Final Report

Heroin users, housing and social participation: attacking social exclusion through better housing

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EXECUTIVE SUMMARY

Introduction

Heroin use arguably sits at the centre of some of the most serious social problems experienced by Australians. A considerable body of research has been compiled, in respect of both the aetiology of heroin addiction and the policy options for the control of illicit drugs. Much of this research has been informed by not always helpful intellectual and practical assumptions. However, little if any research has tried to capture the experience of heroin users, and their social relationships and practices. In this research, we report on the social experience of heroin users in regard to housing as a prelude to establishing what housing policies better assist heroin users in the community. Certainly there is a prima facie case, given the costs associated with housing provision and heroin use, for exploring and better understanding the relationship between housing and heroin use.

Project Aims

In seeking to better understand the connections between drug use, housing options and social experience, the members of this research project address three primary research questions:

- In what ways if any, do accommodation options affect the wellbeing and social experience of heroin users, taking into account such factors as age, gender and mental health?

- In what ways does current service provision for long-term heroin users address their housing needs?

- What changes in current service provision and housing policies would improve the social opportunities of heroin users?

In this respect, the research focus has been modified somewhat since the initial design of the project. During the course of the project, the research team altered its focus from young heroin users to all heroin users. The reasons for this decision are discussed in the introduction to this report.

Policy Context

There are four key features of the policy context for this research:

1. Dramatic fluctuations in the availability and use of heroin and in the subsequent policy responses of federal and state governments. In 2000-01, in the face of evidence of a significant increase in the availability of heroin, the policy responses of federal and state governments became increasingly unstable with the federal government urging a tighter prohibitionist approach while some state governments sought relaxation of prohibitionist policies.

2. In recent years, policy research and advocacy has directed the attention of policy makers towards recognising broader 'environmental factors' in the lives of heroin users. The growing number of heroin users within the crisis accommodation service system in 2000/01 brought the issue of housing into particular focus.

3. At the same time as there has been an increased focus on homelessness and possible housing responses, access to affordable housing has declined especially in the public housing sector.

4. The use of illicit drugs, like heroin, has stimulated an interest in 'whole of government' responses. Government agencies, at both state and federal levels, are playing a significant role in supporting policy research and debate designed to inform a whole of government approach.

Literature Review

We observe through the literature review that few research studies have paid specific attention to the impact different accommodation options have on patterns of drug use. However, we are able to draw upon a range of studies to suggest why the accommodation available to drug

users influences their patterns of drug use. Some of the research has suggested that the less stable the housing environment, the greater the capacity for problematic drug use patterns to develop. We want to establish whether our data validates this argument – or not.

Methodology

This project used the following discrete research methods:

1. A comprehensive descriptive and critical literature review;

2. Ethnographic interviews with 47 heroin users;

3. A focus group of heroin users;

4. A survey of 150 heroin users;

5. Three focus group discussions with service providers.

The field research through interviews, survey and service provider focus groups were conducted in three locations:

- Yarra City Council – Fitzroy and Collingwood;

- Geelong;

- Cabramatta.

The rationale for these three locations was to relate the experience of illicit drug use to inner city, suburban and provincial centre service systems and housing markets. It is important to recognise that when we speak of accommodation options, we are not simply restricting these options to different forms of accommodation. Instead, we have consciously sought to include the different options that are available within different housing markets and by different housing service systems. Furthermore, each of the selected areas has a documented history of heavy drug use and a range of government and non-government organisations active in attempting to address the problems.

Research Findings

In chapter 5 we demonstrate the need to avoid making generalisations about heroin users as a group. The reasons an individual chooses to use heroin are as varied as the impact that it will have upon other aspects of their lives. If policy is to be sensitive and attentive to the needs of heroin users, then policy makers need to be able to move beyond stereotypical generalisations of heroin users and appreciate the complexity and richness that defines their individual lives.

In chapter 6, we look at the ways in which different accommodation options affect the wellbeing and social experience of heroin users. We do so by examining linkages between heroin use and different forms of housing. We sought to understand how their housing environment, (or their lack of housing environment), influenced their patterns of heroin use. Furthermore, we examined the manner in which housing and heroin use intersected with the larger shape of our participants' lives.

Our findings reveal the potential for safe and secure housing to increase the well being and social capacity of heroin users. In terms of physical wellbeing, access to housing is shown to result in a range of general health benefits, including better nutrition and improved hygiene. Additionally, we highlight the ways in which stable housing minimises the potential for drug-related harm, particularly the potential harm arising from injecting drug use. A number of participants also associated their homelessness with depression, anxiety and low self esteem, indicating the potential mental health benefits of stable housing.

Moreover, being 'homeless' is shown to exacerbate problematic drug use. In this context, stable accommodation provides the means by which an individual may place distance between themselves and their drug using peers in the 'street' environment.

In respect of their 'social capacity', the stability provided by secure housing allows heroin users to look beyond their immediate survival to the consideration of longer term issues such

as employment, education, health and relationships. In this respect, stable housing enhances the individual's capacity to access basic life opportunities that *should* be available to all.

In Chapter 7, we examine the ways in which current service provision addresses the housing needs of long-term heroin users. This chapter is divided into two main sections. In the first section of Chapter 7, we focus on the provision of public housing, the only realistic option for low-income dependent heroin users seeking secure, affordable housing. However, we demonstrate that public housing is becoming unsuitable for some people in housing need as a consequence of an embedded and endemic drug trade in certain public estates. Indeed, for a number of those in need of housing, homelessness is seen to be preferable to a tenancy in these estates.

Additionally, we demonstrate that the provision of public housing is further complicated by the need to place tenants with increasingly complex needs in appropriate forms of housing. However, a serious shortage of suitable housing is shown to place considerable constraints on the capacity of housing officers to effectively address the needs of public housing tenants.

In the second section of chapter 7, we consider the relationship between housing and other forms of service provision, such as medical and drug treatment services. Indeed, the relationship between medical and housing services was shown to be a problematic and one with the potential to impact negatively on service providers and their clients alike. In this context, we highlight the need for greater cooperation so as to achieve a system where the various services are in step and informed about the initiatives and operations being undertaken in other sectors.

In chapter 8, we conclude by presenting ideas about how future policy program development might respond to the above issues. In doing so, we argue for four changes in current service provision.

Firstly, we identify a need for increase in the supply of social housing, either through state authorities or community housing providers. Given the current shortages and complexities that complicate public housing allocation, an increased supply would result in more people being housed and less reliance on rationing. We also state that there is a need to reconfigure the location and distribution of public housing.

Secondly, we address the location of the illicit drug market. Given the tendency for law enforcement 'crackdowns' to simply displace illicit drug markets, we argue that it is necessary to think creatively about placing drug markets in locations where it will do the least harm. Indeed, this question was recently posed in Victoria in relation to the illicit street-based sex trade. At present the drug trade is firmly embedded in high-rise public housing estates, a location that offers the greatest gain for those who profit from drug dealing at a significant cost to other tenants and to the broader community.

Thirdly, we argue that, if policy is to be sensitive to the needs of illicit drug users, policy makers must engage drug users in program development. To date, there has been relatively little effort undertaken to explore and appreciate the experiences of drug users themselves. This is a significant weakness of current policy approaches and one that must be addressed as a priority. The actual experiences of drug users differ markedly from widely accepted assumptions that continue to inform drug policy debate.

Fourthly, we make the case for improving the knowledge and understanding of service providers in respect of the above issues. We suggest that this could be done through the development of a short course or training module. As noted in the conclusion of this report, there are numerous tertiary level courses of varying lengths that directly address illicit drug-related issues. However, there are none that directly address the particular concerns faced by state housing officers.

1 INTRODUCTION

Heroin use has become central to some major contemporary social problems. Through the 1990s, heroin use became one of the most widely discussed and researched forms of social activity (Lennings 1996; Premier's Drug Advisory Council, 1996; Drugs and Crime Prevention Committee, 1997; Drug Policy Expert Committee 2000). A considerable body of research has been undertaken, in respect of both the aetiology of heroin addiction and heroin use and the policy options for the control of illicit drugs. Often there is an assumption that users are 'socially excluded', meaning that they do not participate in 'society' or 'the community', which in turn deflects attention from the way government and community agencies stigmatise, hurt or deny access to valued social resources like justice, jobs or housing. This research rejects this assumption and analyses the social experience of heroin users in a way that provides a basis for policy and program development that will enhance the person wellbeing and social opportunities of heroin users. We do this by focusing on the way in which heroin users gain access to affordable and secure housing.

Through this approach we recognise the 'accentuating factors' that intensify the conditions of social disadvantage under which some people live (Peace 2000). One such factor is a lack of 'fair recognition' that may take the form of social discrimination, prejudice in the wider community, hostility and stigmatising behaviours (Peace, 1998). In undertaking this research project, we could not but help be aware that heroin users are one of the most stigmatised groups in Australia. Similarly, we could not but help note that this is largely a consequence of the misinformation and prejudice that characterises the public discussion and representation of illicit drugs (Engels, et.al. submitted). Given this context, our study is conscious of what Percy-Smith (2000) calls the 'moral agenda' that seems to underpin public discussion and representation and many contemporary policy interventions. She notes:

> The intolerant attitudes towards and punitive treatment of those who are considered to be deviant and non-conforming … There is a strand [of] thinking which suggests that such voluntary self-exclusion itself constitutes a social problem and as such is the legitimate target for possibly punitive action (Percy-Smith, 2000: 20).

There is no value in continuing to view heroin users as deviant and non-conforming. At the same time we do not see much point in advocating that heroin users should be dealt with by being reinserted into some mythical 'mainstream society'. Rather, we explore the social experience of heroin users and in particular what it means for heroin users when they talk about their housing. We ask whether an improvement in housing environment would permit an improvement in personal wellbeing. Such an improvement could be expected to enhance the wellbeing of heroin users if the right kinds of housing policies and service provision would cancel out factors in their current living environment that accentuate their social deprivation. As Peace (2000) points out 'spatial intensifiers' of social deprivation, include the lack of adequate shelter, social and geographical isolation, and loneliness.

Improving the wellbeing of heroin users, as well as enhancing their access to social resources like jobs, may well contribute to major health benefits for heroin users and indirectly achieve broader cost benefits to government. As the following literature review suggests, higher rates of problematic drug use have been consistently documented among homeless populations. This has been linked to higher rates of acquisitive crime (Baron, 2001). Dealing with this kind of crime places considerable demands on the criminal justice system. In 1997-98, the national cost of imprisonment was $52,049 per prisoner per year (Carcach & Grant, 1999). Additionally, the loss of an individual to a cycle of crime and drug use deprives the community of a potentially productive member. Problematic drug use has also been linked to unsafe sex practices and unsafe injecting techniques (Rogers, 1992; Walsh, 1998; Tyler et.al., 2000). There are obvious implications for public health in respect to these practices.

A strong stimulus for researching the housing circumstances of heroin users is found in research of homelessness that points to an apparent relationship between the poverty and depression that often accompanies the transient lifestyle of homeless individuals and heroin use. The Burdekin Report *Our Homeless Children* first identified a link between illicit drug use

and housing in 1989 in its discussion of the increase in youth homelessness (Human Rights and Equal Opportunity Commission, 1989). More recently, policy research and advocacy from within the public health field has focussed attention on broader environmental and structural factors. Housing for example, has been identified as one such factor by each of the Victorian Government's Ministerial Advisory Committee on Homelessness (2001), the Australian National Council on Drugs (2000) and the Alcohol and other Drugs Council of Australia (2000).

Although this type of policy research focuses on the characteristics of drug users and/or homeless people, it has not investigated the housing histories and recent housing circumstances of heroin users. Consequently, policy-makers lack the evidence necessary to develop linked policy and program responses, especially policies relating to the health and housing needs of heroin users. The primary aim of this study is to address this gap.

We want to pay particular attention in this research to the capacity for appropriate housing policies to enhance the wellbeing and social opportunities available to heroin users. In seeking to understand the connections between drug use, housing and social opportunity, our research project aims to answer three primary research questions:

- In what ways if any, do accommodation options affect the well being and social experience of heroin users, taking into account such factors as age, gender and mental health?

- In what ways does current service provision for long-term heroin users address their housing needs?

- What changes in current service provision and housing policies would improve the personal wellbeing and social opportunities of heroin users?

During the course of this project, the research focus was altered from young heroin users to all heroin users. The decision to alter the research focus in this way was influenced by the commonly reported tendency for the late teens to be a period of experimentation, sometimes involving drugs, and resulting in what some describe as 'chaotic' lifestyles (i.e. Spooner et.al., 2001; Baron 1999, Klee & Reid 1998, Kipke et.al., 1997). In contrast, users entering into adulthood, like the broader population, often establish more structured lifestyles. In this context, it was thought that older users would be better positioned to talk about their efforts to find secure and affordable housing.

In order to answer the primary research questions our research has done five things:

- It has established the kinds of social and economic resources (including income levels, employment characteristics, quality of housing and well-being) characterising long-term heroin users who either reside in three separate study areas or who use services in those areas. The three areas of study are inner-city Melbourne, south-western suburban Sydney and Geelong. The rationale for these locations is to relate the experience of illicit drug use to inner-city, suburban and provincial housing markets. The selection of these sites is discussed further in Section 4.2;

- We provide an account of the housing histories and housing market experiences of long-term heroin users and assess how these histories and market experiences relate to their experience of other aspects of social and economic life including employment, access to education and training services, health and welfare services, and recreation. This demonstrates the way in which accommodation options have the potential to affect the well being and social experience of heroin users;

- We provide an account of long-term heroin users' experiences of a variety of human service agencies and programs, their perception of the quality and relevance of housing services and programs, and the impact of these services on the quality of their lives. This demonstrates the ways in which current service provision does (and does not) meet the housing needs of long-term heroin users;

- We provide an account of service providers' perceptions of the degree to which integrated service provision is available to the long-term heroin using population, and the extent to which the degree of integration impacts on their social opportunities.

- We argue for four measures. In summary terms they are

- a focus on social housing provision and improved service delivery arrangements capable of supporting tenants to maintain access to other essential health and welfare services.

- encouraging governments to consider what are the most appropriate urban locations for drug markets so that they are 'pulled' out of public housing estates

- state housing authorities should ensure that users, through representative and self help organisations, are consulted on future program development aimed at improving the level of service to users

- the development and provision of training on drug and alcohol issues to housing officers in state housing authorities and workers employed by community housing providers

This Report is the last in a series of papers that were prepared throughout the course of the project. It examines the links between housing access and heroin use, with particular emphasis on those who are stigmatised and disadvantaged through their illicit drug use and their access to housing. The paper first puts the study into its policy context. It then presents a literature review of the association between housing access and drug use. Following this, the Report presents an overview of the study's methodology. Then in Chapters 5, 6 and 7 we provide a report of our findings. In chapter five we offer an overview of the people who were part of the study. In chapter six we describe and discuss the participants' experience of the housing options available to them and their perception of the salience and quality of the housing services available to them. In chapter seven we identify and discuss the key findings regarding the recommended policy initiatives which governments might consider introducing.

2 HOUSING AND HEALTH: SEEKING A WHOLE OF GOVERNMENT POLICY RESPONSE[1]

The policy context for this research has four elements. First, there has been an increase in illicit drug use, especially heroin use, in the past two decades. The federal and state government responses to this increased use have been extensive, especially within the public health and criminal justice portfolios. Second, in recent years, research and advocacy in the health portfolio areas has begun to direct policy attention to broader 'environmental factors' in the lives of heroin users. Largely because a growing number of heroin users are using the homeless persons service system, the access of heroin users to secure and affordable housing has become a particular focus. Third, at the same time as there is an increasing focus on homelessness and possible housing responses, access by low-income people to affordable housing has been declining. Fourth, illicit drug use is an issue that is stimulating an interest in 'whole of government' type responses. Both state and federal levels governments, along with central agencies and committees auspiced by the Prime Minister and premiers, are now playing a significant role in supporting policy research and debate.

2.1   Heroin use and health policy

Since the National Advisory Committee on AIDS (NACAIDS) first sponsored benchmark research on drug injection by young Australians in 1988, the last decade has seen a marked increase in illicit drug use (Australian Institute of Health and Welfare 1999). Research suggests that the number of Australians who have used heroin increased by 50% between 1995 and 1998 (Australian Bureau of Criminal Intelligence 1999). It is estimated that approximately 112,000 Australians used heroin in the past 12 months (Australian Institute of Health and Welfare, 1999). This is thought to be a significant underestimation of the total number, as there is likely to be an unwillingness to disclose this information.

Heroin users have a mortality rate 13 times that of their non-using peers. Overdose deaths in Australia increased from six in 1964 to 958 in 1999 (Ministerial Council on Drug Strategy, 2001). Although exact figures are not yet available, there is evidence that heroin related deaths have begun to drop dramatically following a 'drought' after December 2000 (Miller et.al., 2001) In 1964, overdose deaths represented 0.1% of all deaths in the 15 to 44 year age group. By 1998, almost 10% or one in ten deaths among Australians aged 15 to 44 were attributed to heroin overdose (Hall, Degenhardt & Lynskey (1999)). Estimates indicate that between 12,000-21,000 non-fatal overdoses occur in Australia every year. Non-fatal opioid overdose can result in significant permanent morbidity, such as brain damage (Ministerial Council on Drug Strategy, 2001).

As levels of illicit drug use have increased, so too have levels of expenditure within the health system. It has been estimated that this treatment services expenditure has more than trebled over the past five years as services have struggled to meet demand (Standing Committee on Family and Community Affairs, 2001). There is also significant demand for the expansion of additional public health programs such as needle and syringe exchange and methadone maintenance treatment (Standing Committee on Family and Community Affairs, 2001). The methadone program in Victoria has grown at a rate of approximately 15 per cent per annum since its introduction (DPEC, 2000).

2.2   Heroin use and the physical environment

In recent years the policy discussion of heroin use has increasingly recognised other areas of policy and in particular housing (Australian National Council on Drugs 2000; Alcohol and Other Drugs Council of Australia 2000). This broadening of the analysis by public health professionals and service providers in other service systems, like homeless accommodation, prisons and public housing, recognises the need to adjust to new and complex demands placed on these systems by long-term heroin users.

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[1] The policy context of this research is provided in greater detail in the project's Positioning Paper. This can be accessed online at http://www.ahuri.edu.au/attachments/pp_heroinusers.pdf

2.2.1   Policy Focus: Broadening the context

The increasing use of illicit drugs, and heroin use in particular, has been the subject of a number of inquiries by both state and federal governments since the mid-1990s. These inquiries have provided a forum for discussion of broader contextual factors and have encouraged an extension of the policy focus beyond the behaviours of users. As one of many examples, the DPEC, in its report *Heroin: Facing the issues* (DPEC 2000a), directs attention to environmental factors and states, 'environments also play a critical role in shaping adolescent behaviour, as shown by risk and protective research'. The DPEC identifies risks associated with 'transition and mobility', 'low neighbourhood attachment' and 'poverty' all of which are closely associated with the operation of housing markets.

Similarly, the Australian National Council on Drugs (2000) in a submission to the House of Representatives Standing Committee on Family and Community Services Inquiry into Substance Abuse argued for:

> … a better understanding of the structural determinants, that is housing, employment, education, socio-economic status etc. for drug use, and approaching the issue as a whole.

In this respect, public health policy makers are focussing attention on a broader range of factors in the lives of illicit drug users. It is clear that housing is a key element in this broader approach.

2.2.2   Heroin use and homeless persons services

Perhaps the most influential stimulus encouraging policy makers to consider other factors in formulating drug policy responses is the growing demand being placed on homeless persons services by drug users. In 2001, the Department of Human Services in Victoria reported:

> Consistent anecdotal evidence from providers of supported and emergency accommodation and evidence from official statistics points to the significant proportion of young people in the homeless service system, and a cross-over between homelessness and drug use, particularly intravenous drug use (Tomaszewski & Edwards, 2001: 39).

In this respect, the increasing use of illicit drugs, including heroin, appears to be a factor in increasing levels of homelessness. The Ministerial Advisory Committee formed to develop the Victorian Homelessness Strategy identifies links between illicit drug use and homelessness. In its strategic report, the Committee notes:

> It has been conservatively estimated that people who experience homelessness and use homelessness services have prevalence rates of illicit drug use ten times greater than that of the broader community (VHS 2000: 3).

A consequence has been the changing nature of demand on services.

> Working with people with high levels of drug use is now core business for homeless person services. However, the capacity of homeless services to provide effective pathways out of homelessness for active drug users is being challenged by the complexity of their needs (VHS, 2000: 13).

It seems reasonable to assume that homelessness *prima facie* impacts heavily on a range of social factors affecting the heroin user's health, well being and access to social and economic resources.[2] In this context, there are good arguments for broadening the focus of drug policy-related research to understand better the role of appropriate housing in supporting people's wellbeing and capacity to access these resources.

2.3   The housing policy context

In urban Australia the 'good life' has traditionally been associated with home ownership. In the period after 1945, mass housing provision centred on young families in the private rental

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[2] See the following literature review for a concise discussion of how homelessness impacts upon other factors affecting the heroin users' life.

market moving onto owner occupation (Berry 2000; Dalton 1999). Citizenship and all the associated elements of social and economic opportunity had a housing dimension (Winter 1995; Greig 1995; Murphy 2000). In this context private rental housing came to be understood as a transitional tenure. Public housing up until the 1970s was also defined as a transitional tenure as a consequence of a mass sales program and relatively high rates of social mobility. In this context, workforce participation, educational levels, access to health and welfare services, and active engagement in political activity was associated with young families who started in the private rental market before moving on to purchase and outright home ownership (Davison & Davison 1995).

Since the 1980s housing patterns have been changing (Yates 1997, 1998, 1999; Winter & Stone 1999). The purchaser rate has fallen for all age groups and for all income groups but is most pronounced for low-to-middle income households. In the private rental market, the length of time in the rental market has been increasing, as has the age of people moving into the private rental market. This has led to a faster rate of growth of households in the private rental market. These trends have placed additional demands on the private rental market that have not been met by a commensurate growth in supply. The lowest income households have experienced the resulting shortage in supply disproportionately. Their problems are compounded by the short-term nature of leases and discrimination by landlords or their agents. Public housing, which is in short supply, has become a tenure for very low income households, a large proportion of whom experience significant social and economic disadvantage (Wulff & Newton 1994). There has also been a growth in homelessness (Chamberlain 1999).

Both overseas and Australian policy research indicates that housing tenure in combination with other factors (including employment status, income, education level and health status) come together to perpetuate social disadvantage and economic deprivation (Marsh & Mullins 1998; Musterd & Ostendorf 1998; Berry, 2000). Given evidence to suggest that long-term heroin users are likely to have insecure housing tenures, inadequate incomes and unstable employment (White, 1997) research is needed into the ways in which housing options affect the wellbeing of long-term heroin users. Our research provided an opportunity to address this gap.

What is the housing policy development context for considering the housing issues of long-term heroin users? The answer to this question has two parts.

First, there is now a body of recent research that provides a good understanding of the changes taking place in housing markets. Some contributions to this research were referred to above and further research, principally through the AHURI research program, is underway. This research has made it possible to relate the housing issues faced by long-term heroin users to housing policy research more broadly.

Second, policy responses to declining housing affordability have been limited. Burke (2001) describes the present policy context in the housing field as a 'policy vacuum'. He notes how public discussion of housing issues is limited to commentary on house price increases; grants for home buyers; and conflict around development in existing urban areas. He states 'There is little policy debate around housing, and even less leadership'. Possibly this will change. In 2002, for example, an intergovernmental policy development process met to consider the future of the Commonwealth State Housing Agreement. Further there are the research and the policy proposals of the Affordable Housing National Research Consortium (2001), put before both federal and state housing ministers and officials.

2.4   Policy Relevance – A whole of government response

It is clear that policy makers in both housing and public health sectors are recognising the existence of interconnections. In the housing sector, policy makers are considering how to respond to the relationship between illicit drug use and housing issues such as homelessness. In the public health sector policy makers, who have traditionally focussed on health and behavioural issues associated with drug use, are increasingly considering environmental issues including housing. This research will provide an opportunity to establish a shared analytical framework to inform policy development across these two sectors.

Central agencies are key players in the above policy process. At state level these are Departments of Premier and Cabinet and nationally it is the Department of Prime Minister and Cabinet.

In Victoria this has been evident since the development of the *Turning the Tide* drug strategy in 1996 auspiced and led by the Department of Premier and Cabinet and the subsequent development of working relationships across the law enforcement, health and education and training sectors. This work is continuing under the guidance of advisory bodies such as the DPEC. Indeed, as the DPEC has noted:

> The significant and growing impact of illicit drug use in our community provides a major challenge to organisations responding to the problem and to the Government in providing common and consistent support for those services (2000: 13).

The DPEC has also noted the challenge this cross-sectoral approach presents for future policy development. This committee has stressed the importance of cross-sectoral and cross-government coordination required for the management of the diverse range of programs necessary to reduce drug use and harm.

> The priority and resources afforded bodies such as the Drug Expert Policy Committee ensures their access to the highest levels of government. At the national level the Prime Minister has a direct role in developing government strategies. Currently the Australian National Council on Drugs (ANCD), established by the Prime Minister in 1998, is the peak advisory body to government on drug policy and programs.

3 LAYING THE FOUNDATION: RESEARCH INTO LINKS BETWEEN DRUG USE AND HOUSING[3]

3.1 Introduction

Drug and alcohol researchers have increasingly recognized the social context of drug use. For example, researchers have identified increased levels of drug use within areas of 'social deprivation', defined as areas characterised by such things as high levels of crime, poverty, unemployment, educational disadvantage and / or inadequate housing (Stimson 1992; Smart et.al., 1994; Williams, et.al., 1997; Bell, et.al., 1998; Davies, 1998; Lloyd, 1998; Venkatesh, 1999; Foster 2000; MacLean et.al., 2001; Neale 2001). In the following literature review we outline what researchers have identified as broader social and economic factors that shape the wellbeing and social opportunities of heroin users. We do so by referring to three primary research questions:

- In what ways, if any, do accommodation options affect the wellbeing and social experience of heroin users, taking into account such factors as age, gender and mental health status?;

- In what ways does current service provision for long-term heroin users address their housing needs?;

- What changes in current service provision and housing policies would improve the personal wellbeing and access to social opportunities of heroin users?

In order to establish what is known we review the research conducted in this area by examining the extent to which relationships have been found to exist between housing environment, illicit drug use and access to valued social resources.

3.2 In what ways do accommodation options affect the wellbeing and social experience of heroin users?

Despite growing research interest in the influence of the spatial environment as a determinant of drug use, few studies have paid specific attention to the impact different housing and accommodation options have on patterns of drug use. Most research into the influence of environmental factors has focused on 'social deprivation.' Writing in 1984 Nurco noted:

> Although there is widespread agreement among social scientists that drug abuse is merely a symptom of a more general syndrome of social malaise, relatively few investigations have sought to answer this question directly. Exceptions to this statement include the pioneering research of Chein, Gerard, Lee, and Rosenfeld (1964) and the more recent study by Nurco (1972). Both investigations, despite differences in location scope, and methodology, concluded that narcotic addiction is most prevalent in those geographic areas characterised by deprivation and crime as well as by other indices of social and personal upheaval (1984: 442).

Our project has narrowed the research focus by identifying the day-to-day influence of housing environment. We have used the relatively few research reports that have sought to establish links between 'marginal' or 'inadequate' housing and patterns of drug use. We will also make use of the significant body of research documenting the relationship between the *absence* of accommodation (i.e. homelessness) and drug use (i.e. Adlaf et.al., 1996; Diaz et.al., 1997; Klee et'al., 1998; Morse, et.al., 1998). We have done this by examining the research for, 'private accommodation', public housing, rooming houses and homelessness.

3.2.1 Private Accommodation

It is important to recognise that although the use of heroin is a 'classless' phenomenon it may be more visible in different contexts. Indeed, neither large nor small-scale studies have shown disparities in the incidence of drug use on the basis of ethnicity, socio-economic status or

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[3] This is a summarised version of an earlier literature review. The full version is contained in this research project's Positioning Paper, published online at http://www.ahuri.edu.au/attachments/pp_heroinusers.pdf

population density (Saxe, et.al., 2001). This also appears to be the case in a number of epidemiological studies in Australia that have reported on heroin use among middle and upper 'class' professionals (DCPC, 1997). The 1997 'Fitpack' study of injecting drug users conducted by Curtin University in Western Australia found that seventy percent of respondents were employed, most in full-time positions (Middleton, 1997). However, middle and upper-class substance use is more easily concealed and is less accessible to researchers. The privacy and security afforded by such drug users simply means that their activities occur behind closed doors and are, consequently, less likely to attract unwanted attention. This does not mean that drug use is less prevalent among the financially secure. Indeed, ethnographic studies in the United States uniformly report that middle class whites venture into poor African American neighbourhoods to buy drugs (i.e. Williams, 1992; Riley, 1997).

3.2.2   *Public Housing*

> Residents had learned to tolerate a certain level of drug use. However their tolerance levels have been far exceeded and there is widespread concern about drug use and dealing … Dealers are active all over the flats. If residents move to other public housing to escape the drug scene, they face the same problem. (Guinness 2000: 16).

Recent research reports have documented the increases in drug-related activity on public housing estates in Australia (Heinrichs, 1995; Digney, 1999; Guinness, 2000). There is evidence that, following saturation policing on a visible street-level drug trade in inner-Melbourne in mid-1998, Melbourne's heroin trade has become further entrenched in the less visible confines of the housing estates (Fitzgerald et.al., 1999). In Digney's (1999) study of the North Richmond Housing estate, residents spoke of dealers living on the estate, of drug users injecting in stairwells, lifts and laundries, of drug use and dealing inside a nearby public school, and of children being offered drugs and being asked to carry drugs for dealers (Digney 1999).

International research also documents higher rates of drug use in public housing estates when compared to the broader general community. Inner-urban housing estates in the US, for example, are notorious for a thriving and violent drug trade (Venkatesh, 1999; Vergara, 1992). Similarly, studies of housing estates in the United Kingdom report endemic illegal drug activity (Foster 2000; Davies, 1998).

Why is public housing, and especially high density public housing, so susceptible to illicit drug activity? Public housing estates, particularly those in the US and the UK, have been identified as 'catchment areas' for low-income residents beset by crime and poverty (Williams, et.al., 1997; Davies, 1998; Venkatesh, 1999). Writing about the Blandon housing estate in England's north, Foster (2000: 318) documented:

> Drug abuse and crime combined with a debilitating range of other social problems, high levels of truancy, poor health and pervasive unemployment … Housing staff felt under siege, reticent and sometimes fearful of encountering difficult and potentially volatile tenants … exclusion and desperation were very much in evidence.

Although Williams et.al. (1997) acknowledge that few studies have examined whether these conditions affect 'drug abuse risk status', they cite studies (McLloyd, 1995; Hawkins, Catalano & Miller, 1992) that suggest public housing residents are at increased risk of 'poor behavioural outcomes'.

Researchers have documented similar levels of disadvantage on Australian housing estates. A study by McDonald and Brownlee found that, compared to the 'average' Australian suburban family, those in public 'high-rise' accommodation experienced 'a high concentration of disadvantage' (McDonald & Brownlee 1993: 15). In Digney's study of the North Richmond estate, just 13 per cent of residents reported a private income, the great majority being reliant on government benefits for their survival (1999). Indeed, eligibility requirements for public housing mean that this composition is inevitable.

To these problems we should add problems of stigma. Housing-estate residents have to put up with widespread perceptions that their housing estates are 'drug ghettos'. Residents

themselves complain of the vandalism, graffiti and litter that compromises any sense of pride or respect (Digney, 1999: 18). The stigmatisation of public housing estates as centres of crime, poverty and drug use simply adds to the problems faced by many occupants of these estates. For example:

> The filthy Collingwood, Fitzroy, North Richmond and Carlton tower blocks are littered with syringes and house dozens of drug users, dealers and prostitutes. Terrified residents say they are too scared to report the myriad crimes committed on the estates. They fear cooperating with police will bring violent retribution from the criminal gangs flourishing in and around the blocks ('High Rise Hell' Herald Sun February 4, 2002).

One consequence of the drug trade and the stigmatisation that accompanies it is that public housing, the only form of low-income housing in places such as inner-Melbourne, is becoming a wasted resource as those in need of housing are refusing vacancies out of fear (de Kretser, 2002). This is illustrated by the rate at which prospective tenants reject offers of housing on inner city estates in the City of Yarra in inner city Melbourne. In the March quarter of 1999, when the heroin trade was at its height, acceptances, as a percentage of offers, for the three high-rise estates in Yarra were 17 per cent (Collingwood),19 per cent (Fitzroy) and 50 per cent (Richmond).

