawal while at Gorman House?

Yes _____
No _____ (End of interview)

2.a. What medication have you been using?

_____
_____
_____
_____
_____

2.b. Where did you get the medication you have been using?

From a GP (in general practice) ____
From a GP (in a community health centre) ____
From a hospital Emergency Department ____
Bought it off the street ____
From somewhere else _____

We are at the end of the interview. Thank you for your time and patience.

APPENDIX 3: STAFF SURVEY

ST VINCENT'S HOSPITAL AND UNIVERSITY OF NEW SOUTH WALES

Process evaluation of Gorman House non-medicated detoxification unit

Staff questionnaire

As you are aware, an evaluation of Gorman House is underway. An important aspect of this study is to learn more about what it's like to work at Gorman House and how you feel about the services which are provided. All staff will receive a copy of this questionnaire.

The questionnaire should take about 20 minutes to complete. It is totally **anonymous** so please do not put your name or staff number anywhere on the paper. Most of the questions are short answer style. There are no right or wrong answers. If you need more space to answer add extra paper but remember to clearly mark which question you are answering. If you have any questions feel free to ask Sarah or Ed who are assisting with this study.

In order to get the most accurate picture about the experiences of staff at Gorman House it's important that as many questionnaires are returned as possible.

When you have finished the questionnaire, place it in the envelope provided, seal it and hand it to Sarah or Ed. If you prefer, you can return it by mail to:

Gorman House Evaluation

c/- Ed Silins

National Drug and Alcohol Research Centre

University of New South Wales

Randwick, NSW, 2052.

1. What do you believe are the main aims and objectives of Gorman House?

_____
_____
_____
_____

2. In your opinion, is Gorman House achieving the aims and objectives you listed above? (Please circle the most appropriate response).

1	2	3	4	5
Definitely	To some extent	More or less	Not really	Definitely not

3. Please indicate (by rating **1** most important to **5** least important) the **main** reason you think **most** clients come to Gorman House.

I think clients come to Gorman House mainly to: Rating (1-5)

get a bed and/or a decent meal _____

sober up / get straight for something important
(eg going to court, visiting kids, medical appointment) _____

have a break from drinking and/or using drugs for a while _____

get into treatment like rehab or counselling _____

other reasons (please describe:) _____

For each of the areas listed below, please indicate (by rating between 1 and 5), whether you think the needs of the residents are being adequately met during their admission at Gorman House.

It would be helpful if you could write your reasons in the space provided for each item you rated as **4** '**inadequate'** or **5** '**very inadequate'.**

1	2	3	4	5
Very adequately	Adequately	Neither one nor the other	Inadequately	Very inadequately

Rating (1-5)

a. Quality of shelter and food _____

_____
_____

b. Assessment _____

_____
_____

c. Treatment plan _____
_____
_____

d. Withdrawal management _____
_____
_____

e. General medical care _____
_____
_____

f. Psychiatric care _____
_____
_____

g. Resident rights _____
_____
_____

h. Duration of admissions _____
_____
_____

i. Discharge plans _____
_____
_____

j. Referral to ongoing community care _____
_____
_____

4. Are there other needs resident have which you think are **not** being adequately addressed by Gorman House?

No ____
Yes ____

If Yes, please specify:

_____
_____

5. What do you think may be the **main** reasons some clients at Gorman House drop out before completing withdrawal?

_____
_____

6. In general, how satisfied do you think **residents** are with the services that Gorman House provides for them?

1	2	3	4	5
Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Unsatisfied	Very Unsatisfied

7. If you circled **5 'very unsatisfied'** or **4 'unsatisfied'** in question 7, list what you think the **residents** of Gorman House are least satisfied with.

_____

_____

8. In terms of **your own** level of satisfaction with your role at Gorman House, please indicate how satisfied **you** are, by rating between 1 and 5 under each area below**.** Your reasons for each rating of **4 'Dissatisfied'** or **5 'Very Dissatisfied'**, would be appreciated.

