PENINGTON INSTITUTE

Breaking the cycle: Opioid dependence and housing stability

Final report

March 2020

For more information, contact:

Penington Institute
95 Drummond Street
Carlton Vic 3053

T: 61 3 9650 0699
F: 61 3 9650 1600
www.penington.org.au

It is too easy to judge people who use drugs.

Legal or illegal, the misuse of any psychoactive substance impacts us all.

At Penington Institute, we think it's far more productive to prevent and tackle drug use in a safe, effective and practical way.

Risky behaviours are part of being human.

Our focus is on making individuals and families safer and healthier, helping communities, frontline services and governments reduce harm, respect human rights and improve the rule of law.

Founded by needle exchange workers and people with lived experience of drug use in 1995 as a peak body, The Association of Needle Exchanges (ANEX) grew into Penington Institute, named in honour of Emeritus Professor David Penington AC, who led Australia's early and world-leading approach to HIV/AIDS.

Like Professor Penington, who remains our Patron to this day, we confront the most important issues and champion innovative evidence-based action to improve people's lives – no matter how challenging our perspective might appear.

A not-for-profit organisation, Penington Institute's research and analysis provides the evidence needed to help us all rethink drug use and create change for the better.

We focus on promoting effective strategies, frontline workforce education and public awareness activities. Our work has a positive impact on people, health and law enforcement systems, the economy and society.

An independent voice of reason on drug policy, we are a straight-talking ally for practical insights, information and evidence-based action for people in need.

Acknowledgments

This research could not have been conducted without the funding provided by the Lord Mayor's Charitable Foundation and the considerable support and co-operation of staff at the three housing organisations: Melbourne City Mission, Launch Housing and Ozanam House. Most importantly, the research would not have been possible without all the people who gave so generously of their time to share with us their experiences, insights and views on the relationship between homelessness and substance use. Penington Institute is grateful for participants' willingness to open their lives to us as part of this project.

Penington Institute would also like to thank the Advisory Committee for their time, comments and expertise in guiding the project through to completion.

Contents

Executive summary

On their own, both homelessness[1] and drug misuse are serious social problems. Each is associated with a range of negative health and social outcomes for individuals, families and their communities. But when homelessness and drug misuse occur together, those negative outcomes are compounded.

While misuse of many types of drugs (including alcohol) is associated with poor housing and mental health outcomes, the relationship between homelessness and drug misuse is especially pronounced for opioids, particularly heroin. The use of effective interventions for treating opioid dependence is therefore critical not only to address the negative consequences of substance use, but also to tackle those broader, co-occurring problems such as homelessness.

This report aims to identify the impact on homelessness of treatment for opioid dependence, to determine if best practice responses to dependence can have broader positive effects in people's lives. It describes a small-scale project that was undertaken by Penington Institute in partnership with Melbourne City Mission and Launch Housing, and funded by the Lord Mayor's Charitable Foundation, to examine the nexus between homelessness and medically-assisted treatment for opioid dependence (MATOD).

The project adopted a qualitative approach to learn from the experiences of housing service staff and their clients. Interviews with 10 staff from three housing service providers and 25 of their clients suggested a number of key findings:

- **There is a high level of disadvantage among this group of people experiencing both homelessness and drug use:** High levels of both prior incarceration and prior homelessness, as well as childhood experiences of homelessness, institutionalisation and family instability, abuse or neglect, illustrate the multiple, compounded vulnerabilities among this group.
- **There is a reciprocal relationship between homelessness and drug use:** The relationship between homelessness and drug use is complex: there is no clear pathway between the two. While drug use among the participants of this research was a common way to cope with the stress of housing instability or homelessness, most participants believed that their poor housing situation had a negative impact on their drug use: the more dire the housing circumstances, the more extreme the drug use became. When homelessness and drug use co-occur, they each exacerbate the other and intensify the associated difficulties in a reciprocal feedback loop.
- **There are substantial barriers to accessing MATOD for people experiencing both homelessness and drug use:** Both client and staff participants appreciated the value of MATOD in responding to drug use, with clients suggesting that they would have few problems adhering to the regime were their housing stable and the treatment affordable. But both clients and staff identified substantial barriers to accessing MATOD.

[1] The Australian Bureau of Statistics identifies four types of homelessness: marginalised housing (housing that borders on the minimum acceptable living standard); tertiary homelessness (living in single rooms or boarding houses without their own kitchen, bathroom or security of tenure); secondary homelessness (moving between forms of temporary shelter, such as emergency assistance, friends and family); and primary homelessness (people without conventional accommodation, instead sleeping in locations such as streets, parks, disused buildings or impoverished buildings). See further: Chamberlain, C. and MacKenzie, D. (2008). *Counting the homeless 2006*. Canberra: ABS cat. no. 2050.0.

    - **Financial barriers:** Financial barriers were commonly reported among client participants, in terms of both the cost of MATOD and the cost of housing. When having to bear the costs of both at the same time, there is a far lower likelihood of continuing in treatment as housing is given priority in people's lives.
    - **Practical barriers:** Being homeless was reported to make treatment adherence more difficult in practical ways, such as the requirement to travel to the dosing location on a daily basis. Being homeless also made it more difficult to *want* to stay in treatment: opioid use can make homelessness more bearable.
    - **The dual stigma of drug use and homelessness:** The stigmatisation of both drug use and homelessness is experienced as a significant barrier to accessing and adhering to MATOD. This is particularly problematic given the dearth of prescribing doctors and dispensing pharmacists.
- **Staff and clients hold conflicting views of the direct impact of MATOD on homelessness:** Staff participants all agreed that access to MATOD was crucial to improve their clients' outcomes, including finding stable accommodation – staff saw a clear link between MATOD and positive housing outcomes. In contrast, many of the client participants doubted the direct benefits of MATOD for their housing situation: while they saw that MATOD could provide stability and improve their housing prospects, many felt that securing stable housing remained very difficult or impossible.

The MATOD system provides an important treatment mechanism for people with opioid dependence. However, existing barriers to MATOD mean that the current system is inadequate to meet the needs of many people who could benefit from it, particularly those experiencing homelessness.

Expanded and facilitated access to MATOD for clients of specialist housing services – dismantling some of the barriers to access that they face – is likely to improve a range of quality-of-life outcomes, including assisting people to secure and maintain stable accommodation.

To this end, Penington Institute makes the following recommendation to build the evidence base to address barriers and create better access to MATOD for people with unstable housing circumstances:

Recommendation
That a multi-site trial be undertaken in partnership with homelessness services (crisis and transitional accommodation), of an intervention that enhances access to treatment for opioid dependence (MATOD) for their clients. The intervention will be designed to test a range of identified barriers and enablers to accessing MATOD for people experiencing homelessness. The trial will consist of three main study groups: 1. Clients receiving daily dosing of opioid treatment, with the daily dispensing fee paid by the study. 2. Clients receiving monthly dosing of opioid treatment. 3. A 'control group' of clients who access MATOD under the existing systems. The primary intervention will involve strengthening pathways to care. An AOD worker will be employed and located within the homelessness service to work with clients with a focus on

integrating AOD support into the broader housing support provided to clients. Emphasis will be given to building a therapeutic relationship and facilitating referrals to related services (such as mental health) and supporting participants to access doctors who can prescribe MATOD. The AOD worker will work with clients to create linkages back into their local communities, families, activities, employment and the like, thus providing wrap-around support to help people navigate parallel systems and government bureaucracies.

Alongside the intervention, a campaign promoting the benefits of MATOD to clients of each homelessness service will be developed and incorporated into the trial.

Introduction

On their own, both homelessness[2] and drug misuse are serious social problems. Each is associated with a range of negative health and social outcomes for individuals, families and their communities. But when homelessness and drug misuse occur together, those negative outcomes are compounded: poor health and social difficulties are more likely to become intractable, and there is an increased likelihood of other co-morbidities emerging, such as mental health problems.[3]

While misuse of many types of drugs (including alcohol) is associated with poor housing and mental health outcomes, the relationship between homelessness and drug misuse is especially pronounced for opioids, particularly heroin. The use of effective interventions for treating opioid dependence is therefore critical not only to address the negative consequences of substance use, but also to tackle those broader, co-occurring problems such as homelessness.

This report aims to identify the impact on homelessness of treatment for opioid dependence, to determine if best practice responses to dependence can have broader positive effects in people's lives. It describes a small-scale project that was undertaken by Penington Institute in partnership with Melbourne City Mission and Launch Housing, and funded by the Lord Mayor's Charitable Foundation, to examine the nexus between homelessness and medically-assisted treatment for opioid dependence (MATOD).

Increasing opioid use and harm

Dependence on opioids, particularly heroin and pharmaceutical opioids, is increasing around the world: globally, there were an estimated 53 million opioid users in 2017.[4] The use of prescription opioids is also increasing, particularly in the United States but also in Australia: between 1992 and 2012, opioid dispensing episodes in Australia increased 15-fold (from around 500,000 to almost 7.5 million) and the corresponding cost to the Australian government increased 32-fold (from $8.5 million to $271 million).[5]

In 2016-17, around 3.1 million Australians were dispensed opioid prescriptions. In the same year, there were more than 5,000 emergency department presentations and almost 10,000 hospitalisations

---

[2] The Australian Bureau of Statistics identifies four types of homelessness: marginalised housing (housing that borders on the minimum acceptable living standard); tertiary homelessness (living in single rooms or boarding houses without their own kitchen, bathroom or security of tenure); secondary homelessness (moving between forms of temporary shelter, such as emergency assistance, friends and family); and primary homelessness (people without conventional accommodation, instead sleeping in locations such as streets, parks, disused buildings or impoverished buildings). See further: Chamberlain, C. and MacKenzie, D. (2008). *Counting the homeless 2006*. Canberra: ABS cat. no. 2050.0.

[3] Austin, J., McKellar, J.D. and Moos, R. (2011). The influence of co-occurring axis I disorders on treatment utilisation and outcomes in homeless patients with substance use disorders. *Addictive Behaviours*, 36(9): 941-944.

[4] In 2017, around 53.4 million people worldwide had used opioids in the previous year – 56% more than the estimate for 2016. See further: United Nations Office on Drugs and Crime (2019). *World Drug Report 2019*. Vienna: UNODC.

