

## Part 2

# PROFILE OF HDDT PART B PARTICIPANTS

The following profile of Part B participants includes all those participants who entered the HDDT during its three-year Trial period, consented to be part of the evaluation and had completed an Initial Recording Form (IRF).

The dynamic nature of the Trial's evaluation meant that the IRF grew and changed in the Trial's early stages. Given this, and the limitations discussed previously, the data reported in this section is based only on the valid responses to each question.

This profile covers:

- Demographic characteristics
- Accommodation history
- Lifetime and current drug and alcohol use including history of overdose and risk-taking behaviours related to drug use
- Mental and physical health status
- Legal history
- Recent utilisation of support services (including drug treatment services)
- Meaningful connections in participants' lives

The analysis undertaken on the IRF data has been extended beyond that documented in the first and second-year reports.

Based on feedback from services about the significance of gender and participant mental health status, time has been spent exploring the impact of these on a participant's profile and progress in the Trial.

Given the differences between the number of women and men in the Trial and the high rate of diagnosed mental illness in the Trial population overall, differences noted throughout can only be considered exploratory.

## 2.1 INTRODUCTION

The following profile is based on the information gathered from Trial participants by PCMs using the Initial Recording Form (IRF). This profile focuses on the demographic characteristics of participants and their accommodation, drug and alcohol use, mental and physical health at the time of assessment. Profile data was also collected on recent utilisation of services, the level of meaningful connections in participants' lives, participants' legal history and history of overdose.

As already outlined, discussions with key stakeholders indicated that mental illness is a significant factor in participants' histories of homelessness and substance use and appears to greatly impact on the process of rebuilding their lives. Additionally, feedback from staff at Hanover Southbank, the only participating service to accommodate women, indicated that women's histories were different and required further exploration.

Given these observations, a more detailed level of analysis into these factors has occurred in this final report.

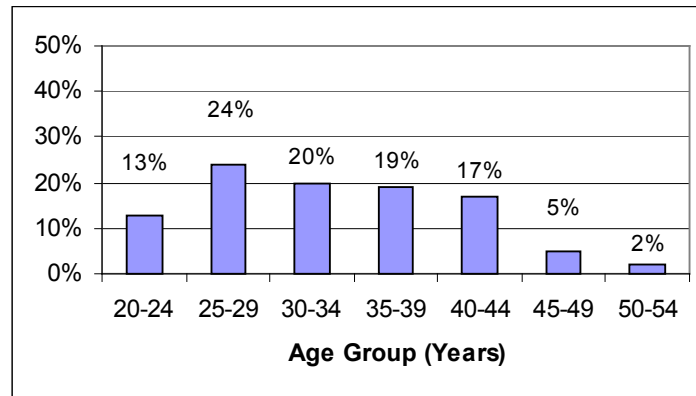
## 2.2 DEMOGRAPHIC CHARACTERISTICS

As of the 30 May 2004, a total of 161 participants had completed an IRF. Their demographics are summarised in Table 2.1. Of these 161 participants, 42% entered the Trial through Flagstaff, 29% entered the Trial through Hanover Southbank and 29% entered through Ozanam House (see Table 2.1).

Twenty-five participants (16%) were female and 136 participants (84%) were male. As explained in the previous Part B report, the proportion of males participating was a result of the process of entry to the Trial. While there were some provisions for women to access the Trial through Flagstaff and Ozanam House, Hanover Southbank was the only facility able to accommodate women and families. As a result of this entry process, 88% of females (n = 25) entered through Hanover Southbank, 4% through Flagstaff and 8% through Ozanam House. As detailed and explored in Section 2.6, 72% (n = 120) of participants presented with a diagnosed mental illness.

The average age of participants on entry into the Trial was 33 years (median 33 years, range 20–51 years, n = 161). The average age of males was 34 years (median 33, range from 20–51 years, n = 136). The average age of females was 32 (median 33, range 20 – 43 years, n = 25). While 72% (n=120) of participants had been diagnosed with a mental illness prior to entering the Trial, there were no differences in the age of participants based on whether or not they had a diagnosed mental illness. The greatest age bracket for those entering the Trial was between 25–29 years, as shown in Figure 2.1.

**Figure 2.1: Age distribution of participants on entry into the Trial (n = 161)**



Consistent with previous reports, a majority of participants (89%, n = 160) were Australian-born, including three male participants who were of Aboriginal/Torres Strait Islander descent. No differences in country of birth by gender or mental health status were evident.

As with other profiles of the homeless population, there is a significant level of early school-leaving and poor educational qualifications. The majority of participants had not furthered their education beyond secondary school. A clear majority of participants (70%, n = 147) completed Year 10/11 or below. A further 13% (n = 147) had completed Year 12. The remaining 17% (n = 147) had completed Trade or TAFE qualification at TAFE Level, a TAFE diploma or university degree. A higher proportion of men (73%, n = 130) completed Year 10/11 or below than women (52%, n = 17). Women were more likely to continue and complete Year 12, TAFE or a university degree (48%, n = 17) than men (27%, n = 130).

Participants with a previously diagnosed mental illness had more varied levels of educational attainment. All of those participants whose highest level of educational attainment was primary school or less were males with a diagnosed mental illness. However, all those who had completed a university degree had a previous diagnosis of mental illness.

An overwhelming majority of participants were unemployed (97%, n = 154), with no substantial difference between men and women or those with or without a diagnosed mental illness. Consistent with this, almost all participants were dependent on government benefits (97%, n = 154), with only 3% (n = 154 – five participants) having a waged income. The two main income supports accessed were Newstart (55%, n = 158) and the Disability Support Pension (DSP) (36%, n = 158). The proportion of females accessing either Newstart or DSP was relatively equal (46% and 42%, n = 24, respectively), whereas more men were accessing Newstart (57%, n = 134) more than DSP (37%, n = 134). This difference is most likely due to the higher incidence of diagnosed mental illness among women in the Trial (see Section 2.6). As is to be expected, a higher proportion of participants with a diagnosed mental illness accessed DSP (48%, n = 87) compared to those without a diagnosed mental illness (18%, n = 33). However, this is low given the prevalence of mental illness among Trial participants. In addition, this data highlights the impact poor mental health has on an individual's ability to participate in the paid workforce and their capacity to attain and then maintain housing.

**Table 2.1: Demographic characteristics of Trial participants at the time of assessment (n = 161)**

Variable	Male 84% (n = 136)		Female 16% (n = 25)		Total 100% (n = 161)	
	%	N	%	n	%	n
<b>CSAS</b>						
Flagstaff	49	67	4	1	42	68
Ozanam House	32	44	8	2	29	46
Hanover Southbank	18	25	88	22	29	47
<b>Age (Median)</b>	33 years (n = 136)		33 years (n = 25)		33 years (n = 161)	
<b>Country of Birth</b>	%	(n = 135)	%	(n = 25)	%	(n = 160)
Australia	87	118	92	23	89	141
New Zealand	3	4	-	-	2	4
European	3	4	-	-	2	4
British	3	4	-	-	2	4
SE Asian	2	3	4	1	2	4
Caribbean Islander	1	1	4	1	2	2
Southern and East African	1	1	-	-	1	1
Missing		1		-		1
<b>Education</b>	%	(n = 130)	%	(n = 17)	%	(n = 147)
Primary or less	5	6	-	-	4	6
Year 7	1	1	6	1	1	2
Year 8/9	18	24	11	2	18	26
Year 10/11	49	63	35	6	47	69
Year 12	12	16	18	3	13	19
Trade or TAFE qualification at Trade level	10	13	18	3	11	16
TAFE – Diploma	3	4	6	1	3	5
University Degree	2	3	6	1	3	4
Missing		6		8		12
<b>Employment</b>	%	(n = 130)	%	(n = 24)	%	(n = 154)
Unemployed	98	127	92	22	97	149
Employed	2	3	8	2	3	5
Missing		6		1		7
<b>Income Support</b>	%	(n = 134)	%	(n = 24)	%	(n = 158)
Newstart	57	76	46	11	55	87
Youth Allowance	1	2	4	1	2	3
Disability Support Pension	37	48	42	10	36	58
Sickness Allowance	2	3	-	-	2	3
Parenting Payment Single	-	-	4	1	1	1
Special Benefit	1	1	-	-	1	1
Pension	1	2	4	1	2	3
Wage/Salary/Own Business	1	2	-	-	1	2
Missing		2		1		3

This profile is representative of clients using ‘crisis’ homeless services in the inner city as documented by NDCA SAAP data. However, males and those with a diagnosed mental illness are over-represented compared to the broader population.

## 2.3 REASONS FOR ENTERING THE TRIAL

During assessment, participants were asked by their PCM to identify their main reasons for entering the Trial. Participants usually listed multiple responses. Sixteen themes were identified overall, however the most common responses remain the same as those reported in the second year (Rayner, Batterham & Wiltshire, December 2003) and first-year reports (Rayner, Batterham & Mugavin, May 2003). Ninety-two percent (n = 162) of participants reported that they entered the Trial for support around their alcohol and drug use, 40% stated they entered the Trial for support around housing issues, and 18% entered the Trial because of the links to other services the Trial provided or for access to Trial resources.

**Table 2.2: The eight most common reasons given by participants for entering the Trial**

<b>REASON FOR ENTERING THE TRIAL</b>	<b>Proportion of participants (n = 162)</b>
For support around alcohol and/or drug use	92%
To seek assistance around housing issues	40%
For support around access to services and access to Trial resources and funding	18%
For assistance with work, training or education	18%
For ongoing/support	15%
For support or to work on problematic emotional states or mental health	12%
For help establishing links in the community and non-drug using social networks	11%
For assistance in rebuilding family networks	6.3%
For help and support in stabilising their lives	6.3%

\* multiple responses included

## 2.4 ACCOMMODATION HISTORY

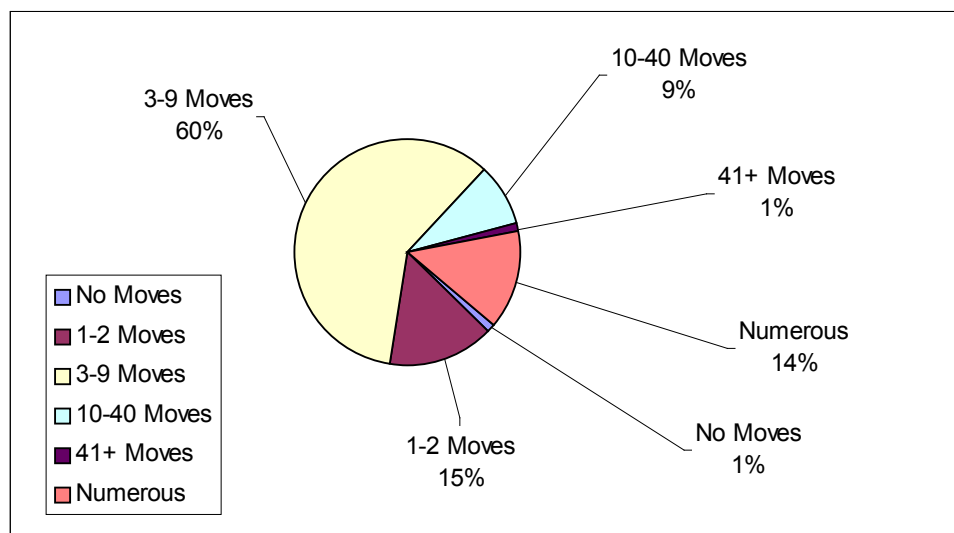
As stated in the first (Rayner, Batterham, & Mugavin, May 2003) and second-year reports (Rayner, Batterham & Wiltshire, 2003), a key focus of the Trial has been to establish housing stability among participants. The following section describes participants' levels of homelessness on entry to the Trial.