Figure 3.1: Public housing offers and acceptances, City of Yarra (March 1999)
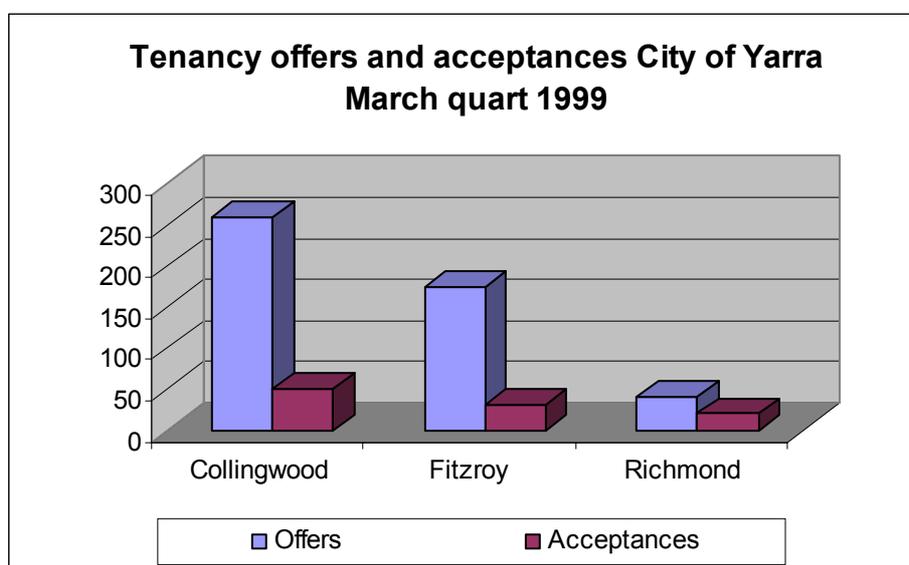
The concentration of deprivation and drugs within a confined housing environment increases the risks of drug use and indicates the intertwining of problematic drug use and selling within the broader context of access to adequate housing. It also emphasises the fact that the simple provision of shelter is not, of itself, a means of enhancing social opportunity. Placing a heroin user in an environment in which drugs are readily accessible is not a solution, something with which the non-drug-using residents of public housing would doubtless agree (Digney, 1999; Guinness, 2000).

3.2.3   Rooming Houses

Drug users unable to obtain permanent private or public housing sometimes take residence in private rooming houses. This accommodation is less than ideal, given the lack of professional support and management that problematic drug users may require. A number of lower income rooming houses have been found to be unsafe and unhygienic (Neale, 2001; Jope, 2000). Furthermore, there is often a high incidence of drug activity that occurs in such premises (Neale, 2001). This suggests that heroin users may have difficulty managing patterns of drug use in this form of accommodation

There is evidence of a declining availability in rooming house accommodation. In the City of Yarra in inner-Melbourne, once home to a concentration of rooming houses, the demand for single, affordable accommodation far outweighs demand (Jope, 2000). In the 12 month period

from July 1998 to June 1999, 3,527 individuals sought housing with Yarra Community Housing. Of these only 8.9 per cent were able to be accommodated (Jope, 2000: 23). This increases the danger of homelessness. As Maher et.al. (1997: 68) noted:

> Loss of boarding and rooming house accommodation leads to increased demand for night shelter and emergency accommodation. Persons displaced from boarding houses tend to end up homeless, on the street or in informal arrangements, which may be overcrowded and insecure.

3.2.4   Homelessness

Homelessness lacks an agreed definition in the research literature. Popular perceptions are often dictated by personal observation of those 'sleeping rough'. The reality is that a far greater number of people are living with friends, or using temporary shelters and refuges. Chamberlain and Mackenzie (in House of Representatives Standing Committee on Community Affairs, 1995) distinguish between three levels of homelessness:

- **Primary homelessness** – This refers to people without conventional accommodation, such as people living on the streets, sleeping in parks, squatting in derelict buildings, or using cars for temporary shelter;

- **Secondary homelessness** – Is the experience of people who move frequently from one temporary shelter to another. Those experiencing such a degree of homelessness would include hostels and night shelters, refuges, and those staying temporarily with friends or family, or those using boarding houses on an intermittent basis;

- **Tertiary homelessness** – Is the lifestyle of people who live in boarding houses on a medium to long-term basis. Such residents are often without 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.

We have used Chamberlain and Mackenzie's understanding of homelessness.

For *some* people drug use may be a precursor to homelessness, causing irreconcilable tension between household members or consuming income that could be used to meet accommodation costs (Johnson et.al., 1997). However, this is an inadequate representation of the relationship between homelessness and substance abuse. For many, drug use may begin as a means of coping with being homeless (Neale, 2001). The long-term effects of homelessness can include poverty, hunger, health problems, unstable relationships and difficulty accessing and maintaining employment (Baron, 2001). Furthermore, as Klee and Reid (1998) note, the potential isolation, lack of privacy and the attitudes of the general public can be particularly damaging to the psychological health of homeless persons. For *some*, these circumstances may increase the attraction of drug use as a form of self-medication. A study of 200 young homeless drug users by Klee and Reid (1998) found 71 per cent had self-medicated with drugs for depression, 23 per cent for aches and pains and 15 per cent for insomnia. A recent qualitative study by Neale (2001) found that drug taking helped to fill the time and diminish the physical and emotional pain of being homeless.

A further *potential* link between homelessness and drug use is that drug use offers a point of entry into groups of homeless people (Horn 1999). The presence of drug-using peers provides users with the means of negotiating street networks to find support. Kipke et.al., (1997) suggest that the use of drugs for the above reasons can mitigate against homeless youth seeking treatment, preferring the use of drugs to the 'cold reality of life on the street'.[4]

Regardless of whether homelessness or drug use came first, a variety of research has consistently found that the proportion of homeless young people who use illicit drugs is significantly higher than that of the general population (Howard & Zibert 1990; Brown 1991; Doyle, 1993; Groenhout, 1994; Forst, 1994; Stahler & Cohen 1995; Kipke, et.al., 1997; Horn, 1999; Morse et.al., 1998; Slesnick, et.al., 2000; Nicholson, 2001). In April 1996, a survey by Hanover Welfare Services of its client group reported that people experiencing homelessness

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[4] For further discussion of this issue, see Norden (2001) 'Heroin use as a form of self-medication' in *Pathways: Causes and Consequences: Problematic drug use and homelessness* 14(8)

were 7.5 times more likely to be 'heroin dependent' than the general community in Victoria (Horn, 1999). Furthermore, Hanover CEO Tony Nicholson noted:

> In the past three years, heroin addiction amongst Hanover's clients has increased by 40 per cent to the point that they now have a prevalence rate of heroin addiction 10 times greater than that in the general community (Hanover Welfare Services, 1999).

Homelessness represents an extreme form of social disadvantage. The lack of a fixed address often prevents individuals from accessing health and welfare services, finding or keeping a job and many amenities which most Australians associate with a desirable standard of living (Seddon, 1998). Indeed, studies have found that the lifestyle associated with homelessness greatly exacerbates problems associated with drug use (Rogers, 1992; Groenhout 1994). As Doyle noted:

> Heavy illicit substance use can take over one's life. Making money, whether from property crime, muggings or prostitution, can be a full-time occupation. Homeless young people can be further marginalised by what they (must) do to obtain their drugs of choice … (1993: 8)

In addition, the poor self-image and the problems in living that often accompany a transient lifestyle increase the tendency towards drug-using behaviour that puts individuals at risk of disease and / or sickness. As Matthews et.al. (1990) note, given the orientation to the present, when one's bottom line is survival, homeless people may find it difficult to focus on potential health problems which may not kill them for years to come. Needle sharing, for example, may occur among people who inject heroin and who lack the ability or motivation to plan ahead, who are unable to keep quantities of sterile injecting equipment in a safe, secure place, (Rogers, 1992). A 1998 study of 900 young homeless persons, found that 20 per cent had shared needles at some stage (Walsh, 1998). In spite of such alarming figures, the situation could, conceivably, be worse.

Lack of secure, stable housing can have a big impact on heroin users. Not only is the homeless person more susceptible to problematic drug use, but they are susceptible to chaotic and dangerous drug using practices. In the next section of the literature review we examine the response of service providers to the accommodation needs of heroin users.

3.3 In what ways does current service provision for heroin users address their housing needs?

There are no services, beyond specialist clinical services, provided exclusively for heroin users. Instead, a number of services exist for illicit drug users. VIVAIDS, the Victorian drug user group, and similar organisations in other states, act as advocacy groups for drug users. Others, such as Turning Point Alcohol and Drug Centre, incorporate a range of services that include outreach and advocacy to assist drug users to address a range of drug-related problems (Turning Point, 2001). Public servants, Tomaszewski and Edwards (2001) outlined a number of planned programs in Victoria with which the government would seek to address 'the underlying personal, social and structural factors which may lead to or exacerbate drug use'. However, despite these intentions, there are no initiatives that specifically address the housing needs of heroin and other illicit drug users.

On the basis of past research, the task of obtaining housing for a drug dependent person in Australia is a daunting one. This was largely due to abstinence based policies in emergency and refuge accommodation (Hirst 1989; Brown 1991; Rogers 1992; Doyle 1993; Groenhout 1994; Pritchard 1995; Hunter 1996). More recently, however, the urgent need for accommodation for homeless drug users has received attention as a result of programs such as the *Victorian Homelessness Strategy* and the increasing recognition of connections between an unstable housing environment and problematic drug use (VHSPT, 2001). As a consequence, some organisations have adopted a policy of 'no prejudice' when assessing potential clients. Such is the prevalence of illicit drug use amongst the young and homeless, that some have suggested that the continued refusal of accommodation would leave crisis

housing providers struggling to fill available beds and, consequently, struggling to attract Government funding.[5] Of 100 emergency accommodation services that responded to an agency survey in Australia, 92 per cent reported working with homeless young people with problematic substance use issues (Szirom, 2001). Government funded supported accommodation services are also increasingly providing drug support services to clients (AIHW, 2000). In this sense, both community and government accommodation service providers are beginning to address the needs of drug users.

In addition, existing models of drug treatment services are not designed to meet the needs of homeless people (Hogan, 2001; Slesnick et.al., 2000). The homeless do not have a place to stay while on waiting lists for treatment. They do not have contact addresses or phones and, consequently, cannot make the calls needed to reserve one's place on waiting lists (Henkel, 1999). A transient lifestyle is not conducive to keeping counselling appointments when individuals do not know where they'll be from day-to-day. Even drug substitution programs place barriers in the way of the homeless, most commonly through cost or travel requirements. A number of studies have evaluated the effectiveness of outreach interventions for the homeless (i.e. Fors & Jarvis, 1995; Kipke et.al., 1997). However, while these interventions were found to make valuable contributions, these were largely restricted to risk reduction (i.e. safer injecting practices, syringe distribution) as opposed to reducing drug use.

In this context, research has documented the need for secure and affordable accommodation for those seeking to address their drug use. As early as 1967, Dole and Nyswander noted that the most urgent problem for the discharged, detoxed heroin addict was housing (Dole & Nyswander 1967). Without an interim period of support and shelter, they argued that the recovering user will simply return to an environment without support and a peer network where drug use is an accepted practice. As Green (1999) has noted, without the shelter and support needed to address such problems, the vacuum that accompanies the removal of an all-consuming drug dependency would make the return to an 'accepting' group of drug users a strong attraction indeed.

As housing services and drug treatment services struggle to address the housing and health needs of dependent drug users without secure accommodation, it becomes increasingly obvious that a holistic policy approach that bridges both accommodation and health needs is required.[6] Too often the focus has been upon one area as concern. As Szirom (2001:29) argues:

> The service systems for responding to homelessness and drug and alcohol issues for young people have been developed over time to provide a single-issue response. When SAAP agencies seek the assistance of D&A or vice versa, the referrals between systems have been highly problematic due to waiting lists or a lack of immediate capacity to provide accommodation or treatment contributing to inappropriate, inefficient and ineffective referrals.

In this respect, the approach of service provision needs to change to allow both drug use and additional social needs to be addressed.

3.4 What changes in current service provision and housing policies would improve the social opportunities of heroin users?

Current service provision is clearly not adequate to address the needs of problematic heroin users lacking of secure and affordable accommodation. Jope (2000: 42) argues that problems of accommodation would be best addressed by direct investment in the provision of housing for those on low incomes. This includes both community and public housing. However, there is now enough evidence to demonstrate that the enjoyment of public and community housing by all tenants, whether they are drug users or non-users, can be undermined by the presence of drug-related activity. In Victoria, the State Government is committing $56 million to improve

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[5] Michael Horn, (Hanover Welfare Services) personal communication

[6] At the same time, the ability of some drug users to retain their housing despite their drug use, and the successful rehousing of a number of drug users despite lengthy periods of previous homelessness are important sources of hope and optimism.

security of high-rise public housing estates (Frenkel, 2002). However, few would suggest that such problems are easily solved.

This research project validates the need to link accommodation and drug treatment services in a more effective manner. To this end, new research and trial programs need to be initiated. Initial steps are being taken top meet this need. The three major providers of crisis accommodation in inner Melbourne – Hanover Welfare Services, the Salvation Army and St Vincent De Paul, in collaboration with the Victorian Government, are undertaking a trial to 'build pathways out of homelessness and drug dependency and towards secure accommodation and stable lifestyles' (Nicholson 2001: 7). One component of the trial will be trying to establish clear links between crisis accommodation services and appropriate forms of drug treatment and support services (Nicholson, 2001). In addition, the Victorian State Government is pursuing the establishment of measures such as Youth Alcohol and Drug Supported Accommodation Services to provide short-term support in a safe, *drug-free* environment. A 24 hour, 15-bed statewide residential program will complement these services, offering a range of interventions for young people whose established use of drugs is causing significant harm (Tomaszewski & Edwards, 2000).

Despite these initiatives, there is still the need for additional services. As Horn (2000: 10) stated:

> Whilst over the past three years, the Victorian Government's redevelopment of Drug and Alcohol Services has been successful in making detoxification and rehabilitation programs more accessible and responsive to those who are homeless, it has not matched the 60% increase in people who are experiencing homelessness and attempting to gain access to such services, leaving, according to Hanover's data, at least a third are missing out.

The DPEC has recommended the allocation of additional government funds to be directed towards prevention strategies and treatment reform, with particular attention paid to those involved in, *or at risk of involvement in,* heavy street usage. The DPEC recommendations highlight the need for greater research in these areas (DPEC, 2000a). In this respect, while there is agreement regarding the need for the different sectors to work together, there is a need for further information as to how this is to be achieved.

3.4.1   Conclusion

The nature of accommodation available to drug users has a clear capacity to influence patterns of drug use. Those in marginal housing environments or who are without accommodation are at far greater risk of developing problematic patterns of drug use. However, the experiences of those in public housing suggest that the simple provision of housing is far from an adequate response. It is only the provision of *suitable* accommodation that has the potential to improve the wellbeing of heroin users and enhance their capacity to make choices about social opportunities.

However, given the gaps in current service provision, those who are both homeless and drug dependent face numerous obstacles in addressing either of these issues. There is an acknowledged necessity for drug services and housing services to be better integrated so as to provide a holistic solution to these problems. This is far from a simple matter however, and a lack of understanding within both the housing and health sectors has greatly compromised past attempts to structure a more holistic policy response to these issues.

4 INVESTIGATING HEROIN USE AND HOUSING

4.1 Introduction

The research design developed for this research has two main features. First, the research sought to understand drug use, housing and broader social experience through a literature review, in-depth interviews with users, a survey of users and focus group interviews with service providers. No one research method was privileged over another. All sources and types of data were seen as important. Furthermore, the use of multiple research methods allowed for verification and confirmation of information and evidence gathered from a number of sources.

Second, because housing access and affordability is shaped by local housing markets and the past policy decisions of public housing providers, the research also required a spatial dimension. This led to the second feature of the research design, the choice of three research locations for interviewing, surveying and focus group discussion. This provided the basis for assessing and comparing the difference that local housing markets and public housing provision made to the connections between drug use and social experience.

4.2 Research methods

4.2.1 Literature review

The researchers first carried out a comprehensive descriptive and critical literature review of the international and national literature. Framed around the three primary research questions central to this research project this provided a basic understanding of the issues involved and exposed gaps in current research knowledge. A summary version of this literature review is presented in Chapter 3.

4.2.2 Ethnographic interviews

In the 12 month study period from July 2001 - June 2002, the six researchers engaged in a range of qualitative and 'ethnographic' research activities, from extended interviews through to systematic weekly field observations. Ethnography is an especially valuable approach in the research of populations who are 'hidden' or about whom little is known (Maher 2000). This is largely because ethnography searches for 'meaning'. It does not try to describe behaviour in objective terms or to provide causal or explanatory connections for patterns of behaviour. Ethnography is all about the researcher getting close to the field of social practice or interaction that they want to understand. In doing so, it relies on the researcher's capacity to make sense of what is going on around by using the 'others' tongue and meanings through a practiced ability to hear and understand what the other person is saying. As Feld (1990, x) has stated, ethnography, whatever form it takes, involves:

> … something at once empirically brutal and interpretively subtle … in the end the ethnographer's accountability for depiction is more than an accountability for representation: it is an accountability to other human beings whose lives, desires and sensitivities are no less complicated than his or her own.

Ethnographic interviewing makes the narrative of users presenting accounts of everyday life, including stories and vignettes, a central feature of the data collection (Finch 1987; Freeman 1993; Gubrium et al 1995; Riessman 1993). Because the emphasis was on narratives, interview preparation only went as far as a set of headings which guided our questioning around 'drug using career ', 'housing career', 'drug use and marginalisation', 'income', 'treatment', 'friend and family networks' and 'education and training' (See Appendix 2). A variation on the interviews was a focus group of heroin users convened through VIVAIDS where the group was invited to discuss these issues in a more interactive way. Afterwards it was the reading and re-reading of 47 interview transcripts, from interviews that usually ran for an hour, and the user focus group transcript, which provided a basis for identifying themes and issues. In particular it provided a way of better understanding patterns of sense-making and explanations offered by the users to represent their understanding of connections between choice and constraint in their lives around their use of drugs, obtaining income,

finding and using housing, friends and relationships and use of services, especially health services.

Prior to beginning the ethnographic interviewing two key issues around selection of participants were identified and clarified.

First, we decided that we were researching the drug use, housing and broader social experience of users who need and use services, are members of broader user networks and who were willing to be interviewed. In other words, our participants were likely to have experienced difficulty in finding secure and affordable housing and were associated with services with organisational histories and cultures shaped by broader policy and program governance arrangements. We were clear from that outset that the study would not present data and research findings drawn from a 'random sample' of heroin users. A 'random sample', even if the participants could be recruited, would be drawn from the across the income range and a large proportion would be well established home owners with no experience of housing market disadvantage.

Second, we developed a position, based on discussion with service providers and the literature, on the participant profile. In terms of age we aimed to interview users who were in their twenties and older. Our reason for this focus was that people, both non-users and users, under 20 years often lead lives characterised by mobility and experimentation sometimes described as 'chaotic'. In the case of users drug use is often an element in the 'chaos'. However, users entering into adulthood, like the broader population, establish more routine ways of living and become more focussed in their efforts to find secure and affordable housing. Because this study is primarily a housing study, the participants recruited for interviews and survey purposes were mostly in their twenties and older. Beyond the age variable recruitment reflected service provider judgements about the gender profile of user populations. This was important because, as the literature suggests, gender relations shape womens' housing affordability and access (Watson 1988; Cass 1991). Similarly the literature and service providers stress the importance of the interviewee profile reflecting the ethnic mix of people using services (Crofts & Louie, 1996; Thomas, 1998; Maher, Ho 1998; Maher 2000; Maher et.al., 2000; Higgs et.al., 2001).

Current and past heroin users were recruited in each of the three research sites using snowball sampling techniques based on advice from service providers, street and social networks and previous research contacts.[7] Interviews took place at a number of locations. These included the project office in Cabramatta, a needle and syringe program in Smith Street, Fitzroy, at Barwon Health Services in Geelong, in public places where participants felt comfortable (i.e. a MacDonald's restaurant) or in people's current housing.

In-depth interviews, using a theme list, ranged in length from twenty to one hundred minutes and participants were paid $20 for each interview. Questions were designed to collect basic demographic information and explore participants' housing-related experiences with the opportunity to discuss other relevant issues arising during the course of the interview. The primary areas of interest included:

- 'Housing career', particularly over the last few years;
- Circumstances associated with drug use and leaving home;
- Experiences with emergency accommodation;
- Experiences with the private rental sector and public housing;
- Homelessness;
- Community attitudes towards heroin users; and
- Income.

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[7] In Cabramatta-Fairfield, for example, Lisa Maher (Maher in press; Maher, et.al 2001; Coupland et.al., 2001; Maher (2000); Maher et.al., (2000) Maher & Dixon (1999), Maher & Ho (1998); Maher et.al. (1998)), one of the principal investigators in this project, has carried out a sustained and ongoing presence over the past decade.

Tape-recorded interviews were transcribed verbatim and data analysed (by reading and re-reading) for content and identification of emerging themes. Needless to say all of the people we interviewed have been assigned pseudonyms and, if necessary, identifying remarks have been altered or removed altogether.

Throughout the course of their interviews, heroin users told us a great deal about their public and private lives. We learnt about their views on drug use, their hardships especially around housing, their routines, families, friendships, love, fears, joy and despair and much more. We also learnt about their aspirations for the future which sometimes included continued use of drugs and sometimes abstinence.

4.2.3   Survey

Following an initial analysis of the interview narratives a survey instrument was designed and used to further understand social experience especially in relation to private and public rental housing, squatting, crisis accommodation, and sharing with friends. Survey participants were recruited via the same means as those people we interviewed. The survey instrument elicited data from 130 heroin users across the three study areas. It focussed on housing histories, income and further explored the relationships between the degree and duration of heroin use and experiences of different forms of housing and homelessness. Analysis of the survey material is presented in the body of the report and further detail is presented in Appendix 1.

4.2.4   Service provider focus groups

Focus group discussions were held with four groups of service providers. In each of these focus groups service providers were invited to discuss issues associated with heroin use and the issues confronting service providers. In particular they were asked for their views on the housing needs of heroin users and the challenges that heroin users posed to service providers especially those with responsibility for housing provision. A general running sheet of focus group questions is contained at Appendix 3. The composition of these groups were developed around the categories of public housing managers; private rental market managers; crisis accommodation and housing advice service workers; and health service providers.

A focus group was held in the City of Yarra on 13 December 2001 with nine service providers. Participants were:

- 2 community service organisation public housing support workers;
- 2 Housing Officers from the Inner City Area Office of the Victorian Office of Housing;
- A City of Yarra Housing officer;
- A Victoria Police officer;
- A representative from the Yarra Drug and Health forum which regularly meets with service providers and organisations to discuss local drug-related issues;
- A representative from VIVAIDS (Victorian Drug User Organisation)

A focus group was held at Liverpool in western Sydney on March 22nd 2002 with seven service providers. The participants were:

- 3 Housing officers from the New South Wales Department of Housing, including a specialist public housing support worker based in Western Sydney, the acting area manager for the Liverpool-Fairfield area and a project manager;
- The president of the south-western Regional Tenants Association;
- A youth development officer employed by the Supported Accommodation Assistance Program (SAAP);
- A senior education officer with the Drug Intervention Service Cabramatta
- A NSW Police officer

A second focus group was held in inner-Melbourne in September 2001 with three workers at the Women's Drug and Alcohol Service (formerly the Chemical Dependency Unit) at the Royal Women's Hospital in Carlton. This was held to gain further insight into the specific needs of

pregnant and homeless drug users, which a number of young women discussed in a number of initial interviews. Participants were:

- A drug and alcohol clinician from the Drug and Alcohol Service;

- A midwife from the drug and alcohol unit from the Drug and Alcohol Service;

- A midwife / drug and alcohol counsellor from the Drug and Alcohol Service;

A focus group was held in Geelong on 20 September 2002 with six service providers. Participants were:

- The Supported Accommodation Assistance Program worker with Barwon Health Drug Treatment Services;

- The Housing Support Coordinator with the Barwon Region Office of Housing;

- A worker with the Homeless Outreach Mental Health Service;

- A Victoria Police Officer based in Geelong;

- The accommodation manager from BAYSA (Barwon Association for Youth Support and Accommodation);

- An academic from Deakin University with significant research experience of the Geelong drug market.

During the course of the service provider focus groups we were directed by participants to a number of program development documents circulating within their departments. These documents, particularly those within the New South Wales Department of Housing and the Victorian Office of Housing, provided useful additional discussion of problems and current thinking around program development.

4.3   Research locations

The three locations for the research were inner city Melbourne, Geelong, a Victorian provincial city, and Fairfield in the south-western suburbs of Sydney. The rationale for selecting these locations was to relate the experience of illicit drug use to inner city, suburban and provincial centre housing markets. When we speak of accommodation options, we do not simply restrict these options to different forms of accommodation or housing. Instead, we consciously sought to include the different accommodation options that are made available by different housing markets and by the organisations that provide non market housing services. Inner Melbourne is an area of very expensive private housing reflected in very high house prices and rents and low affordability. The only low-income housing is found in public housing most of which is in readily identifiable estates of high rise towers and walk-up flats. In Geelong house prices are much lower resulting in more affordable owner occupation and private rents. Low income renters in Geelong have an effective choice between private and public rental housing. Housing in Fairfield on the affordability scale is between the inner city of Melbourne and Geelong. Each of these areas has a documented drug abuse problem and associated issues and a range of government and non-government organisations active in attempting to address the problems.

4.3.1   Inner City Melbourne – Fitzroy and Collingwood

The inner city areas of Fitzroy and Collingwood are adjacent to Melbourne's Central Business District. It is a gentrifying area with a substantial private rental market and public housing supply in which high levels of social and economic disadvantage are evident. Indicators demonstrating this are high levels of mobility; a high proportion of households on low incomes; a low rate of home purchase; high rate of unemployment and underemployment; a lower than average proportion of Australian born in the population; a higher than average proportion speaking a language other than English; and a significant number of people in group households. In this area the only affordable housing for low and moderate income households is public housing concentrated in a small number of highly visible estates (Hartley and Anderson 2000).

This area has a large number of human service agencies including emergency housing (10), services to Aboriginal peoples (7), children's, family and youth services (64), employment and ethnic services (43), legal services (2), and generalist health and welfare agencies (31). As an area with a major drug problem it is also not surprising that these agencies are having to accommodate people seeking to access their services many of whom are also long term heroin users (Hartley and Anderson 2000). Given the large number of agencies which are currently providing a wide range of support services to the residents of Fitzroy and Collingwood, it would be useful to establish if the quality of their service delivery to clients who are using heroin on a long-term basis could be improved if more was known about the linkages between housing provision and heroin use.

4.3.2 Geelong

The City of Greater Geelong is 75 kilometres south-west of Melbourne and is the second largest population centre in Victoria with a population of 146,000 in the urban area. The City includes the hinterland areas of Lara and the Bellarine Peninsula where there are a further 29,000 people, making a total of 175,000. The population increases to 265,000 at peak holiday times, with a number of coastal townships doubling in population. Overall the population is projected to continue growing at between 0.5% and 1% per year. The population is relatively young with 71% of the population under 50; 36% of the population is in the 15-39 age group. The majority of needle exchange users are in this age group. The unemployment rate in the area is 7.9%. Youth unemployment rates are at least double this figure and the area has a lower than average apparent Year 12 retention rate of 67%. The index score for participation in higher education is well below the Victorian average (KPMG Consulting 2000, Department of Human Services 2002, City of Greater Geelong 2002, Miller 2000).

The City comprises almost 79,000 dwellings with an average occupancy of 2.6 residents. 74% of residents own or are buying their home. Three per cent of households live in public housing while 18 per cent live in the private rental market (KPMG Consulting 2000) A good reason for choosing Geelong as a location for this research is that it has a private rental market where low and moderate income households can find affordable housing. It is considered to have a 'functioning' private rental market. This will provide an opportunity to explore what difference available and affordable rental housing might make in the lives of heroin users and their capacity for making choices about social opportunities.

The Human Services infrastructure is quite complex, with a number of funded and private service providers. There are 23 major funded providers. Thirteen of these agencies provide a mix of services, some providing services to the larger sub-region or region. Within the Geelong region, the majority of drug treatment services are provided by Barwon Drug Treatment Services. In addition to this, there are a number of community-based organisations that provide treatment for heroin users (such as the Salvation Army and Crossroads) (Miller 2000).

In response to community concern, the City of Greater Geelong has adopted a Drug Action Plan in partnership with a range of community agencies and interest groups. Following the adoption of the plan the Geelong Advisory Drug Committee was established with responsibility for advising on the implementation of the plan through developing agency networks and new projects. It has done this through such initiatives as a services directory, an interagency protocol and training on environmental design issues (Human and Cultural Services 2001)

4.3.3 Cabramatta/Fairfield, South Western Sydney

Cabramatta is a large, ethnically heterogeneous suburban centre in South Western Sydney. It is part of the Fairfield Local Government Area (LGA), which has the second highest concentration of young people (aged 12-24) in New South Wales. Fairfield LGA also has the highest number of overseas migrants of any local government area in Australia, and the most diverse ethnic community. Sixty-one percent of young people in the area speak a language other than English and almost half (46%) were born overseas (compared to the state average of 16.7%). While unemployment in the area is generally higher than the state average, it is endemic amongst some groups - notably young people and the Vietnamese, Lebanese, Cambodian, Chinese, and Aboriginal and Torres Strait Islander communities (Maher et al. 1998; Berryman and Finch 1999).

Since 1975, approximately 180,000 thousand former residents of Vietnam, Laos and Cambodia have made Australia their home. Cabramatta is an important nucleus of commercial and cultural life for these groups. However, the suburb also has the dubious distinction of being Australia's "heroin capital" and, despite sustained and intensive policing efforts, continues to host a vibrant street-level heroin market. During the last five years, heroin use has emerged as a major health and social problem in the area (Maher et al 1998).

The expansion of the heroin market has been accompanied by an increase in associated harms, including crime, street prostitution, disease and homelessness (Coupland et al. 2001). Earlier this year, a group (Accommodation for Drug Users) was formed to advocate for housing for homeless heroin users in the area. Comprised of representatives from the NGO/community sector and government departments, the group has enlisted the support of local council and the NSW Premier's Department (Maher, Dixon, Hall and Lynskey (1998)).

Housing provision in the City of Fairfield in terms of tenure is, like Geelong, close to the national average with 65 per cent in owner occupied housing, 22 per cent in private rental and 8 per cent in public housing. The public housing in this municipality is in the main provided in large suburban estates. There is very little public housing in the Cabramatta area. Most of the rental housing in this area is provided in the form of one and two bedroom flats which replaced detached suburban houses on large blocks of land in the period of the late 1960s and 1970s (Berryman & Finch 1999).

5 'A VERY STABLE LIFE STYLE': A PORTRAIT OF HEROIN USERS, 2001-2002

5.1 Introduction

Over the space of a year, the six members of the research team spoke with forty seven people who use heroin, (or methadone / buprenorphine)[8] on a more or less regular basis. We talked with them in three quite different places, the City of Yarra and the City of Geelong (in Victoria) and the City of Cabramatta (in New South Wales). Here we offer a kind of collective portrait of these forty seven people based on these interviews. At the same time, we demonstrate that constructing a collective portrait of a 'group' of people who share one distinguishing attribute – in this case their use of heroin – is a difficult undertaking. It would certainly be a mistake to presume that due to this single attribute, all heroin users share a common personality or lifestyle.

While many in the group started using heroin in their teen years – some as young as 12 – others did not start using until their mid-thirties. Some reported experiences of violence and abuse inside their families while others reported a stable, happy family background. Some were using heroin daily while others had been clean for a number of years. We met people who had spent too many years in jail and others with no experience of crime.

From this group of people we heard very diverse stories about their lives as heroin users and their relationships and experiences as sons or daughters, as brothers or sisters, or as parents themselves. Some, for example, haven't told their parents about their drug use at all. Some have told and have been accepted by their parents while still others tell and are rejected.

In each case there are complex histories of relationships and responses to the ordinary vicissitudes of modern family life, from parental conflict through to issues with unemployment and poverty and the need to deal with emotional stress and ill-health.

Our primary interest in the conduct of this research was in establishing how different kinds of housing intersected with heroin use. In this context, it is important to recognise that some of those people we spoke with lived in rapidly changing accommodation options. For example, one young man we spoke to in Yarra had been evicted from a Church-run emergency shelter just the day before we met him. He had only that day found alternative accommodation in the form of a nearby squat. Likewise, we interviewed Mike only hours after the squat that he and several others shared had been closed down, its entrance reportedly chained and locked by police. In Cabramatta, one young Australian-Vietnamese man, currently in rental accommodation with his girlfriend's family, could recall at least five changes in his living arrangements over the past six months.[9]

We owe a great deal to those people who talked with great candour about their lives.[10] Like many other ordinary Australians, the people we spoke to do not always live in easy or happy

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[8] Buprenorphine is increasingly being used as an alternative to methadone maintenance treatment. Buprenorphine is a partial agonist (chemicals that bind to and stimulate opiate receptors in the brain) and partial antagonist (chemicals that bind to opiate receptors without stimulating). Accordingly, while buprenorphine produces similar effects to heroin, it does so to a lesser degree. Buprenorphine is thought, by some, to be preferable to methadone because it is released more slowly than the latter, producing a longer lasting effect and allowing it to be taken every second day as opposed to every day. Furthermore, some studies have suggested that withdrawal from buprenorphine is less severe than methadone withdrawal.