[5] Blanch, B., Pearson, S-A. and Haber, P.S. (2014). An overview of the patterns of prescription opioid use, costs and related harms in Australia. *British Journal of Clinical Pharmacology*, 78(5): 1159-1166.

due to opioid poisoning. Over the 10 years prior, there was a 25% increase in the rate of hospitalisations due to opioid poisoning.[6]

From 2007 to 2016, the rate of opioid deaths in Australia increased by 62%, from 2.9 to 4.7 deaths per 100,000 population. This increase was driven by accidental opioid deaths and pharmaceutical opioid deaths. It is estimated that, each day, three people die from drug-induced deaths involving opioids, 150 people are hospitalised and 14 people present to emergency departments due to opioid harm. The majority of these harms are related to prescription opioids.[7]

Research has shown that, of all illicit drugs, it is opioids that make the largest contribution to the global burden of disease, largely because of the substantial contribution that opioids make to premature mortality from fatal opioid overdoses – it has been estimated that opioids are responsible for two-thirds of the 585,000 people who died as a result of drug use in 2017[8] – but also due to associated liver and cardiovascular disease, motor vehicle accidents, homicide and assault.[9] The global economic burden of opioid dependence has been called 'profound' both directly (in terms of HIV and hepatitis C virus transmission and various direct healthcare costs) and indirectly (through criminal activity, absenteeism and lost productivity).[10]

In Australia, concerns have been expressed about the 'staggering increases' in prescription opioid use and related harms.[11] In 1998, 65% of hospitalisations due to opioid poisoning were attributable to heroin and 23% due to 'other opioids'. In 2001, 'other opioids' overtook heroin as the leading cause of opioid-related hospitalisations; by 2009, this had increased to 58%.[12]

Unintentional drug-induced deaths have continued to rise across Australia. Opioids continue to be the primary drug type that is associated with these deaths, accounting for 56% of all such fatalities, with pharmaceutical opioids comprising the largest proportion of deaths in this group.[13]

A study of opioid overdose deaths in Australia between 2001 and 2012 found that pharmaceutical opioid overdose deaths increased during the study period (from 21.9 per million population in 2001–36.2), and in 2012 they occurred at 2.5 times the incident rate of heroin overdose deaths. Increases in pharmaceutical opioid deaths were largely driven by accidental overdoses. They were more likely to occur among males than females, and highest among Australians aged 45–54 years. Rates of fentanyl deaths in particular showed an increase over the study period (from a very small number at

---

[6] Australian Institute of Health and Welfare (2018). *Opioid harm in Australia and comparisons between Australia and Canada*. Canberra: AIHW.
[7] Australian Institute of Health and Welfare (2018). *Opioid harm in Australia and comparisons between Australia and Canada*. Canberra: AIHW.
[8] United Nations Office on Drugs and Crime (2019). *World Drug Report 2019*. Vienna: UNODC.
[9] Roxburgh, A. et al. (2017). Trends in heroin and pharmaceutical opioid overdose deaths in Australia. *Drug and Alcohol Dependence*, 179: 291-298.
[10] Tetrault, J.M. and Fiellin, D.A. (2012). Current and potential pharmacological treatment options for maintenance therapy in opioid-dependent individuals. *Drugs*, 72(2): 217-228.
[11] Blanch, B., Pearson, S-A. and Haber, P.S. (2014). An overview of the patterns of prescription opioid use, costs and related harms in Australia. *British Journal of Clinical Pharmacology*, 78(5): 1159-1166, p. 1160.
[12] Blanch, B., Pearson, S-A. and Haber, P.S. (2014). An overview of the patterns of prescription opioid use, costs and related harms in Australia. *British Journal of Clinical Pharmacology*, 78(5): 1159-1166.
[13] Penington Institute (2019). *Australia's annual overdose report 2019*. Melbourne: Penington Institute.

the beginning of the period) but in 2012 rates of morphine deaths were higher than those for oxycodone, fentanyl and tramadol.[14]

A recent Australian study of people in AOD treatment found that those whose primary drug of concern was opioids stood out as particularly severe and marginalised on a range of measures, reporting especially high rates of recent homelessness, criminal justice involvement, secondary drugs of concern (including much higher rates of problems with benzodiazepines than other groups), past-year AOD service use, number of GP visits, and poorer physical and environmental quality of life.[15]

High levels of harm across a range of health and well-being outcomes means that this cohort is in particular need of effective treatment.

Co-occurring homelessness and drug use

Long-term homelessness and substance abuse can have a devastating impact on people's physical and psychological health and their connectedness to mainstream society.[16]

While the empirical link between substance abuse and homelessness is well established,[17] there is substantial variability in reported rates of problematic drug use among people experiencing homelessness, with estimates ranging from 25% to 70%.[18] For example, a study of homeless people in Sydney found that they were six times more likely to have a drug use disorder and 33 times more likely to have an opiate use disorder than the general population.[19] A study of almost 800 people in AOD treatment in Victoria and Western Australia found that people whose primary drug of concern was an opioid were more likely to have experienced homelessness in the previous three months than those with other substance use problems: 31% for those with opioids as their primary drug of concern, compared with 25% for those with a primary drug of stimulants, 18% for alcohol and 13% for cannabis. Overall, 21% of the sample had experienced homelessness in the past three months, with 23% accessing homelessness services.[20] The most recent Victorian data from the *National Illicit Drug*

[14] Roxburgh, A. et al. (2017). Trends in heroin and pharmaceutical opioid overdose deaths in Australia. *Drug and Alcohol Dependence*, 179: 291-298.
[15] Lubman, D.I. et al. (2016). Characteristics of individuals presenting to treatment for primary alcohol problems versus other drug problems in the Australian patient pathways study. *BMC* Psychiatry, 16(1): 250.
[16] Johnson, G. and Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, 61(4): 342-356.
[17] Meta-analysis of studies on co-occurring drug use and homelessness has shown that up to 54% of people experiencing homelessness were dependent on an illicit drug and up to 58% were dependent on alcohol. See further: Whittaker, E. (2015). Multiply disadvantaged: Health and service utilisation factors faced by homeless injecting drug consumers in Australia. *Drug and Alcohol Review*, 34(4): 379-387.
[18] Johnson, G. and Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, 61(4): 342-356.
[19] Teesson, M., Hodder, T. and Buhrich, N. (2003). Alcohol and other drug use disorders among homeless people in Australia. *Substance Use & Misuse*, 38(3-6): 463-474.
[20] Lubman, D.I. et al. (2016). Characteristics of individuals presenting to treatment for primary alcohol problems versus other drug problems in the Australian patient pathways study. *BMC* Psychiatry, 16(1): 250.

Reporting System show that 28% of those surveyed in 2019 reported living in either boarding houses/hostels or had no fixed address.[21]

The AIHW's report on clients of specialist homelessness services shows that, in 2018-19, 42% of clients were homeless and 58% were at risk of homelessness. Of those seeking support from specialist homelessness services, less than one-third (30%) were provided with accommodation and they spent a median of 29 nights being accommodated. When considering all forms of support, the median duration of support among clients of specialist homelessness services in 2018-19 was 44 days.[22]

One in ten clients (10%) of specialist homelessness services in 2018-19 disclosed problematic AOD use. People with an AOD issue were more likely than the specialist homelessness service clients as a whole to be homeless (55% compared with 42%) and were less likely than the whole group to be at risk of homelessness (45% compared with 58%). Clients with an AOD presentation were much more likely to receive accommodation (50% compared with 30%) and they spent more time being accommodated – a median of 35 nights (compared with 29 nights). The median duration of all forms of support for clients with AOD issues was double the support duration for the client group as a whole (87 days compared with 44 days).[23]

Few studies have examined the relationship between housing status and substance use in particular sub-groups of the drug-using population. However, one study examined this nexus among people who inject drugs, comparing health measures and service use between those with stable housing and those without. The study found that those among this cohort who were experiencing homelessness were significantly more likely than those with stable housing to be unemployed, to inject drugs in public, to have worse mental health, to report schizophrenia and to have higher rates of contact with the criminal justice system, including a prison history. In the month before interview, people who had been experiencing homelessness were significantly more likely to have attended an emergency department and were almost twice as likely to have consulted a social/welfare worker.[24]

Pathways between homelessness and substance use

The relationship between homelessness and substance use is complex and has yet to be fully disentangled. Substance use may contribute to homelessness if people become unemployed or physically or mentally unwell and lose their capacity to pay for stable housing. Homelessness may lead to substance use and other health issues due to lack of access to timely and appropriate support and services. And homelessness and substance abuse may interact, each exacerbating the effects of the other. As one study suggests:[25]

---

[21] Peacock, A. et al. (2019). *Australian drug trends 2019: Key findings from the National Illicit Drug Reporting System (IDRS) interviews*. Sydney: National Drug and Alcohol Research Centre, UNSW, p. 17.
[22] Australian Institute of Health and Welfare (AIHW) (2019). *Specialist homelessness service annual report 2018-19*. Canberra: Australian Government, Table CLIENTS.1.
[23] Australian Institute of Health and Welfare (AIHW) (2019). *Specialist homelessness service annual report 2018-19*. Canberra: Australian Government, Table SUB.1.
[24] Whittaker, E. (2015). Multiply disadvantaged: Health and service utilisation factors faced by homeless injecting drug consumers in Australia. *Drug and Alcohol Review*, 34(4): 379-387.
[25] Johnson, G. and Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, 61(4): 342-356, p. 349.

Substance abuse is common among the homeless population, but, for many people, substance abuse follows homelessness. Drug use is an adaptive response to an unpleasant and stressful environment and drug use creates new problems for many people.

A study of more than 4,000 people accessing two homelessness services in Melbourne found that almost half (43%) of the sample had substance abuse problems, most commonly with heroin. Of these people, one-third (34%) had substance abuse problems *before* they became homeless and two-thirds (66%) developed these problems *after* they became homeless. The prevalence of substance abuse varies by age at first homelessness: among people who had their first experience of homelessness when they were 18 or younger, 60% had subsequently become involved in problematic drug use, compared with only 14% of those who first became homeless as adults.[26]

Several studies have identified additional pathways into homelessness – financial crisis, family breakdown, family violence, unresolved trauma due to adverse childhood experiences, mental illness and transitioning from youth care into adult homelessness, among others – although substance use remains a key pathway.[27] Once substance use has become problematic, dominating a person's life at the expense of other activities and priorities, it may become difficult to maintain employment. Without a job, alternative sources of income must be found; when borrowing money or selling possessions are no longer viable, people may divert rent money to fund their dependence. Eventually, tenancies are lost and homelessness ensues. Almost one in five (17%) people accessing two homeless services in Melbourne found themselves without a home after following the substance use pathway, with almost three-quarters of these (72%) being classified in the long-term (more than 12 months) homeless population.[28]

Considering the relationship in the opposite direction, the same research in Melbourne found that, among people who developed substance use problems *after* becoming homeless, the majority (63%) were those who had been in care and who had transitioned to homelessness in adulthood. Almost one-quarter (23%) initially entered homelessness via the mental health pathway before going on to develop a substance use problem, while 17% entered homelessness following the family breakdown pathway. The development of substance use problems after becoming homeless may be seen as a coping mechanism to deal with a raft of other issues.[29]

Research on co-occurring drug use and homelessness therefore shows that drug use can lead to, result from or occur alongside housing instability and homelessness, and often acts as a barrier that prevents people from exiting homelessness. Facilitating access to MATOD should therefore improve housing outcomes for people who are experiencing housing instability and/or homelessness.

---

[26] Johnson, G. and Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, 61(4): 342-356.

[27] Chamberlain, C. and Johnson, G. (2013). Pathways into adult homelessness. *Journal of Sociology*, 49(1): 60-77.