### 2.4.1 Accommodation History Twelve Months Prior to Entry

Participants typically moved five times in the twelve months prior to the Trial (median five moves, mean six moves, range no moves to fifty moves). A number of participants (20) were not able to recall exactly how many moves they had made. However, they reported having made 'numerous' moves. Feedback from PCMs suggests that those participants specifying 'numerous' had moved too often to recall the exact number of moves they had made. As such, the average number of moves reported can be considered an underestimate.

As can be seen in Figure 2.2 the majority of participants moved 3–9 times in the twelve months prior to assessment (60%,  $n = 144$ ) prior to assessment. A further 15% ( $n = 144$ ) of participants had moved 1–2 times in the past twelve months, 9% ( $n = 144$ ) had moved 10–40 times, 1% ( $n = 144$ ) had moved over 40 times, and 14% had moved 'numerous' times ( $n = 144$ ) This suggests a substantial level of transience and homelessness among Trial participants. Two participants had not moved at all (1%,  $n = 144$ ) as they had been in transitional supported accommodation/and crisis accommodation for at least 12 months.

**Figure 2.2: Number of moves in twelve months prior to assessment ( $n = 144$ )**



Both males and females moved a median of five times in the twelve months prior to completion of the IRF, however women experienced a higher mean number of moves (9.6,  $n = 18$ ) compared to men (mean: 5.6,  $n = 106$ ). Participants' mental health status had no impact on the number of moves made prior to assessment.

## 2.4.2 Duration of Homelessness

While participants were not asked to specify the total duration of their homelessness or total number of moves since they became homeless, later versions of the IRF included questions relating to the last time the participant felt they had a home. Of the 79 participants who responded to the question: ‘When was the last time you felt you had a home?’<sup>2</sup>

- Thirty-nine participants (49%) felt they had not had a home for longer than a year
- Four participants (5%) felt they had never had a home
- Fourteen participants (18%) were unsure/couldn’t remember the last time they felt they had a home
- Fourteen participants (18%) felt they had a home in the last year
- Eight participants (10%) felt they had a home in the last week

The 39 participants who felt they had ‘not had a home for longer than a year’ were asked to specify how long it had been since they felt they had had a home:

- Eleven participants (28%) stated 1–2 years
- Ten participants (26%) stated 3–6 years
- Six participants (15%) stated 10–40 years
- Two participants (5%) stated ‘numerous’, but gave no exact number
- Ten participants (26%) did not respond

These findings are similar to those reported by Rayner (2003), with over half of participants indicating it had been more than a year since they’d had a home, and only 28% felt that they had a home in the previous year.

## 2.4.3 Accommodation Type

### 2.4.3.1 Accommodation Types Accessed in the Two Years Prior to Assessment

The proportion of participants who had accessed each accommodation type at least once in the two years prior to completion of the IRF was calculated. As can be seen in Figure 2.3, almost all of the participants 94% (n = 161) had stayed in crisis accommodation at least once in the two years prior to assessment. Many had subsequently returned to a CSAS.

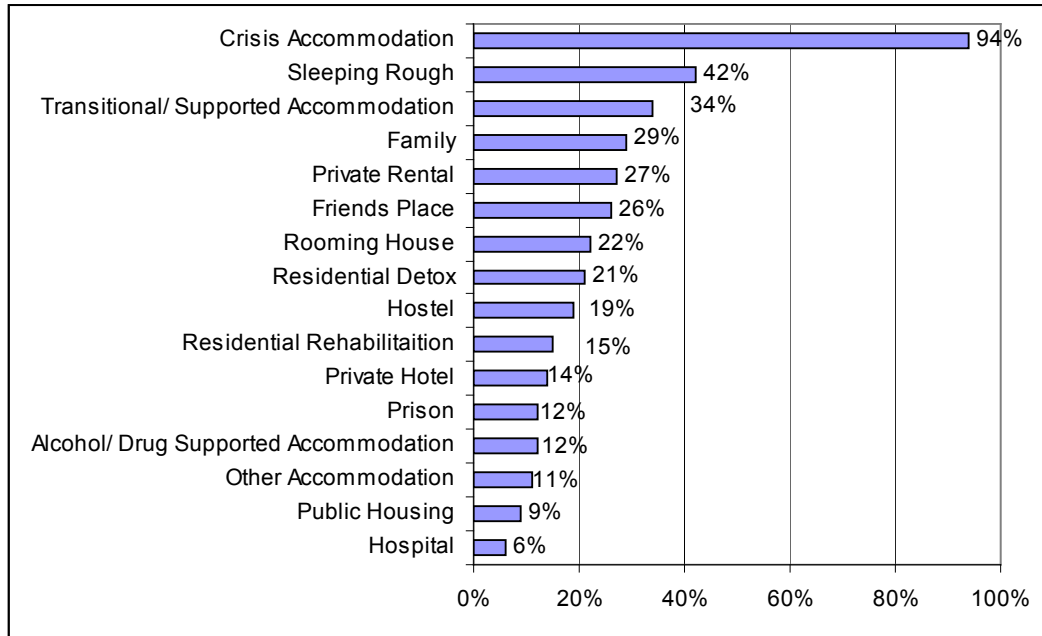
Significantly, nearly half of the participants had experienced sleeping rough (42%, n = 161) at some time in the two years prior to accessing the Trial. Sleeping rough was reported more often by male participants (45%, n = 136) than female participants (28%, n = 25), however this difference was not statistically significant. DACMCs and primary case managers suggested that women were less likely to sleep rough because they were more likely to be staying with

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<sup>2</sup> There were no ‘last month’ responses which were reported in second-year report due to two participants being excluded from the analysis.

friends or with men and were often concerned about the perceived threat of violence on the street.

**Figure 2.3: Proportion of participants who had accessed accommodation type at least once in the two years prior to completion of the IRF (n = 161)**



Many participants had also stayed in accommodation types such as transitional/supported accommodation (34%, n = 161), private rental (27%, n = 161), family (29%, n = 161), and public housing (9%, n = 161) during the two years prior to completion of the IRF. While these forms of accommodation may be viewed as more ‘stable’ it is unknown how stable these forms of accommodation had been for participants.

Another accommodation type accessed frequently was ‘friend’s place’ (26%, n = 161). Participants not previously diagnosed with a mental illness (51%, n = 33) were more likely to have stayed with a friend compared to 23% (n = 87) of those with a diagnosed mental illness. DACMCs and primary case managers suggested that this was because participants without a diagnosed mental illness had more social contacts and greater capacity to connect with people, giving them extra short-term accommodation options like friends. Further, the support offered by family and friends is often eroded over time, especially when an individual with a mental illness is unstable and their behaviour is erratic.

#### 2.4.4 Reasons For Leaving Accommodation by Type and Movement Through Accommodation Types.

The following subsection examines both participants’ reasons for leaving their accommodation and the places they moved to after leaving each accommodation type. These findings have been presented together to aid interpretation.

## Overall Reasons for Leaving Accommodation

Participants were asked about their reasons for leaving the places they had stayed in the 12 months prior to assessment. Overall, 581 reasons were given and these reasons were classified into 18 themes. The most common themes were:

- Moving into different accommodation or into D&A treatment (35%, n = 581)
- Eviction (8.6%, n = 581)
- Didn't like it/unsuitable environment but left of own accord (7.1%, n = 581)
- Released from/sent to prison or hospital (6%, n = 581)
- Asked to leave, kicked out or overstayed welcome (5.7%, n = 581)
- Drug use or behaviour related to drug use (5.2%, n = 581)

## Places Most Commonly Moved to

Using all of the recorded places stayed in the IRF, an analysis was undertaken showing the types of accommodation moved into from each type of accommodation. This showed where people were most likely to have moved to after having been in, for example, crisis accommodation or residential detoxification (Appendix 10). Participants' reasons for leaving each accommodation type are discussed below along with the places most commonly moved to.

### Crisis Accommodation

The most common reason reported for leaving crisis accommodation was in order to move into a different form of accommodation (51%, n = 135). The next most common reason for leaving crisis accommodation was eviction (10.4%), followed by 'miscellaneous' (8.1%). From crisis accommodation participants were most likely to have moved into transitional or supported accommodation (20%, n = 164) followed by residential detoxification (13%, n = 164), another crisis accommodation service (12%), a hostel (9%) or sleeping rough (9%).

### Family

The most common reason for leaving family was 'miscellaneous' (19%, n = 47) followed by moving to a different form of accommodation or treatment (17%, n = 47), asked to leave, kicked out or overstayed welcome (15%, n = 47) and drug use (13%, n = 47). Participants leaving their family most commonly moved to crisis accommodation (26%, n = 57), followed by sleeping rough (14%, n = 57) then private rental (11%, n = 57). Some participants also stayed with friends or in a rooming house (9% each, n = 57).

### Private Rental

The most common reasons for leaving private rental were for non-payment of rent (14%, n = 59) followed by asked to leave, kicked out or overstayed welcome (12%, n = 59), miscellaneous (12%, n = 59), eviction (10%, n = 59) and moved to a different type of accommodation (9%, n = 59). Participants were most likely to move from private rental to crisis accommodation (29%, n = 65) followed by different private rental (26%, n = 65) then

sleeping rough (12%, n = 65). Six percent of moves were to transitional/supported accommodation.

### Hospital

The most common reason for leaving hospital was to move to another form of accommodation or to go into treatment (42%, n = 12). Treatment having finished was the next most common reason (25%, n = 12) followed by drug use (17%, n = 12). After leaving hospital, most participants moved to crisis accommodation (38%, n = 13), into residential rehabilitation (15%) or into different hospital treatment (11%). Some participants were sleeping rough (8%) or moved to a private hotel (8%).

### Hostel

The most common reason for leaving hostels was to take up different accommodation or to go into treatment (38%, n = 32). The next most common reason was unsuitable environment, didn't like it there but left of own accord (22%, n = 32), followed by non-payment of rent (16%, n = 32). After leaving a hostel, 34% (n = 38) of participants moved to crisis accommodation, 18% (n = 38) moved to a different hostel, and 11% (n = 38) left hostels to sleep rough.