[9] This 25 year-old Vietnamese-Australian male went to live with his girlfriend's family but this relationship ended within a few months. Juan got a job working in a laundromat and started sharing a flat with an old man in Merrylands. However he was asked to leave after a few weeks when he lost his job. He started living on the streets of Cabramatta and in an abandoned car with a friend who had just been released from gaol. He stayed overnight in his parents' restaurant on a few occasions and went to stay with friends intermittently. He eventually reconciled with his girlfriend and went back on methadone and is currently living with his girlfriend's family once again.

[10] The level of candour was generally very high, especially given the intrusiveness of many of our questions. However, participants may, for their own reasons, have chosen to withhold information about themselves. In one

circumstances. In this case, their difficulties may be exacerbated by their use of heroin, a substance which is illegal and subjected to a wide array of public stigma and moral opprobrium, a fact which they are all too keenly aware of.[11]

5.2 Who are they? Identity as a heroin user

At the point we met them, most of forty seven people we spoke to were continuing to use heroin. Those who were not currently using had ceased to do so quite recently and were either on a methadone or buprenorphine program and / or had entered detoxification. While some had varying levels of heroin dependency, others used infrequently or recreationally.

In Yarra, fourteen of the people we spoke with said they were currently using heroin (the remaining two were on a buprenorphine program). Among participants in Yarra, patterns of use varied widely. Some participants were spending upwards of $300 a day on heroin while others were using once a fortnight.

The Geelong cohort had the lowest incidence of active heroin use. Only three of the Geelong participants reported current heroin use when we spoke with them. Alternately, seven of the group were on a methadone program and another five claimed to be completely clean.

In Cabramatta, the majority of participants were using heroin at the time of interview (although participants' patterns of drug use varied during the study period with some entering treatment and others relapsing to heroin dependency).

How did heroin, in effect, figure into the identity of those people we spoke to? In what follows we have adopted a discursive approach to give an identity to our participants, specifically in relation to the one common characteristic they share – the use of heroin use.

For many, their use of heroin allowed their identification as part of a network of friends and associates who used drugs. For Rob, it was friends and associates that made up the landscape which, as he put it, '… is like a small country with big highways'.

Ade, a long-term squatter in Yarra spoke about the sense of community among the squatting community:

> There is actually a good community feel about this place and especially in the subculture. It's quite tight knit, and pretty much everyone knows everyone. Personally I've only been in this area for five or six years and I definitely know a good few hundred by sight that I know are users and are in an unstable housing situation.

Indeed, for some, being free from drugs threatened to remove this sense of community and with it, their own sense of who they were. Nineteen-year-old Ben, for example, recently became 'clean', a step that had left him in fear of being alone:

> My big fear is that I am alone now. I don't do drugs so I don't have friends and I find it hard to be friends with people who are straight but I have been straight now for two months.

For others, the use of heroin was the cause of much personal introspection. Sara, who we spoke to in Yarra, succinctly summed up her experience with an intense reflexivity about the inherent aridity of her life - and of so many others who engage in any joyless, repetitious and habitual pattern of life broken by brief moments of joy.

> It is just a really quick fix. A quick rush of joy… It is a full time occupation being a junkie like me. You don't have to think about what you are not doing, because you don't have time, because it is actually quite time consuming. I think it is so weird

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case we learnt inadvertently that a young woman had chosen not to disclose that she was pregnant. This was something that we discovered only from her partner.

[11] Ethics approval for the project was granted by the University of New South Wales Humans Research Ethics Committee for the Cabramatta project and by RMIT University for the Yarra and Geelong studies. In addition ethics approvals were obtained from health authorities in Geelong given our recruitment through 'Barwon Health' facilities in that area.

that so many people do this, and they don't like what they are doing. They are just passing time like everyone else only they are doing it their way. Like it wouldn't be so stupid if everyday you could open your cupboard, and you had your drug there, because you could still do everything else. But it is stupid when you wake up in the morning, and it is the first thing you think about, and you actually have to put everything in mind and you go through all the steps to get it and when you finally get it, you have to start all over again.

In contrast, Sven drew the parallels between heroin use and working in ways that valorised the analogy by alluding to the value that having a job is a good thing:

It's been part of our life kind of thing – going out there making the money – it's like an everyday job. Junkies aren't lazy people you know. It's like an everyday job. We wake up in the morning at a certain time – we try to be home at a certain time - we've got other people we do business with, people we see everyday that we sell things to. It is like being in wholesales in chocolate and razor blades.

Most of the people we spoke to distinguished between themselves and 'junkies'. For example, Mike described junkies as:

… someone who steals and rorts and god knows what, anything to get money. I don't do that …

Apart from the idea that their need for income overrides any other moral impulse, 'junkies' are marked by the fact that their heroin use is out of control. Mia, for example, conceded that 'the heroin was in control'. Junkies were desperate people who, interestingly, drew as much hatred from 'respectable' heroin users as they often draw from the tabloid media. Josephine, a self-described sex worker and 'addict' provided the following distinction:

It's the junkies that are making it hard for the addicts to make a fucking dollar. Where you used to be able to sell anything hot for a third of the price, you're now lucky to get half the price for what it's worth in the shops. Say you've got something for $350. You're flat out selling it for $50 to these cunts because the junkies are fucking saying, 'oh, I'm hanging out, I'll give it to you for $20'.

Carla was quite clear that she had been a 'junkie' at various points especially after the heroin-related death of her husband, an event that sent her 'ballistic':

I was a junkie, had no morals, no pride, nothing, you know what I mean. Didn't care who I ripped off, you know and I was scum you know…

In Geelong, Jim, a schizophrenic, thieved from cars to feed his heroin use. He has been in prison for a total of two years and two months and acknowledged that his heroin use had introduced him to crime. In this respect, his heroin use had impacted substantially upon his future life opportunities. In effect, his heroin use had contributed to a criminal identity.

We done a burg and we were about to sell the stuff for heroin and the police pulled up from behind and at the front, and threw us out of the car and anywhere else … Anyway I got charged. The 12 months sentence was a one off thing because I never usually do house burgs. This one time me mate just sort of talked me into it and it sounded good. We were getting a half a gram, so, you know, it sounded good.

Alternatively, for others, heroin use (along with the use of other drugs) was assimilated into a clearly delineated spiritual or political practice that offered an expansion of experience. Del, for example, observed that:

I was aware, using drugs, how much further my transient thought went and how I saw things and sort of came to understand things that I probably wouldn't have.

Alternatively, Dylan at 35 had a long history of involvement in a politicised anarcho-punk rock culture in which the use of drugs was an explicit political statement. An intense, energetic and highly articulate man he had been part of a brand of anarcho-community development politics since his time in Geelong in the 1980s beginning when:

… we rented above Griffith's Bookshop … the whole top floor was like a Geelong punk scene … it was probably fifty of us and we made up like, five different bands and we rented this as our club rooms… I was influenced by … the French Situationist movement in 1967 … and their critiques on society as a spectacle … At the beginning of the nineties we had a record label called Bent Edge which was a reaction to the militant Straight Edge movement which was' don't drink, don't smoke, don't fuck, don't take drugs'. We were the opposite and we would do all of the above and whatever else. We had the Bent Edge label and a half dozen bands and I was in a band called the Tooth Patsy… [Later] we took out a lease on a small warehouse in …Chippendale and we opened a club there called Jelly Heads and we had a restaurant called Feed the World… we had the Prisoners Action Group, gave them an office for their printing press and a they would print our newspaper… I was using heavily all the way through…

For most of those we spoke to, there was a shared belief or aspiration that 'one day' they would stop using heroin. As Mike put it:

I think people just naturally outgrow it. When there's no enjoyment anymore and its not doing anything for you. I haven't got there… not really.

For Mia, the fact that she was pregnant was helping to reshape her sense of the future. Her pregnancy seemed to offer hope as a circuit breaker:

I am actually having a baby and I have to get on methadone to save the life of the baby and keep the baby alive … I don't really want to go on methadone I despise the shit actually and if there was any other way I could do it, I would …

Drew, a 33 year-old ex-user with a long criminal past and significant jail time behind him connected with his use put the universal truth simply:

It is just not an option anymore. It is a hard thing though. You have to not want it. People say you go through all these rehabs and detox and stuff, [but] if it is not in the heart they are not going to succeed-that is all there is to it.[12]

Sharon displayed courage and resilience in making the decision to go clean. Indeed, it is a decision she seems to have taken as a matter of self-pride:

I just thought nobody else in this world is going to help you. I didn't want to be like my mother. I didn't want to be like my father. I watched my sister deteriorate and I couldn't handle it anymore and I just stopped. I didn't get on the methadone program because I had seen what it had done to everybody I just took heaps of pills and waited for it to cease … If I say something I have to stick to it because it is my word. I have nothing else and like there is nothing else so once I have said it, it has to be done. There is no way that I could keep on going.

Some, such as Rob, had accepted their involvement with heroin without sorrow or regret. Asked if he could see a time when he stopped, Rob considered the question before answering:

I can never say that I will never use. I can say that I won't use for periods of time, maybe even long periods of time. But that is like saying I will never get hit by a bus. You just don't know what will happen.

Similarly, Ade had incorporated his heroin use into his lifestyle and summed up his relationship with heroin in terms of the stability and purpose that it brought to his life:[13]

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[12] Unsurprisingly, the time he spent in jail (the longest stretch was 18 months) did not interrupt Drew's heroin use:

I did the Bendigo junk program … here they were thinking, I was the best bloke … I had to do the program to get the parole and that was Chief Justice Frank Vincent's sort of program … Here I am with him patting me on the back saying, 'you're a nice bloke' and 'you're a top fellow'. The report was really good, you can go home … and I had been getting a gram of heroin thrown over the wall every morning. Straight over the wall.

I've talked to quite a few doctors and people like that, and they'd say that the heroin using lifestyle is not very stable. I beg to differ. I think it's a very stable lifestyle. There's only one thing that you have to do every morning and that's get on and that's it. There's nothing else, nothing else even comes close. If you do that, you're fine.

For some, like Ade, the acceptance of one's heroin use has informed a desire to educate other drug users and to advocate on their behalf. It is this willing identification as a heroin user and a shared sense of responsibility that had led to the formation of organised peer-based drug user groups in Australia, both nationally and in each state and territory (Crofts & Herkt, 1993). These groups such as VIVAIDS in Victoria and the NSW Users and AIDS Association (NUAA) provide advocacy for drug users and input to policy makers. These organisations publish regular journals (*Whack!* In Victoria, *User's News* in New South Wales) and run active programs to benefit both users and the broader community. As Ade explained:

Both Finn and I are on a committee, working with VIVAIDS, to try and improve the whole using thing. Educate users and the [public housing] residents about correct disposal of syringes and stuff … It's all about education. Education and knowledge is an empowering thing, the more you know, the better off you'll be.

5.3 Who are they? Demographics

Despite their shared involvement with heroin, it is difficult to characterise the individuals we spoke to as a group. While there were some obvious similarities and differences between the clusters of people we were speaking to in Yarra, Geelong and Cabramatta, is it unknown whether these differences simply reflect the way we in which we met these people or whether they reflect real differences between these areas.[14]

In the following section, we have presented key descriptive demographic information, much of it in table form. This information provides a 'snapshot' of the sample characteristics at one point in time during the study period (time of interview).

5.3.1 Age and Gender

The interview sample ranged in age from sixteen to fifty-two years with the majority of participants aged in their middle to late twenties. The oldest person we spoke with was 52 (in Geelong), while the youngest was 16 (in Cabramatta). There were 22 men and 23 women.

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[13] As noted in Chapter 3, this is not an altogether uncommon experience. Researchers have pointed to the sense of purpose and meaning that the daily need for heroin can bring to the drug dependent person's life (i.e. Hogan 2001)

[14] Participants were recruited through different means at different research sites. Participants in Cabramatta were recruited primarily through street and social networks. In contrast, participants in Geelong and Fitzroy / Collingwood were recruited via a community health organisation, a needle exchange and a drug users union. For a brief discussion of how different recruitment sites can result in different sample populations, see Appendix 1.

Table 5.1: Age (in years) of participants

Area	Male	Female	Total
Yarra	10	6	16
Mean	28	25	26.6
Range	21-37	24-28	21-37
Geelong	7	8	15
Mean	29	31	30
Range	20-40	19-52	19-52
Cabramatta	6	10	16
Mean	25	24	24
Range	16-40	19-39	16-40

The groups in each of the three areas tended to be somewhat different in terms of average ages. In Geelong we met a somewhat older group, while the group in Cabramatta constituted a younger cohort.

Almost every participant was in some sort of a sexual and or long-term relationship. In Cabramatta two participants identified as gay or lesbian while no-one identified as gay or lesbian in the other two sites.

5.3.2 Ethnicity

The overwhelming proportion of people we spoke with were Australian-born. Only in Cabramatta were the majority of participants born overseas (n=9). This may have reflected the ethnic diversity of the area.[15] Overall, six participants were born in Vietnam, two in Cambodia and one each in Portugal, Italy, Germany and Britain.

Table 5.2: Country by birth

Area	Male	Female	Total
Yarra			
Australia	9	5	14
Europe	1	1	2
Geelong			
Australia	7	7	14
United Kingdom	-	1	1
Cabramatta			
Australia	5	2	7
IndoChina	4	4	8
Europe	-	1	1

In terms of ethnic identity most of the participants identified as Anglo-Celtic. Three Australian-born participants, all in Cabramatta, self-identified as 'Asian'. Although only a few people in Yarra and Geelong identified as having been born overseas (i.e. in Britain or in Europe), a

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[15] However, it may also have reflected recruitment methods. Like Cabramatta, the City of Yarra is home to a large IndoChinese community. However, no members of this community were recruited through organisational sites such as needle and syringe programs and community health centres. In contrast, recruitment through street networks was conducted in Cabramatta by researchers who had significant contacts with street-based Indochinese drug injectors.

few more laid claim to a European background, chiefly because their parents had been immigrants who spoke no English on their arrival in Australia. One person identified as mixed Asian and European background. Only two people identified as Koori.

Table 5.3: Ethnic self-identification

Area	Male	Female	Total
Yarra			
Anglo-Celtic	8	3	11
European*	3	2	5
Geelong			
Anglo-Celtic	6	8	14
Koori	1	-	1
Cabramatta			
Anglo-Celtic	2	1	3
Asian	5	6	11
European	-	1	1
Koori	-	1	1

*One of these people claimed mixed Singaporean and Irish descent

> Previous research has highlighted the problems confronting young people from Cambodia, Laos and Vietnam. Many of these problems arise out of the refugee and resettlement experience as well as the social and economic hardship associated with recent immigration (Frederico, Cooper & Picton 1997).

5.4   On Housing

In this research project we explore the way in which heroin use, access to housing and patterns of social participation (including access to human services) intersect and interact. In what follows, we report on the main descriptive features which have emerged in our research. We begin by describing the current housing circumstances of the forty seven participants in our study.

In terms of current living circumstances the participants essentially divided into three groups: homeless, private rental and public housing. Twelve of the group were, more or less, 'homeless', living mostly in squats. This was most notable in Yarra. In contrast, no-one in Geelong was living in a squat. Just under half of the group were living in private rental accommodation. At the time of interviews, thirteen of the forty seven people were in some form of public housing. Details of living arrangements are contained in Table 5.4.[16]

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[16] For a broader discussion of housing in the different study sites, see survey data in Appendix 1.

Table 5.4: Current accommodation circumstances

Area	Male	Female	Total
Yarra			
Homeless	6	2	8
Private rental			
- formal	1	-	1
- informal	-	1	1
Public housing	3	3	6
Community housing	-	-	-
Geelong			
Homeless	-	-	-
Private rental			
- formal	4	2	6
- informal	1	1	2
Public housing	1	4	5
Community housing	1	1	2
Cabramatta			
Homeless	3	2	5
Private rental			
- formal	2	3	5
- informal	1	2	3
Public housing	-	2	2
Community housing	-	-	-
Totals			
Homeless	9	4	13
Private rental			
- formal	7	5	12
- informal	2	4	6
Public housing	4	9	13
Community housing	1	1	2

The apparent precision of this table presentation needs to be qualified. For a number of interview participants, the need for stable and secure accommodation was very much a hot issue given their 'anomalous' housing circumstances. Indeed, some of those people we spoke with had faced major housing crises over the course of the past 24 hours.

Alex, for example, had been paying rental of $85 a week, half the cost of a property in the eastern suburbs of Melbourne. However, he had only just left this house after his girlfriend had discovered that he was using heroin again. Consequently, he was:

> … now partly splitting time between a squat just up in Johnston St., and ah, some friends of mine who had been living in a house in Burnley [whose tenants had stopped paying rent in a dispute with the landlord].

Mike was in a similarly unstable situation, having arrived at his regular squat that morning to find it closed down:

I found out this morning, I wasn't there last night, the police came around and locked [the squat up]. At the moment as of now, I'm presently homeless … I do have a couple of places I can doss and I have a girlfriend who is overseas at the moment…

In Cabramatta, five participants had experienced major changes in their accommodation circumstances close to the time we spoke with them. More generally, participants in Cabramatta had lived in an average of seven different places over the preceding three year period. Even so, this figure may significantly under-represent actual levels of residential instability given that many participants had difficulty recalling all the places they had stayed during this timeframe. Indeed, unstable housing was a recurring occurrence for many of our study participants. In Yarra it says something about the lack of accessible housing options that half of the group were currently in 'squats.' Even those in private rental or public housing could point to situations within the past three months in which they had been sleeping rough or moving frequently from 'couch to couch'.

There were some interesting differences in the housing profile of the three groups. In Yarra and Geelong, for example, over one third of interview participants were public housing tenants. In contrast, relatively few were doing so in Cabramatta. A further difference was the evidence of partial housing stability in Geelong. In part, this may reflect the more affordable cost of private rental in the Geelong region, a factor reflected in the accommodation circumstances of both interview and survey participants in this area (see Appendix 1).

We address the significance of housing options fully in the next chapter, drawing particular attention to the importance of housing to these people and the potential difference that suitable housing can make to their lives and capacity for social agency.

5.5   Initiating heroin use and leaving home

Although many of our participants had experiences that pointed to linkages, there was no axiomatic connection between heroin use and leaving home (or becoming homeless). This was apparent in the case of those participants whose use of heroin had not begun until their twenties and, in some cases, their thirties. There is no obvious 'cause' or 'link' which makes heroin use and housing circumstances into an interdependent relationship. Indeed, there are many elements in the life circumstances of these people that prevent the production of a neat simplifying story about how heroin use begins and the subsequent impact that it has upon housing circumstances. At the same time, many of our participants began heroin use at an early age (see below). As noted earlier, the teenage years are sometimes a period of experimentation that may involve chaotic drug use. Indeed, many of our participants reported such drug using experiences. These patterns of drug use at an early age may have impacted upon the ability of participants to access and maintain education, employment, housing and other social resources. Such drug use may also have damaged relations in the family home. These issues are discussed further below.

5.5.1   Starting to use heroin

In Yarra, the average age at which heroin use began was 17, just as it was in Cabramatta. In Geelong the average age was somewhat higher at 21, though this was partially explained by the more extreme age range in this group.

Table 5.5: Age first used heroin

Area	Male	Female	Total
Yarra	10	6	16
Mean	17	18	17
Range	14-30	12-23	12-30
Geelong	7	8	15
Mean	20	22	21
Range	18-28	13-36	13-36
Cabramatta	6	10	16
Mean	17	18	17
Range	12-20	12-23	12-23

Most of those we spoke to started using heroin in their mid-to late-teens. For some, heroin was part of 'the scene' and its use offered entry into an exciting and sophisticated sub-culture. Sara, a 24-year-old of European parentage, first used heroin at 15, (although she did not start using regularly until she was 20). She was emphatic that when she was 15, she 'liked drugs' *and* the life-style they were part of:

> I managed to finish school but drugs were always my main priority. They were just always a bit more interesting than anything else … all my friends took drugs and they were all a lot older as well usually. Like, I used to sneak out with friends that were 17 when I was a lot younger.

> I met this guy -it was about six months from my sixteenth birthday – and we broke up on my sixteenth birthday, and, like, he was 21, a DJ. Gave me cocaine and heroin and stuff. I reckon he was an idiot now for doing it, but I don't know what he was thinking. I thought, 'that's cool'.

Past research has found the influence of drug-using peers to be particularly pervasive for homeless participants (Baron 1999, Klee & Reid 1998). However, as some of our participants showed, living at home does not necessarily shield young people from drug-using friends. As Mia, a twenty-six year-old from a strict Italian immigrant family told us:

> It's quick and simple really. A really good agent came over to our [family] house and he said, 'If you like marijuana, you'll love this.' And I tried it and ended up having a habit. But the thing is, I can't really blame him at all really. I blame myself because I wasn't educated enough about it. I didn't really know anything about this habit thing, this sickness that you get. I though it was just like marijuana. And, yeah, I just woke up one morning really ill. It was free and all of that when it started for me and just went on and on from there.

In fact, for some, the introduction came from within the family home. Carla, now 36 years old and free of both heroin and sex work for two years told us about her introduction to heroin.

> I am not blaming my brothers but I had two older brothers … they started smoking when they were like 14 or whatever, they were drinking, they started smoking pot and it went from that and it went to speed and then they got into the heavy stuff, the smack … one night my brother [was] making up a shot you, know, and I said, 'what are you burning?' – the thing was burning, I was very curious … I would have been about 17 … Anyway, he said, 'do you want to give it a go?' I said, 'oh, I'm scared the needle will hurt. 'You'll be fine.' So he got me all set up and gave me a hit and here I am leaning out the bungalow window spewing up. I was constantly spewing up, every time I had a drink of water, I would just bring it up. I said oh never again, never again … But, bugger me dead, the next day what do I do? It was dole cheque day … I went to the bank and I got money out and I went to my brother and I said, 'can you get me some of that stuff?' And, yeah, 'no worries, no worries'.

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For some, it was their work that led them to heroin. Sex work sometimes figures in this scenario, although more often than not it is the heroin that leads the user to sex work. For Suzie, now in her fifties in Geelong, heroin, sex work and involvement with serious criminal networks just went together. Her memory of the first use of heroin is clear:

> It was 1971 … I was living up at the Cross. I was using speed at the time. I had gone through marijuana, acid, speed ... And the girl that offered it to me asked me if I had ever used it before. And I lied to her and said 'yes', because I didn't want it on her head that she had given me my first whack of heroin. And I remember I started rushing and I pulled the syringe out of my arm because I thought that I was going to overdose you know. I really, really freaked out. It was just a rush.

She also recalls, somewhat wistfully, the halcyon days of the early 1970s as US troops came to 'the Cross' on R&R from Vietnam 'absolutely loaded with Cambodia white powder, Thai white powder powder':

> You know it's good heroin when you're sitting there and what they call 'the nod off', when you are going like that, your head is full of colours. It is a dream. It's not like a trip. It's not like acid. It's just beautiful dreams. Like heroin, morphine. You go back to the Goddess Morpha, dreams.

For some of our participants, their initiation to heroin use was a puzzle with which they continued to grapple. Pete, separated from his wife and children and recently arrived in Geelong from South Australia, continued to be frustrated in his search for answers.

> I have questioned what [led me to it], because like I didn't have a bad childhood like most. You know what I mean? I wasn't abused, had good parents, good home, well looked after. There wasn't much emotional content, but I was well looked after. And I just look through the whole history … and I find at a point, it was there, and I did it and I love it so I keep doing it.

Indeed, reasons and explanations for the continued use of heroin were as varied as those that surrounded their initiation. In many cases, a clear cut explanation was not always available. Aden, in Geelong, started using in his late twenties and simply stated that his heroin use is a reaction to:

> Boredom. Not knowing how to do anything else with my life. It just seems to follow me wherever I go.

Mike, a 34 year old who started using heroin when he was 30 wasn't sure why it had happened, but he acknowledged his dependence on the drug.

> An addiction is an addiction. There are all kinds of degrees … I don't see it any different to alcoholism, or even cigarettes except the effect is different. It's a habit, and it's very hard to change habits.

For Mike, who began to use after a decade of heavy drinking, heroin at least offered a healthier alternative to alcohol:

> It was good to walk away from alcohol like that health wise. Alcohol is much more damaging; it's a solvent whereas heroin isn't so much. OK, you withdraw and you feel sick and get all sorts of symptoms but it's not doing damage, except for the hepatitis factor. Alcohol is very bad for your liver and so forth.

For many of our participants, the use of heroin was imbricated with sickness, sadness, emotional, sexual or physical abuse and pain. We met Ace, a young man living in Geelong after a lifetime in Queensland. He was extremely angry and frustrated; a state partially explicable by the fact that he was two days into an attempt to quit heroin. However, the anger he expressed through his interview was also connected to the death of his father from heroin:

> I just got home it was like Christmas night or New Years Eve or something like that … Well me old man was fuckin' dead, man, in the kitchen, man, and the other cunts that were with him, had the shot, didn't die. And they didn't do anything, man and they were too scared and shit man, you know. I took to them with baseball

bats and I beat all these people up and shit, man, that were in the house. I was so angry, man.

For some, heroin use was caught in a complex web of emotional distress and mental illness. PB was 45 and living in Geelong when we met her. She had been thrown out of home when she was14 and had spent 9 months on the street before getting work and later training as a nurse. She confesses to being 'a bit of a rager' back then. Nonetheless, her life had held together, even after a divorce in 1986. However, things seem to have collapsed when she found she couldn't cope with her youngest child and had what seems to have been a breakdown when the girl was 3. Things got no better following the death of another of her children at 15. She took up dope, then speed and moved onto heroin when she was 36. Soon after, PB told us that she was diagnosed with 'schizoid affective disorder'.

Nineteen year old Ben remembers using heroin to deal with painful memories of sexual and physical abuse:

> I was in pain with like, sexual abuse issues. I just loved drugs, they blocked everything out. A friend said to me that it's the best drug, you know what I mean, and so I thought, OK I will try it once. The same day I was robbing a house to get my second hit and from there on it was downhill.

Even Pete, who couldn't understand why he started using heroin, readily acknowledged that his continued drug use was related to an inability to cope emotionally.

> I run to it. Anything that gets hard: drugs. Anything that requires anything emotional: drugs. I just don't know how to deal with it because of the drugs. I never learned. I was always stoned off my head, you know. So I never learned to deal with stuff, so I deal with stuff in drugs and anger. I am not physically violent in any way. I just get really pissed.

5.5.2   Leaving home

On average, participants in our study left home at the age of fifteen. In Yarra the average age for leaving home was 14, in Geelong it was 15, and in Cabramatta it was 16. The actual range of experience entailed in leaving home – which may not always lead to homelessness – is registered in the fact that the youngest person to leave home did so at age five -and was taken into care by the State welfare department. The most 'elderly' person leaving home – found in the Cabramatta group – did so at 39!

Table 5.6: Age first left home

Area	Male	Female	Total
Yarra	10	6	16
Mean	14.5	16	14
Range	5-19	12-19	5-19
Geelong	7	8	15
Mean	18	12	15
Range	13-24	11-20	11-24
Cabramatta	6	10	16
Mean	20	14	16
Range	11-39	10-17	10-39

Those people who left home as teenagers identified four key factors as contributing to their decision to leave home:

- Sexual and/or physical abuse
- Conflict with parents or carers

- 'Coming out to play'[17]
- Drug use.

Sexual and physical abuse was a commonly reported reason for participants having left home (See also Appendix 1). This reflects the findings of other research (Coupland et.al. 2001, Neale 2001). 'Baby Doll', a 21 year-old woman in Cabramatta told us:

> I came here but the first few weeks I [didn't] get to live with my dad but cause he was working at Brisbane at a bakery. That's like near Coffs Harbour. So … he leave me with his friends. And during that time I got like um, abused, you know sexually abused when I was young.

John, a 16 year-old Vietnamese-Australian living in Cabramatta told us how he:

> … was going to school, studying and everything. The only problem was my dad was alcoholic. He used to abuse me for no reason at all. Like when he's full on drunk he'll hit me like for no reason at all. If I do one slight thing wrong like just like raise my voice or something he'll hit me for that. And I didn't appreciate that. Because I'm getting hit for nothing, like for no reason at all

Sharon is a 19 year old living in Geelong. At the age of 11, she was taken from her parents by the Department of Human Services. The personal pronouns she uses enables her to distance herself from them. They also provide some indication of the reasons for her removal from the family home.

> My mother was a prostitute and my father was a coke dealer and they mistreated their children.

When we spoke with Sharon, she was quite alone: the one relative that she knows anything about is her sister (a heroin user) who is dying of cancer. Sharon started smoking marijuana at 10 because it was in the house. She began using heroin at 13 - having been introduced to it by the family that was fostering her! After six years of foster care and institutional care she was released into the community; the welfare order had run out when she turned 17, so, as she said:

> I stayed with an abusive boyfriend and did what I could to keep my head above water… I have slept on the beach, toilets, trains, empty train lots, people's couches, people's front verandas … anywhere.

Family conflict, often associated with the young person's need for freedom and independence, was described by participants from Asian, European and Anglo-Australian backgrounds. It was highlighted as a reason for running away from home or simply for leaving. Jill, for example, recalled running around from the family home at age 12:

> It was the discipline, rules. [I] didn't get along with Dad as well as mum and stuff like that. I was smoking marijuana already. Tried cigarettes and got into trouble for that. From what I can remember, it was more like I couldn't do what I wanted. Like I wasn't using when I left, but it wasn't long after that I started.

Tiffany, in Cabramatta, had a similar recollection:

> Yeah. I had really hard times at school and all that and my mum was really strict. When I came home from school, I wasn't allowed to talk to boys and if I been seen talking to a guy, I would have got smacked with a stick. If I got not A's in my test I would have got a smack and all that.

Alex clearly recalled the circumstances of his eviction from home:

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[17] 'Coming out to play' was the phrase used by many Asian participants to describe their initial immersion in street life. The phrase referred to escaping from the strictures of the home/family environment to be with friends and was characterised by fun and excitement rather than by drug use.

When mum and dad came up and found a strange girl in the bed it precipitated a row. And it was like: 'Well, if you can't live in our house under our rules then don't live here.' I called their bluff for the first time ever, packed a bag … and left.

Cheryl, a 27 year-old Vietnamese-Australian woman told us, 'coming out to play' was as important a factor as escaping the discipline of the family home.

Like my group of friends, like we all ran away together … about seven, eight of us. [And what happened after you left there?] After we left there, we used to sleep like we all go to the beach and sleep out at the beach. [So why did you stay out when you had a mum that would let you come home?] Oh because it was, mainly the fun. We were all going out, having fun at night. We go to the beach that day. We sleep there that night you know

Ariel, who was on the streets in Adelaide when she was fifteen, recalled a similar experience:

It was kind of like an adventure being on the streets, because we had a little gang and stuff. And we had a squat, an old advertising building and we used to rooftop climb to get into the joint … We used to steal cars and sleep in them and it was like a big adventure. I was in and out of juvenile detention centres but at the same time I had so much fun.

In addition to the physical abuse meted out by his father, John told us that his decision to leave home followed a family break-up that had seen his mother's workload shifted onto his own shoulders. In some cases, such as this one, conflict arising from intergenerational clashes between the cultural values of immigrant parents and the aspirations of children growing up in Australia could be seen to have influenced their decision to run away from home.

When I was young my mum and dad split up and I was living with my dad. He lived in a Housing Commission house and I didn't like the environment cause he was always drinking and all that. [Did he work?] No, he was unemployed. And he was drinking and even though I was still young I learnt to cook when I was ten years old. That kind of stuff. Then my dad would drink and then he'd get me to clean up and I didn't like the environment. That's why one of the reasons I left home

Parental separation was a factor that led to a period of 'homelessness' for a number of our participants, although for some, such as Lana, 'being homeless' didn't describe her experience so much as instability:

My mum and dad split up and I didn't want to live with dad and my sisters left. I left with my older sister. She's three years older than me. We came down to Melbourne for a few weeks, then we went over to Perth, then we stayed there for a while. Then we went up back to Darwin and stayed there for a while. Then I went over to Thailand with my dad

Some participants who had commenced drug use prior to leaving home reported they had left home to protect the family from their drug problems. This was more commonly reported by Asian participants reflecting cultural values associated with 'saving face', or saving the reputation of the family. During interviews, Asian participants made repeated references to the importance of family. Nikki, a 19 year-old woman told us about the choice she had made:

My family had nothing against me. They always welcome me home. I had the choice to go home but I chose to stay out there 24/7. I hang out on the bus stop cause there's always a train … a customer coming. And my mum gets upset.

It is important to note that this trait was not restricted to Asian participants. For 26-year-old Rob, the member of an established Anglo-Australian family, the desire to protect family was a factor in his decision to live in a squat in Yarra despite the option of staying at the family home.

