

# **Making Change Possible**

***Sharpening the Focus on Homelessness  
and Substance Use within Crisis Supported  
Accommodation Services in Inner  
Melbourne, Victoria.***

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# GLOSSARY

AA	Alcoholics Anonymous
ADCA	Alcohol and Other Drug Council of Australia
ATOS	Australian Treatment Outcomes Study
BBV	Blood Borne Virus
CCCC	Counseling, Consultancy and Continuing Care
CSAS	Crisis Supported Accommodation Services
DATOS	Drug Abuse Treatment Outcome Study
DHS	Department of Human Services
DPEC	Drug Policy Expert Committee
GP	General Medical Practitioner
HDDT	Homeless and Drug Dependency Trial
IAWP	Inter Agency Working Party
IDRS	Illicit Drug Reporting System Survey
IDU	Injecting Drug User
NA	Narcotics Anonymous
NDARC	National Drug and Alcohol Research Council
NTORS	National Treatment Outcome Research Study
RDNS	Royal District Nursing Service
RMIT	Royal Melbourne Institute of Technology
SAAP	Supported Accommodation Assistance Program
Trial	Refers to the Homeless and Drug Dependency Trial
WHO	World Health Organisation
VHS	Victorian Homeless Strategy

## **SUMMARY**

This study investigated the profile of homeless drug users staying within Crisis Supported Accommodation Services in inner Melbourne, in terms of their accommodation, drug use and heroin overdose histories, prior use of treatment services and health related issues. It also examined the extent of barriers that have prevented this homeless population's access to drug treatment services, and identified the barriers or issues that may impact on their future retention in treatment. A cross sectional study design utilising a semi structured survey, with both quantitative and qualitative questions was administered during face to face interviews with 95 individuals, in the first quarter of 2002. A non-random sampling method was employed, as the exact population of residents with drug dependency issues staying within Crisis Supported Accommodation Services is not known, due to the under reporting by residents of this issue.

A high level of social, economic and health disadvantages exists amongst the study group. Ninety percent of participants were unemployed and eighty four percent had not progressed past secondary education. Accommodation history represents one of instability and long term homelessness. Seventy two percent had stayed at a crisis supported accommodation service in the past, and the mean number of moves in the past year was eleven. Sixty three percent reported their current state of homelessness was due to their drug addiction, revealing a strong association between homelessness and problematic drug use.

Participants reported that their current main drug of choice was cannabis (39%), followed by heroin (25%), amphetamines (12%), and alcohol (12%).

Over fifty percent of participants had changed from a previous drug of choice with heroin being the most common drug used in the past. Reported reasons for first using drugs were often linked to social factors such as peer pressure or to socialize with others, while the reasons for current use were related to achieving a desired drug effect or to assist with the management of their other drug use. These self reported reasons support the functional role of drug use as a coping mechanism and a form of fulfillment for this socially excluded group.

The study group had experienced a wide range of health issues and had engaged in a number of risk taking behaviours.

- Poly drug use was widespread, increasing their risk of overdose and associated harms.
- More than half of those who had ever used heroin had experienced one or more overdoses in their lifetime. Forty percent reported that they usually used alone, impacting on their ability to receive timely help if they did overdose.
- Drug injecting behaviours among the study group indicate that the risk of transmission of a blood borne virus such as Hepatitis C, Hepatitis B, and HIV is high. Three-quarters of participants had injected drugs in the last month with heroin (40%) and amphetamines (26%) the most common. Almost fifty percent of those who had injected in the last month reported that they had shared some form of injecting equipment.
- Forty one percent reported that they had been diagnosed in the past with hepatitis C (HCV).

- Seventy nine percent had been diagnosed in their lifetime with clinical depression while the incidence of other mental health disorders was significant.
- High rates of attempted suicide (41%) and self-harm (34%) amongst participants exposes an alarming picture of vulnerability and potential high rates of mortality.

While the majority of participants had accessed a service for drug treatment in their lifetime, the low levels of participation within the past 12 months reflects a somewhat different picture of limited access to a range of treatment options and possible opportunities for recovery. The most utilized service types were not funded specialist treatment services (except for CCCC) but public health services such as the general practitioner.

The most significant barrier to accessing treatment was related to structural issues, such as lengthy waiting lists. Motivation to address their drug use was often lost while they waited. While access to services is a significant problem, the retention of homeless people in treatment poses a variety of challenges for practitioners and the service system. An improvement in staff communication, counseling and engagement skills, and the availability of follow up care and support after treatment were the main factors identified by participants, that would improve their retention in future treatment.

A wide range of personal factors was reported to have influenced their decision to not seek assistance for their drug use in the past and reveals the complexity

of issues. These factors were related to change, such as not being motivated or ready, while others reported that they did not see their drug use as a problem. The extent to which these factors still exist is not known. However, only nine percent reported the personal lack of motivation to change as a current factor preventing them from changing their current situation of homelessness and drug dependency. Fifty two percent of participants instead identified significant structural factors, such as the lack of permanent accommodation as well as financial supports to secure and maintain accommodation and build stability, as the main barriers.

Its difficult to generalize these findings to represent all homeless drug users, they do however suggest that homeless drug users accessing Crisis Supported Accommodation Services are significantly disadvantaged, experiencing multiple health issues, high rates of mental illness and low levels of utilisation within the specialist drug treatment service system. Tackling a homeless person's drug use, without assisting them to acquire the housing and personal stability they need to address these issues will yield short-term outcomes, rather than create long term pathways of sustainable change. Future service responses need to be designed to address these issues in collaboration, as is being trialed in the Homeless and Drug Dependency Trial. This requires proactive leadership from all sectors founded on strong cross sector partnerships and realistic program responses that are adequately funded, and specifically attuned to the diverse needs of homeless drug users, rather than reactive.

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# STATEMENT OF AUTHORSHIP

I certify that this thesis does not incorporate without acknowledgment any material previously submitted for a degree or diploma in any university. That to the best of my knowledge and belief it does not contain any material previously published or written by another person except where due reference is made in the text.

**Signed** .....

**Date** .....

# 1. INTRODUCTION

Within Victoria's Supported Accommodation and Assistance Program (SAAP) service system, there has been a growing awareness that organisations need to engage and work more effectively with homeless individuals, who also have drug dependency issues (VHS, 2001).

In November 2000, the Victorian Government announced the implementation of a three year \$7.6 million Trial, that would

Utilise major Crisis Supported Accommodation Services as strategic sites for engaging drug using homeless people with the aim of reducing their drug dependence, minimizing the harm they do to themselves and building pathways out of homelessness and drug addiction toward secure accommodation and stable lifestyles (Interagency Working Party, 2001).

The funding of this initiative by Drug Treatment Services, was in direct response to the growing number of homeless people presenting at Crisis Supported Accommodation Services (CSAS) with problematic substance abuse issues and a service system under resourced to effectively address the individuals presenting alcohol and drug problems.

The Homeless and Drug Dependency Trial commenced operation within the three CSAS in July 2001. During the initial development and implementation phase, there was an identified need to collect baseline data on this population, in order to provide evidence for the observations underpinning the Trial and to provide a greater understanding of the complexity of issues as reported directly by homeless people, in relation to their drug use and housing situation. The information gathered in this report, will provide the Trial and participating Crisis Supported Accommodation Services, Drug Treatment Services and other associated health and welfare services with a current and comprehensive understanding of the resident's associated homelessness and drug use history. It will also shed light on the issues and barriers experienced by residents with drug and alcohol problems when they have tried to access a treatment service.

This understanding will inform and support the development and implementation of initiatives within the CSAS, against agreed Trial objectives. It will also provide an evidence base to work from in regards to understanding the barriers to accessing Drug Treatment Services for this specific group and will inform future planning and work undertaken by the service system. While there is a significant body of research into the causes of addiction and the effectiveness of treatment responses for individuals with drug dependency issues, limited research on the relationship between homelessness and drug dependency exists. This study will also assist in developing a body of knowledge into an area of inquiry that to date has had little investigation in Victoria both within the crisis supported accommodation service system and the broader drug and alcohol field.

## **1.1: STUDY PURPOSE**

**This study will aim to answer the following research questions:**

- What is the current profile of homeless drug users staying within Crisis Supported Accommodation Services (CSAS), in relation to their drug use history (past six months), overdose history, blood borne virus transmission risk, use of Drug Treatment Services (past 12 months) and other drug related health issues (injection related, dental, general health, emotional/psychological)?
- What barriers have prevented homeless drug users who are current residents of a Crisis Supported Accommodation Service (CSAS) from accessing Drug Treatment Services?
- What barriers prevent homeless drug users who are current residents of a Crisis Supported Accommodation Service (CSAS) from sustaining involvement with Drug Treatment Services?

## **1.2: DEFINITIONS**

### **The Homeless and Drug Dependency Trial (HDDT)**

*Comprise three key components:*

Part A – Strengthening the capacity of major CSAS to effectively assist their residents who are drug and alcohol dependent. Training will also be provided for specialist Drug Treatment Services staff in dealing with this complex client group.

Part B – The development and trial of pathway models that provide clear and direct links between CSAS and forms of treatment and support services. This includes access to Drug Treatment Services appropriate to the particular needs of people who are homeless and strategies to build self-esteem, establish new personal relationships, rebuild community networks and provide access to employment and training, using an intensive case management model.

Part C – Project development, management, evaluation and targeted research.

### **Crisis Supported Accommodation Services (CSAS):**

A facility that provides temporary accommodation for individuals experiencing homelessness. The study was conducted within the following three major Crisis Supported Accommodation Services (CSAS) that are located in and around the city of Melbourne:

- *Hanover Southbank*
- *Ozanam House*
- Flagstaff

**Homeless:**

A homeless person “is someone who is without a conventional home and lacks the economic and social supports that a home normally affords. He or she is normally cut off from the support of relatives and friends, has few independent resources and often has no immediate means and, in some cases, little prospect of self support” (Council to Homeless Persons, 1998).

**Overdose:**

Overdose was defined as any of the following symptoms occurring in conjunction with heroin use: collapsing, cyanosis, difficulty breathing, losing consciousness and unable to be roused (Darke and Ross, 1997).

**Polydrug Use:**

The regular use of one or more drugs that may be either legal or illegal (DPEC, 2000)

**Resident:**

Individuals staying at the CSAS are referred to as residents as at that period of time they are a resident of these facilities.

**Substance Use**

The ingestion of substances, legal and illegal, on a regular basis (DPEC, 2000).

***Treatment:***

Treatment involves interventions that aim to eliminate dependence and /or reduce substance use to safer levels in the context of the amelioration of the harms associated with ongoing drug use (DPEC, 2000).

## **2.0: LITERATURE REVIEW**

### **2.1: Introduction**

This chapter is a review of literature relevant to homelessness and drug use. It endeavors to inform and explore the impact of these two factors on a persons housing status, physical health, mental health, use of Drug Treatment Services and the associated health risks attached to drug use experienced by homeless people. The following examination of both national and international literature will contribute to building an understanding of a homeless person profile and experiences in relation to drug use, overdose, risk of blood borne virus transmission, health issues and the use of Drug Treatment Services. It also aims to identify reported barriers both personal and structural that have prevented homeless clients from accessing and sustaining drug treatment.

### **2.2: Homelessness**

Homelessness is one of the most serious forms of social exclusion. Homelessness can be the devastating result of poverty, unemployment, violence, and/or lack of access to affordable housing. It can also be triggered by factors such as family breakdown, mental health problems, alcohol and other drug misuse, financial hardship, gambling and social isolation. (Australian Federation of Homeless Organisations, 2002).

Individuals experiencing homelessness are not a homogenous group. The term “Homeless person” refers to a group and a social problem with varied and heterogeneous characteristics, profiles and necessities, but with a series of common dimensions: severe poverty, social isolation, rootlessness, breakdown

of social and family bonds, personal deterioration and a lack of place (a home) to cover needs of accommodation and social support (Gonzalez et al., 1998). They are people living in unstable or unsafe housing, not just those living on the streets.

Homelessness includes people who are in insecure or in unsatisfactory housing situations that cannot be sustained, such as staying temporarily with friends and family or in accommodation provided by Crisis Centres (VHS, 2000a).

Chamberlain and Mackenzie's (1999) definition of homelessness provides a cultural definition of homelessness and is based on accepted minimum community standards in current housing practices. This definition involves 3 groupings of homelessness – primary, secondary and tertiary.

***Primary Homelessness*** – people without conventional accommodation such as people living on the streets, sleeping in parks, squatting in derelict buildings or using cars or railway carriages for temporary shelter.

***Secondary Homelessness*** – People who move frequently from one form of temporary shelter to another. It covers: people using emergency accommodation (such as hostels for the homeless or night shelters) teenagers staying in youth refuges; women and children escaping domestic violence (staying in women's refuge). People residing temporarily with other families (because they have no accommodation of their own) and those using boarding houses on an occasional or intermittent basis.

***Tertiary Homelessness*** – People who live in boarding houses on a medium to long-term basis. Residents of private boarding houses do not have a separate bedroom and living room, they do not have a kitchen and bathroom facilities of their own, their accommodation is not self contained, and they do not have the security of tenure provided by a lease.

The Council to Homeless Person's (1998) states that a homeless person is:

*Someone who is without a conventional home and lacks the economic and social supports that a home normally affords. He or she is normally cut off from the support of relatives and friends, has few independent resources and often has no immediate means and, in some cases, little prospect of self-support.*

As evidenced in the literature, homelessness is much more than not having a place to live. It involves two interconnected dimensions: the absence of secure, appropriate and affordable accommodation and the fracturing of relationships and connections with families and communities of origin (Driscoll and Wood, 1998).

### **2.3: Homelessness and Drug Use**

In the context of homelessness, drug and alcohol abuse is an additional problem in the unstable lives of individuals experiencing homelessness. It may be the individual's most debilitating issue and a central factor in "understanding why that individual is homeless, and is also a strong factor in

perpetuating that person's state of homelessness (Advisory Council on the Misuse of Drugs, 1998).

The relationship between homelessness and drug use is complex. Work with individuals experiencing homelessness and drug use frequently means “engaging with a range of other issues such as abuse, poverty, sexual exploitation, physical and mental health problems, poor educational achievement and disrupted family life” (Flemen, 1999). Research documenting patterns of use amongst young people clearly indicates the interrelationships between the level and frequency of substance use by a young person with the degree of marginalisation experienced. There is a strong correlation between deteriorating social circumstance and the frequency and level of substance abuse (Miller, 2000).

For some individuals, drug dependency may be a precursor to homelessness, causing irreconcilable tension between household members or consuming resources needed for accommodation costs (Bessant et al., 2002). For others it is a means of coping with their current life situation, and the circumstances they find themselves in as they manage each day. One way of coping with homelessness is to seek support or a connection to others experiencing the same situation. Shared drug use has been cited in the literature as a act of socialization (Horn, 1999), that in some way creates a sense of acceptance and belonging that is often missing from the lives of those who are homeless and isolated from family and mainstream society. The relationship between these factors is complex and not clearly understood, requiring further examination.

Social and economic changes within Australia have seen the increase of homelessness in the community. Within the last three decades, there has been an overall shift in economic and social policy from one of redistribution and regulation to greater competition and deregulation (Australian Federation of Homeless Organisations, 2002a). These changes have led to higher levels of poverty and growing polarization within the labour market (Australian Federation of Homeless Organisations, 2002a). The casualisation of the labour market and sustained levels of unemployment has made it more difficult for households to establish and maintain long-term housing (Victorian Homeless Strategy, 2000). This has been exacerbated by the decline in affordable private rental accommodation since the 1980's, for low income households and an increase in single person households, due to family breakdown and changing patterns of housing formation, resulting in isolation and a reduced capacity to meet rental costs (Victorian Homeless Strategy, 2000). Individuals and families are considered to be in 'after housing poverty' if they are in the lowest income quartile, paying more than 25 percent of income on housing (Australian Federation of Homeless Organisations, 2002a), leaving very little income for other living expenses. If a person is experiencing after housing poverty and trying to maintain an addiction, it is only a matter of time before they fall into homelessness as their day to day needs compete with the costs of their addiction.

The restructuring in the labour market has had an impact on homelessness.

*The changing nature of work and the decline in manufacturing and labour intensive industries has led to a significant increase in long term joblessness for people with low level skills. Not only has this contributed to an increase in homelessness, but the lack of access to employment is a major barrier to people moving out of homelessness and participating in the life of their community (VHS, 2000c).*

The prevalence of drug and alcohol use amongst homeless people within Australia is not exactly known due to inadequate recording and the previous lack of homeless identifying questions in state and national drug and alcohol studies. One study, however, that is particularly relevant to the Trial noted the prevalence of drug dependency (predominately heroin) amongst residents at Hanover Southbank Crisis Accommodation Centre was 63% while 20% of Hanover Welfare Service clients were heroin dependent, a prevalence rate ten times greater than that in the general community (Horn, 1999). More than a quarter of the clients in this study had a psychiatric disorder, challenging behaviors and probable substance use (Horn, 1999). Further estimates, have reported that 25 percent of those experiencing homelessness are also experiencing problematic alcohol and /or other drug use, and that in crisis services, the proportion is up to 70 per cent (Ministerial Advisory Committee, 2000).

Further, a study of people who were homeless in inner Sydney (Hodder, et al., 1998), found that 49% of the homeless men and 15% of the women surveyed

had a diagnosis of an alcohol use disorder in the previous 12 months. An overview report from this study reported that 34% of people using inner city hostels and refuges are dependent on drugs, 19% of men and 23 % of women abuse or are dependent on opiates, including heroin (St Vincent de Paul Society et al, 1998).

In addition, client data from the Victorian Supported Accommodation Assistance program (SAAP) shows that at least 15% are dependent on or abusing drugs. Many services identified these low levels of reported drug use within SAAP are mainly due to a homeless persons fear of disclosure to services about their drug use and possible subsequent exclusion from a service if they report this activity. Such a situation further marginalizes the individual from receiving the assistance they need and subsequently prevents an agency from effectively responding to this client groups needs.

A recent study (Crofts and Reid, 2000) that identified the primary health care needs among the street drug using community in Footscray, Melbourne, reported that amongst this population the level of homelessness was very high. From the sample surveyed (n= 196), 37% identified as being homeless at the time of interview, while 89% of the participants had difficulty finding affordable accommodation and 80% of respondents stated they could not afford rental accommodation (Crofts and Reid, 2000). The 2001 Victorian IDRS survey (Fry & Miller, 2002) interviewed 151 injecting drug users and identified that 8% of the sample were homeless (no fixed address), while 17% were residing at a boarding house or hostel. Similarly, a study conducted among

Melbourne's homeless in 1995 – 1996 found that 28% of the study group had injected drugs and that 11% regularly injected heroin (Kermode et al., 1998).

In the United Kingdom, the extent of drug use amongst people who are homeless or vulnerably housed and use drugs is substantially higher than those of a comparable age who are homeless (Flemen, 1999). The growing body of research emerging from the UK demonstrates a high prevalence of drug use amongst those who are homeless or vulnerably housed. In one such study (Hammersley and Pearl, 1997), 89% of homeless respondents reported having a drug dependency issue with one or more drugs. While another study reported levels of use at 88% among homeless youth (Flemen, 1997). In the United States, prevalence estimates of substance use among homeless individuals are approximately 20 –30 per cent; as many as 10 –20 per cent are dually diagnosed with an additional mental health diagnosis (Zerger, 2002a).

## **2.4 Homelessness, Housing and Drug Use**

Housing instability, or the lack of, is a significant environmental influence that may be a contributing factor to an individual's drug use and to their general health and well-being.

Difficulty accessing and maintaining affordable accommodation while supporting a drug addiction creates barriers that only compound the level of social exclusion experienced and the homeless person's ability to access and maintain treatment. A current Australian study being undertaken by RMIT and the Australian Housing and Urban Research Centre, reported from an early

analysis of housing issues and circumstances of heroin users in inner City Melbourne that:

*Users make housing choices within acknowledged constraints. A generally acknowledged constraint is cost of entering the private rental market. This narrows their options to squatting, homelessness and public housing. Another factor, which users include in their discussion of housing options, is the competition in their lives between paying the rent and supporting an expensive heroin habit. Alex describes his situation as one in which ‘ you realise that, you know, your habit cant’ afford \$150 a week to be going on rent’; and Finn similarly states’ you know, you spend all your money on drugs, you’ve got no money to pay for rent, usually none for food either, so most people are in squats (Dalton and Rowe, 2002).*

Additional international literature supports the notion that access to housing for the homeless, particularly those with high needs such as those who are drug dependent or have a mental illness yields improved outcomes. Studies, which have focused on supportive housing interventions for homeless individuals with mental illness, consistently find high rates of retention in those programs. (Culhane et al., 2001). A United States study that tracked homeless individuals through administrative records, found that even when they adjusted for demographic and other pre-intervention differences between cases and controls, ‘regression results reveal that homeless people placed in supportive housing experience marked reductions in shelter use, hospitalizations

(regardless of type), length of stay per hospitalization, and time incarcerated' (Culhane et al., 2001).

Government commitment within the United Kingdom to address the connected issues of homelessness and drug use is well established and one of the key roles of the government's Social Exclusions Unit. A report on 'Rough Sleeping' notes that there is: 'Too little provision for those with high support needs,...(and that resettlement) is more likely to be successful if housing is combined with help for non- housing problems such as employment, drugs, drink and mental health' (Social Exclusion Unit, 1998).

## **2.5: Health, Homelessness and Drug Use**

Health is a resource that enables individuals to promote their social and economic development (WHO, 1986). For many homeless, their fundamental right to good health is denied because of their social disadvantage and social exclusion. Homelessness creates health problems; it also simultaneously makes health care more difficult to obtain (RDNS, 1999, Success Works, 1999, Song et al., 2000; Stronks et al., 1998). National and international literature has clearly identified the link between homelessness and poor health. Those who are experiencing homelessness are at greater risk of experiencing most health conditions than the general population ( Kermode et al.,1998; Rossiter et al.,2003; Zerger, 2002b).

Studies and reports of homeless populations report a higher incidence of lifestyle related health problems compared to the adequately housed. These

include injury, poor dental health, poor nutritional needs, skin infestations and infections, infectious disease such as tuberculosis, viral hepatitis, STD'S, poor management of chronic illness, pneumonia, low compliance with, and inappropriate use of medication (Royal District Nursing Service, 1999; Rossiter et al., 2003; AFHO, 2002; Zerger, 2002b; Drake, 1992)

Affordable housing is a fundamental priority in addressing the needs of homeless people. A report by RDNS highlighted that the lack of appropriate resources to address health needs in terms of basic support, comfort and even privacy to recover from illnesses, contributes to their chronically poor health. (RDNS, 1999). Chronic health problems among homeless persons often go unrecognized, and even when detected compliance problems result in unabated progression of the disease, disability, morbidity and premature death (Zerger, 2002b).

Time spent homeless directly correlate to the person's perception of poor health. Studies have shown that homeless persons are likely to report their health as fair to poor than housed persons (Fischer et al., 1986; Gelberg et al., 1990; Trevana, 2001).

Chronic illness or poor health, often associated with homelessness and exacerbated by drug use, will in itself limit the person's ability to engage in the employment market and consequently prohibit their ability to maintain long-term housing.

While studies have examined health conditions among the general homeless population, the prevalence of health conditions specifically among the homeless drug using population within Australia is limited. However, estimates of a national US study of self reported data from homeless clients receiving services in assistance programs in both urban and rural areas found that, 46 % of the sample reported having one or more chronic health conditions and that homeless clients with alcohol, drug, or mental health problems were even more likely to report one or more chronic health conditions (53%) than those without these problems (33%) (Burt et al., 1999 cited in Zerger, 2002b).

Key informants of a recent study (Crofts and Reid, 2000) within the western suburbs of Melbourne frequently reported the impact of homelessness and the problems of affordable accommodation as a major primary health care issue among injecting drug users (IDU). These problems were believed to manifest themselves in an array of debilitating conditions affecting both the physical and mental wellbeing of the drug user. Blood borne viruses, in particular Hepatitis C, were believed to be widespread and of concern among drug users. Various other physical conditions reported, included problems of hygiene, dermatological conditions including abscesses, various wounds around the body, dental problems, and poor nutrition (Crofts and Reid, 2000).

As reported, the risk of blood borne virus transmission in particular HIV/AIDS, hepatitis C (HCV) and hepatitis B (HBV) are major health risks for individuals who inject drugs. The sharing of needles/syringes and other equipment associated with the preparation and injection of drugs causes significant risk of

exposure to blood borne viruses such as HIV/AIDS, and hepatitis B and C (Crofts, Aitken & Kaldor 1999). Over 90 percent of the 200,000 hepatitis C infections estimated to have occurred in Australia by the year 2000, have been attributed to the sharing of injection equipment among injecting drug users (Wodak and Moore, 2002). The multiplier effect of HIV infection among injecting drug users is higher than for any other group at risk of this infection (Wodak and Moore, 2002).

In the UK, higher levels of HIV prevalence and HIV risk behavior have been found among drug injectors with no experience of treatment or help for their drug use (Rhodes, 1994). One of the main reasons that people share injecting equipment is the lack of access to sterile equipment (Dear 1996, Loxley and Davidson, 1991; Miller et al., 1990; Williams, 2000). If an individual is homeless and is forced to inject on the street or in unsafe/un-sterile environments with limited access to sterile equipment their risk of transmission notably increases.

An article on young people who inject and Hepatitis C (Rance, 1997), noted that some young people who inject, often do not have a safe, secure, clean and quiet place where they can prepare and inject their drugs, let alone store clean injecting equipment or fresh bleach. In the 2001 Victorian Drug Trends Intravenous Drug Users Study (IDRS) (Fry, Miller, 2001), 24% of the respondents (n=152) reported lending a used needle/syringe to someone else in the past month, and 15% reported borrowing and using someone else's used needle in the same period. The 2001 Victorian IDRS study, collected

accommodation-identifying information for the first time and reported that 8% of the sample were homeless, while 17% lived in unstable accommodation such as boarding house or hostel. The above findings present a concerning picture of increase risk takings amongst injecting drug users, a proportion of which are representative of homeless people.

## **2.6: Heroin Overdose**

Overdose from the use of heroin is well established as a major public health issue in Australia. Drug overdoses are estimated to be 13 times higher than expected for age and sex when matched with peers with no history of injecting drug use (Wodak, 1998). The rate of opioid deaths amongst Australian adults has increased six fold between 1979 and 1995 (Lynsky and Hall, 1998). In 1979 deaths from opioid use were 79, compared to 550 in 1995. Within Victoria, the prevalence of deaths from heroin toxicity since 1991 has risen from 49 to 268 in 1998 (Gerostamoulos, Staikos and Drummer, 1994) representing a five-fold increase over a seven year period. The Drug Policy and Expert Committee (2000) reported that heroin related deaths within Victoria had risen from 49 in 1991 to 359 in 1999. Most were aged between 25 – 35 years and their period of drug use was seven to ten years (Drug Policy Expert Committee, 2000)

Research has also indicated that non-fatal overdose is a common experience amongst heroin users (Banner and Sengoz, 1994:572-573; Darke, Ross and Hall, 1996:413-417). Darke et al (1996) reported that 67% of a sample of Sydney heroin users had overdosed while using heroin, with 29% of that same group overdosing in the preceding year. Similarly, the 2001 Victorian Drug

Trends IDRS study reported that non-fatal overdoses were common among respondents. More than half (58%) of the 2001 respondents reported that they had experienced one or more heroin overdoses ever, 45% had been administered Narcan (fast acting opioid antagonist given to reverse the effects of heroin in case of an overdose) and most respondents (77%) had witnessed an overdose (Fry and Miller, 2002). However, recent experiences of overdose amongst this population had decreased from 27% in 2000 to 13% in 2001 (Fry and Miller, 2002). Non-fatal overdose can result in significant permanent morbidity, such as brain damage (Ministerial Council on Drug Strategy, 2001). While the above studies did not specifically indicate the prevalence of non fatal overdose amongst homeless people, it demonstrates however the growing incidences of overdose amongst injecting drug users, many who at the time of overdose may have been homeless, compounding their risk of overdose.

## **2.7: Mental illness, Drug Use and Homelessness**

Studies have demonstrated the strong association between homelessness, substance use and mental illness (Horn, 1999; Hodder et al., Crofts and Reid, 2000; Kermode et al, 1998).

The co existence of both mental illness and substance use is often referred to as dual diagnosis. Both national and international research had shown that the incidence of dual diagnosis is high (Reiger et al., 1990; Gilverry, 1998; Crofts et al., 2000; Australian Bureau of Statistics, 1997; Drake et al., 1992a). At least 20 percent of people with mental health disorders also engage in harmful

drug use, with increased risks of suicide, hospitalisation, violence and homelessness (Australian Bureau of statistics, 1997).

Studies indicate that the prevalence of severe mental illness among those at risk of homelessness is increasing (VHS, 2000d). Homeless people have been found to have twice the lifetime prevalence level of schizophrenia, bipolar disorder, depression, alcohol and drug abuse compared to the general population (Mental Health linkages Project, 2000). Within the US approximately 20 –25 % of the single adult homeless population suffers from some form of severe and persistent mental illness (Koegel et al., 1996 cited in National Coalition for the Homeless, 1999a).