### Private Hotel

The most common reason for leaving private hotels was to take up another form of accommodation or to go into treatment (44%, n = 23). The next most common reason given was financial (17%, n = 23), followed by drug use (8.7%, n = 23) and non-payment of rent (8.7%, n = 23). Nearly half of all participants leaving a private hotel moved to crisis accommodation (48%, n = 29). A further 10% (n = 29) moved to hospital or to another private hotel, while 7% left private hotels to sleep rough.

### Public Housing

Only six responses were given for leaving public housing. The most common reason was relationship breakdown (33.3%, n = 6), followed equally by moving into different accommodation or treatment (16.7%, n = 6), safety concerns (16.7%, n = 6), non-payment of rent (16.7%, n = 6) and miscellaneous (16.7%, n = 6). Of the eight stays in public housing, 25% of moves were to residential detox, and 25% were moves to a friend's place. One person slept rough after leaving, one person moved into different public housing, one person moved in with family and one person went to crisis accommodation.

### Prison

Ninety-five percent (n = 21) of people leaving prison gave 'released' as a reason for leaving. The remaining 5% (n = 21) indicated they were moving to a different form of accommodation. After leaving prison, a high proportion (41%, n = 22) moved to crisis accommodation, 23% (n = 22) slept rough, and 23% (n = 22) were staying with friends.

### Rooming House

The most common reason for people leaving rooming houses was eviction (26%, n = 39)

followed by moving to a different form of accommodation or into treatment (18%, n = 39), miscellaneous (15%, n = 39) and financial reasons (13%, n = 39). After leaving rooming houses, 34% (n = 53) moved to crisis accommodation, 19% (n = 53) were sleeping rough, and 17% (n = 53) moved to another rooming house.

### Sleeping Rough

Sixty percent (n = 62) of people who ceased sleeping rough indicated that they were moving into accommodation or into treatment. Eighteen percent (n = 62) reported miscellaneous reasons for ceasing to sleep rough, and 6.5% (n = 62) reported safety issues. Most participants moved to crisis accommodation after having slept rough (44%, n = 102). A further 9% (n = 102) moved to residential detox while 11% (n = 102) moved, but remained sleeping rough.

### Transitional/Supported Accommodation

The most common reason for leaving transitional/supported accommodation was to move to a different form of accommodation or to go into treatment (32%, n = 31). The next most common reason for leaving was eviction (26%, n = 31), followed by drug use (13%, n = 31) and conflict (13%, n = 31). After leaving transitional/supported accommodation included, participants most commonly moved to crisis accommodation (29%, n = 34), 12% (n = 34) moved to different transitional supported accommodation, 9% (n = 34) were sleeping rough, 9% (n = 34) went to public housing and 9% (n = 34) went into private rental.

### Residential Rehabilitation

The most common reason for leaving residential rehabilitation was to move to a different form of accommodation or into treatment (33%, n = 15). The next most common reasons were being discharged before completing the program (20%, n = 15), drug use (13%, n = 15) and eviction (13%, n = 15). Participants were most likely to move to crisis accommodation 37% (n = 19) after leaving residential rehabilitation, followed by 11% moving to private rental, 11% moving to a rooming house and 11% who slept rough. Feedback from DACMCs suggests that most exits from residential rehabilitation before entry to the Trial were due to non-completion of treatment. In many of these cases moving into another form of accommodation was often a step taken by services because treatment was not completed.

### Residential Detoxification

The majority of participants leaving residential detox left to go to other types of accommodation or into further treatment (83%, n = 36). Forty-three percent (n = 44) of participants leaving detox moved to crisis accommodation, 11% moved into private hotels, 11% moved to A&D supported accommodation, 7% were sleeping rough and 7% moved to public housing.

### A&D Supported Accommodation

Only five responses were given for leaving A&D supported accommodation. The two most common were moving to a different type of accommodation or into other treatment (40%, n = 5) and eviction (40%, n = 5). One participant listed drug use as a reason for leaving (20%, n = 5). Fifty-seven percent (n = 7) of those leaving A&D supported accommodation moved to crisis accommodation.

## Summary

Together, the data on reasons for leaving types of accommodation and the places participants commonly moved to highlight the complexity of participants' housing history. Few participants were able to obtain more stable types of accommodation such as private rental or public housing, and those who did were unable to maintain it. Once homeless, these participants commonly cycled through short term accommodation such as crisis accommodation, occasionally securing transitional housing, only to have it breakdown and move back into crisis accommodation, sleep rough or to be placed in private hotels, rooming houses, or hostels with HEF funds. Occasionally participants have entered some form of drug treatment, but most exit back into Crisis Accommodation. Further, the data shows that there is frequent movement of individuals to the CSAS from institutional settings such as prisons and hospitals, representing poor release/discharge planning, not conducive to positive outcomes.

DACMCs suggested that participants' chronic transience was the result of a number of factors. Initially, there is a shortage of short-term accommodation options and lack of low-cost housing. However, housing stability is not as simple as putting a roof over someone's head. Trial participants struggled with social isolation, mental and physical health issues, problematic substance use, financial difficulty, and a general lack of support and advocacy. As such, participants were unable to sustain longer-term and even shorter-term accommodation, continuing to cycle through the service system without having their needs adequately addressed.

### 2.4.5 Participation in Public Housing

Public housing is considered to be stable accommodation because of the security of tenure provided by a lease and the affordability of this option. At the time of assessment 38% (n = 156) of participants had submitted an application for public housing.

On the most recent versions of the IRF participants were asked a number of questions concerning their participation in public housing. Of the 74 participants who completed these questions, a significant proportion (34%, n = 25) had accessed public housing at some time in their lives. A higher proportion of females had accessed public housing in the past (53%, n = 15) than males (29%, n = 9).

- Of the 25 participants who had accessed public housing at some time in their lives, nine were currently in public housing. These participants accessed this accommodation prior to completing the IRF or were in this accommodation prior to entering the Trial but had been referred by a participating service for support by the Trial. Of the remaining fourteen participants, three participants had stayed in public housing for less than six months, one participant had stayed in public housing for less than 12 months, five participants had stayed in public housing for less than 24 months, three participants had stayed in public housing for more than 24 months and four participants were missing information.
- Most of those currently in public housing were male (eight male participants, one female participant), with a previously diagnosed mental illness (six previous diagnosis, two no previous diagnosis, one missing information), and a legal history (five had a legal history, three no legal history and one missing information).

## Bond Assistance

Of the participants who answered this question (n = 147), 73% had not received bond assistance in the past. Of the participants who had received bond assistance in the past, 54% (n = 39) had a repayment of bond outstanding, and a further 8% (n = 39) were unsure if they had a repayment of bond outstanding. The remaining 39% (n = 39) did not have a repayment of bond outstanding.

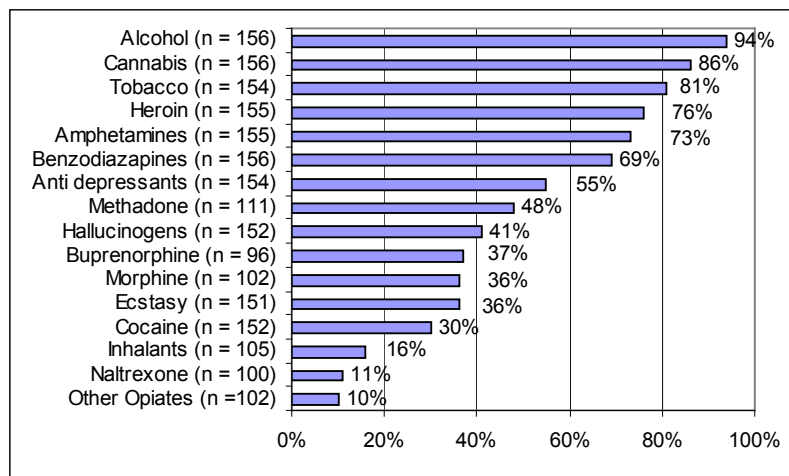
The low proportion of participants accessing bond assistance is indicative of the difficulty faced by this client group in accessing or being supported to access the private rental market. Further DACMCs believed that bond assistance is only of real assistance in many cases if it is attached to support around maintaining housing. Otherwise it risks becoming yet another avenue of debt for this group.

## 2.5 DRUG AND ALCOHOL USE

Participants reported high lifetime use of both licit and illicit substances with the proportion of participants who had used the substances varying with drug class (see Figure 2.4).

Consistent with previous reports, the most commonly used drug was alcohol with 94% of participants having used at some point in their lifetime (n = 156). This was followed by cannabis (86%, n = 156) then tobacco (81%, n = 154), heroin (76%, n = 155), amphetamines (73%, n = 155) and benzodiazepines (69%, n = 156). These substances were also the most commonly used substances in the 28 days and the seven-day period prior to IRF assessment (see Table 2.3 on page 72). These most commonly used substances are hereon referred to as the ‘top five’ substances.

**Figure 2.4: Lifetime use of drugs reported at assessment (IRF) (n = 161)**



The median age participants had first used any substance was thirteen years old, (mean 12 years, range 2–21 years, n = 145). The median age of first use of an illicit substance was fifteen years old (mean 15 years, range from 9–27 years, n = 133). Cannabis was the illicit drug used at the youngest age (average 15 years, median 15 years, range 9–51 years), followed by inhalants (average 16 years, median 15 years, range 12–27 years).

All females had previously used an illicit drug, whereas eleven male participants did not report previous use of any illicit drugs (their drug of choice being alcohol).

Though not always statistically significant, some gender differences emerged in the participants’ lifetime use of a number of drugs. Women were more likely to have used heroin (91%, n = 21 compared to 74%, n = 134) and consistent with this were more likely to have used buprenorphine (50%, n = 16, compared to 34%, n = 82). Women were also more likely to have used morphine (47%, n = 15, compared to 35%, n = 87), ecstasy (50%, n = 22, compared to 33%, n = 129), benzodiazepines (83%, n = 23, compared to 66%, n = 133) antidepressants (71%, n = 17 compared to 52%, n = 87) and cannabis (96%, n = 23 compared to 84%, n = 133).

Those with a diagnosed mental illness were more likely to have used heroin (78%, n = 82 compared to 64%, n = 33), benzodiazepines (82%, n = 83 compared to 46%, n = 33)

antidepressants (69%, n = 68 compared to 22%, n = 32) and cannabis (89%, n = 83 compared to 79%, n = 33) compared to those without a diagnosed mental illness.

These findings suggest that gender and in particular mental health status are influencing factors in people's drug-use histories, with women (many of whom have a diagnosed mental illness) and those with a diagnosed mental illness being more likely to have used a wide range of substances. While there are many reasons why people use drugs, feedback from DACMCs and primary case managers suggests that Trial participants with a diagnosed mental illness are more likely to use substances situationally, that is subject to availability, finances (i.e. pay day) and environment. These participants are also less likely to prioritise their drug use with a drug of choice and actively seek it out, largely due to the psychological instability they are experiencing and their need to seek a 'quick fix'. This is reflected in the use of a wider range of substances with no other consistent pattern.

