Australian Government
Australian Institute of Health and Welfare

Alcohol, tobacco & other drugs in Australia

Web report | Last updated: **14 Aug 2018** | Author: **AIHW**

Latest edition

The consumption of alcohol, tobacco and other drugs is a major cause of preventable disease and illness in Australia. This report consolidates the most recently available information on alcohol, tobacco and other drug use in Australia, including key trends in the availability, consumption, harms and treatment for vulnerable populations. Further, information on a range of health, social and economic impacts of alcohol, tobacco and other drug use are highlighted.

Cat. no: PHE 221

Findings from this report:

Self-reported levels of psychological distress are increasing among recent users of tobacco and illicit drugs

The proportion of Aboriginal and Torres Strait Islander people smoking has declined significantly

There is a strong link between problematic alcohol or other drug use and experiences of homelessness

Tobacco smoking is the leading cause of preventable death in Australia

Homeless people

On this page

Key findings

- **There is a strong link between problematic alcohol or other drug use and experiences of homelessness.**
- Between 2012–13 and 2016–17, almost one in ten (9%) clients presenting to specialist homelessness services (SHS) reported having problematic drug or alcohol use.
- Clients of both SHS and alcohol and other drug treatment services (AODTS) presented with more complex needs such as poly drug use, mental health issues and poorer housing outcomes compared to other AODTS and SHS clients.
- In 2016–17, around 6% of clients' (17,000) main reasons for seeking assistance from SHS was for problematic drug or substance use.
- Around 1 in 5 SHS clients reported that they were leaving or had recently left an alcohol and drug treatment rehabilitation facility.

The most recent data from the census of population and housing shows that there were approximately 116,000 homeless persons in Australia in 2016 [1]. This is a rate of 50 people for every 10,000 population and includes people who were in supported accommodation for the homeless, in temporary accommodation, in severely crowded dwellings (those requiring 4 or more extra bedrooms to accommodate them adequately) and people who were 'sleeping rough' [1].

The Journeys Home project (a longitudinal survey of Australians), found that of those people who had experienced housing instability or homelessness, risky use of substances was also reported for alcohol (57%), illicit drug use (39%) and the injection of drugs (14%) in the previous 6 to 12 months [2].

Research from homelessness services in Melbourne showed that 43% of the homeless population reported that they had alcohol and other drug use problems. Of these, one-third reported that they had these problems prior to becoming homeless, with the remaining one-third reporting that they developed problems with alcohol and other drugs following homelessness [3]. The duration of substance use problems is often prolonged in the homeless population, because their social networks may perpetuate their alcohol and other drug problems.

Specialist homelessness services (SHS) are delivered by non-government organisations and include specific services for those persons seeking housing as well as other services that assist them to maintain housing. These include people who experience alcohol or other drug issues.

In 2016–17 [4]:

- Around one in ten (9% or 27,295) of SHS clients reported problematic alcohol and or drug use.
- 57% presented to SHS as homeless and 43% at risk of homelessness (**Table S3.16**).
- Most clients were males (54%) and clients tended to be aged between 35–44 (26%) (**Table S3.17**).
- Clients with AOD issues also were less likely to be provided with accommodation, decreasing from 58% in 2012–13 to 49% in 2016–17 (**Table S3.18**).
- One in five clients (20%) had no shelter or improvised/inadequate dwelling when they sought services and 12% exited services with no shelter or improvised/inadequate dwelling (**Table S3.19**).

Tobacco smoking

The general health status of the homeless persons tends to be poorer than the general population.

- In the absence of national smoking rates for homeless persons, a study in Melbourne from 1995–96 found that 77% of people who were experiencing homelessness were smokers and this increased to 93% for those homeless persons who were sleeping rough (living on the streets) [5].
- Studies have shown that homeless persons may adapt their smoking behaviours in order to save money, thus exposing themselves to greater health risks. This can include sharing cigarettes and smoking from used cigarette butts or filters [6].
- The Journeys Home data showed that an average increase in consumption of one cigarette a day increased the risk of experiencing homelessness by 0.2% [7].

Alcohol consumption

Research has found that problematic alcohol consumption is associated with homelessness. For example:

- The Journeys Home data showed that an average increase in alcohol consumption of one drink a day, increased the risk of experiencing homelessness by 0.2% [7].
- Around 3% (9,267) of SHS clients reported that they had sought assistance for problematic alcohol use, a similar proportion to previous years [4].
- Alcohol was the principal drug of concern (40.4%) for people who sought both SHS support and alcohol and other drug treatment services and was slightly higher than those who had not sought assistance for homelessness [8] (**Table S3.20**).

Illicit drug use

Regular drug use is correlated with entries into homelessness [7]. For example, around 6% of clients (17,023) who sought assistance from SHS in 2016–17 also reported problematic drug or substance use [8].

