



Australian Government

Australian Institute of
Health and Welfare

Exploring drug treatment and homelessness in Australia

1 July 2011 to 30 June 2014





Australian Government

**Australian Institute of
Health and Welfare**

*Authoritative information and statistics
to promote better health and wellbeing*

Exploring drug treatment and homelessness in Australia

1 July 2011 to 30 June 2014

Australian Institute of Health and Welfare

Canberra

Cat. no. CSI 23

The Australian Institute of Health and Welfare is a major national agency that provides reliable, regular and relevant information and statistics on Australia's health and welfare. The Institute's purpose is to provide authoritative information and statistics to promote better health and wellbeing among Australians.

© Australian Institute of Health and Welfare 2016



This product, excluding the AIHW logo, Commonwealth Coat of Arms and any material owned by a third party or protected by a trademark, has been released under a Creative Commons BY 3.0 (CC-BY 3.0) licence. Excluded material owned by third parties may include, for example, design and layout, images obtained under licence from third parties and signatures. We have made all reasonable efforts to identify and label material owned by third parties.

You may distribute, remix and build upon this work. However, you must attribute the AIHW as the copyright holder of the work in compliance with our attribution policy available at <www.aihw.gov.au/copyright/>. The full terms and conditions of this licence are available at <<http://creativecommons.org/licenses/by/3.0/au/>>.

A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISBN 978-1-74249-976-5 (PDF)

ISBN 978-1-74249-977-2 (Print)

Suggested citation

Australian Institute of Health and Welfare 2016. Exploring drug treatment and homelessness in Australia: 1 July 2011 to 30 June 2014. Cat. no. CSI 23. Canberra: AIHW.

Australian Institute of Health and Welfare

Board Chair

Dr Mukesh C Haikerwal AO

Director

Mr Barry Sandison

Any enquiries relating to copyright or comments on this publication should be directed to:

Digital and Media Communications Unit

Australian Institute of Health and Welfare

GPO Box 570

Canberra ACT 2601

Tel: (02) 6244 1000

Email: info@aihw.gov.au

Published by the Australian Institute of Health and Welfare

This publication is printed in accordance with ISO 14001 (Environmental Management Systems) and ISO 9001 (Quality Management Systems). The paper is sourced from sustainably managed certified forests.



Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

Contents

- Acknowledgments..... vi**
- Abbreviations..... vi**
- Summaryvii**
- 1 Introduction1**
 - 1.1 How SHSC and AODTS data were matched2
 - 1.2 Overview of key findings3
 - Overview of key findings for vulnerable cohorts within the matched population.....5
- 2 Clients with a current mental health issue8**
 - 2.1 Client characteristics.....10
 - 2.2 Why did these clients seek SHS assistance?10
 - 2.3 Which drugs were they using?.....11
 - 2.4 What services and support did they receive?12
 - AOD Treatment type and setting12
 - How long did their AOD treatment last?13
 - What SHS services did they need?15
 - How much SHS support did these clients receive?17
 - 2.5 What were the outcomes for clients?.....19
 - Why did their AOD treatment end?.....19
 - What were their SHS housing circumstances and outcomes following support?.....20
 - 2.6 What does this tell us?.....23
- 3 Clients who have experienced domestic and family violence24**
 - 3.1 Client characteristics.....26
 - 3.2 Why did these clients seek SHS assistance?27
 - 3.3 Which drugs were they using?.....28
 - 3.4 What services and support did they receive?29
 - AOD Treatment type and setting29
 - How long did their AOD treatment last?29
 - What SHS services did they need?31
 - How much SHS support did these clients receive?34
 - 3.5 What were the outcomes for clients?.....38
 - Why did their AOD treatment end?.....38
 - What were their SHS housing circumstances and outcomes following support?.....38