In a study of homeless people being accommodated or supported at a SAAP funded homeless service in Melbourne, reported that half the clients with an alcohol or drug problem (53%) also had a psychiatric disorder (Horn, 1996). This study was repeated in 1999 at the same service and reported that of those who had a drug or alcohol problem, 80% had one or more categories of psychiatric disorder, the most common being depression (Horn, 1999).

In addition, a recent study conducted in the western suburbs of Melbourne among injecting drug users found a high prevalence of self reported mental health conditions (Crofts and Reid, 2000). From the sample of 196, 37% identified as being homeless, and of this study group, the prevalence of serious psychiatric conditions (schizophrenia, manic depression) was high (18% and 36% respectively). The high levels of depression (89 %), and of not feeling

good about one's self (94%) reported, further highlights the vulnerable nature of this groups mental well being and overall health (Crofts and Reid, 2000). "It is likely that, in at least a proportion of those affected, their drug use – licit or illicit – relates to attempts to self medicate for their psychiatric condition" (Crofts and Reid, 2000).

In examining heroin users alone, a quarter of entrants into treatment for heroin dependence in the NSW component of the Australian Treatment Outcome Study (ATOS) being coordinated by NDARC, have met criteria for a current diagnosis of major depression (Darke, 2002a). Harris and Barraclough, (1997) estimated that major depressive illness is associated with a 20 fold increased risk of completed suicide. In a critical review of the literature on 'Suicide among heroin users: rates, risk factors and methods', Darke and Ross (2002b) identified a clear link between the high rates of mortality among heroin users and suicide. In systematically reviewing the international literature, researchers (Darke and Ross, 2002b) identified that nearly one in ten deaths among heroin users is due to suicide. Highlighting that suicide is a significant health issue among drug users requiring a prompt response by those working with this group. Examination of attempted suicide among heroin users further highlights this significant problem. In an Australian study, conducted among methadone maintenance patients in Sydney that examined the relationship between suicide and overdose, reported that 40 per cent of patients had attempted suicide at least once in the past, 8% had attempted suicide in the past 12 months and 10% had done so in the course of the present drug treatment (Darke and Ross, 2001).

There is a strong link between substance misuse and attempted suicides as evidenced in the research, with many factors known to predispose individuals to suicide also being associated with the misuse of drugs. The factors that predispose an individual to suicide may also be those that have lead to the individuals current drug use. As reported (ADCA, 2000) these factors include mental health problems, particularly depression; physical illness, including HIV/AIDS and hepatitis C; poor family relationships; social isolation; unemployment; and stressful life events, such as physical and sexual abuse. Similar if not identical factors linked to the causes of homelessness.

Finally, a review of treatment for co occurring substance abuse and mental illness found that those with severe mental illness who were also using substances to be more likely to exhibit:

- *Increase in relapse and re-hospitalisation rates*
- *Increase in depression, suicide and violence;*
- *Greater Housing instability and homelessness;*
- *Non- compliance with medications and other treatments;*
- *Increased vulnerability to HIV infection;*
- *Increased family burden;*
- *Higher service utilization and costs* (Meuser et al., 1996)

The above issues are no different from the health issues identified to be present among homeless people. While the above study did not focus on homeless people with co –occurring disorders it does highlight the complexity of needs

amongst those who are marginalised, namely drug users and those with mental illness, many of whom are homeless or at risk of homelessness.

## **2.8: Use of Drug Treatment Services by the Homeless**

International longitudinal outcome studies (DATOS and NTORS) have demonstrated that the length of time that a person stays in treatment was directly related to improvements in follow up outcomes (Simpson et al., 1997; Gossop et al., 2001). As identified in a review of these (Success Works, 1999) studies, individuals will have “several relapses and several episodes of treatment, and that clients derive a cumulative benefit from treatment, most relapses will occur within 3- 6 months of treatment termination. Retaining people in treatment who have substance abuse problem poses many challenges as the individual grapples with their addiction and the concept of change. When you add homelessness to the equation the challenge is intensified. Reports of drop out rates of two thirds or more among the homeless are common (Zerger, 2000a).

While access to services has been argued as a key barrier to treatment for the homeless, sustaining and supporting an individual to complete treatment is equally an issue requiring examination.

Research conducted by Hanover Welfare Services (Horn, 1999), indicated that whilst past redevelopment of drug and alcohol services had been moderately successful in making treatment services more accessible to those experiencing homelessness, the service response had not matched the 60% increase in potential demand from this client group. Victorian Homeless Strategy Regional

Consultations (2000a) with service providers has shown that there is agreement that neither the current homeless service system nor the drug and alcohol treatment system are adequately set up to provide pathways out of homelessness for people with substance abuse issues.

In one study (Horn, 1999) conducted in a homeless service, at least one third were missing out, whilst most experienced significant delays in gaining access, risking loss of motivation during the waiting period. The most common reasons reported by workers as to why residents had difficulties being able to access a Drug Treatment Service was due to the lack of vacancies at referral or that the individuals mental illness prevented them from accessing treatment. Similarly, 70% of participants of a recent study conducted where a significant proportion (37%) of the sample reported being homeless found it difficult to get into a withdrawal program in the past year and the average number of times a participant tried to detox was six (Crofts and Reid, 2000).

Utilisation rates of Drug Treatment Services by homeless people cannot presently be accurately reported on. However, preliminary analysis of clients accessing Drug Treatment Services in Victoria, during the period of 1999-2000 suggests that homeless persons with drug and alcohol problems are significantly under represented in Drug Treatment Services. Using the operational definition of Homelessness by ADIS (unknown postcode), homeless clients totaled 1,787 over the 12 months (July 1999 – June 2000), accounting for approximately 8% of all clients of Drug Treatment Services. In comparison, 29,000 adults were provided with 43,000 periods of support by

SAAP homeless services in Victoria over the same period. The SAAP client data indicates that 11% of support periods identify a need for drug treatment. Although this is likely to be an under representation of the prevalence of the problem of substance use, this figure equates to about 3,190 clients.

A United Kingdom report into research and the delivery of HIV and drug and alcohol service provision (Rhodes, 1994) identified that the majority of drug users remain out of contact with treatment and helping services. Examination of help seeking patterns of drug users highlighted the inadequacies and limitations of medically oriented models of primary prevention. The author of this report argued that services operate on an assumption that “given an individuals recognition of the severity of an illness they will necessarily and appropriately seek help” (Rhodes, 1994). Rather services need to provide other opportunities for proactive engagement and access to treatment services.

Reported barriers to treatment for the homeless often refer to the structural barriers that need to be overcome in order to access a service. Extensive waiting lists was a key issue cited in the literature (Day et al., 2002; Croft and Reid, 2000; Horn, 1999; Darke, 2002; National Coalition for the Homeless, 1999) as impeding the commencement of treatment.

In the United States, the National Association of State Alcohol and Drug Abuse Directors estimated that in 1997, over one million people were waiting for treatment nationwide. Moreover, people who are not easy to contact, such as the homeless, are often dropped from lists (National Coalition for the

Homeless, 1999). An analysis of barriers to treatment for the homeless within the US noted that much of the gap in access to treatment is explained in terms of structural barriers (Zerger, 2002). The realities of homelessness further compounding the situation and often leading to the homeless person receiving lower priority than non homeless clients, who are often seen as less complex. Homeless people are much more likely to use the most expensive health services, such as emergency departments and hospitals, due to limited access to more appropriate alternatives (O'Connell, 1999; Salit et al., 1998). This highlights the unmet service needs particularly in terms of substance abuse and mental illness treatment for the homeless.

Additional structural barriers to treatment include lack of transportation, lack of documentation, lack of supportive services, and abstinence- only programming. (National Coalition for the Homeless, 1999). In a report titled 'Addiction Disorders and Homelessness' (National Coalition for the Homeless, 1999b) discusses the policy issue related to treatment programming, noting that within the US "the bulk of addictive disorder treatment and recovery public policies and programs, focus on abstinence as the single goal for individuals partaking in programs and for programs themselves, and in some cases forbids the alternative programs". While this policy is not the sole approach to treatment within Australia, it is still a focus within the service system that is often at odds with reality of addiction where relapse is a common event in the cycle of recovery from addiction. This singular focus has served as a barrier to the establishment of relapse tolerant programs in the United States and possibly prevented many from approaching the treatment service system for help. An

abstinence only approach does not consider the outcomes achieved from participation in terms of improvement in the individuals physical and mental health. It also narrows the range of options available, rather than providing continuous support, coupled with treatment options that can be matched to the homeless person needs and stage of recovery.

While structural barriers, such as waiting lists are impacting on the level of access to treatment, there is evidence to suggest that interpersonal issues and the perception of order of needs of homeless individuals are additional barriers. Acosta and Toro (2000) noted that the homeless population do not always rate their need for substance abuse treatment as their highest priority or even as an important one. A divergence also exists at times between client perceptions of treatment needs and those of their providers (Calsyn et al., 1997; Rosenheck et al., 1997 cited in Zerger, 2002a). Some homeless people do not perceive their drug use as problematic, and that for some people any problems caused by substance use possibly seems insignificant compared to more immediate problems and needs such as shelter and food.

Homeless people with a dual diagnosis are one particular subgroup who faces many barriers to receiving appropriate treatment. Consultations conducted with service providers as part of the Victorian Homeless Strategy (VHS) (2000a) identified that the presence of co-occurring disorders often precluded homeless people from accessing appropriate and adequate treatment in either of the service systems, further exacerbating their state of health and homelessness. Both the mental health service system and drug treatment services are not

designed to meet the needs of individuals presenting with a dual diagnosis, many of who may also present as homeless and in need of significant support and treatment interventions. The poor integration of services systems and the lack of adequate funding to meet the needs of this target group diminish their chances of treatment and appropriately managed care that will yield improved health outcomes.

While the above barriers discussed apply to both homeless men and women, the literature and supporting research also raises gender differences experienced and the presence of such as a barrier to accessing and continuing treatment. While the examination of gender differences between homeless men and women was beyond the scope of this study, it is nevertheless an important issue worthy of consideration and future examination.

Studies which have examined the outcomes of women only programs versus mixed gender programs have unanimously concluded that women specific programs result in positive outcomes for women, especially in terms of program retention (Zerger, 2002a).

The need for gender specific treatment is often advocated due the higher incidence of sexual abuse, victimization and domestic violence and subsequent effects of that abuse on their drug use (Copeland and Hall, 1995; Thom, 1987). The lack of support from family and friends (Thom, 1987) to undergo treatment further compounds the situation particularly if there are children to be cared for. A study that examined both men and women on entry into treatment found that women were more likely to have had a recent experience

of violence from their partners and to have received less support for entry into treatment (Thom, 1987). Research on homeless mothers with substance abuse disorders points to the needs for childcare, the lack of which has created a significant barrier for many women seeking treatment. (Zerger, 2002a). In an Australian study that evaluated specialist drug and alcohol treatment service for women – Jarrah House (Copeland et al., 1993) found that more women with dependent children prematurely discharged themselves from traditional mixed sex services, where their parenting and child- care needs were not being met. While the above studies did not examine the needs of homeless women, they do draw attention to specific needs that may exist for homeless women and which may be having an impact on their involvement in treatment.

*As long as drug users in Australia continue to find it more difficult to enter drug treatment than to obtain illegal drugs from traffickers, poor outcomes are inevitable. In order to recruit and retain the majority of drug users in treatment, the target population must be offered drug treatments they find attractive and accessible (Wodak and Moore, 2002).*

Homeless people are one such target population that needs choice in treatment options and a system set up to meet their specific needs.

## **2.9: CONCLUSION**

Despite an emerging body of literature on homelessness and drug use, both nationally and internationally, there exists a gap in research on this population group's use of Drug Treatment Services and the barriers they face within

Australia. Hence the need for further research into this area. A key objective of the Trial is to strengthen the capacity of Crisis Supported Accommodation Services to effectively assist drug-using clients and to provide a point of referral into Drug Treatment Services. As noted above, structural barriers experienced by CSAS residents trying to access Drug Treatment Services are often reported as the key factor preventing the homeless person's ability to access services. The full extent of what barriers are being experienced by homeless clients is however not clear, and such information has, as yet, not been gathered from the clients themselves. In order to answer the study's research questions on what the barriers are that prevent homeless individuals from accessing and then sustaining drug treatment this study will endeavor to shed light on both the structural and personal barriers experienced by residents, which will inform individual agency responses to this client group. In addition, information gathered in relation to this target groups accommodation, drug use, and heroin overdose histories, as well as current health issues will also provide the necessary data and insight on the profile of homeless drug users staying in CSAS that is required to inform health enhancing program responses and support advocacy strategies of the Homeless and Drug Dependency Trial. Findings will be shared with the wider community and will add to the body of knowledge on homelessness and drug use.

## **3. METHODOLOGY**

### **3.1 Introduction**

The purpose of this study is to develop an understanding of the profile of homeless residents with a drug dependency that are staying within three of Melbourne's major Crisis Supported Accommodation Services. The knowledge gained will inform and support the Homeless and Drug Dependency Trial's development and implementation of initiatives against Trial objectives. It will also provide a baseline of information on this particular group, that to date has had limited investigation, but is placing increased demand for assistance on the Crisis Supported Accommodation Service system. The specific questions that are at the centre of this study were discussed in section 1.

This chapter will detail the methodology chosen, methods of enquiry, ethical considerations, processes undertaken prior to the study, strategies implemented to enhance reliability and validity of the study and noted limitations to the study. This discussion will provide the detail necessary to replicate this study and make the "research process traceable, a factor that adds credibility to the research undertaken" (Baum, 1998).

### **3.2 Methodology**

A cross sectional study design was chosen utilizing a semi structured survey, as this methodology is suited to measuring the prevalence of a situation (such as homelessness and drug dependency) by studying a cross section of the

population. The survey was retrospective in its reference period, calling on eligible residents to recall events. This methodology was also chosen, as the researcher believed it offered the best approach to exploring and answering the research questions. While the majority of questions asked in the survey were closed and quantitative, a series of open-ended qualitative questions was also included, in order to acquire a deeper understanding of the participant's experiences and meanings and to obtain information relevant to the purpose of the research.

Face to face interviews were conducted across three Crisis Supported Accommodation Services within inner Melbourne during the first quarter of 2002 by the researcher and one other interviewer.

As discussed, a semi-structured questionnaire that was both quantitative and qualitative in design was administered to individuals who were homeless but currently residents of one of the three major Crisis Supported Accommodation Services within inner Melbourne and were current drug and alcohol users. A mix of open and closed questions was asked in order to elicit a range of measures, and to build a profile of the populations homelessness, drug use and health related history, as well as their subjective experience of barriers that affect their access to Drug Treatment Services and the continuation of treatment once admitted.

### **3.3 Methods of Enquiry**

#### ***Field Sites***

Given that the study was about generating a profile of residents who are homeless and current drug and/or alcohol users within the Homeless and Drug Dependency Trial's participating Crisis Supported Accommodation Services, interviews were conducted on site at these three services, namely Hanover Southbank, Ozanam House and Flagstaff.

#### ***Hanover Southbank:***

Hanover Southbank is a crisis accommodation service located in South Melbourne. Hanover Southbank is part of Hanover Welfare Services, an independent welfare agency that began in 1964 to work with Melbourne's homeless. On any one night the crisis accommodation facility provides temporary accommodation for 50 people, which includes men, women and families.

#### ***Ozanam House:***

Ozanam House is a Crisis Accommodation Service located in North Melbourne. Ozanam House is part of the Ozanam Community, which is a special work program of St Vincent de Paul Society, Victoria. On any one night Ozanam House provides temporary refuge accommodation for 60 homeless men.

***Flagstaff:***

Flagstaff is a crisis accommodation service located in West Melbourne. Flagstaff is part of the Salvation Army's adult services program. On any one night Flagstaff provides temporary refuge accommodation for 64 homeless men

### **3.4 Population under Study**

This study was open to homeless people between the ages of 18–70 years of age who identified as being a current drug and /or alcohol users, and at the time of the interview was staying at one of the three Crisis Supported Accommodation Services (CSAS) within the Trial. The actual age range of participants was however between 19-48 years of age. To be eligible for the study, participants needed to be current residents of the crisis supported accommodation service and identify as a current drug and/or alcohol user.

### **3.5 Sample Size**

The sample size calculation was based on a total population of 2,770 people experiencing homelessness who accessed crisis accommodation services in one year (SAAP, 1998-1999). The total population who accessed crisis supported accommodation was used as the benchmark for calculation, as the exact number of people who used the services and also presented with a drug and/or alcohol issue is not known due to the under reporting of this issue by residents. In addition it is difficult to know what percentage of short stay clients have a high level of personal issues such as drug and alcohol use.

Population: 2,770

Desired confidence interval that the sample results reflect the population  
results: 95%

Anticipated population proportion: 50% (Because this is unknown 50% is  
selected as it yields the highest sample size requirement)

Absolute precision required on either side of the proportion: +/- 10%

**Sample size required: 92 residents**

Based on this sample of 92 it will be possible to conclude that within a 95%  
confidence interval, the proportion of the population of the factors under study  
as reported in this thesis are within +/- 10% of the proportion as measured  
within the sample

A minimum sample size of 92 was therefore required in order to achieve a statistically significant sample. However, 95 surveys were completed, and have been analyzed and reported on in this thesis. Of these 95 participants, 5 people did not complete all relevant sections (health section). This does not however affect the validity of the instrument or the analysis, as the total non-completion rate is < 8%.

The sample group does not represent all homeless drug users, but rather focuses on homeless drug users staying within the three crises supported accommodation services under examination.

### **3.6 Recruitment and Selection**

All participants were volunteers recruited from the three Crisis Supported Accommodation Services and were given \$20 for their participation as compensation for any expenses they may have incurred.

A non-random sampling method was employed, as the exact population of residents with substance use issues is not known due to under reporting by residents of their drug use.

Recruitment occurred through the “Snowballing” approach where residents were informed about the study via advertisements posted around the CSAS and through word of mouth from other residents and crisis accommodation staff. Interested residents placed their name down on a list at each of the CSAS and were screened for eligibility by the researcher, prior to conducting the interviews. The snowballing approach was chosen as it is the best method employed when the target population is unknown, or when it is difficult to approach the respondents in any other way (Sarantakos, 1998). A limitation of adopting a non-probability sampling frame is that the findings may not be representative of all homeless people with substance use issues.

Further, participants had stayed at one of the CSAS for a mean of 36 days prior to being interviewed. Given this length of stay, participant experiences from staying within a CSAS with improved service capacity may have influenced their responses to questions about services.

## **3.7 Instrument**

### **Development Phase**

The inception of this study came out of an identified gap in current knowledge and statistical information directly related to homeless drug users accessing crisis accommodation, the target group of the Trial. While Hanover Welfare Services has conducted studies into the prevalence of drug use among its clients (Horn, 1996 and 1999), there had been no detailed study into drug use history, patterns of use, overdose history, risk of blood borne virus transmission, drug related health issues or the use of Drug Treatment Services, particularly from the target group themselves. The Inter Agency Working Party and the Trials research and advisory group recognized the need to gather this information firstly in terms of providing solid baseline information for the Trial as well as providing data to support claims and to strengthen the service systems advocacy strategy.

There was initial resistance by some practitioners to conducting this research as they felt it would be too intrusive and could not see the relevance in asking certain questions that they felt they already knew from experience in the field. In light of these issues, considerable time was taken by the researcher to discuss these issues with practitioners. Every opportunity was given to both managers and practitioners within the Trial to offer feedback on the survey design at several intervals. After extensive consultation with each service and the Trial's Research and Evaluation Advisory group, final development of the survey and research proposal was completed.

The survey instrument (Appendix 1) consisted of six sections and was semi structured in design, allowing for the collection of in depth information while at the same time considered a more appropriate tool to administer in terms of the complex and sensitive nature of the study.

## **Instrument Design**

The following is an outline of all six sections of the survey tool (see Appendix 1):

### ***Section 1: Background***

This section gathered information related to the participants demographic characteristics. The demographic details obtained included: gender, age, country of birth, cultural identity, marital status, highest level of education, employment status and income supports.

### ***Section 2: Accommodation/Homeless History***

This section firstly focussed on identifying the participants level of homelessness by asking questions related to their current period of stay at the CSAS, number of moves in the past year, type and duration of last three places stayed and their previous level of stays at crisis accommodation services. Participants were also asked to define what a home means to them and to recall when they last felt that they had a home. Reasons for coming to the CSAS were recorded and the participant's main reasons for currently experiencing homelessness or having nowhere to stay were explored. Similar questions had previously been asked of homeless people in a snapshot analysis study conducted in 1999 by the Inter Agency Working Party, which examined the

current demand on major Crisis Supported Accommodation Services in inner Melbourne (Inter Agency Working Party, 1999).

### ***Section 3: Drug Use History***

In order to identify the overall level of drug use, patterns of use and reasons for drug use, participants were asked a series of questions, about their current main drug of choice, whether this had changed from a previous drug of choice and what that was, whether they had ever injected drugs and if so what was this last drug and what was the drug they injected most often in the last month.

A detailed table of information related to the participant's level of use for each drug class was collected. This table was adapted with permission from Craig Fry (Turning Point), and from the 2001 Victorian Drug Trends Illicit Drug Reporting System (IDRS) survey, modified and then supplemented with additional questions. The IDRS study aims to provide a rapid and reliable method of monitoring trends related to the use of opiates, cannabis, cocaine and amphetamines (Fry and Miller. 2000). For the first year in 2001, this study identified homeless participants, making the data collected useful for comparative analysis with certain sections of this study notably drug use history, overdose rates and needle risk taking behaviors. Limitations in comparison exist however as only 8% of the sample (n=151) were homeless (no fixed address) while 17% were living in a boarding house/refuge/hostel.

Participants were asked to identify against each drug class, age of first use (not included in 2001 Victorian Drug Trends IDRS study), reason for first use (not

included in 2001 Victorian Drug Trends IDRS study), ever injected, injected in last six months, ever smoked, smoked in last six months, ever snorted, snorted in last six months, ever swallowed, swallowed last six months, number of days used in the last six months, days used in the last 7 days (not included in 2001 IDRS study) and reason for current use (not included in 2001 Victorian Drug Trends IDRS study).

#### ***Section 4: Heroin Overdose History***

Participants were asked questions related to heroin overdose in order to identify their history of overdose, potential risk of further heroin overdoses and their perceived risk of overdose. For the purpose of this study overdose is defined as any of the following symptoms occurring when using heroin: collapsing, difficulty breathing, cyanosis, losing consciousness and the inability to be roused (Darke and Ross, 1997).

Participants who had ever used heroin were asked whether they had ever overdosed, how many times within the last 12 months, the last time that they overdosed, whether they had been administered naloxone and how many times they have been around when someone else had overdosed. Participants were also asked questions related to their environment when using, such as whether they usually use alone or with someone else and who that person is, place that they last used, where they have usually used in the last month. Additional questions related to risk of overdose were also asked. These included whether participants use other drugs at the same time as using heroin, do they spilt the dose when buying new heroin and do they buy from the same or different

dealers. Finally, participants were also asked to identify what they thought their risk of overdose was and why.

#### *Section 5: Prior use of Drug Treatment Services*

In order to gain an indication of the level of use of Drug Treatment Services by homeless people drug users, participants were first asked to report whether they had ever wanted to access a drug treatment service in the past and why they wanted to access treatment or why they had not wanted to access treatment. These questions were then followed up with a question asking whether participants had ever actually accessed a drug treatment service. Participants were then asked which treatment services according to service type they had accessed in the past 12 months, the outcome and their perception of service episodes.

The drug treatment system within Victoria is seen as comprising several interdependent components and includes the primary health care system, specialist Drug Treatment Services and in parts the broader service system such as mental health (Drug Policy Expert Committee, 2000). Participants were asked to report against a range of service types within these three domains. Anecdotal evidence from within the Crisis Supported Accommodation Services and the homeless sector often refers to the many difficulties and barriers faced by homeless people when they try to access the service system, often resulting in poor outcomes. In order to gain an indication of these barriers and a more detailed understanding directly from homeless drug users, questions were asked in order to explore:

- Barriers experienced by participants when they have tried to access a drug treatment service;
- Elements in the past that have stopped participants from seeking assistance with their drug and alcohol problems;
- Issues or aspects within the participants lives that stop them from changing their current situation (homeless with drug dependency problems)
- Factors that in the future if they were interested in accessing a drug treatment service would help them continue their involvement.

### ***Section 6: Health Issues***

The final section of the survey consisted of three parts, health issues experienced in the last month, mental health issues and the participant's risk of blood borne virus transmission.

Participants were asked to report whether they had experienced health issues within the last month from a list of possible responses related to injection related problems, dental, general health and emotional/psychological factors (link to depression indicators). Participants were then asked whether they had been diagnosed with a mental health illness and whether they had experienced and episode of self-harm or attempted suicide in the past.

The final part of this section asked questions related to the participant's risk of blood borne virus transmission. Four out of the nine questions (questions 43.1 – 43.6) asked in this section have been sourced from the IDRS Survey (Fry and Miller, 2001). Questions were asked to assess behaviors in the last month that

placed the participant at risk of either contracting or transmitting a blood borne virus.

### **3.8 Data collection**

Data collection took place during the first quarter of 2002. Ninety-five face to face interviews were held with participants and took on average 50 minutes to complete. Participants appeared engaged and happy to answer questions and wanted to discuss issues in detail, often taking longer than 50 minutes to complete the survey. At the completion of the interview many of the men and women commented that they found it informative to discuss and also reflect on their drug use and associated issues. They were also pleased to be involved in a study that asked them “first hand” about these issues and their experiences. Little difficulty was experienced in meeting the sample size target, particularly once the study was underway and being discussed by other residents.

Only two interviewers (the researcher and one other trained interviewer) administered the survey, enhancing the consistency and therefore the reliability of the data collected. The researcher also conducted 66 of the 95 interviews. While limiting the number of interviewers to two increased the reliability of the study, using two interviewers instead of one may have increased the potential for interviewer bias. Every effort was made however prior to conducting the interviews and during the interview period to eliminate or control any error producing factors through training, shared discussion and supervision.

Interviews were conducted on site within the three major crisis accommodation services, Hanover Southbank (34 interviews), Ozanam House (30 interviews)

and Flagstaff CSAS (31 interviews). Every effort was made to collect an equal sample size across the three services as requested by the Crisis Supported Accommodation Services, however a slightly larger sample at Hanover Southbank was collected in order to capture a percentage of female participants within the study (Hanover Southbank is the only service out of the three participating services that is able to accommodate men, women and families). While it would have been beneficial to the study if more women had been interviewed, Hanover Southbank were also interested in capturing a representative sample from their service where possible. This therefore involved interviewing both men and women, as was managed within this study.

Interviews were conducted in interview rooms at the three Crisis Supported Accommodation Services or in other spaces that felt comfortable for the participant, such as outside garden areas or in the canteen /common room space that was not being utilized at the time. At all times prior to and during discussion the researcher assessed the interview spaces nominated by participants for their ability to maintain privacy and confidentiality during discussion.

All interviews were scribed on to the survey form independently by the two interviewers and later entered into the database by the researcher only, enhancing the reliability of the study.

### **3.9 Data Analysis**

Data analysis consisted of two approaches in order to analyse both the quantitative and qualitative data collected. During data analysis patterns in data were analyzed for recurrent behaviors, events, trends and irregularities.

In terms of procedure, data collected was entered into the software package SPSS Version 11 for Windows by the researcher. Some of the open ended questions (Question 22 – Reason for first use, reason for current use and questions 37 through to 40 on barriers to treatment) required additional categorization and reduction of data into themes prior to data entry into SPSS. Frequencies of subgroups were manually charted under themes and counted in order to capture the range and texture of responses to specific questions. These charts were then studied using the following processes:

“Review the charts and research notes; compare and contrast the perceptions, accounts, or experiences; search for patterns or connection and seek explanations for these internally in the data” (Ritchie and Spencer, 1994).

Once all of the data had been entered into the database or manually recorded it was screened for any errors that may have occurred during data entry. These errors were then corrected by the researcher and then checked by an independent person prior to commencing analysis.

Comparative analysis against the 2001 Victorian Drug Trends IDRS (Fry and Miller, 2002) study occurred, in order to identify meaningful differences and similarities between the two sample groups. Limitations exist however in the

level of comparison that can be inferred to homeless drug users from this study, as only 7% of the sample were of 'no fixed address', while 17 % were staying in 'boarding house/refuge/hostel' at the time of interview. It does however provide up to date illicit drug use trends amongst injecting drug users in Victoria and within close proximity to each studies reporting period (June – December 2001 Vs January –April 2002).

Additionally, comparative analysis with drug use patterns in the 2001 National Drug Strategy Household Survey (AIHW, 2002) also occurred as a source of comparison against the general community. Data from the 1998 Victorian Drug Household Survey (Victorian Department of Human Services, 2002) that has been reported in the 2001 Victorian Drug Statistics Handbook has also been used in instances when comparable data was not available from the 2001 National Drug Strategy Household Survey (AIHW, 2002).

Comparative analysis with the 2001 Resident Outcomes Study conducted within crisis accommodation services in Melbourne (Thomson and Goodall, 2001,) also occurred in terms of accommodation/homelessness histories. While the two samples are the same in terms of being homeless and having stayed at a CSAS, strong inferences cannot be drawn, as participants within the 'Resident Outcome study' were not all current drug and alcohol users.

### **3.10 Validity and Reliability**

To improve the validity and reliability of this study a number of safeguards were put in place. This involved identifying areas of possible bias or concern

and implementing strategies to address these. The following section will also outline events that occurred which support the validity of the study.