The Illicit Drug Reporting System (IDRS) is an annual survey of regular injecting drug users across Australia [9]. Of the 888 participants interviewed in 2017, almost 1 in 4 (24%) reported that they were homeless (i.e. that their current accommodation was either no fixed address, shelter refuse or boarding house / hostel). The proportion of those who were homeless in the IDRS sample has gradually increased from 2009 (20%) (Figure HOME1; **Table S3.21**).

Figure HOME1: Accommodation type of IDRS sample, 2001 to 2017 (per cent)

Homelessness

Homeless

Type of homelessness

The 2016 IDRS also asked recent injecting drug users about their lifetime history and duration of experiences of homelessness [10]. The report showed that:

- 80% had a history of homelessness
- 25% were currently homeless
- 25% total duration of their lifetime homelessness was 3–5 years.

Queensland (91%), New South Wales (NSW) (90%) and Victoria (86%) had the highest proportion of respondents reporting a lifetime history of homelessness, while Tasmania (70%) and the Australian Capital Territory (ACT) (73%) had the lowest.

Similarly, NSW (37%), Victoria (31%) and Queensland (29%) had the highest proportion of respondents currently homeless (**Table S3.22**).

Health and harms

Data from the SHSC [4] shows that in 2016–17:

- Around 1,500 (5%) of clients with problematic drug and/or alcohol use were formally referred to a SHS agency by an alcohol and drug treatment service.
- 1 in 5 (18% or over 4,800) SHS clients stated that they were leaving or had recently left an alcohol and drug treatment rehabilitation facility.

- The Northern Territory had the highest rate of clients presenting to SHS with problematic drug or alcohol issues (42.7 per 10,000 population), followed by Tasmania (16.3 per 10,000) and the ACT (15.4 per 10,000) (**Table S3.23**).
- NSW and Victoria had the highest number of clients at 8,800 and 8,600 respectively, while the ACT had the lowest at 600 (**Table S3.23**).

Treatment

Research has shown that there is often overlap between drug and alcohol misuse and homelessness [8]. The Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS-NMDS) collects information on clients who seek treatment for alcohol and other drug services, yet it does not collect information on the client's experience of homelessness.

To better understand the characteristics of those experiencing homelessness and alcohol and other drug issues, a recent study linked the AODTS dataset to the SHS data collection [8]. The key findings demonstrate that the homeless population experiences additional complexities. Specifically, clients who had sought assistance from both SHS and AODTS:

- had lower rates of unemployment (6%), compared to 13% of SHS-only clients
- comprised a higher proportion of Indigenous Australians (27%) compared to 13% of AODTS only clients
- sought treatment for multiple drugs (18%), three times higher than the AODTS only population
- had poor AOD treatment and housing outcomes compare to the AODTS-only and SHS-only populations.

Of those who had sought assistance for both homelessness and AOD treatment, the most common principle drug of concern (the main substance that the client sought treatment for) were cannabis (28.6%) and amphetamines (20.5%) (Figure HOME2).

Persons who sought assistance from both SHS and AODTS were twice as likely to report heroin as a principal drug of concern (11.3%) compared to 5.7% for AODTS only [8] (**Table S3.20**).

1. Data are unweighted

AODT only clients (per cent)

2. Closed support includes only clients with closed support at the end of the study period

Source: AIHW; Table S3.20

Policy context

The National Housing and Homelessness Agreement

From July 1 2018, the National and Homelessness Agreement (NHHA) replaced the National Partnership Agreement on Homelessness and the National Affordable Housing Agreement (supported by the National Affordable Housing Specific Purpose Payment). The NHHA is a multilateral national agreement and its objective is to contribute to improving access to affordable, safe and sustainable housing across the housing spectrum, including to prevent and address homelessness, and to support social and economic participation [11].

The Federal Government in partnership with states and territories to outline priority homelessness cohorts and policy areas that must be addressed in homelessness strategies [11]. The NHHA has a focus on policy areas that include achieving better outcomes for people, early intervention and prevention, and commitment to service program and design. The priority homelessness cohorts identified in the NHHA include:

- women and children affected by family and domestic violence
- children and young people
- Indigenous Australians
- people experiencing repeat homelessness
- people exiting institutions and care into homelessness
- older people.

Other priority homelessness cohorts may be identified with states in their respective bilateral schedules.

Whilst there is not a specific reference to those persons experiencing alcohol and other drug related problems and homelessness, some of the key groups will be likely to include this population.

Further information can be found at the Council on Federal Financial Relations (http://www.federalfinancialrelations.gov.au/content/housing_homelessness_agreement.aspx).

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Last updated 16/08/2018 v14.0