My parents don't know about my heroin use, they know about drug use in general, smoking pot and magic mushrooms. My mother I'm sure she suspects, for years she had the sly comment here and there … but dad is getting old and worries a lot about things like that. He worries a lot about me and where I'm going and things

like. So I keep it from him as much as possible, just the fact that I don't want to worry him. I don't want him thinking is my son alive today, is my son alive today, it's not fair.

In stark contrast, some participants were kicked out of home by parents because of drug use. Art, 20 years old and living with his girlfriend in Geelong was forced from home in violent circumstances.

My parents' house got raided and then my dad stopped trusting me and he beat me up real bad and I couldn't go back.

5.6   Heroin and housing – The need for income

It would seem to be a truism that in a market economy that people's access to various housing options tend to be largely shaped by their levels of income, and that income levels in turn are a function of the distributive effects of people's capacity to access labour markets. Given this, it is useful to explore the kinds of economic resources which these forty seven people had. It would be a reasonable generalisation to say that very few of the people we spoke with were living on anything like average let alone above-average incomes. Indeed, the participants in our study were overwhelmingly reliant on income derived from the social security system.

As Table 5.7 suggests in Yarra, every participant in the study was either on Newstart or a disability or sickness benefit. In Geelong, likewise, every participant, bar one (who was engaged in full time employment) was accessing the social security system. In Cabramatta, fourteen of the participants were on either Newstart or a sickness or disability benefit. Given that most participants were in some form of relationship, they were accessing two incomes. However a significant number also had children or teenagers to care for.[18]

Table 5.7: Current income sources

Area	Male	Female	Total
Yarra			
Self employed	3	1	4
Social security	10	6	16
Crime / Dealing	2	2	4
Geelong			
Employed	1	1	2
Social security	7	7	14
Cabramatta			
Social security	5	9	15
Crime / Dealing	2	4	6

Of those participants who were using heroin when we spoke with them, most were also relying on some kind of 'extra income' to support their heroin use. For a number of reasons we did not seek too much explicit information in response to our questions on this aspect of their experience.

The people in Yarra were generally forthcoming about their 'legal' or 'not so legal' extra income earning activities. Consequently, the following discussion looks at their experiences in greater depth. All sixteen of this group were on either Newstart or a sickness/disability benefits. However, four were actively involved in car window-washing and/or busking. Lana, who busked, and washed car windows at major intersections, argued that the money she

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[18] For a broader discussion of income sources, see Appendix 1.

made from car window washing (between ($20 and $50 an hour) was legitimate income despite the fact that the activity was illegal[19]:

> You get harassed by the police doing car washing whereas busking's legal; we've got licences for that. But if you get caught window washing you get a $200 fine. I've never got one … I think that's bullshit … at least they're out earning their money rather than doing crime or doing armed hold up with blood filled syringes.

In contrast, the 'heavier' users of heroin were engaged in high levels of income-earning crime. For some of them this involves dealing in prohibited substances, sometimes heroin, speed or ecstasy. (Many of the participants had relied on dealing in the past, if they were not actually dealing when we spoke with them). While obviously a criminal activity, dealing was an activity that certain individuals saw as a means of paying for drugs without compromising personal ethics. Ade, for example, was passionate in making a distinction between dealing and criminal activity.

> I don't see that really as a crime because the way I look at it is if I'm not going to sell it to them, they're going to go somewhere else and get it. So why should I let the other person make a very comfortable living off it when I can do it, you know. I don't do it to become a big drug tycoon - I just do it so I don't have to do crime. Because I can't afford to support my habit with a regular job or a job that I could get at the time.

Indeed, nearly all participants drew a clean line as to how far they were prepared to go to raise money for drugs. Suzie has a very clear ethic about who she will steal from:

> I would never thieve off my friends, I will never break into a house, I will not touch other people's property in that respect … but OK if I can walk into a shop and If I can steal something from that shop and make money on it I will … It's like look at the way these big shops rob us … and we let them get away with it … and I don't feel bad about it. I could never rob an old person.

Chris, 37 years old and something of a veteran after 18 years of heroin use, displayed a similar ethos, telling us:

> A drug habit's going to make you do things you wouldn't normally do, but even when you've got a drug habit, a lot of people have their limits.

For some, prostitution presents as a means of earning lucrative amounts of money without necessarily harming others. As Josephine, a 39-year-old sex worker in Cabramatta, related:

> I just decided, and that was at a very young age too, to do that. I decided, hey, you don't have to go next door and rip off your neighbour's video. You can hock your box.

The conscious decision to raise money through sex work was a decision that was made at considerable cost. Indeed, the potential health risks associated with such work are obvious. Rape is an immediate danger and one that occurs with disturbing regularity among sex workers. Carla made the dangers of her past profession clear in graphic detail.

> I have been raped several times in my life. I have been bashed … I have lost probably eight girlfriends as in they were working girls that were murdered, raped and murdered, you know.

Other participants relied intensively on high income-earning crimes like shoplifting or burglary. Mia and her partner Sven were each spending at least $200 a day on heroin, were engaged in a form of commissioned shoplifting insofar as they stole to order for legitimate shopkeepers who literally put in orders for items of high cost clothing:

> It has become a routine as well, like a job. And people treat you like employees and it becomes a funny way of life, but it can be very good and it can be very, very bad too.

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[19] In Victoria, car window washing at street intersections has been made a summary offence.

Sven spelled out his approach to shoplifting:

> Clothing is very good business. You've just got to be like a marketing person, you've just got to realise what people want at the moment ... At the moment, summer, people want new clothes - very good clothes – so you've got to find people who can actually resell the clothes which you find very easy. At the moment there is a lot of clothing type business which we are doing quite well with … People just give me orders - can you get that much of that, can you get that much of this and I just go out and get it for them.

Past research consistently reported crime as a key source of income for homeless drug users in Australia (i.e. Coupland, et.al., Groenhout, 1994).[20] Indeed, a significant proportion of those that we interviewed earned money from illegal activities. These individuals rarely considered potential sanctions, instead prioritising their immediate needs. In this respect, they were compelled to raise significant amounts of money so as to avoid the agony of heroin withdrawal. However, despite their disregard for sanctions, the continuous illegal activity of certain users made their apprehension and punishment something of inevitability. As Mia told us:

> The first time I got a one-month sentence and only really did two weeks there. I was expecting 'Prisoner', you know, but it's not like that at all. It's just what you make of it really. Since then I've been to jail four or five times including that one and probably the longest time I did, it has always been for heroin, was nine months and that was the last time, I haven't been locked up since. I've got court this month but I am on a suspended sentence so I don't know really how that is going to go because usually they lock you up straight away, so I'm a little bit worried about that.

In Geelong every participant (N=15) in our research was either on unemployment benefits or on a sickness or disability benefit. Given that almost half of the Geelong group claimed not to be using heroin – and hadn't been for significant periods of time- it was perhaps easy to believe that no-one engaged in extra-legal ways of earning income. Indeed, one man and one woman were in regular employment. It was also significant that in Geelong a number of the people had experience of both mental illness and prison.

The majority of participants in Cabramatta were drawing unemployment benefits. This may reflect the fact that most participants were not homeless. Previous research has indicated that significant numbers of homeless people do not receive Centrelink benefits (Coupland et al. 2001) and rely on income generated through criminal activities. While only six of the people in Cabramatta reported that they were involved in income-generating crime at the time of interview, observations made during fieldwork suggest that participants' criminality varied throughout the course of the study.

5.7   Education/Training

For many participants, the inability to find legitimate employment was related to their limited education and / or training.

In Cabramatta, one participant had completed a Hospitality course at TAFE and two others had completed courses while in gaol. Otherwise, educational experiences had not extended much beyond secondary school. This experience was shared by participants in Geelong who generally conformed to the pattern of incomplete secondary schooling. By contrast, in Yarra, most participants had finished secondary school and five had spent time in TAFE colleges and universities (though only three had actually completed post-secondary qualifications).

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[20] It is important to emphasise that criminal activity is not invariably tied to illicit drug use. Nor are all drug users opportunistic criminals who act without thought for their place in the community. Indeed, it became apparent throughout the course of the interviews that some users ranked themselves according to a value system. This was based primarily upon the lengths an individual was prepared to go in order to secure their 'hit.'

However, a lack of academic ability was not necessarily the reason for leaving school before completion. As indicated by their own comments, many of the people we spoke with were well informed, well read and intelligent people. Many reported doing well at school academically but being forced by other factors to take their leave. Cheryl, a 27 year-old Vietnamese-Australian woman, told us:

> I didn't leave until about half way through Year 11, stupid me. I wanted to come out and play you know. [So you got sick of school?] No I wasn't sick of school. I loved school. I loved it, school cause I was doing really well. My best subject was English and um I did Intermediate Maths 2 Unit, Intermediate Maths, yeah. I wasn't very good at Science though. Yeah and like I came out to play with friends and that and… And kept wanting to play instead of going to school

It was not uncommon for participants to report being expelled from school for failing to attend. In some cases selling and/or using drugs was a reason for failing to attend school. However, being homeless also made it very difficult for people to remain in school. John, a 16 year-old, related the difficulties he had experienced in respect of education:

> Moving around here and there, not staying in one place, trying to go to school was not that easy. Because maybe one day I live in one suburb and go to school in that suburb and then move, move kind of a bit far and try to go back and forth. And it was kind of hard and sometimes don't show up because you can't get there and then you get kicked out.

Two participants were enrolled in TAFE courses at the time of interview. These young people described their motivations for further study as both short term ('keeping occupied') and longer term (getting a job that paid enough to support their lifestyle).

5.7.1   Summary

In terms of the question we addressed in this chapter (Who are they?) we think we can demonstrate that heroin users are not what the popular-cum-media stereotypes suggest they are. The complexity and richness of the lives of those we spoke to is something which we would hope policy makers might want to take into account, but policy makers can only do this, if this complexity is more or less faithfully represented. Indeed, the decision of both the Victorian Office of Housing and the New South Wales Department of Housing to move past a model of service delivery relying on a rule-bound approach in favour of a judgement based case management approach which recognises that the complex needs of public housing tenants and applicants is welcome. We hope that this research may play a small part in confirming the wisdom of this policy shift and help to inform it.

6 'WE SLEEP WITH AN IRON BAR UNDER OUR BED' HOUSING, HEROIN AND SOCIAL WELLBEING

6.1 Introduction

Throughout the last chapter of this report, we sought to demonstrate the diverse and varied lives of those past and current heroin users who took part in our research. At the same time we drew attention to the difficulties that this group of individuals had experienced in their lives. Indeed, several of our participants had endured significant periods of hardship. In many cases this hardship was directly related to their inability to access secure and affordable housing, a factor made all too apparent throughout the course of the following chapter.

In this report, we wanted to determine how an improvement in housing environment might enhance the personal wellbeing and social capacity of heroin users. With this aim in mind, we turn directly to the first of our three primary research questions:

- In what ways, if any, do different accommodation options affect the wellbeing and social experience of heroin users?

In answering this question, the following chapter looks at two separate and yet closely connected issues. Firstly, we wanted to understand potential linkages between heroin use and different forms of housing (or lack of it). Consequently, we asked those people we spoke to how they understood and experienced their use of heroin in relation to their housing environment and how their desire for heroin impacted upon their access to housing of their choosing. Alternately, we sought to understand how their accommodation, or lack of it, impacted upon their use of heroin. For example, did the stability and / or security of their particular living environment affect the nature and extent of their drug use?

Obviously, the more problematic an individual's pattern of heroin use, the greater the negative impact upon their wellbeing. This leads us to the second area of interest - understanding how linkages between heroin use and housing environment have the potential to intersect with the larger shape of an individual's life. In particular, what effect can links between housing and heroin use have upon the ability of the individual to live their life in the manner that they choose? How, for example, might the ability to pursue important self-developmental educational, cultural or leisure activities be affected by the nature of one's housing and, in turn, the influence that this housing had upon their heroin use? Certainly, many of our participants invested significant value in housing in the context of the social agency and personal autonomy that it was perceived to offer. Indeed, the notion of autonomy was, more often than not, directly related to their housing aspirations for the future.

In exploring the above issues, we were fortunate to have access to the rich variety of experience that we did. Indeed, the results of this study are consistent with past research that has highlighted significant levels of mobility and transience amongst injecting drug users (Maher et al. 2001, Coupland et al. 2001). For many individuals with problematic patterns of drug usage, this mobility may be an involuntary consequence of a range of factors. Factors that arose during the course of interviews included:

- Inadequacy of income and fluctuating income levels;

- Conflict or reconciliation with families;

- Relationship breakdowns;

- Reliance on tenuous 'informal' housing arrangements;

- Eviction – related to behaviour of tenants or circumstances of landlord;

- Discrimination / rejection by real estate agents;

- Incarceration; and

- Availability of and access to emergency accommodation.

For others, mobility was a matter of personal choice related to decisions about drug use (i.e. proximity of drug markets), relationships and the availability of preferred accommodation options. We met Drew, for example, a 33-year-old part Koori, soon after his release from Barwon prison. He explained his need to keep moving in relation to the illicit activities he undertook to finance his drug use.

> I have lived in Collingwood, Werribee, high rise in Collingwood, and I lived in Melton and I lived in houses in Werribee, a couple, and I lived in Geelong and two houses in Whittington … I usually stay in places for a while, it just depends.

One of the consequences of this mobility was the exposure of our research participants to a range of different housing environments. What was notable about these differing environments was the different extent to which they constrained the lifestyles and personal choices of their occupants. Furthermore, in a number of cases, the level of participants' heroin use was directly related to their ability to live with a sense of personal autonomy and control.

6.2   Private rental accommodation

Those participants who were effectively homeless, or living in unstable housing, aspired to private rental accommodation as the first step towards a secure and stable living environment. This, it was thought, might enable the better management of their drug use and provide some much desired stability. However, despite their aspirations, most of those we spoke to found private rental accommodation an unattainable goal. This was related to both the unaffordable nature of private rental (for the active drug user) and the business practices of real estate agents unwilling to offer a tenancy to those perceived, rightly or wrongly, to be 'high-risk.'

6.2.1   Rental affordability

Private rental housing affordability varies considerably between the study areas of the City of Yarra, the City of Greater Geelong and the City of Fairfield. Table 6.1 looks at the proportion of the private rental property market in each of these three areas, that was considered to be affordable to households on statutory incomes during the 2001 March quarter.[21]

Table 6.1: Affordable Housing in Yarra, Geelong & Fairfield (March 2001)

	1 Bedroom		2 Bedroom		3 Bedroom		4+ Bedroom		Total	
	No.	%	No.	%	No.	%	No.	%	No.	%
City of Yarra	9	3%	9	1%	4	2%	1	2%	23	2%
City of Greater Geelong	176	91%	276	56%	474	83%	54	71%	980	74%
City of Fairfield	190	17%	438	38%	294	26%	324	28%	1246	27%

Note 1: Percentage refers to the percentage of all rental housing in the relevant area.

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[21] The definition of rental affordability used is that used in the Victorian Rental Report.

> The assessment of affordable supply is based on the number of properties that are within 30% of income including rent assistance for low-income households that will not be overcrowded. The rental thresholds are taken from the household incomes for whom that number of bedrooms is a minimum and may have been rounded up to the nearest $5 increment. For one bedroom properties, we have taken the income of singles on Newstart allowance; for 2 bedroom properties, we have taken a single parent pensioner with one child aged under 5; for 3 bedroom properties we have taken a couple on Newstart with 2 children; and for 4 bedroom properties, we have taken a couple on Newstart with 3 children. This table is meant only as an indicator of the amount and distribution of affordable rental stock in Victoria. The numbers should not be taken literally, except perhaps as an indicator of order of magnitude.

In the City of Yarra, only 23, or 2 per cent, of the dwellings leased during the March 2001 quarter were affordable by low-income households. In contrast, in the City of Greater Geelong, 980 (74%) of dwellings were affordable to low income households during the same period. This data suggests that there is a functioning private rental market in Geelong for low-income households, whereas in the City of Yarra affordable rental housing is virtually non-existent. This impacted greatly upon the housing options available to our participants in each of our research sites.

Of 16 individuals interviewed in the City of Yarra, 15 were unemployed and all were receiving government income support. Although these benefits provided an income reported to be between $350 and $450 per fortnight, those interviewed reported spending $350 to $2,500 a fortnight on heroin. In this context, the prohibitive cost of private rental is obvious. As Alex, 34 years old and squatting told us:

> You realise that your habit can't afford $150 a week to be going on rent or $100 a week to be going on rent. It's $100 you don't have to spend on gear. So you'd rather be squatting or living somewhere you're not paying rent.

Indeed, even in more affordable rental markets, the cost entailed in maintaining a problematic drug habit is such that private rental accommodation is often not an option until drug use ceases. When we met 19-year-old Sharon, she was sharing an apartment in Geelong with her partner Art. However, her access to the private rental market had only been made possible after she had stopped using heroin.

> Being able to pay the bills is the one thing. Like when I was 16 there was no way that I could earn. I was a heroin addict, I couldn't pay my bills, I couldn't rent a house or anything like that.

As these accounts illustrate, choices about accommodation are sometimes made in the context of a lifestyle dictated by the demands of a heroin dependency. Indeed, the guaranteed and sometimes violent discomfort of heroin withdrawal is such that the placation of their drug dependency will take priority for those users with more problematic patterns of drug use.

6.2.2   Rental accessibility

Financial barriers were only one obstacle faced by participants in this research. Those individuals who *were* able to afford a rental property reported barriers in the form of real estate business practices. A number of interviewees reported that real estate agents would not approve prospective tenants who were unemployed or could not produce acceptable references from past employers or landlords. Such requirements precluded the majority of our participants from being considered acceptable tenants.

Discrimination by real estate agents was also reported. When she could finally afford accommodation, Sharon found few real estate agents willing to let an apartment to a woman of her age:

> Nobody in Geelong, there in only one real estate agent in Geelong who will rent to someone who is young and that is Shrimpton & Son and it is still hard to get a house [through them]. So it is really hard to get rental when you are younger … or that's how I found it anyway … I was six months looking for flats and I was just really nice to this one real estate [agent], wore a low cut top and I got it. I had to lie, had to say I had a job and I was working and doing a part time course. [Did they ask you for references?] Yes, I got my friends to write them.

In Cabramatta, young people of South East Asian origin added racial discrimination to the list of barriers faced when attempting to access private rental properties though real estate agents. Juan, a 25 year old Vietnamese-Australian, thought that his appearance, ethnicity and youth were seen as synonymous with drug use and/or other criminal activities.

> They freak out and reject me. They don't like me because I look all tattoo and maybe I look Asian. You know what I'm saying? Maybe because they think I'm using drugs too?

However, being an Anglo-Australian of a more mature age did not necessarily remove barriers to private rental. Sandy, a 45 year-old Anglo-Australian woman reported similar obstacles in Geelong where the lower cost of private rental (as compared to the other research sites) made it a more affordable option.

> Lindsay and I, we don't look like your normal, average run-of the mill straight people, right? And estate agents always seem to zoom in on that with us. You know like just things I have to go through to try and get a new place. It is just unbelievable you know? Got to put the hair up, the glasses on and, but, I mean, I shouldn't have to do that.

Interviews with two real estate agents confirmed that these discriminative practices do exist. However, they considered the filtering of 'undesirable' tenants justified in order to uphold the agent's responsibility to protect the interests of landlords.

6.2.3   Private accommodation and the desire for space of one's own

It is important to note that, for those interviewed private rental was not necessarily equated with privacy and personal space. Private rental was not seen as a 'cure-all' solution. Rather, 'a place of *one's own'* that allowed an individual to make decisions by themselves, for themselves, was the goal to which many of our interviewees aspired. It was this circumstance, as opposed to private rental in itself, which was perceived as necessary to allow individuals to begin to address problematic drug use patterns.

Although the majority of interviewees could report past experience of private rental, these were overwhelmingly share properties, the pooling of living resources offering one means by which users balanced the costs of drug use and rental accommodation. However, those who had lived in such arrangements found that they often ended in acrimony as an increasing proportion of their income was diverted from rental costs to pay for drugs. Disputes within households shared by heroin users were reportedly common, a consequence of a shared dependency and the prioritization of this dependency over all else. Mel, a 27 year old Anglo-Australian woman, drew upon her own experience to provide the following perspective:

> It can't happen. Users cannot live together because, I don't care what anyone says, it's very hard to find a true friend that's a user because in the end the drug will always over-ride. It's sad but it's true. Desperate times call for desperate measures. If we need it bad enough we thieve. We thieve off our family, so just imagine what we do to an acquaintance.

For a number of users, the primary problem with sharing accommodation with other drug users was that it allowed sometimes fledgling habits to become entrenched. Living with other users sometimes increased an individual's commitment to a drug-using lifestyle by limiting their social contact to other drug users. For Sara, her drug use only became problematic when sharing accommodation with other drug users.

> I was living in the City in a house. It was good … Just working in, like, a bar but I was getting $17.80 an hour and that was back then, four years ago. So I was just getting that and I wasn't declaring it. I was getting the dole as well, so I had heaps of money. The guy we were living with was a really good friend of my boyfriend. He had a heroin habit already but it took us about three months of living with heroin to sort of, like, to get right into it.

The complications associated with the 'share house' led a number of interviewees to specify that their housing aspirations revolved around independence and autonomy. For Aussie, whose intravenous drug use began while living with a 'speed' dealer, privacy was equated with keeping clean.

> If I did have my own place, I would be telling a lot of people where I lived. I would be keeping a low profile and, more or less, just letting a few people come over and visit me, not letting anyone move in. I want the place to myself … just sort of security thing, you know.

6.3   Public rental accommodation

Although public, government-subsidised rental housing offers a more affordable form of housing, a number of our participants refused to even consider the possibility of entering the public housing system. This was directly related to the presence of drug markets and related behaviour, such as predatory crime, on public housing estates within each of the three study areas. Furthermore, for those seeking to better manage their drug use, the proximity of heroin markets presented issues of obvious concern.

Certainly, the experiences of those who lived on or visited the estates testified to the precarious nature of life on those estates where an active yet chaotic drug trade had become entrenched.[22] The following quotations are from participants who live on the relevant estates or visit them regularly in the course of their daily lives.

Fitzroy Collingwood

> There is violence that happens around this estate. You see more, not so much in the buildings, but it does happen in the building, but more in the grounds of the estate and that's stand over violence just for cash and drugs … There's always a sense of fear … If you've got money on you, or drugs on you. There's always a sense of fear. Even when you haven't got anything someone might stop you (Chris 37-year-old Anglo-Australian male).

> I would say that at least 70% of flats use or deal with drugs and you get to know your neighbours. You see it every day … the kind of thing you see is syringes lying around and stuff … People come to you to see if you can score, that sort of thing (Jill 22-year-old Malaysian female)

Geelong

> I would say that every public housing estate has two or three dealers with each different drug at least. It is pretty much on hand in every estate at the moment. Like I just left home in Norlane and I stopped at the shopping centre at Corio Village and I seen someone that I know … What's he doing? Not hard to tell what he's up to. But he had only just walked up from home around the corner to the village and rang them and there you go, he's on. It's pretty free even with the drug shortages that I have heard are on at the moment (Drew 33-year-old part-Koori).

> In Norlane, [I lived in] another commission house which was a dump, a run down dump. It was one thing that made me get back involved in drugs … I met this bloke I used to score off and he used to do things like rip off cars and strip them and do all sorts of crazy things. One day he came around and threatened to bash me if I didn't put the car in the back yard … (Aden 35-year-old Anglo-Australian male).

Cabramatta (Sydney Western suburbs)

> Oh there's lots of drug dealers. I blame this area …. That's why I don't want to raise my baby here. I do not want to raise her here. Every, practically every second house had got drug dealers or drug users. And the houses are very dirty and disgusting. They wreck it (Elisabeth, 19 year-old European-Australian female).

> Most of the people that I have spoken to in Muswellbrook, they've been some sort of victim of drug crime. Like whether it's been a break and enter, purse snatch or whatever. They just seem to think that it's just a one off thing like they're the only victim in the fuckin' town. And you say to them listen it's not like that. People used to come round to my place all the time asking me if I wanted to buy a hot telly, a video, um, like hundred dollar fuckin' CDs, yeah, video cameras whatever. Everything that goes with the drug fuckin' scene (Josephine, 39 year-old Anglo-Australian female).

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[22] Although all those participants who lived on or visited the public housing estates told us of the violence and fear associated with the drug trade on the estates, they also told us about positive aspects of public housing. For example, all those participants who were public housing tenants expressed a high degree of satisfaction with the amenities and services on the estates. The positive aspects of public housing are addressed further in Chapter 7.

6.3.1   Public housing location

The refusal to enter public housing was a direct consequence of the drug trade on certain estates as opposed to a prejudice against government subsidised housing. The presence of drug markets, and associated crime and violence at the margins of these markets, meant that residents of public housing estates had little personal control over their living environment. For those who were struggling to better manage problematic patterns of drug use, the easy availability of heroin on the estates posed obvious issues for their wellbeing. For others, the lack of personal security was the primary concern. A number of those we spoke to were unwilling to walk around estates unaccompanied. A constant and pervasive sense of menace and fear was reported by all, particularly those with experience of the high rise estates in Fitzroy / Collingwood.

Those we spoke to who *were* willing to accept a tenancy did so on the understanding that it would allow a greater degree of personal control than their previous living arrangements allowed. For one couple, the chance to escape a shared squat environment for the officially recognised privacy of a public housing apartment was the foremost consideration in their decision to pursue housing within the Fitzroy / Collingwood high-rise estates. While acknowledging the potential negatives, Ade and Finn were quick to emphasise that public housing was the only affordable option that offered some semblance of long-term residential stability.

More telling, however, was the decision of a number of interviewees to apply for public housing in areas away from established drug markets. Those few individuals who had succeeded in these applications reported a high level of satisfaction and a marked degree of success in the management of both drug use and financial affairs. However, they also noted the distinct shortage of suitable public rental accommodation in areas apart from the drug trade. As Bob, a 22 year-old male with a long history of homelessness told us:

> Two weeks ago I got public housing accommodation, so I have got my own flat. It's a breeze, the rent gets taken out of my dole check and I am clean as well … we put down the area of Caulfield and Caulfield's got 14 supporting areas attached to it and Moorabbin is one of them but it is better than living in a high rise. You can't escape from drugs in the high rise, it's all around you. That is another thing they don't seem be able to get you anywhere that is not affiliated with drug use - you look through their list [of available accommodation] and it is pretty poor.[23]

6.4   Short-term accommodation options

Short term accommodation options also presented significant problems for the wellbeing of the individuals interviewed.

6.4.1   Rooming houses

From the perspective of the heroin user, rooming house accommodation is often less than ideal. A study of those rooming houses within Collingwood / Fitzroy found them to be unsafe and unhygienic (Jope 2000). Carla was quick to agree:

> I got a bed sitter … just one room, communal showers and all that sort of thing, communal kitchen. But you come home and our bloody door would be wide open. Other drug users, because it was all drug users that lived in them sort of places. And you know you would come home and your door would be kicked in and your stuff would be rifled through and things would be taken … That was a real, real slum you know, like cockroaches oh it was disgusting and there was always a bad smell about it because a lot of alcoholics lived there too as well as drug users and that. And like they die and no one would notice it and then this rotten smell after a few days of a dead body being in there and it was just oh that smell of death. It was just horrible.

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[23] Service providers also acknowledge significant difficulties that frustrate their attempts to locate drug users in suitable and appropriate public housing locations. See Chapter 7 for a discussion of this issue from the perspective of service providers.

The presence of other drug users and the use of drugs on the premises made rooming house accommodation inappropriate for those seeking to better manage their drug use. Indeed, in some cases, communal kitchens reportedly functioned as de facto shooting galleries (Jope 2000). Adding further to the oppressive atmosphere, many rooming house residents suffer from serious mental or physical ill-health or have recently been released from prison (Jope, 2000). For this reason, a number of those interviewed deliberately sought to avoid such an environment. Del, a long-term squatter, was adamant in his preference for his squat over accommodation in a rooming house:

> I don't really want to live in that environment. Like I've seen some of the boarding houses in Gertrude Street and around the area and they seem to be full of ex-cons and more violent type criminals. People whom if they knew that I was doing business they'd kick the door in and take what they wanted. I don't want to associate with the in and out of jail clique.

Bob, whose homelessness had driven him to stay, periodically, in rooming houses, provided a graphic picture of the rooming house environment. In doing so, he gave some insight into its potential impact on the mental state of vulnerable individuals.

> The people are forcing you to pay $160.00 for a room as big as this and share a bathroom with a bunch of piss heads - it's criminal. In a rooming house it is so mixed up like you've got old alcoholics, young schizophrenics, middle aged prostitutes all these different minorities - they've all got enough problems and then once they get together all you are seeing is everyone else's problems … It is a nightmare living in a rooming house.

6.4.2 Community / transitional housing

Those participants who had managed to gain a placement in community housing reportedly expected to receive substandard places and old furniture and were surprised at the standard of housing and the level of support provided. 'Baby Doll', the 21-year-old recipient of a temporary community housing placement in western Sydney, told us:

> I don't expect to get this. Like it was unexpected you know cause I'm thinking one bedroom it's gonna be like one, just like one room with everything united (bedsit). But I didn't expect just like a normal flat … A kitchen, and a lounge room and the eating room is together. But is really separate. It's really individual. Which I'm also glad you know. Cause I been to one bedroom place like a bed-sitting before and never liked it [And bathroom?] Yeah, the bathroom is next to the bedroom but it's really huge and humungous. And the kitchen is a bit small but it really fit for one person. I'm so happy now I can do the cooking because I miss out the cooking for so long. I can cook the basic food you know. Being on the street, always crave this and that. And I can have that if I wanted to. I'm so happy.

The overwhelming concern of participants with regard to community and transitional housing was its temporary nature. Leases offered by Hume Housing under one particular state government sponsored scheme in Sydney's western suburbs linked the housing to various support and treatment programs. In this example housing was made available for a three-month trial period with the option of further lease renewals, being subject to continuing participation in treatment and support services until the tenant in question was considered 'ready' to move into long-term housing options. This was intended to include private rental market, public housing or community housing. Case workers for the support agencies were responsible for assisting people with this process with the emphasis on gaining living skills to maintain their independence and ensuring employment opportunities were sustainable and could support the cost of accomodation. However, participants reported they had received conflicting information. While this confusion may have resulted from different advice being given by the housing and various support providers, some participants claimed to have been told that leases were for three months *only* and, consequently, questioned the value of community housing. Options for extension were not well understood. Despite her happiness with her living arrangements, 'Baby Doll' was able to give us as similar insight into the perceived insecurity and its negatives:

They start me out with everything and after three months I'm thinking I'm gonna end up on the street if they ask make me to move out, looking for a place of my own. I don't know how I'm gonna do that without any help. Like now I got a place with their help but…Yeah or I'll probably end up doin the whole thing around in a circle again. Cause then I think it's not worth it to try your best for that three months, getting myself out of trouble and then being on it and going through the same what you been through like in your life before. I'm not sure.

6.4.3   Emergency accommodation

There was a profound lack of emergency accommodation places reported in each of the research sites. This was an issue of considerable concern given the nature of this accommodation as, for many, a last resort before 'sleeping rough.' Access to refuges was further hindered by restricted eligibility criteria that did not necessarily reflect the characteristics of the population seeking shelter. Corroborating previous research (Groenhout 1994, Hunter 1996, VHS 2001), age, sex and drug and alcohol use were identified as potential barriers to refuge accommodation. Mel told us of the frustrations she had encountered in her attempts to access emergency accommodation:

> There's nothing around here. There's no hostels for women or anything and if there is you're either too young or you're too old. There's no in between. And there's more men, more stuff available for men than there is women. In Canley Vale itself they've got a lot of boarding houses but mainly for single males.

A number of participants had stayed in emergency accommodation on at least one occasion. However, it was not generally seen as a viable accommodation option in its current form. Refuges were sometimes perceived as less desirable than living on the street. A common criticism by participants was the imposition of curfews and contracts that demanded a certain standard of behaviour from their signatories. These disciplinary requirements meant that some, such as 16-year-old John, were unwilling to consider using refuge accommodation:

> I wouldn't like it because one you don't, there's all rules and then you have to abide by the rules and I don't think I can. You have to have fun cause I was still a kid. Cause living in a refuge you have a curfew and all that.

In at least one instance, a couple within the project was forced to separate in order to gain access to single-sex accommodation. Ade and Finn were both experiencing major depression while each acknowledged the other as their primary emotional support. The potential impact of such a separation gives further emphasis to the importance of suitable emergency accommodation for couples. This lack of *suitable* refuge accommodation was an issue that arose on a number of occasions during interviewing.

Many participants also raised the issue of drugs within emergency accommodation and one prominent provider of such accommodation said the facility was being used by some clients as a de facto injecting facility. The presence of drugs in refuges and emergency accommodation was a significant issue for those interviewed. It complicated management of problematic drug use and brought with it the pervasive threat to personal safety that accompanies the use of drugs among those without the income required to support their own habits.