[28] It is likely that this is due to a focus on raising money and finding drugs, rather than searching for jobs or stable accommodation, such that people are left homeless for long periods. See further: Chamberlain, C. and Johnson, G. (2013). Pathways into adult homelessness. *Journal of Sociology*, 49(1): 60-77.

[29] Chamberlain, C. and Johnson, G. (2013). Pathways into adult homelessness. *Journal of Sociology*, 49(1): 60-77.

Medication-assisted treatment for opioid dependence

There are various terms and acronyms for MATOD, such as Opioid Substitution Therapy (OST), Opioid Replacement Therapy (ORT) or Opioid Maintenance Therapy (OMT), as well as the more general term 'pharmacotherapy'. The medications used to treat opioid dependence – usually methadone or buprenorphine – also have several commercial brand names (Biodone, Suboxone, Subutex, etc.) and may be referred to by these.

In addition, MATOD clients will often use slang terms, such as 'the program', to refer to treatment. Methadone may be referred to as 'done' (rhyming with 'own') and buprenorphine as 'bupe' (rhyming with 'loop').

For the purpose of this report, the acronym MATOD is used, except where referring to a specific medication or where interviewees have used a different term.

Long-acting opioid agonist medications, such as methadone and buprenorphine – falling under the general banner of Medicated-Assisted Treatment for Opioid Dependence (MATOD) – offer a highly effective treatment.[30] Such medications work by activating the opioid receptors on nerve cells,[31] ameliorating symptoms of withdrawal without causing intoxication.[32] As withdrawal symptoms are debilitating and include significant physical distress – which can reduce people's ability to function – MATOD medications offer substantial help in navigating daily life.

MATOD has long been used as a treatment for opioid dependence in Australia and is widely available.[33] On a snapshot day in 2017, almost 50,000 people across Australia received MATOD at approximately 2,700 dosing sites. In addition, there are an estimated 40,000 people who are eligible for MATOD but who do not currently access the treatment.[34]

MATOD is delivered in a variety of treatment settings to facilitate wide accessibility, including specialised public and private clinics, general practice clinics, correctional services, community pharmacies and some public hospitals, with most services provided through GP clinics with supervised dispensing at community pharmacies.[35]

---

[30] Tetrault, J.M. and Fiellin, D.A. (2012). Current and potential pharmacological treatment options for maintenance therapy in opioid-dependent individuals. *Drugs*, 72(2): 217-228; Dolan, K. and Mehrjerdi Z.A. (2015). *Medication-assisted treatment of opioid dependence: Your questions answered*. Canberra: Australian National Council of Drugs.

[31] Methadone is a full opioid agonist, meaning that it continues to produce effects on opioid receptors until either all receptors are fully activated or the maximum effect is reached. Buprenorphine is a partial agonist, meaning that it activates opioid receptors to a lesser extent, with effects increasing until they reach a plateau at a moderate dose.

[32] Ryan, J., Thomson, N., Muhleisen, P. and Griffiths, P. (2015). *Chronic unfairness: Equal treatment for addiction medicines?* Melbourne: Penington Institute.

[33] Acknowledging the value and effectiveness of MATOD for people with opioid dependence, Australia has developed a comprehensive set of national guidelines for its use. See further: Gowing, L. et al. (2014). *National guidelines for medication-assisted treatment of opioid dependence*. Available at: https://www.health.gov.au/sites/default/files/national-guidelines-for-medication-assisted-treatment-of-opioid-dependence.pdf.

[34] Harm Reduction Australia and ScriptWise (2018). *National MATOD Summit Report: A better system for better outcomes*. Leura, NSW: Harm Reduction Australia.

[35] Kovitwanichkanont, T. and Day, C.A. (2018). Prescription opioid misuse and public health approach in Australia. *Substance Use and Misuse*, 53(2): 200-205.

MATOD provides a 'regular, consistent and long-acting opioid dose that allows people the opportunity to regain control of their lives'.[36] Its benefits include stabilised and reduced drug use, improved retention in treatment, decreased HIV risk behaviours, improved health and wellbeing, increased workforce or education participation, reduced overdose risk[37] and reductions in drug-related crime.[38] It reduces the risk of overdose and gives people the opportunity to study, work or rejoin their families.[39] For these reasons, the World Health Organisation listed methadone and buprenorphine on its Essential Medicines List for disorders due to psychoactive substance use.[40]

The effects of MATOD on housing stability, however, are currently unknown.

Barriers to accessing MATOD

Despite evidence of its efficacy, MATOD remains under-funded and difficult to access; accessing MATOD in Australia is far from simple. Indeed, less than 10% of general practitioners and 40% of pharmacies are registered in the program nationwide.[41] There are some critical and longstanding factors that limit the accessibility and affordability of MATOD. These include dispensing fees that must be paid by the patient,[42] a dearth of prescribing doctors and participating pharmacies, perceived lack of knowledge to be able to perform the work, and the stigma and discrimination that accompanies

[36] Ryan, J., Thomson, N., Muhleisen, P. and Griffiths, P. (2015). *Chronic unfairness: Equal treatment for addiction medicines?* Melbourne: Penington Institute.

[37] A NSW study of mortality among more than 42,000 MATOD clients over 20 years estimated that the program produced a 29% reduction in mortality across the entire cohort: Degenhardt, L. et al. (2009). Mortality among clients of a state-wide opioid pharmacotherapy program over 20 years: Risk factors and lives saved. *Drug and Alcohol Dependence*, 105: 9-15.

[38] Tetrault, J.M. and Fiellin, D.A. (2012). Current and potential pharmacological treatment options for maintenance therapy in opioid-dependent individuals. *Drugs*, 72(2): 217-228; Nosyk, B. et al. (2011). Health related quality of life trajectories of patients in opioid substitution treatment. *Drug and Alcohol Dependence*, 118: 259-264.

[39] Dolan, K. and Mehrjerdi Z.A. (2015). *Medication-assisted treatment of opioid dependence: Your questions answered*. Canberra: Australian National Council of Drugs.

[40] World Health Organisation (2015). *Model list of essential medicines: 19st list*. Geneva: WHO.

[41] King, Ritter and Berends, 2011; cited in Kovitwanichkanont, T. and Day, C.A. (2018). Prescription opioid misuse and public health approach in Australia. *Substance Use and Misuse*, 53(2): 200-205.

[42] The affordability of MATOD is a significant determinant not just of treatment accessibility, but of retention as well; as the effectiveness of MATOD is dependent on people staying in treatment, the barrier of cost is a key issue. See further: Kelsall, J. et al. (2014). *Opioid pharmacotherapy fees: A longstanding barrier to treatment entry and retention*. Melbourne: Centre for Research Excellence into Injecting Drug Use; Ryan, J., Thomson, N., Muhleisen, P. and Griffiths, P. (2015). *Chronic unfairness: Equal treatment for addiction medicines?* Melbourne: Penington Institute.

substance dependence,[43] both in the community and in healthcare settings.[44] Further, there is no national system for MATOD, resulting in an ad hoc system that can be difficult for patients to navigate.

Barriers to accessing MATOD are even more pronounced in rural and regional areas, where inadequate training/knowledge, lack of access to experts/services for substance dependence and the role of stigma in small communities all combine to exacerbate general barriers.[45]

Housing problems and/or homelessness are likely to compound the effects of these factors, rendering access to appropriate treatment even more difficult.

Homelessness exacerbates existing barriers in the MATOD system by creating additional layers of social and financial disadvantage, leaving some of the most complex cases facing the greatest obstacles to attaining health and well-being.[46] For example, many clients of specialist homelessness services who report problematic AOD use also face additional challenges, which may make them more vulnerable to homelessness: 81% of clients with AOD issues who accessed Australia's specialist homelessness services in 2018-19 (nearly 23,000 people) also reported additional vulnerabilities such as family violence or mental health issues, with 30% reporting all three vulnerabilities.[47]

This multiple, compounding disadvantage creates significant and complex barriers to service engagement among people experiencing or at risk of homelessness. With reduced access to appropriate treatment, people experiencing homelessness are therefore susceptible to additional harms from their substance use. And without ongoing AOD treatment, they often relapse and return to problematic substance use, which in turn threatens whatever form of housing they may have been able to secure.[48]

Housing provides a stable base that is necessary to start the process of recovery but, on its own, the provision of housing is rarely sufficient: appropriate, effective and timely AOD treatment is critical to overcoming barriers for this particularly vulnerable cohort.

The importance of housing stability for effective MATOD participation has been illustrated in a study of the impact of MATOD on health-related quality of life. The research showed that people who moved from unstable housing before MATOD participation to stable housing after reported a statistically

---

[43] Studies have shown that the stigma associated with substance use, and the stigmatisation involved in seeking help for substance use problems, contributes to low levels of help-seeking, such that people delay seeking help until their substance use problems start affecting multiple domains in their lives. When they do finally seek help, people often present with a variety of additional health and social issues, including unstable housing. See further: Lubman, D.I. et al. (2016). Characteristics of individuals presenting to treatment for primary alcohol problems versus other drug problems in the Australian patient pathways study. *BMC* Psychiatry, 16(1): 250.

[44] For example, a New Zealand study identified service-related factors as key barriers to accessing MATOD, including staff having abstinence-oriented beliefs, poor staff/client relationships and negative staff attitudes. See further: Deering, D.E.A. et al. (2011). Consumer and treatment provider perspectives on reducing barriers to opioid substitution treatment and improving treatment attractiveness. *Addictive Behaviors*, 36(6): 636-642.

[45] DeFlavio, J.R. et al. (2015). Analysis of barriers to adoption of buprenorphine maintenance therapy by family physicians. *Rural and Remote Health*, 15(1): 3019-3029.

[46] Kourounis, G. et al. (2016). Opioid substitution therapy: Lowering the treatment thresholds. *Drug and Alcohol Dependence*, 161: 1-8.

[47] Australian Institute of Health and Welfare (AIHW) (2019). *Specialist homelessness service annual report 2018-19*. Canberra: Australian Government, Table SUB.2.

[48] Johnson, G. and Chamberlain, C. (2008). Homelessness and substance abuse: Which comes first? *Australian Social Work*, 61(4): 342-356.

significant improvement in health-related quality of life. People who were categorised as having low health-related quality of life both before and after MATOD participation were more likely to live in unstable housing – housing instability compromised the effectiveness of the treatment. The study's authors suggest that access to stable housing helps these patients realise the health benefits that MATOD can offer.[49]

Given the benefits outlined above, MATOD is a good candidate for improving the quality of life and housing stability of people who inject drugs who are also homeless. However, no dedicated research has been conducted on the nexus between homelessness and MATOD.

It is crucial that the benefits of MATOD for people experiencing housing crisis are understood. This will help to ensure that this highly effective treatment is prioritised and easily accessible for particularly vulnerable groups, and will assist services to address gaps in access for people in housing crisis.

Understanding the gaps and barriers to accessing MATOD for people experiencing housing difficulties is therefore critical to ensuring equitable access to effective treatment for drug dependence. This report aims to provide that understanding and to identify potential interventions that could be trialled to address the barriers to MATOD uptake.