Data collected was via the self-report mode. This method of reporting by drug users has been challenged in the past in terms of its reliability and validity.

Studies into this area have however identified that drug abusers self reports are reliable and valid (Sherman and Bigelow, 1993). In a study of the validity of patients self reported drug use as a function of treatment status, Sherman and Bigelow (1992) concluded that:

*Drug abusers self reports are neither accurate nor inaccurate, but rather vary as a function of different cognitive motivational and social factors. As previous researchers (Cannell, Miller, Oksenberg, 1981; Nurco, 1985) have indicated, methodological procedures, such as question length and response modelling, obtaining commitment from the respondent, establishing rapport between interviewer and the respondent, guaranteeing the confidentiality of responses, and informing the respondents of external checks of their self reports, also contribute to the accuracy of drug abusers self reports of drug use (Sherman and Bigelow, 1992).*

All of the above factors were carefully considered and applied to the research design and interview process. From the moment of the first meeting with participants, every effort was made to build rapport, trust, and to make the participants feel comfortable. Prior to commencing the screening of each

potential participant (potential participants needed to be current drug users), individuals were taken into a private room or space that would ensure confidentiality and privacy right from the beginning. Once it was identified that participants were eligible, the study was described in general terms as an introduction and then the participant information sheet (Appendix 2) was read through in detail by the interviewer with the participant. The interviewers answered any questions as they arose and addressed any issues of language difficulty or terminology confusion. Written informed consent (Appendix 3) was then obtained, and finally participants witnessed the interviewer placing these forms into a separate folder prior to interview commencement ensuring that all possible avenues of confidentiality were maintained. Interviewers also explained their role and how they would take care of and store all collected information so that no identifiable information could be accessed or linked to their non-identifiable survey form.

Both interviewers had extensive experience in the social welfare field as both practitioners and researchers, the principal researcher having worked in the homeless field as an outreach community health nurse for a number of years. Sensitivity to the issues facing this target group was always at the forefront, which enhanced the level of understanding and open dialogue between the participant and interviewer.

The design of the survey allowed for the cross checking of information between some questions (injecting heroin use and heroin overdose history as

well as injecting drug use and blood borne virus transmission) and demonstrated the accuracy of self-reports.

In one instance, a participant completed the survey twice by seeking out another interviewer while the researcher who had interviewed them two weeks previously was interviewing someone else and also had the log book of participants (an additional check to ensure that participants are only interviewed once). This event did however allow for a tentative reliability check between the two collected surveys. The second survey form was excluded from analysis. While it provided only one opportunity to test the reliability of self reports by participants, it did demonstrate that the information reported in the first interview was the same in the second, further supporting the validity of the study.

As discussed previously, only two interviewers (the researcher and one other trained person) interviewed and conducted the interviews. The researcher was always present, conducting interviews at the same times. While the other interviewer was experienced and also trained in the design of this survey – field supervision and checks of data collected also occurred.

All data was entered by the researcher only, and went through a process of screening and checking by both the researcher and one other independent person at the end of the data entry period in order to check for errors.

The interviewer's ability to build rapport and trust appears to have been successful as participants appeared comfortable and open to answering questions. Several participants raised the issue at the end of their interviews that "no one ever asks about gambling addiction and how it leads to family breakdown, drug use and homelessness". Following the interview two of these participants left a letter for the researcher at reception in the Crisis Supported Accommodation Services, outlining what they believed the issues were in terms of gambling addiction and what services should be offered. While the study did not explore issues of gambling addiction it does highlight this as another area requiring further examination. These events also highlight the participant's comfort level and willingness to be actively involved in such discussion and debate.

### **3.11 Limitations of the study**

- Non-random sampling was the method employed, as it was deemed the most appropriate method to use given the sensitive nature of the study. This method of sampling however may lead to sample bias, as such a method may not accurately reflect all homeless drug users in crisis accommodation, for instance short stay clients.
- Given that this study was conducted with homeless drug users in crisis accommodation, it is therefore not representative of all homeless drug users.
- Due to the scope of the masters program, an exploratory comparison between men and women did not occur.

- This study did not allow for the direct analysis of relationships between variables. While this was not the purpose of the study, such analysis may have further illuminated the field of enquiry. Due to the scope of this masters program, the author did not therefore immerse herself in the depths of the statistics. It is hoped however that this study leads to further examination of these relationships by other researchers in the future.
- The design of the depression indicators questioned could have been worded differently to elicit stronger indicative data according to the specific diagnostic criteria. While the results lend themselves to further exploration they should only be viewed as exploratory.
- The payment of participants, while considered a standard practice in the social health field may have influenced participants.

### **3.12 Ethics**

Ethical considerations were central to this study from its early stages of development. As discussed in the section on Instrument Design the construction of questions was determined by a balance to yield the required data while at the same time being sensitive to the issues of this target group. All drafts of the tool were reviewed by the Homeless and Drug Dependency Trials Research Committee on two occasions which included a number of individual discussions with practitioners to ensure that it meet with their approval and addressed any concerns that may have been raised.

Ethics approval from the Homeless and Drug Dependency Trial's Ethics Committee was obtained for this study prior to ethics approval being granted

from the Flinders Medical Centre/Flinders University – Flinders Clinical Research Ethics Committee/Clinical Drugs Trials Committee. Approval was also given from the heads of the three CSAS.

Ethical dimensions pertaining to this study have been fully considered and included the following:

- Confidentiality and anonymity of all subjects was guaranteed and these issues were discussed with participants prior to the interview.
- Participants were informed of their right to check, withdraw or limit information, including their right not to answer particular questions.
- Data collected has been stored in the researcher's office (Kim Rayner) and can only be accessed by the researcher.
- Hard copy data collected has been transferred and stored on the computer under a password system and in a locked filing system in the researcher's office (Kim Rayner). This information will only be able to be accessed by the Trial research team.
- Identifiable information collected, such as the consent form, has been stored separately from the coded questionnaire data to ensure confidentiality is preserved at all times.
- Responsibility for the security of confidential data rests with the researcher - Kim Rayner.
- Data will be held for sufficient time to allow reference. NHMRC recommend that the minimum period of retention is at least five years from the date of publication.

- The provision of information pertaining to the study was given to the client in both a verbal and written format (Appendix 2). At this time the participant was informed that their participation was entirely voluntary.
- Written informed consent was obtained from each participant prior to conducting the interview (Appendix 3).
- A payment to participants of \$20 was made on completion of each interview as compensation for any expenses incurred.
- Publication of findings will only include non-identifying information.
- All participants were from an English speaking background, interpreters were therefore not required.

### **Management of Potential Harm to Participants**

Individuals participating in this research study were not at risk from any physical, social or legal harm. Throughout the interview process, participants were asked sensitively designed questions related to their drug. To minimize any psychological or other risks only two interviewers, experienced and qualified in the areas being examined administered the questionnaire. At all times interviews were conducted in a skilled and sensitive manner, ensuring that the client's well being and right not to answer questions underpinned the process.

If issues arose during the interview process that required follow up, participants were referred to their CSAS caseworker for assistance as requested by participating services.

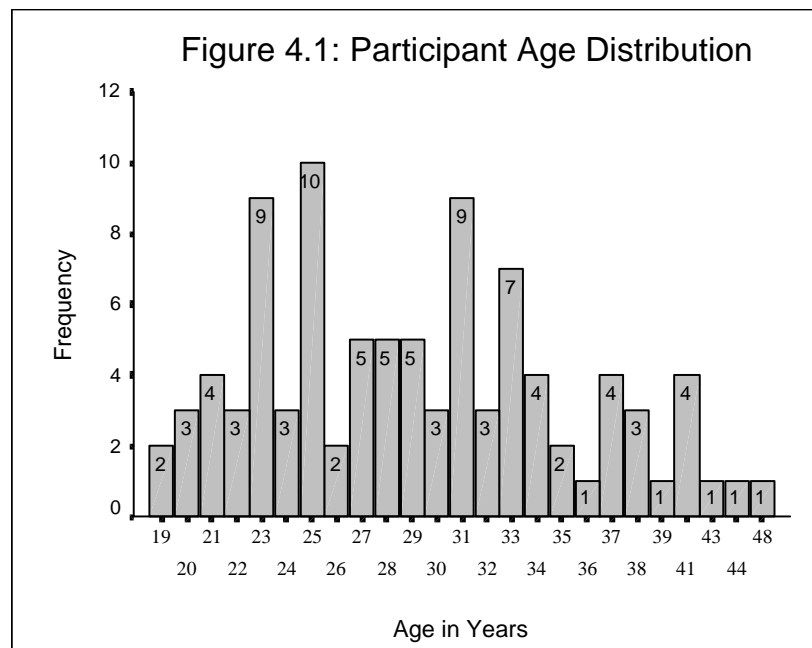
Only on one occasion did a participant seem upset at the end of completing the interview. Time was taken to support this person who stated, “He would be alright”. He expressed to the interviewer that the discussion had made him “think about things in his life”. The interviewer expressed her concern at the participant’s distress and asked if she could speak with his CSAS worker, who would be able offer additional support and check how he was feeling over the course of the day. The participant was reluctant at first for this to happen and requested other referral options. These options were also given to the participant but the interviewer also encouraged the participant to think about accepting support from their CSAS worker. After a short discussion the participant allowed the interviewer to speak with their worker. The participant also expressed that he was keen to see a counselor after participating in the study. At the end of completing this discussion, the interviewer was unable to locate the participant’s worker, so the interviewer spoke directly to the manager on duty that acted on the report. A follow up phone call was made to the manager the next day to check how the participant was. The manager reported that the participant was doing well and had showed no other signs of distress.

## 4. Overview of Sample

A total of 95 homeless people were interviewed. At the time of interviews, 33% of the sample were residents of Flagstaff CSAS, 32% were residents of Ozanam House and 36% were residents of Hanover Southbank.

The majority of participants were males (77 %) compared to females (23%) due to Ozanam House and Flagstaff CSAS accommodating men only.

The mean (average) age of all participants was 29 (median 29, SD 6.3, range 19–48). The mean age for males was 29 years, for women it was 30 years. In comparison, the average age of the study group was three years younger than that reported in the Resident Outcomes Study (Thomson Goodall Associates, 2001) where the average age of the participating CSAS residents was 32 years.

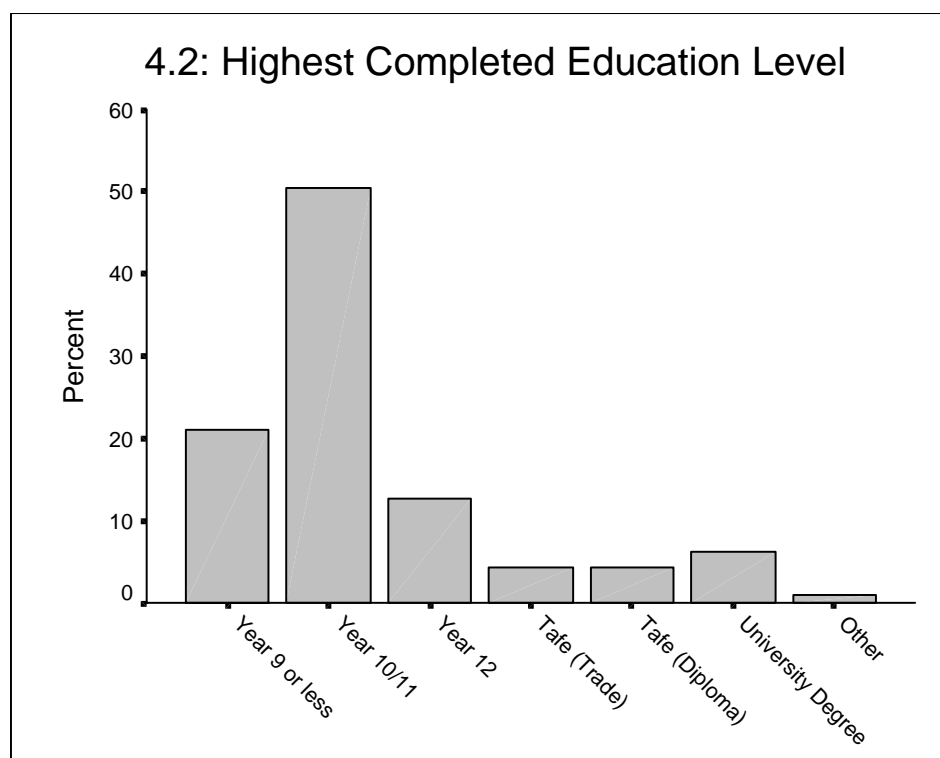


The majority of participants (86%) were born in Australia. The remaining were born in the United Kingdom (8%), New Zealand (2%), Italy (1%), Sri Lanka (1%), Papua New Guinea (1.1%) and Cuba (1.1%).

Eighty percent (80%) of participants reported their cultural identity was Australian, with the remaining participants identifying their cultural identity as English (4%), Italian (3%), Irish (4%), Aboriginal (2%), Sri Lankan (2%), Croatian (1%), Maltese (1%), New Zealand (1%) and Dutch (1%).

Seventy two percent of participants were single, while 12% were in de facto relationships and 17% were divorced or separated.

The majority of participants (figure 4.2) had not progressed past secondary education (84%), with 21 % achieving year 9 or below, 50 % completing Year 10 or 11 and 13 % completing Year 12. Eight percent had completed a trade or TAFE qualification, 6% had completed a university degree and 1% had completed a hospital based general nursing qualification.



Ninety percent of participants were unemployed, 7% were in casual employment, 2% were in full-time employment and 1% were in part time employment. For participants who reported being employed (n=10) they reported being employed in the following industries – Building (n=3), Hospitality (n=2), Retail (n=1), Professional (n=1) and other (n=2).

Ninety three percent of participants received some form of income assistance from the government. The majority were receiving Newstart payments (51%), while a significant proportion were on a Disability Support Pension (32%), affecting their ability to participate in the labour market. The remaining 8% received other means of income. Table 4.1 summarises the demographic characteristics of the sample, differentiating between men and women.

**Table 4 .1: Demographic Characteristics of the Sample**

<b>Variable</b>	<b>Males (n= 73 )</b>	<b>Females (n= 22)</b>	<b>Total (n=95)</b>
<b><i>Crisis Accom Service</i></b>			
Hanover Southbank	12	22	34
Flagstaff CSAS	31		31
Ozanam House	30		30
<b>Age (mean yrs)</b>	29	30	29
<b><i>Country of Birth %</i></b>			
Australia	86	86	86
UK	7	9	7
New Zealand	1	5	2
Italy	1	-	1
Sri Lanka	1	-	1
PNG	1	-	1
Cuba	1	-	1
<b><i>Marital Status %9</i></b>			
Single	71	73	72
De Facto	10	18	12
Divorced/Separated	19	9	17
<b><i>Highest Level of Education Completed %</i></b>			
Year 9 or less	19	27	21
Year 10 or 11	52	46	51
Year 12	14	9	13
TAFE apprenticeship	6	-	4
TAFE –Diploma	6	-	4
University Degree	3	18	6
Other	1	-	1
<b><i>Employment status %</i></b>			
Not Employed	89	91	90
Full Time	3	9	2
Part Time	1	-	1
Casual	7	-	7
Other	-	-	-
<b><i>Source of Income Support %</i></b>			
Newstart	55	36	51
Youth Allow.	1	18	5
Disability Sup. P	33	27	32
Sickness Allow.	3	-	2
DVA Disa. P.	1	5	2
Parenting payment	-	5	1
State Trustees	-	5	1
Wages/salary	4	-	4
None	1	-	1
Other	1	-	1

## 5. Accommodation/ Homeless History

Chapter five details the participant's accommodation and homelessness history as well as their experience of being homeless in order to understand the profile of homeless drug users who access CSAS. A series of questions was asked in relation stays with the CSAS system, accommodation movement in the previous twelve months, reasons for currently experiencing homelessness and their subjective view of what a home represents to them and when they last felt that they had a home.

### 5.1 Stays within CSAS:

Participants interviewed had stayed at the CSAS for a mean of 36 days prior to being interviewed (median 24 days, SD 34.5, Range 1- 182 days) compared to 32 days in the Resident Outcomes Study (Thomson Goodall Associates, 2001). The length of stay reported suggests that participants in the study are representative of more long-term residents.

**Table 5.1: Length of Current Stay in the CSAS**

Length of stay (days)	Number of participants N=95	Percentage %
Less than one week	17	18 %
8-21 days	30	32 %
22 – 28 days	6	6%
1- 2 months	31	33%
2 + months	11	11 %
Total	95	100 %

A large proportion (72 %) of participants had stayed at a crisis accommodation service in the past, indicating a need for repeat crisis accommodation. The level of stays (Table 5.2) at participating Trial Crisis Supported Accommodation Services (CSAS) and other crisis accommodation services, indicates that out of those who had stayed at a CSAS in the past (n=68), 50% had stayed at Hanover Southbank before, 49% had stayed at Ozanam House in the past, 41% had stayed at Flagstaff in the past and 56% had stayed at other non Trial CSAS within Victoria and interstate.

**Table 5.2: Previous Stays at CSAS**

<b>CSAS</b>	<b>No. of stays in the past</b>	<b>No of residents N=68</b>	<b>%</b>
<b>Hanover Southbank</b>	0	34	50
	1	17	25
	2	9	13
	3-4	6	9
	5+	2	3
<b>Ozanam House</b>	0	35	52
	1	8	12
	2	15	22
	3-4	7	10
	5+	3	3
<b>Flagstaff</b>	0	40	59
	1	12	18
	2	12	18
	3-4	3	4
	5-6	1	2
<b>Other CSAS</b>	0	30	44
	1	12	18
	2	7	10
	3-4	9	13
	5-6	10	15

## 5.2: Mobility of Participants

Participants identified as being a highly mobile/ transient group. The following data provides an indication of the sample group's level of homelessness and patterns of movement. The mean number of moves in past year was 11 (median 6, SD 16.4 5) with a range of between 1- 100 moves. 89% of the sample had 3 or more moves in the past year, compared to 68% of those in the Resident Outcomes Study (Thomson Goodall Associates, 2001).

Thirty two percent had moved 4-6 times, 16% had moved 7-10 times, 6% had moved 10 –15 times and 19 % had moved more than 16 times in the last year.

Table 5.3 summarises the last three places stayed by participants, prior to entering the crisis supported accommodation service.

**Table 5.3: Type of Accommodation – Last Three Places Stayed**

Type of Accommodation	Last place stayed (N=95) %	Second last place stayed (N=95) %	Third last place stayed (N=95) %
On the Street	21	8	11
Friends Place	13	14	8
Hospital/Rehab/A&D Supported Accom	12	3	5
Crisis Accommodation Service	8	15	10
Hotel	7	8	8
Jail	6	2	3
Private Rental	5	16	10
With other family members	4	6	3
Boarding/Rooming House	4	6	2
In Car	4	4	6
Caravan Park	4	5	3
Parents Place	3	4	12
Park/Beach	2	1	0
Public Housing Rental	1	1	1
Squat	1	1	4
THM	0	3	2
Other	0	1	1

The last three types of accommodation give an indication of the sample group's accommodation pathway and security in terms of tenure of housing. Examining the top three places stayed for each category does not indicate one strong pattern but rather a mix of housing type movement, generally characterized by movement from less stable accommodation (CSAS/Friends place) to highly unstable accommodation, such as the street.

### **5.3: What's a Home?**

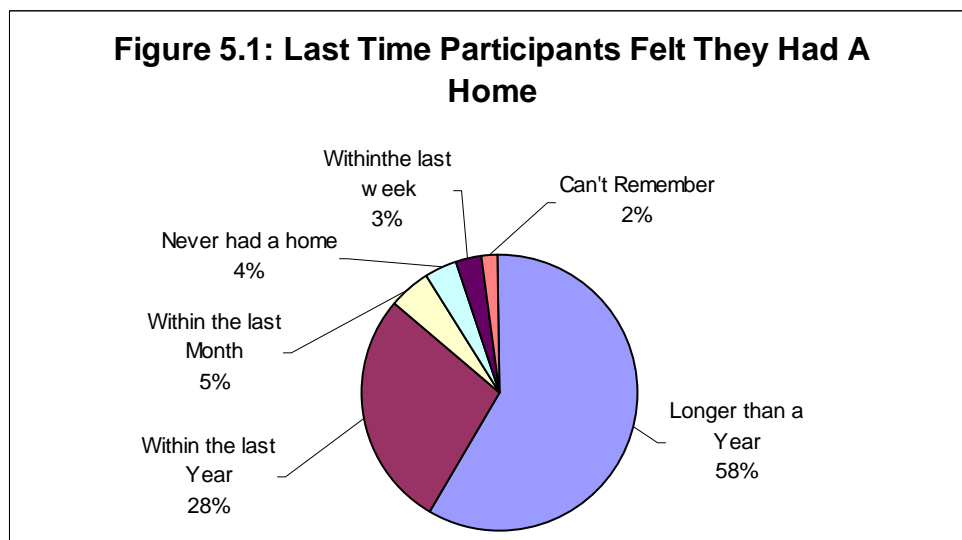
Participants were asked to *define what a "home" represents to them*. The study group gave a range of 13 responses. Fifty eight percent of participants defined "home" according to two separate responses. Multiple responses were included in the analysis. While home represents different meanings for different participants a central theme emerging when you look at three out of the top five response's reported below (\*) is of "home" representing safety and security in the participants lives. A second theme is that of independence, where home is defined according to the presence of substantial personal belongings in their place of residence, giving "home" a sense of permanency and security also.

The main responses reported by the study group (n=95) included the following:

- Place with my own belongings and furniture - **39%**
- Place that is safe and secure – **37% \***
- The house I lived in with family/where I grew up – **16% \***
- Somewhere comfortable, clean and relaxing **13%**
- Place that is peaceful – no worries – **9% \***

Participants were asked to report *when they last felt that they had a home* (figure 5.1). The majority (58%) reported that it had been longer than year since they had a home. While allowing for the differences in question order and sample characteristics, a larger proportion of the study group had experienced homelessness for longer than a year, compared to 34% in the Resident Outcomes Study (Thomson Goodall Associates, 2001).

Further, 28% of participants said it had been within the last year that they felt they had a home, 5% within the last month, 4% felt that they had never had a home, 3% within the last week and 2% could not remember when they last felt they had a home.



Those who reported that it had been longer than a year (58%) since they had a home were asked to nominate in years how long it had been. The mean number of years reported since they felt they had a home, if longer than a year, was 5 years (median 3years, SD 4.82). Data suggests that many participants have

experienced long periods of housing instability and disconnection from personal supports and the community.

#### **5.4: Reasons for coming to the CSAS**

Participants were asked why they had come to the crisis supported accommodation service (CSAS) on this occasion. Forty three percent of participants gave more than two reasons why they had come to the Crisis supported accommodation service. All responses have been recorded in Table 5.4 in order to represent the level of texture and scope of responses.

While there was a range of reasons (Table 5.4) given by participants as to why they had come to the CSAS, the main theme reported was in relation to the lack of housing in terms of having “nowhere to stay” (52%) or in order “to get assistance with housing” (20%).

**Table 5.4: Reasons for Coming to the Crisis Supported Accommodation Services**

<b>Reasons</b>	<b>Number of participants</b>	<b>% of sample N=95</b>
Nowhere to stay	49	52 %
To get assistance with housing	19	20%
Relationship Breakdown	12	13%
Evicted from previous accommodation	10	11%
Came from interstate – no accommodation	7	7%
Tired of sleeping on the street	8	8%
Referred by THM	5	5%
Released from jail	5	5%
To get assistance and support with drug use	9	9%
Knew CSAS would give me support	7	7%
CSAS is safe and secure	6	6%
Released from hospital	1	1%
No money /unemployed	4	4%

*\* Multiple reasons were recorded in this table.*

## 5.5: Reasons for Currently Experiencing Homelessness

Participants listed multiple reasons for currently being homeless. 67% of participants listed more than one reason as to why they were currently homeless. All of the responses discussed by participants have been recorded in Table 5.5.

In contrast to having nowhere to stay, which was reported as the main reason for coming to the CSAS, a majority of participants reported that their drug use/addiction (63%) was the main reason why they were currently homeless or had nowhere to stay. A significant proportion also reporting that family or relationship breakdown was one of the reasons why they were homeless, followed by 30% linking their current state of homelessness to the absence of employment/ or income.

**Table 5.5: Reasons for Currently Being Homeless**

Reasons	No of participants who reported these reasons	% of sample N=95
Drug use/addiction	60	63%
Family Problems/breakdown	23	24%
Mental illness	17	18%
No Income/money	17	18%
Relationship Breakdown	16	17%
Unemployment	13	14%
Nowhere to Stay	9	9%
No family support	8	8%
Been in jail- no references	6	6%
Evicted	5	5%
Past Abuse	4	4%
Domestic Violence	2	2%
Waiting for public housing	2	2%
Gambling Problems	2	2%
Harassment in previous accommodation	1	1%

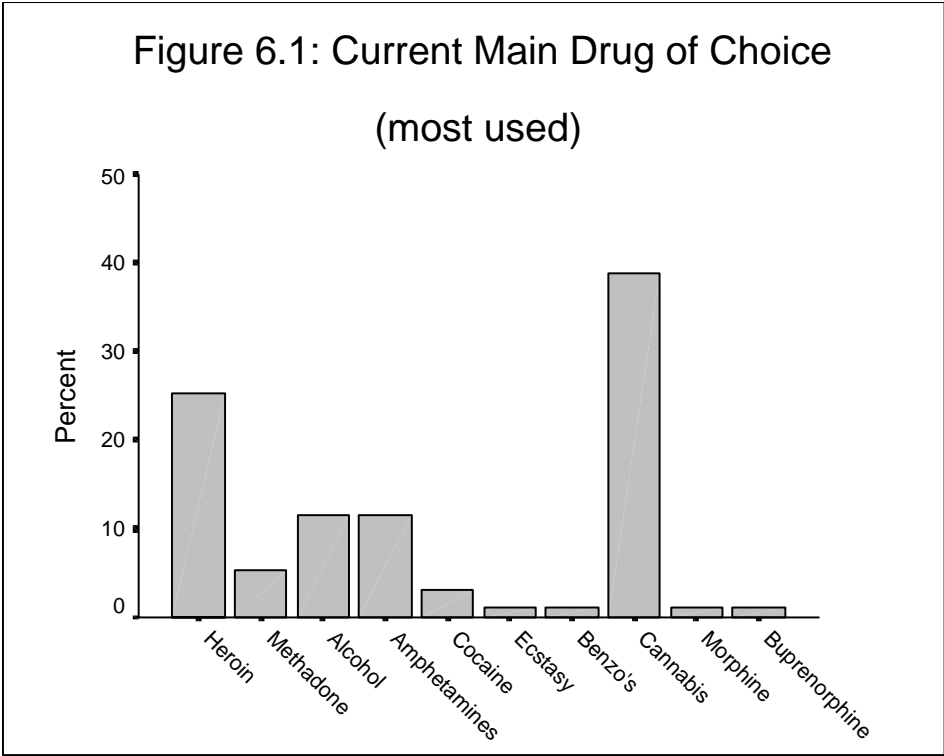
- *Multiple responses recorded*

## **6. Drug Use History**

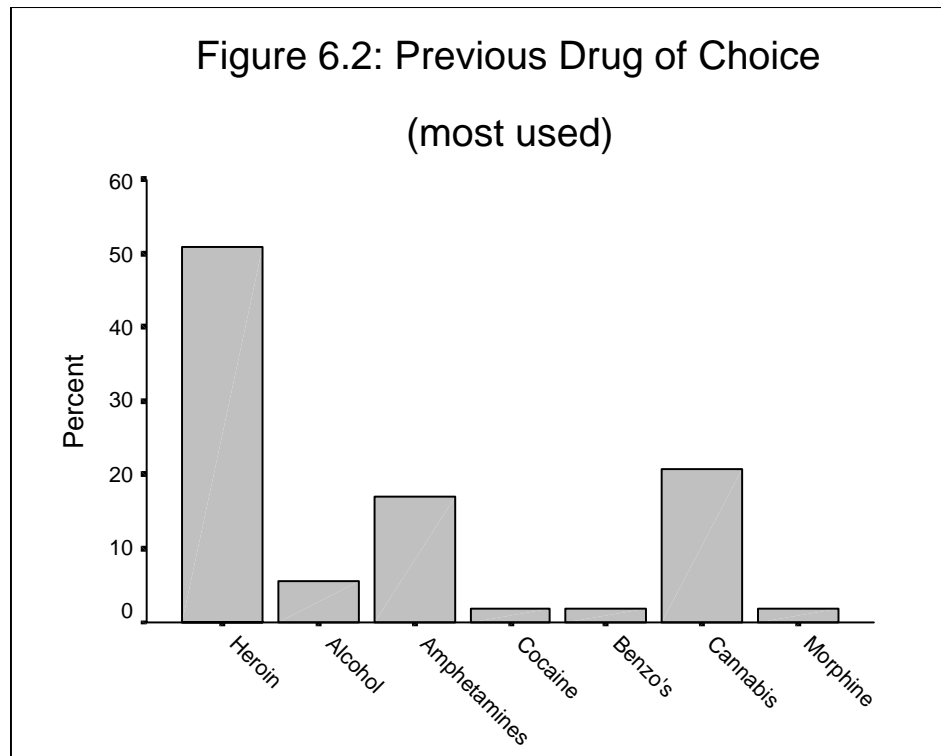
Chapter six examines the participant's drug use history of both illicit and licit drugs and the prevalence and frequency of use against key drug classes. Comparative data is used where available when examining prevalence and frequency throughout this chapter with the 2001 National Drug Household Survey (AIHW, 2002) and the 2001 Victorian Drug Trends IDRS injecting drug users survey (Fry and Miller, 2002). In addition, reasons for current and first use of the most used drug classes are examined in order to understand more fully the reasons or motivators for drug use among homeless drug users staying within CSAS.