6.4.4   'Informal' housing options

With profound limitations on access to both public housing and rental accommodation, informal housing options provide financially poorer heroin users with an alternative. These, technically illegal, sublets have less stringent tenancy requirements allowing 'high-risk' tenants to negotiate barriers to private rental accommodation. 'Accommodation' is typically basic, often no more than a free-standing shed or bedsit in the backyard. Alex told us of his experience living in a shed in Richmond:

> I was living for about a year and half in this house, just behind the corner of Coppin and Swan Street, Central Club Hotel, it was a 4 bedroom, well 4/5 bedroom house that had like a bungalow / shed out the back and I had the shed at $35 a week, so, for a small price to pay of having to get yourself wet on winter

evenings to come in and use the toilet or kitchen, whatever, no problems. And a padlock on the door so it was secure.

However, 'leases' of this nature were often subject to the whims of the 'landlords' rather than written agreements where tenants had the right to contest the actions of the landlords. Participants described a number of situations where they had been evicted without adequate notice because the landlord's personal circumstances had changed (i.e. a relative coming to stay). In general, informal arrangements tended to be tenuous and temporary.

Furthermore, there were situations described by (particularly female) participants and observed during fieldwork that were clearly exploitative. One young couple in Cabramatta were effectively made to pay for their accommodation in both money and drugs. As Cheryl explained:

And then we moved up to you know Kristin and Trent. Do you know them? The two Aussie? Yeah yeah. I lived up there right. You know what I was doing? I was looking after their habits, paying the rent at the same time ... Stay in one room and each of us had to pay $50 a week. And the rent was like only $130 a week. And plus we had to look after their habits too. And one night because we didn't have nothing and they wanted it and we said 'we've got nothing' they kick us out at 3 o'clock in the morning.

6.4.5   Family and friends

Some participants described instances during periods of drug use and homelessness where family and friends were supportive. However, the majority experienced a profound lack of emotional and material support from others at this time.

Some participants acknowledged that they could return to the family home for short periods, an option that is occasionally taken up. However, as noted in the previous chapter, for some there was a conscious decision to 'protect' their family from their drug use, particularly among Asian participants. Some of these individuals elected to remain in squats or temporary and informal living arrangements.

For many participants, however, the family home was simply not an option, as 20 year-old Art stated in no uncertain terms.

My own parents don't want to know me when I'm using. My own mum just looks at me and and says, you're green in the face, I don't want to see you.

Friends and partners provided differing levels of support. Some female participants continued to live in potentially abusive relationships because of the lack of an alternative housing option.

This housing thing is killing me because when I argue with my parents and argue with (boyfriend) it makes me go crazy because then I think where am I going to go? When me and (boyfriend) argue I say 'oh I'm sick of this place' and he always tells me, 'then fuck off. Pack your bags. Get out'. And I feel so ashamed because I've got nowhere to go. You know? And it's his house. He has every right to kick me out you know but I've got nowhere to go and I just turn around and I just think fuck (Elisabeth, 19 year-old European-Australian female).

I mean I am alright now, I am fine where I am. But sometimes that is dodgy because he is an alcoholic, the man I live with, and one minute he is happy go lucky and, bang, he turns on you and he says get out and, you know, it's his home so I've sort of got to play by his rules because if I don't I'm out you know and where am I going to go, you know what I mean (Carla 37-year-old Anglo-Australian female).

Others spoke of an informal 'share house' lifestyle, something that arose frequently during interviews, particularly with younger participants in Geelong. Both young participants and service providers in Geelong have referred to a culture of sleeping on floors or 'couch-hopping' between friends. Ben told us how he made do 'couch hopping' before returning the favour when he gained accommodation of his own.

> Just sleeping from one friend's to another's, just sleeping everywhere, anywhere they can crash. And you find most of the houses, like there are only meant to be two people and you will find there are five or six people staying there, if you know what I mean … I had my own place … it was in East Geelong and it was the best flat. Because I was using drugs and all that kind of stuff, it was like a half-way house for people who were like in town and had nowhere to go. My house was always spotless and clean but I never ate or anything like that and there were always bodies on the floor and stuff like that. I couldn't let those people, knowing they were on the streets, couldn't let them be on the streets, so they came back to my house.

This arrangement may reflect the comparatively cheaper price of rental properties in Geelong and the difficulty faced by young people accessing their own private rental property. In all instances, one or two individuals had managed to attain a legitimate rental property which was then opened to others. These arrangements were invariably short term, often as a result of damage done to property or increasingly chaotic and problematic patterns of drug use. As Aussie lamented:

> My last one was in Hearn Hill. I had my own flat and I ended up letting junkies stay and whoever else come over and because they had a place to stay they would shout me drugs and whatever else … The place got more or less trashed and I owed rent and everything like that.

6.4.6   *Short-term accommodation – Some general observations*

The impact of temporary living arrangements is often overwhelmingly negative. There is little sense of security or stability. In this respect, there is an inability to gather possessions through which to imbue one's environment with any sense of personal identity. Furthermore, the continued mobility of those in such accommodation can often frustrate attempts to enter into long-term employment or undertake educational opportunities. The added pressure upon social relationships is considerable and there is little likelihood that those separated parents seeking joint custody of children would be successful in their attempts to spend extended periods of time with their children.

6.5   'Sleeping rough'

For some of our participants, the inability to afford or access appropriate housing meant intermittent periods of outright homelessness, sleeping under bridges, in the laundry rooms of public housing blocks, or simply in parks. There are obvious issues of personal security and physical wellbeing associated with 'sleeping rough', issues that were recognised by users who sought to limit the danger to the degree allowed by the extremity of their personal situation. Sven, for example, chose a location where he would be least likely to be disturbed:

> Mainly I'd choose little side alleys, like sanctuary kind of places because I get woken up quite early, which is good because I've got to get up quite early to do the day. They're just like quiet at night, there's no-one around, no-one gets there. Parks and stuff I'm still wary of because, like, anyone can come - especially at the moment I'm with my girlfriend and she is pregnant right now as well.

Alternately, a number of those we spoke to saw squatting in disused or derelict premises as a means of negotiating a lifestyle within areas in which housing was inaccessible or inappropriate. This allowed them to remain close to drug markets and valued social services. In Fitzroy / Collingwood, for example, the area's working class past and the current existence of an established drug trade provides the basis for an extensive range of social service agencies including drug treatment services, needles exchange, emergency housing, employment services, legal aid and generalist health and welfare services. Of an initial sample of 16 participants interviewed in Collingwood / Fitzroy, nine were squatting. A further five acknowledged having squatted in the past. These individuals acknowledged a certain degree of autonomy as one positive of the squatting lifestyle. Indeed, for some, the autonomy of squatting was seen as preferable to the bureaucratic requirements of public housing and the unsuitable nature of shorter-term accommodation options. However, the most important aspect was obviously the opportunity to access shelter that would not consume limited funds.

All squatters interviewed in the Fitzroy / Collingwood area reported having access to cold running water. None reported access to gas supplies or to hot water. Despite the absence of gas supplies, the use of portable gas cookers was reported as was the use of televisions, toasters and blow heaters. Electricity was illegally connected, interviewees reporting a common tendency to 'fiddle' the fuse box. Indeed, despite the transient nature of the squatting lifestyle, pride was taken in creating a 'home'. Ade and his partner Finn, for example, had gone to considerable effort:

> The thing is my home is important to me. I like to keep it clean, organised, nice and neat … I'm like everyone else, you know. I like to feel at home where I'm living… Finn and I tried to really make the place up. I remember trying to clean it up. Like, I'd say at least ninety five per cent of the furniture in the place, Finn and myself, but mostly Finn actually sourced and got for the place.

Some squatters reported an almost communal approach to tasks such as cleaning. All, however, made clear that the success of such arrangements was dependent upon the willingness and goodwill of all parties. The arrival of one or two individuals unconcerned with such matters would be enough to ruin the sometimes delicate balance of communal respect and responsibility. Jill, 22 years old and now a public housing resident expecting her first child spoke of the structure and discipline maintained in one squat she stayed in:

> Everyone will chip in to help out to make the house work as best as it can … If you have running water you are kind of lucky. That means like cleaning up, like you have only got cold water and everyone has to do dishes and stuff. I was in a squat where the toilet didn't flush so we had to make sure that someone would flush the water down the toilet every day with a bucket. Just sweeping, like get a broom and sweep whenever you can and don't leave syringes laying around and stuff like that. And then the last one I was in we even had times for, hours when people, like towards the end, the last squat I was at, people started getting work and getting clean and all that so you couldn't have friends come around after certain hours and stuff. We got locks put on the doors and keys and stuff like that. So it can work out good if you have a good group of people.

Often, squatters occupied vacant properties with the consent of owners. Advocacy groups such as Melbourne's Hanover Welfare Services have reported acting as intermediary between property owners and squatters. Sometimes their negotiations have led to surprising outcomes with squatters allowed to stay on provided a property is kept clean (Middendorp, 2000). Alternatively, squatters themselves have entered into informal negotiations with the owners. As a somewhat bemused Josephine told us:

> I thought Mary Poppins was visiting though with her brolly and her button hair … I'm thinking, fuck oh no …. And I've sat up and she's gone 'What you do? Why you sleep in my house? Why you break in?' I said 'Oh, we didn't break in. We're going now' and her attention's straight away gone from me to the floor you know. She's just looking all around. She went through the house. She come back and she said, 'You good girl. You people clean my house. You clean everything. All drug thing gone. I know you do needle. I know needle in your arm, I see. But you clean everything up, cleaned, all good.' And she's fuckin let us stay there. We offered to pay her $100 a week. She said 'No you can't do this. Keep your money for this. You look after my house. You keep it clean. No drug people come here. I know you do. You keep it clean.'

For law enforcement agencies, squatting presents a case of trespass dealt with in accordance with the law. In Victoria, under the *Summary Offences Act 1966* (S.9f), trespass is only a crime *if* the owner of a property asks a squatter to leave and he or she does not. Unless the owner makes a complaint to police, squatters are likely to be left alone. Those squatters we interviewed who *had* been asked to leave properties generally reported pressure from neighbouring residents. Others cited specific incidents, such as a fire, as the reason for their eviction. Ade provided an example of the former:

It had quite a reputation in the area. At the peak of the dealing in that house, there was some dealers living upstairs and what people were doing - they were on the footpath - and they'd throw money up to the window and the dealers would throw deals down ... We were very lucky in having a very understanding owner of the property. It was just fortunate for us that he didn't have the money at the time to renovate the place or do what he had planned for it. So, he was more than happy just to let us stay there but it got to the point where he had too many complaints from neighbours, businesses, police and council and he had to get us out.

Despite the positive aspects associated with the squats, all of those interviewees who were or had been squatting pointed to negative experiences. First among these was the inability to distance oneself from a lifestyle centred on illicit drug use. Squatters were invariably living in an environment shared with dealers and, consequently, the site of frequent injecting activity. Finn, a long term squatter and eager applicant for public housing, told us with no small amount of despair

These two guys moved in, brothers, and we told them if they moved in, we did not want it shoved in our faces cause we're trying to give up. And they said 'yeah, yeah, yeah' Of course, as soon as they moved in, they pretty much started dealing. You'd walk out of the bedroom and there'd be five people I didn't know in the lounge whacking up. Walk downstairs there'd be ten people I didn't know whacking up.

The association of drugs with the squats greatly compromised squatters' personal security. Although the generally accepted rule was that possession comprised 9/10 of the law, there was no means of preventing others using standover tactics to enter or take control of a squat. While the threatened or actual use force was an accepted part of life in the squats, it contributed significantly to the anxiety and depression of those sheltering within them. Lana referred to a constant state of anxiety.

We sleep with an iron bar under our bed ... A lot of other people in the house use drugs and I'd say that they'd rip people off. You get rumours all the time that people are going to come around … bash this person and that person. You sort of have a fear sometimes of people coming around. In some squats, if you've got anyone dealing when you're living with it, then that's the worst. You've got a lot of traffic coming in and out, a lot of people you don't know, a lot more things go missing and you've also got the threat of people doing run-throughs, they come in and bash the dealer and take all his stuff. If they do that then they're likely to do it to other people in the house as well, to see if they've got anything.

Thieving of personal property was also reportedly common and squatters were unwilling or unable to keep possessions of value within squat accommodation. This compromised the creation of a 'home' and the inability to keep books, instruments and electrical goods were all reported reasons for wanting to access alternative accommodation. Rob made the reality of theft perfectly clear when talking of the 'security' initiatives he undertook:

There is a lot of thieving that goes on. Even when I've had nothing, just two garbage bags of clothing and candles - they're gold. I've had to load my bag with blood filled syringes with no lids on and say to one person, my bags are full of syringes without lids full of blood. These are my bags, if you with to go looking please do and that stopped [it]. Everybody always has something stolen.

The tendency towards chaotic behaviour in squats is doubtless reflective of the living environment in which many homeless heroin users find themselves. Human behaviour cannot be divorced from its social context. Boredom, frustration, anxiety, depression and alienation are all motives commonly ascribed to drug use. They are also potential consequences of homelessness and an unstable, insecure housing environment. A number of users spoke of lacking self-esteem and linked this directly with their housing situation, associating their inability to access stable accommodation with personal failure. In such circumstances, the temporary escape offered by illicit drugs may present as an attractive escape, however temporary. Alex summed up this commonly reported link between homelessness and drug use in the following exchange:

Looking at my surroundings, [there] didn't seem to be a lot of prospects to change my circumstances and it was all too easy to crawl into a heroin bubble and just say, 'Look it's too hard' … Really, it's a self-esteem thing. When you're feeling a lot better about yourself, you don't feel the need to use – It's when you look at your circumstances and say I'm really living in the shit. That's when, you know, it's the ideal escape, it really is. It can allow you to forget anything … I think that's really what it was about – it was just using frantically to cover up the fact that, you know, this is a hellish condition and really no way to live.

6.6   The bigger picture: injecting drug use and health

6.6.1   General health

Housing provides protection from the 'elements' as well as access to facilities to maintain personal hygiene (i.e. showers and washing machines), the opportunity to prepare and eat regular meals, and the option of an uninterrupted night's sleep. As Cheryl, a 27-year-old woman remarked:

> If I had my own place to stay I could have regular showers, feed, you know, wash my clothes. Don't have to walk around thinking 'God do I smell?'

Health problems associated with unhygienic living conditions such as exposure to the elements, asthma, fungal/skin infections, as well as malnutrition, weight loss and sleep deprivation were commonly experienced by those living on the streets or in squats. 'Baby Doll' in Cabramatta told us about her own experience:

> My health. I came to the point that everyone, I think that everyone thinks that I was dying cause how skinny I was. I was like, it was really bad. I was on the cocaine too and yeah it just make it worse. I always look lost you know what I'm saying. I was real paranoid. I was like, I'm double my size at the moment.

6.6.2   Public health concerns

As noted above, homelessness has the potential to exacerbate levels of injecting drug use. However, the absence of secure housing was also found to have an impact on injecting practices. Participants all preferred to inject at 'home' or at least in a protected environment. Twenty-seven-year-old Mel described the advantages of being able to keep a supply of clean injecting equipment available when they had a place to stay.

> I know when I'm at home I'll have like a draw of surgical waters, clean syringes all the time. I never share but sometimes I do have to re-use my own syringe. Well you wouldn't do that at home. You'd have swabs all the time. You'd have your own tourniquet. If you've got bad veins you've got hot water to get your veins up.

Injecting at home also provided a degree of control over one's environment and usually involved a smaller number of people, reducing the chance of getting needles and syringes mixed up. In contrast, those without a secure living environment often had limited opportunities to keep a 'stash' of clean injecting equipment. Indeed some participants told stories about the desperate measures that some injecting drug users had been prepared to take. Alex described one scene of desperation he had been witness to:

> I know what the people are like when they get bad enough. I've seen people pick an old syringe out of a fire hose cupboard and rinse it out. Like do you know who has used that? No, I need a fit.

Injecting drug use within squats was associated with a higher risk of the transmission of blood borne diseases. In this environment, drug use often involves groups of people. Consequently, users may be more likely to share injecting equipment and higher volumes of used injecting equipment may result in an increased risk of needle-stick injuries (Maher, et.al., 2001; Maher and Dixon, 1999). Furthermore, squats are frequently littered with discarded needles, needle stick injuries posing a very real public health threat. Finn painted a particularly disturbing picture when she told us:

> People had obviously been coming in while we were not there and using, breaking off their needles, throwing them on the ground - you just couldn't get away from it

anywhere, they were everywhere you went in that place, fits or needles … I used to tell everyone, just don't wander round in bare feet, please

A commonly reported concern associated with injecting in public was avoiding detection. Injecting furtively in often dark places under pressure was not conducive to safe injecting or disposal of used injecting equipment (Maher and Dixon 1999; Maher et al. 2001). Mel provided a graphic illustration of the sense of panic that accompanied injecting in public:

Oh is someone gonna come? Is someone gonna see me? It's pouring with rain, you haven't got shelter. It's dark, you need light. It's freezing cold, you can't get your veins up and you know I don't have any. You can't sit and relax. You can't take the time to find a good vein to go in. It makes a mess. It's unhygienic. And, because it takes so long to do it, that's why people rush to get out of there straight away. They leave their stuff, even though there's no excuse. It takes longer to open it and do it all than it does to actually put a cap on it and put it in the bin. But that's how it happens because like the police run in on you. Well you just get up and run. You're not gonna sit there and pack up cause the police have come. You run. And you quickly forget about that and ten syringes have been left there. Now every user does that. Very quick you get a big pile of them.

Steve, a middle-aged veteran of the Cabramatta 'scene', highlighted the increased risk of overdose when people were rushing while injecting.

I've rung the ambulance twice since July. Because they've been caught and given a move – on order, they score the drugs and jump over a fence, mix up and shove it in and overdose cause they're in a rush, not thinking straight and they're done and they drop.

Housing was associated with perceived increases in quality of life, stability and health, as well as less harmful drug use including safer injecting practices and reduced risk of overdose. This research indicates that access to stable housing should be a cornerstone of any harm minimisation approach to injecting drug use.

6.7   The bigger picture: location and managing heroin use

Housing, or the lack of housing, is not, in itself, a panacea for problematic drug use and associated risk behaviours. Indeed, a number of participants in this project reported periods of heavy drug use while living at home or in rental accommodation. For some, rental accommodation was only affordable at times when selling heroin was most lucrative, and the corresponding increased access to heroin at these times was often associated with periods of heaviest personal drug use. In Tiffany's case, income, as opposed to environment, was the primary influence over the extent of her drug use.

I was using a lot cause I had a lot of money. I was dealing a lot so I could use a lot. I had the money to do it.

In this respect, some participants associated housing with being able to make choices about their lifestyle as opposed to a reduction in, or abstinence from, drug use.[24] Some, Cheryl in Cabramatta, continued to use, but were able to better manage their drug use:

It was good. I was eating properly you know. Yeah, like if I had my own place 'cause I like to cook and do normal things. I'll get up in the morning. I have my shot and then I'll clean up the house, do the washing you know, cook you know.

Nonetheless, having a safe place to stay was thought to be an essential component in better managing patterns of drug use. As Nikki, a 19-year-old Vietnamese-Australian woman explained:

Having a house helps them get their act together. People on gear should be given more of a chance to get a place because it helps them get their life together. There's the possibility of turning someone's life around.

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[24] It is important to reiterate that this research does not necessarily associate abstinence with wellbeing. Indeed, some users did make this association. Others, however, simply sought to better manage their drug use.

This is certainly the case in respect of detoxification. Understandably, the discomfort of withdrawal will be exacerbated by the nature of one's surrounds. Although not a solution in itself, a protected space where friends can offer support is certainly more conducive to enduring withdrawal than an unheated and unhygienic squat.

While some homeless participants believed that having stable and secure accommodation would assist them to stop using drugs, others emphasised that the provision of accommodation alone was not enough. For many, the location of housing is as, if not more important, than the issue of housing itself. Weinberg (2000) has noted that a separate setting can possess medicinal force in itself, removing an individual from an environment where the social organisation of homeless peer groups and their drug use are so influential. Obviously, when one is struggling to shed a dependency of the intensity of opiate addiction, then the close proximity of drugs could be expected to have an impact upon an individual's resolve. Sven was adamant about his and Mia's need to escape from all aspects of the drug scene:

> We want to stop because we're sick of going out rorting every day, we don't want to get locked up … that's why we're planning to move to Mitcham, close to my girlfriend's parents for support as well. That's why we want to go out there because [that's] the only way we can really stay off it … You have to completely stop being in the environment where there is users and syringes which very hard around the city because you know you walk into users, you know, and they're still using and if you tell them you are straight they don't want to take that fact you know – that's what makes it hard - the only way to stay off it, you've got to stay away from everything else - you even have to stay away from just syringes because it is that needle fixation that is the worst - just sticking that needle, everyday, into your arm.

Alex was another of several others who stressed the importance of location. He had, to date, been frustrated in his attempts to address drug use issues by re-locating to Macedon area.

> All I needed to do is get out of Melbourne, and like it [obtaining drugs] would have ceased to be a problem. No easy access. I don't drive really, so I couldn't easily organise to go and get it.

However, other participants argued emphatically that the decision to reduce or abstain from drug use would succeed or fail on the basis of willpower and that location, housing and other issues were of secondary importance. This was based on the belief that drugs were 'everywhere' and that the individual who sought to place distance between themselves and drugs would be forever running. Sharon, proud of, and somewhat toughened by, her own successful rehabilitation, told us:

> It's going to be everywhere you go, so you may as well be strong about it. I can watch people have a taste now and not think, gee, I want to be able to do that. A year ago, that wouldn't have been the case. It is all willpower. It is everywhere you go. I can see people walking down the street and I know they are junkies just by looking at them, but you just have to be strong.

For the majority of participants in this study, the 'homeless' lifestyle was associated with higher levels of drug use. Participants identified close contact with drug-using peers and a sense of hopelessness as the primary contributing factors. However, once drug use patterns had been established, it did not necessarily follow that housing created an environment that encouraged people to quit. Nonetheless, it was thought that housing could make a significant difference in the provision of a stable and protected environment and additional motivation for those who are ready to quit. In an appropriate location, it could also play a prominent role in the prevention of relapse by enabling people to distance themselves from familiar drug-using environments and the influence of drug-using peers. In contrast, participants believed that the transience, poverty, poor health and inevitable involvement in criminal activities associated with homelessness was thought to make relapse inevitable.

6.8   The bigger picture: housing and choice

Those we spoke to who had succeeded in accessing stable and secure accommodation acknowledged that it had brought both stability and a sense of empowerment to their lives.

They could begin to focus on life decisions and take steps to actively pursue these decisions as opposed to simply struggling to survive. Twenty-three-year-old Tiffany explained the positive difference suitable housing made as follows:

> Stability. You're not worried about where you live, where your clothes gonna be, how you're gonna shower. You can get along with other things in life like getting a job, get socialising, get a bunch of new friends. How to get money, what would you like to buy next. Work on how you look. Um go back to school. Work out the future things. Not the things…work on things that normal people would work on… the essential things should already be there if you had a house, so you could worry about the things that you're supposed to worry about.

The stability and the space in which to consider personal choices greatly improved the capacity of individuals to pursue personal interests and 'make the most' of the opportunities available to them. John, our 16-year-old participant in Cabramatta told us about the difference housing had made in his life:

> Everything changed. I went back to school. My life seemed better like no-one looking down on me and all that. I feel more happy.

Many of our participants had artistic aspirations. However, the degree to which they were able to pursue them depended upon the stability and security of their housing. Bill, a public housing resident, had obtained permission to paint the inside walls of his high-rise apartment in Fitzroy.

> I have painted the wall; I can just stare at it for hours. I like it. We've got a bit of freedom. I asked if I could paint the walls. They didn't think that I meant a mural. It made it feel a bit more like home

In contrast, Del, a 26-year-old squatter living in Yarra, was unable to securely keep the materials he needed in order to pursue his own artistic interests.

> I paint, draw or sculpt [but] I tend to make stuff and it's gone. It's very hard to accumulate materials at times. Anything worth anything is gone as soon as you turn around.

One issue of considerable importance for participants, particularly male fathers separated from their children was the need for a housing environment that would allow them to spend time with their children. Aussie had been unable to have his son on weekends because his housing was of an informal nature and shared with three males, all with mental health issues:

> I want to try and get a Ministry of Housing, what do you call it, priority housing, because I have got my son and I want to have custody of my son for a weekend or so, so I have to have a good environment like a flat, a stable environment for me to be able to have him.

The inability to make such arrangements in a state of homelessness or unstable housing was commonly noted by participants. The experiences of those in temporary housing arrangements of in squats testified to the difficulty faced in attempting to fulfil personal plans. In a sadly ironic fashion, their current situation greatly compromised their ability to access a more secure accommodation. As Bob told us:

> Because we were so scattered and moving around and stuff like that it took us three months to get our paper work ready for our housing application … It is not something you are thinking about when you are sleeping on concrete - where's that form - got to file it with the right ones. It's just a piece of paper in the bottom of your bag, down with your dirty socks or whatever.

Sven illustrated the 'Catch 22' in which he found himself. He could not address his heroin dependence until in a stable environment. However, his heroin dependence prevented his accessing a stable environment:

> If you are still using, you can't keep appointments, you're too busy doing certain things because you're always thinking: whack, whack, whack, always the next

whack. Not because you love it, I don't love it no more. It's just that I've got to have it and if I'm not having it I'm going to be sick – simple.

On the basis of the experiences of those people we spoke to, it seems that secure and appropriate housing can clearly provide opportunities for people to extricate themselves from street life and the drug scene and to re-establish their social capacity to act in pursuit of their own interests.

6.9   Aspirations: housing, a home and autonomy

We want to actually own a house and live our own type of life, sit on our couch, watch our TV, do our job, go to work – that is what I am really hanging for; to come home from work, have a couple of beers, watch the footy that's what I'm hanging for you know (Sven 21-year-old German male).

A number of those who took part in this study acknowledged that their drug use had become problematic to the degree that it had become a dependency. These individuals had endured periods in which the need for drugs exerted some control over their decisions and priorities. However, our participants also spoke of the constraints imposed by the different social settings in which they had lived and of the impact of these constraints upon both their wellbeing and their ability to manage different aspects of their lives.

Certainly, one of the key themes to emerge through the course of this research is that personal wellbeing is directly related to an individual's capacity to make decisions about their lives. When participants spoke of their perceptions of the meaning of a 'home' there was a very deliberate association of an 'owned' space in which personal control could be exercised and personal choices contemplated free of unwanted intrusions. The following accounts are just two variations upon a common theme:

[When] you get your own private place … you can really start all over again there because it's not, it doesn't belong to someone. It's yours. You can start all over again. You can you know, get your own furniture. You're not being ordered around by anyone. You're the boss of your place you know. So I do prefer that and I think most people do prefer having their own place than staying at someone's place or share accommodation. Cause you don't get your own privacy, freedom (Nikki, 19 year-old Vietnamese-Australian female).

I can go on with my career. Can do things that are interesting to do. These not about drugs. These are other things for me. And I have time off for my family and for my family to feel that I have safe not to do, not to be doin nothing and getting naughty with friends. I can actually just you know, cook at home and eat your own (food) and that kind of thing. Sleep in your own space. And you don't have to worry about the rent cause it, you can support it, and the meal, each day you eat and the transport you pay. Don't have to worry oh I'm gonna (have a) shot, what can I do? (Juan, 25 year-old Vietnamese-Australian male).

There can be little doubt that the emphasis given to privacy and personal control reflects their absence during periods of homelessness. Whether living on the streets, in full view of the general public, or residing in squats with other occupants, transient and homeless participants were sometimes forced to reveal their most intimate and private activities.

6.10   Heroin and housing: Some preliminary conclusions

The findings of this study have revealed the potential for secure and suitable housing to increase both the wellbeing and the social capacity of heroin users. The stability provided by a secure housing environment enabled participants to look beyond the 'survival mode', to be more future-orientated and consider longer term issues related to employment, relapse prevention and relationships.

In addition, there are a range of general health benefits associated with access to housing including better nutrition, adequate sleep and improved personal hygiene. Participants highlighted ways that housing minimised the potential for drug and injecting-related harm. Being homeless tended to increase participants' levels of drug use with the increased time

spent with drug-using peers and sense of 'hopelessness', described by participants as significant mediating factors.

Homelessness frequently necessitated injecting in public places where access to clean injecting equipment and running water was limited, increasing the likelihood of needle-sharing. Injecting in public was also characterised by rushing to avoid discovery by police or other people and poorly lit environments exposed to the elements, precluding strategies to control hand-to-blood contact, vein damage and prevent overdose. These issues have implications for managing the transmission of blood-born viruses such as Hepatitis C and HIV, and suggest access to housing should play a key role in any harm minimisation approach.

While housing did not necessarily lead to the decision to abstain from drug use, the importance of housing as a motivating factor and in preventing relapse was highlighted by a number of participants. Access to stable accommodation enabled people to distance themselves from drug-using peers and the street environment, both considered by participants to be critical in preventing relapse to drug use. In some cases, housing did provide a suitable environment for home detoxification and was implicated in the decision to quit.

Stable accommodation may also have mental health benefits according to participants. Feeling depressed, 'having no future' and low self esteem were commonly reported in relation to homelessness and chronic residential instability. The psychological impact of the lack of privacy and personal belongings associated with homelessness is unclear but may also have important implications.

Finally, access to secure accommodation makes a significant contribution to alleviating the social disadvantage by enhancing an individual's capacity to take advantage of education, employment and other opportunities (should they choose to). In this context, shelter must be considered a basic right for all individuals regardless of the circumstances of their lives.

7 'I WANT THEM OFF MY FLOOR' SERVICE PROVISION FOR LONG TERM HEROIN USERS

7.1 Introduction

The illicit drug problem affects significant numbers of people, some of whom are young, homeless and addicted to drugs like heroin. Accordingly, since the mid-1990s, governments around the world have been ploughing millions of dollars into service provision such as health, homeless person services, social security, and particularly disability services, policing, and social welfare programs as part of what all too often has been declared a 'war against drugs'.

In this report we have sought to deconstruct some of the myths about heroin use and the ways heroin use intersects with the kinds of housing options and the quality of housing available. We have done this on the premise that if governments can better understand the realities of the lives of those who use drugs, then policy makers will be better placed to ensure drug and other relevant service provisions will be both relevant and effective.

We have already made the obvious point that those using heroin are not a homogenous group, a fact with immediate and significant implications for service provision. Moreover, the fact that our research covers three very different geographic areas that are also varied in terms of their ethnic, socio-economic and cultural composition only highlights the issue of heterogeneity. Put simply the service needs of a 35 year old outer-urban Anglo-Celtic middle class male living in public housing in Geelong are likely to be quite different to those of an Aboriginal 17 year old woman, pregnant and homeless, in the City of Yarra.

In this chapter we examine a closely connected issue, the adequacy and relevance of the services provided for drug users in regard to their housing needs. In doing so, we turn directly to the second research question.

- In what ways does current service provision for long-term heroin users address their housing needs?

Our point of entry in this research was largely through service providers, principally those working in drug user health services in Collingwood in the City of Yarra, in Newtown in the Greater City of Geelong and in Cabramatta in the City of Fairfield, who assisted us to gather a considerable body of evidence in response to these questions. They introduced us to users who answered questions about their lives as drug users. In each of these three areas service providers also assisted us convene a focus group of service providers. Information on the composition of these focus groups is provided in Chapter 4. The discussion in these focus groups provided many insights into services and service system issues. Through the interviews, surveys and focus groups it became clear that services played a key role in the daily existence of dependent drug users.

Evidence about current service provision and the way it addresses the housing needs of long-term heroin users is addressed in two main sections. The first focuses on public housing – the only realistic option for low-income dependant heroin users, largely excluded from the private rental market, who are seeking affordable and secure housing. It does this by considering the availability of appropriate public housing stock; the additional demands that heroin users place on public housing service provision; what heroin users say about their experience of public housing service provision; and how service providers seek to establish 'sustainable tenancies' for long-term heroin users.

The second section considers the current relationship between housing and other forms of service provision. We consider

- How housing and drug use intersects with a user's need for and capacity to access a range of services; and

- The degree to which those services meet the needs of 'clients' and help open-up socio-economic opportunities for them.

7.2   Public housing service provision and heroin use

In this section we report on what users, public housing managers and other service providers say about the workings of the public housing system. On one hand the context for this discussion is one where public housing managers face dilemmas resulting from increased demand, limited resources and greater use of complex rationing systems that are used to rank the needs of applicants. On the other hand users who are seeking secure and affordable housing generally have no other option. A network of service providers assists applicants to fill out forms and to negotiate both the priority system (that rations this scarce resource) and conditions of tenancy. The discussion proceeds by considering

- The availability of public housing for drug users, particularly those in need of one or two-bedroom accommodation;

- The additional demands that heroin users place on public housing service provision;

- What heroin users say about their experience of public housing service provision; and

- How service providers seek to establish 'sustainable tenancies' for long-term heroin users.