## 2.5.1 Participants' Reasons for Current and First Use of Substances

### Current Use

Participants were asked about their reason/s for their current use of each drug. Responses were analysed for the five most-commonly used drugs ('top five') together and then separately. Use of substitute pharmacotherapies was also analysed. Further analyses were conducted on gender and mental health. Please note that the participants' reasons were given for each substance the participant had used. As such, the proportion reported is based on the number of responses, not the number of participants.

Of the 94 participants giving reasons for their current use of drugs, 266 reasons were given (participants could list a reason for each substance). The top-five reasons for use of the five most-commonly used substances (heroin, alcohol, benzodiazepines, amphetamines and cannabis) were: to calm/relax/reduce stress/help sleep 19% (n = 242), followed by addiction/habit/dependence (17%, n = 242), infrequent/social/recreational use (12%, n = 242), enjoyment/party/good feeling (11%, n = 242), mental health/self-medication/anxiety/depression (9%, n = 242) and help manage/abstain from another drug (3%, n = 242).

Women were more likely to be currently using one of the top-five substances for enjoyment (20%, n = 40) compared to 9% of men (n = 202), whereas males were more likely to be currently using for relax/calm/help sleep (21%, n = 202) than females (10%, n = 40) though this last difference was not statistically significant.

The most common reason for the current use of the top-five drugs by those with a diagnosed mental illness was to relax/stay calm and help sleep 18% (n = 137) followed by addiction 13% (n = 137) and then by enjoyment 12%, (n = 137) and infrequent/recreational use 12% (n = 137). Conversely, those without a diagnosed mental illness were much more likely to have addiction as a reason for current use 31% (n = 35), followed by social/infrequent use (17%, n = 35) and then to relax/stay calm (11%, n = 35). Both groups equally reported depression/anxiety/mental health/self-medication as a reason for current use.

## First Use

The 139 participants responding to questions about first use of the top-five substances gave 617 reasons. They were: peer pressure (21%, n = 617), experimentation/to try it/curiosity (17%, n = 617), social/recreational use (12%, n = 617), enjoyment/party/good feeling (9%, n = 617), family problems/breakdown (5%, n = 617) and to help manage/abstain from another drug (2%, n = 617).

Women were more likely to have first used one of the top-five substances due to family of origin difficulties/breakdown (10%, n = 92 compared to 4%, n = 525) or violence/conflict/abuse (6%, n = 92 compared to 1%, n = 525). Women also seemed to be more likely to have a partner or family member introduce a substance to them than men (9%, n = 92 compared to 3%, n = 525). This is consistent with the data presented on what was happening in participants' lives when they first started using drugs.

Those without a mental health diagnosis were more likely to have first used because of peer influence/pressure (33%, n = 129) than those with a previous diagnosis (18%, n = 345). Family breakdown/problems was slightly higher for those with previous diagnosis (6%, n = 345) than those without (1%, n = 129), though this last difference could not be tested for statistical significance.

## 2.5.2 Alcohol Use

Ninety-four percent of participants (n = 156) had used alcohol at some time in their lives. Sixty percent (n = 137) of participants had used alcohol in the last 28 days, for an average of 11 days (n = 79) and 51% (n = 142) had used in the last seven days for an average of four days (n = 71). The average age of first use was 14 years (median 14 years, range 3–39 years, n = 133).

Though not statistically significant, women were more likely than men to have used alcohol in the 28 days prior to IRF assessment (87%, n = 15 compared to 57%, n = 122). However, men were more likely to have used alcohol in the seven days prior to assessment (54%, n = 127) than women (20%, n = 15). DACMCs suggested that this was indicative of higher situational or opportunistic substance use among women.

Further, those diagnosed with a mental illness were more likely to have used alcohol in the 28 days prior to assessment (72%, n = 68) compared to those without a diagnosis (41%, n = 32). However both groups were equally likely to have used alcohol in the seven days prior to assessment. As with the gender differences just reported, DACMCs suggested that this was indicative of situational or opportunistic substance use.

The major reason for current use was infrequent/recreational/payday use 23% (n = 73), followed by addiction/dependence/habit 19% (n = 73), relax/calm/reduce stress/help sleep 12%, (n = 73), enjoyment/party/good feelings/like it 10% (n = 73) and 8% (n = 73) for each of boredom and escape/block thoughts and repress.

Reasons for first use of alcohol included: social/recreational 24% (n = 154), peer group/pressure/influence (21%, n = 154), experimentation/to try it/curiosity (11%, n = 154), enjoyment/party/good feelings (10%, n = 154) and family/partner introduced (8%, n = 154).

**Table 2.3: Drug-use history of participants based on IRF (n = 161)**

Drug Class	Ever Used		Age First Used		Used in Last 28 Days*		Used in Last Seven Days*					
	% Yes	(n)	Mean Years	(n)	% Yes	Mean Days	% Yes	Mean Days				
Alcohol	94	(n = 156)	14	(n = 133)	60	(n = 137)	11	(n = 79)	51	(n = 142)	4	(n = 71)
Cannabis	86	(n = 156)	15	(n = 120)	61	(n = 136)	16	(n = 78)	56	(n = 137)	4	(n = 72)
Heroin	76	(n = 155)	20	(n = 107)	35	(n = 140)	9	(n = 47)	20	(n = 139)	3	(n = 28)
Benzodiazepines	69	(n = 156)	20	(n = 105)	29	(n = 135)	15	(n = 38)	21	(n = 136)	5	(n = 27)
Amphetamines	73	(n = 155)	18	(n = 85)	24	(n = 144)	5	(n = 34)	16	(n = 146)	2	(n = 24)
Buprenorphine	37	(n = 96)	29	(n = 28)	20	(n = 86)	24	(n = 17)	21	(n = 86)	6	(n = 18)
Naltrexone	11	(n = 100)	34	(n = 9)	3	(n = 95)	23	(n = 2)	4	(n = 96)	4	(n = 2)
Methadone	48	(n = 111)	27	(n = 40)	9	(n = 98)	23	(n = 9)	8	(n = 98)	6	(n = 8)
Morphine	36	(n = 102)	25	(n = 31)	3	(n = 99)	19	(n = 3)	2	(n = 101)	6	(n = 2)
Other Opiates	10	(n = 102)	23	(n = 9)	3	(n = 101)	12	(n = 3)	2	(n = 101)	7	(n = 2)
Cocaine	30	(n = 152)	21	(n = 43)	1	(n = 148)	4	(n = 1)	1	(n = 148)	1	(n = 1)
Ecstasy	36	(n = 151)	25	(n = 47)	6	(n = 144)	2	(n = 8)	2	(n = 144)	1	(n = 3)
Hallucinogens	41	(n = 152)	18	(n = 54)	2	(n = 143)	3	(n = 3)	1	(n = 143)	4	(n = 2)
Inhalants	16	(n = 105)	16	(n = 15)	2	(n = 103)	19	(n = 2)	2	(n = 103)	7	(n = 2)
Antidepressants	55	(n = 154)	28	(n = 121)	26	(n = 87)	22	(n = 23)	26	(n = 88)	7	(n = 23)
Tobacco	81	(n = 154)	12	(n = 108)	76	(n = 135)	27	(n = 100)	76	(n = 135)	7	(n = 100)

\* based on the time of initial assessment  
 Number in brackets represents valid number of participants for each category.

### 2.5.3 Cannabis Use

Eighty-six percent of participants (n = 156) had used cannabis at some time in their lives. Sixty-one percent of the participants (n = 136) had used in the last 28 days, for an average of 16 days (n = 78) and 56% (n = 137) had used in the last seven days, for an average of four days (n = 72). The average age of first use was 15 years (median 15 years, range 9–25, n = 120).

Similarly, those with a diagnosed mental illness were more likely to have used cannabis in the 28 days prior to assessment (68%, n = 68) compared to those without a diagnosed mental illness (47%, n = 32). This difference diminished in the seven days prior to assessment (57% of those diagnosed using, n = 68, compared to 47% of those not diagnosed, n = 32).

Further, feedback from services suggests that cannabis use reported may be an actual under-representation of use, as this drug is often considered by participants to be a ‘soft’ drug. That is, participants don’t consider themselves to be using when they’re using cannabis. For this reason, and partly due to ease of availability, participants tend to use this substance fairly regularly, and yet not report their use as use.

The most common reason given for current use of cannabis was to relax/calm/reduce stress/help sleep (37%, n = 57), addiction/dependence/habit (16%, n = 57), enjoyment/party/good feelings/like it (12%, n = 57), and 9% for both infrequent/recreational/payday use, and boredom.

Reasons for first use of cannabis included, peer group/pressure/influence (28%, n = 128), experimentation/to try it/curiosity (20%, n = 128), social/recreational use (13%, n = 128), enjoyment/like it (10% n = 128) and, relax/calm/reduce stress/help sleep (6%, n = 128).

### 2.5.4 Heroin Use

A significant proportion (76%, n = 155) of participants had used heroin at some time in their lives. Thirty-five percent of the participants (n = 140) had used in the last 28 days for an average of nine days (n = 47) and 20% (n = 139) had used in the last seven days for an average of three days (n = 28). The average age of first use was 20 years (median 18 years, range 12–39, n = 107).

The major reason for current use of heroin was addiction/dependence/habit (28%, n = 40), followed by availability/preference/drug of choice 13% (n = 40), mental health/depression/anxiety 15% (n = 40), enjoyment/party/good feelings/like it 10% (n = 40) and infrequent/recreational/payday use 8% (n = 40).

The main reason for first use of heroin was peer group/pressure/influence (22%, n = 121), followed by experimentation/to try it/curiosity (22%, n = 121), family of origin problems/breakdown (7%, n = 121) and 6% for each of enjoyment, availability and homelessness.

### 2.5.5 Amphetamine Use

Seventy-three percent of participants (n = 155) had used amphetamines at some time in their lives. Twenty-four percent of participants (n = 144) had used in the last 28 days for an average

of five days (n = 34) and 16% (n = 146) had used in the last seven days for an average of two days (n = 24). The average age of first use was 18 years (median 17 years, range 11–40, n = 105).

No differences between men and women, or those with or without a diagnosed mental illness were detected. DACMCs commented that amphetamines are not a substance usually used for depressing and blocking out feelings and thoughts when participants self-medicate. Rather, amphetamines are more typically involved in ‘trying to get everything done’ and/or for confidence. As such, it would appear that situational use among those with a diagnosed mental illness is lower.

The most reported reason for current use of amphetamines was enjoyment/party/good feelings/like it (24%, n = 34), followed by 12% (n = 24) for each of addiction/dependence/habit, relax/calm/help sleep/stress, and to manage/cope function/use at work. The fifth most common reason for current use of amphetamines was infrequent/social/payday use.

The most reported reason for first use of amphetamines was peer group/pressure/influence (23%, n = 116), experimentation/to try it/curiosity (21%, n = 116), enjoyment/like it (12%, n = 116), social/recreational use (10%, n = 116).