### **6.1 Drug of Choice**

Participants were asked to identify what their current main drug of choice (most used drug) was. All of the participants identified as currently using drugs, with Cannabis (39%), Heroin (25%), amphetamines (12%) and alcohol (12%) identified as the current main drugs of choice that were most often used at the time of interviews.



Over half the participants (55%) reported that the drug they most often used at the time of interviews had changed from a previous drug of choice. Of those who had changed their regular drug of use, Heroin was identified as the previous drug used most often by 51%, followed by cannabis (21%) and amphetamines (17%).



This change in drug use patterns appears indicative of changing habits by participants prior to the data collection period, moving away from regular heroin use towards cannabis, substitution of one drug for another (ie morphine instead of heroin) and poly drug using behaviors. As indicated by participants and staff observations, it appears that the drug most often used is often largely determined by access and availability to certain drugs and the availability of money at the time of use rather than their preferred choice.

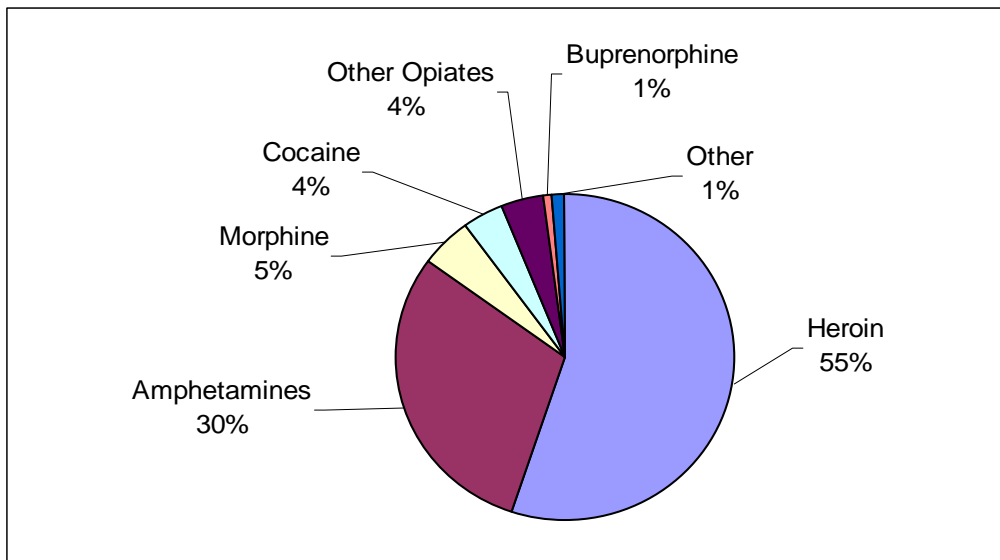
Participants reported that access to cannabis on a daily basis was easily accessible at the CSAS and a more affordable option. Others reported that many residents used cannabis, which had for some influenced their current level of use. Others reported that it was something they shared with other residents and offered both social and personal benefits, particularly in terms of coping with their current state of homeless and surrounds while at the CSAS.

Speculative factors that appeared to influence patterns of use included, availability and costs linked to the heroin drought, the environment they find themselves in (CSAS), as well what others are using within their immediate environment.

## 6.1 Injection Related History

A significant proportion of participants (87%) reported they had injected drugs in their lifetime. Heroin was the last drug to be injected by 55% of participants, followed by amphetamines (30%), morphine (5%), cocaine (4%), other opiates (4%) and buprenorphine (1%).

**Figure 6.3: Last Drug Injected**



Over three-quarters (77%) of participants had injected a drug at some time in the last month. Heroin (40%) and amphetamines (26%) were the most common drugs injected in the month prior to interviews. Twenty three percent of

participants reported that they had not injected any drugs in the month prior to interviews.

## **6.2 Prevalence and Frequency of Drug Use**

Table 6.2 shows the self reported drug use history of the homeless sample in terms of prevalence and frequency of use within the last seven days, over the last six months and in their lifetime. Table 6.2 also summarises the survey sample's routes of administration in their lifetime and during the last six months for each drug class.

The majority of participants reported they had previously used cannabis (98%), tobacco (97%), amphetamines (93%), Heroin (87%), benzodiazepines (87%), and anti depressants (73%) in their lifetime. Rates much higher than the national statistics on drug use reported in the 2001 National Drug Strategy Household Survey (Australian Institute of Health and Welfare, 2002). In this study, lifetime use of illicit drugs among the population aged 14 years and over was below 10% (Table 6.1) for each drug class except cannabis (33.1%).

In the 2001 National Drug Household Survey (AIHW), 33.1% of the sample had used marijuana in their lifetime, followed by amphetamines (8.9%), hallucinogens (7.6%), ecstasy/designer drugs (6.1%), Heroin (2.3%), tranquilizers/sleeping pills (1.1%), and barbiturates (0.2%).

When comparing lifetime drug use against other drug users (Table 6.1) from the 2001 Victorian Drug Trends IDRS Injecting Drug Users Survey (Fry & Miller, 2002), similar trends appear. Respondents of this study, reporting

lifetime use of tobacco (97%), heroin (99%), amphetamines (94%), Cannabis (97%) and benzodiazepines (87%).

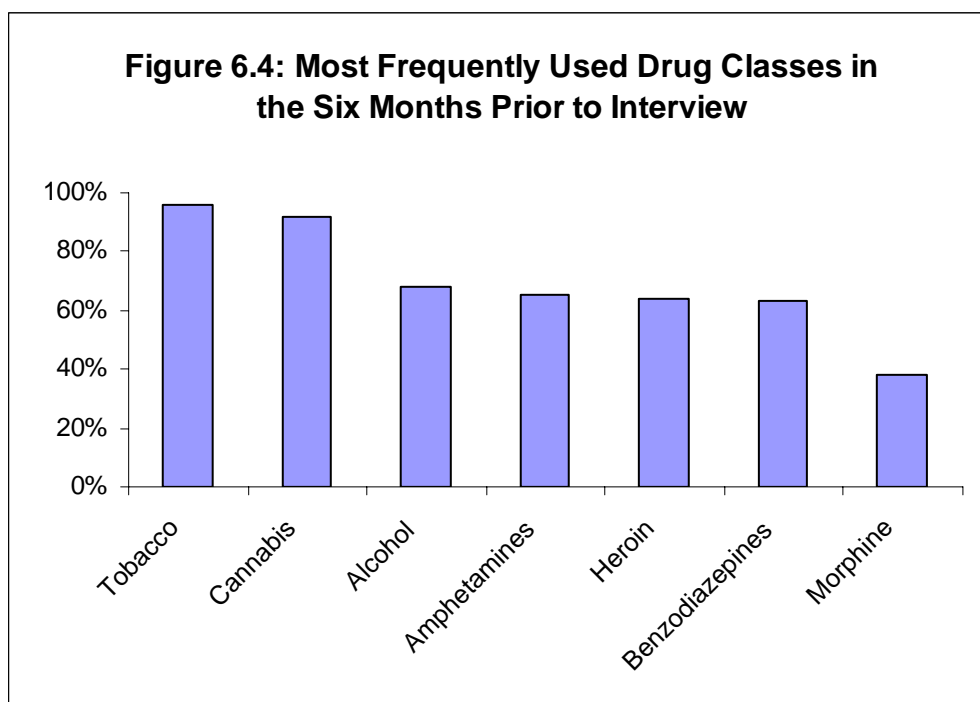
**Table 6.1: Three Way Comparison of Lifetime Drug Use.**

<b>Drug Class Ever Used (Lifetime)</b>	<b>Homeless Drug Users in CSAS Study 2002 n=(95)</b>	<b>2001 National Drug Household Survey n=(26,744)</b>	<b>2001 Victorian IDRS Injecting Drug Users Survey n=(151)</b>
Tobacco	97%	Lifetime not reported	97%
Alcohol	83%	Lifetime not reported	97%
Amphetamines	93%	8.9%	94%
Cannabis	98%	33.1%	97%
Heroin	87%	2.3% (Heroin, methadone and other opiates)	99%
Methadone	46%	-	71%
Other Opiates	21%	-	58%
Morphine	68%	-	66%
Benzodiazepines (Sleeping Pills/Tranquillisers)	87%	1.1% 0.2% barbiturates	87%
Anti depressants	73%	-	49%
Hallucinogens	73%	7.6%	71%
Ecstasy	61%	6.1%	65%
Cocaine	61%	4.4%	64%
Inhalants	30%	2.6%	31%

The median number of drug classes used by participants in their lifetime was 11 (mean 10, SD 2.67), a rate similar to the 2001 Victorian Drug Trends IDRS injecting drug users Survey (Fry & Miller, 2002) where respondents reported using a median of 10 drug classes in their lifetime.

## 6.4 Drug Use History: Last 6 Months

The most commonly used drug classes over the preceding six months prior to interview were tobacco (96%), cannabis (92%), alcohol (68%), Amphetamines (65%), heroin (64%), benzodiazepines (63%), and morphine (38%).



Drugs used with the highest median number of days in the preceding six months by those using the drug included, tobacco (181 days), cannabis (120 days), methadone (120 days), anti depressants (76 days), Heroin (30 days) benzodiazepines (27 days), alcohol (25 days), and other opiates (14 days).

The median number of days used for each drug class in the 6 months prior to interview was less than the level of median days used in the 2001 Victorian Drug Trends IDRS Injecting drug users survey. Except in the case of tobacco where median days used was equal at 180 days.

Drugs used with the highest median number of days in the six months prior to interview in the 2001 IDRS injecting drug users survey were, Tobacco (180 days), methadone (180 – n=41 only), Anti Depressants (165 days), cannabis (160 days), Heroin (65 days) and amphetamines (25 days).

Differences in median days of use may be due to the two samples not being identical, as 77% of participants had injected in the month prior to interviews compared to all participants in the 2001 Victorian Drug Trends IDRS study who needed to have injected at least monthly in the six months prior to interview to be eligible for this study. Additionally, only 7% of participants in the 2001 Victorian Drug Trends IDRS study identified as being homeless or of “no fixed abode” at the time of interviews, while 17 % reported to be staying at a boarding house, hostel or refuge and could effectively be homeless. Compared to the study group where all participants were homeless.

The mean number of drug classes used by participants was 7 in the six months prior to interview compared to a slightly lower median of 6 drug classes reported in the 2001 Victorian Drug Trends IDRS survey.

Over half (62%) the participants had injected heroin in the preceding six months prior to the interview, followed by amphetamines (60%), morphine (37%) and benzodiazepines (20%).

## 6.5 Drug Use History: Last 7 Days

The majority of participants reported that the main drugs used most often in the past seven days were tobacco (96%) and cannabis (83%) alcohol (52%), heroin (38%), benzodiazepine (38%), and amphetamines (26%). Four out of the six drugs being central nervous system depressants, highlighting the potential risk of overdose among the study group. The mean number of drug classes used in the last 7 days was four.

Drugs used with the highest median number of days in the seven days prior to interviews by those using the drug were, cannabis (7 days), tobacco (7 days), anti depressants (7 days), methadone (7 days), benzodiazepines (6 days), other opiates (5 days) and heroin (3 days).

### *Amount of Money Spent on Drugs*

A mean of \$37 was spent on illicit drugs on the day prior to interview (median \$14, SD 45) with a reported range of between \$0 –160 dollars.

## **6.6 Poly Drug Use**

Poly drug use involves the use of a number of drugs on a single occasion or within a given period. (Victorian Department of Human Services 2002). The risk of overdose attached to poly drug use is of significant concern, particularly when individuals combine the use of central nervous system depressants such as heroin, alcohol, cannabis, benzodiazepine and anti depressants. Examination of the study group's daily drug use over the last seven days (Given period) indicates that the practice of poly drug use is common amongst this homeless sample, where the mean number of drug classes being used is four.

Drug Class	Ever used	Age of first use	Ever injected	Injected last 6 months	Ever Smoke	Smoke. last 6 months	Ever snorted	Snorted last 6 months	Ever swallowed	Swall last 6 months	used in last 6 months	<u>Median</u> No days used in past 6 months	Used in last 7 days	<u>Median</u> No days used in past 7 days
	%	<u>Mean</u>	%	%	%	%	%	%	%	%	%	%	%	
Heroin	87	20	83	62	47	6	14	0	10	<1	64	30	38	3
Methadone	51	31	22	4	-	-	-	-	48	21	22	120	11	7
Morphine	68	23	59	37	<1	0	0	0	20	10	38	7	15	1
Other opiates	21	25	9	3	2	0	0	0	11	5	8	14	4	5
Naltrexone	10	22	1	0	0	0	0	0	10	1	1	2	0	0
Buprenorphine	25	28	16	16	0	0	0	0	17	16	24	19	18	4
Alcohol	82	14	8	-	-	-	-	-	81	67	68	25	52	2
Amphetamines	93	18	83	60	22	7	52	17	48	16	65	20	26	2
Cocaine	61	21	29	6	13	3	44	11	9	3	17	5	2	1
Hallucinogens	73	18	9	1	3	0	1	2	50	7	9	3	0	0
Ecstasy	61	23	30	13	4	2	9	5	57	27	29	5	11	2
Benzodiazepines	87	20	45	20	3	<1	4	2	83	60	63	27	40	6
Cannabis	98	14	1	1	96	85	0	0	23	12	92	120	83	7
Anti –depressants	73	23	5	<1	2	<1	<1	0	70	33	36	76	21	7
Inhalants	31	17	-	-	-	-	-	-	-	-	4	2	0	0
Tobacco	97	13	0	0	94	94	2	0	<1	0	96	180	96	7

**Table 6.2: Drug Use History of Homeless Sample (N=95)** *Median number of days used relates only to those using the drug.*

## **6.7 Patterns of Drug Use**

This section details the age of first use, the levels of use (lifetime (ever), 6months and 7 days), routes of administration, and reason for first use and current use of each drug class. For the purpose of this study, only the main drugs (highest percentage of use in the last 6 months) used by the sample will be reported on in terms of reason for first use and reason for current use. In depth discussion of each drug class is beyond the scope of this study.

Reason for first time use and current use of each drug class was built into the design of the drug use history chart in Question 22 (Appendix 1). This occurred in order to identify factors influencing participants use of that drug for the first time and currently (last 7 days) and to identify any noticeable shifts.

Comparison of data with other studies in terms of prevalence and frequency of use for each drug has occurred under each drug section. Where possible (comparable data availability), a three-way comparison is provided between this study, the 2001 Victorian Drug Trends IDRS Injecting Drug Users Survey (Fry & Miller, 2002) that acted as the norm (other drug users, although only 24% could be identified as technically homeless) and the general community as represented in the 2001 National Drug Household Survey (AIHW, 2002).

### **6.7.1 Tobacco**

Tobacco was the most commonly used drug reported by participants, 97% reporting that they had used in their lifetime (ever), with 96 % reporting use in the six month and seven days prior to interview. In comparison a smaller percentage (19.5%) of the Australians aged 14 years and over smoked on a daily basis as reported in the 2001 National Drug Household Survey.

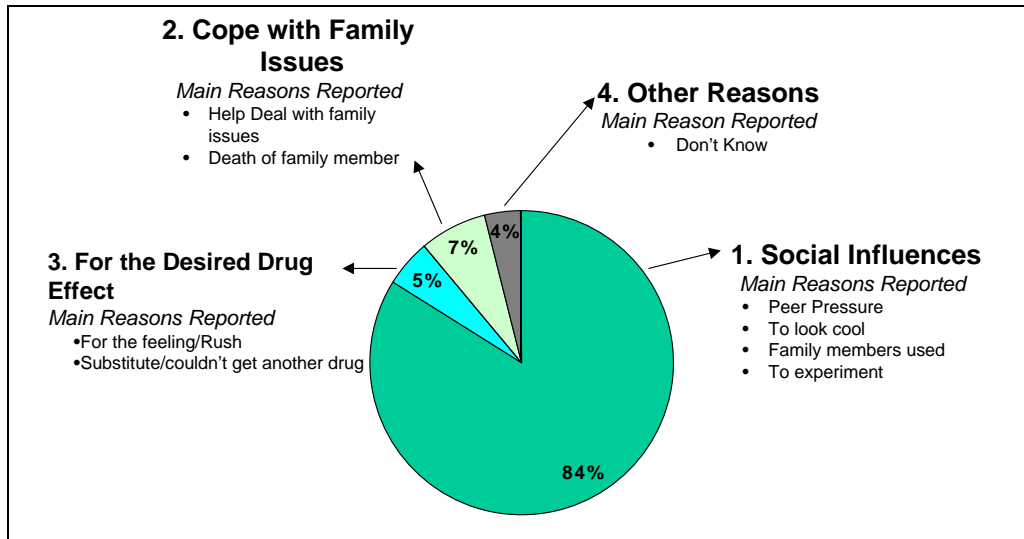
The mean age of first use was 13 years of age and 84% of participants who had ever used tobacco reported (Figure 6.5) that their main reason for first use was due to Social factors such as peer pressure, desire to experiment, to “look cool” or because family members used.

Smoking was the main route of administration in the last six months (94%), however 2% of participants reported that they had snorted tobacco in the past.

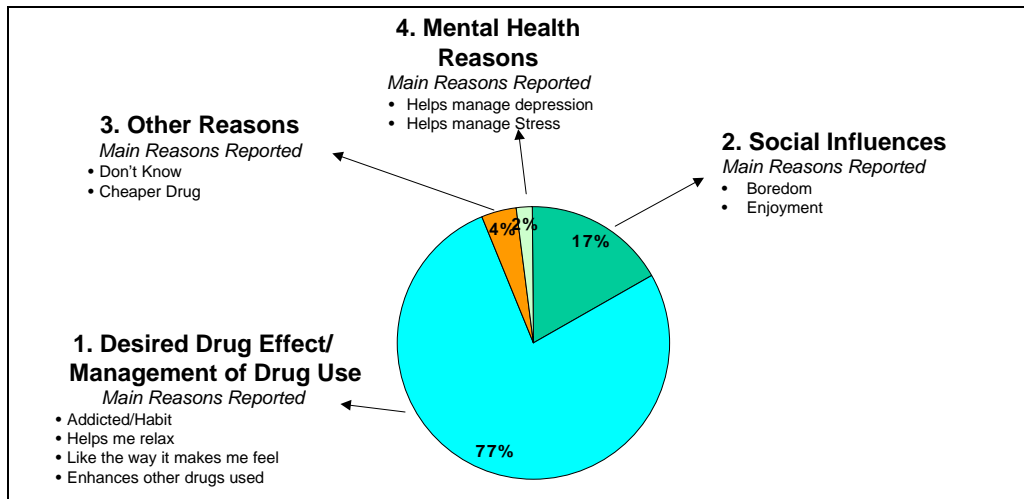
The median number of days used in the last six months was 181 days, with a median number of 7 days use within the last seven days prior to interview.

The main reason reported by 77% of participants (Figure 6.6) for currently using tobacco (last 7 days) was related to achieving a desired drug effect (“helps me relax”, “enhances other drugs used”) or in relation to management of their drug (“I’m addicted – need to use”).

**Figure 6.5 Tobacco - Reason for First Use (n=92)**



**Figure 6.6: Tobacco- Reason for Current Use (n= 91)**



## 6.7.2 Cannabis

Apart from tobacco, cannabis was the most frequently used drug class amongst the homeless sample, with 98% reporting they had used in their lifetime, making this the most commonly used illicit drug. The majority (92%) of the sample had used cannabis in the six months prior to being interviewed, while a large proportion (83%) had used cannabis in the week (7 days) prior to being interviewed. Thirty nine percent of participants reported that cannabis was their current main drug of choice.

The 2001 National Drug Household Survey also identified cannabis to be the most commonly used illicit drug within the community, reporting that just over a third of those surveyed (33.1%) had used cannabis in their lifetime, a significant contrast however to the much higher level of use among the study sample.

While allowing for the higher rates of drug use among the study group (all being homeless and current drug users) comparison of the recent use of cannabis reveals significantly higher levels of regular use among the study group than national figures. The 2001 National Drug Household Survey identified that 5.6% of those surveyed had used cannabis in the last week compared to 83% of the study group.

Compared to the norm (other regular drug users), 88% of respondents in the 2001 Victorian Drug Trends IDRS injecting drug users survey had used

cannabis in the six months prior to being interviewed compared to a slightly higher percentage (92%) in the study sample.

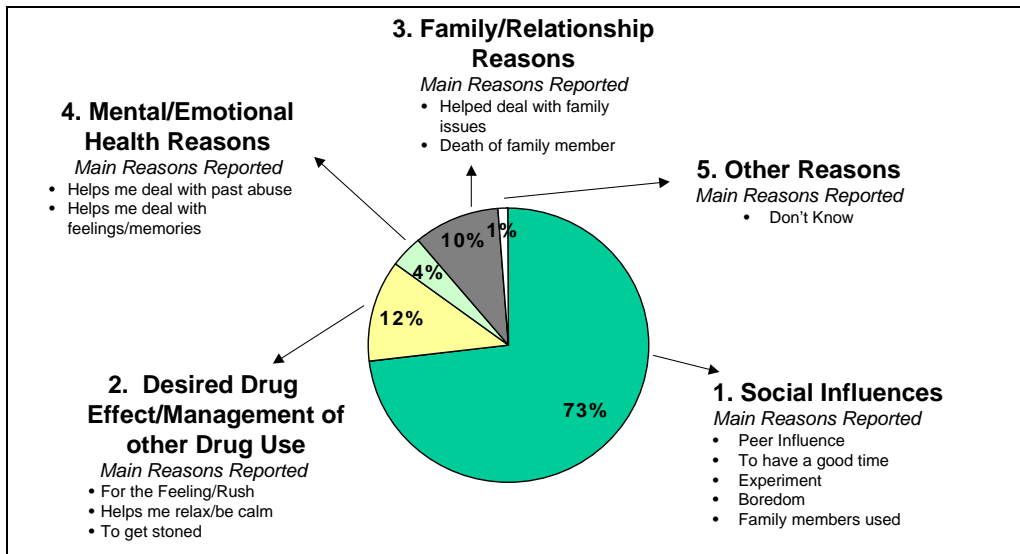
The mean age of reported first use was 14 years in the study sample, compared to the average (mean) of 18.5 years reported in the 2001 National Drug Household Survey. The main reason reported (Figure 6.7) for first use was due to social influences (73%) such as peer pressure, to have a good time, experimentation, boredom or because other family members used.

Smoking was the main route of administration (85%) in the past six months, while 12 % reported swallowing cannabis and 1% reported injecting cannabis in the six months prior to interview.

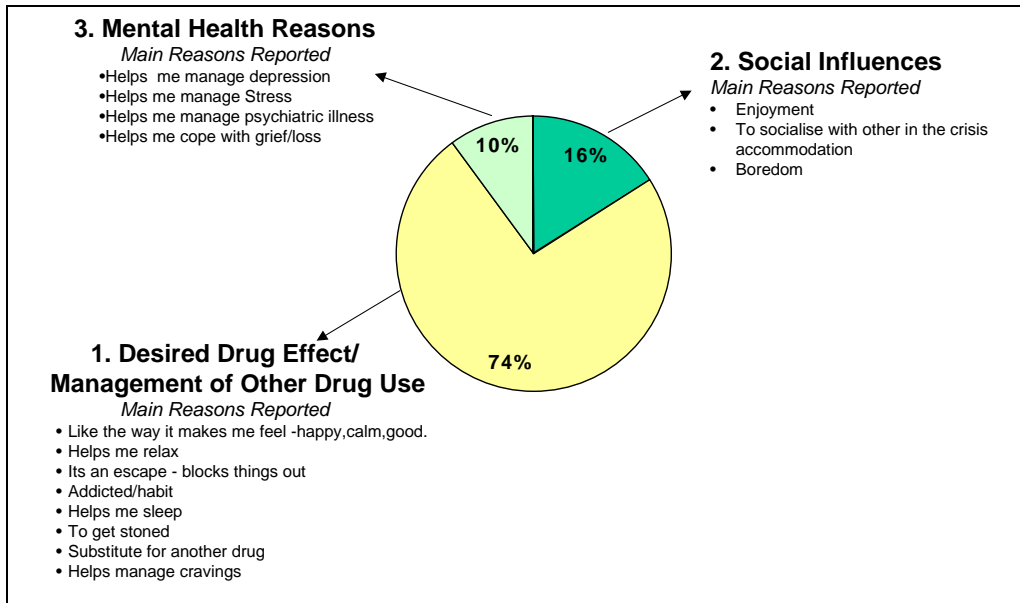
The median number of days used in the past six months was 120 days, with a median number of 7 days use in the week (7days) prior to interview by those using the drug.

The main reason reported (Figure 6.8) for current use (last 7 days) was due to achieving a desired drug effect (74%) such as feeling happy, calm or relaxed. For others, using cannabis helped “ block things out” or helped them sleep. Others reported they currently used cannabis because they were addicted.

**Figure 6.7 Cannabis- Reason for First Use (n=93)**



**Figure 6.8 Cannabis - Reason for Current Use (n=79)**



### **6.7.3 Alcohol**

A large proportion (82%) of the study group had used alcohol in their lifetime. A rate 9% lower than reported in the 1998 Victorian Drug Household Survey where 91% of the sample had ever tried alcohol, while 97% of participants in the 2001 Victorian Drug Trends IDRS survey had used alcohol in their lifetime.

The majority of participants (68%) reported using alcohol in the past six months, while 52% of participants had used alcohol in the 7 days prior to interviews, compared to 46% of the 1998 Victorian Drug Household Survey who identified as current regular drinkers (Drink at least once a week). Seventy four percent of the 2001 IDRS injecting drug users sample had used alcohol in the last 6 months.

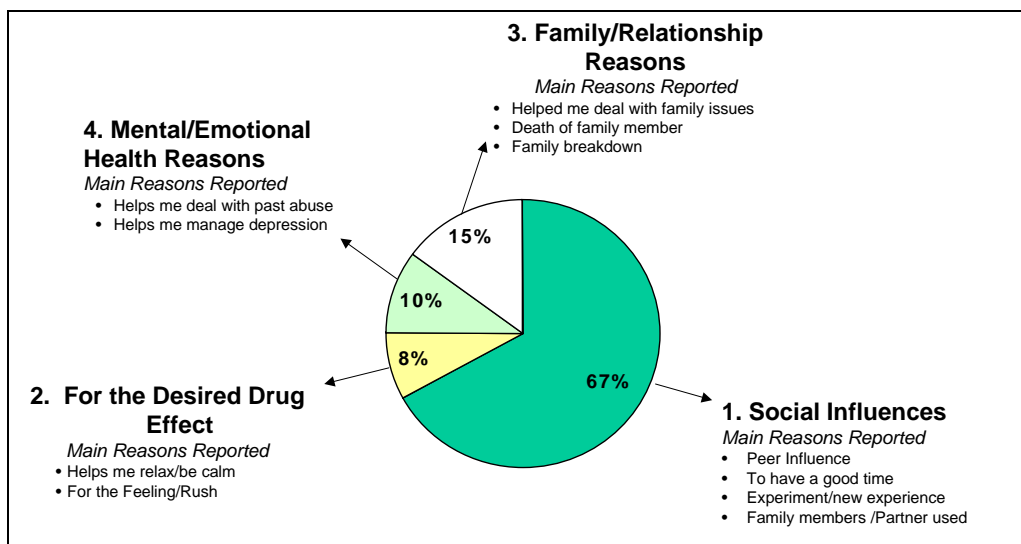
The 52% of the sample who drank alcohol in the last 7 days had done so on a median of 2 days per week (mean 6 days, SD25.5). While this study has not identified the level of daily use (how many standard drinks) amongst participants who drank alcohol in the last 7 days (52%) and can therefore not speculate on the level of short term risk of harm (Injury or death) or long term risk as outlined in the National Health & Medical Research Council's Australian Alcohol Guidelines (NHMRC, 2001), it does highlight, given that over half the sample drank alcohol in the last week that further examination of harm attached to regular alcohol consumption among those who are homeless is warranted.

The mean age of first use was 14 years of age, lower than the national average (mean) of 16.2 years (male) and 17.6 years (female) reported in the 2001 National Drug Household Survey.