7.2.1   The availability of public housing

In each area of our study, there were significant shortages in the amount of *suitable* and *appropriate* public housing stock.

In areas such as Cabramatta, the NSW Department of Housing reports that there is a huge demand for public housing but very low levels of available stock, resulting in some of the longest resolution times (of applications) in the South West Region. Waiting times of about ten years in the Cabramatta/Fairfield area are considered average, a fact acknowledged by one Housing Officer:

> I think we've got to acknowledge though, say in the Fairfield area, the average wait
> for certainly a cottage or a townhouse is about ten or eleven years

Many participants reported that they wanted to apply for priority housing. In NSW, Department of Housing policy states that in order to be eligible for Priority Assistance you must demonstrate you are:

- Eligible for public Wait/Turn housing (i.e. applicants must meet the requirements of an income test, must be over 18 years of age, a resident of NSW, and an Australian citizen or permanent resident), and

- In *urgent* need of housing, and

- Unable to resolve this need yourself, and

- Unable to meet this housing needs in the private rental market.

Applicants could be considered to have an *urgent* housing need if they demonstrated:

- Unstable housing circumstances (i.e. homelessness, staying with friends/relatives, imminent eviction, in crisis accommodation, hostel or halfway house);

- "At risk" factors (e.g. domestic violence, sexual or physical abuse, neglect, threats to custody of children);

- Inappropriate existing accommodation (e.g. overcrowding or substandard conditions);

- A medical condition (i.e. exacerbated by current housing or inability to access medical services);

- Disability (eg. mental illness, intellectual or physical disability limiting options for private rental).

According to these criteria almost all participants within the Cabramatta cohort were eligible for priority housing at some stage during the study period. However, despite meeting several of the eligibility criteria in some cases, a number of participants were unable to access housing or were only able to do so after a significant waiting period. This can lead to drastic

problems. Mel, as a homeless single mother, had to wait eight years before being offered a place two hours drive away from her local area. During that time she got into a temporary living arrangement with her baby's father with domestic violence and injecting drug use as regular features. She lost the support of her family (mother) because of her relationship with her boyfriend, lost custody of her child after three years and ended up living on the streets:

> I waited nearly eight years for my housing and I ended up getting that in Wollongong and that's just, I've just lost that. [So even when you had a baby you weren't eligible for like priority housing?] No. I had to wait. I still had to wait. I went to and from mum's place. Because I had that family support I always come up with bond or something but it wasn't until my daughter was about three that I lost that family support. [What happened?] Well throughout the years of my drug use and me being with this man who was violent and introduced me to heroin. Well mum hated him naturally and she turned against me. We slowly but surely fell apart. My grandparents both passed on. Well that was my support gone. I had no more home to go to so to speak and that was when I learnt you live on the street. I've lived in shelters, done the Kings Cross thing but Cabramatta was always my home.

Similar stories were reported by participants in Yarra, where Chris, for example, a 37-year-old with an 18 year heroin 'habit' had waited for 12 years before being housed. Part of the problem is the availability of *suitable* stock. Most of our participants had applied for one or two-bedroom apartments. Indeed, the profile of the priority housing applicant is of an increasingly younger population without children (DPEC 2000). In Victoria, this is demonstrated by reference to the Supported Accommodation Assistance Program (SAAP) a national program that provides housing and support. In 2000, it was reported that 59 per cent of SAAP places were utilised by those aged under 30 (DPEC 2000a). Single people accounted for 62% of support periods. However, whilst the Office of Housing has an excess of available two and three-bedroom (family) stock, particularly in the City of Yarra, there is exceedingly high demand for the limited numbers of one and two-bedroom stock. In this context, the approval of an application does not necessarily translate into housing. As Ade, currently awaiting a response to his own application for an apartment in Yarra, noted:

> When it's approved, you go into a pile of applications that have been approved but are waiting to get located … the thing is, the office [of Housing] that makes these decisions actually rang around to a number of agencies … asking them to send in as many two and three bedroom applications as they can because there's a glut of them that haven't been filled.

The extent of the shortage of appropriate accommodation in Victoria was noted by the Drug Policy Expert Committee (DPEC) in 2000. The DPEC reported that, in June 2000, there were 41,000 people awaiting public housing in Victoria. However, at the same time, funding allowed for the purchase or building of only 1,380 units (DPEC, 2000). The DPEC also noted that the demand for housing would continue to outstrip the supply, resulting in an increasing gap between growth rates in housing supply and demand. Indeed, the high cost per unit of housing is such that even an investment of $12 million in the current year to increase accommodation for the homeless can only provide an additional 70 accommodation units (DPEC 2000).

In addition to shortages of stock, Housing officers must consider the potential consequences of locating all priority housing applicants in certain areas. In Geelong, for example, there was greater availability of housing. However, there was a concentration of drug use and dealing within those same estates in which there were available units. This issue is addressed further below when we consider the increased complexity of public housing management.

The lack of suitable public housing availability means that housing officers in both New South Wales and Victoria are unable to meet the high level of need that exists for affordable long-term housing. Furthermore, the experiences of research participants suggest that eligibility criteria do not reflect what the Department of Housing can provide. Indeed, the concept of priority housing is somewhat further constrained by considerations such as the availability of suitable housing stock in appropriate locations.

The shortage of public housing stock has had further consequences. Housing officers are not always able to offer public housing to applicants on the priority wait list, while applicants who do not qualify for priority housing may face substantial delays, in some areas, before an offer can be made. There can also be administrative problems in coordinating applications from a large number of applicants, many of whom are mobile, requiring application forms and supporting documentation to be transferred from office to office as the applicant moves. This can be frustrating for some applicants. This issue was raised by interview participants in relation to the way in which inquiries were handled by administrative staff and in respect to the difficulties lodging application forms. Juan told us about the frustrations he encountered when dealing with administrative staff in western Sydney:

> I still chase them up. Ask them what's going on, if they receive my form … Some of them say that they never heard nothing … some of them reckon they never put down the form for me on computer. It's just all sort of different drama every time I come, even still this day I'm not sure if they have my new address yet, like where to post stuff … I feel I bit rude to ask 'oh, can I know your name' or whatever so I can write it down. I feel rude to do that so I just get up and go out and the next time I come I say, 'oh, how's the application going?' And they will say, 'what application?' It's a joke

7.2.2   Additional demands on the public housing system

When they are able to access limited public housing stock, heroin users who become tenants place extra demands on a system under considerable stress. This has challenged a system that was originally designed, primarily, to provide rental housing to households firmly connected to the labour market adjacent to expanding post WWII industries. However, policy changes, beginning in the 1970s, have increasingly emphasised the targeting of public housing to low-income households and those experiencing other forms of disadvantage. The Victorian Director of Housing (Westacott 2002) has described the transformation of public housing that has resulted from this policy:

> This shift in the types and sources of households being housed in public housing has occurred quickly and within a system oriented to property management with a simple tenancy management model. As a consequence, a number of difficulties have arisen due to the unsuitability of many allocation decisions. This rigid allocations system, combined with changing populations in the estates has led to increased difficulties on some estates by concentrating communities of disadvantage.

The interviews and focus group discussions with public housing tenants, both drug users and non users, housing managers, other service providers provided us with an opportunity to identify three ways in which heroin use places additional demands on the public housing system. They are

- loss of amenity in residential environments;

- the engagement of housing officers in increasingly constrained and complex housing allocations; and

- difficulty in integrating housing service provision with other support services.

7.2.3   Loss of amenity

Drug use has led to the loss of neighbourhood amenity for tenants on public housing estates in the three study areas. It is important to note that loss of amenity affects both drug users and non-users, even though the former may contribute through their participation in the drug trade. Loss of amenity on the public housing estates takes three forms.

First, it can result in the degradation of public spaces and the neighbourhood. In high-density public housing in Melbourne this degradation was profound. Harry, a long-term user who visits inner city Melbourne high rise estates to buy heroin described the environment as follows:

> You're worried about finding somewhere clean that you can go and have your shot. Because if you go into a stair well people there's fits [needles] around. There's always blood and God knows what. It's not a place that you really feel comfortable walking around by yourself.

During the course of our focus group conducted with users in the City of Yarra, Harry challenged another user about the source of the pervading smell of stale urine in the stairwells. He made his point by posing a question and answering it in the same breath.

> Does that mean you've never pissed in the stair well? Tell me that and tell me you're not lying.

A non-using tenant described the detritus left behind by users who inject immediately after scoring from a dealer living near him.

> One day, we counted them out here [syringes] outside the front door, by the lift], we counted 37.

Drug use and dealing can also degrade the residential environment in low-rise suburban estates. A housing officer in Western Sydney described what could happen to a hard-to-let property[25] in a public housing estate.

> When we have a property that's been vacant for quite a while, and it's one of our hard to lets and it's those sort of issues, one of the things that tends to happen is that the locals use it like a club room and they break in. […] They're in there, they're using it to do their drugs and all that sort of stuff. Not dealing I'm not talking about. I'm just talking about the users from around the place. When we finally put somebody in that property they're likely to suffer because of people coming in there all hours and really frightening them, and it takes a pretty solid and strong sort of person to cope with that sort of thing.

A similar description was made of parts of the public housing estate in Geelong where there was a 'pooling' of drug users in neighbourhoods. A Housing Support Coordinator observed:

> When we are talking about housing for people in this situation is the tendency to pool them into the same area, the same neighbourhood and the same street even. And you go out to Corio and we could name the streets where you have got groups of people all pooled together and subsequently from our perspective there are causing problems for the community in general by that. And plus I think it does make it harder for these people to try and, we are talking about drugs, to try and get out of drugs if everybody else in the neighbourhood has the same problem. In some ways it might be a support base but in other ways it's got to lead to problems. So we see a lot of dealing come out of those sorts of neighbourhood and that sort of thing.

Second, the loss of amenity results from the chaotic behaviour of users who are hanging out for their next fix. Dependent users are often at the point of desperation by the time they get to purchase their next 'fix', 'cap' or 'whack' of heroin. Delays can result in screaming and verbal abuse. Bill, 27-years of age, a long-term user and new public housing tenant, describes what he has seen and heard and indicates that he wants some action.

> I am sick of people waiting and getting shitty with the dealers taking too long so they start screaming and there goes another window. It is just not on. I mean I understand but it is still not on. They are like pussycats. They have rung the dealer and the dealer says wait on this floor and they are waiting and the dealer says I will be down in ten minutes ... The dealer has taken twenty and the user is getting shitty, hanging out, plus the whole thing of waiting and waiting another ten minutes to get fitted. … The people in that situation are volatile so it is not healthy. They should see them on their own floor. I want them off my floor.

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[25] "Hard-to-let" refers to properties where there is a lack of demand due to the unsuitability of the housing for needs of most applicants, not because of the condition of the property, but because of its configuration or location: for example a bed-sit apartment in an area where almost all applicants have a housing need for one, two or three-bedroom units.

It seems, however, that this chaotic behaviour is not just due to heroin use and dependency. Alcohol dependency and overuse is also a contributing factor. Chris, a long-term heroin user and tenant of the Collingwood estate for the past four years describes the effects of alcohol, which can also be drug of dependency.

> Drunks screaming at each other all night so you don't get any sleep. You're always hearing that going on. So there's the noise factor, there's the destruction they create. Those people who get drunk seem to get into vandalising the facilities on the estate more and vandalising the tenants.

The effects of chaotic behaviour on trust relations amongst neighbours can vary. In the high rise flats these trust relations have diminished but also continue amongst the chaos. Chris suggests that some sense of community had returned to life in the high rise.

> I may not be the closest friend with my direct next door neighbours, but I know a few people on my floor that I get on well with, talk with, swap books and that, and some from a couple of floors above. There is a bit of a sense of community. It died off for a bit because there's been a really stressful time around the inner city flats. Especially, it's the drought that went on about a year ago and that made everybody sort of go and hide indoors. But it's reappearing again. I'm noticing that people are starting to talk to each other again.

Effie, a non-using tenant, confirms that there is some trust and sense of community. She is a person who says that in 2001 she called the ambulance more than fifty times to attend people who had overdosed.

> We hated them [users] when we first came, you know, but slowly you sort of adapt and you feel for their cause after a while. A lot of them are pretty decent. They help me out with my shopping, help me with my little girl, you know, the washing.

Use and dealing in the neighbourhood can also have a profound impact on users and non-users in suburban public housing estates. A housing officer working in the western Sydney tells the story of a non-using tenant whose life became more difficult because she complained about dealing and using.

> There's a lady that's come to us and she's surrounded with drugs and she reckons that there's dealing going on and there's users at either side of her and one thing and another, and she's in this type of situation where she's got a transfer [application] in … but it's slow, and she's actually getting abused when she goes outside her door because she rings the police. She's been harassed and of course the police are coming out, so therefore she's targeted by the people that are users...

Situations like this can lead to increased isolation and levels of fear and can undermine trust, leading to the 'say nothing and do nothing' approach to neighbourly relations. A housing officer describes what happens in the suburban public housing estates of western Sydney.

> One of the other things that can happen … where you have a lot of problems in the street caused by the drug usage and visitors and all that sort of thing, it actually modifies the behaviour of all of the other people in the street, because they've got to find ways to survive. And what they do, and you know I've had them say they don't dob, they don't call the police, they don't tell [The Department of] Housing, they won't write anything down. No names. Nothing. They say hi, never talking anything to anybody else. They become terribly isolated. They watch their backs the whole time.

However, as in the high-rise flats, non-users on suburban estates can be tolerant and seek neighbourly trust relations. A non-user tenant in the western suburbs of Sydney described circumstances in her street.

> The drug use, opposite to my house, is a house where a couple live, got a couple of kids too, and they're IV drug users. And there is an issue. Like we've got a bit of a mixed bag I suppose around me. I've got one neighbour on one side who films just about everything they do. He gets his camera out and takes photos of them.

> Whereas the bloke on the other side has offered to assist them at various times, and copped a hiding actually just recently for doing so. And so there's a bit of a mix, within the immediate neighbourhood, there's a bit of a mixed sort of opinion about how we go about sort of communicating or just living with I suppose with these people across the road.

Users in public housing suburban estates can also experience a loss of amenity when they become enmeshed in networks of dealers and users as Ace, a young user in Geelong, described.

> No I just rang yesterday and cancelled it all and gave the lease back to them [the OoH] because I was being held hostage in my own house man, pretty much me and my … and shit man, they just wanted to use my flat as a dealing place … I had no say over it man you know because they had already shouted me heaps of drugs and I owed them apparently you know what I mean and I fucking got beaten up a few times and … shit I didn't even need that man you know. Five of them already they come in and beat the fuck out of me and they beat the fuck out of a few of the people in my flat too.

Third, the amenity of estates can be diminished by the practices of users, such as sex work, shoplifting and burglary, used to fund their drug supply. The impact on other low-income tenants can be profound as described by a housing officer who described the impact of a sex worker on her neighbours.

> Because she wanted to maintain her drug supply, her way of dealing with that was to undertake prostitution. So the problems that we were having was with all the comings and goings, and I mean the households around were outraged with the whole thing you know.

A practice that has an even more direct impact on low-income neighbours is robbery.

> Theft increases. A lot of the tenants can't afford insurance because they're low income earners and therefore the possibility of losing quite a lot of the home if there's a user in the street, you know, in terms of a robbery. And it's them type of issues you know, and they don't want to live where there's people taking drugs or where there's dealing going on. They want to move.

7.2.4   Increased complexity of housing management

The degradation of public spaces, chaotic behaviour and users trying to fund their drug use increases the complexity of housing officer work and workloads. Against this background there is also the expectation that they will continue to implement, what Westacott describes as a 'rigid allocations system', which will increase the proportion of tenants with multiple and complex needs through the use of priority access criteria. A housing officer responding to the question 'What proportion of your allocations are priority in this region?' describes the effect of this policy at the local level in outer western suburbs of Sydney.

> Theoretically it's supposed to be, I think, something like 75%. Yeah it's about 75% but there's some variation across the different teams and that sort of thing. That's the general rule. I mean the policy in broad terms is that we house the clients most in need first. So, I mean theoretically you should really be housing 100% people off the priority list, if you ever get through them, you go to the rest of the list. Then there's the obvious problem that that clearly skews the demography of an estate or something. You've got all these single parents or all these drug users, all these people with mental illness. Essentially that's what the Commonwealth State Housing Agreement says.

NSW Department policy requires that officers balance a number of objectives when making allocation decisions. A key principle is that public housing will be allocated to the people most in need: and in the metropolitan regions at least, the people most in need will generally be those on the Department's "priority wait list". These people will often have complex needs. At the same time the Department's policy is to develop sustainable communities, and allocations need to have regard not only to the needs of the individual on the waiting list and the suitability

of the premises for the particular household, but also to the demography of a housing estate and its capacity to successfully accommodate people with complex needs.

Since this high point of drug activity, the Office of Housing and Victoria Police have launched a series of measures aimed at the 'disruption' of the drug trade in the high-rise public housing estates in the City of Yarra. Security services have increased and now include a 24 hour security presence in the foyers of estates and controlling access to lifts. Foot patrols are also conducted on the estates. Toilets on ground floors are now locked and stairwells are to be fitted with security cameras. Each and every tenant is to be issued with an identification 'swipe' card that will allow access to estate buildings. The Office of Housing and Victoria Police have undertaken a program of tenancy verification with a view to ending the use of apartments for the sale of drugs. The process of going from door-to-door and verifying whether a tenant is who they are supposed to be is time consuming and complicated. However, it has been shown to have results, as we were told by a senior officer in the Office of Housing. On the Collingwood high-rise estate, 80 per cent of tenancies were verified immediately. Ten per cent were verified over the course of a month (suggesting that arrangements were made to re-install the registered tenant) and 10 per cent could not be verified (suggesting that residents were indeed, being bought out or stood over by drug selling syndicates). Of course, there is little to prevent tenants re-establishing informal arrangements following the completion of the tenancy verification exercise. This is the key to the Office of Housing's acknowledgement that such measures represent an attempt to 'disrupt' as opposed to halt the drug trade, a pragmatic approach.

However, despite these measures, the continued refusal of tenancies on the Yarra estates (despite the shortage of public housing and lengthy waiting lists) indicates continued concerns about drug trading. On the Collingwood estate for example, 33 per cent of offers made in respect to the estate in 2001/02 were refused.

Despite being eligible for priority housing many applicants simply will not live on some estates because they are aware of the prevalence of drug use and dealing. This phenomenon creates considerable additional work for housing officers who aim to achieve vacancy rate and waiting list reduction targets.

At the same time housing officers are also acutely aware that the housing options they have to offer prospective tenants are limited. This becomes a significant issue for them when they are aware that an applicant is a user or an ex user and a dwelling in an area where drugs are prevalent is not a good idea. In the west of Sydney a housing officer states what she sees as the problem

> I guess the problem for us is … how could we allocate where we can feel confident they're not going to be having a supply [of drugs] really readily available. So I suppose if there was, you know, it's really difficult to allocate more appropriately.

 'Special allocations' are made for some applicants but these are inevitably constrained by what stock is available and the pressures to allocate housing quickly and maximise the number of people housed. Our west Sydney housing officer continued:

> We do have what we call 'special allocation strategies' for certain blocks, but when you're looking after thousands of homes, and we have a lot of vacant or void properties in a period of a year, it'd be hard to do special allocations for everybody.

> If you've got somebody who's emergency and really needs a house, and the only place you've got vacant is in a block where there's known drug users there, and then you put this person there, then that becomes a problem in itself because you put them in that type of environment.

A housing officer in Geelong says something very similar about the constraints they work under when trying to locate a new tenant, who is trying to change their way of life and not use drugs, into an area where they are not confronted with drug use on a daily basis.

> Yeah we see that all the time. We will see somebody who has just gone through rehab or something like that, really wants to make a new start and the only house is in Corio, back into that area. Every now and then I know that what people have done, like letters of support to try and get a move, what's the other choice,

Whittington, you know. They are going back into that same environment and the risk is enormous. We just as an organisation if we want to do a house swap in Belmont it can take us three to six months as an organisation to get a house done, for an individual you are talking years.

Transfers are constrained in the same way that allocations are constrained. When neighbourly relations do break down for users or non-users and tenants want to move there is little that can be done quickly. Because the possibility of moving into better housing in well serviced and less stigmatised areas is so constrained, rules have been developed to govern the small number of moves that are possible. A housing officer in western Sydney provided insight into the frustration felt by some residents wanting to transfer to estates where drug use is less common. The officer explained that when an application for transfer is based on the desire to move away from other residents in the estate, the policy requires that the applicant first make an attempt to resolve their problem with the other resident.

> They have to be able to provide substantiation that they've tried to solve their own problem and that means going to the police and getting AVO's [Apprehended Violence Order] and they're not going to do that. So they don't move.

On one of the City of Yarra inner city high-rise estates in the pressure for transfers from the estate was extreme. A member of the housing outreach team told us:

> The principal amount of work that we're doing at the moment is processing priority applications to leave the estate. That's a sad indictment when you know your support network is effective in moving people *out* of housing.

7.2.5   Integrating housing and support services

The other major issue facing housing officers is trying to ensure that tenants, who they think require support services, if the tenancy is to remain viable, receive those services. Again the accounts listened to in the course of this research suggest that this is difficult (although the problem has been recognised and some new initiatives have been put in place). This issue of continued service provision is particularly important for tenants who are or have been users. In Geelong the problem was summarised by an officer who fills a newly created Housing Support Coordinator position.

> The Office of Housing is finding that people get into priority housing and that the agency [supporting their priority housing applications] cannot stay and support that person although you can prove that they have been through homelessness. They might have had a dozen addresses in two years, the agency knows [that], Housing knows that, but very shortly after a person moves into their new address in the public housing unit the agency has to walk away because the pressure on them is so great they have to work with somebody else. That is a significant contributing factor to failure of tenancies.

The situation is similar in the west of Sydney. Here a housing officer talks about the difficulty of clearly allocating responsibility between the Department of Housing and the agencies providing other community services. He suggests that there is a tendency for some service providers to argue that the Department of Housing is ultimately responsible for support services, when these are not in the Department of Housing's area of responsibility and the Department in not resourced to provide these.

> I guess there's this assumption particularly in the estates that the people on our estates, it's our problem and we're supposed to subsidise extra services and we need to coordinate them, which of course is really problematic for us. Because our argument … would be that we take care of our side of things [housing] and you have a responsibility to this client regardless of whether they're in our estate or not. There's that sort of constant issue of trying to engage other stakeholders…

Not surprisingly there is also suggestion that a shortage of services ultimately makes the integration of existing services a fraught process. A youth services worker in the same focus group makes this point in his area of youth support services.

I think what the issue is for say example here in Liverpool is who are we going to find to support a young person? There isn't the existence of those services here to support a young person in a tenancy in Liverpool for example. It's not going to happen. I cover Liverpool, Fairfield, Bankstown, there's no way I can take on any more. And I'm the only person I know in the area who does it.

Then there is also the problem of resistance to the provision of services to drug users. NSW Department of Housing officers describe how non-users will sometimes object to the obvious presence of drug user support services on the estates.

There's really a lot of rejection to needle exchange programs coming in the area, and any support services that are known to be for drug users coming into an area, people are getting very very concerned.

7.3   Heroin users on their experience of public housing

Users and ex-users find that the prevalence of drugs on public housing estates is a problem because it made controlled use or abstinence difficult. This experience was discussed in Chapter 6. However, their views of the broader public housing estate environment must be distinguished from what users or ex-users say about their public housing dwelling. Some users and ex-users are fortunate enough to obtain public housing located outside of large public housing estates, while others make a careful distinction between what they say about their dwelling, on one hand, and their neighbourhood on the other. This is the context for some users or ex-users speaking positively about living in public housing, especially about its affordability, security of tenure and domestic amenity. For 25-year-old Juan, a public housing tenant in the west of Sydney clearly recognised housing affordability as one benefit.

Yeah. Yeah and the best thing about Housing Commission is the cheap rent.[26] That's it. Sometimes the environment where's the Housing Department is not a good environment either because they've all got the history of themselves but if it matter of the person who want to change they can start from the Housing Commission because the cheap rent. You don't have too much pressure on and you can get on with life or even study, whatever, find job in the meantime. Don't have to be so rushed. Don't say oh have to do this, have to do that and then there's some days you can't do nothing cause you haven't got any money left. But if someone really, I really want to change and that's what I just say that's what I hope for. I think other people feel the same too (25 year-old Vietnamese-Australian male).

Juan added that this affordability had also helped to remove the imperative for crime as a source of income:

It's good for a person like me. That's why, cause I just want a stable place. If I don't have to pay rent expensive I don't have to do crime.

Likewise, Vicki, who is 'on the dole', emphasises affordability. She lives in a two-bedroom town house on a Geelong public housing estate, is enrolled in a methadone program, and continues to use heroin occasionally.

I am grateful for the roof that I have got over my head from the Ministry and that's why I would never loose the Ministry place. How pathetic if you can't keep it. I pay $45 a week rent. It is not even a cap of heroin.

For Vicki this affordability is coupled closely with her agreement to have her rent automatically deducted from her fortnightly Centrelink payment.

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[26]   Public housing authorities in all states have had different names over the years. Applicants and tenants in both Victoria and New South Wales continue to refer to the 'Commission', shorthand for Housing Commission, the first name used in both states. Many of our interviewees referred to the public housing provider as the 'Commission'. The 'Ministry' is a similar shorthand name for Ministry of Housing, the name used in Victoria during the 1980s.

They just do it all and I find that is the only way that you can use drugs and keep a roof over your head. Because if I have the money I wouldn't go on payday and pay the bills. You know you just don't. It is not something that you do.

Users and ex-users in public housing also speak about the security of tenure that follows as long as the rent is paid. As 27-year-old John, a Vietnamese-Australian tenant noted:

You don't worry about much. You paying rent not so much and you can stay there as long as you like. Not like an agent. You sign a contract, they can kick you out.

This was a view shared by 23-year-old Tiffany:

Um it's cheap. And then it's permanent. There's nothing, if you can't afford to buy your own house, it's permanent. You're not gonna be afraid that they're gonna want the house back for whatever reason. You're not gonna get chucked out of that house cause you're never not gonna have enough money to stay there and you don't need, what do you call it? You don't need a deposit. Do you know, you don't need your bond or anything.

Housing amenity can also be good. For those lucky enough to have public housing in an untroubled neighbourhood the reports can be glowing.

For example, there is Aden in Geelong who, when he first became a public housing tenant, lived in 'a dump' which 'had grass growing through wall of the house and stuff like that'. He then obtained a transfer to a new town house in a well-serviced neighbourhood which enables him to have his two sons stay with him during his access times: 'Yes it is a two bedroom unit. It's lovely… You just couldn't get better public housing than what I have got'. Similarly PB is very satisfied with her town house in Geelong: 'It is a nice flat. Got a lot of potential. I would like to buy it… It's like a bay of flats. Two storey town houses all lined up'.

However, even when the neighbourhood has its troubles, as in the inner city Melbourne high-rise flats the housing can still be good. When users talk about their flats they are almost invariably complimentary about what the 'Commission' has provided. A group discussion amongst users about life in the high rise elicited these comments

It's a two-bedroom flat, separate lounge room, bathroom, toilet. It's surprisingly large. Everyone was shocked. When they see a tower block [they think] you're going to be living in some pokey little thing. But actually they're reasonably roomy I think.

The views are quite nice …

It's got really good washing machines and everything in there. That's one thing I really love about it. Saves heaps.

You've got reasonably good facilities I suppose like washing and that sort of thing … heating's provided …

Maintenance, saves you money in a lot of respects

It is not luxurious but it's good..

Similar comments are made when users talk about the level of service provided by the 'Commission'.

Pretty good. Usually things are attended to within a week.

They do try and look after you. That's one thing, the infrastructure of the flat seems to be improving all the time. In the estate that I'm on they're giving all the tenants, everyone who's on the lease, access to computer courses, giving you a free computer and hook up to the net.

One thing that they offer there is an outreach each week, and that is 1 o'clock to 4 o'clock. Somebody in the office and that's somebody that you can approach about all your issues. If you're behind in your rent, you need maintenance done – any issues whatsoever. I think that's really good to have someone there.

It is therefore important to distinguish between what users and ex-users say about the issues they face because of the location of their housing and what they say about the dwelling itself. Whilst they will talk about the difficulties they face in controlling their drug use if drug using and dealing are nearby. However, at the same time, they can and do praise the affordability and amenity of their public housing dwelling.

7.4 Establishing 'sustainable tenancies' for long-term heroin users

The New South Wales and Victorian housing authorities have responded in similar ways to the concentrations of 'communities of disadvantage' on public housing estates. Broadly categorised these responses have been of two types. First, there has been significant reinvestment in the public housing stock resulting in major up grades and reconfiguring of the public housing stock through sales, acquisition and redevelopment. All of this has occurred in a context of diminishing resources made available by the Commonwealth Government through the Commonwealth State Housing Agreement. A consequence of this reinvestment has been a reduction in an already slow growth in the number of new rental dwellings. Second, there has been an emphasis on improving service provision to tenants and applicants. This has been pursued both through changes in the direct service provision arrangements of the authorities and the way in which authority staff work with other health and welfare service providers.[27]

The emphasis on improved service provision to tenants and applicants is the most relevant to this research because it aims at supporting the provision of additional services and integration of services for tenants who have multiple and complex needs. Drug users and ex users are included in this category of tenants.

In the Victorian Office of Housing these new arrangements are being developed through the Housing Office Review (Office of Housing 2002a) and Labour Market Analysis (Office of Housing 2002b). A key focus of this work is changing the job design of housing officer positions, skill development, workforce stabilisation and recruiting more skilled people. The service delivery focus of these initiatives is summed up in this description of the remodelled role of the Housing Services Officer (Office of Housing 2002a):

> A fundamental role of the Housing Services Officer within the neighbourhood teams is increasing the emphasis within work practices on sustaining tenancies through regular and earlier home visiting and increased support to tenancies identified as being at risk. This work would be planned in conjunction with Housing Support Coordinators and would assist tenants to remain housed and manage their rent requirements. Critical to its success is the need to refine work practice, to reduce the administrative burden on teams, which preclude greater field contact. We need to also ensure that customers exiting THM properties into rental general stock are continued to be supported to ensure that these tenancies are provided with every opportunity of succeeding.

In NSW this approach has lead to the establishment of a number of 'Intensive Tenancy Management' (ITM) projects New South Wales Department of Housing 1999, 2001). The main elements of ITM are 'an on-site housing management team; a flexible local allocations strategy; a smaller number of tenancies per housing manager than in other areas; use of a local handyperson for small general maintenance items; and support for local community development work to enhance community cohesion'.

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[27] Beyond this the NSW Department has responded with one further form of service delivery innovation by transferring some estate housing to two community housing providers. Both of these providers developed small-scale management approaches to specific 'difficult' neighbourhoods based on higher ratios of staff to tenants (New South Wales Department of Housing 2001; New South Wales Department of Housing, Office of Community Housing 1999)

As in Victoria there have been changes in the design of jobs. Housing Managers are being relocated on or near estates and are being encouraged to get to know tenants and encourage their involvement in community activities. Team service contracts that devolve decision making to the local level within a service standards framework provide a key mechanism for this change in direct housing services management. The other job change has been the establishment of Specialist Client Service Officer positions aimed at providing intensive housing assistance and supporting the provision of other services to tenants with complex needs.

There is, it seems, a consensus for these changes in public housing management practices and greater integration of housing service provision and other human services. However, the implementation of these measures is difficult. First, it requires changing the structure of housing officer jobs involving retraining workers and recruiting and training new staff. Second, this approach to housing service delivery is increasing the demands on health and welfare service providers. The dynamic being set in train is the following. Because housing authorities provide the only affordable housing in current housing markets they are concentrating low-income households, often with other needs, in estates. With the changed approach to public housing management, especially the establishment of Housing Support Coordinators in Victoria and Specialist Client Service Officers in New South Wales, a new mechanism has been established that is placing more pressure on other non-housing agencies for additional services. This creates a dilemma that is well expressed by western Sydney housing manager.

> So more people with that level of need are being – I shouldn't say dumped – are coming into these outer areas because this is where the accommodation is. So the higher proportion you have of people with those needs the greater demand and pressure is being placed on all of the other health and service agencies. So that's our fault they're getting all these people.

A non-government service provider describes the dilemma from his perspective.

> There isn't the existence of these services here to support a young person in a tenancy in… for example. It's not going to happen. I cover (three different areas). There's no way I can take on any more. And I'm the only person in the area who does it (Community-based Youth Worker).

In these areas there is, therefore, a constant process of negotiating integrated service arrangements for clients using such mechanisms as 'service agreements'. In effect what is happening is that the housing authorities, using their revamped approach to service delivery, are seeking to have a greater say in the deployment of the resources of other service providers who are also working with constrained budgets.

7.5   What is the relationship between service provision and housing?

In this section the relationship between service provision and housing is considered from the standpoint of both the 'client' and service providers. We ask how housing and drug use connect to:

- User's need for and capacity to access a range of services; and

- The degree to which those services meet the needs of 'clients'.