1	2	3	4	5
Very satisfied	Satisfied	Neither satisfied nor dissatisfied	Dissatisfied	Very dissatisfied

Rating (1-5)

a. physical work environment _____

_____

_____

b. safety _____

_____

_____

c. support in case of emergency or critical incident _____

_____

_____

d. range of services provided to residents at Gorman House _____

_____

_____

e. ongoing training and supervision _____

_____

_____

f. resources (eg access to computers, library, etc) _____

_____

_____

g. other concern (please specify: _____) _____

9. How **do you feel** about **your** own training, skills and competencies relevant to working with Gorman House residents? Please indicate your feelings by circling between 1 and 5 below.

   I think my training, skills and competencies have prepared me well for my work at Gorman House.

1	2	3	4	5
Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree

10. Are there changes you would make to Gorman House that in your opinion may improve the services provided to residents?

    No _____
    Yes _____

    If Yes, please describe:

    _____
    _____
    _____
    _____

11. Do you have anything else you would like to say about Gorman House?

    _____
    _____
    _____
    _____

Thank you for taking the time to complete this questionnaire.
Please place the questionnaire in to the envelope provided, seal it and hand it to Sarah or Ed who are assisting with this project. Alternatively you can return it by mail to:

Gorman House Evaluation

c/- Mr Ed Silins

National Drug and Alcohol Research Centre

University of New South Wales

NSW 2052

APPENDIX 4: KEY INFORMANT SURVEY

1. Who does your organisation refer to Gorman House and why?

2. Who does your organisation *not* refer to Gorman House and why not?

3. What is your organisation's perception of the role of Gorman House?

4. Taking into account the needs of your residents, what services would you like to see offered at GH?

5. What does your organisation think of the service provided by Gorman House?

6. Does your organisation receive feedback from clients about Gorman House? What is the feedback?

7. Does your organisation think Gorman House occupies a unique niche among detoxification services? (Is there duplication of services?)

8. What are your organisation's views in relation to the current model of service at Gorman House which provides a detoxification of 5 days duration?

9. Can your organisation comment on how Gorman House deals with the clients you refer (or who are referred to you) who have special needs, such as clients with acute mental illness or medical conditions?

10. Does your organisation think there are any areas of improvement for Gorman House? What changes, if any, would you like to see?

11. Does your organisation have any other comments to make about Gorman House?

APPENDIX 5: CLIENT SATISFACTION QUESTIONNAIRE

How would you rate the quality of the service you received? N (%)			
Excellent	Good	Fair	poor
35 (44)	37 (46)	8 (10)	0

Did you get the kind of service you wanted? N (%)			
No, definitely not	No, not really	Yes, generally	Yes, definitely
0	11 (14)	33 (41)	36 (45)

To what extent has our program^ met your needs? N (%)			
Almost all of my needs have been met	Most of my needs have been met	Only a few of my needs have been met	None of my needs have been met
29 (36)	35 (43)	16 (20)	0

If a friend were in need of similar help, would you recommend our program^ to him or her? N (%)			
No, definitely not	No, not really	Yes, generally	Yes, definitely
0	8 (10)	22 (28)	50 (63)

How satisfied are you with the amount of help you have received? N (%)			
Quite dissatisfied	Indifferent or mildly dissatisfied	Mostly satisfied	Very satisfied
2 (3)	10 (13)	32 (40)	36 (45)

Have the services you received helped you to deal more effectively with your problems? N (%)			
Yes, they helped a great deal	Yes, they helped somewhat	No, they really didn't help	No, they seemed to make things worse
23 (29)	47 (59)	9 (11)	1 (1)

In an overall, general sense, how satisfied are you with the service you have received? N (%)			
Very satisfied	Mostly satisfied	Indifferent or mildly dissatisfied	Quite dissatisfied
34 (43)	38 (48)	7 (9)	1 (1)

If you were to seek help again, would you come back to our program^? N (%)			
No, definitely not	No, not really	Yes, generally	Yes, definitely
1 (1)	6 (8)	20 (25)	53 (66)

^Gorman House does not provide a structured program for residents. However, in order to preserve the integrity of the scale, the original wording was retained.