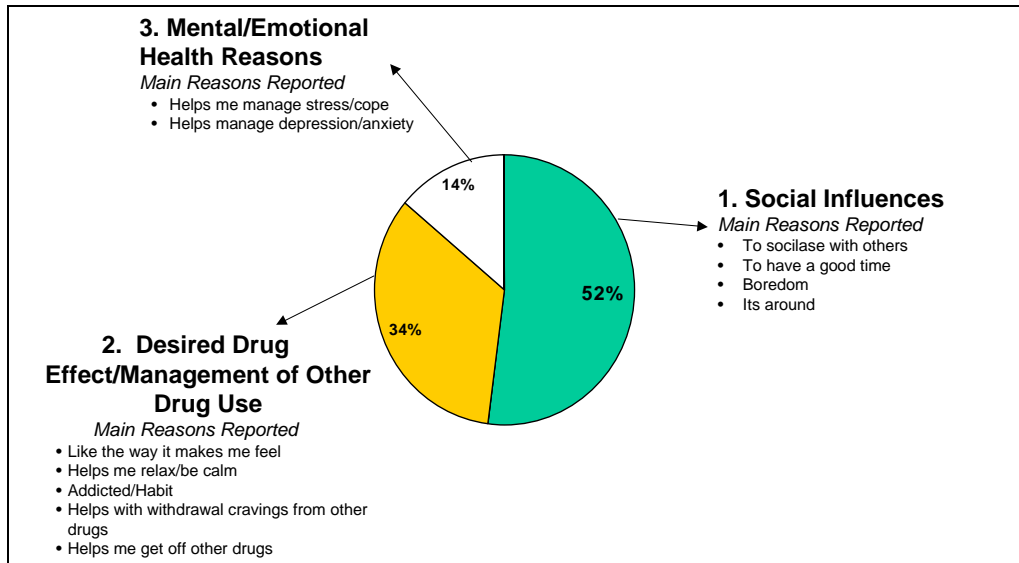
The main reason reported (Figure 6.9) for first time use was due to social reasons (67%) such as peer pressure, to have a good time, experimentation and because family members/partners used.

The main reason reported for current use (last 7 days) (Figure 6.10) was due also to social and environmental influences (52%), such as drinking alcohol in order to socialize with others through to boredom and also because “it is around the crisis accommodation services”.

**Figure 6.9 Alcohol – Reason for First Use (n=78)**



**Figure 6.10 Alcohol – Reason for Current Use (n=50)**



### 6.7.4 Heroin

Eighty seven percent of participants had used heroin in their lifetime compared to 99% in the 2001 Victorian Drug Trends IDRS survey. Only a very small percentage (2.2%) of respondents in the 1998 Victorian Drug Household Survey had used heroin. Heroin was reported as the current main drug of choice (most used) by 25% of participants, the second highest drug used by the study group, however heroin was reported by 51% of participants as their previous drug of choice (most used)

Over two thirds (64%) of participants had used heroin in the six months prior to interviews compared to 90% in the 2001 Victorian Drug Trends IDRS survey. While only 1% had used heroin in the 12 months prior to the 1998 Victorian Drug Household Survey. Over a third (38 %) of participants had used heroin in the 7 days prior to being interviewed.

The mean age of first use was 20 years, similar to the average age of 20.7 years (mean) reported for first time use in the 2001 National Drug Household Survey.

The main route of administration in the six months prior to interview was via injection (62%), while 6% of participants had smoked heroin in the six months prior to interview.

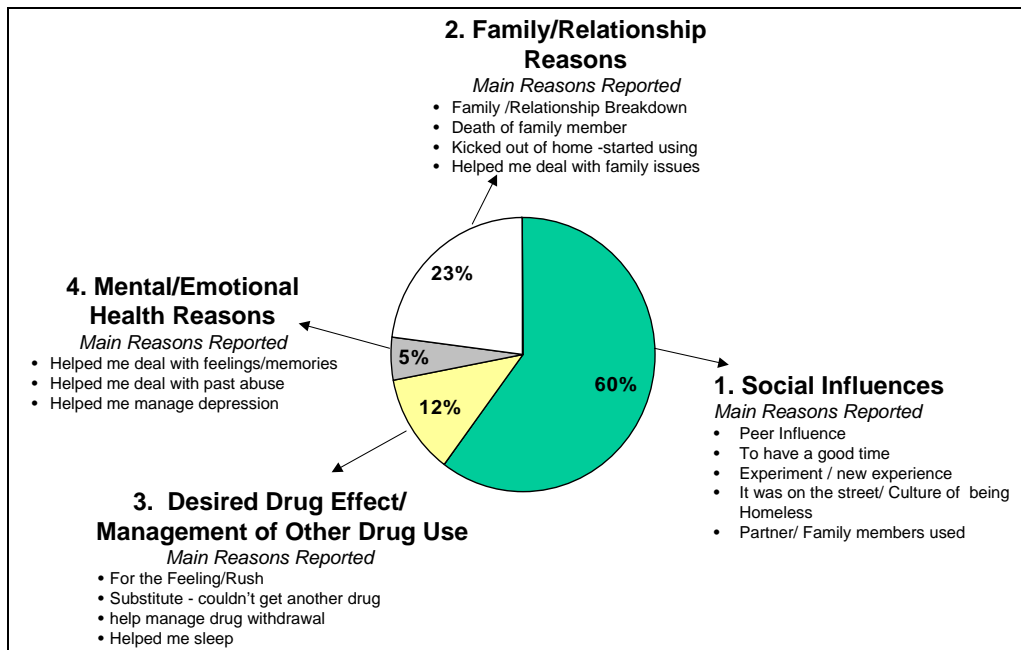
A large proportion of participants (83%) had injected heroin in their lifetime and heroin was the main drug injected by the study group (60%) in the six months prior to interviews.

The median number of days that heroin was used by those using the drug in the six months prior to interview was 30 days (mean 49 days, SD 54.9), with a median number of 3 days (2.5) use (mean 2.83, SD 2) in the 7 days prior to interview by those using the drug. The median number of days that heroin was used in the study group was less than that reported in the 2001 IDRS Injecting drug users survey of 65 days in the preceding six months.

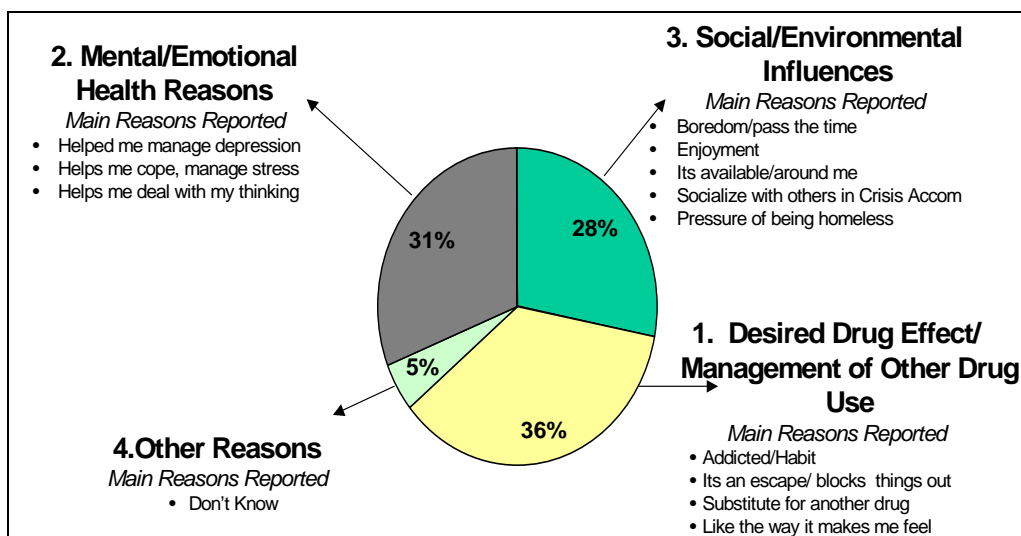
The main reason reported (Figure 6.11) by participants for first time use was due to social factors (67%) such as peer pressure, to have a good time, to experiment or because family members or partner used. In contrast the main reason reported for current use (last 7 days) showed a close split between three reasons, namely desired drug effect/management of other drug use (36%), for

mental/emotional health reasons (31%) and social/environmental influences (28%).

**Figure 6.11 Heroin – Reason for First Use (n=83)**



**Figure 6.12 Heroin –Reason for Current Use (n=36)**



### **6.7.5 Amphetamine**

A significant proportion (93%) of the study group has used amphetamines in their lifetime, a rate similar to that reported by injecting drug users of 93% in the 2001 Victorian Drug Trends IDRS survey. In comparison 9% of those surveyed in the 1998 Victorian Drug Household survey had use amphetamines in their lifetime (ever), while 8.9% of those surveyed in the 2001 National Drug Household Survey had used amphetamines in their lifetime. Twelve percent of participants reported amphetamines as their main drug of choice.

Over two thirds (65 %) of the study group had used amphetamines in the six months prior to being interviewed. While 26 % reported using amphetamines in the 7 days prior to being interviewed, a rate much higher than 0.6% reported in the 2001 National Drug Household Survey for use in the last week.

The mean age of first use was 18 years, 2.4 years younger than the national average of 20.4 years reported in the 2001 National Drug Household Survey

The majority (80%) of participants had injected amphetamines in their lifetime (ever), with 60 % having done so in the six months prior to interviews. Other routes of administration used in the six months prior to interviews by the study group were snorting (17%), swallowing (16%) and smoking (7%).

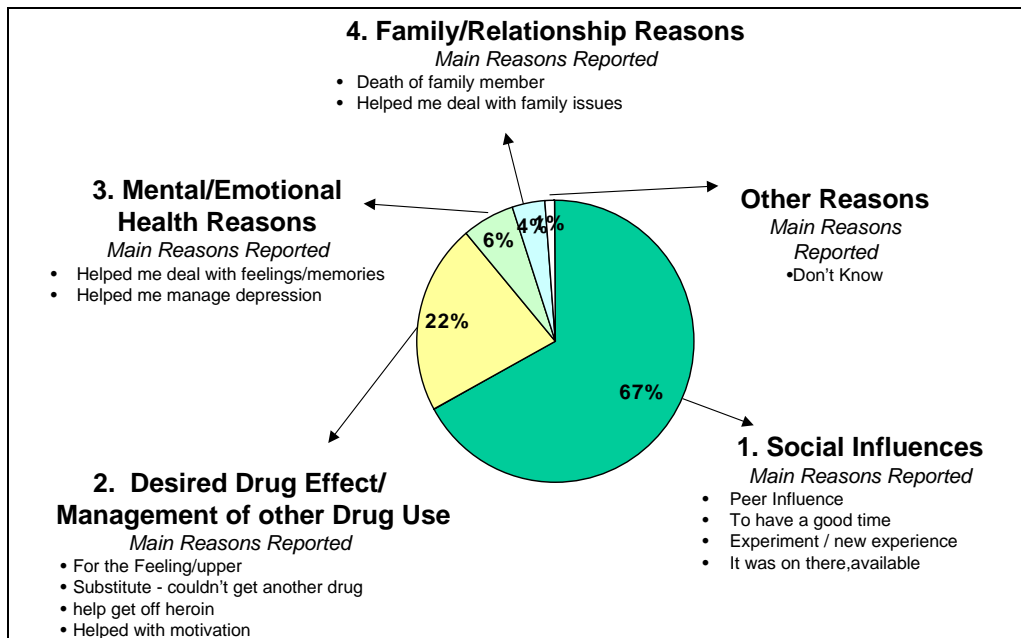
The 65 % of the sample who had used amphetamines in the six months prior to interviews had used on a median of 20 days in that six month period, compared to the 2001 Victorian Drug Trends IDRS survey where the 76% of the sample

who had used in that same period had done so on a median of 25 days. The 26% of participants in the study group who had used amphetamines in the 7 days prior to interviews had done so on a median of 2 days in that week.

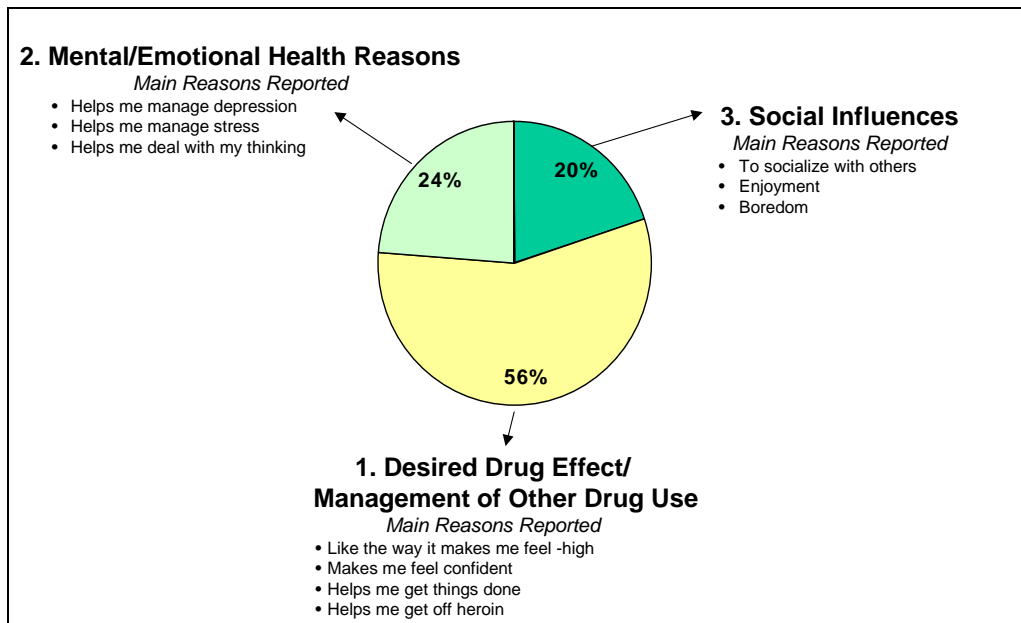
The main reason reported (Figure 6.13) for first time use was due to social reasons (67%), such as peer pressure, to have a good time, experimentation and because “it was there/available”.

The main reason reported for current use (last 7 days) was due to achieving a desired drug effect or to help them manage other drug use (figure 6.13). Main reasons given included that “amphetamines makes me feel confident or high”; “helps me get things done” and “helps me get off heroin”.

**Figure 6.13 Amphetamines – Reason for First Use (n=88)**



**Figure 6.14 Amphetamines – Reason for Current Use (n=25)**



### 6.7.6 Benzodiazepine

Benzodiazepine refers to the use of tranquilizers, sleeping pills or sedatives within this study. The same definition applies to other Victorian studies and reports (Department of Human Services, 2002).

The majority (87%) of participants had used benzodiazepines in their lifetime, the same rate reported in the 2001 Victorian Drug Trends IDRS survey. It was the sixth most used drug in the six months prior to interview by the study group. Just under half (45%) the study group had injected benzodiazepines in their lifetime, while 83% had also used oral routes of administration in their lifetime

The mean age of first use was 20 years whether this was for medical or non-medical purposes is unknown. A starting age 2.8 years more than that reported

in the 2001 National Drug Household Survey where the use of prescription drugs for non medical purposes was 22.8 years for tranquilizers.

Two thirds of the (63 %) sample had used benzodiazepines in the six months prior to interviews, with 20 % reporting that they had injected the drug and 60 % having swallowed the drug in that period.

The rates of injection in the study group are lower than those reported in the 2001 Victorian Drug Trends IDRS survey (40% compared to 20%), possibly due to the study group not all being current injectors. However, given the health risks attached to injecting benzodiazepines, the level of current injection rates among current drug users in the CSAS is of concern and requires a concerted harm minimisation response. The injection of benzodiazepines places the individual at significant health risk of developing serious vein damage leading to permanent damage of human tissue and an increase risk of overdose. Any reported rates of injecting benzodiazepines should therefore raise concerns.

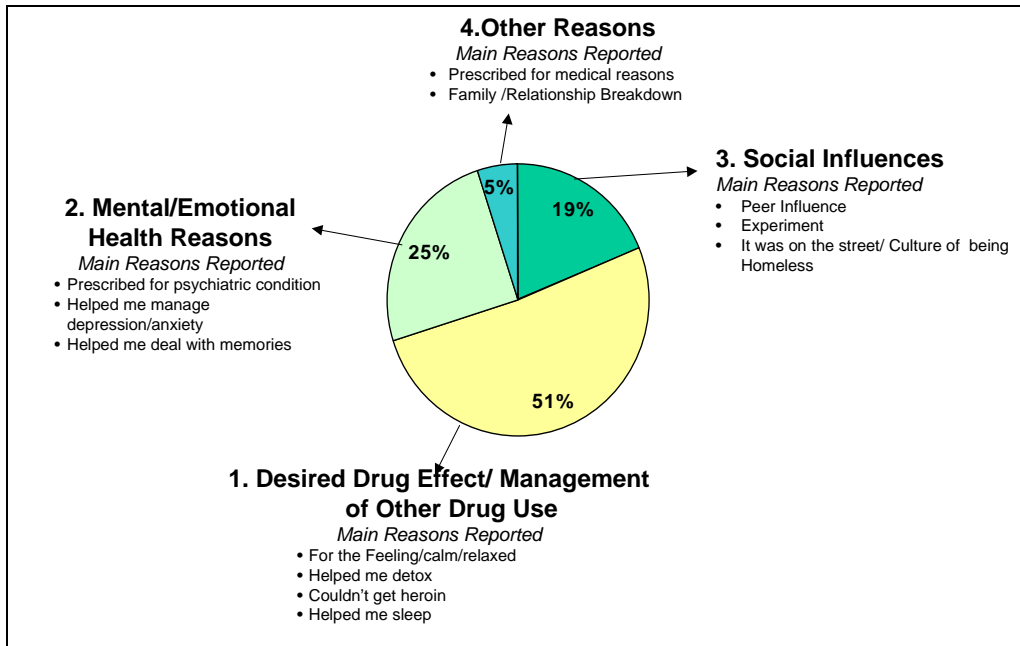
The 63% of the sample who used benzodiazepines in the six months prior to interview did so on a median of 27 days in that period (mean 57, SD 26.5), a rate slightly higher than that reported in the 2001 Victorian Drug Trends IDRS survey, where 78% of their sample had used benzodiazepines on a median of 26 days. In the 7 days prior to interviews, 40 % of the sample reported that they had used benzodiazepines and had done so on median of 6 days (mean 4, SD 2.7).

The main reason reported by participants (51%) for first use (Figure 6.15) was due to the desire to achieve a particular drug effect or to assist with the management of other drug use. Additionally, 25% of participants reported first using benzodiazepines for mental and emotional health reasons, while 19 % reported first using the drug because of social influences.

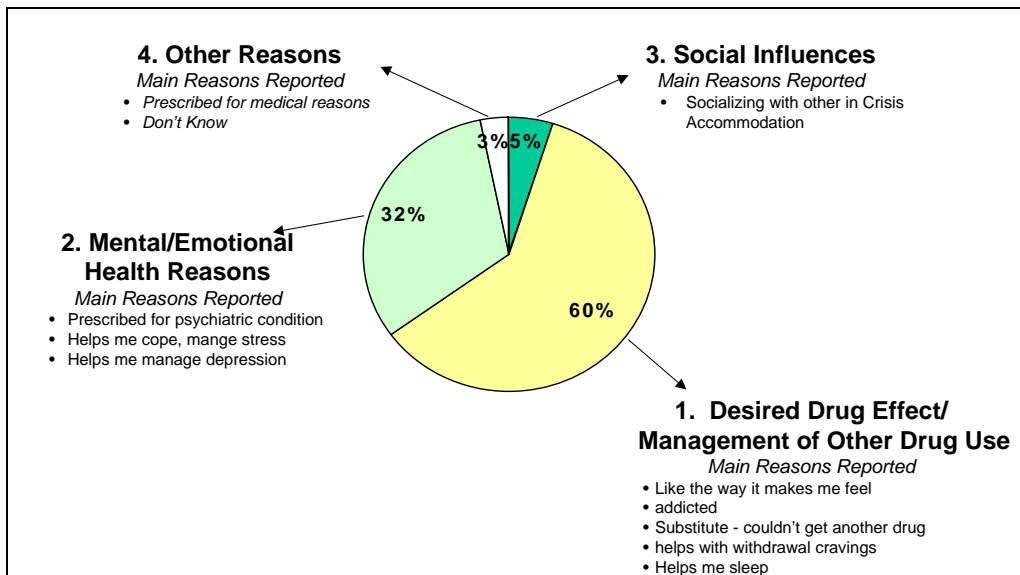
The main reason reported by 60 % of participants for currently using the drug (last 7 days) was in order to achieve a desired drug effect or to manage their other drug use (figure 6.16). Reasons given included using benzodiazepines because they like the way it makes them feel, it's a substitute drug when they cannot get the drug they want through to it helping participants sleep.

The exact rate of medically prescribed benzodiazepine use to non-medically prescribed use is unknown, and was not directly asked in the survey. However 14 participants reported that they had been prescribed benzodiazepines for first use, where as only 7 participants reported that they had been prescribed benzodiazepines for current use.

**Figure 6.15 Benzodiazepines – Reason for First Use (N=83)**



**Figure 6.16 Benzodiazepines – Reason for Current Use (n=38)**



### **6.7.7 Cocaine**

More than half (61%) of the sample reported lifetime use of cocaine, rates similar to that reported in the 2001 Victorian Drug Trends IDRS survey where 64% of the sample had a lifetime use of cocaine.

Only a small percentage (2%) of participants had used cocaine in the week (7days) prior to being interviewed.

The lifetime use of cocaine was much higher in the study group (61%) compared to the 2001 National Drug Household Survey where only 4.4 % of participants had used cocaine, while only .1 % reported ever using cocaine in the week prior to interviews compared to 2% in the study group.

Compared to the norm (other regular drug users), 28% of respondents in the 2001 Victorian Drug Trends IDRS survey had used cocaine in the six months prior to being interviewed compared to a lower percentage (17%) in the study sample. The main routes of administration in the six months prior to interview were through snorting cocaine (11%), while 6% reported having injected the drug.

The median number of days used in the past six months was 5 days (mean 16 days, SD 27.4), with a median number of 1 days use in the week (7days) prior to interview by those using the drug.

The mean age of reported first use was 21 years in the study sample, compared to a mean of 22.6 years reported in the 2001 National Drug Household Survey. The main reason reported for first use was due to social influences (76%) with the main responses being due to peer pressure or to have a good time.

The main themes reported for current use (last 7 days) by the 2% using the drug was due to achieving a desired drug effect (50%)( I like the feeling) and social (50%) – to socialize/party with others

### **6.7.8 Morphine**

More than half (68%) of the sample reported lifetime use of morphine, rates similar to that reported in the 2001 Victorian Drug Trends IDRS survey where 66% of the sample had a lifetime use of morphine.

Compared to the norm (other regular drug users), 32% of respondents in the 2001 IDRS Injecting Drug Users Survey had used morphine in the six months prior to being interviewed compared to a higher percentage (38%) in the study group. The main routes of administration in the six month period prior to interview was through injection (37%), while 10% reported having taken the drug orally, rates higher than the 2001 Victorian Drug Trends IDRS survey (injection 31%; Oral 9%).

The median number of days morphine was used in the past six months was 7 days (mean 21 days, SD 32.9), with a median number of 1 days use in the week (7days) prior to interview. The median number of days that morphine was used in the 2001 Victorian Drug Trends IDRS survey was 5 days.

The mean age of reported first use was 23 years of age in the study sample. The main reason reported for first use was the management of other drug use (47%) with the main response reported for first using morphine, was as a substitute for heroin.

Two main reasons were equally reported for current use (last 7 days), by those using the drug (15%). The first was related to the Desired Drug Effect/Management of the their other drug use (36%) where participants reported using morphine as a substitute for heroin or because they were addicted. The second main reason reported (36%) by participants was due to social influences such as boredom or to use with others in the crisis accommodation service.

### **6.7.9 Anti Depressants**

Just over three quarters (73%) of participants reported lifetime use of anti depressants, a rate much higher than that reported in the 2001 Victorian Drug Trends IDRS survey where 49% of the sample had a lifetime use of anti depressants. Comparison with other data sets such the 2001 National Drug Household survey is not possible due to the absence of reporting on this drug class in that study.

Compared to the norm (other regular drug users), 28% of respondents in the 2001 Victorian Drug Trends IDRS survey had used anti depressants in the six months prior to being interviewed compared to a higher percentage (36%) in

the study group. The main route of administration in the six month period prior to interviews was oral (33%).

The median number of days that anti depressants was used in the six months prior to interview was 76 days (mean 99 days, SD 79.3), with a median number of 7 days (mean 6.8, SD 2.3) use in the week (7 days) prior to interview by those using the drug.

In comparison, the median number of days that anti depressants was used in the 2001 Victorian Drug Trends IDRS Survey in the six months prior to interviews was 165 days.

The mean age of first use was 23 years of age in the study sample. The main reason reported for first use was for mental health reasons (86%). Main response reported for first using anti-depressants was that it had been prescribed for reported psychiatric condition – mostly depression

The main reason reported for current use (last 7 days) by the 21% who used the drug was Mental Health Reasons (95%) with participants reporting currently using because it had been prescribed for a reported psychiatric condition - depression

### **6.7.10 Ecstasy**

Over half (61%) the participants reported lifetime use of ecstasy, a rate slightly lower than that reported in the 2001 Victorian Drug Trends IDRS Survey where 65% of the sample had a lifetime use of ecstasy. In comparison, 6.1% of

those surveyed in the 2001 National Drug Household Survey had used ecstasy/designer drugs in their lifetime, a rate significantly lower than the study group.

Compared to the norm (other regular drug users), 39% of respondents in the 2001 Victorian Drug Trends IDRS Survey had used ecstasy in the six months prior to being interviewed compared to 29% in the study sample. The main route of administration by the study group in the six month prior to interview was oral (27%).

Eleven percent of participants reported using ecstasy in the 7 days prior to interviews compared to 0.5% who reported use (in the last week) in the 2001 National Drug Household Survey.

The median number of days ecstasy was used in the preceding six months was 5 days (mean 17 days, SD 22.4), with a median number of 2 days (mean 2,SD1.22) use in the week (7 days) prior to interview by those using the drug. In comparison, the median number of days that ecstasy was used in the 2001 Victorian Drug Trends IDRS Survey in the six months prior to interviews was higher at 4 days by those using the drug.

The mean age of reported first use was 23 years of age in the study sample, slightly higher than the mean age of 21.9 years reported in the 2001 National Drug Household Survey

The main reason reported for first use was social influences (93%) with the main responses reported being to “party with friends”, “experiment” or “to have a good time”.

The main reason reported for current use (last 7 days) by the 11% using the drug was still social influences (73%), such as enjoyment or to party with friends.

### **6.7.11 Methadone**

Just over half (51%) the sample had a lifetime use of methadone, compared to 71% of respondents in the 2001 Victorian Drug Trends IDRS Survey.

Compared to the norm (other regular drug users), 44 % of respondents in the 2001 Victorian Drug Trends IDRS Survey had used methadone in the six months prior to being interviewed, compared to 22% in the study sample. The main route of administration in the six months prior to interview by the study group was oral (21%), however 22% of participants reported that they had injected methadone.

The mean age of reported first use was 31 years of age in the study sample, close to nine years older than the mean age of 21.8 years reported in the 2001 National Drug Household Survey. While it is difficult to interpret these findings without more investigation, it would appear that the homeless sample have limited access to this form of treatment until much later in their drug using careers.

The main reason reported for first use was the management of other drug use (88%), with the key reason reported for first using methadone was “to help get off heroin”.

The main reason reported for current use (last 7 days) by the 11% who used the drug was still management of other drug use (100%) with participants still reporting using methadone to “stay off heroin” or because they are “addicted to the drug”.

### **6.7.12 Other Opiates**

Twenty one percent of participants had a lifetime use of other opiates such as panadeine forte and pethidine, compared to a higher rate of 58% in the 2001 Victorian Drug Survey. Other opiates such as morphine, methadone and heroin have been reported separately in this report.

The mean of age of first reported use was 25 years of age and the main route of administration was oral (5%), while 3% of the sample had injected other opiates in the six months prior to interviews. All other patterns of “other” opiate use are listed in Table 6.2.

### **6.7.13 Buprenorphine**

Over a quarter (25%) of participants had a lifetime use of buprenorphine and 24% of participants reported using the drug in the six months prior to interviews, on a median of 19 days (mean 35, SD47). 18% of participants

reported using the drug in the 7 days prior to interviews on a median of 4 days (mean 4, SD2.4).

The mean age of first use was 28 years of age and the main routes of administration in the past six months was injection (16%) and oral (16%). Given that buprenorphine is prescribed to be taken orally, over half of those who had used in the six months prior to interviews had injected the drug (n=15).

### **6.7.15 Naltrexone**

Ten percent of participants had a lifetime use of naltrexone, while only 1% of the sample had used the drug in the preceding six months.

The mean age of first use was 22 years of age and the main route of lifetime administration was oral (10%).

### **6.7.16 Hallucinogens**

The majority (73%) of participants had a lifetime use of hallucinogens, compared to 71% of respondents in the 2001 Victorian Drug Trends IDRS Survey and 7.6% in the 2001 National Drug Household Survey.

Compared to the norm (other regular drug users) 20% of respondents in the 2001 Victorian Drug Trends IDRS Survey had used hallucinogens in the six months prior to being interviewed compared to 9% in the study sample. The

main route of administration in the six months prior to interview was oral (7%), while 9% reported having injected hallucinogens in their lifetime.

The mean age of reported first use was 18 years of age in the study sample, an age close to that reported in the 2001 National Drug Household survey of 19.1years.

### **6.7.17 Inhalants**

A third (31%) of participants had a lifetime use of inhalants, the same rate reported by respondents in the 2001 Victorian Drug Trends IDRS Survey, while only 2.6% of respondents in the 2001 National Drug Household Survey reported a lifetime use of inhalants.