Project description

This research involved a small-scale project designed to gauge the availability of MATOD for clients of housing services, including identifying any barriers to access faced by housing clients.

Methodology

The project primarily adopted a qualitative approach to learn from the experiences of housing service staff and their clients; as there is scant literature on the everyday experiences of people who access housing services who have also experienced MATOD, the qualitative analysis fills a significant gap in the evidence.[50] The initial intention for the research was to adopt a mixed-methods approach, also undertaking a detailed quantitative analysis of service data from the three organisations. The aim of this analysis would have been to identify the proportion of clients currently or previously on MATOD and their support histories. However, these data were not available. Collecting and maintaining detailed data on people's AOD experiences is a resource-intensive task; as the focus of the service providers must necessarily be on housing issues, they do not routinely collect data on alcohol and other drug use. Nonetheless, a brief manual data collection exercise, undertaken by the staff

[49] Nosyk, B. et al. (2011). Health related quality of life trajectories of patients in opioid substitution treatment. *Drug and Alcohol Dependence*, 118: 259-264.

[50] The main perspectives canvassed in previous research on treatments are either the pharmacological impact of MATOD or the views of prescribers and dispensers: there is little discussion of consumers' views. See further: Patil, T., Cash, P. and Penney, W. (2018). Consumers' experience of the opioid replacement therapy program conducted in the Central Highlands and Grampians regions of rural Victoria. Ballarat: Federation University Australia.

themselves, allowed for some examination of quantitative data for those clients who had participated in the interviews.

With funding from the Lord Mayor's Charitable Foundation, and with key partnerships with Melbourne City Mission and Launch Housing, Penington Institute adopted the following methods:

- Qualitative data were collected via interviews with clients and staff from three large housing service providers in metropolitan Melbourne.[51] Issues discussed in the interviews included:
    - perceptions of MATOD;
    - current levels of access/availability of MATOD;
    - the perceived link between homelessness and MATOD; and
    - the effects of treatment on housing status.
- Quantitative data on the client participants were provided by Launch Housing and Ozanam House.[52] To allow comparison of service histories for the participating clients with those represented in national data, the following information was provided for each person interviewed:
    - the number of periods of support the person had received from the organisation;
    - the duration of the support periods; and
    - the number of nights of accommodation per support period.

Participants

There were 35 people who participated in this research: 10 staff from the three housing service providers and 25 of their clients. All participants were interviewed by the primary researcher, following a semi-structured interview to guide discussion yet allow for the conversation to flow organically.[53]

Participants were recruited via staff at each housing service, who had been briefed on the project. Potential interviewees were informed about the opportunity to participate in an interview; staff impressed upon them that their participation was voluntary and would not affect service provision.

Ethics approval was provided by the Brotherhood of St Lawrence's Human Research Ethics Committee. All participants provided either written or verbal informed consent[54] and most interviews were transcribed.[55]

---

[51] Ozanam House (run by VincentCare) joined the project after it had already begun; it was not yet open when the project was first developed. See Appendix A for detailed profiles of each service provider organisation.
[52] Client data were anonymised so that individual participants could not be identified. Data were only provided with participant consent.
[53] Interview duration ranged from seven to 45 minutes.
[54] Participants were informed about the project both verbally and in writing with a plain language statement. People who participated via telephone interview were offered to have the statement read or mailed to them, although none requested this. All interviewees were informed that participation was voluntary and that consent could be withdrawn at any time (up until transcription). For client interviewees, it was explained clearly that nothing they said would impact the service they receive.
[55] Several people who were interviewed by phone declined to have the interview recorded. Instead, detailed notes were taken for these interviews.

Clients

Semi-structured interviews were conducted with 25 clients (see Appendix B for the client interview schedule). Participants recruited via Launch Housing and Ozanam House were all staying in crisis accommodation and were interviewed on-site.[56] Participants from Melbourne City Mission were either in transitional housing or had moved into other housing arrangements, such as staying with family or having moved in with a partner.[57] These interviews were conducted via telephone.

Client interviewees received a $30 Coles-Myer gift card to reimburse them for their time.

The following analysis offers a profile of the 25 clients who participated in this study.

- **Gender**: 16 men, 9 women (including one who identified as a trans woman) – 36% female.[58]
- **Age**: Average age was 42.2 years, with a range from 22 to 61.[59]
- **Country of birth**: Only three participants (12%) had not been born in Australia: one had been born in the United Kingdom, one in Lebanon and one (who had arrived in Australia as a refugee fleeing political persecution) preferred not to say.[60]
- **Indigenous status**: While participants were not asked whether they were Aboriginal or Torres Strait Islander, three clients (12%) made reference to their Aboriginal heritage during interviews.
- **MATOD**: 20 of the 25 participants (80%) were currently on MATOD treatment, while the remaining five had been on MATOD in the past. Among these five, the time since treatment ranged from 5 weeks to 15 years.
- **Age at first drug use**:[61] Average age was 14 years, with a range from seven to 20 years.[62]
- **Age of first opioid use**:[63] Average age was 19.5 years, with a range from nine to 44 years.[64]

[56] Thirteen people were interviewed at Launch Housing, six people at Ozanam House and six at Melbourne City Mission.
[57] Participants recruited via Melbourne City Mission were not considered to have successfully transitioned into private tenancies or stable housing: their housing relies on maintaining relationships with others and their autonomy within that housing is likely to be minimal.
[58] In 2018-19, 60% of clients of specialist homelessness services in Australia were female. However, among clients of housing services with identified problematic AOD use, only 46% were female. See further: AIHW (2019) *Specialist homelessness services annual report 2018-19*, Canberra: Australian Government. These statistics represent all specialist housing services which includes crisis accommodation, transitional housing, long-term subsidised housing, tenancy assistance and brokerage, and mortgage foreclosure prevention. Two of the three services involved in this project provided crisis accommodation as their main service type, and the other provided transitional housing support.
[59] The three organisations only offer services to adults. National data show that, among adults, clients aged 25-34 represent the largest cohort as clients of homelessness services. See further: AIHW (2019) *Specialist homelessness services annual report 2018-19*, Canberra: Australian Government.
[60] This is broadly consistent with national averages, with 84% of clients born in Australia. See further: AIHW (2019) *Specialist homelessness services annual report 2018-19*, Canberra: Australian Government.
[61] Excluding alcohol or medication.
[62] Three participants were unable to recall.
[63] Excluding for medical treatment.
[64] Three participants were unable to recall.

- **Prior incarceration**: 12 participants (48%) reported having been incarcerated.[65]
- **Prior homelessness**: All participants but two (92%) reported experiences of primary homelessness (sleeping on streets or in cars).
- **Childhood homelessness**: 16 of the 25 participants (64%) reported experiences of childhood homelessness or severe housing instability.[66]
- **Childhood instability**: Participants were not asked to reflect on the quality of care they experienced during childhood; nonetheless, a majority reported or made reference to unstable childhoods including abusive homes, parental neglect, parental drug use, parents forcing them to consume drugs and institutional child abuse.
- **Childhood institutionalisation**: 10 out of 25 participants (40%) reported having been institutionalised as a child, either as a ward of the state or spending time in juvenile justice settings or orphanages.

The profile data clearly show a high level of disadvantage among this cohort of homelessness service clients, with multiple, compounded vulnerabilities.

Staff

Ten staff interviews were conducted with housing case managers or AOD case managers from each organisation: six from Launch Housing, three from Melbourne City Mission and one from Ozanam House (see Appendix C for the staff interview schedule). Staff interviewees were not reimbursed for their time.

Launch Housing is a large organisation providing several types of housing services. This project was undertaken at its Southbank crisis accommodation service.

Melbourne City Mission also provides a range of housing services, most of which are youth-focused, with an adult and family housing service in Melbourne's west. This service provides support and case management to people in transitional housing, as well as a range of other support services such as childcare, counselling, financial counselling, legal aid, training and education, migration and employment assistance.

Ozanam House is a large, built-for-purpose crisis and short-term housing centre that provides a range of support services, including crisis accommodation, short-term accommodation and subsidised permanent living units. It also runs a homelessness resource centre, allowing clients to access a range of services and facilities, such as the internet, library facilities, nurses, dental services, financial counselling and the like.

---

[65] One participant had been incarcerated overseas for political reasons, prompting his emigration to Australia as a refugee. Clients were not asked about criminal records but those who reported experiences of incarceration described themselves as having been 'in and out' of jail over a period of years rather than serving long sentences. (only one participant reported that he had been sentenced for 10 years). Those who reported criminal activity usually reported drug offences, interpersonal violence (including domestic violence) or property theft (usually involving burglary of houses).

[66] This included being kicked out by parents, running away from home, state care or foster housing, staying in shelters with parents, and sleeping on the street (with or without a parent).

Results

This section first presents the results from the qualitative interviews, arranged thematically to identify key issues identified by clients and staff, followed by the quantitative analysis.

Qualitative analysis – clients

All client participants were either currently on MATOD or had been in the past. Out of 25 clients, 20 were currently on MATOD, with five having past experience.

Past experience ranged from as little as five weeks since last on MATOD (and currently trying to re-enrol), to more than 10 years since last on MATOD. For example, one participant had had short periods on MATOD more than a decade ago (first methadone and, two years later, buprenorphine) but had no intention of initiating either treatment again. He was a long-term user of prescribed morphine (15 years – prescribed for chronic pain associated with a workplace accident) and his morphine use was steady.

A number of themes emerged from the client interview data.

Drug use

Histories of drug use, and specifically opioids, were common to all participants. Opioid use included recreational use of prescription opioids such as methadone, but all participants also reported that they had used heroin at some point in their lives, with 20 reporting current or recent use.

Most of those who were actively using drugs reported using multiple types of drugs:

> Interviewer: Do you still use any drugs?
>
> J: Yes, heroin and or ice.
>
> Interviewer: How often would that be?
>
> J: Heroin, I'd say every day maybe every couple of days. Ice, maybe every few days.

Some identified a form of home-made replacement therapy amongst their poly-substance use:

> G: Heroin, ice and we just stopped smoking weed and we smoke a mixture of different herbs, like rosemary, mugwort and stuff to get off the weed.

Notably, those who were currently using drugs reported that they had reduced their drug intake while they were on MATOD, differentiating their current occasional use from their regular, intense use:

> Interviewer: And you're both still currently using heroin?
>
> R: Yes, we reduced a lot but we're still adjusting on our methadone dose.

Similarly:

> E: Yes. I am using a little bit of heroin. Sometimes it's a little bit of dope. Not much. I don't really want to be.

Ice use was common among those who were actively using drugs. One participant, now 34 years old, hadn't used heroin since she was 16 but was currently using ice:

> Interviewer: So, you're currently using drugs?
>
> AL: I'm using ice, yes.
>
> I: And not heroin?
>
> AL: No, I'm not using heroin. My boyfriend is, like, he sometimes does heroin sometimes but he tries not to have it in front of me.… Because I know if I do pick it up, I'll be fucked. I know I will because I liked it too much.
>
> I: With ice, how often are you using?
>
> AL: Oh, I use a lot of ice. Probably… I mean, if I can afford it, I'll use nearly… I could use a gram a day. Everyday.