## 2.5.6 Benzodiazepine Use

Sixty-nine percent of participants (n = 156) had used benzodiazepines at some time in their lives. Twenty percent of participants (n = 105) had used in the last 28 days for an average of 15 days (n = 38) and 21% (n = 136) had used in the last seven days for an average of five days (n = 27). The average age of first use was 20 years (median 18 years, range 4–39 years, n = 85).

Not surprisingly, those diagnosed with a mental illness were more likely to have used benzodiazepines in the 28 days prior to assessment (43%, n = 67 compared to 19%, n = 32) and also in the seven days prior to assessment (27%, n = 67 compared to 13%, n = 32).

As can be seen from the reasons for current use, benzodiazepines are used by participants to help them cope with their daily lives.

The most common reason given for current use of benzodiazepines was relax/calm/help sleep/cope with stress (26%, n = 38), followed by mental health/depression/anxiety/self medication (24%, n = 38), assist manage/abstain from another drug (18%, n = 38), prescribed (11%, n = 38) and 8% for each of addiction/dependence/habit, and in order to enhance other drug use.

The reasons for first use of the drug were as follows: experimentation/to try it/curiosity (13%, n = 98), 12% (n = 98) for both relax/calm/help sleep/cope with stress and prescribed, followed by assist manage/abstain from another drug (11%, n = 98).

## 2.5.7 Substitute Pharmacotherapies – Methadone, Naltrexone and Buprenorphine

### 2.5.7.1 Methadone

Close to half of Trial participants (48%, n = 111) had previously used methadone, with the average age of first use being 27 years. Nine percent (n = 98) had used in the past 28 days, for

an average of 23 days, while 8% (n = 98) had used in the past seven days for an average of six days.

### 2.5.7.2 Naltrexone

Eleven percent of participants (n = 100) had previously used naltrexone, with an average age of first use of 34 years (n = 9). Three percent of participants (n = 95) had used in the 28 days prior to assessment on an average of 23 out of 28 days (n = 2) and 4% had used (n = 96) in the seven days prior to assessment for an average of four out of seven days (n = 2).

### 2.5.7.3 Buprenorphine

Thirty-seven percent of participants (n = 96) had used buprenorphine at some point in their lives. The average age of first use was 29 years. Twenty percent of participants (n = 86) had used in the past 28 days for an average of 24 out of 28 days (n = 17), and 21% (n = 86) had used in the past seven days for an average of six days (n = 18).

As stated previously women had a higher lifetime use of buprenorphine than males. This is consistent with a higher lifetime use of heroin.

### 2.5.7.4 Reasons for Current and First Use of Pharmacotherapies

Reasons for current use of the pharmacotherapies (including buprenorphine, naltrexone and methadone) included to manage/abstain from another drug (75%, n = 24). Other reason given were prescription (8%, n = 24) then 4% (n = 24) for mental health/anxiety/depression, to manage/cope function, and 4% (n = 24) escape/block thoughts. The major reason for first use of pharmacotherapies was to manage/abstain from another drug (78%, n = 74), followed by peer group/pressure/influence (4%, n = 74). Prescribed, enjoyment, and availability were each 3% (n = 74).

## 2.5.8 Current and Previous Most Used Drug

Participants were asked about their current most used drug at the time of assessment. Results indicate that the most common primary drug of choice was alcohol 29% (n = 106), then cannabis 19% (n = 106) and heroin 14% (n = 106). However, while participants were required to list only one drug (the most used), 19% (n = 106) of participants listed numerous drugs indicating equal use of a number of drugs in a given time frame (poly-drug use).

Multiple drug combinations reported included:

- Alcohol and either cannabis, buprenorphine or benzodiazepines
- Amphetamines and cannabis
- Heroin and benzodiazepines
- Heroin and buprenorphine
- Alcohol, cannabis and amphetamines
- Heroin, cannabis and amphetamines
- Methadone, benzodiazepines and cannabis
- Alcohol, heroin, cannabis, and amphetamines
- Heroin, methadone, naltrexone, alcohol and cannabis.

### 2.5.8.1 Changes from Previous Drug of Choice

Forty-three percent (n = 105) of participants stated that they had changed their drug of choice. A high proportion of those who had changed drugs had changed from heroin 47% (n = 45) to another substance. Most had changed to cannabis (33%, n = 21), methadone or buprenorphine (19%, n = 21) or a combination of many substances including cannabis, methadone, buprenorphine, benzodiazepines, amphetamines and heroin. Of the seven females who had changed to another substance all had changed to either methadone or buprenorphine with one changing to a combination of methadone, benzodiazepines and cannabis.

These findings are consistent with Rayner's (2003) and Horn's (1996, 1999) findings on heroin use in CSAS and related services. In her study Rayner used the same questions finding that while only 25% of participants reported using heroin at the time of interview, 55% of participants had changed their drug of choice, with 51% of these participants having previously used heroin. Similarly, Horn reported that in 1996, 49% (n = 92) of clients accessing Hanover crisis or support services were using heroin, with an increase to 69% (n = 109) in 1999. Given the often referred to 'heroin drought' which began in November 2000 (Rayner, 2003; Fry and Miller, 2002) the observed decrease in heroin use by CSAS and related service users is likely to be due to a slump in availability and affordability of heroin. Our findings indicate that homeless drug users have shifted to using different substances or a combination of different substances often in relation to access, affordability and availability within the illicit drug market as well as their immediate environment (i.e. CSAS/Street).

### 2.5.9 Poly-drug Use

The level of poly-drug use among people who came in contact with CSAS was raised as a particular concern during joint and individual project management meetings with Drug and Alcohol Case Manager Coordinators. The Victorian Department of Human Services (2002) defines poly-drug use as the use of more than two drugs (excluding tobacco) over a given period of time or on a single occasion. Using this definition, we investigated rates of poly-drug use among Trial participants over a seven-day and a 28-day period during the assessment period.

The majority (67%, n = 152) of Trial participants met the criteria for poly-drug use in the 28 days prior to assessment. No statistically significant differences emerged according to participants' gender or mental health status.

Men (n = 111), and those without a diagnosed mental illness (n = 23) were likely to have used more substances (median of three substances range 2–9) when engaging in poly-drug use in the 28 days prior to assessment. While women (n = 20) and those with a diagnosed mental illness (n = 74) had a median use of two drugs for the same 28 day period (range 2-9).

Just over half (58%, n = 152) of participants met the criteria for poly-drug use in the seven days prior to IRF assessment. There were no differences in proportion of participants using or the number of substances used by those engaging in poly-drug use by gender or mental health status in the seven days prior to assessment. Overall, participants used a median of two drugs with the number of drugs used ranging from two to seven.

Participants were also asked a direct question in relation to poly-drug use as part of a drug-use risk-taking assessment. Responses to this question indicate that 83% (n= 124) of participants

usually used more than one substance when they are using drugs, with 100% of females (n = 21) indicating they usually used more than one drug, compared to 80% (n = 129) of males (see table 2.4). While the calculated rates of poly-drug use previously discussed are lower than those reported directly above, differences appear to be attributable to a number of factors. These consist of differences in question design and participants abstaining from drug use or only using one drug regularly at the time of assessment. While difficult to substantiate, the under-reporting of drug use by some participants at the time of assessment as reported by DACMCs and primary case managers may have also impacted on the rates of poly-drug use. What is evident however is that when Trial participants use substances, a large proportion will use two or more drugs at the time and that the majority of participants were poly-drug using seven and 28 days prior to assessment.

### 2.5.10 Risk-taking/Harms Related to Substance Use

As documented in table 2.4, the majority of participants engaged in high risk-taking behaviours or experienced harms when they were using drugs. The levels of injecting (85%, n=26) and sharing of injecting equipment (54%, n= 149) among Trial participants put many as well as others who shared with them at risk of a blood-borne virus.

The proportion of people who usually used alone (83%,n=150) or used more than one drug when they used (83%, n=150) were at greater risk of overdosing. Further, many participants felt suicidal or self-harmed (65%, n=153) when they usually used drugs, highlighting the high level of emotional and psychological instability resulting from or connected to the participants' drug use. Finally, the majority (60%, n=149) of participants reported that they drive while intoxicated, potentially putting themselves as well as others at risk of serious physical harm.

**Table 2.4: Proportion of participants that had engaged in risk-taking and experienced serious psychological and physical outcomes as a result of drug use**

<b>Question: When you are using drugs.....</b>	<b>%</b>
Have you ever shared injecting equipment? (n = 149)	54
Have you ever experienced blackouts? (n = 147)	65
Have you ever used alone? (n = 150)	83
Do you usually use more than one drug (poly-drug use)? (n = 150)	83
Do you drive while intoxicated? (n =149)	60
Do you feel suicidal/self-harm? (n = 153)	65
Have you ever experienced difficulty injecting into your veins? (n = 150)	36
* Has your client ever injected?(n = 26)	85
* Have you ever used a needle after someone else? (n = 33)	55
* Has anyone ever used a needle after you had already used it? (n = 32)	53

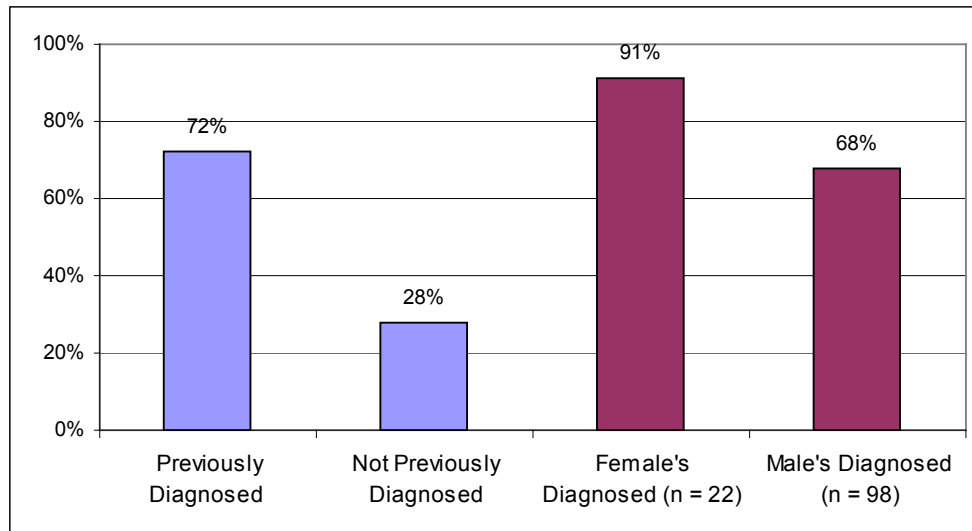
\* These questions only appeared on later versions of the IRF

## 2.6 MENTAL HEALTH

### 2.6.1 Previous Diagnosis of Mental Illness

Consistent with previous Trial reports, the majority of participants had been diagnosed with a mental illness prior to assessment (72%, n = 120), as shown in Figure 2.5.