Compared to the norm (other regular drug users), only 8% of respondents in the 2001 Victorian Drug Trends IDRS Survey had used inhalants in the six months prior to being interviewed compared to 4% in the study sample. The median number of days inhalants was used in the six month period by those using the drug was 2 days (mean 2, SD .9), while no participants reported inhalant use in the 7 days prior to interviews.

The mean age of reported first use was 17 years of age in the study sample, an age close to that reported in the 2001 National Drug Household survey of 17.6 years.

## **7. Heroin Overdose History**

Chapter seven details the responses to Section 4 of the survey where participants who had ever used heroin were asked questions related to their experience of overdose and patterns of behavior when they use heroin in order to ascertain their history and risk of overdose. At the time of interviews the availability and quality of heroin had reduced as a continued outcome of the “heroin drought” which began in November 2000. The supply of some heroin was re-established in Melbourne, in March 2001 but the purity and availability remain significantly lower than pre drought levels (Fry and Miller, 2002). These changes in supply were supported by participant’s comments, reporting similar shifts in their experience of heroin supply, impacting on their use of the drug. Even with the shift in heroin use, 64% of the sample had used heroin in the past 6 months while 38% had used heroin in the last 7 days indicating that heroin is still a drug used by a significant proportion of the sample.

### **7.1 Prevalence of Overdose**

More than half (54%) of those who had ever used heroin (n=83) had experienced one or more overdoses in their lifetime, a rate similar to that reported in the 2001 Victorian Drug Trends IDRS study where 58% of respondents had ever overdosed.

18% of participants identified that they had overdosed between 1- 4 times (median 4, mean 3, mode 4, SD .9) while using heroin in the past twelve months.

Of those who had ever overdosed, their last reported overdose was a median of 24 months (mean 28, SD 25.8, range 1- 121 months) ago.

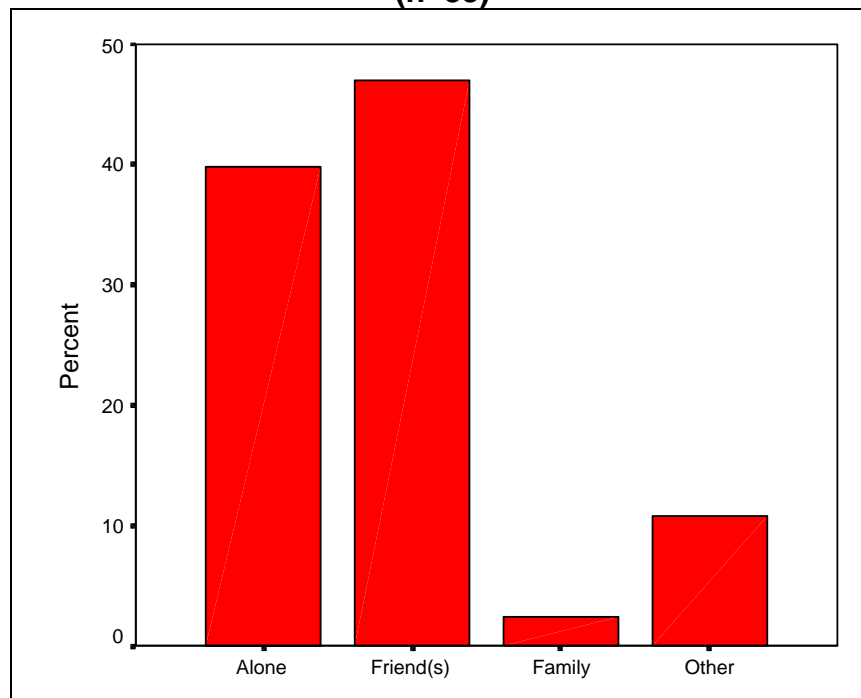
For those who had overdosed in the past (n=45), more than half (58%) had been administered narkan (naloxone), 9% could not remember and 33% reported never being administered narkan in the past when they had overdosed.

Of the 83 participants who had ever used heroin in the past, most (77%) had been present when someone else had overdosed, the same exposure rate reported in the 2001 Victorian Drug Trends IDRS Survey where 77% had witnessed an overdose. Those who had witnessed an overdose (77%) in the past had done so on a median of 3 occasions (mean 10 SD 18.7, range 1-100). Whether the overdoses witnessed had been fatal was not asked.

## **7.2 Overdose Risk Behaviours**

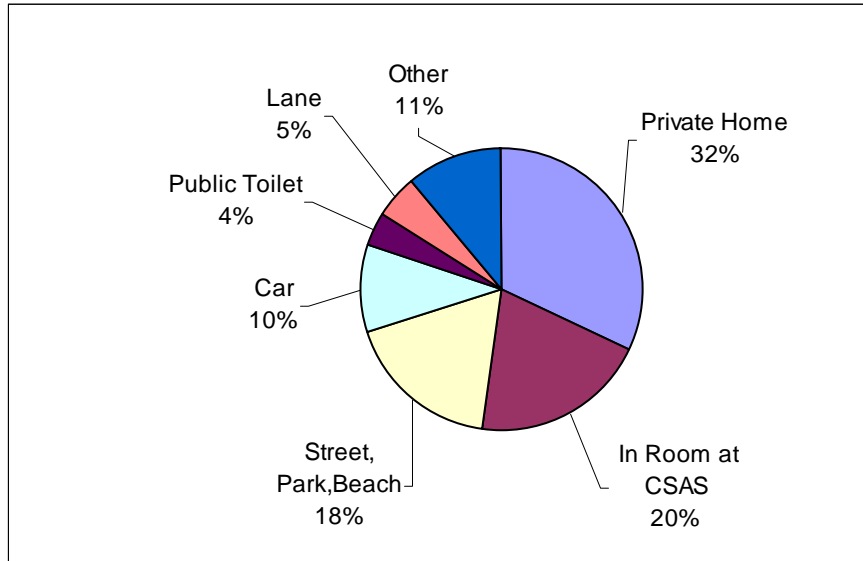
Just under half (47%) of participants who had ever used heroin reported that they were usually with friends when they had used heroin. A significant proportion (40%) however, reported usually using alone, affecting their ability to receive timely help if they did overdose. Others reported using with others such as acquaintances (11%) or family (2%).

**Figure 7.1: Person that Participants usually Used Heroin With (n=83)**



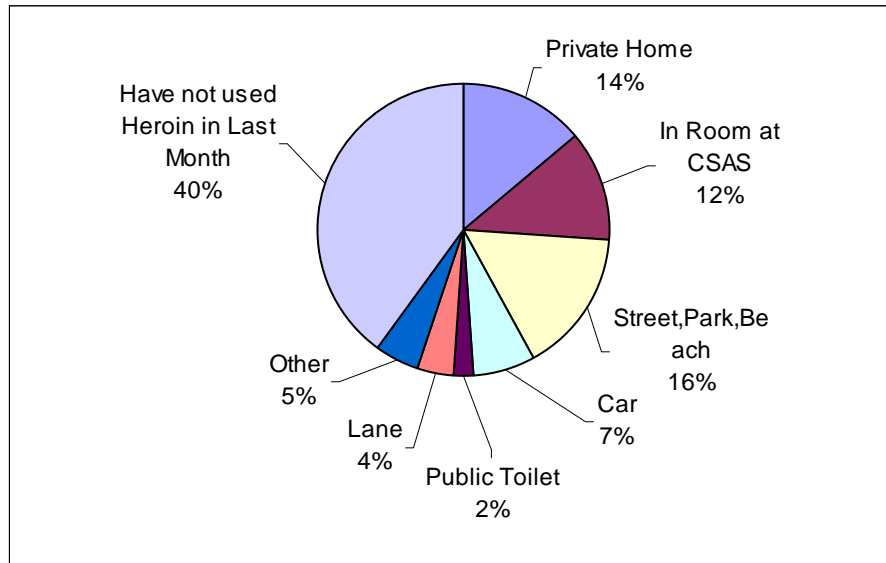
The last location reported (figure 7.2), as the site of using amongst those who had ever used heroin was a private home (33%), in their room at the crisis supported accommodation Service (21%), in the street, park or beach (18%), at another (other) location, usually the public housing high rise flats (11%), car (10%), lane (5%) and public toilet (4%).

**Figure 7.2 Last location to Use Heroin (N=83)**



Participants were asked to report on their usual location for using heroin in the last month (figure 7.3). Forty percent reported that they had not used heroin in the last month. Of those who had used heroin in the last month (n=50), 16% reported that their usual location for using was the street/ park/beach followed by private home (14%), in their room at the CSAS (12%), car (7%), other (5%), Lane (4%) and the public toilet (2%).

**Figure 7.3 Usual location when using heroin in the last month (N=83)**



Participants were then asked to report on whether they utilized strategies to avoid overdose when they use heroin, as summarized in table 7.1

**Table 7.1 Overdose Risk Behaviours (n=73)**

Behavior	Always %	Often %	Sometimes %	Never %
<b>Split the usual dose</b>	12	7	26	55
<b>Buy from same dealer</b>	24	35	23	18
<b>Also Drink alcohol</b>	5	14	27	54
<b>Also use valium</b>	7	10	43	41
<b>Also use cannabis</b>	41	22	26	12
<b>Also use Rohypnol</b>	-	-	12	88
<b>Also use Temazepam</b>	3	7	39	51
<b>Also use Methadone</b>	5	-	22	73

When using heroin, 55% of respondents had never split the usual dose, while 26% reported doing so sometimes. The majority of respondents reported that

they bought heroin from the same dealer often (35%), always (24%) and sometimes (23%).

In terms of concomitant drug use, the majority of respondents reported that they had never (54%) or sometimes (27%) consumed alcohol in conjunction with heroin in the past when they have used heroin. A smaller proportion (5%) reported that they always used alcohol with heroin, while 14% reported that they often used alcohol in conjunction with heroin. Fewer than half the participants (43%) sometimes used Valium when using heroin, while others used Valium with heroin often (10%) and always (7%). A significant proportion reported that they never used (41%) Valium with heroin. Cannabis was the drug used most often by participants when using heroin, 41% reporting that they always used cannabis when using heroin. The majority of participants had never used Rohypnol when using heroin, while 12 % had sometimes used Rohypnol when using heroin. Most (51%) reported to never use Temazepam when they used heroin, however 39% of participants sometimes used Temazepam with heroin. The majority (73%) of participants never used methadone when they used heroin, while 22% sometimes used methadone in conjunction with heroin and 5% reported to always use the two together.

### **7.3 Perceptions of Overdose Risk**

Forty percent of participants who had ever used heroin (n=83) believed that their risk of overdosing in the future was very low, the remainder believing it to be low (21%), moderate (22%), high (7%) and very high (10%). The key

reason reported for having a very low risk of future overdose was that they perceived they had a high tolerance to heroin.

When asked why they believed their risk was such, a wide range of responses was given to this open-ended question as indicated in Table 7.2. Twenty two percent of participants reported more than one reason for perceived risk of overdose.

**Table 7.3 Perceived Risk of Overdose and the Reason Why**

<b>Perceived Risk of Overdose</b>	<b>Reasons Why</b>	<b>No of participants who reported this reason n=83</b>
<b>Very Low</b>  <b>40%</b>	Street quality of drug is poor I have a high tolerance Recently cut down Know my tolerance level Careful when using On Buprenorphine Do not use anymore Use when someone is around Split dose if buy from different dealer Too much to lose	3 11 6 1 5 3 9 1 2 1
<b>Low</b>  <b>21%</b>	Street quality of drug is poor I have a high tolerance Recently cut down Know my tolerance level Careful when using On Buprenorphine Do not use anymore Use when someone is around Split dose if buy from different dealer Score from same dealer Know the quality I am buying	2 6 1 1 4 2 1 1 2 1 2
<b>Moderate</b>  <b>22%</b>	I have a high tolerance Recently cut down Know my tolerance level Careful when using Do not use anymore Use when someone is around Split dose if buy from different dealer Score from same dealer I take pills as well as heroin Been taught how to use safely I use clean fits Not sure of the drugs I take all of the time Never know what is going to happen	3 2 2 4 1 2 1 1 2 2 1 1 2
<b>High</b>  <b>7%</b>	I access high quality Never know what is going to happen Tolerance is low Not careful enough Complacency increases risk Do not know	1 1 1 1 1 1
<b>Very High</b>  <b>10%</b>	Use too much heroin I take pills as well as heroin Tolerance is low Never know what is going to happen Not careful enough No tolerance Not used for a long time Do not know	1 1 1 1 1 1 1 1

## **8. Prior Use of Drug Treatment Services**

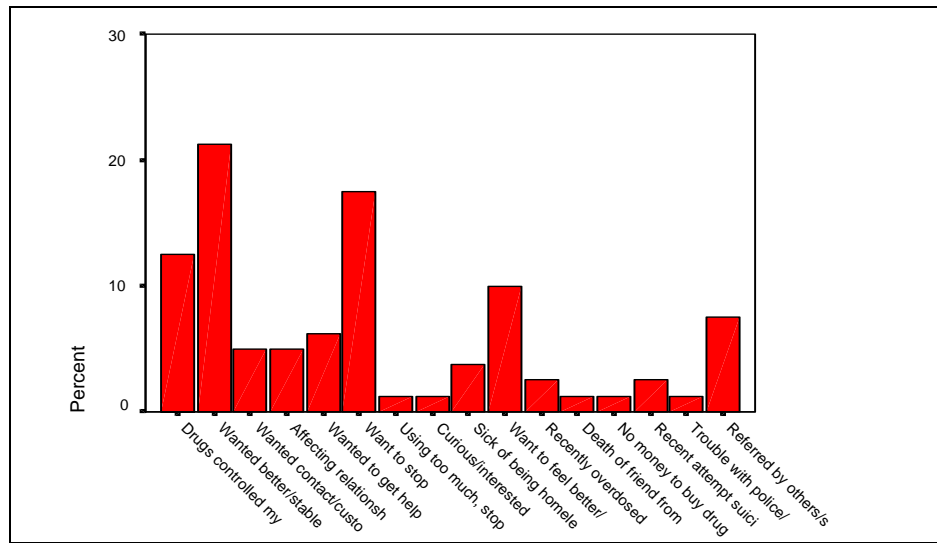
Chapter eight details the experiences and utilisation of Drug Treatment Services by homeless drug users staying within CSAS. In order to answer two of the study's key questions, both open ended and closed questions were built into the design of the related survey section in order to identify in greater detail the context and meaning of participant experiences and the barriers faced when wanting to address their drug use and homelessness situation.

### **8.1 Prior Use and Reasons**

The majority (84%) of participants identified that they had wanted to access a drug treatment service and 83% had actually accessed a drug treatment service in the past. Such findings indicate that the majority of the study group had been in contact with the service system during their lifetime and had also been motivated to address their drug use problems.

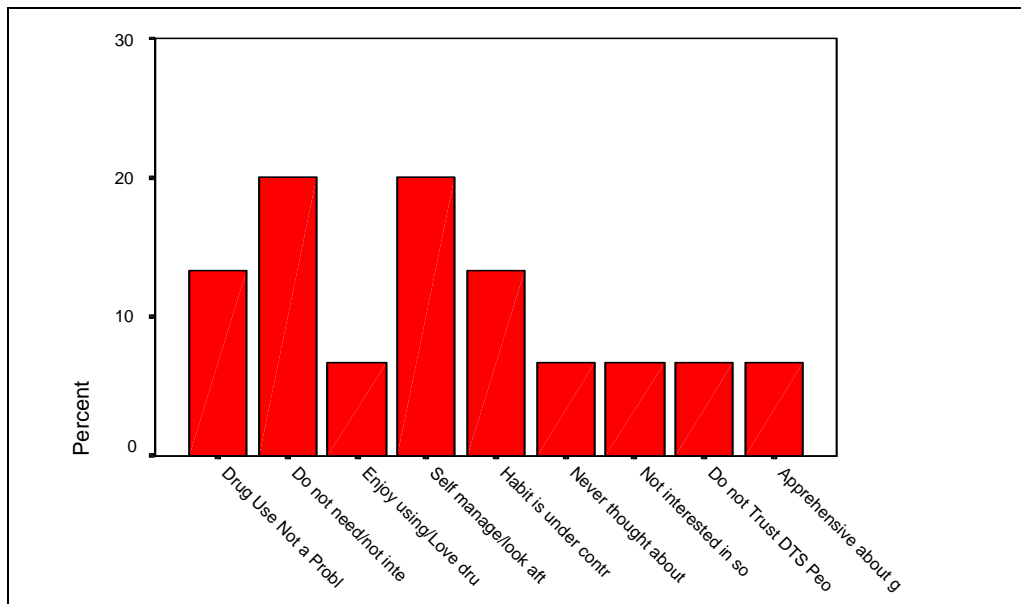
For those who had wanted to access a drug treatment service (84%) a range of reasons was given for wishing to do this (Figure 8.1). The most commonly reported reasons that prompted participants to want to access a form of drug treatment was the desire for a better, more stable life (21%); wanting to stop drug use (18%); drugs now controlling their life (13%); and wanting to feel better and to not suffer (10%).

**Figure 8.1 Reasons for wanting to access a Drug Treatment Service**



Sixteen percent of participants reported they had not wanted to access a drug treatment service in the past, while 17% had never accessed a service for treatment or support with their drug use. For those who had never wanted to access a service for treatment the most commonly reported reasons (Figure 8.2) reported were, not needing help (20%); happy looking after self/self managing; drug use is not a problem (13%) and habit is under control (13%).

**Figure 8.2: Reason for not wanting to access a Drug Treatment Service**



## 8.2 Use of Drug Treatment Services in the Past 12 months

Participants were asked to recall which services from a list DHS funded and non funded services they had used in the 12 months prior to interview for treatment or assistance with their drug and alcohol problems (Appendix 1). Participants were also asked to recall the outcome of treatment and their perception of how it went (Table8.1).

Over half (58%) of the participants had seen a general practitioner in the preceding 12 months, the most utilized service type by the study group. Twenty percent of these participants had seen a GP as part of their involvement in a substitute pharmacotherapy program such as buprenorphine or methadone.

The second most used service type was outpatient counseling (35%) which is often referred to as Consultancy, Counseling and Continuing Care (CCCC), a specialist drug treatment service, followed by a Psychiatrist (28%), Hospital (24%) and Narcotics Anonymous (24%). These top five services represent the services used by 24% or more of the sample. Interestingly, the most utilized service types were not funded specialist treatment services except in the instance of CCCC, but rather public health services such as GP's and hospitals.

Examination of these five services reveals some possible trends. All of these service types, excluding psychiatrists perhaps (need referral), appear to be easier to access (can self refer) and a lot more widely available in the community. The high incidence of mental illness reported by participants in this study may account for the utilization of psychiatrists in managing drug and alcohol as well as mental health issues. Five participants reported contact with a psychiatrist at a hospital after receiving treatment for drug and alcohol related events such as drug-induced psychosis. Participants may also feel more comfortable seeking assistance with drug and alcohol problems with services and practitioners they already have a relationship with.

The level of funding and subsequent availability of services attached to government funded specialist treatment services may partly explain why CCCC's was the most utilized out of specialist treatment services. Confirmation of such from the Governments Drugs Policy and Services Branch at the time of writing this report was not available as a review was currently underway into this area. It could be suggested however (speculation only) that

this service type has more funded positions and is not as costly as funding a treatment bed for extended periods of time, as is the case for residential rehabilitation and A&D Supported Accommodation. In addition, seeing a counsellor in an community setting may not as confronting for some as they are not expected to cease their drug use prior to or during their involvement as is the case with withdrawal and rehabilitation programs.

In terms of withdrawal services, 21% of participants had accessed a residential withdrawal service compared with only 5% who had been able to access a home based withdrawal program. An inappropriate service option for people experiencing homelessness, as in most instances you require stable accommodation and a home support network, elements missing in the lives of those who are homeless. Individuals can make a self-referral to withdrawal services, and this may partly explain why residential withdrawal was the second most utilized specialist treatment service in the preceding 12 months.

Only a small number (9%) of participants had been able to access a residential rehabilitation program in the 12 months prior to being interviewed and only 2% had accessed an A&D Supported Accommodation Program. The significantly low level of participation in these two service types by homeless people will be due in part to the limited places available compared to the demand for these services. However, given that these two service types are the only programs to combine treatment with accommodation, a format ideally suited to the homeless, who require a period of stability in their accommodation status in

order to be able to address their drug addiction, their participation is therefore alarmingly low.

Close to a third (30%) of participants had received a form of or were still involved in a substitute pharmacotherapy program. 15% of participants had used buprenorphine in the past 12 months prior to interview, followed by methadone (14%) and naltrexone (1%).

Outreach services had been used by 15% of participants in the past 12 months and in all but two cases this outreach service was a needle exchange program, namely Foot Patrol or a mobile (car) needle exchange program. The other two cases related to the use of interstate D&A Outreach services.

In addition, 15% of participants reported that they had used a Community Health Centre in the past 12 months, to either access a needle exchange program, to find out about services or to see a counselor who was not specifically funded as a drug and alcohol counselor.

This study did not ask participants about their use of needle exchange programs and therefore is unable to report the study group's use of fixed site needle exchange programs. The use of the above services in order to access clean fits and injecting equipment does indicate the importance of this type of primary health care service.

### **8.3 Level of Repeated Use of Service Types in the Past 12 months**

Largely, most of the service types had only been used once by participants in the twelve months prior to being interviewed, indicating a low level of repeat service type use.

However, eight out of the twenty-one service types listed (Table 8.1) had been used more than once by a small percentage of participants in the 12 months prior to being interviewed. In summary, 7% of those who had accessed a GP in the preceding 12 months had been more than once, 7% of participants who had been into residential withdrawal in the preceding 12 months had been more than once, 4% of participants who had been in hospital in the preceding 12 months had been more than once, followed by home based withdrawal (2%), residential rehabilitation (2%), psychiatrist (2%), psychologist (1%) and outreach (1%).

**Table 8.1: Services used in the last 12 months (only relates to health services accessed in relation to drug and alcohol issues)**

*\*The following numbers of cases have been included and represent the same episode –double counting*

*7 People saw a GP & also accessed Buprenorphine*

*4 people saw GP & also accessed Methadone*

*5 People saw a Psychiatrist as a part of their stay in hospital. In these cases all service types have been counted in this table in order to represent the context of service access.*

SERVICE TYPE	% of people who accessed service in past 12 months N=95	Reported Outcome of first or only episode reported					Participant Perception of their experience			
		Completed	Left Early	Asked to leave	Info / Referral	Still Ongoing	Positive	Negative	Ambivalent	Other
CCCC – outpatient counseling	35%	9%	49%	-	-	42%	58%	27%	6%	9%
Residential Withdrawal	21%	62%	29%	9%	-	-	57%	19%	24%	0%
Residential Rehabilitation	9%	11%	67%	22%	-	-	33%	22%	44%	0%
A&D Supported Accommodation	2%	50%	-	50%	-	-	50%	0%	0%	50%
Outpatient Withdrawal	1%	0%	100%	0%	0%	0%		100%		0%
Home Based Withdrawal	5%	80%	20%	0%	0%	0%	40%	40%	20%	0%
Rural Withdrawal	-	-	-	-	-	-	-	-	-	-
Specialist Methadone	14%	29%	21%	-	-	50%	29%	35%	29%	7%
NA	24%	-	57%	-	17%	26%	44%	17%	35%	4%

SERVICE TYPE	% of people who accessed service in past 12 months N=95	<i>Reported Outcome of first or only episode reported</i>					Participant Perception of their experience			
		Completed	Left Early	Asked to leave	Info / Referral	Still Ongoing	Positive	Negative	Ambivalent	Other
<b>AA</b>	6%		29%	14%		57%	44%	22%	30%	4%
<i>Aboriginal A &amp; D Service</i>	-	-	-	-	-	-	-	-	-	-
<b>Outreach Service</b>	15%	-	7%	-	72%	21%	100%	-	-	-
<b>Youth Outreach</b>	2%	-	50%	-	50%		50%	0%	50%	0%
<b>Mobile Overdose Response</b>	1%	-	-	-	100%	-	100%	0%	0%	0%
<b>Naltrexone</b>	1%	100%	-				0%	0%	100%	0%
<b>Buprenorphine</b>	15%	-	14%	-	-	86%	100%	0%	0%	0%
<b>GP</b>	58%	51%	5%		2%	42%	76%	7%	5%	13%
<b>Psychologist</b>	13%	50%	17%	-	-	33%	75%	0%	5%	0%
<b>Psychiatrist</b>	28%	44%	16%	8%	4%	28%	71%	21%	0%	8%
<b>Hospital</b>	24%	70%	13%	13%		4%	65%	22%	4%	9%
<b>Community Health Centre</b>	15%	-	21%	-	36%	43%	72%	7%	14%	7%

\* Other-Refers to participants who did not state their perception of the episode, but rather detailed what happened unless otherwise stated in the discussion

## **8.4 Use of Treatment Services, Outcomes and Participant Perception**

Table 8.1 also represents the participants reported outcomes and perceptions of their first episode and experience of that service type in the 12 months prior to interviews. The first episode for each service type was only recorded as very few participants had been to a service type more than once in the 12 months prior to interviews (see section 8.3).

For the purposes of this report the most pertinent service types will be discussed according to highest level of use and significant perceptions. In depth discussion on each service type is beyond the scope of this masters study program, particularly in terms of time.

### **8.4.1 General Practitioner**

As reported, 58% of participants had seen a GP in the past 12 months for treatment or assistance with a drug and alcohol problem, the most utilized of all service types. Fifty one percent of those who had seen the GP, reported an outcome of completing treatment, while 42% reported that the episode was still ongoing largely due to receiving a form of pharmacotherapy treatment or drug and alcohol counseling. Five percent reported leaving early before receiving the assistance or treatment they required and 2% reported receiving information and referral only. Participants reported a high rate of satisfaction (76%) with the care and treatment they had received, while 7% reported the experience as negative. Five percent were ambivalent, reporting mixed feelings about the experience and 13% of participant perceptions were reported as

‘other’ as they did not describe the experience as positive or negative but rather only detailed the treatment received.

This high level of use in the past 12 months corresponded with a high level of satisfaction with services received from GP’s, a possible reason why this form of treatment was the most utilized.

#### **8.4.2 Outpatient Counseling – Counseling, Consultancy and Continuing Care (CCCC)**

A third of (35%) of participants had seen a drug and alcohol counselor funded as a CCCC worker, in the past 12 months. While 58% of participants who had accessed a counselor reported a positive perception of their experience counseling, 49% of those who had used this service type had however left early.

*“Saw him 3- 4 times. Thought it was ok. It did help me. Helped me with strategies of what to do instead of using drugs”*

*“Good support. Got into short-term detox. Didn’t go back”*

*“It was good but I moved”*

Forty two percent of those who had accessed a counseling service were still going to that service at the time of interview, all but two people describing

their involvement as positive, often referring to a positive relationship with the counselor, where trust had been established and participants felt that they were being listened to.

*“ I like my counselor – feel that I am listened to”*

*“Its good. You trust Chris. Keep going there when I can”*

### **8.4.3 Psychiatrist**

Twenty eight percent of participants had seen a psychiatrist in the 12 months prior to interview for their substance use, mental illness or both.

Under half (44%) of those who had seen a psychiatrist in the past 12 months had completed treatment, while 28 % reported still seeing their psychiatrist on a regular basis. Sixteen percent of those who had seen a psychiatrist had left early of their own accord while 8% had been asked to leave and 4% reported that they had only received information and a referral.

The majority (71%) of participants reported a positive perception of their experience, often describing their involvement as helpful, supportive and informative, allowing them to gain insight into their situation and health.

*“ Went well, learnt a lot about drugs and life in general. Medication has been helpful’*

For those who described their involvement as negative (21%), this usually corresponded with them either feeling they had been coerced into going or it was linked to their discomfort at having to talk about issues

#### **8.4.4 Hospital**

Twenty four percent of participants accessed a hospital for treatment of a drug and alcohol or associated mental health issue such as withdrawal, drug induced psychosis, attempted suicide or from a physical injury they had sustained as a result of their drug use. This section includes both hospital admissions and emergency room treatment.

The majority (70%) of those who had accessed a hospital in the past 12 months had completed treatment, while 13% reported leaving the hospital early or being asked to leave. Four percent of participants were still receiving treatment at the hospital after sustaining a ‘stroke’ from heavy drug use.

Sixty five percent of participants reported that they had a positive experience while in hospital due largely to supportive staff and the care they received. Others were positive about their experience, which they reported as “time out” or “therapeutic”.

*“Hospital staff were excellent, treated me like a human being”*

For those who reported a negative experience, (22%) this was due to their perception of how they had been treated by staff in the hospital.

*“I have been admitted to hospital for two overdoses – treated me like crap”*

#### **8.4.5: Narcotics Anonymous**

Twenty four percent of participants had been to Narcotics Anonymous in the 12 months prior to being interviewed, however 57% reported leaving early on in their involvement in the program compared to 26% who reported still going to groups on a regular basis, while 17% reported that they had been once to get information but had not returned for a second meeting.

Forty four percent of participants reported that their experience of NA had been positive, often reporting feeling reassured, supported and “not alone”. Thirty five percent of those who had accessed NA were ambivalent about their experience, usually leaving early, as they believed that NA was not suited to them, as evidenced in the following statement:

*“It was alright, encouragement by others that they give you is positive but I feel more suited to one on one with someone. Group therapy is not for me”*

For those who found the experience negative (17%), this was largely reported as being due to the program approach, rather than how the people there had treated them.