While poly-substance use did not appear to include heroin and ice being used at the same time, the use of the two drugs would overlap. One participant said he had started using ice to stay awake at night while sleeping rough and would use heroin to help him sleep during the day:

> CH: It was a cycle. I would be coming off one and up on the other.
>
> Interviewer: And you're still using both?
>
> CH: Yeah, that's how it started. Now I'm hooked on both. I only use heroin occasionally, like if a friend comes to town.

Relationship between drug use and homelessness

Most interviewees noted that their drug use had affected their housing in some way. For several, it was their drug use that had led to their entry into homelessness:

> Interviewer: Do you think using drugs has ever affected your housing situation?
>
> G: Definitely.
>
> I: In what ways?
>
> G: Well, if we're not managing the drugs properly it makes the situation worse and if you do manage the drugs effectively and sell enough to cover what you use and stuff, you can use it to pay your rent and stuff. But usually it [drug use] has an adverse effect [on housing].

Similarly:

> Interviewer: Were there other things going on that affected your housing?
>
> D: No, it was all to do with the drug use.

For others, housing instability and homelessness preceded their initiation into drug use; drug use was not perceived as a cause of their housing instability:

J: I've been homeless on and off since I was 15. So, it's a cycle sort of thing.

Interviewer: That's really tough. What happened that first time you became homeless when you were 15?

J: My mum used to use drugs herself, she was a speed user. I left home when I was 15. I was just sick of it; do you know what I mean? So, I moved out and sort of just did my own thing. I fell into the drug scene myself. I started using heroin at about 18 or so.

For some clients, increased drug use functions as a coping mechanism to deal with the 'misery' of homelessness:

Interviewer: And so, you think your [drug] use and homelessness really kind of link up like that?

J: Yes, definitely. When I'm homeless I start using and drinking, whatever. If I'm out there, I'd start probably using every day or drinking every day just to block out the misery, or if I was in a boarding house. That's what I've found in the past, my drug use spirals out of control. Whereas here, it's a bit more stable.

Similarly:

Interviewer: And so, do you think being on, sort of when you've been homeless it's made it harder to get methadone?

JY: Financially, yes, because I'm using when I'm homeless most of the time, you know, just to block out stuff. But yes, I suppose so.

For a minority, poor housing and drug use were not seen as causally related. In these cases, housing and drug use were understood as inevitable outcomes of something else. Some struggled to describe exactly what this was, using phrases like 'the system', 'just everything' and 'just how it is'. Others were more circumspect or clear about what had caused their homelessness:

CA: It wasn't the drugs. For me, it was domestic violence. Rich people use drugs, are they homeless? It's about other stuff. If you're poor and shit happens, you're fucked. My relationship ended and that was it.

For these people, drug use and housing did not have a causal relationship but were instead predictable outcomes of what might be described as severe systemic disadvantage.

Relationship breakdown

Approximately a third of participants (nine people) reported that relationship breakdown precipitated or contextualised their entry into homelessness. For some, drug use had been initiated prior to this whereas for others, drug use followed the break-up.

DM: Living in my car and before that, I was living at mum's in Thomastown, with the hubby but when the hubby left, that's when everything just went downhill.

For one participant, it was the use of drugs that had contributed to the relationship breakdown and his entry into homelessness:

> ED: We were both using a lot of cocaine and amphetamines, and I told her, I said this is going to end up nowhere if we don't stop… But in the end, I was glad it finished. It hurt for a long time, and I punished myself by living on the streets and started using heroin.

Another participant noted that a lack of available support services and treatment were an important factor in his relationship breakdown:

> D: There's no drug counselling support up there.
>
> Interviewer: So, you couldn't get support for your drug use and that made your housing kind of…?
>
> D: Made my relationship go really sour because I'm trying to get help and there's nothing around there, so I end up getting depressed and then just staying at home and not doing nothing. She eventually got sick of it.
>
> I: So, then the relationship ended?
>
> D: She got a restraining order on me to move out.

Incarceration

Almost half of the study's participants reported histories of incarceration. For one person, incarceration occurred in his country of birth and was politically motivated. He fled his country of birth and arrived in Australia as a refugee several years later. His experience of incarceration in Australia is limited to immigration detention, not the criminal justice system.

The other 11 participants with a history of incarceration reported intense periods of cycling in and out of prison. The longest single sentence served was 10 years, for a 'stick up'.

While the interviewer did not directly ask about histories of offending, most participants discussed their experiences unprompted and openly. All the participants who had mentioned criminal behaviour reported that their offending was drug-related: either directly (possessing, selling or trafficking illicit drugs) or it was contextualised by drug use, such as committing property offences to pay for drugs.

One participant who had a history of military service described robbing drug dealers:

> ED: I did commit crimes to do it [purchase heroin]. I don't rob houses or steal from cars, but I rob drug dealers. Yes, I used to rob drug dealers. They have money and drugs, so it just made sense.

Another saw the cycle of incarceration as more relevant to his housing than drug use:

> P: I'm not sure if… It [drug use] hasn't affected my… Well, it has affected my government housing because every time you go to jail you get taken off the list. So, in that way it has affected me in getting my housing because I would've got it [public housing] quicker, I suppose.

History of childhood homelessness or institutionalisation

Almost two-thirds of the participants (16 of 25) reported childhood experiences of homelessness or severe housing instability. Ten reported experiences of childhood institutionalisation, such as being a ward of the state or growing up in orphanages or foster homes. All those who reported childhood institutionalisation also reported childhood experiences of homelessness.

> DO: Well, I grew up in a boys' home since I was five, so accommodation's always been a problem for me.

Running away and abuse in state-care or foster homes were common:

> A: Because of my age I was fostered out to a different set of foster people. Some of the foster parents used to abuse me… Assault me, not sexual assault. Bash me.

One participant, who is transgender but identified herself as being male as a child, shared a particularly powerful experience of her history of childhood homelessness and drug use. She reported being kicked out by her parents at age 11. As an 11-year-old boy, she was sexually abused by an older man who demanded sex in exchange for accommodation, and who gave her heroin for the first time. At age 13, she was living in a tent with a different man (also much older – posing as her father) in a regional town. She was taken into police custody when the man was arrested for theft:

> AL: Then I was shipped back home. Oh, my God, a heroin addict 13-year-old shipped back home. You can just imagine. My mother was distraught.

Family dysfunction, abuse, childhood trauma and experiences of childhood homelessness and institutionalisation were common among participants. Even among those who reported no experiences of childhood homelessness or institutionalisation, there was nonetheless family dysfunction:

> E: My mum… Her and I didn't get along very well at all. She was very strict and just very dominating, nasty, nasty with her words… The house was perfect, she cooked beautiful meals and looked after us. She wasn't not loving at all. She was quite a bitter, nasty, jealous person. I didn't want to be anything like her. So, in a way, there was that big rebellious streak in me without even realising it.

Cost

Both housing and MATOD pose significant costs for clients. Several participants noted that stable housing and MATOD work best together but that this is the hardest combination in terms of cost. The two crisis accommodation services involved in the project charge clients for accommodation, usually in the form of a percentage of their fortnightly income (30%). The other service supports clients who pay a subsidised rate for transitional housing. Several participants noted that after paying for their accommodation, other inflexible costs and their MATOD, they were left with very little money:

> Interviewer: What made you stop the methadone program the first time you were on it?
>
> D: I couldn't afford it.

Similarly:

> Interviewer: So, you mentioned the finances, do you think finances become more difficult on the program?
>
> R: If we had our own place, we wouldn't have the finances to do it [be on MATOD].

By 'own place', this last person was referring to the subsidised transitional accommodation that he and his partner had been offered.

One participant who was receiving welfare payments had to pay for his accommodation, child support and $60 a fortnight for his methadone. He had also been offered subsidised transitional housing but was forced to turn it down due to cost. He summarised the situation neatly:

> J: By the time you take everything out, all your bills, and you're only getting $490. And they charge $450 rent [for the subsidised transitional housing]. If I took that, I couldn't even pay for my methadone. So, people choose to live on the streets because they can't afford the rent.

Another said this:

> DM: I'm on the 'done [methadone], but I'm having trouble funding it because I'm paying for this joint and only getting Newstart. I don't get that much money. It's like, I have to do what I have to do just to, I know it sounds stupid but I work [sex work] to support my habit. So, if I don't have the funding with the help of the government, to stay on my methadone, I'd rather use than pay for my methadone.

Similarly:

> I mean, maybe if, because although it's only a small amount, seeing your chemist is $100 a fortnight. It's not a lot, but it is when it's out of $380. That's before anything else.… [T]here's some places where they won't give you [your dose] if you haven't got $5 that day, even if you can give it to them the next day.

While the financial costs of MATOD certainly presented an objective obstacle to participants, there appeared to be little recognition of the financial and other costs of drug use that people had been very willing to pay.

Access to prescribers

As most participants were currently on MATOD programs, they were seeing a prescribing doctor regularly. For most, their doctor was nearby their current accommodation. However, many pointed out that staying on MATOD was difficult during periods of rough-sleeping or unstable accommodation, so they had initiated treatment in their current housing service accommodation.

Those who travelled farther to see a prescribing doctor did so because they had an established relationship and were reluctant to change. Those who had re-initiated treatment following entering crisis accommodation often preferred to keep their existing relationship, rather than seeing a new doctor. Indeed, three participants stated that they would prefer to postpone their appointment than see a different doctor.

Most participants reported having difficulty finding a prescribing doctor when wanting to *initiate* MATOD. This was due to a scarcity of doctors who prescribe MATOD and was exacerbated if they did not like or trust that doctor. Returning to a doctor once a relationship was established was generally considered easy, if occasionally inconvenient.

The scarcity of doctors may leave people to find other options for seeking help:

> JA: There wasn't or didn't seem to be as many doctors, prescribers, so I don't know. I couldn't get in anywhere so I just rang a hotline.

Those who reported recent experiences of sleeping rough said that attending a prescribing doctor was very difficult, for three primary reasons:

- appointments are difficult to keep when sleeping rough;
- people were more likely to be using drugs again or using drugs more intensely while sleeping rough; and
- rough-sleeping and using drugs were perceived as reasons for which a doctor may discontinue prescribing.

Concern about the impact of rough-sleeping and drug use on MATOD accessibility was expressed by several participants:

> CH: I haven't told my doctor that I'm homeless yet – he still thinks I'm living with my partner.

> G: They [the doctor] seems to be understanding. They don't kick us off for being honest and telling them we're still using and stuff.

One person who was not on MATOD but currently using prescribed morphine pills to manage back pain reported the farthest and most extreme travel. He had recently moved to Queensland to be with his adult son who had been diagnosed with a serious illness. He flew to Victoria monthly to renew his prescription and have it filled. When asked if he could transfer his care to a doctor in Queensland, he said no; he was unsure why he was not able to, but had been told that he could not.