**Figure 2.5: The proportion of participants entering the Trial with a diagnosed mental illness**



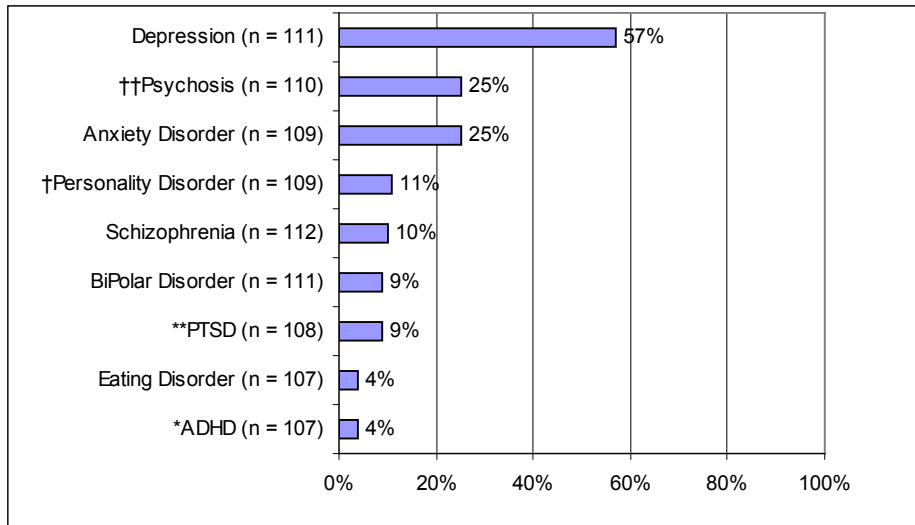
Further, female participants were far more likely than males to be diagnosed with a mental illness, with 91% (n = 22) having a previous diagnosis compared to 68% (n = 98) of male participants.

Statistics compiled by the Australian Institute of Health and Welfare (AIHW, 1999) suggested that close to 20% of all Australians would have some kind of mental health problem throughout their lifetime, with depression being the most common disorder. The prevalence of mental illness among Trial participants in comparison to these figures is alarming.

Of those participants who had been previously diagnosed (n = 87), the median number of diagnoses per participant was one. However, a breakdown by gender reveals that female participants had a median of two diagnoses (with a range of one to six diagnoses) per person (n = 20), while male participants had a median of one diagnosis (also with a range of 1–6 diagnoses) per person (n = 67).

The proportion of participants diagnosed with each mental illness was also calculated. Consistent with the second-year report, the most common diagnoses were depression, anxiety disorder and psychosis. The proportion of participants with each diagnosis remained stable from the last report, with only minor fluctuations attributable to random variance

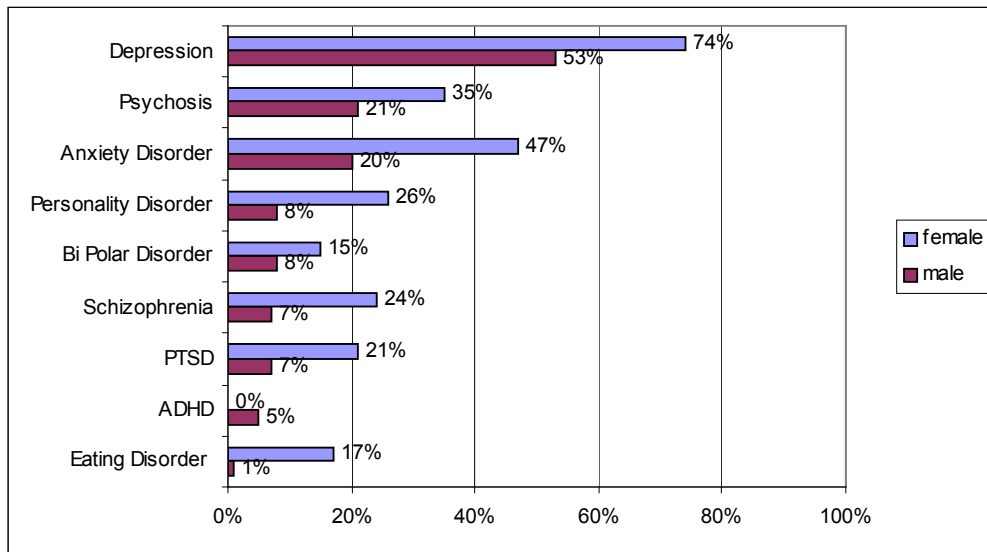
**Figure 2.6: Proportion of participants previously diagnosed by type of diagnosis**



\*ADHD denotes Attention Deficit Hyperactivity Disorder  
 †PTSD denotes Post Traumatic Stress Disorder  
 \*\*Personality Disorder includes both Borderline Personality Disorder and Anti-social Personality Disorder  
 ††Psychosis includes Drug-induced Psychosis.

As can be seen in Figure 2.7, women showed higher prevalence of all types of diagnosis apart from ADHD.

**Figure 2.7: Type of diagnosis by gender \***



## 2.6.2 Prevalence of Attempted Suicide and Suicidal Ideation

Forty-percent of participants (n = 144) had previously attempted suicide, while 20% (n = 157) were experiencing suicidal ideation at the time of assessment. These figures have remained stable from the last reporting period. In addition to these questions, the most recent version of the IRF asked about self-harm. Sixty-two percent of respondents (n = 47) reported self-harming in the past, while 6% (n = 36) were currently self-harming.

Analysis of this information by gender revealed interesting and alarming results. Consistent with the higher incidence of mental illness among female participants, females were nearly twice as likely to have had a previous suicide attempt (65%, n = 23, compared to 35% of males, n = 121), but were less likely to be currently experiencing suicidal ideation at the time of assessment (13%, n = 24) compared to their male counterparts (22%, n = 133). Women were also more likely to have self-harmed in the past (82%, n = 11, compared to 56%, n = 36) and more likely to be currently self-harming (11%, n = 9 compared to 4%, n = 27) compared to men though these last differences could not be tested for statistical significance.

As expected, those participants with a diagnosed mental illness had much higher incidences of suicidal ideation at assessment (28%, n = 86 compared to 9%, n = 33) and were far more likely to have previously attempted suicide (54%, n = 76, compared to 19%, n = 31) compared to those without a diagnosed mental illness. However this first difference could not be tested for statistical significance. Further, those with a diagnosed mental illness were nearly three times more likely to have self-harmed in the past (71%, n = 38, compared to 25%, n = 8), while all participants currently self-harming at assessment had a diagnosed mental illness.

While the proportion of participants who answered questions about self-harm is quite low, these findings indicate an unsettling trend. Taking the incidence of hospitalised self-harm as an indicator of prevalence (lifetime rates: 137.5 persons per 100,000 people; Steenkamp & Harrison, 2000), Trial participants have engaged in self-harm at alarming levels. These findings attest to the vulnerability of this client group, the need for direct intervention and support, and the complexity of work needed to engage them in a process of change.

## 2.7 PHYSICAL HEALTH

### 2.7.1 Physical Health Issues Present at Assessment

Table 2.5 summarises the physical health issues discussed and the proportion of participants experiencing them at the time of assessment. The most significant physical health issue reported was dental (37%, n = 153), with fifteen participants requiring immediate attention at the time of assessment. The second most common physical health issue reported was liver disease (30%, n = 152), for which five participants required immediate attention. The third most common was head injuries (24%, n = 152) for which two participants required immediate medical attention.

**Table 2.5: Proportion of participants with physical health issue**

Physical Health Issue	Yes (%)	Valid n	Physical Health Issue	Yes (%)	Valid n
Dental	37	153	Seizures/Epilepsy	11	153
Liver Disease	30	152	Gastro Intestinal	12	153
Head Injuries	24	152	†Pregnancy	15	13
Skeletal Injuries	18	152	Cardiac Problems	5	153
Chronic Pain	18	153	Diabetes	1	153
*Respiratory	18	154	**Intellectual Disability	2	100
** Acquired Brain Injury	17	100	Allergies	13	153

\*Includes Asthma

†Note: The question relating to pregnancy was only on version 4 of the IRF which 13 females completed with two participants not answering the question. Only females were included in the sample so higher than the last report

\*\* Not on version 1 of IRF

A significant issue commonly raised by services was the incidence of acquired brain injury (ABI) and intellectual disability among clients. These conditions were typically undiagnosed and difficult to detect and work on, given the myriad complicating factors and behaviours due to the participants' experience of mental illness, substance use, homelessness, social isolation and disconnection. As such, stronger links between CSAS and disability services needs to be developed. In addition CSAS staff require further training in the detection and referral of ABI and a greater level of focus needs to be directed at this area generally.

The only physical health issues more predominate among female participants were respiratory (35%, n= 23, to male 15% n = 131) and, of course, pregnancy. Though not statistically significant, men were more likely to have ABI (19%, n= 83 to 6%, n = 17), dental problems (39%, n = 130, to 21% n = 23), head injuries (26%, n = 129 to 9% n = 21), skeletal injuries (20%, n = 129, to 9% n = 21), gastrointestinal problems (13% n = 130, 4% n= 22), and fits/seizures/epilepsy (12%, n = 130 to 4%, n = 23) than women. Some physical health conditions were exclusively male, cardiac (6%, n = 130), intellectual disability (2%, n= 83), and diabetes (2%, n= 130).

Participants with a diagnosed mental illness were more likely to suffer from a majority of the physical health issues reported. All those reporting seizures/fits/or epilepsy, gastrointestinal

problems, intellectual disability and diabetes had been previously diagnosed with a mental illness.

The comparably high rate of physical health issues experienced by those with a diagnosed mental illness adds a further layer of complexity to their lives. These problems coupled with homelessness make it difficult for participants to be concerned with their health needs and engage successfully with primary health services.

### 2.7.2 Medication Use

Participants were also asked about current medications. The majority of participants (65%, n = 156) reported they were using some form of medication at the time of assessment. The median number of medications being used was two, (an average of two with a range of 1-5 medications). Of the 171 reasons given in total, the most common reasons for use of medication were for depression 20%, manage drug withdrawal 14%, substitute pharmacotherapy treatment 12%, and anxiety 9%. This is consistent with the high levels of diagnosed mental illness amongst Trial participants.

As is to be expected, the most common reasons for use of medication reported by participants with a previously diagnosed mental illness were depression (26%, n = 115) and anxiety (11%, n = 115), whereas participants without a previous diagnosis of mental illness were less likely to report these reasons (depression, 5%, n = 22 and anxiety, 9%, n = 22). The most common reason for use of medication by people who had not been previously diagnosed with a mental illness was substitute pharmacotherapy (32%, n = 22) or withdrawal (27%, n = 22), whereas participants who had been previously diagnosed with a mental illness were less likely to report these reasons (substitute pharmacotherapy, 10%, n = 115 and withdrawal 10%, n = 115).

### 2.7.3 Hospital Admissions

The majority of participants (70%, n = 115) had been admitted to hospital prior to IRF assessment. Those with a diagnosed mental illness (81%, n = 58, compared to 65%, n = 23) were more likely to have been previously admitted to hospital. These figures are consistent with a higher incidence of a range of physical health issues among those with a diagnosed mental illness.