The above five services types discussed were chosen as they represented the most pertinent services, defined according to the highest percentage of use by participants in the 12 months prior to interviews being conducted. Three other

services (Residential Withdrawal, Residential Rehabilitation and Buprenorphine) also warrant discussion, particularly given their significance within the government's specialist drug and alcohol service system.

#### **8.4.6 Residential Withdrawal**

Twenty one percent of participants had accessed a residential withdrawal service in the 12 months prior to being interviewed and 62% of those who had accessed residential withdrawal had completed treatment, followed by 29% who reporting leaving early and 9% were asked to leave.

Fifty seven percent of participants reported a positive experience of residential withdrawal, often referring to feeling comfortable, welcome and supported by staff. Others saw the experience as self-imposed respite from their drug use. Interestingly, not one person reported the experience as positive because they were able to withdraw from their drug of addiction and to continue to cease its use.

*“Good, allowed me to get away from drugs for awhile”*

Twenty for percent of participants reported feeling ambivalent about their experience in residential withdrawal, in all cases due to the lack of post withdrawal options available to them after withdrawal.

*“OK until Rehab person said I could not get in for another two months. So I left. Why bother. I came back here to the Crisis Accom – started using again”*

Nineteen percent of participants reported a negative experience while in withdrawal. This was either related to how they were treated by staff, some reporting the episode as stressful and unhelpful through to not being able to cope, as they had not received medication to manage their withdrawal.

#### **8.4.7 Residential Rehabilitation**

Only 9% of participants had accessed a Residential Rehabilitation program in the 12 months prior to being interviewed. Only 11 % of those who had accessed residential rehabilitation had completed the treatment program. The majority (67%) left early, while 22% were asked to leave the program.

Forty four percent of participants had mixed feelings about their experience in rehab often reporting that the staff and residents had been “good’ and supportive but reported leaving early because of the program structure (too much work/strict) or the environment that for some felt like a “prison’. Thirty three percent reported that their experience had been positive citing the level of support during and after the program as good, while 22% reported their experience as negative referring also to the rehab service being “like a prison”.

#### **8.4.8 Buprenorphine - 100 % Satisfaction**

Buprenorphine (pharmacotherapy treatment program) had been used by 15% of participants in the 12 months prior to interviews. Eighty six percent of participants, who had used this therapy, reported that they were still on

buprenorphine, while 14% had left treatment early, reporting psychological as well as peer pressure to use again rather than a physical craving.

100% of participants reported their experience of this treatment as positive, the only treatment type outside of outreach services and the mobile overdose response team (only 1 participant used his service) to record such a result. This high rate of positive feedback is evidenced in the following statements:

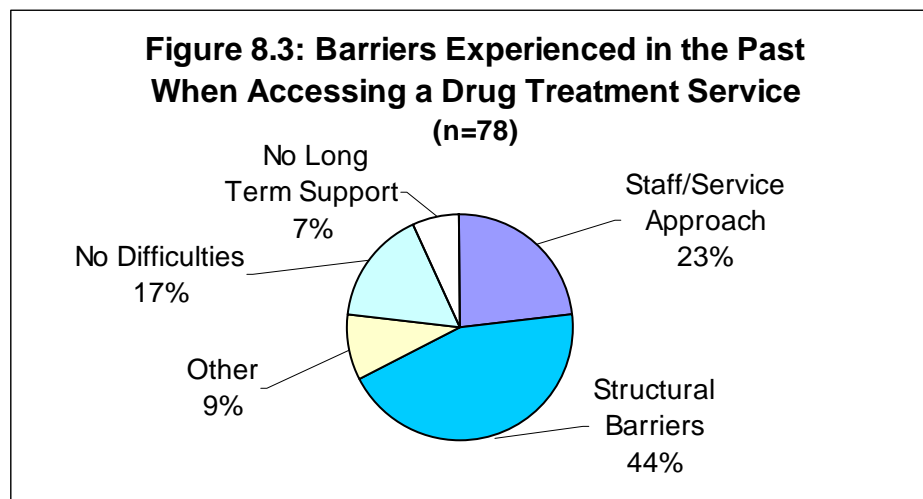
*“Good, Doctor prescribes it. It’s excellent. I can concentrate better, sleep better and feel better”*

.

*“Good. It’s different than methadone, as I don’t get dependent on it. Stops cravings. Feels different and it holds me. I don’t need to use on it. I do use because of pressure.”*

## 8.5 Barriers to Drug and Alcohol Treatment

Participants were asked to report on any barriers or difficulties they have experienced in the past when they have tried to access a drug treatment service. Barriers experienced have been grouped into five major themes as indicated in Figure 8.3. Under each of these five major themes, sub themes have been discussed in order to reflect the depth and texture of the homeless person's experiences. These experiences have been reported for all 78 participants who have tried to access a treatment service in the past. Sixteen participants within the study had not accessed a service for drug treatment in the past and did not respond to this question.



Of those who had accessed a drug treatment service in the past service (78 participants), the most significant barrier reported by 44 % of participants was related to structural issues, followed by staff /service approach (23 %) other reasons (9%) and the absence of long terms support (7%). Seventeen percent of participants reported that they had experienced no difficulties when they had accessed a service in the past.

## 1. **Structural Barriers**

Participants have experienced various structural barriers as detailed in Table 8.2, which had impacted on their ability to access a service. These structural barriers were perceived by many to still exist, often preventing participants from pursuing treatment. Lengthy waiting lists were the most significant barrier reported in response to question 37. Over half of the sample that had accessed a service (42 participants) had experienced a delay in accessing treatment. While participants had become motivated to address their drug use and approach a service for assistance, this motivation was lost while they waited. As stated by one participant;

*“Waiting times for detox are too long. You should not have to wait as it makes it hard to get off. In the end you give up –Sometimes its easier to keep using”*

**Table 8.2: Structural Barriers Experienced**

<b>Barriers experienced</b>	<b>No of participants who reported these structural reasons</b>
Lengthy waiting Lists	42
Need to ring every day	9
Difficulty finding out about services	5
No money to pay for treatment	3
Denied access because of Psychiatric /disability issues	2
No Transport to get there/Too far away	2
Need lots of personal information/identification	1

Additional structural barriers experienced that had an impact on access to services, included having to ring the service (9 participants) every day in order to demonstrate their motivation and willingness to access treatment. For most, this proved difficult, as they did not have easy access to a phone, particularly a phone that would allow some privacy. A couple of participants reported that they had been told to ring at a specific time, which had been difficult due to their moving around and “forgetting to call”. Five participants reported that finding out about services had proven difficult for some participants who were keen to know more about who could help. Accessible information that could also be explained was reported by one participant as lacking. Others stated:

*“People are uneducated about treatment – they do not understand. Access to information is hard”*

*“There is a perception that I do not need treatment because I do not use harsher drugs, but I do need it – finding out where services are and who is available to help me has been difficult”*

Having no money to pay for treatment was reported by three participants as the reason why they had been denied access to a specific service all together or had limited their choice of treatment options, particularly in regards to methadone. Two participants reported being denied access to treatment because of their psychiatric or physical disability and exclusion criteria to admission in some cases. This had left those affected by such a decision feeling frustrated and

depressed rather than supported in their attempt to seek assistance for their drug use, as stated by one participant;

*“They haven’t let me in because of my psych background – left me pretty depressed”*

Two participants reported difficulties accessing services because they had no transport to get there or services were located too far away. While only reported by a small number of participants, it does highlight the need for services to be located in areas that are accessible to public transport or can offer other options of meeting the individuals transport needs.

Finally, one participant reported that needing lots of personal information and identification to get on buprenorphine had proven to be an exhaustive process, requiring perseverance;

*“Took me 5 days to be prescribed buprenorphine because I had lost my identification and needed to also get more certificates. They did not help me. They did not tell me everything I needed to get. I would go and they would send me away to get more information”*

## **2. Staff and Service Approach**

Barriers faced by participants in terms of how they were approached by staff or the service’s approach to service delivery accounted for 25% of the barriers reported, the second major theme identified.

**Table 8.3: Barriers Experienced Due to Staff and Service Approach**

<b>Barriers experienced</b>	<b>No of participants who reported these structural reasons</b>
Staff not helpful/ Do not seem to care/ understand	12
Lengthy assessment	3
Not Knowing enough about service and what to expect prior to admission	3
Previous bad experience with service	2
Counselors who are abstinence based/no choice	2
Service too directive/ controlling	2

How staff approached participants was the most significant barrier reported under Theme 2. Twelve participants reported that they had experienced staff that were not helpful and did not seem to care or understand their issues. This approach by staff early in the participant’s contact with the service had discouraged them and appears to have had an impact on the participant’s willingness to access certain services again because of this negative experience. Two participants reported that counselors who are abstinence based, and therefore unable to offer a choice in how to manage their drug use was a barrier. This experience had been negative and had subsequently lead to the participants not returning to the service again.

Services that were too directive in their approach during the first stages of contact with participants was another barrier reported. Three participants also felt that lengthy assessments were time consuming and difficult to complete.

*“ Filling in application forms and the assessment was difficult and too long”*

Others reported that services were too controlling or directive in their approach to managing their drug problem and felt that they had no control over the process. Three participants also reported that not knowing enough about the service and what to expect when they were admitted had created a sense of “fear” of the unknown and prevented them from going to the service or leaving early once they had arrived.

Theme 2 highlights the importance of offering a service response from first contact that is supportive, encouraging, informative and respectful of the individual’s needs and experiences. It should be a two way process based on building mutual trust and understanding between both parties

### **3. Long Term Support**

Four participants reported that a barrier for them in accessing a service is that there is nowhere to go post detox. This was extended further with three participants reporting that the services inability to offer long-term support had prevented them from returning for assistance again. Participants reported feeling failed by a service system that only offered short-term responses to the long-term problem of their addiction.

*“Not enough pathway options – all the time the system has let me down.*

*Nowhere to go post detox”*

*“They do not support you long enough – only three weeks at DASWEST. I went back on heroin, as it was too hard. It take time to build trust – when it is breached it is hard to trust again”*

#### **4. Other Reasons**

An additional three barriers were reported and have been grouped for the purpose of this report under the Theme – ‘Other’.

Only one participant reported that other “users” was a barrier to them accessing treatment.

*“Being around other junkies or old friends - would be terrible to continue using”*

One participant reported feeling scared about accessing a treatment service because of their psychiatric illness, while another participant reported that for him the barrier is *“not wanting to go”*.

*“You have to want to go”*

## **5. No Difficulties Experienced**

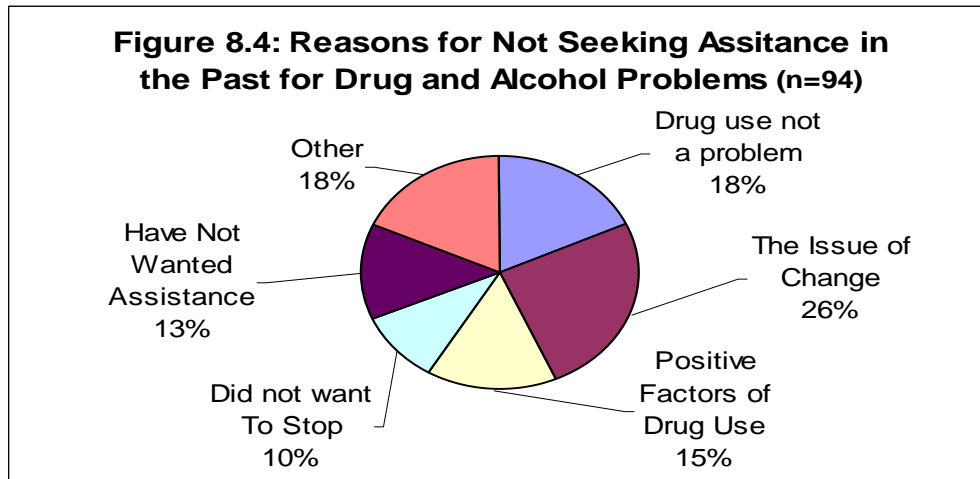
Seventeen percent of participants reported that they had experienced no difficulties when trying to access a drug treatment service in the past. Six participants reported that they had experienced no difficulties because a worker had helped to organize their access to a service.

*“Did not experience any, as a worker helped be at the hospital”*

*“No barriers because court organised the group therapy”*

*“None – I went through worker at Visy Care”*

## 8.6 Personal Factors that have Prevented Homeless Drug Users from Seeking Assistance in the Past



Reasons for not wanting to seek assistance for drug and alcohol problems in the past were grouped into six themes, as reported above in Figure 8.4. Participants reported a wide range of reasons, which highlights the complexity of factors influencing their decision to not seek assistance in the past.

Of those who responded to this question (n=94), 25% of participants reported reasons related to change (Theme 1) such as not being motivated or ready, while others (18%) reported that they did not believe their drug use was a problem now or in the past (Theme 2). This was followed by 15% reporting that positive factors (Theme 3) attached to using drugs had stopped them from seeking assistance in the past, 13% reported that they have not wanted assistance (Theme 4), 12% had not wanted to stop (Theme 4) and 17% reported other (Theme 6) reasons being present that had stopped them from seeking assistance in the past.

Under each of the above themes there exists several sub themes (reasons), which are discussed in detail under each theme. In some instances, participants have reported more than one barrier (reasons) under each theme.

**1. 1. The Issue of Change**

Initiating or confronting change was the most significant reason reported by participants (26%), as to why they had not sought assistance in the past for their drug use, as summarized in Table 8.4. Two participants reported two barriers under this theme. Issues related to change still remain as personal barriers for some participants as indicated in the statements listed below.

**Table 8.4: Factors Related to Change**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
Not motivated	14
Not ready	8
Fear of change/future	3
Fearful/scared about actually asking for help	5
Fear of failure	2

*\*Multiple responses included*

Fourteen participants reported that they had not been motivated in the past to address their drug use problems, while seven participants reported that they had not been ready to address this issue in their life due to other issues that they had to cope with.

*“Could not be bothered. I am not motivated, even though I want to stop”*

*“Not sure if I could cope. Couldn’t be bothered going through the process”*

*“Myself, I was not motivated and I didn’t care. I am now more grown up”*

*“My social Circle – who am I going to see. I would have to change my whole lifestyle...If I quit marijuana and stop going to clubs I would be too lonely and unhappy”*

Several participants reported that the presence of fear had stopped them in the past as well as in the present from seeking assistance. The presence of this emotion was a debilitating factor and a barrier in itself to accessing support and the services that they needed.

Five participants reported feeling fearful, scared and anxious about going to a service or asking for help particularly in terms of the stigma attached to being a drug user as reported in the following statements.

*“Feel anxious about it. I don’t know what to say, I am uncomfortable talking to people I do not know”*

*“I am fearful and concerned about going to services. I am embarrassed and afraid to tell people”*

Three participants reported that fear of change and what the future would hold had influenced their decision to not seek help. Sticking with what they knew remained the best option, even if circumstances related to their drug use were difficult.

*“I am scared of being straight, I seem to lose the plot and get chronic depression. It’s been so many years since I was straight”*

Three participants reported that a fear of failure had influenced their decision in the past to not seek assistance.

*“I was scared to fail, scared that I would not be able to stop even though I wanted to succeed and get a job”*

## **2. Drug Use - Not a Problem**

Eighteen percent of participants reported that they did not see their drug use as a problem either in the past or at present. While the question asks participant to report on the past, four participants reported that they did not believe their drug use to be a problem now or in the past, and were happy with their current situation.

*“Drug use is not a big problem”*

*“I’m not wanting to quit – they (drugs) do not make me do crime”*

Sixteen participants however, reported that in the past they did not perceive their drug use to be a problem and had therefore not asked for assistance.

*“Did not realize that I had a problem – it made me feel better”*

*“ Did not think I was addicted - I use to say to myself “ I do not need speed – I just need use it”*

### **3. Positive Factors of Drug Use**

Fifteen percent of participants reported that the positive factors that they gained from using drugs outweighed their need or even desire to seek assistance for their drug use in the past. For ten participants, these reasons still remain as positive influences that have stopped them in the past and now from seeking assistance with their drug use.

**Table 8.5: Reported Positive Factors of Drug Use**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
Drugs were good thing in my life/rewarding	6
Drugs are a good thing in my life	3
Drugs made me feel better	3
Drugs help me cope/ block out bad thoughts	7

Six participants reported that drugs were a good thing in their life, some referring to their drug use as “*rewarding*”.

*“It use to be such a battle and drugs were better than most things I could think of – it was the most rewarding thing in my life. I had no family, no religion, no house, no other things – so what else could I do”*

*“Never really wanted to stop before. To get clean is too confronting. Drugs have kept me alive and helped with emotional state, so they served a purpose. I have now had enough”*

Three participants still perceived their drug use to be a “ good thing” in their life, having no desire to seek assistance at all for their drug use

*“Love heroin too much”*

*“Not ready to give up as I enjoy use – stress reliever, difficult to give that up”*

Seven participants reported that drugs helped them cope with their feelings and thoughts.

*“It (drug) was helping me cope, and so I did not think it was a problem. Drugs block out the bad things”*

*“I used to drink just to get through the day, without drugs I would not be here”*

*“Marijuana helps with my schizophrenia – reduces the voices”*

#### **4. Have not wanted Assistance**

Thirteen percent of participants reported that they had not wanted assistance. Nothing had stopped them from seeking assistance in the past, as they reported having no real wish for assistance, believing that they could manage on their own. There were no subgroups under this theme as the responses reported were consistently the same and were either, not wanting or needing assistance or preferring to self manage their drug use.

*“I have always helped myself”*

*“I want to make myself better – do it on my own”*

*“ I have been through Rehab – I know what to do. Prefer to self manage – pull myself out”*

#### **5. Did Not Want to Stop Using Drugs**

Ten percent of participants reported that their reason for not seeking assistance in the past with their drug and alcohol problem was because they had not wanted to stop using drugs. Some participants stated they had no desire to stop, period. While others, linked their response to events in their life, as reported in the following statements;

*“Most of the time, half of me had not wanted me to stop, Life was still good, until I used heroin”*

*“Awhile back I did not care, did not want to stop because of my brothers death.  
I am getting over the grief”*

## **6. Other**

Several participants (22) reported a variety of other reasons that had stopped them from seeking assistance in the past with their drug and alcohol use. Table 8.6 represents this range of responses that for the purpose of analysis were grouped under the theme ‘Other’.

**Table 8.6: Other Reasons Reported that Stopped Participants from seeking assistance in the past**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
Bad past experiences	4
Fear of withdrawing/feeling sick	4
Family related reasons	3
No support from people	2
Don’t know	2
Nothing has stopped me	3
Admitting drug use-fear of eviction	1
Can not get into rehab	1
Didn’t know about services	1
My prolonged drug use	1

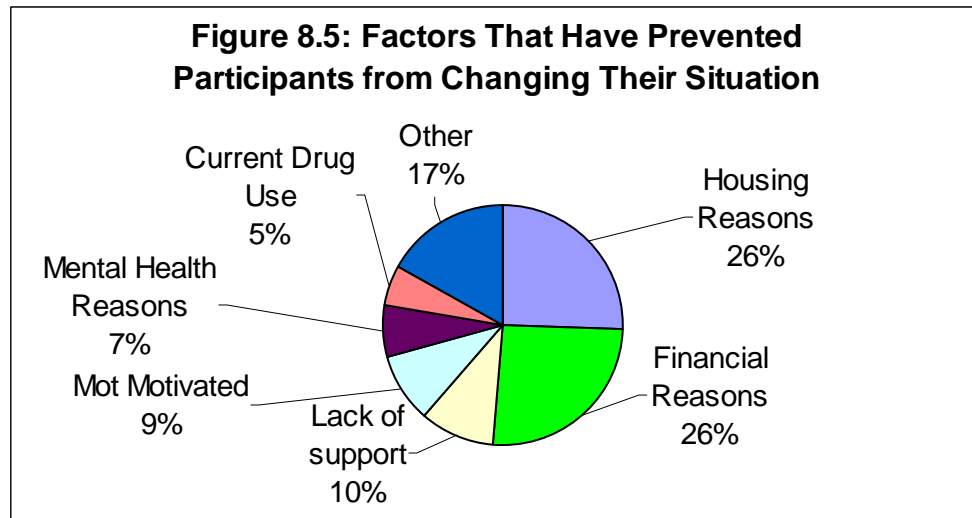
Table 8.6 represents participant responses as directly stated, except for family related reasons, where the three participants listed differing reasons as indicated below:

*“I had no one to mind my children”*

*“I did not want my family to find out”*

*“I did not want to worry my family”*

## 8.7 Barriers to Changing the Current Situation of Homelessness and Drug Dependency



Factors reported by participants that stop them from changing their current situation were grouped after analysis into seven themes (Figure 8.5). In order to understand the context and the experiences of participants, several sub themes under each theme (except Theme 3: Not motivated) will also be discussed.

Twenty six percent of participants reported that financial reasons had prevented them from changing their current situation, followed by housing reasons (26%), a variety of “Other” reasons as reported below, lack of support in their life to make changes (10%), not being motivated to change (9%), mental health reasons (7%) and current drug use (5%).

Not surprisingly, structural factors such as the lack of secure and permanent accommodation as well as financial supports (employment, money) that would allow them to secure and maintain accommodation were the most significant

factors reported. The scarcity of these key elements in their life was reducing their capacity to change detrimental behaviors such as their problematic drug use. Interestingly, the person’s current drug use was only reported by 5% of participants, highlighting that for many they did not see this issue as the greatest barrier to changing their situation. Drug use was often seen as temporary relief from the difficult circumstances that exist.

**1. Housing Reasons**

Twenty six percent of participants reported that housing related reasons had prevented them from changing their current situation. Two participants reported two separate housing reasons, which have been included in Table 8. 7.

**Table 8.7: Housing Reasons**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
Unable to Access Permanent accommodation/ that affordable	35
Cannot access rent assistance because of past behaviors	3
Need help to access rent assistance	1
Waiting to get into public housing	1

The inability to access permanent accommodation, particularly housing that is affordable, was the most significant reason reported by the majority of participants (35 participants).

*“I have nowhere to live, insecure. This is my most immediate need”*

*“Need secure long term housing. Need to settle”*

*“Nowhere to go – no transitional housing”*

Three participants reported that they could not get rent assistance because of past behaviors, while one participant reported that being unable to get any help to access rental assistance was affecting her ability to access accommodation. One participant reported that having to wait for public housing had prevented them from changing their current situation.

## **2. Financial Reasons**

Twenty six percent of participants reported that financial reasons had prevented them from being able to change their current situation of homelessness and drug dependency. Seven participants reported two separate financial reasons (lack of money and being unemployed), all have been included in this discussion, as summarized in Table 8.8.

**Table 8.8: Financial Reasons**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
Lack of money	30
Unemployment	13
No Money for bond	2

Thirty participants reported that the “lack of money” in their life made it difficult to change things, in particular, to secure accommodation.

*“Just money and being unemployed. Have stopped using heroin over the past week or two”*

*“Not having any money to pay board here and rent”*

*“Finances, debts”*

Thirteen participants reported that being unemployed had lead to significant financial constraints, which affected their ability to access housing and also maintain rent payments.

*“Yes – money for bond, no job, no permanent accommodation”*

*“Accommodation not cheap – not working at the moment”*

*“I need more work – finances. Being homeless is depressing – it effects you”*

### **3. Other Reasons**

Seventeen percent of participants reported a variety of “other reasons” that they perceived as preventing them from changing their current situation. These have been grouped into the following categories as summarized in Table 8.9.

**Table 8.9: Other Reported Reasons**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
No, making changes now	7
Other users/partner	6
Legal Problems	4
Happy where I am at	4
Not Sure, do not know	3
No Transport	1

Seven participants reported that they were making changes now, and that nothing was stopping them from making changes in their life. While it is encouraging that seven participants were able to make changes, it only represents 7% of the sample. The remaining 93% of the sample, face significant hurdles that they need to overcome, if their current state of homelessness and drug dependency is to improve.

Six participants reported that the influence of other users or partners (peers) was in itself a barrier to making changes.

*“Hanging around people, it tempts you to use. Difficult here at Oz”*

*“My partner who is manipulative – still seeing him. He is always there when I get paid or work”*

Four participants reported that legal reasons were impacting on their ability to change their current situation, while in contrast, a further four participants were happy with where they are at and did not feel they needed to make changes.

*“I have a lot of legal issues, financial hardship. Too many other issues you know – go to the doctors regularly and have to sign in every day”*

Three participants were ‘not sure’ or ‘did not know’ what things stopped them from changing their current situation and one participant stated that ‘no transport’ was a factor that had made it difficult.

#### **4. Lack of Support**

Ten percent of participants reported that a lack of support had made it difficult for them to make changes as summarized in Table 8.10.

**Table 8.10: Lack of Support Reasons**

<b>Reason Reported</b>	<b>No of participants who reported these reasons</b>
Lack of support from family and friends	12
Hard to find services that will help and support you	3

Twelve participants reported that the lack of support from family and friends had impacted on their ability to change their current situation, often feeling overwhelmed by their circumstances and disconnected.

*“Loneliness and isolation – I am cut of from family support”*

*“Lack of support, money, no love from family, No friends”*

## **5. Not Motivated**

Nine percent of participants reported that not feeling motivated to change was a personal obstacle. This lack of motivation was often associated with other issues present in their life.

*“Can only look one day ahead – hard to get motivated”*

*“Yes, it is not easy to do. You cannot get into a service. I have no money and the dole is not helpful. Not motivated to get work as I have no housing –it’s a vicious circle”*

## **6. Mental Health Reasons**

Seven percent of participants reported mental health issues as factors that had stopped them from changing their current situation. Seven participants reported that the symptoms of depression and/or anxiety, which they were experiencing, made it difficult for them to make changes, while one person stated that their mental illness (schizophrenia) made it difficult.

*“My health-depression .It stops me from accessing and maintaining work. I want to be ready for work”*

*“My mental Illness (schizophrenia) – scared of change – scared of how I will turn out”*

Under this theme of mental health, one participant stated that they were “*still coping with past abuse*” and one other participant reported that they were still trying to “*work things out in their head*”.

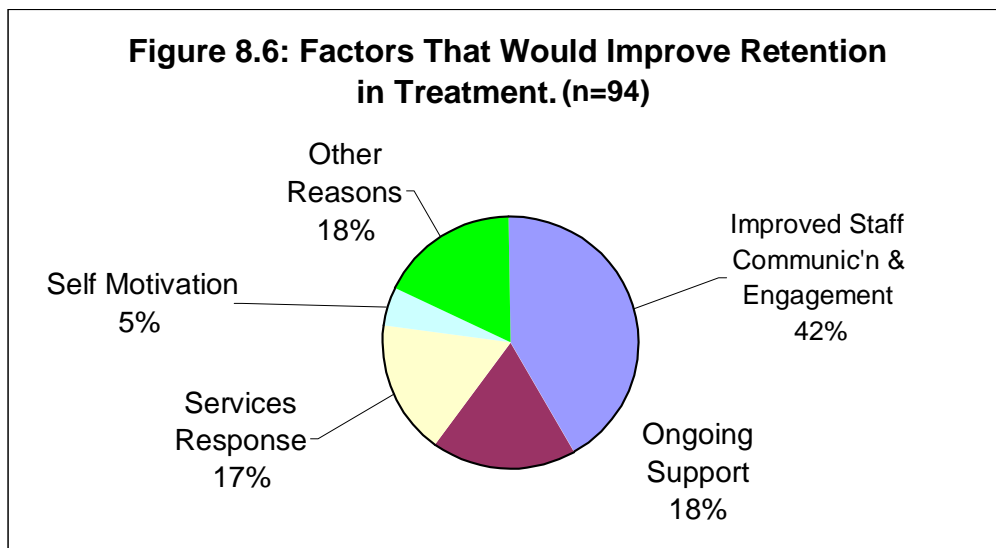
*“ I haven’t worked things out in my head – trust what I think. I am frustrated with other people, angry with myself”*

## **7. Current Drug Use**

Five percent of participants reported that their current drug use prevented them from making changes to their current state of homelessness and drug dependency. The wording of responses did not vary greatly between the eight participants who reported this reason. Most stating “their drug use” made it difficult to change their current circumstances

## 8.8 Improving Retention in Treatment

Participants were asked to identify factors that would help them to continue treatment if they were to access a service in the future. This question was asked in order to identify factors that may assist homeless people to stay engaged with a treatment service. Practitioners and managers in the Homeless and Drug Dependency Trial and other homeless workers within the CSAS reported that many of their clients did not stay in treatment once accessed and therefore wanted to identify critical factors to successfully deliver a treatment service to individuals experiencing homelessness. Twenty-eight participants reported more than one theme (n=94), all responses have been included in the discussion.



Forty two percent of participants (n=94) reported that an improvement in how staff communicated and engaged with them while they are in treatment would directly impact on their decision to continue treatment. Eighteen percent reported that the availability of follow up care and support after treatment would make a difference to their decision to continue/ complete treatment.

Seventeen percent reported that services needed to address areas related to how the program responded to preventing the access to drugs in treatment through to its ability to assist clients to address a range of issues in their lives. In contrast, 5% of participants reported that they needed to be self motivated in order to continue treatment, while a further 18 % reported a variety of other responses to this question, ranging from “not sure” of what would make a difference (8 participants) to “not being interested” in treatment (6 participants).