Several participants reported experiencing stigma at doctors' surgeries, either from the doctors themselves or from other staff:

> R: They [doctors] don't want you in their waiting rooms.

Access to dispensing pharmacists

As with their prescribing doctors, most participants currently on a program attended a pharmacy near the service. Only one reported travelling farther to a preferred pharmacy, which was located at a hospital.

While accessing a dispensing pharmacy was generally reported as being easier than accessing a prescribing doctor, rough-sleeping was described as a significant barrier. Further, participants reported a greater degree of anticipated stigma when attending pharmacies:

> R: And in a pharmacy, you get looked at weird. On the street, everyone knows you.

Interviewer: Does it get better once you've been going there for a while?

R: Yes, but other customers and that, they don't know you. It kind of, doesn't look good for their business.

Attending the pharmacy to collect doses was regularly described as the worst part of MATOD, due to factors such as the travel required, anticipated and actual stigma, confrontations with pharmacy staff and feeling powerless in this context:

Interviewer: And so, was there anything you didn't like about being on the program?

E: I don't like anything having control over me. And there's a whole stigma from outside people and even to yourself that you just feel… Some pharmacists are great, they are beautiful. But then there's some places you go and you can feel like a real lower-class citizen because everyone gets served before you. You'll get served separately and it's really obvious. It is what it is, but anything having control like that isn't good.

Similarly:

R: The worst thing was trying to tell the chemist that I didn't have the money that day and try and get it for free.

Another participant was very concisely negative about the need to visit a pharmacy to receive the methadone dose:

Interviewer: What would you say is the worst thing about being on methadone?

A: Going to the fuckin' chemist.

One participant said that if he could change one thing about the program, it would be to have more pharmacists participating in the program:

Interviewer: This is the last question, what do you think would make being on the program easier?

J: Just if more pharmacists were, I don't know what they refer to the pharmacists as, but if more pharmacist were licenced to dose, I'm assuming it would open the doors for a bit more convenience, but, yes.

Stigma

Participants were not asked specifically about stigma, but most made references to either anticipated or experienced stigma. This was often in the context of doctors' offices or pharmacies, as well as relating to homelessness. One participant requested that the interviewer move on to other questions because she was embarrassed discussing her homelessness:

Interviewer: And where were you living prior to here?

E: This is actually embarrassing. I was actually on the street for the first time in my life. I thought I'd been homeless before, but that was because I didn't have my name on a lease. I might have been renting a room. I mean, up until six years ago, I was totally stable in every

way anyway. But I lost my property. I had an apartment in Elizabeth Street. Unfortunately, I lost that. We should move on.

Another participant articulated how stigma — specifically, that associated with drug use — operates internally too.

> A: Absolutely. I think it affects your self-awareness mostly. Like, you live in places any… You let things happen, like, you let things get stolen and you get raped and you do this all for a hit. Then you look at yourself and it's… It's just disgusting.

Perceptions of MATOD

Several of the staff who were interviewed for the project said that client misconceptions about MATOD were common; these misconceptions acted as obstacles to treatment participation. While beliefs around MATOD were not directly addressed in interview questions, several participants articulated beliefs regarding the negative impacts of MATOD medications, particularly methadone, such as:

- rotting your teeth;
- being stronger or more addictive than heroin;
- affecting bone strength; and
- causing weight gain.

Rotting teeth and weight gain were the most common side effects reported by participants:

> DA: It rots your teeth away. I've got one good tooth left. When I first started on the methadone I had all beautiful teeth, now I'm stuck on the waiting list to try and get my teeth fixed.

Similarly:

> J: I don't like methadone. It makes you fat. That's why I'm on bupe.

One participant, who had experienced a significant workplace injury, claimed that methadone was the reason the injury resulted in chronic pain:

> DR: It gets into your bones, you know? So, when the boxes hit me, my bones just couldn't handle it. That's why I'm on morphine now, because of the pain. That was 15 years ago.

Two participants believed that methadone was responsible for their opioid dependence. Both reported infrequent heroin use at the time of initiating treatment. One became pregnant and when she informed her doctor of her drug use, he recommended MATOD:

> E: But I believe that gave me an opiate addiction, that time on methadone. Not that I haven't had a heroin addiction since then, but that was where it started probably.

The other had been arrested for drugs charges including heroin possession at 18 years of age. His parents made joining a methadone program a condition of him continuing to live with them. Both participants believed that methadone had initiated their opioid dependence, resulting in a lifetime of chronic dependence, opioid use and housing instability:

D: Methadone has wrecked my life.

Myths and misconceptions about MATOD presented people with perceived obstacles to their involvement in treatment.

Perceived benefits of MATOD

Most participants stated that MATOD had granted them a level of stability not otherwise achievable, and was effective at disrupting the cyclical pattern of chronic drug use:

> J: Once you find that steady, that happy medium, the actual stability is paramount and that would be the actual biggest key element to it.
>
> Interviewer: It lets you do other things?
>
> J: Yes, it allows you to just, once you've got your dose behind you, you can get on with your life.

Similarly:

> You don't have to steal from anything just to go support your habit, do you hear me? So it was just there, it's cheap. You're not getting high off it but it's holding you and you're not going through the cramps, the sweats. It's a horrible thing.

Even those who viewed MATOD programs sceptically acknowledged that there were significant benefits:

> Interviewer: Aside from that methadone was a bad thing for you to go on, do you think there were any positives to being on methadone?
>
> D: Yes. That I didn't go out to have to steal to make money every day and all that kind of thing, that's the only positive side of it.

In terms of housing, however, the benefits of MATOD were less tangible. MATOD provided stability, which was seen as crucial to 'sorting things out', but even with MATOD, gaining stable housing felt very difficult or impossible:

> Interviewer: Right, okay. I wanted to ask about if when you're on a program, if that kind of makes your housing situation better or helps you?
>
> JY: Not really, no.
>
> I: Not really?
>
> JY: No, it really doesn't affect my housing at all, it doesn't help me.
>
> I: So why don't you think it kind of helps?
>
> JY: Well, being on methadone doesn't help with housing, because there's no criteria, like I'm not going to get housing any quicker than someone who is not on methadone. I don't think it helps.

Another two participants (a couple who were interviewed together) were highly cognisant of the state of housing in Australia, particularly capital cities:

> Interviewer: Would you say that being on methadone helps you with your housing situation?
>
> R: We're just finding it hard at the moment, I don't know. There's a housing crisis, you know.

While being on MATOD was understood by most participants as improving their prospects for gaining and maintaining stable housing, there was also a high degree of cynicism about this. As one interviewee stated:

> R: I'm clean now. I'm ready now. I need housing now. Why can't I get it when I need it? By the time the housing's ready, who knows where I'm at.

'Liquid handcuffs'

Several participants mentioned the constraints experienced when on a MATOD program – commonly referred to as 'liquid handcuffs'. Those who used this phrase explained that they didn't like the restrictions that come with the program. These restrictions felt constant: regular doctor appointments, daily or almost daily dosing and being subject to the scrutiny of others. One participant was frustrated by the rigidity of the program:

> D: My whole day is all around waking up. Okay, I feel okay, don't need to go get any methadone until I get sick and then I go and get my methadone. It's the same day every day.

Another participant described how he hated feeling controlled:

> A: I hate that feeling [of being controlled], y'know? But it's better than using because you can't do shit when you're using. But at least then you're high, you're out of it. But on the program, you feel it [the sense of control].

Others were very clear about the benefits of MATOD but did describe the limitations as a significant downside:

> JY: Being on methadone? It can get a bit, yes, it's like the old liquid handcuffs. Like, you can't travel. I went to Queensland when I was on methadone and I was only able to get three takeaways. I went on a Friday and came back three days later. You're just sort of stuck to the chemist.

Another participant used a different, though powerful, analogy:

> J: It's [methadone] an anchor, you're anchored to attend daily. And, also, no matter where you are, what you're doing, you've always got to bear in mind that you need to get your dose. It a bit of an issue but in order to maintain your stability and stay off the drugs, you need to attend.

Best and worst parts of MATOD

All client participants were asked to identify the best and worst parts of being on a MATOD program. Answers were varied and often reflected the complexity of people's lives. The benefits of MATOD were often closely intertwined with its less desirable aspects.

As a result, many of the answers to these questions reflected the contested nature of MATOD in people's lives:

Best part: Not using anymore. Worst part: Not using anymore.	Best part: Gives you the space to sort out the other shit that's going on. Worst part: Sorting out all that other shit.
Best part: It costs less than heroin. Worst part: Still too expensive.	Best part: I don't have a best part for the program. Worst part: Being on the program

Generally, participants saw MATOD as a complex undertaking. The benefits were significant; however, these came with an array of conditions, scrutiny and restrictive obligations. Further, the benefits were generally understood as being limited to a specific area of their life – drug use.

MATOD had few noticeable impacts in other areas such as housing, social connection, relationships or helping people cope with trauma or grief (which heroin did, albeit temporarily). MATOD also brought increased awareness of the challenges they faced in these other areas (compared to continuing to use heroin).

One participant said that while MATOD helps you stop using, it fails to replace the social and physical pleasures of drug use with anything else:

> D: The methadone gets boring. It's the same shit. You eventually have enough and you just want to blow your mind and not have any worries in the world and that's what does it for you.

In sum, participants understood the long-term benefits of MATOD, but the treatment itself was seen as onerous, difficult and requiring abstinence from an enjoyable (albeit, destructive) activity.

Given the difficulty in ceasing use and the unpleasant aspects of MATOD, participants were frustrated that stable housing was still elusive, despite their efforts:

> R: We've been here for months now and hadn't even got a look in for anything yet. That's ridiculous and you go back on the streets. You go back to using. It's the warmth. Methadone, you still eat and things like that, with heroin, you do that on the street, so you don't have to eat. It's survival.

Qualitative analysis – staff

Ten interviews were conducted with staff members from three Melbourne-based services. All participants had experience working with people who use drugs and people on pharmacotherapy treatment programs. Two staff had been working in their roles for less than one year.

One service had an in-house AOD team; staff interviews involved six housing case managers and four AOD support workers. Client engagement with housing case workers is a condition of service engagement at the organisations, whereas engagement with AOD workers is voluntary.

Three of the housing case managers worked with clients in transitional housing, while the remaining staff worked in crisis accommodation services.

While AOD workers' roles were dedicated to assisting clients with alcohol and drug use, housing workers reported that assisting clients with drug use as well was a common part of their work. Joint meetings between the client and both the AOD and housing case managers were described by staff as a constructive way to ensure that housing case management and AOD support work were synchronised.

The following themes emerged from interviews with staff members of the three housing services.

Drug use

All staff reported past or current drug use (including problematic alcohol use) within their client base. Current use of illicit drugs was reported to be lower among clients in transitional housing, though lifetime illicit drug use and current alcohol use were high.