Further, on a modified version of the IRF, participants were asked if they had been admitted to hospital in the past 12 months and 47% (n = 32) had been.

## 2.8 NON-FATAL OVERDOSE

More than half the participants (56%, n = 156) reported having overdosed at some point in their lifetime, with 23% (n = 152) of all participants having overdosed in the last 12 months. Participants who had overdosed in the last 12 months averaged two overdoses, (median of 1, range of 1–4).

Women were more likely than men to have overdosed in their lifetime, though not in the past 12 months, and were more likely to have overdosed multiple times. Fifty-three percent (n = 134) of males had previously overdosed, with 23% (n = 131) having overdosed in the past 12 months, whereas 76% (n = 21) of females had previously overdosed, with 25% (n = 20) having overdosed in the past 12 months. Women were also more likely to have overdosed multiple times in the last 12 months (mean and median of two, range 1-3, compared to men: mean and median of one, range 1-4).

The higher frequency of non-fatal overdose in the last 12 months among women is consistent with the higher lifetime use of a wide range of substances, particularly depressants such as heroin and benzodiazepines, and higher lifetime rates of poly-drug use. Further, chaotic or situational poly-drug use will lead to lower tolerance for substances generally and therefore increase the risk of overdose.

In total, 170 substances were reported as used prior to overdose in 119 cases of overdose. Heroin (43%, n = 170) was the most used substance prior to overdose, followed by alcohol (18%, n = 170), and benzodiazepines (15%, n = 170). Other substances used in overdoses included: other prescribed drugs (7%, n = 170), other non-prescribed drugs (5%, n = 170), combination of drugs/unsure/can't remember (4%, n = 170), amphetamines (2%, n = 170), antidepressants (2%, n = 170), and 1% for each of other opiates, hallucinogens, cannabis and methadone.

Differences emerged in the substances used at the time of overdose between men and women. Males were far more likely to have been using alcohol at the time of overdose (20% of the 147 substances reported as used by males) compared to females (4% of the 23 substances reported by females). Women, however, were more likely to have used benzodiazepines (30% of the 23 substances compared to 13% of the 147 substances). Though not statistically significant, women were more likely to be using heroin and amphetamines at the time of overdose than men. These figures are consistent with the reported higher lifetime usage of these substances by women.

Participants with no previous diagnosis of a mental illness were more likely to have used heroin prior to overdose (58% of the 31 substances reported by the 11 participants) than participants with a previous diagnosis (37% of the 82 substances reported by 35 participants). However, both of these groups were about equally likely to have used benzodiazepines and alcohol prior to overdose. Participants with a previous diagnosed mental illness were also more likely to have used an 'other non-prescribed drug', although it is unclear what these substances actually were.

## 2.9 LEGAL HISTORY

Consistent with previous Part B reports, participants reported high levels of past criminal behaviour, with 74% (n = 136) of participants reporting some kind of legal history, and 27% (n = 154) of participants reporting that they had charges pending at the time of assessment. Further, a significant number of participants had previously been imprisoned (42%, n = 137), and 24% of participants (n = 37) had been given a court order to attend a drug treatment service in the past.

A clear majority of participants (68%, n = 121) reported previous convictions, with 67% (n = 76) of those participants reporting their convictions were due to drug-related crime. Further, 80% (n = 20) of those previously convicted for drug-related offences had been convicted multiple times for drug-related offences, with the number of times ranging from two to six times, with some participants unable to recall the exact number.

The only difference that emerged between men and women upon further analysis was that men were far more likely to have been imprisoned (46%, n = 116 compared to 24%, n = 21). Female Trial participants, however, were just as likely to have had prior convictions (57% of females, n = 14, compared to 69% of males, n = 107), and were just as likely to have charges pending at the time of assessment (29% of females, n = 24 compared to 26% of males, n = 133). No differences emerged in the legal histories of those with a diagnosed mental illness and those without.

In general, DACMCs commented that the higher rates of criminal activity among this client group are closely related to their levels of drug addiction and their need to meet this addiction. Secondly, key stakeholders have often reported the link between criminal activity and survival for those who are homeless and experiencing extreme poverty. Criminal activities for female participants have usually consisted of prostitution, possession of drugs and shoplifting. While male participants have also engaged in these crimes, key stakeholders report that men are more likely to have been involved in more violent crimes, such as armed robbery and assault than women.

## 2.10 SERVICE UTILISATION HISTORY

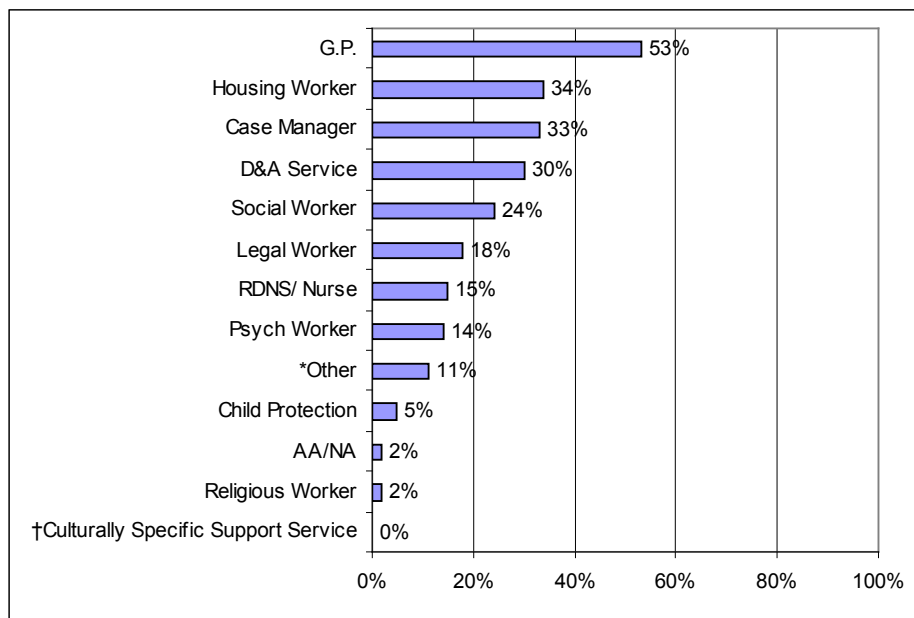
### 2.10.1 Involvement with Support Services Prior to Assessment

At the time of assessment, 89% (n = 160) of participants indicated that they were in contact with at least one support service, indicating high need for support among participants. As stated in the previous Part B report, a majority of these services have been accessed through the CSAS or the Trial.

Of the participants who were in contact with a service (n = 143), the average number of services was 2.4 (median 2), with a range of one to eight services per person. While there was no difference in the proportion of participants accessing a service according to mental health status (94%, n = 87, compared to 94%, n = 33), those with a previously diagnosed mental illness had accessed a slightly higher number of services on average (mean 2.9, median 3, n = 87) than those who did not (mean 2.4, median 2, n = 33). All the women in the Trial (n = 25) were in some contact with services at the time of assessment, compared to 87% (n = 135) of men.

Consistent with the previous Part B report, the most common service participants had accessed (see Figure 2.8) at the time of assessment was a GP (53%, n = 160). The relatively high proportion of participants accessing housing workers, case managers, drug and alcohol services and social workers, is likely to be the result of CSAS support provided prior to entering the Trial officially or referrals and support offered by their PCM in the first three months of their involvement in the Trial. Such occurs as primary case managers can take up to three months if needed to complete the full Trial assessment.

**Figure 2.8: Services utilised by participants at time of IRF assessment (n = 160)**



\*Other included: Medical Services (not a GP), Employment Services, Corrections, and RHEDS (formerly Prostitutes Collective).

†Cultural Service was on the latest version of IRF only (n = 33)

Some interesting differences emerged in analysis of the type of service accessed by gender and mental health status. Consistent with the higher rates of mental illness among women in the Trial, women were much more likely to have a psychiatric worker (40%, n = 25, compared to 10%, n = 135, of men). Women were also more likely to have contact with a housing worker (60%, n = 25 compared to 29%, n = 135) and a legal worker (32%, n = 25 compared to 16%, n = 135) highlighting that, overall, women were more supported.

Another interesting finding was that all those participants using AA or NA had a diagnosed mental illness. As is to be expected, more participants with a diagnosed mental illness had a psychiatric worker (23%, n = 87, compared to 6%, n = 33), however, this difference could not be tested for statistical significance. Further, 6% of those who reported no mental illness had a psych worker suggesting possible under-reporting of diagnosis at the time of assessment. Of note was that 77% of participants with a diagnosed mental illness were not supported by a psychiatric worker at the time of assessment. This appears to be due to the focus of treatment provided by psychiatric services being largely directed at serious forms of mental illness such as schizophrenia.

Feedback from key stakeholders suggests that peer-based services such as AA/NA are more easily accessible for participants, especially those with a diagnosed mental illness. There are no assessments or entry criteria and they can attend as little or as often as they like. The low proportion of participants with a psychiatric worker is at least in part due to the mental health service system. Many Trial participants do not qualify for a worker if they have been diagnosed with 'only' depression or anxiety. Further, for those with a serious mental illness the onus is typically on them to maintain contact with mental health services. This often proves difficult for many, particularly those who are homeless and dually diagnosed. This commonly results in a breakdown of support for the participant's mental health problems, continued instability, recurrent homelessness and continued problematic drug and alcohol use.

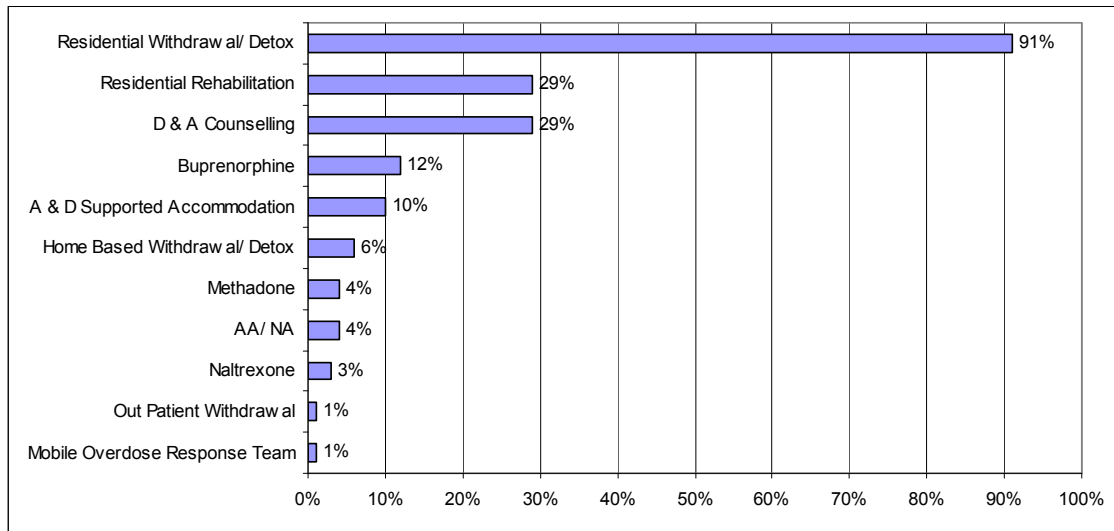
## 2.10.2 Prior Involvement with Drug Treatment Services

Consistent with the previous Part B report, 86% (n = 156) of participants reported contact with Drug Treatment Services at some point in the past. For 72% of participants, involvement with these services had occurred in the last 12 months.