With this material in hand we ask whether any improvements are required in current service provision and housing policies to enhance the social opportunities of heroin users? We need to make clear that we do not, and indeed cannot within the confines of this report offer a comprehensive survey of all services that users access and the role of secure accommodation in that relationship. What we do offer by way of examples are insights into the divergent lives of users and the difference that having secure accommodation can make in respect to their capacity to access services. In particular we consider the relationship between housing and access to health services, drug treatment services and family services.

7.6   Housing and access to health services

Among the many stereotypes of problematic drug use is the idea that 'drug habits', homelessness and a relatively chaotic lifestyle go together. There is sufficient evidence from law enforcement, public health interventions and our own research to suggest that this image corresponds, at least in part, to the reality (Neale, 2001; Hutson and Liddiard 1994). One of our findings is that this way of life does have a significant impact on a person's ability to access and maintain a connection with service providers. Of course the needs and ability of users to access services will vary. For some people access to health or welfare services is vital while others are relatively self-sufficient. Furthermore, people's needs change over time. While they may be relatively autonomous during some periods, they may have significant needs during others.

One thing many services and clients agree on is that substance abuse takes a toll on the user's health. Given this, it is not surprising that people who are long term users often experience a range of health problems, which, if untreated, can result in high costs to both the individual and the community.

Bacterial infections that can arise from injecting drugs include distal bacterial infections such as septicaemia and endocarditis (an infection of the heart valves). One of our interviewees, Carla, lost her husband to the latter after he injected heroin mixed with water from a car radiator. Damage to, and infection of, veins is a common result of frequent and prolonged injecting drug use. Cellulitis (a subcutaneous inflammation) and abscess formation around injecting sites is also a common effect of poor injecting practices and syringe re-use. Of course, the less than hygienic conditions in which those without stable housing inject drugs increase the risk of infections of this nature.

Other health complaints commonly reported by drug users include skin diseases and gynaecological complaints. Sexually transmissible infections (STI) are reported to be common among IDU, *particularly* those who are homeless. Walsh (1998) reports that young homeless injecting drug users are 2.5 times more likely to have a STI than non-injectors. This is largely a consequence of engagement in sex work, a factor that places dependent drug users at increased risk of violence and / or sexual assault. Among female IDU, amenorrhoea (the cessation of the menstrual cycle) has been reported. This condition is often resolved following commencement of substitute therapy (e.g. methadone) and the introduction of improved diet and *stable living conditions* (Crane 1991; Wodak 1998).

Respiratory conditions generally suggestive of bronchitis (often as a result of smoking) are widespread (Wodak 1998). Further conditions that could arguably by related to a drug-using lifestyle include pneumonia and viral and gastrointestinal infections. Drug users have also been identified as being at high risk for contracting and spreading tuberculosis due to poor environmental conditions and problems of access to primary health care. This is *particularly* the case for homeless drug users whose periodic exposure to the elements, poor nutrition and often unhygienic living conditions may lead to and exacerbate a range of chronic health problems.

Consequently, from the perspective of health professionals, accommodation is crucial. The degree to which it is so, however, will, differ according to the needs of the user. For some, the immediate availability of secure and appropriate housing can make all the difference in terms of their physical and psychological well-being, while for others it is not an urgent matter. Indeed a number of those we spoke to were happy to live in squats and had a limited need for services. However for others, the absence of appropriate housing was an issue in need of immediate address.

Certain groups of homeless drug users, like those with a mental illness, are more vulnerable to health complications without secure and appropriate accommodation. Indeed, Hodder et.al. (1998) have documented significant rates of mental illness among homeless populations in Australia. Despite their needs, this population also typically experiences greater difficulty than others in accessing and maintaining contact with health and welfare services. However, as one service provider in Geelong told us, there are jurisdictional complications associated with dual diagnosis (i.e. mentally ill drug users who are also homeless) which sometimes mean

that the homeless and mentally ill fall through the gaps between the services established to address the needs of each *specific* population.

Pregnant women who use heroin are another vulnerable group. For pregnant women wanting to achieve a healthy pregnancy any of hope successful parenting is significantly undermined by the lack of appropriate housing. As one health worker at the Royal Women's Hospital explained to us:

> [We] would have had no hope with her if she hadn't been accommodated so quickly after the stabilisation … I mean there were lots of issues going on but her accommodation and being in a house made a huge difference.

The very fact that these expectant mothers 'use' is a barrier that keeps them from securing certain forms of accommodation. Indeed, it is used by some housing services as grounds for excluding them (Szirom and Desmond 2001). Yet for these people, stable and secure housing is essential if they are to keep their child out of the state child protection system and receive neo-natal and post-natal care. As one neo-natal health worker told us:

> …without accommodation it is really hard to prepare with material aid and assist women getting baby clothes, bassinets and a cot because they have got nowhere to store it … And there are no material aid bills so that can deal with other support post-natally, like maternal child health nursing and drug and alcohol counselling. It is hard to do it.

Despite the priority listings they often receive, there is a significant shortage of public rental housing for vulnerable groups (Review of Public Rental Eligibility Criteria Reference Group 2001; Yates and Wulff, 2000). Furthermore, in the same way that the larger category of 'heroin user' is complex, so too are these smaller sub-groups. For example, not all pregnant women who use heroin have the same housing, social, welfare and health needs. Some, for example, already have children, while others do not. This has implications for housing. For the former, one-bedroom accommodation may be preferred, while for those with children, they may be a requirement for additional bedrooms. Consequently, there is not only a significant shortage of housing stock but there is a further shortage of *suitable* housing stock, leaving many people homeless and unable to access appropriate shelter.

Unfortunately, for those who remain in a state of homelessness, generalist medical services are ill-equipped to deal with their needs. Being without secure and stable accommodation makes accessing services extremely difficult, if not impossible. Getting accurate data about these matters is not always easy. Many generalist medical services require an appointment before treating a patient. However, the transience that can characterise the life of the homeless individual makes the keeping of appointments extremely difficult. Indeed, there is little incentive to make an appointment in the first instance for an individual who is unaware where they will be from day to day. A study by South East Health in New South Wales reported:

> There are low levels of awareness among general Practitioners about the issues involved in providing good health care to homeless people, and the general practice representative on the [study] working party believed that both education and support for practices with homeless patients are needed (South East Health, 2000: 32).

7.7　Housing and access to drug treatment services

Drug treatment entails taking part in one or more programs as well as accessing allied support services. The kind of treatment available includes:

- Maintenance treatment (substitution pharmacotherapy (i.e., methadone / burprenorphine).

- Inpatient / residential detoxification;

- Out-patient detoxification

- Home detoxification (both supervised and unsupervised programs)

More broadly, however, drug treatment entails general health improvements, including the rebuilding of a person's physical and emotional health.

7.7.1 The need for accommodation

While not all those we spoke to wanted to limit their drug intake, quite a few did. When a person decides to make such a change in their life they will typically require help. For those with family and financial support a range of options can come into play including hospitalization and private drug rehabilitation centres. On the other hand, for most of the people we interviewed, public sponsored drug treatment programs are the only available services. In this respect, access to appropriate housing is vital for achieving some semblance of well-being.

The absence of secure accommodation creates significant hurdles for those wanting to undertake drug treatment. To begin with, the absence of secure accommodation means having little if any control over who enters the space in which you live. In the case of a 'squat', it also means being in an environment characterised by constant drug use and sharing with people who are 'shoving drugs in your face' (Dalton, Rowe 2002). More generally, it places the individual beyond the reach of health support services.

These difficulties can soon frustrate any attempt to develop a relatively healthy life-style. As noted in Chapter 3, the attempt to better manage problematic patterns of drug use invariably fails without access to secure and appropriate housing. In this respect, given the high costs associated with long-term substance abuse, it makes good policy sense to make appropriate accommodation available for just this purpose.

Here too we reiterate the point that heroin users are a variegated section of the population. While the need for accommodation applies to most drug dependent people wanting to achieve a level of physical well being, it is accentuated for pregnant users. As noted on the previous page, accommodation is essential if a young woman is to receive post-natal care and, consequently, have any chance of keeping her child from the state child protection system. One health specialist provided a graphic example of the difference that suitable and stable housing can make:

> When a young woman is committed to working toward a successful pregnancy, the availability of appropriate housing can make all the difference. I had a woman who came in off the street and she was drug affected when she came in … I found out she was pregnant and when I assessed her accommodation needs, she was actually living in a Brotherhood bin … and she was doing a lot of sex work on the street. We assisted her in getting some transitional housing and then stable accommodation and she engaged quite well with the services and stabilised … [We] bought her in on the Monday to this new stabilisation program, started her on methadone … and while she was in hospital assisted her with some accommodation that was safe and secure. Once she had accommodation she attended the clinic quite regularly and engaged well with the service and by the time she delivered there was no child protection involvement. She secured her own Ministry of Housing and was able to keep the baby in her care.

7.7.2 Maintenance Treatment

Maintenance treatment involves the substitution of one drug (methadone or, increasingly, buprenorphine) for another (heroin). This can require daily visits to a methadone / buprenorphine dispenser (usually a pharmacy or drug treatment agency). It is generally a long-term program extending for a period of months or years.

Given that methadone is a (synthetic) opiate, albeit a state sanctioned opiate, a user must be registered with the appropriate authorities. The rigorous enforcement of detailed registration requirements means that maintenance programs often present as an impractical option for the homeless. Indeed, as currently constructed, methadone and other maintenance treatment programs are unable to accommodate a transient lifestyle as each subsequent move entails reorganising the alteration of prescriptions and drug administration arrangements; often involving a lengthy search to locate a new chemist willing to dispense methadone. For a drug dependent person, who may also be unwell from other 'conditions' (i.e. hepatitis C, under-

nourishment) tiredness, nausea and general poor health can make such tasks complicated and extremely difficult. Such frustrations are all too often simply too much, resulting in treatment lapse and a return to heroin.

For those with secure accommodation, such organisational tasks may seem minimal, but when they are understood in the context of lives typically characterised by chaos, ill-health, fear, stigma and desperation such tasks can become impassable barriers. This is particularly so when trying to make a simple doctor's appointment that might entail waiting a day or more to see their doctor, or for hours in a medical waiting room. There is also the added obstacle that often arises in the form of the uncooperative or narrow-minded medical practitioner (Neale 2001, p. 364).

The following comments from one health worker illustrate how the absence of secure accommodation undermines even the most dedicated attempt to stay in a methadone program.

> Even when they are really dedicated and want to stop their drug use, it is very difficult, and we have had a lot of women who want to stop. There was one in particular who was committed to not using heroin any more. She went on methadone. However you need to be in the one place at just about the same time of the day to collect your methadone. She was going from hostel to hotel. After a while she just couldn't follow through collecting methadone because it is just so much easier to score than having to train it. She would be catching two trains into the pharmacy here because she couldn't tell you where she would be from day to day.

Another health worker used a second example to demonstrate that, despite the individual's commitment to complete a methadone program, the barriers associated with homelessness can sometimes prove too much:

> She was pretty committed … but after you change your pharmacy three times and she's tired … By the end she would be walking around, it was mid summer and she would be 33 weeks pregnant and starting to puff away trying to get to the pharmacy. She was committed to being on methadone, but just couldn't carry through after a while.

There is also the issue of the cost of drug maintenance programs. For people on minimum social security payments, even adding in rental assistance, the costs of methadone can amount to 20 percent of their total income. Horn makes the point:

> When one considers the rental cost of a modest low-cost one bedroom flat is around $95 pw, the person is left with having to make choices between paying their rent or paying the costs of the methadone program (Horn, 2001, p11).

While the shortage of appropriate housing makes a significant difference for people wanting to under go a drug treatment program, the task in respect to other drug treatment options like withdrawal services is no easier.[28]

7.7.3   Withdrawal services and accommodation

When it comes to withdrawal services there are three basic options. The first option is residential detoxification whereby the person lives in the residential unit (for a number of weeks) while withdrawing and receiving intensive support. The second withdrawal option is 'out-patient detoxification'. This involves supervised withdrawal and daily visits to a doctor or alternative drug treatment providers. Commenting on the problems that homeless people experience when attempting to complete withdrawal programs, Carmichael observed:

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[28] Accommodation generally for homeless people is in short supply, and suitable housing for drug-dependent pregnant women wanting to normalise their life is in even harder to find. This has serious implications for the likely success of their drug treatment programs. (AIHW 1999-2000; AIHW, 2000-2001; Yates, J., Wulff, M., 2002).

> If a client is homeless or in crisis accommodation the likelihood of attending appointments is greatly reduced. … Until suitable accommodation is found the client is likely to continue to relapse, effectively trapped in a cycle of homeless and substance abuse (2001, p. 31).

The third option is 'home-based withdrawal'. As the name implies, this involves withdrawal in your own home. The service typically includes support and supervision from health and welfare specialists. Home-based treatment is obviously reliant upon the existence of a relatively stable place of residence, and secondly, on the presence of a suitable support person who will be on hand while the person is undergoing withdrawal. Finn, squatting and awaiting the outcome of a public housing application, raised an obvious but often ignored reality when she told us:

> As soon as I have stable accommodation I think it will be much easier to do that … to have a home based detox … When you don't have a home you can't really have home based detox.

Her partner, Ade, attempted to detoxify prior to beginning a buprenorphine maintenance treatment, despite the lack of appropriate housing and support. His experience makes very clear the need for a supportive presence in such attempts:

> I had a terrible experience with the buprenorphine in the transition period where I was squatting at the time, down on Wellington Street … They suggested that I take two days off of not taking anything – which I did – and I went and picked up my first dose of buprenorphine in the morning [and] pretty much went into instant withdrawals within half an hour to forty-five minutes. I was just lying in the backyard in foetal position, diarrhoea dribbling out my arse and vomit and bile coming out of my mouth. That continued on until the next afternoon went in again to pick up my next dose, the same thing happened all night. That pretty much carried on for three days and three nights – they wouldn't even give me a Valium – not even one Valium tablet to help me sleep – I was going nuts – and the whole time I was just in constant withdrawals … so that wasn't too successful … I thought, bugger this, I think I'd rather deal with having a habit again.

Many of these difficulties similarly apply to those living in rooming or boarding house accommodation. Many of the people using such accommodation also tend to have a transient life-style and relatively insecure social and familial support networks. Horn (2001) has suggested that most drug-dependent homeless people have relatively weak support networks that are able to provide the level of assistance necessary for a successful home-based treatment.

Furthermore, Horn pointed to a the way in which *some* health specialists, such as general practitioners, work in isolation from housing services and with a relative naivete of the issues facing homeless people attempting to withdrawal in temporary accommodation.

> In most cases there are inappropriate levels of supervision for people experiencing homelessness and who have been prescribed drugs by GPs to reduce some of the symptoms of withdrawal. There has been at least one near fatal accident at the Hanover Southbank crisis centre due to the lack of appropriate supervision a client using such prescribed drugs. …. In order to exercise appropriate levels of care, much greater coordination is required between general practitioners and staff in major homeless services (2001, p. 11).

7.8   Family and community services and child protection

Housing is critical for dependent drug users and who have children. Typically once a child is present, a constellation of professionals and institutions become involved (i.e., health services, police, and welfare services). In this context, without a home in which the child, or children, can be cared for, an array of interventions are likely to take place. Indeed, for some women the very prospect of losing their child to Child Protection Services is enough to deter them from accessing certain services. As a clinician at the Women's Drug and Alcohol Service told us:

I think they would have just kept putting child protection on me. In some way sort of monitoring … they try and make every excuse up to be involved with you, for the government to be involved with you because they hate junkies. … I was having a bad day and I was saying, 'I'm just having a bad day, I'm tired, I'm expressing milk'. I was just doing everything and it was so new. What I needed to do was drink tap water and have a rest. But what they ended up doing was getting child protection around.

As one welfare-health specialist explained further, when housing is not available child protection intervention is inevitable:

When housing hasn't come … [when] the woman hasn't had a house, a safe place to go; it has meant child protection has been involved as we had no plan for discharging the baby into her care, and, you know, that's made a big difference to her confidence … I had to make a notification to child protection purely on housing.

Paradoxically such circumstances can throw-up quite bizarre examples of government and non government agencies working in isolation. Unaware of the work being done in other sectors, each has the potential to cancel out the good intentions of their counterparts. In the case just mentioned, the expectant mother's homelessness caused significant administrative complications for Child Protection. As one worker explained:

Because she was homeless they couldn't decide which area would be looking after her, because she wasn't living in an area… They were saying [to the women], 'well you have to choose where you want to live when you have the baby'. So they wouldn't do anything [in respect to intervention]. And … she ended up in a residential unit… So what that meant for us was that it gave us a bit more time to work on the housing because this woman did engage with housing services, she was quite proactive, she was ringing, had completed all her forms and yet she was about to deliver and there was no accommodation.

This highly creative strategy provides an illuminating example of, on one hand, the commitment of workers to clients and their willingness to 'work the system' and, on the other, an appalling failure in respect of the provision of an integrated all-of government approach.

It was reported explicitly how services like child protection simply can't cope with people who do not have an address. As one worker at the Women's Drug and Alcohol Service reported:

DHS [Department of Human Services] … don't want to know. They are busy, and they don't want to deal with it. So if she is homeless they say: 'oh really where is she going to be living, make a notification when you find out.

There is also a flip side to child protection, drug use and housing. In the case of Ben, now 19 and recently returned to the family home in Geelong, it was a child protection intervention when he was 13 that paradoxically led to homelessness and drug use.

I left home because someone had dobbed my mum in for bashing me and Human Services took me off my parents. I went to a foster care place which I hated. I hated every single one of the placements and I got into drugs because I was sexually abused and stuff like that. Got into heroin when I was 16 or 17 … I've lived on the streets a number of times even when I was under a custody order with Human Services…

7.9   Concluding Comments

In this chapter, we have examined the ways in which current service provision addresses the housing needs of long-term heroin users. In doing so, we have focussed on the availability and appropriateness of public housing and the way this service relates to other health and welfare services. For most of the low income heroin users that we interviewed and surveyed in the course of this research public housing is the only realistic housing option. In the private rental market there is evidence of discrimination against low income users. Then there is the question of affordability. For most users in the locations we researched private rental housing is not affordable.

It is against this background that the shortage of public housing constrains the ability of housing officers to meet the service needs of long term drug users. These constraints continue despite the development of new tenancy management approaches, such as those provided by Housing Support Coordinators in Victoria and Specialist Client Service Officers in New South Wales. These officers are developing new way of connecting the provision of housing to the provision of health and welfare services. However, the extent to which they can house users and connect them to these other services is constrained by the high level of demand for housing services and the need to ration access to housing, by users and many other high needs groups, through the priority system.

The difficulty of housing heroin users in public housing is made more difficult because of the endemic nature of drug use on some public housing estates has resulted in a significant loss of amenity. Both users and non users in need of housing will often refuse to live in residential environments where drug-use is rife and there is accompanying violence and crime. Indeed, for some users in desperate need of housing, homelessness was preferable to a tenancy in a public housing estate with a reputation for drug use and trading.

The high level of demand for public housing and the presence of heroin users amongst tenants and amongst those eligible for priority housing have led to the work of housing officers becoming more difficult. The increasingly complex needs of people now applying for public housing tenancies, combined with the shortage of appropriate housing, increases the level of demand and complexity of work for front line housing officers.

There was also evidence that workers providing health and welfare services to heroin users sometimes fail to recognise the significance of unmet housing needs. Often the consequence of these needs not being met are serious safety and continuing long term health problems. This highlights the need for greater cooperation between housing and the broader health and welfare system around the needs of heroin users. However, our research also makes clear that the needs of heroin users are diverse and that the required service system responses must take account of this diversity.

8 CONCLUSION

We were prompted to undertake this research when we became interested in policy research suggesting that some heroin users are another group who are disadvantaged by not being able to access secure and affordable housing. In part this came from the homelessness policy research that found that many of those using homelessness services are also users of illicit drugs. Other research has explored connections between drug use and exclusion from important areas of social and economic life. However, while these studies have described patterns of homelessness and exclusion and made connections to illicit drug use there appeared to us to be little research that focuses directly on housing provision.

Our research proposal therefore argued that we should broaden the focus of drug-related policy research by aiming to better understand the housing issues faced by heroin users and how housing provision can enhance their wellbeing.

The report has sought to accomplish this task by focussing on three research questions addressed in the earlier chapters:

- In what ways if any, do accommodation options affect the wellbeing and social experience of young heroin users?

- In what ways does current service provision for long-term heroin users address their housing needs?

- What changes in current service provision and housing policies would improve the social opportunities of heroin users?

The approach adopted was to listen to experiences of heroin users and service providers through the use of ethnographic interviewing techniques, focus group discussions and a small survey undertaken in each of the three study locations.

The key findings of our research were as follows:

- The reasons an individual chooses to use heroin are as varied as the impact that its use will have upon other aspects of their lives;

- Safe and secure housing has the potential to increase the wellbeing and social capacity of heroin users. It can support choices about stopping heroin use or taking action to prevent a relapse. These decisions are more difficult in living environments which users do not control and heroin is readily available and where drug use offers temporary escape from deprivation;

- Homelessness and the lack of stable housing makes injecting practices high-risk and increases the risk of infection and the spread of blood-borne viruses such as HIV and Hepatitis C;

- There are a range of health benefits associated with secure housing, including better nutrition, adequate sleep and improved personal hygiene. Secure housing also has mental health benefits by addressing the alienation and depression often associated with an unstable housing environment;

- Access to secure and affordable accommodation enhances an individual's capacity to make use of the social opportunities offered by education and employment, opportunities that are often inaccessible to the homeless and transient;

- Public housing, the only affordable and secure housing option for low-income, dependent heroin users, on some public housing estates, is becoming a wasted resource. This is a consequence of an embedded and endemic drug trade in some public housing estates. The loss of amenity accompanying this drug trade often leads to public housing applicants being reluctant to accept tenancies on these estates and for significant number of existing tenants requesting transfers to other estates;

- There is a serious shortage of public housing. This constrains the work of service providers seeking to meet the needs of heroin users. For housing officers it means that they must allocate housing within an inadequate and constrained stock portfolio. This can

negatively affect users seeking to avoid living near other users and existing tenants, both non users and users, by lifting demand for drugs in some areas. For other service providers it means that they are often unable to obtain secure and affordable housing for their clients even though it is necessary for their health and welfare.

We conclude by responding to our third research question about changes in current service provision and housing policies by arguing for four changes in service provision that respond to the issues we have identified. They are

- Social housing provision and improvement

- Locating drug markets in cities

- Engaging heroin users in program development

- Service provider knowledge and understanding

8.1 Social housing provision and improvement

The experience of heroin users and service providers discussed in chapters 5 – 7 directed our attention to the features of private rental and social housing provision. There were features of both tenures that undermined the ability of heroin users to find and maintain secure and affordable housing.

Our research showed that some heroin users, predominantly in Geelong, were able to find housing in the private rental market. To some extent, this was because a number of interviewees and those surveyed in Geelong were no longer using heroin, having instead entered into drug maintenance programs such as the methadone program. However, we conclude that it was also because private rental housing in Geelong, compared to inner city Melbourne and western Sydney, was available at rents that were more affordable for low income renters than the other two locations. This experience of users is perhaps what we might expect, based on the picture of the private rental market apparent in the availability and affordability data displayed in Table 1 in chapter 6. However, it is also clear that real estate agents continue to make judgements about who will be a reliable tenant and therefore exclude people they think may be users. Many of those we interviewed, in all three research areas, recounted how agents have excluded them from the private rental market (see chp 6)

This is the context for heroin users finding they have two possible options beyond the private rental market. First, there is temporary housing found in crisis accommodation services and boarding houses. However, neither provides the basis for living arrangements where users can plan to develop capacities and make choices about their participation in social and economic life. The second option is public and community housing. It does provide the possibility of secure and affordable housing for heroin users as demonstrated in some interviewee and housing manager accounts where they are overwhelmingly positive about the benefits that public housing provides. However, users can also experience problems with public housing. These problems lead to three suggestions about directions for change.

First, there is the need to continue with the service delivery innovations associated with the introduction of Housing Support Coordinators in Victoria and Specialist Client Service Officers in New South Wales. These positions have been established in response to a recognition in the housing agencies that there is a need to create the conditions for 'sustainable tenancies' for clients with multiple and complex needs. This requires that the provision of rental housing is connected to the provision of other health and welfare services. Evidence provided by service providers during this research indicated that these innovations were resulting in better outcomes for tenants and making the processes associated with maintaining tenancies more robust. However, no broad evaluation of these innovations was available. However, it was also made clear that these service delivery innovations were operating in a context of limited resources. The extent to which housing officers can house users and connect them to a broader range of health and welfare services is constrained by the excess demand for housing services and the need to ration access to housing, by users and many other high needs groups, through the priority system.

This leads to the second suggestion for change, an increase in social housing supply, provided either through state housing authorities or community housing providers. Overall there is a sustained high level of demand for public and community housing caused by private rental market failure and decline in access to homeownership by some demographic groups (Yates 1999; Yates and Wulff 2002; Brotherhood of St Laurence 2003; ACOSS 2002). Many of our interviewees spoke about the difficulty that they experience in getting into public housing. They join long waiting lists. They either wait for a long time or become involved in establishing a case for priority allocation based upon evidence that they are homeless, face the possibility of homelessness and/or have other significant needs. This is the context for a policy change over the last few decades, which has guided increased rationing of this scarce resource, expressed through allocations policies. It has increasingly targeted housing to very low-income households who have other significant needs, including heroin users. Increased supply would result in more people being housed and less reliance on rationing.

Third, there is a need to continue to reconfigure the location and distribution of public housing in metropolitan areas and in provincial cities. A consistent message coming from both users and housing managers is that providing tenancies to heroin users on large-scale housing estates is often a problem. On many of these estates there is continuing use and dealing. There is an almost unanimous view that this reduces the opportunity users and ex users have to exercise control over the use of heroin. Its 'in your face' presence in the neighbourhood makes it harder to reduce use or abstain. However, housing managers in the current context often have little choice but to offer public housing tenancies to users in these large estates because only a small proportion of the stock is provided outside of these estates and there is virtually no expansion of the public housing stock under the provisions of the Commonwealth State Housing Agreement.

8.2   Locating drug markets in cities

The embedded and endemic nature of the illicit drug trade in certain public housing estates underlines the need to think creatively about its future location. Indeed, focussing the concentrated resources of law enforcement upon one area has been demonstrated to simply displace drug markets into surrounding areas (Maher & Dixon, 1999, Fitzgerald et.al., 1999). In this respect, participants in the drug trade will continue to exercise the type of invention that they have already shown as the market has been pushed and pulled around the inner city and the suburbs. The drug markets in the high rise flats in inner-city Melbourne and in the suburbs of western Sydney are simply the most recent locations, a consequence of choice and circumstance. This leads to a question about where it might go next if enforcement initiatives succeed in dislodging the markets again. The alternative is for mutual agreement between stakeholders to 'pull' the heroin market out of the high rise and suburban estates and locate it 'elsewhere'. Clearly the location of 'elsewhere' is an issue beyond the scope of this research. However, we must make the simple point drugs markets will continue to operate and generate externalities. It may be worthwhile to recognise this and make their location a focus of public policy.

Although the idea of 'managing' the illicit drug trade in this way is contentious, this type of location decision was recently considered in relation to illegal sex workers in Victoria. In an attempt to address the problems associated with a street-based sex trade in the Melbourne municipality of Port Phillip, the Victorian Government, in consultation with the Port Phillip City Council short-listed four areas as 'tolerance zones' for street-based prostitutes (Costa & Tomazin, 2002). Only a potentially powerful community backlash in the lead-up to a state election saw the government shelve these plans. However, the government's willingness to address this issue demonstrated how it is possible to entertain innovative approaches to better manage an illegal activity and associated problematic behaviour.

There are, of course, significant complexities to such a proposal. Nevertheless, if the problems associated with a highly mobile illicit drug trade are to be addressed, difficult questions must be asked. Until such questions are answered, the drug trade will remain firmly embedded in those locations that offer the greatest individual gain for those who seek to profit from such illicit activities. In this instance, that location is the valuable but wasted resource that is high-rise and suburban public housing estates. The tragedy is that the majority of those who share

this location with participants in the drug trade will continue to bear the costs of their activities and the community will remain robbed of a valuable and much needed resource.

8.3 Engaging heroin users in program development

If policy is to be sensitive to the needs of illicit drug users, then policy makers must be prepared to engage drug users in program development. To date, there has been relatively little effort undertaken to explore and appreciate the experiences of drug users themselves. Indeed, while links between issues of homelessness and problematic drug use have been the subject of a substantial body of policy research, there has been relatively little effort undertaken to explore and appreciate the experiences of drug users themselves. This is one of the most significant weaknesses of current policy approaches and one that deserves to be addressed as a priority.

The actual experiences of drug users often differ markedly from widely accepted assumptions that continue to inform drug policy debate. All too often these experiences are lost amidst the discourse of health experts, policy-makers and the official and self-appointed representatives of law and order. And, as this research has demonstrated, drug users are able to talk in an informed manner about their experiences in relation to housing and the impact that housing has upon the extent and nature of their illicit drug use and the impact this has upon other aspects of their lives.

For as long as this situation remains, policy makers will continue to be, at best, only partially informed and policy will be designed to meet and address *assumptions* about illicit drug use and illicit drug users, as opposed to the reality of their existence and experience. We suggest that a good place for policy and program development people to start the consultative process is with the organisations that already represent heroin users and users of other illicit drugs, VIVAIDS in Victoria and the NSW Users and AIDS Association (NUAA).

8.4 Service provider knowledge and understanding

The increased targeting of public and community housing has increased the difficulty and complexity of work undertaken within the housing service sector. State housing authorities, in particular, have become involved in allocating housing and managing the tenancies of households who are on very low incomes. A significant proportion of these households are experiencing other significant challenges and disadvantages. Households with members who are heroin users are amongst them. In Chapter 7 we argued that the presence of these and other households with complex needs sometimes made the sustainability of tenancies more problematic. This has led to a new emphasis on the management of 'sustainable tenancies' by trying to ensure that the provision of other services was made a condition of tenancy through the employment of specialist housing managers.

However, there is case for ensuring that these specialist housing managers are working in an organisational context where there is a better understanding of drug issues. Another element of this program of organisational development is an extension of workplace training. It is within this context that a case can be made for establishing a means for systematically increasing the understanding that housing officers have of drug issues. Because there is significant overlap in the issues faced by housing officers dealing with drug users and alcoholics there is a case for linking learning about drug and alcohol issues and housing services provision. We are suggesting that this might be done through the development of a short course or training module that could be linked to broader training programs undertaken by workers in these two service areas. Furthermore, we would suggest that such a short course or training module be accredited by TAFE and higher education providers.

Information provided by the National Centre for Education and Training on Addictions (NCETA) revealed a range of drug and alcohol courses currently offered at tertiary level in Australia. In Victoria alone, the NCETA has identified 19 tertiary level courses ranging in length from one semester to two years. Although there are no courses aimed specifically at housing workers, a number of these courses contain curriculum material that is relevant to the delivery of housing services. The Community Services Certificate (Alcohol and Other Drugs Work) at Chisholm TAFE, for example:

Provides students with the knowledge and skills required to function competently in a range of community settings where clients may be affected by drug and alcohol issues (NCETA 2003).

However, this type of knowledge is not available to housing service providers. Housing service workers are one group of workers, amongst many, that become involved in the management of drug an alcohol issues who do not have systematic access to knowledge about the issues. A NCETA parliamentary submission has summed up the problem in the following way:

Problems relating to alcohol and drug use have been an area of growing concern in Australian for some time. Over the past one to two decades specific efforts have been developed to strategically target alcohol and drug problems. These efforts have largely focussed on a number of select areas of attention including demand and supply control and treatment and more recently, but to a considerably lesser extent, prevention. Efforts to up-skill the diverse workforces that are directly and / or indirectly involved with the management or containment of alcohol and drug related problems have been less prominent. Overall, the area of workforce development has received considerably less systematic attention that most other areas intended to impact on the alcohol and drug problem (National Centre for Education and Training on Addictions 2000: 2).

It is in this context that state housing authorities should consider commissioning the development of a module that makes use of existing course material that is relevant for housing officers. In line with our discussion about how important it is to include users in discussions about program development the design of this module should involve relevant drug user and alcoholic self-help organisations.

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10 APPENDIX 1 - SURVEY DATA

10.1 Introduction

This research has used data drawn from a literature review, in-depth interviews with users, a survey of users and focus group interviews with service providers. No one research method was privileged over another. All sources and types of data were seen as important. Furthermore, the use of multiple research methods allowed for verification and confirmation of information and evidence gathered from a number of sources.

The following appendix provides an overview of data collected through surveys within each of the three study sites. Fifty surveys were conducted in Cabramatta, forty-five in Geelong and forty in Fitzroy / Collingwood. It has two broad purposes. First, it provides further detail on the housing circumstances of users and ex users in each of the three study areas. Second, it provides a broader description of the population groups from which our interview participants were drawn.