Staff working with clients in transitional housing (rather than in crisis accommodation) were less likely to report current drug use as a primary cause of housing instability. Their clients were more likely to report other factors, such as domestic violence or unemployment, as drivers of housing instability. However, substance use (including alcohol) was reported as 'part of the mix' of challenges that their clients faced.

Staff working with clients in crisis accommodation also reported a mix of causes of housing instability, although current drug use was more likely to be reported as an acute factor. Staff noted that clients were just as likely to report other factors (trauma, domestic violence, histories of childhood homelessness or experiences of state care, etc.) as contributing to housing instability and contextualising drug use.

Relationship between drug use and homelessness

Housing was consistently identified by all staff participants as the most pressing need for their clients, above mental health and substance dependence/misuse. However, mental health and substance dependence/misuse were identified as being intertwined with housing instability and homelessness in a highly complex way.

Staff perceived housing instability as presenting additional problems for their clients who were initiating and adhering to MATOD. One staff participant, an AOD worker, reported that in the last 12 months she had six clients wanting to begin MATOD treatment, with only one doing so. This client found adherence to treatment difficult, however, and ceased within a month.

Staff participants identified several key ways in which housing instability affected their clients' ability to initiate and continue treatment:

- Difficulty accessing a prescribing doctor.
- Difficulty attending appointments and having necessary documentation.
- Difficulty attending a pharmacy for daily dosing.
- Unstable living situation making organisation and preparation difficult.
- Delays between the moment when a client is ready to initiate treatment and the time when treatment is available.

Access to MATOD

Most participants identified a lack of access to enablers of treatment initiation and adherence to the treatment regime as significant barriers for their clients. Several identified a significant gap in time between a client deciding to access MATOD and treatment being available. With this delay, maintaining client interest and motivation to initiate MATOD was reported to be difficult.

Further, staff participants noted the lack of infrastructure to support client access to MATOD, with few prescribing doctors and dispensing pharmacists. One participant stated:

> It's clunky. So, we often use [name withheld] but their hours are really limited. So, I'm taking folks down to Footscray. I'm taking folks to St Kilda. It's really wherever you can get an appointment with a methadone prescribing doctor, and they are few and far between. And it's a rigmarole. You've got to get photos, you've got to get certified, there's a start-up fee. I wish we had a pharmacotherapy doctor here...

Support for MATOD

Most staff participants were familiar with MATOD and had worked with clients who were either on treatment or wanting to begin treatment. Staff actions in support of MATOD ranged from the more straightforward – a housing case manager encouraging a client to consider treatment and referring the discussion to the client's AOD worker – to the more intensive – an AOD worker organising an appointment with a doctor, accompanying the client to the appointment, organising payment for the dispensing fee and accompanying the client to the pharmacy for dosing.

All staff participants reported that their clients were very familiar with MATOD. Reflecting this, discussions with clients about MATOD were not introductory but rather practical: wanting to get back on a program, asking for assistance in accessing their dose, or explaining to their worker why they were not interested or ready. Several staff reported negative perceptions of MATOD among their clients and some degree of misinformation:

> Oh, they all know about methadone and bupe. They're very savvy in that sense. They've heard about it from friends, they know people on it, they hear it on the grapevine. So, my conversations are usually just about softening some of those attitudes, nudging a bit against those misconceptions.

All staff participants stated that they saw MATOD as an effective means of stabilising a person's opioid use, allowing clients to begin addressing other issues in their lives. One participant referred to this as

'giving space' to the client. Others referred to it as an effective way for clients to reprioritise their needs:

> Clients want to sort all that stuff out – they want better housing, stable housing, less chaotic lives. They've got heaps of stuff they need to get done, but when they're actively using, that's the first thing on their list. And they can't get past it: you're either high or looking to use, so you never get around to anything else. OST [MATOD] removes that, let's them get around to some of those other things.

Staff participants were adamant, however, that MATOD was not a 'silver bullet' to opioid dependence, and that their clients faced other challenges, such as traumatic pasts and unresolved grief, and systemic issues such as a lack of appropriate or affordable housing. One participant described a client who, upon beginning MATOD, increased her use of methamphetamine considerably. Another said that she had had several clients who wanted to begin MATOD but did not feel ready to face the other issues in their lives, from which heroin provided an escape.

All staff participants identified current drug use (including use of drugs other than opioids) as a barrier to stable housing for their clients. In relation to MATOD, one participant stated:

> I think it [MATOD] is a really protective thing on housing applications, [it shows] that people are engaging with services, they have some degree of routine, they're meeting that expectation with a degree of regularity. And people [on MATOD] are seen as less likely to reoffend if they are on parole. They're seen as less likely to have a housing breakdown situation.

Participants also identified a series of barriers that clients face in accessing MATOD. One summarised the reasons that several of her clients who would benefit from MATOD were not accessing it:

> Some of them don't want to stop using. Some of them find it [MATOD] cost-prohibitive. Some of them have part-time jobs that would make it difficult for them to get enough takeaways to access consistently. And I think that… there is a sub-set of the population who feels like it's still an opioid, still a drug. Like a 'either-heroin-or-nothing' kind of thing.

Reluctance and misinformation regarding MATOD

Participants identified substantial negative views about MATOD among their clients. Some of this was accurate and understandable, such as the restrictive effects of having to attend a pharmacy daily. However, some perceptions of MATOD were based on, or exacerbated by, misinformation.

Four staff participants reported clients having abstinence-focused attitudes towards drug use. One described this as the 'cold-turkey-or-nothing' belief. This idea views MATOD as trading one dependence for another. Clients who hold this view often say that they would rather cease opioid use without the assistance of MATOD.

Other staff participants described a reluctance to initiate MATOD due to the additional obligations that come with 'getting clean' or 'getting on the program': for some clients, stopping drug use implied having to face and deal with a range of other issues and challenges that awaited them. In this sense,

MATOD represents a 'first step' that some clients are reluctant to take due to the additional steps that follow.

Improvements when pharmacotherapy is maintained

All staff participants noted that, when successfully maintained, pharmacotherapy is an important way of improving outcomes for clients who used opioids. One went so far as to say:

> For opioid-dependent clients, you are really just treading water until they start OMT [MATOD}. That's the point where the work can become really productive. And expecting clients to get clean before they get housing, it's just nonsense. It's cruel.

Another described a client who, once they initiated buprenorphine-based MATOD:

> …that was the end of our intervention. They didn't feel like they needed case management once they were on [MATOD]. And that came with, after housing. Once they were housed, they were like 'Yep, let's do this [begin MATOD]!'

This example is unusual – most clients who initiate MATOD continue to need proactive case-management and support. However, it also demonstrates the potential benefits of an accessible MATOD system, given the reported difficulties in matching client readiness with treatment availability.

Stigma

Stigma was identified regularly by staff participants as a significant barrier for their clients. Several noted how difficult some clients find it to attend a doctor due to negative past experiences. One participant illustrated this level of difficulty for clients:

> I forget when I'm like 'Just go to the doctor's'. And then my client has a panic attack and I'm like, 'What's wrong?' Then you realise what they're about to experience.

This participant suggested that, when encountered in healthcare settings, stigma had the function of preventing some clients from accessing essential services, including opioid substitution therapy.

Another staff participant, a housing case manager, described how clients often refuse to admit drug use, especially in a first meeting or after a period of abstinence. In most cases, this reluctance dissipates and a client will discuss their drug use in case management meetings. However, this participant described a client who would attend meetings clearly affected by drugs yet steadfastly refusing to acknowledge her drug use or to see an AOD worker, due to repeated exposure to drug-related stigma.

While clients are under no obligation to disclose this kind of information, the staff participant pointed out that this sort of reluctance makes linking people to an AOD support worker particularly difficult.

Quantitative analysis

The data provided by the organisations for client participants were averaged to allow comparison with national averages for clients staying in specialist homelessness services.[67] The focus of the data was on the nature of the support that clients had received (see Table 1).

Table 1: Nature of support provided by specialist homelessness services, by sample

	Current research sample	National sample – all clients (2018-19)	National sample – clients with AOD issues (2018-19)
Average number of support periods per client	2.4 (Launch: 1.9) (Ozanam: 3.8)	1.8	2.9
Length of support (number of days – median)	47 (Launch: 58) (Ozanam: 34)	44	87
Number of nights accommodated (median)	47 (Launch: 78) (Ozanam: 22)	29	35

Compared with the overall national sample, clients of the homelessness services who participated in this research required more support in terms of the average number of support periods per person, the duration of support and the number of nights of accommodation. Compared with the national AOD sample, clients who participated in this research had fewer periods of support per person and shorter durations of support, but they required more nights of accommodation.[68]

Key findings

Results of the analyses suggest a number of key findings of this research:

- **There is a high level of disadvantage among this group of people experiencing both homelessness and drug use:** High levels of both prior incarceration and prior homelessness, as well as childhood experiences of homelessness, institutionalisation and family instability, abuse or neglect, illustrate the multiple, compounded vulnerabilities among this group.
- **There is a reciprocal relationship between homelessness and drug use:** The relationship between homelessness and drug use is complex: there is no clear pathway between the two. While drug use among the participants of this research was a common way to cope with the stress of housing instability or homelessness, most participants believed that their poor housing situation had a negative impact on their drug use: the more dire the housing circumstances, the more extreme the drug use became. When homelessness and drug use co-

[67] Australian Institute of Health and Welfare (AIHW) (2019). *Specialist homelessness service annual report 2018-19*. Canberra: Australian Government, Tables CLIENTS.21; SUB.1.

[68] Comparisons between the research sample and the national sample should be considered with caution due to the small number of research participants.

occur, they each exacerbate the other and intensify the associated difficulties in a reciprocal feedback loop.

- **There are substantial barriers to accessing MATOD for people experiencing both homelessness and drug use:** Both client and staff participants appreciated the value of MATOD in responding to drug use, with clients suggesting that they would have few problems adhering to the regime were their housing stable and the treatment affordable. But both clients and staff identified substantial barriers to accessing MATOD.
    - **Financial barriers:** Financial barriers were commonly reported among client participants, in terms of both the cost of MATOD and the cost of housing. When having to bear the costs of both at the same time, there is a far lower likelihood of continuing in treatment as housing is given priority in people's lives.
    - **Practical barriers:** Being homeless was reported to make treatment adherence more difficult in practical ways, such as the requirement to travel to the dosing location on a daily basis. Being homeless also made it more difficult to *want* to stay in treatment: opioid use can make homelessness more bearable.
    - **The dual stigma of drug use and homelessness:** The stigmatisation of both drug use and homelessness is experienced as a significant barrier to accessing and adhering to MATOD. This is particularly problematic given the dearth of prescribing doctors and dispensing pharmacists.
- **Staff and clients hold conflicting views of the direct impact of MATOD on homelessness:** Staff participants all agreed that access to MATOD was crucial to improve their clients' outcomes, including finding stable accommodation – staff saw a clear link between MATOD and positive housing outcomes. In contrast, many of the client participants doubted the direct benefits of MATOD for their housing situation: while they saw that MATOD could provide stability and improve their housing prospects, many felt that securing stable housing remained very difficult or impossible.