**1. Improved Staff communication & engagement:**

Forty two percent of participants reported that an improvement in staffing factors related to communication and engagement would have an impact on their decision to continue their involvement with a drug treatment service. A range of responses was reported under this theme, as summarized in Table 8.11.

**Table 8.11: Improved Staff Communication & Engagement Factors**

<b>Reported Staff Factors</b>	<b>No. participants who reported this factor</b>
Staff who communicate well, give you tips, talk straight and are persistent.	17
Staff/counselor that make you comfortable and understand the issues	13
Workers who really care and respect me	12
Service who employs staff that have given up drugs	9
Staff who are positive towards you/non judgmental	8
Counselor/workers who actually listen	7
Continuity in the staff you see	5

The main reason reported related to the communication and counseling skills of staff within Drug Treatment Services. Seventeen participants felt that a worker needed to be able to communicate well and offer practical tips that would help. Participants reported feeling frustrated with how staff

communicated, often reporting that staff /counselors offer no real solutions or tips and seem to avoid what really needs to be discussed.

*“I don’t want people to tell me what they think I want to hear – I want the truth”*

*“Staff that listen to me and do not talk shit”*

*“People who show genuine concern. Not textbook junkies (workers). I want to see results from workers, see that I am achieving my goals”*

A large proportion of the sub themes in Table 8.11 related to how participants are made to feel when they are engaging with staff. Thirteen participants reported staff that made you feel comfortable and were able to understand the issues, was critical to their decision to stay involved in a treatment service. Similarly, twelve participants reported that staff needed to be respectful and to genuinely care for their well being. Followed by eight participants who reported that staff who were positive and non-judgmental, as well as staff (7 participants) that actually listened were critical factors to the delivery of a quality service.

Nine participants felt that services, which employed staff that had given up drugs, would have an impact on their decision to continue their involvement with a service. This response was often linked to the participants being able to relate to that staff member and to also see that change is possible. Five

participants felt that knowing that they would have continuity with the staff that they saw was important, particularly in terms of building a trusting relationship.

*“Being able to see the same person – build a relationship, trust”*

## **2. Ongoing Support**

Eighteen percent of participants reported that a services ability to provide ongoing support would influence their decision to stay involved in treatment.

Three sub themes emerged under the theme of “Ongoing Support” as summarised in Table 8.12. Twelve participants felt that knowing that a service offered follow up support post treatment would make a difference, while nine participants reported that they would continue their involvement with treatment if the service provided long term support, as the central element to their response. Three participants also reported that they would continue their involvement with a service that gave them something meaningful to do each day as part of their treatment program.

**Table 8.12: Ongoing Support Responses**

<b>Ongoing Support Responses Reported</b>	<b>No participants who reported this factor</b>
Follow up support provided post treatment	12
Service that is able to provide long term support	9
A service that gives you something to do each day -volunteer work	3

**3. Treatment Services Response**

Seventeen percent of participants reported that how a service responds in terms of managing a participants exposure to drugs in treatment (9 participants), through to a service that does not make individuals repeat their life story (1 participant), were factors, that if addressed would help them continue with treatment. As summarized in Table 8.13, eight participants also reported that a service without waiting lists, able to provide quick access to treatment was important, as is a service that can address a range of needs (5 participants).

**Table 8.13: Treatment Services Response**

<b>Factors Related to the Treatment Services Response</b>	<b>No participants who reported this factor</b>
A service that does not expose you to drugs while in treatment	9
A service without waiting lists/ quick access	8
A service that is able to look at all the issues in my life/address all my needs	5
A service that does not make you repeat your life story	1

**4. Other Factors**

Eighteen percent of participants reported a variety of ‘other’ responses to this question as summarized in Table 8.14.

Eight participants were “not sure” or “did not know” what might help them to continue their involvement in a treatment service if they were to access one in the future, while seven participants reported that they were not interested in accessing a service in the future.

**Table 8.13: Other Responses**

Other Responses	No participants who reported this factor
Not Sure/Do not Know	8
Not interested in accessing a treatment service	7
Services Like Flagstaff	3
Good facilities	3
A service that gets you a job	1

Three participants reported that services needed to be more like Flagstaff, where they had their own room, support, privacy and meals.

*“A service that meets all your needs – like Flagstaff”*

*“Like Flagstaff – privacy of own room, three meals a day, support and they let you know about services. Improves personal health – helps you stabilize”*

Similarly, three participants reported that having access to good facilities was a consideration, while one participant reported that they would continue their involvement in treatment if the service would help them get a job.

## 9. Health Issues

As evidenced in the literature, homeless people, especially those with problematic drug use issues often experience poor health and are at risk of many health related problems as a consequence of their drug use. This chapter therefore examines the participant's physical and mental health as well as experienced injection related health problems such as those related to blood borne virus transmission in order to understand the profile of homeless drug users who access CSAS.

### 9.1 Injection Related Health Problems

Injection related health problems reported by participants in the last month are summarized below in Table 9.1.

**Table 9.1: Injection Related Health Problems**

<b>Injection Related Health Problem</b>	<b>No. of participants who had experienced the problem in the last month n=91</b>	<b>% (n=91)</b>
Overdose	1	1%
Abscess/infection	10	11%
Dirty Hit	14	15%
Prominent scarring/bruising	23	25%
Difficulty Injecting	22	24%
Thrombosis	8	9%

A quarter (25%) of participants had experienced at least one injection related health problem in the previous month. The most common problems reported by participants were prominent scarring/bruising (25%) and difficulty injecting into veins (24%).

## 9.2 Prevalence of Hepatitis C, B and HIV

Participants were asked to report whether they had ever been diagnosed with Hepatitis C (HCV), B (HBV) or HIV in the past (lifetime).

Of those who responded to his question (n=91), a significant proportion (41%) had been previously diagnosed with Hepatitis C (HCV), 4% had been diagnosed with Hepatitis B (HBV) and no one reported being ever diagnosed with HIV.

The rate of hepatitis C (HCV) among the study group was much higher than that reported in a previous homeless study where thirteen percent (51/384) of participants reported testing positive to hepatitis. Of these, 61% (51/384) were positive for hepatitis C (HCV) and 33% (17/51) for hepatitis B (HBV) (Kermode et al, 1998).

## 9.3 Dental Health

**Table 9.2: Dental Health Problems**

Dental Health Problem	No. of participants who had experienced the problem in the last month	% (n=91)
Gum Abscesses	26	29%
Painful Mouth	45	49%
Dental Cavities	55	60%
Bleeding Gums	39	43%
Lost Teeth	24	26%

A Council to Homeless Persons Australia study found that over half of the homeless people surveyed had tooth decay (NSW Council of Social Service,

2000). A rate similar to this study where over half (60%) of the participants reported experiencing dental cavities (noticeable holes in the teeth) in the previous month. In addition just under half (49%) of participants reported experiencing a painful mouth, while 43% had experienced bleeding gums in the previous month indicating a poor level of dental health among the study sample.

## 9.4 General Health

**Table 9.3: General Health Problems**

General Health problem	No. of participants who had experienced the problem in the last month n=91	% (n=91)
Inadequate diet/nutrition	34	37%
Poor sleeping pattern	60	66%
Respiratory Infection	23	25%
Cold/flu	31	34%
Skin infection/infestations	23	25%
Other health issues	11	12%

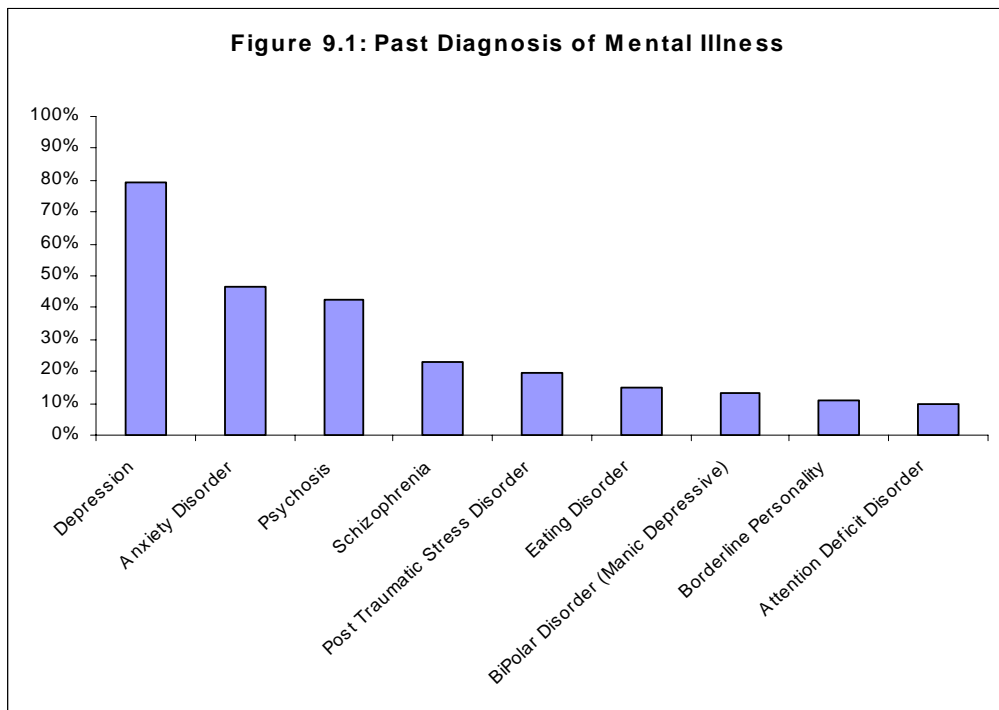
Over half (66%) of participants had experienced a general health problem in the previous month. The main problems reported were poor sleeping problems (60%), inadequate diet/nutrition (lack of regular meals) (37%) and cold/flu (34%). Interestingly, participants reflected while completing this survey section that their general health had improved since staying at the crisis supported accommodation service because they had access to regular meals and a safe room to sleep in. A percentage of interviews were conducted over the summer months, which may have impacted on the experienced levels of colds/flu and respiratory infections. Nevertheless, even with improved temporary living conditions the level of general health issues experienced in the previous month was still high.

## 9.5 Mental Health

### 9.5.1: Mental Health Disorders

The high prevalence of diagnosed mental health disorders in the study group reflects the poor health status of this group and complexity of health needs (figure 9.1).

The most significant diagnosed mental health disorder reported by participants (n=92) was clinical depression (79%). Followed by anxiety disorder (47%), psychosis (42%), schizophrenia (23%), post traumatic stress disorder (20%), eating disorder (15%), bipolar disorder (13%), borderline personality (11%) and attention deficit disorder (10%).



### 9.5.2 Attempted Suicide and Self Harm

Participants (n=92) were also asked to report whether they had ever self harmed in the past or ever attempted suicide in the past. A significant proportion (41%) of participants reported that they had attempted suicide in their lifetime, while 34% of participants reported that they had self harmed themselves in their lifetime (Table 9.4). The reported rate of attempted suicide by participants (41%) was slightly higher than that reported by participants who were entering treatment for heroin dependence, in the baseline findings of the Australian Treatment Outcome Study (Ross et al, 2002), where 34% of the sample had attempted suicide at some stage in their lives. It was however equal to that reported in a 2001 study on the relationship between suicide and overdose among methadone maintenance patients in Sydney, where 40% of the sample had attempted suicide at least once in the past (Darke & Ross, 2001).

**Table 9.4: Past attempted suicide and self harm Rates (n=92)**

Ever Attempted Suicide in the past	41%
Ever Self harmed in the past	34%

In addition, a study that examined the suicidal behaviour among homeless people (Horn, 1998) receiving support and accommodation at Hanover Welfare Services, identified that the rate of attempted suicide was 18% and that 22% had engaged in self harm, putting their life at serious risk (Horn, 1998). While these rates are concerning, they are lower than those experienced by homeless drug users staying within crisis accommodation. This in part may be due to the

differences in the sampling frame and the level of crisis that the study group is in (all are in crisis accommodation) compared to the above study (Horn, 1998) where a percentage of participants were in transitional housing, which offers greater stability. However the level of reported attempted suicide and self harm among the study group as supported in the literature reinforces the relationship between drug use and mental health and its negative impact on the homeless persons health status and social functioning. This issue requires further examination and a review of existing protocols within services in terms of assessing for suicide risk and action plans to support those at identified risk.

### **9.5.3 The Issue of Depression**

As reported, the majority (79%) of the study group reported being diagnosed with depression in the past. A significantly higher rate than the general community, where 5.1% of the 1997 National Survey of Mental Health and Wellbeing sample (AIHW, 1998) reported symptoms of depression in the 12 months prior to interview.

In this study participants were asked to report whether they had experienced any of the symptoms of clinical depression in the last month as summarized in Table 9.5. These findings can only be viewed as exploratory in ascertaining the current state of depression among participants. Assessment of an affective disorder such as clinical depression requires individuals to undergo assessment by a medical clinician.

This process involves the individual reporting that they have:

” Five or more of the following symptoms which have been present during the same 2 week period and represent a change from previous functioning; at least one of the symptoms is either (1) depressed mood (e.g. feels sad, empty) or (2) loss of interest or pleasure” (American Psychiatric Association, 1994).

Assessment also requires the clinician to rule out that the present symptoms are not due to physiological effects such as substance use and that they cause clinically significant distress or impairment in social, occupational or other areas of important functioning (American Psychiatric Association, 1994).

**Table 9.5: Depression indicators experienced by participants in the past month- *Exploratory only***

Symptoms of Depression experienced in the past month	Number of participants n=90	% (n=90)
Feelings of sadness	74	82 %
Feelings of low self worth/worthlessness/guilt	65	72 %
Felt isolated	63	70 %
Experienced suicidal thoughts	30	33 %
Increased feelings of anxiety/worry	66	73 %
Felt angry more often than usual	45	50 %
Felt bored more often than usual	63	70 %
Reduced interest/pleasure in activities	45	50 %
Felt more restless or tired than usual	62	69 %
Loss of libido	32	36 %
Have been eating more or less than usual	69	77 %
Have been sleeping more or less than usual	64	71 %
Reduced ability to concentrate/make decisions	46	51 %

The most common symptoms reported by participants included feelings of sadness in the last month (82%), eating more or less than usual (77%),

increased feelings of anxiety (73%), feelings of low self worth/guilt (72%) and sleeping more or less than usual (71%). The remaining responses reported were feeling bored more than usual (70%), feeling isolated (70%), feeling more restless or tired than usual (69%), reduced ability to concentrate and make decisions (51%), loss of libido (36%) and suicidal thoughts (33%).

Thirteen percent of participants (n=90) reported experiencing between 1- 4 symptoms of depression in the last month. Forty seven percent reported between 5 - 9 symptoms of depression and 39% reported 10 or more from a list of 13 indicators.

Using the operational diagnostic measurement for depression as previously discussed 79% of participants self reported to have had a depressed mood (Feelings of sadness) and four other symptoms in the month prior to interviews. Fifty percent reported to have had a reduced interest or pleasure in activities and four other symptoms.

While the above list of indicators related to depression is not a formal diagnosis and should be viewed with caution, it does highlight that a significantly high proportion of participants were experiencing moderate to high levels of depressive symptoms in the month prior to interview. These finding also support the literature on the prevalence of depression among homeless individuals and drug users. If nothing else these findings support the need for further examination of the incidence of depression among homeless drug users and action to address this debilitating health issue. The need for

homeless drug users staying within Crisis Supported Accommodation Services to have greater access to health care services where appropriate assessment by a specialist clinician can occur, with possible treatment and follow up care is also required.

Eighteen percent of participants (n=90) also reported feeling ‘other changes’ in their mental/emotional health state in the past month. A range of emotions /feelings were expressed by these participants in addition to reporting against the above symptoms of depression. Other feelings experienced in the last month as reported by participants included feeling deflated, helpless, impulsive, frustrated, erratic, overwhelmed, wanting to cry a lot, cloudy head, feeling up and down, have self mutilated twice and felt depressed. This was the only “other” comments section in the study to be responded to by participants.

## **9.6 Risk of Blood Borne Virus Transmission**

This section of questions asked participants who had injected in the last month to report on risk taking behaviors related to their injecting practices. While 77% (73) of participants had previously reported to injecting drugs in the last month only 72 people responded to this section of questions.

### **9.6.1 Injecting Behaviours**

Fourteen percent of participants (n=72) who had injected in the last month had used a needle after someone else in that period. Six percent of those who reported doing so had used a needle once after someone else, while 8% of those who reported doing so had used a needle after someone else two or more occasions in past month.

Seven out of the ten people who reported using a needle after someone else in the last month indicated that the borrowed needle had been used by only one other person. This person was usually an acquaintance (6 cases), and in one instance, a casual sexual partner. For the remaining three cases, two participants could not remember how many different people had used a needle before them in the last month, however they reported that the person(s) were either close friends or acquaintances. One person reported that between three and five people had used a needle before them in the past month and these people were either their regular sexual partner and/or close friends.

Seventy five percent of participants who had injected in the past month reported that there had been no times when a needle had been used after they had already used it. Thirteen percent reported that on one occasion someone had used a needle after them.

Eight percent reported that on two occasions someone had used a needle after them, while 3% reported that someone had used a needle after them between 3-5 times in the past month. 1% reported that someone had used a needle after them more than ten times in the past month.

**Table 9.6: Injecting equipment that had been used after someone else in the last month**

<i>Injecting equipment used after someone else in the last month</i>	<i>%</i>
No Equipment	49
Spoons or mixing containers	49
Filters	25
Tourniquets	13
Water	25
Other	3

*\* Multiple responses reported*

Forty nine percent of those who had injected in the last month reported that they had shared spoons or mixing containers with someone else, while 25% had shared their filters and 25% had also shared their water for injecting (Table 9.5).

Given that the “sharing of needles/syringes and other equipment associated with preparation and injection carries a significant risk of exposure to blood borne viruses such as HIV and Hepatitis B (HBV) and C (HCV) “(Crofts et al, 1999), the above rates of reported sharing of injecting equipment is disturbing. Further, just under half (41%) the participants surveyed in this study reported that they had been diagnosed in the past with Hepatitis C (HCV) and 4% with Hepatitis B (HBV). With such high rates of hepatitis among those who are homeless, the risk of blood borne virus spread in this population and the general community is of concern.

**Table 9.7: Reasons for Sharing injecting equipment**

<b>Reason for sharing</b>	<b>No of participants who reported this reason n=72</b>	<b>%</b>
Did not share equipment	35	49 %
Happy to share with friends	19	26%
Unable to access sterile equipment	17	24%
Forgot to get sterile equipment	6	8%
Hanging out at the time	4	6%
Living on the streets at the time	3	4%
imprisonment	-	-
No money to buy equipment	-	-

*\*12 participants reported more than one reason*

The main reasons reported for sharing injecting equipment in the past month (Table 9.6) varied from 26% being “happy to share with friends”, while 24% shared because they were unable to access sterile equipment and 6% forgot to get sterile equipment.

### **9.6.2 Other BBV Risk Taking Practices**

A significant proportion (38%) of those who had injected in the last month had engaged in unprotected sex. Eleven percent had engaged in unprotected sex once in the past month, while 6% had engaged in unprotected sex twice, 7% between 3-5 times, 1% between 6 to 10 times and 12% more than 10 times in that period.

Only 1 % of participant, who had injected in the last month, had been tattooed by a non-professional tattooist. Fourteen percent of participants who had injected in the last month reported that they had used another person’s personal hygiene equipment such as toothbrush and nail scissors.

## 10. CONCLUSIONS

Homeless drug users accessing Crisis Supported Accommodation Services face significant social, health and economic disadvantages. They represent a high needs sub group of the homeless population who require careful consideration and planning in the development and delivery of services. These initiatives must be responsive and flexible to the diversity of needs that exist and offer a long-term view to addressing the significant and often entrenched behaviours and social circumstances experienced by this group. A whole of government response, based on solid service system integration, as recommended in key government documents, such as 'Drugs Meeting the Challenge: Stage Two Report' (DPEC, 2000) and the 'Victorian Homeless Strategy Directions for Change' report (VHS, 2002), is necessary in order to effectively address the complexity of issues that often reinforce each other.

### **Effective Engagement**

Crisis Supported Accommodation Services are well placed to engage homeless drug users into treatment and housing, as indicated by the high level of repeat use of crisis services. Intervening in this cycle of homelessness and drug addiction requires skillful engagement and the resources to offer meaningful and timely support. The level of long term homelessness and chronic instability experienced by the study group emphasises the need for such action. The longer a person remains homeless the more difficult it will become to engage and build sustainable pathways out of homelessness and drug dependency.

## **Association between Homelessness and Drug Use**

Sixty three percent of participants reported that their current state of homelessness was due to their drug addiction, revealing a strong association between homelessness and problematic drug use. In addition, the loss of support and meaningful relationships in their lives had also impacted on their current situation.

The study group's high level of transience, long term homelessness and extensive drug use history further supports this association. While acknowledging differences in methods, the study group had significantly higher rates of drug use than the general community and similar patterns of use to injecting drug users in the 2001 Victorian Drug Trends IDRS study, in terms of lifetime use and previous six months use.

The consideration and continual examination of contextual dynamics (supply and affordability of drugs) influencing the shifts in drug using behaviors and the direct impact of the homeless persons environment and social situation on patterns and levels of drug use, is also required. For example, current main drug of choice was cannabis followed by heroin, amphetamines, and alcohol. However, over fifty percent of participants reported changing from a previous drug of choice, with heroin being the most common drug used in the past. The high level of cannabis use appeared to also be influenced by the homeless persons current environment and the availability and widespread use of this drug by other residents.

## **Functional Role of Drugs**

Reasons for first using drugs were often linked to social factors such as peer pressure or to socialize with others, while in the main, reasons for current use had shifted, and were related to achieving a desired drug effect or to assist with the management of their other drug use. Common responses being, “ I like the way it makes me feel”; “It relaxes me”; “ helps me cope”, “helps me get things done”; “it’s a substitute” and “helps me manage cravings/ withdrawal symptoms”. These self-reported reasons support the functional role of drug use as a coping mechanism, and a form of fulfillment in their lives. Until the person can see that their situation is able to change, that appropriate support and treatment is available, and that they are ready for this shift, the use of drugs and the benefits they offer will remain a significant focus in their lives.

## **Heroin Overdose – Risks Remain**

The inception of the Trial was at a time when the CSAS were facing widespread heroin use and an increase in heroin overdoses. While the ‘heroin drought’ has lead to a reduction in the purity and supply of heroin, this study has identified that heroin still remains one of the main drugs used. Sixty eight percent of participants reported using heroin in the last six months, while 38% had used in the week prior to interviews.

The risks attached to the use of heroin have not diminished, as further supported by the level of poly drug in the week prior to interviews, where four out of the six main drugs used, were central nervous system depressants and

the mean number of drug classes used, was seven. While the rate of overdoses both fatal and non fatal has decreased (Fry & Miller, 2002) the potential risks of death and permanent disability still remain for this group, requiring ongoing monitoring and harm reduction interventions.

### **The Importance of Harm Reduction as a First Response**

As discussed the risk of overdose still exists, as do the other associated health risks attached to injecting and poly drug use. Drug injecting behaviors among the study group indicate that the risk of transmission of a blood borne virus such as Hepatitis C, Hepatitis B, and HIV is high. The majority (87%) of participants had injected drugs in their lifetime, while over three-quarters of participants (77%) had injected drugs in the last month, with heroin (40%) and amphetamines (26%) being the most common.

Almost fifty percent of those who had injected in the last month reported that they had shared some form of injecting equipment, while 41% of the study group had previously been diagnosed with Hepatitis C. The high incidence of sharing injecting equipment and the level of hepatitis C exposes the real and concerning risk of future blood borne virus spread within this population and the general community.

### **Health Issues**

The need for Crisis Supported Accommodation Services to be linked with primary health care services is evident by the magnitude of health issues facing homeless drug users. The period of stability, however brief, offered by a stay

within the crisis accommodation may give homeless individuals the opportunity, possibly for the first time, to address health issues such as depression and to also seek assistance with their drug use.

Of critical significance is the issue of depression. High rates (79%) of diagnosed clinical depression in the past, coupled with alarming reports of previous suicide attempts (41%) and self harm (34%) further exposes the vulnerability of this group and the need for treatment and support.

In addition, the incidence of mental illness among homeless drug users was high as observed and reported anecdotally by staff within the CSAS. The majority of participants being diagnosed in the past with clinical depression (79%), followed by anxiety disorder (47%), psychosis (42%), schizophrenia (23%), post traumatic stress disorder (20%), eating disorder (15%), bipolar disorder (13%), borderline personality (11%) and attention deficit disorder (10%).

### **Utilisation of Treatment & Barriers Experienced**

Given the high level of multiple drug use, risk behaviors and social exclusion, the need to increase this population's participation in treatment is critical to their long-term well being and to the community in general. This requires an improved level of access to treatment that is attuned to the specific needs of the homeless drug user, who may also have a dual diagnosis. In light of the fact that the majority of participants had previously experienced barriers when trying to access treatment, services need to be designed in a way that

encourages and supports the individual to seek help, not place additional hurdles and restrictions on their access.

Low levels of participation in Residential Rehabilitation and A&D Supported Accommodation in the past 12 months, reflects a picture of limited drug treatment service use, in particular, of specialist Drug Treatment Services, reducing opportunities for recovery. The level of previous engagement with treatment services does however suggest that homeless drug users want to receive help for their drug use.

### **Improving Retention in Treatment**

While access to services is a significant problem, the retention of homeless people in treatment poses a variety of challenges for practitioners and the service system. The main factors identified by participants that would improve their retention in treatment included:

- An improvement in staff communication, counseling and engagement skills
- The availability of follow up care and support after treatment
- Service's that respond quickly and provide timely access to treatment
- Services that are able to prevent the access to drugs while in treatment
- Treatment services that are designed to assist with a range of issues in the homeless persons life.

### **Factors Influencing Change**

A wide range of personal reasons was reported as factors, which had influenced their decision to not seek assistance for their drug use in the past.

These factors were related to change, such as not being motivated or ready, while others reported that they did not see their drug use as a problem. The extent to which these factors still exist is not known. However, only a small percentage (9%) reported the personal lack of motivation to change as a current factor preventing them from changing their current situation of homelessness and drug dependency. Participants instead, overwhelmingly identified structural factors, such as the lack of permanent accommodation and financial supports to secure and maintain accommodation and build stability, as significant barriers. The lack of personal supports such as family in their life, mental health issues and finally their drug addiction were additional factors reported to be currently impacting on the homeless drug users ability to make sustainable changes.

### **Closing**

While the findings of this study cannot be generalized to represent all homeless drug users, due to the limitation in the sampling frame, it does however provide detailed baseline data on the profile and level of needs among homeless drug users accessing crisis accommodation. These findings indicate that homeless drug users accessing Crisis Supported Accommodation Services are significantly disadvantaged, experiencing multiple health issues, high rates of mental illness and low levels of utilisation within the specialist drug treatment service system. Tackling a homeless person's drug use, without assisting them to acquire the housing and personal stability they need to address these issues, will yield short-term outcomes rather than create long term pathways of sustainable change. Future service responses need to be designed to address

these issues in collaboration, as is being trialed in the Homeless and Drug Dependency Trial. This requires proactive leadership from all sectors, founded on strong cross sector partnerships and realistic program responses that are specifically attuned to the diverse needs of homeless drug users rather than reactive.

## 11. Future Directions

### **Policy Implications:**

In an environment of scarce health and welfare resources, the need for collaboration between sectors to address the multiple social and health needs of homeless drug users is evident. Tackling one problem in isolation from the other will lead to short term outcomes for the individual, government and the community.

Accessing and sustaining treatment without stable accommodation is difficult if not impossible for homeless individuals. As evidenced in this study, environmental factors such as the lack of permanent housing and financial issues (unemployment; no money), impacted on the homeless drug users ability to change their current situation of homelessness and drug dependency.

The provision of long term housing for the homeless, that is affordable and appropriate remains a significant challenge. However, government and community bodies need to continue to examine the inter relationship between these two issues and seek to develop viable responses that are progressive and able to tangibly address the significant barriers experienced by homeless drug users. Further research into the relationship between homelessness, housing opportunities and drug use, needs to occur, as is presently being conducted by the Australian Housing and Urban Research Institute and the Homeless and

Drug Dependency Trial, in order to illuminate the inter relationships between these factors, and to further inform public health and welfare policy.

### **Service delivery**

As discussed, Crisis Supported Accommodation Services are well placed to engage homeless drug users into a treatment response, as is being trialed in the Homeless and drug Dependency Trial. The high incidence of mental health issues and dual diagnosis among this population, suggests that greater attention needs to be given to this issue in order for practitioners and services to deliver an improved response for this high needs group, that will improve their well being and social functioning. Stronger linkages between mental health services, Drug Treatment Services and homeless services are required. In addition, resources to facilitate the necessary development of service responses and practitioner skills, particularly in terms of detecting mental health issues and in the management of dual diagnosis clients is also required. Future program development must firstly build the necessary infrastructure in terms of cross sector partnerships and resources.

The low level utilization of specialist Drug Treatment Services and the barriers faced in accessing and remaining in treatment, support previous anecdotal evidence and confirm the importance of developing sustainable services response to address both personal and structural barriers. While the Trial is one such initiative developed in response to these barriers, continued examination and the willingness to tackle these barriers needs to be an ongoing task of any service response committed to creating sustainable change and improving the outcomes for homeless drug users.

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# 13: APPENDICES