10.2 A note on the use of surveys

10.2.1 The difficulties of recruitment

When surveying a group like heroin users it is important to be cautious in interpreting the data. Given the hidden nature of illicit drug use, its measurement will always present substantial research difficulties. Illicit drug users in general, and heroin users in particular, have long been a stigmatised group (Engels, et.al., 2002, Manderson 1993; Henry-Edwards, Pols 1991). Consequently, many users of heroin and other illicit drugs are unwilling to take part in research activities for fear that their drug use may become public knowledge. This is especially so for wealthy or 'respected' drug users who may feel that they have much to lose if, for example, their employer became aware of their illicit drug use. The effect of this reluctance is a bias towards research studies of impoverished or powerless drug users (Whiteacre n.d.).

This research continues this bias. These survey participants were recruited through services that ran programs aimed at providing services to users who generally had, or had recently had, significant drug dependency issues, were low income and needed continued support from health and welfare services. This was not a 'random sample' of heroin users. Our survey participants were drawn from needle exchange programs, community health centres and street-based networks. The payment of $10 for participation attracted those who most needed $10. In this context, the survey results should not be considered as a representative sample of drug users.

10.2.2 Some methodological issues

The use of survey instruments to measure illicit drug use is further compromised by a number of methodological issues. Illicit drug users often go to elaborate lengths to conceal their illicit activities. They may, consequently, be unwilling to reveal the extent and nature of these activities to an unknown researcher. Suspicion as to the identity and motives of researchers may further influence the accuracy of the research findings. Indeed, a number of participants expressed concerns about the confidentiality of their responses and their use. Although participants were reassured about the confidential nature of the data and signed a consent form in which their anonymity was guaranteed, such concerns may have influenced their response to questions.

The validity and reliability of survey data may also be affected by false reporting and / or misinterpretation of questions. Furthermore, it is important to recognise that *all* the participants in this research had been users of a variety of psychotropic substances with the greater majority continuing to use. Such drugs are so classified because they have an altering effect on perception, emotion, or behaviour. In this context, it is possible that an individual who has just used heroin is in a far more positive frame of mind that one who is suffering the 'come down' after a prolonged amphetamine 'binge.' This could realistically be expected to affect the nature of participant's responses, particularly when questioned about their perceptions of their personal circumstances. The researcher must be prepared to acknowledge that surveys

record what respondents *say* about their lives, and not how they actually live them. The same qualification of course can be made about in depth interviews.   The following examples that occurred during the survey illustrate the potential for the above circumstances to arise:

- In at least one instance, the same participant filled out surveys on two separate occasions. A comparison of the surveys in question revealed a number of variations in the answers given. These variations were minor, indicating that the participant was not necessarily seeking to evade detection but simply that their recollection of past events and perception of present circumstances had altered slightly;

- In one case, the responses on a survey indicated that one participant had begun injecting cocaine and amphetamines at the age of 12 in 1961. Whilst this is possible, such a story is, at face value, unlikely to be true when placed alongside what we know about the history of drug use in Australia.

- In order to survey participants in one study site, participants were allowed to take surveys home and return them completed in order to receive payment. The absence of a researcher to explain what, in some instances, were relatively complex questions, may have affected the accuracy of participants' responses.

10.3   The Data - Demographics

10.3.1   Age

The age of the 135 participants who took part provide a good indication of why researchers should avoid attempting to generalize about drug users. The popular (or media) image of the illicit drug user is of a young person, an image that is able to draw upon a long vein of antipathy to adolescents (see Bessant and Hill 1997). However, the Table 1 stands in sharp contrast to such a misrepresentation and provides one illustration of the broad nature of illicit drug use in Australian society.

Table 1: Age of Survey Participants

		Frequency	Percent	Cumulative Percent
Valid	15	1	.7	.7
	16	2	1.5	2.2
	17	3	2.2	4.4
	18	3	2.2	6.7
	19	8	5.9	12.6
	20	5	3.7	16.3
	21	7	5.2	21.5
	22	5	3.7	25.2
	23	10	7.4	32.6
	24	7	5.2	37.8
	25	6	4.4	42.2
	26	6	4.4	46.7
	27	6	4.4	51.1
	28	6	4.4	55.6
	29	8	5.9	61.5
	30	6	4.4	65.9
	31	1	.7	66.7
	33	3	2.2	68.9

	Frequency	Percent	Cumulative Percent
34	3	2.2	71.1
35	8	5.9	77.0
36	5	3.7	80.7
37	4	3.0	83.7
38	3	2.2	85.9
39	2	1.5	87.4
40	1	.7	88.1
41	1	.7	88.9
42	3	2.2	91.1
44	1	.7	91.9
45	4	3.0	94.8
46	1	.7	95.6
48	1	.7	96.3
49	1	.7	97.0
51	3	2.2	99.3
52	1	.7	100.0
Total	135	100.0	

When the age of participants was considered according to each of the separate study sites, the same variation was noted. However, at the same time, there was a slight variation between the three study sites in respect of the mean age of survey participants. The mean age of participants in Cabramatta was 25.6 years, as compared to 30.5 years in Geelong and 31.6 years in Fitzroy / Collingwood. The younger age of participants in Cabramatta may well reflect their recruitment through street and social networks. In contrast, participants in Geelong and Fitzroy / Collingwood were recruited via a community health organisation, a needle exchange and a drug users union, organisations less likely to be frequented by younger drug users.

10.3.2   Gender

Males were disproportionately represented in each of the study sites, excepting Cabramatta. Again, in the case of Geelong and Fitzroy / Collingwood, this reflected the recruitment of individuals through organizations in which males were disproportionately represented.

Table 2: Gender of Survey Respondents

		Frequency	Percent	Cumulative Percent
Valid	Male	87	64.4	64.4
	Female	48	35.6	100.0
	Total	135	100.0	

Table 3: Gender of Participants - Cabramatta

		Frequency	Percent	Cumulative Percent
Valid	Male	27	54.0	54.0
	Female	23	46.0	100.0
	Total	50	100.0	

Table 4: Gender of Participants - Geelong

		Frequency	Percent	Cumulative Percent
Valid	Male	31	68.9	68.9
	Female	14	31.1	100.0
	Total	45	100.0	

Table 5: Gender of Participants – Fitzroy / Collingwood

		Frequency	Percent	Cumulative Percent
Valid	Male	29	72.5	72.5
	Female	11	27.5	100.0
	Total	40	100.0	

10.3.3 Education

When educational attainment is analysed, it shows that the majority of participants did not complete high school. Table 6 below shows that only 14.8 per cent of those who took part in this research went on to further study beyond secondary schooling.

Table 6: Highest level of education attained

	Frequency	Percent	Cumulative Percent
Completed primary	2	1.5	1.5
Some secondary	85	63.0	64.4
Completed secondary	28	20.7	85.2
Post secondary TAFE/Trade	6	4.4	89.6
Some tertiary	8	5.9	95.6
Completed tertiary	4	3.0	98.5
Post graduate qualification	2	1.5	100.0
Total	135	100.0	

When each study site is analysed separately, the results show a lower level of educational attainment in the Cabramatta survey cohort when compared to Geelong and Fitzroy / Geelong. This might be explained, at least partially, by the ethnically heterogenous nature of the Cabramatta community, and language difficulties that those from non-English speaking backgrounds may have encountered in the formal educational environment. The fifty participants who comprised the Cabramatta study cohort reported the following languages as their first:

- English (24);
- Vietnamese (14);
- Cambodian (3);
- Cantonese (2);
- Spanish (2);
- Laotian (1);
- Thai (1);
- Arabic (1);

- Yugoslavian (1);

- **Missed** (1);

In contrast, every participant from Geelong came from an English speaking background, as did all but 3 of those participants from Fitzroy / Collingwood. At the same time, it is important to note that language is one of several factors that may cause an individual to leave school (Higgs et.al., 2001). A lack of familial support or the opportunity to pursue interests outside of the educational system may well have been just as influential in the decision to leave school before its completion. The recruitment of participants in Cabramatta from street-based networks suggests that these individuals may have enjoyed less family or other support than participants in other sites.

Table 7: Highest level of education attained - Cabramatta

	Frequency	Percent	Cumulative Percent
Completed primary	2	4.0	4.0
Some secondary	41	82.0	86.0
Completed secondary	7	14.0	100.0
Total	50	100.0	

Table 8: Highest level of education attained - Geelong

	Frequency	Percent	Cumulative Percent
Some secondary	25	55.6	55.6
Completed secondary	12	26.7	82.2
Post secondary TAFE/Trade	2	4.4	86.7
Some tertiary	4	8.9	95.6
Completed tertiary	2	4.4	100.0
Total	45	100.0	

Table 9: Highest level of education attained – Fitzroy / Collingwood

	Frequency	Percent	Cumulative Percent
Some secondary	19	47.5	47.5
Completed secondary	9	22.5	70.0
Post secondary TAFE/Trade	4	10.0	80.0
Some tertiary	4	10.0	90.0
Completed tertiary	2	5.0	95.0
Post-graduate qualification	2	5.0	100.0
Total	40	100.0	

10.3.4   Employment Status

The survey asked respondents to describe their employment status over the past six months. The greater majority of respondents were unemployed. However, it is important to note that many of those who described themselves as unemployed were on disability pensions and sickness benefits.

Table 10: Employment Status (past six months)

	Frequency	Percent (Responses)
Employed full time	5	3.5
Employed part time	3	2.1
Casual / Occasional work	13	9.0
Unemployed	94	65.3
Student	5	3.5
Home duties	9	6.3
Other	15	10.4

Note: Participants were given the option of providing more than one response. Consequently, 144 responses were recorded by the 135 survey participants.

Note 2: 'Other' included participants who were on disability pensions and those who had spent the majority of the past six months in jail.

There was a much higher rate of unemployment amongst participants in Cabramatta (84%) as compared to the Geelong (52.1%) and Fitzroy / Collingwood (58.7%) sites. This may be related to the lower level of educational attainment amongst participants in the Cabramatta study group. It is also a reflection of the recruitment methods used by researchers in different sites, most notably the use of street based networks in Cabramatta (i.e. recruiting participants 'hanging around' on the street).

As elaborated upon in qualitative interviews, a number of participants reported being unable to afford housing while attempting to support drug use and on, sometimes meagre, income support. This experience was also reflected in survey results.

10.3.5 Sources of Income

When sources of income were examined, they highlighted respondents need to supplement official sources of income through other, sometimes illegal, activities. It is telling that 'selling drugs' ranked behind only 'unemployment benefit' as the most common source of income. The underlines the false distinction that is often drawn drug users and drug 'dealers'. Indeed, qualitative interviews support the common research finding that the greater majority of drug dealers tend to be users who sell small amounts of drugs to support their own use (Fitzgerald et.al., 1999). Table 11 details the different sources of income reported by survey participants.

Table 11: Sources of income

	Number	Per cent
Full time job	9	3.8
Part time job	12	5.0
Youth allowance	18	7.5
Unemployment benefit	65	27.2
Supporting parent's benefit	11	4.6
Other government benefit	27	11.3
Parents or family support	10	4.2
Friends	9	3.8
Selling drugs	31	13.0
Sex work	13	5.4
Theft	16	6.7
Begging	8	3.3
Other	10	4.2

Note: Participants were given the option of providing more than one response. 239 different responses were recorded by the 135 survey participants. The 'per cent' column refers to the percentage of responses as opposed to percentage of respondents.

Note 2: 'Other' largely comprised of those who made money through window-washing at traffic intersections.

10.4   The Data – Drug Use

All but one participant reported using heroin intravenously. However, the age at which participants initiated heroin use varied widely, as illustrated by Table 12 below. Although it is alarming to note that almost a quarter of respondents initiated heroin use at the age of fifteen years or less, it is interesting to note that a number of respondents did not begin using heroin

Table 12: Age at which heroin use was initiated.

	Age	Frequency	Percent	Valid Percent	Cumulative Percent
Valid	11	1	.7	.8	.8
	13	6	4.4	4.8	5.6
	14	10	7.4	7.9	13.5
	15	13	9.6	10.3	23.8
	16	16	11.9	12.7	36.5
	17	15	11.1	11.9	48.4
	18	13	9.6	10.3	58.7
	19	10	7.4	7.9	66.7
	20	6	4.4	4.8	71.4
	21	6	4.4	4.8	76.2
	22	5	3.7	4.0	80.2
	23	5	3.7	4.0	84.1
	24	4	3.0	3.2	87.3
	25	5	3.7	4.0	91.3
	26	2	1.5	1.6	92.9
	27	1	.7	.8	93.7
	28	1	.7	.8	94.4
	30	1	.7	.8	95.2
	32	2	1.5	1.6	96.8
	36	2	1.5	1.6	98.4
	40	2	1.5	1.6	100.0
	Total	126	93.3	100.0	
Missing	System	9	6.7		
Total		135	100.0		

As the following series of tables demonstrate, it is perhaps erroneous to speak of a 'heroin user.' Certainly, in respect of this survey, the greater majority of individuals who use heroin use a range of drugs, both legal and illegal.

Table 13: Ever used cocaine

		Frequency	Percent
Valid	No	31	23.0
	Yes	100	74.1
	Total	131	97.0
Missing	System	4	3.0
Total		135	100.0

Table 14: Ever used amphetamines

		Frequency	Percent
Valid	No	26	19.3
	Yes	106	78.5
	Total	132	97.8
Missing	System	3	2.2
Total		135	100.0

Table 15 Ever used benzodiazepams

		Frequency	Percent
Valid	No	21	15.6
	Yes	110	81.5
	Total	131	97.0
Missing	System	4	3.0
Total		135	100.0

Table 16: Ever used marijuana

		Frequency	Percent
Valid	No	5	3.7
	Yes	127	94.1
	Total	132	97.8
Missing	System	3	2.2
Total		135	100.0

Table 17: Ever used tobacco

		Frequency	Percent
Valid	No	2	1.5
	Yes	130	96.3
	Total	132	97.8
Missing	System	3	2.2
Total		135	100.0

Table 18: Ever used alcohol

		Frequency	Percent
Valid	No	17	12.6
	Yes	114	84.4
	Total	131	97.0
Missing	System	4	3.0
Total		135	100.0

There were notable differences in types of drug use between study sites, particularly as regards the use of cocaine and amphetamines. Reflecting the findings of the Illicit Drug Reporting System (IDRS), the use of cocaine was more common in Cabramatta than in the Victorian study sites. The 2001 IDRS Australian drug trends report noted:

> As in 2000, cocaine was considered easy or very easy to obtain in NSW, but was not widely commented on nor available in other jurisdictions (NDARC 2002, 17).

The mean frequency of cocaine use over the past six months was 16.8 days among respondents in the Cabramatta cohort, as compared to 2.4 days among the Geelong cohort and 1.2 days in Fitzroy / Collingwood. However, the use of amphetamines was most widespread in Geelong, providing support to observations made in qualitative interviews that amphetamines were the predominant drug of choice in Geelong. The mean frequency of amphetamine use in Geelong over the past six months was 25.4 days as compared to 19.5 days in Cabramatta and 17.8 days in Fitzroy / Collingwood.

Perhaps the most alarming aspect of participants' drug use was the sharing of injecting equipment. Although 71 per cent of respondents had not shared equipment in the six months prior to the survey, some 72.6 per cent acknowledged that they had shared needles and syringes in the past. This suggests some difficulty in accessing needles and syringes, a factor many respondents reported, particularly at night.

The reported non use of alcohol is interesting to note. This does resonate with the accounts in some user interviews. A number of users very clearly were not interested in using alcohol and said they had never used it.

10.5   The Data – Housing and Accommodation

When participants were asked where they had slept the night prior to completing the survey, they answered with a wide variety of responses. Interestingly, the most common response was at a friend's house or flat while 21.5 per cent of respondents stayed in private or shared rental accommodation. The results of the question are contained in Table 19 below.

Table 19: Where did you sleep last night?

	Frequency	Percent
Private rental house / flat (own)	14	10.4
Private rental house / flat (share)	15	11.1
Government / public housing	17	12.6
Transitional housing	7	5.2
Parent's house / flat	15	11.1
Friend's house / flat	43	31.9
Refuge / shelter	3	2.2
Squat	12	8.9
Street	2	1.5
Rooming house	2	1.5
Extended family	2	1.5
Other	3	2.2
Total	135	100.0

When asked about their current living arrangements, 'friend's house or flat' remained the most common response. However, a significant number of participants also reported living in stable accommodation in the form of private or government rental.

Table 20 Current living arrangements

	Frequency	Percent
Private rental house / flat (own)	15	11.1
Private rental house / flat (share)	13	9.6
Government / public housing	21	15.6
Transitional housing	6	4.4
Parent's house / flat	17	12.6
Friend's house / flat	29	21.5
Refuge / shelter	4	3.0
Squat	13	9.6
Street	9	6.7
Rooming house	4	3.0
Extended family	4	3.0
Total	135	100.0

When each site was analysed in isolation, there were some notable differences in living arrangements. In Cabramatta, for example, there was a much smaller proportion of the survey participants staying in rental accommodation. Eleven participants (22%) were staying at a friend's house or flat and 16 (32%) reported squatting or surviving on the street

Table 21 Current living arrangements - Cabramatta

	Frequency	Percent
Private rental house / flat (own)	3	6.0
Private rental house / flat (share)	3	6.0
Government / public housing	2	4.0
Transitional housing	4	8.0
Parent's house / flat	5	10.0
Friend's house / flat	11	22.0
Refuge / shelter	3	6.0
Squat	8	16.0
Street	8	16.0
Rooming / boarding house	1	2.0
Extended family	2	4.0
Total	50	100.0

On the basis of the above responses, it is not surprising that a majority (64%) of those surveyed in Cabramatta considered themselves homeless. In comparison, only 22 per cent of the Geelong sample considered themselves to be homeless. Only one participant reported sleeping rough and none reported living in squats, although qualitative interviews showed that a number had undertaken this option in the past. An even greater contrast was the high proportion of the Geelong sample (51.2%) who reported living in rental accommodation, both private and government. This supports the evidence showing private rental accommodation to

be a relatively affordable option in Geelong when compared to rental prices in Cabramatta and Fitzroy / Collingwood.

Table 22 Current living arrangements - Geelong

	Frequency	Percent
Private rental house / flat (own)	8	17.8
Private rental house / flat (share)	8	17.8
Government / public housing	7	15.6
Parent's house / flat	10	22.2
Friend's house / flat	7	15.6
Refuge / shelter	1	2.2
Street	1	2.2
Rooming / boarding house	1	2.2
Extended family	2	4.4
Total	45	100.0

Fitzroy / Collingwood was notable for having the highest proportion (30%) of participants living in public housing. This is a reflection of the high rise public housing estates in Fitzroy, Collinwood and Richmond (an adjoining suburb also within the municipality of Yarra). These estates had a far greater capacity that the 'walk up' estates in Geelong and Cabramatta. Indeed, a further 40 per cent of participants from Fitzroy and Collingwood reported being on the waiting list for public housing as compared to 36 per cent in Cabramatta and only 15.9 per cent in Geelong. The latter is perhaps a reflection of the relatively affordable cost of the Geelong private rental market.

Table 23 Current living arrangements – Fitzroy / Collingwood

	Frequency	Percent
Private rental house / flat (own)	4	10.0
Private rental house / flat (share)	2	5.0
Government / public housing	12	30.0
Transitional housing	2	5.0
Parent's house / flat	2	5.0
Friend's house / flat	11	27.5
Squat	5	12.5
Rooming / boarding house	2	5.0
Total	40	100.0

A significant number of the Fitzroy / Collingwood sample reported living in squat style accommodation or staying at a friend's house or flat. Forty per cent of the sample considered themselves to be homeless.

When the 135 survey participants are considered together, they reveal a high rate of mobility. Some participants reported staying in a range of different forms of accommodation over the past six months, something that is illustrated in the following series of tables.

Table 24: Stayed in own rental (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	106	78.5	79.1	79.1
	Sometimes	8	5.9	6.0	85.1
	Often	8	5.9	6.0	91.0
	Always	12	8.9	9.0	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 25: Stayed in shared rent (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	109	80.7	81.3	81.3
	Sometimes	8	5.9	6.0	87.3
	Often	10	7.4	7.5	94.8
	Always	7	5.2	5.2	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 26: Stayed in government housing (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	100	74.1	74.6	74.6
	Sometimes	8	5.9	6.0	80.6
	Often	5	3.7	3.7	84.3
	Always	21	15.6	15.7	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 27: Stayed in transitional (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	121	89.6	90.3	90.3
	Sometimes	7	5.2	5.2	95.5
	Often	5	3.7	3.7	99.3
	Always	1	.7	.7	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 28: Stayed at parents (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	100	74.1	74.6	74.6
	Sometimes	13	9.6	9.7	84.3
	Often	11	8.1	8.2	92.5
	Always	10	7.4	7.5	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 29: Stayed at friend's (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	54	40.0	40.3	40.3
	Sometimes	26	19.3	19.4	59.7
	Often	33	24.4	24.6	84.3
	Always	21	15.6	15.7	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 30: Stayed at a boarding house (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	110	81.5	82.1	82.1
	Sometimes	21	15.6	15.7	97.8
	Often	3	2.2	2.2	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 31: Stayed at refuge (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	112	83.0	83.6	83.6
	Sometimes	16	11.9	11.9	95.5
	Often	5	3.7	3.7	99.3
	Always	1	.7	.7	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 32: Stayed at squat (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	90	66.7	67.2	67.2
	Sometimes	17	12.6	12.7	79.9
	Often	12	8.9	9.0	88.8
	Always	15	11.1	11.2	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 33: Stayed on street (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	92	68.1	68.7	68.7
	Sometimes	25	18.5	18.7	87.3
	Often	10	7.4	7.5	94.8
	Always	7	5.2	5.2	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

Table 34: Stayed in prison (last 6 months)

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Never	108	80.0	80.6	80.6
	Sometimes	17	12.6	12.7	93.3
	Often	6	4.4	4.5	97.8
	Always	3	2.2	2.2	100.0
	Total	134	99.3	100.0	
Missing	System	1	.7		
Total		135	100.0		

10.6   The Data – Crime

Given that just less than 20 per cent of survey participants had spent time in prison over the last six months, it was not surprising to find that many had been charged with a range of offences of which drug related and theft offences were the most common.

Table 35: Criminal offending

Offence	Frequency	Percentage charged
Drug Offences	99	73.3
Theft	95	70.4
Assault	61	45.2
Resisting arrest	47	34.8
Robbery	40	29.6
Loitering	36	26.7
Vandalism	19	14.1
Prostitution	9	6.7
Other	24	17.8

Note: 'Other' included offences such as fraud, driving while unlicensed, drink driving, offensive language, shop lifting, motor vehicle theft, breaking and entering and larceny and firearms offences.

10.7   The Data – Health

Over 80 per cent of survey participants reported having visited a health professional during the last six months. This relatively high visitation rate may, at least partially, reflect the relatively high levels of health problems suffered by those surveyed as shown in Table 36 below.

Table 36: Health problems suffered in the last six months

Health Problem	Frequency	Percentage
Depression	111	82.2
Anxiety	95	70.4
Low-self esteem	89	65.9
Hepatitis C	75	55.6
Flu	55	40.7
Asthma	33	24.4
Bronchitis	23	17
Sexually transmitted disease	9	6.7
Hepatitis B	8	5.9
Pneumonia	4	3
Scabies	1	.7
HIV	1	.7
No known health problems	3	2.2
Other health problems	17	12.6

Note: 'Other health problems' included cancer, broken bones, Chrones disease, kidney failure, epilepsy and eating disorders.

Perhaps most disturbing was the high rate of Hepatitis C confirming the fears of researchers that more needs to done to tackle this easily transmittable disease.(Wodak 1997). In addition to problems of general health, a number of participants reported a range of injecting related health problems as detailed in Table 37 below.

Table 37: Injection-related health problems suffered over last six months

Problem	Frequency	Percentage
Scarring / bruising	70	56.5
Local reaction (Swelling)	29	23.4
'Dirty hit' (sick after injection)	28	22.6
Cellulitis	9	7.3
Phlebitis	4	3.2
Abscess	3	2.4
Endocarditis	1	.8
Other injection related problem	5	4
No injection related problem	38	30.2

Note: The above table is based on responses form 124 participants. Eleven participants had ceased to inject drugs at least six months before surveying.

Note 2: 'Other injection-related problems' included the loss of veins and poor circulation.

Survey participants had entered into a range of treatment options in an attempt to better manage their illicit drug use. The most common method of treatment was the methadone maintenance program, followed by buprenorphine and unsupervised home detoxification. Buprenorphine was most commonly used in Fitzroy and Collingwood (17 of the 26 participants who were on a buprenorphine program was from this cohort). This relatively high rate reflects the close proximity of Turning Point Alcohol and Drug Centre, one of the leading prescribers and dispensers of alternative pharmacotherapies such as buprenorphine. In qualitative interviews, participants sung the praises of buprenorphine when comparing its relatively few side effects with those of methadone (aching joints, tooth decay and general fatigue).

Table 38: Treatment options (last 6 months)

Treatment	Frequency	Percentage
Methadone maintenance	57	52.3
Buprenorphine maintenance	26	23.9
Unsupervised home detox	23	21.1
Outpatient drug counselling	17	15.7
Inpatient detox	21	19.3
Narcotics Anonymous	11	10.1
Supervised home detox	10	9.2
Residential community	5	4.6
Naltrexone treatment	4	3.7

Note: The above table is based on responses from 109 participants who had undergone one or more forms of treatment over the past six months.

10.8   The Data – Social Wellbeing

Participants were asked who they received support from. This was a broad question open to interpretation (i.e. financial support as opposed to emotional support). At the same time, apart from friends, few participants reported enjoying the support of a range of different individuals and organisations.

Table 39: Support networks

Support	Frequency	Percentage
Friends	72	60.5
Family	48	40.3
Outreach workers	34	28.6
Counsellors	33	27.7
Associates (other users)	32	26.9
Drop-in staff	31	26.1
Other relatives	15	12.6
Others	21	17.6

Note: The above table is based on responses from 119 participants, a number of whom reported receiving support from a range of sources.

Note 2: 'Others' included medical staff, psychiatric counsellors and partners and spouses.

The greater majority of survey respondents reported that at least a few of their friends were also heroin users. This factor undoubtedly complicated attempts to cease or better manage their own drug use. In qualitative interviews, participants spoke of the need to move away from their current location and sever all ties with drug using peers and friends. Participants were asked the following question – 'How many of your current friends are heroin users?' Participants' responses are contained in Table 40 below.

Table 40: How many of your current friends use heroin?

	Frequency	Percent	Cumulative Percent
None	16	11.9	11.9
A few	36	26.7	38.5
About half	24	17.8	56.3
More than half	16	11.9	68.1
All or most	43	31.9	100.0
Total	135	100.0	

Most participants were unhappy with their current situation, with a sizeable proportion of participants rating their quality of life as poor or very poor. It is important to reiterate that the question was, again, very open to interpretation. It was also very much dependent upon the participant's state of mind at the time. Obviously a 'bad day' could well result in the participant perceiving their quality of life as poor and vice versa. Participants were asked 'How would you describe your quality of life at the moment? Their responses are contained in Table 41 below.

Table: 41 How would you describe your quality of life at the moment?

	Frequency	Percent	Valid Percent
Very poor	25	18.5	18.8
Poor	30	22.2	22.6
OK	54	40.0	40.6
Good	17	12.6	12.8
Very good	7	5.2	5.3
Total	133	98.5	100.0
System	2	1.5	
	135	100.0	

These data show that more than 50% of those interviewed thought their quality of life was OK or better. Again this picture resonates with the qualitative interviews. Many of the heroin users we interviewed, when talking about their lives, portrayed themselves as engaged and active people. They spoke about their problems but at the same time talked about their accomplishments, their friendships and the people they loved. This same approach appears to be coming through in this ranking of views on their quality of life.

10.9 Conclusion

The survey data revealed some notable differences in the housing arrangements of each of the three study sites. In Cabramatta, for example, at the time of survey, a significant proportion of respondents (32%) were living in squats or on the streets, and a further 22 per cent were living in informal arrangements with friends. Just 12 per cent were living in some form of private rental. In comparison, 35.6 per cent of respondents in Geelong were living in private rental. These findings support observations made in qualitative interviews – that there are comparatively high rates of homelessness amongst drug users in Cabramatta and that the private rental market in Geelong is a functioning rental market that is accessible to those on low incomes.

In contrast with the above, in Fitzroy / Collingwood, 30 per cent of survey respondents were living in public housing, supporting the view expressed in interviews that this represents the only available source of low income housing in the area.

While acknowledging the differences in the nature of housing in each of the three study areas, it is also important to emphasise that the levels of transience revealed by the surveys was supportive of qualitative accounts that suggested a high rate of mobility. Asked about their housing circumstances in the six months prior to completing surveys, respondents reported staying in a range of different forms of accommodation (Tables 24-34).

When considered as a broad group, the answers of our 135 survey respondents also provide a larger portrait of the population group from which our interview subjects were drawn. For example, there were a broad range of health problems suffered by participants, including high rates of depression, hepatitis C infection and problems such as flu, asthma and bronchitis, each of which could potentially be exacerbated by unhygienic and inhospitable living conditions. Participants also reported a high rate of criminal offending. Much of this offending was directly related to acquisitive crimes committed so as to raise money from drugs, an issue expanded upon at length in interviews.

At the same time, surveys also reflected the fact that drugs users come from a broad range of backgrounds in terms of family upbringing, socio-economic status and education. In respect of the latter, although the greater majority had not completed secondary school, some 28 (20%) of survey participants had and a further 20 (14.8%) had gone on to further education.

One factor that many survey respondents had in common was a sense of dissatisfaction about their 'quality of life'. Only 18.1 per cent of respondents described their quality of life as 'good' to 'very good.' In contrast, 41.4 per cent of respondents described their quality of 'poor' to 'very poor'. Again, this supported concerns among interview participants who expressed high levels of concern about their lives and the direction in which they were heading.

In effect, the data collected from the survey questionnaires supported a range of observations made during the course of qualitative interviews. The survey data goes some way to addressing the methodological issues that accompany the relatively small sample of interviewees, while the latter provides the narrative that is so often lacking from quantitative research. In general the information gathered and presented within this report provides a positive argument for integrating a range of research methodologies when undertaking research of so-called 'hidden populations' such as illicit drug users.

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APPENDIX 2 – INTERVIEW GUIDE

Heroin Use, Housing and Social Participation:

Attacking social exclusion through better housing

Age

Employment status

Nationality

Gender

- Drug using career

When did drug use first begin? Have there been periods of heavy use? Abstinence? What else was happening during these periods in respect of – Housing? Education? Employment? Income? Family and friends? Personal Health? (i.e. How have changes in these factors affected the frequency and manner of your drug use?)

- Housing career

Can you tell us about your housing history in terms of where you have lived over the past few years, what was the cost, who was your landlord, have you owned a house; how secure was your housing, what was its standard, where was it? What was your experience of housing while you were growing up? What type of housing did your parents have and what did you think of it? Have members of your family helped you with your housing since you left home and in what ways? Have you used emergency or transitional housing? What has happened after you have left these forms of housing? What would you change about your current housing situation to make your life easier?

- Has your drug use led to other problems?

For example, did it lead to problems at home, have you been refused accommodation or evicted from accommodation? Have you experienced trouble with the police?

- Methods and levels of income support

Where does your income come from now? Is there more than one source of income? How have you earnt or received your income in recent years? Have you been forced to rely on illegal means of income support given the inadequacy of legal means? Has your housing situation ever impacted upon the level and type of income support you receive or vice versa?

- Treatment

Do you think having an unstable housing situation creates difficulties in accessing appropriate treatment options / facilities? What do you think is the best form of treatment for heroin dependency? What environment do you think is necessary to make such treatment successful? What is your own treatment history?

- Recreation / Support.

Have you found the level of support available to you, through friends, family or both, has changed when you housing situation has changed? How have support networks played a role throughout your drug-using career? What sorts of things do you do for relaxation / recreation? Do these change when your housing situation changes?

- Education/training

Can your describe your education history in terms of schooling, TAFE, University or other forms of training? Is there any you can say about how your housing has been related to your schooling or other education and training? Is there anything you can say about how your drug use has affected your education.

APPENDIX 3 – FOCUS GROUP GUIDE

Rmit / Ahuri Research Project

Heroin Users And Housing Focus Group Interview Guide

Themes and questions for discussion:

- **What difference would secure affordable housing make** to heroin users who do not have secure and affordable accommodation? (E.g. Treatment, employability, social security, comfort, private and personal space and so on)

- **The impact of homelessness** (E.g. sleeping rough/squats on the health and wellbeing of the heroin user).

- **Adequacy and responsiveness of existing services.** Housing and health. An identification of service gaps and suggested improvements.

- **Obstacles faced** in accessing secure and affordable housing; What are the key housing issues in this area

- **Housing policy.** Stock levels; Responsiveness of major agencies and suggested improvements.

- **Public housing management issues**

- **Squatting as survival strategy.** Particularly the response of different sectors to this strategy.

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