Of the 96 participants who responded to questions relating to past involvement with Drug Treatment Services, the most commonly accessed treatment type was residential withdrawal, with 91% of participants (n = 96) having accessed this service in the past 12 months. Other common treatment types accessed in the past 12 months included: Drug and Alcohol Counselling (CCCC) (29%, n = 96) and Residential Rehabilitation (29% = 96).

It should be noted that some of this access is a result of the Trial's early efforts to assist participants. Further, DACMCs commented that participants commonly did not complete treatment in the past, especially longer term-treatment such as residential rehabilitation and ADSA.

**Figure 2.9: The proportion of participants accessing drug treatment services in the twelve months prior to completion of the IRF (n = 96)**



Further analyses revealed that twice as many women had been to Residential Rehabilitation compared to men (47%, n = 17 compared to 25%, n = 79). However, none of the women who responded to these questions had accessed A&D Supported Accommodation compared to 13% of men (n = 79), while men accounted for all those accessing residential withdrawal within the past 12 months.

Other interesting differences emerged along the mental health axis, with those diagnosed with a mental illness being far more likely to have accessed residential withdrawal (82%, n = 54) than those without a diagnosed mental illness (50%, n = 17). Men with a diagnosed mental illness were also much less likely to have accessed residential rehabilitation.

## 2.11 MEANINGFUL CONNECTIONS

A specific goal within the Trial was to assist with rebuilding positive community and family connections. It was therefore important to gauge participants' current experiences of connection with family and the community upon entry to the Trial. A series of questions were included on the IRF in order to build an understanding of participants' existing relationships and support systems. These questions were further expanded in the modified version of the IRF.

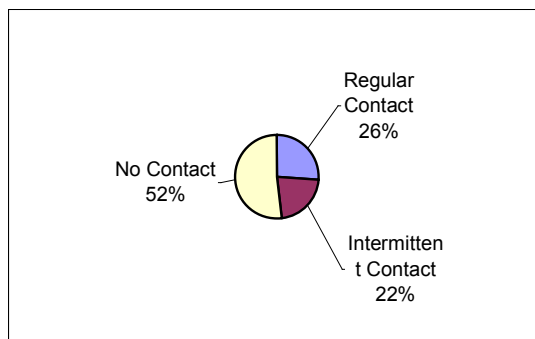
### 2.11.1 Contact with Spouse/Partner

At the time of assessment, 60% (n = 154) of participants had a spouse/partner. There was little difference in the proportion of males and females who had a spouse/partner, however, those participants who had not been diagnosed with a mental illness were more likely to have a spouse/partner (73%, n = 33), than participants who had been previously diagnosed with a mental illness (59%, n= 87).

Of the 92 participants that did have a spouse/partner:

- Twenty-six percent had regular contact with their spouse/partner
- Twenty-two percent had intermittent contact with their spouse/partner
- Fifty-two percent had no contact with their spouse/partner

**Figure 2.10: Contact with spouse/partner (n = 92)**



Women reported more regular contact with their spouse/partner (54%, n= 13) than men (21%, n = 79), and a lower proportion of women reported having no contact with their spouse/partner (31%, n= 13) compared to men (56%, n= 79). Further, a higher proportion of those without a previous diagnosis of a mental illness (62%, n= 24) had no contact with their spouse than those who did have a previous diagnosis of mental illness (47%, n= 51).

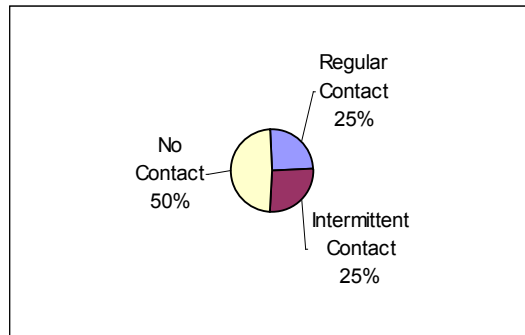
### 2.11.2 Contact with Child/Children

At the time of assessment, 57% (n = 155) of the participants had one or more children.

Of the 88 participants that did have a child/children:

- Twenty-five percent had regular contact with their child/children
- Twenty-five percent had intermittent contact with their child/children
- Fifty percent had no contact with their child/children

**Figure 2.11: Contact with child/children (n = 88)**



Women were much more likely to report regular contact with their children (66%, n = 12) than men (19%, n = 76). Men were more likely to have no contact with their children (55%, n = 76) than women (17%, n = 12). There was little difference in the frequency of contact with children for those with and without a diagnosed mental illness.

Two participants, one male and one female, were the primary carers of children (n = 155).

### 2.11.3 Contact with Family of Origin

#### 2.11.3.1 Parents

Eighty-nine percent of participants reported having parents (n = 38). Of those who had parents, 36% (n = 34) had intermittent contact, 32% (n = 34) had no contact and 32% (n = 34) had regular contact. Of the 30 participants who answered this question and had parents still alive, 13% felt very supported, 40% felt somewhat supported and 47% felt not at all supported. Similar to the preliminary data presented on contact with spouse or partner, these figures indicate that contact cannot automatically be assumed to be supportive.

#### 2.11.3.2 Contact With Siblings

Ninety-two percent of participants (n = 38) who responded to these questions had siblings. Seventeen percent (n = 35) had regular contact, 40% had intermittent contact and 43% no contact. Further, of the 29 participants who responded to questions about degree of support and had siblings, 10% felt very supported, 35% felt somewhat supported and 55% felt not at all supported. This again highlights the tenuous nature of participants' contact with their family.

#### 2.11.3.3 Contact with Extended Family

Ninety-one percent (n = 32) had extended family, 7% (n = 29) had regular contact, 24% had intermittent contact and 69% no contact. Of the 21 participants who responded to questions concerning support and had extended family, 5% felt very supported, 19% felt somewhat supported and 76% felt not at all supported.

## 2.11.4 Other Meaningful Connections

### 2.11.4.1 Contact/Support from Friends

Ninety-four percent of participants reported having friends (n = 34), with 31% (n = 32) having regular contact, 47% having intermittent contact, and 22% having no contact. Of the 28 participants who answered the question about support, 14% felt very supported, 57% felt somewhat supported, and 29% felt not at all supported by their friends. Feedback from services suggests that these friendships are most commonly within the drug-using community, which impacts on the degree of support participants have around decreasing or ceasing their use.

### 2.11.4.2 Contact/Support from Professionals

Consistent with the data on service utilisation discussed earlier, 94% of participants (n = 34) reported being linked to a professional/s. Eighty-eight percent of those (n = 32) reported regular contact, 3% reported intermittent contact and 9% reported no contact. As already mentioned, a majority of the contact with services is likely to be a result of early Trial participation. Of the 30 participants who answered these questions, 50% felt very supported, 40% felt somewhat supported and 10% felt not at all supported. While not all of these responses will be relevant to the Trial, some clearly are. While meeting the expectations of all participants all of the time may not be possible, this client feedback needs further discussion and reflection by all CSAS.

## 2.11.5 Desired Changes to Current Relationships

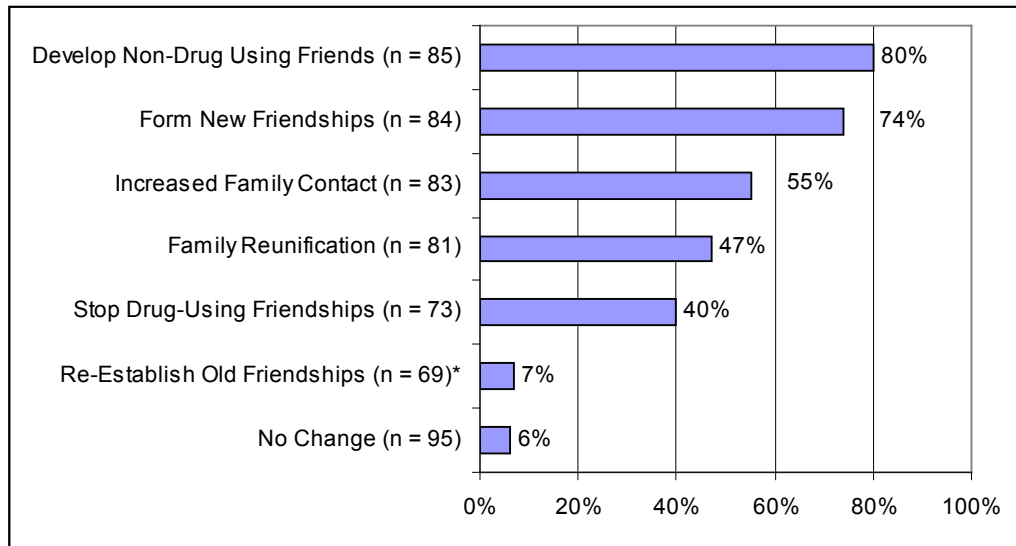
Participants were asked to indicate their desired changes to current relationships and could select more than one of the responses. Developing non-drug using friendships was the change to current relationships most desired by participants (80%, n = 85) at the time of assessment. A high proportion of participants wanted to form new friendships (74%, n = 84) and stop drug-using friendships (40%, n = 73) as indicated in Figure 2.11.

Participants also wanted to make changes to their current relationships with family members. Fifty-five percent (n = 83) of participants wanted to increase family contact, and 47% (n = 81) wanted to be reunited with their families.

Only 6% of participants (n = 95) wanted no change to their current relationships.

The responses to these questions indicate that a majority of participants not only want to establish new connections, preferably with non-drug using members of the community, they would also like to reconnect and rebuild their family relationships.

**Figure 2.12: Desired changes to current relationships**



\*One participant less than from Report 5 due to the removal of two participants

## 2.12 CONCLUSION

The profile of Trial participants is one of significant health, social and economic disadvantages. Histories of homelessness, substance use, family and community disconnection, poor educational attainment, high unemployment, poor physical and mental health and high levels of involvement with the criminal justice system clearly show the many difficulties experienced by this population group. While these factors also draw attention to the many and difficult problems primary case managers and the Trial overall will have to support the participant to address, they also affirm the Trial's approach to working with participants for longer periods of time in order to address these problems and create pathways out of homelessness and problematic drug use.

Analysis of the different participant sub-groups entering the Trial has also identified the different needs and higher levels of disadvantage among those with a mental illness, with a criminal history and for women, many of who had a diagnosed mental illness. These groups require careful consideration in the planning and delivery of services, particularly those with a mental illness, which represent the majority of people entering the HDDP.