Discussion

The MATOD system provides an important treatment mechanism for people with opioid dependence. However, existing barriers to MATOD – particularly relating to accessibility and cost – mean that the current system is inadequate to meet the needs of many people who could benefit from it, including those who are already in treatment, but for whom the costs of treatment significantly affect their financial and housing stability.[69]

MATOD is recognised as an important and effective treatment among both staff and clients of the housing services on which this research is based. However, being on MATOD is not necessarily enjoyable, and the direct benefits of MATOD adherence for housing stability appear to be intangible, long-term and difficult to perceive for these housing service clients. While MATOD has many benefits,

[69] Many respondents decried the cost of MATOD as prohibitive. However, few acknowledged that their illegal drug use had cost them far more than either treatment or accommodation. This may reflect a perceived absence of benefit from MATOD when compared with the immediate benefit gained from the drug.

it also brings with it obligations that may feel onerous, arbitrary and unfair for people facing multiple forms of disadvantage.

Nonetheless, expanded and facilitated access to MATOD for clients of specialist housing services – dismantling some of the barriers to access that they face – is likely to improve a range of quality-of-life outcomes, including assisting people to secure and maintain stable accommodation.

Recommendation

On the basis of this research, Penington Institute makes the following key recommendation to build the evidence base to address barriers and create better access to MATOD for people with unstable housing circumstances:

Recommendation
That a multi-site trial be undertaken in partnership with homelessness services (crisis and transitional accommodation), of an intervention that enhances access to treatment for opioid dependence (MATOD) for their clients. The intervention will be designed to test a range of identified barriers and enablers to accessing MATOD for people experiencing homelessness. The trial will consist of three main study groups: 1. Clients receiving daily dosing of opioid treatment, with the daily dispensing fee paid by the study. 2. Clients receiving monthly dosing of opioid treatment. 3. A 'control group' of clients who access MATOD under the existing systems. The primary intervention will involve strengthening pathways to care. An AOD worker will be employed and located within the homelessness service to work with clients with a focus on integrating AOD support into the broader housing support provided to clients. Emphasis will be given to building a therapeutic relationship and facilitating referrals to related services (such as mental health) and supporting participants to access doctors who can prescribe MATOD. The AOD worker will work with clients to create linkages back into their local communities, families, activities, employment and the like, thus providing wrap-around support to help people navigate parallel systems and government bureaucracies. Alongside the intervention, a campaign promoting the benefits of MATOD to clients of each homelessness service will be developed and incorporated into the trial.

Appendix A: Service organisation profiles

Launch Housing – Southbank

Launch Housing is one of Victoria's oldest and largest homelessness charities. It has multiple service sites, mostly situated in Melbourne and its surrounding suburbs.

Launch Housing's Southbank Crisis Accommodation in South Melbourne provides short-term accommodation for people who are currently experiencing housing crisis. It is a 52-bed facility and accommodates single men, women and couples over the age of 18.

Accommodation is offered for an initial four weeks, with a four-week extension possible upon review. While eight weeks is technically the maximum stay, in practice, it is a lot more flexible. A program manager at the service estimated that the average length of stay is 10 weeks, while the longest stay they had heard of was 42 weeks.

Launch Southbank provides access to allied health services, such as on-site nursing consultations. Additional support services are also available: it has an in-house AOD team, a peer support worker program, access to legal advice, and a wellbeing program that includes art therapy, acupuncture, gardening, crafts and games. It is also a pet-friendly service.

There are 15 people on the case management team, including four AOD case managers and one AOD team leader, each with a small client case load. Launch employs two part-time peer workers as part of their wellbeing program. There are always two members of the operations team rostered on during opening hours.

Clients are required to meet with their housing case manager weekly, but engagement with the AOD team is voluntary.

Launch's Southbank site is unique In Victoria as residents can use drugs on-site as long as they are used safely. While drugs must not be used in communal areas and residents should not be intoxicated in these areas, drug use or intoxication do not breach the service contract as it does in many other accommodation services.

The service also has a needle and syringe program on-site, where clients can dispose of used equipment and access sterile equipment.

See further: https://www.launchhousing.org.au/

Melbourne City Mission

Melbourne City Mission (MCM) is a housing-focused charity that offers a range of housing and support services from multiple sites across Melbourne.

The bulk of MCM's services focus on youth; however, an adult and family service program operates in Footscray in Melbourne's west. This service provides housing and other support services to adults and families who are homeless or at risk of homelessness in the Western and Brimbank-Melton regions of

Melbourne. The aim of the adult and family service is to support clients to enter long-term stable housing (either in private or public rental).

Most of the service's clients are staying in transitional accommodation housing units administrated (though not owned) by MCM.[70]

The adult and family service employs six case managers who provide short- to medium-term support to clients during their stay in transitional housing. Support activities include linking clients to other services (such as employment, financial counselling and family support), assisting with public housing or tenancy applications, and general social supports.

There are no firm limits on the length of the tenancy support period, with durations differing depending on the client's needs.

The client body of MCM's adult and family service is highly diverse compared with Launch Southbank and Ozanam House. Many clients of MCM's adult service will not have experienced primary (on-the-street) homelessness. They are more likely than clients of Launch or Ozanam House to have experienced housing instability due to financial crisis, to be employed, to be from a culturally and linguistically diverse background, and to be living as a family unit.

See further: https://www.mcm.org.au/

Ozanam House

Ozanam House is an accommodation and homelessness resource centre run by VincentCare Victoria – a subsidiary of the Society of St Vincent de Paul Australia.

Ozanam House is in North Melbourne, just outside of the central business district. It began in 1953 as a night shelter for homeless men, and in 2019, relocated to a new purpose-built facility – the largest accommodation service for rough-sleepers in Australia.

Ozanam House provides a mix of crisis accommodation and extended supported accommodation. It also offers independent living units for clients aged 55 and above. The homelessness resource centre offers a range of services and supports for adults, even if they are not residents of Ozanam House.

Ozanam House offers a range of primary and allied health services, such as access to doctors, nurses and dentists, as well as social supports, including women's services, financial counselling and intensive case management. Clients can also access an in-house café, IT services including computer training courses, prayer rooms, LGBTIQ- and women-only spaces, as well as shower, laundry and storage services.

See further: https://vincentcare.org.au/our-services/ozanam-house/

[70] These are public housing units that are owned by the state government.

Appendix B: Interview schedule for clients

Introduction
Age
Gender
Country of birth
Relationship status

Housing history
Can you tell me about your current accommodation? • How long have you been in your current accommodation? *[Specify type of housing: emergency accommodation, rooming house, transitional housing, private rental, etc.]*
Where were you living prior to your current accommodation? • Why did you stop living there?
When was the first time you didn't have a permanent place to live? • How long did that last? When was the second time you didn't have a permanent place to live?

Drug use
I want to ask you some questions about drugs if that's okay?
Have you ever used drugs for non-medical reasons? • If yes: What type of drugs? *[Specify opioids – heroin, oxycodone, etc.]*
Are you currently using drugs?
How often do you use – daily, every few days, weekly, less than weekly? • For how long have you been using drugs regularly?
Do you think using drugs has ever affected your housing situation? • How?
Have you ever tried to stop using drugs?

Opioid substitution therapy
Have you heard of Opioid Substitution Therapy? *[Clarify with terms methadone/buprenorphine if necessary]*
If yes, can you tell me about it? *[What it is for, what it does, how it works, etc.]*
Have you ever been on a methadone or buprenorphine program?
If no: • Do you know anyone who is on a program? • What have you heard about it? How have they found it?
If yes:

• How did you find the program? • Did being on the program help you maintain your housing? Why/Why not? • What was your housing situation when you started?
Are you currently on a methadone program?
If no: • How long were you on the program for? • What made you stop?
If yes: • How long have you been on it? • Are you on methadone or buprenorphine?
Would you say being on a program has been helpful? Why/Why not?

Access to opioid substitution therapy
How did you first get on the program? Was it through a referral? • If yes: Who referred you?
Did you have a regular doctor prescribing you methadone/buprenorphine? • Is the doctor close to where you live? How do you get there?
Do you have a regular pharmacy you go to get it? • Is that pharmacy close to where you live? How do you get there?
How much do you pay for each dose?
How have you found the program? Has it worked for you?
Can you tell me what is/was the best thing about being on the program?
Can you tell me what is/was the worst thing about being on the program?

Housing and opioid substitution therapy
Would you say that being on methadone has helped you with housing? • If yes: In what ways? • If no: Why? Did being on the program made things more difficult?
Has your housing situation ever affected your ability to get your treatment? • If yes: How? Thinking about that time, what was the biggest challenges for you (travel, cost, time)?
Have there been times when being on OST affected your housing situation? • If yes: How?
In your experience, what do you think would make being on a methadone/buprenorphine program easier?

Appendix C: Interview schedule for staff

Introduction
Can you tell me about your role and the work you do here?
Service provided? *[The client needs that are addressed here]*
Size of client base?
Most pressing need(s) of client base?
Drug use among client base?
Of those clients using drugs, for how many would you say drug use is a primary factor impacting their housing?

Opioid substitution therapy
Can you tell me what you understand about opioid substitution therapy, also known as methadone and buprenorphine?
Do clients ever ask about opioid substitution therapy, or talk to you about their drug use?
Do you have any clients currently on opioid substitution therapy?
Where does opioid substitution therapy fit into the work of your organisation? • Is it an important part? Or uncommon?
Do you ever refer clients to opioid substitution therapy? • How many in last 12 months?
How does this occur? Are referrals followed through/up? Does opioid substitution therapy become a part of case management?
What proportion of your clients would be offered a referral to opioid substitution therapy? • Can you give me an example i.e. what their situation was? • What was the outcome of this referral?
Thinking of your clients who have accessed opioid substitution therapy, would you say adhering to opioid substitution therapy is easy or difficult for them? • Why/Why not? What challenges do they face staying on opioid substitution therapy?
Can you give me an example of a client's experience on opioid substitution therapy? • What impact did this have?
Do you have any clients that would benefit from opioid substitution therapy but are not accessing it? • If so: Why not?

Access to opioid substitution therapy
Thinking of prescribers and providers of opioid substitution therapy, what could those services do to improve access for your clients?
What else (i.e. policies, funding, etc.) would need to change to improve access to opioid substitution therapy for your clients?

Housing and opioid substitution therapy
In your opinion, does being on opioid substitution therapy have any effect on a client's housing or capacity to gain or retain secure housing?
In your opinion, are opioid substitution therapy and housing stability related? If so, in what ways do you think they are?
What do you think needs to happen to help those who want to start treatment and don't have secure housing?
What are three things that would make opioid substitution therapy easier or more accessible for your clients?
In your opinion, how are the opioid substitution therapy and housing systems working or not working in relation to mental health?
How do you see mental health being relevant to housing instability and opioid substitution therapy? • Are the systems of addressing these needs well-integrated? • If not, where are the gaps? • What are the consequences of this?