3.6	What does this tell us?.....	42
4	Young clients 15–24 years.....	43
4.1	Client characteristics.....	45
4.2	Why did these clients seek SHS assistance?	45
4.3	Which drugs were they using?.....	47
4.4	What services and support did they receive?	47
	AOD Treatment type and setting	47
	How long did their AOD treatment last?	48
	What SHS services did they need?	49
	How much SHS support did these clients receive?	51
4.5	What were the outcomes for clients?.....	54
	Why did their AOD treatment end?.....	54
	What were their SHS housing circumstances and outcomes following support?.....	54
4.6	What does this tell us?.....	57
5	Older clients 50 years and over	58
5.1	Client characteristics.....	60
5.2	Why did these clients seek SHS assistance?	60
5.3	Which drugs were they using?.....	62
5.4	What services and support did they receive?	62
	AOD Treatment type and setting	62
	How long did AOD treatment last?	62
	What SHS services did they need?	63
	How much SHS support did these clients receive?	65
5.5	What are the outcomes for clients?.....	68
	Why did their AOD treatment end?.....	68
	What were their SHS housing circumstances and outcomes following support?.....	68
5.6	What does this tell us?.....	71
	Appendix A: Data linkage, data gaps and limitations	72
	Linkage.....	72
	Scope and coverage	72
	Data quality and Indigenous Australians.....	73
	Incomplete data.....	73
	Glossary.....	74
	References	80

List of tables82
List of figures83

Acknowledgments

This report was prepared by the staff of the Housing and Specialised Services Group of the Australian Institute of Health and Welfare.

We are grateful to the Department of Health and the state and territory departments responsible for the delivery of specialist homelessness services for funding this research.

The contributions, comments and advice of the Alcohol and Other Drug Treatment Services National Minimum Dataset Working Group and the Housing and Homelessness Data Network are gratefully acknowledged.

We are especially appreciative of all homelessness agencies, drug and alcohol treatment services and their clients for their participation in these data collections, making research of this nature possible.

Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AODTS	alcohol and other drug treatment services
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Dataset
PDOC	Principal drug of concern
SHS	specialist homelessness services
SHSC	Specialist Homelessness Services Collection
SLK	statistical linkage key
WHO	World Health Organization

Summary

There is much research to suggest a considerable overlap between people experiencing precarious housing, and those experiencing drug and alcohol misuse: many present both to alcohol and other drug treatment services (AODTS) with a variety of drug use issues, and to specialist homelessness services (SHS) either at risk of, or experiencing, homelessness. In an effort to better understand clients of both services, data from the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) and from the Specialist Homelessness Services Collection (SHSC) were linked for the period 2011–12 to 2013–14, allowing the identification of a ‘matched client group’ of around 40,000 clients – representing a significant proportion of AODTS (21%) and SHS (8%) clients.

This analysis examined the housing circumstances, treatment types, drugs of concern and service outcomes of matched clients and of their service populations (AODT-only and SHS-only populations). Within the matched client group, 4 cohorts were also examined: clients experiencing domestic and family violence; clients with a current mental health issue; young clients aged 15–24; and older clients aged 50 and over. Analysis of matched clients revealed:

- **high levels of social and economic disadvantage** – employment levels were lower than in the SHS-only population, at around 6% (compared with 13%). Over half of matched clients presented to SHS on their own and were more likely to be itinerant, suggesting that these clients are marginalised and without adequate support networks
- **an over-representation of Aboriginal and Torres Strait Islander people** – around 27% were Indigenous, compared with 22% of SHS-only and just 13% of AODT-only clients
- **the majority were experiencing additional vulnerabilities** – over 3 in 4 (77%) were experiencing an additional vulnerability and half (51%) presented with a current mental health issue
- **the majority were male** – almost 6 in 10 (59%) matched clients were male. However, for those experiencing domestic and family violence as well as seeking AOD treatment and SHS assistance, over 7 in 10 (73%) were female
- **rates of treatment for heroin was double** – treatment was higher among those experiencing precarious housing and homelessness than among the AODT-only population
- **treatment for multiple drugs was significantly higher in the matched population** – nearly 1 in 5 (18%) sought treatment for multiple drugs, nearly 3 times the rate of the AODT-only population
- **over half the young people were homeless** – young clients aged 15–24 were the most likely to present to SHS already homeless
- **over two-thirds of older clients were in treatment for alcohol use** – they also requested assistance for problematic alcohol use from SHS more than any other group
- **they were less engaged with SHS** – they tended to have more frequent periods of support yet fewer nights of accommodation, as clients with complex needs are more likely to ‘churn’ in and out of services (including short-term and emergency accommodation) with each crisis encountered
- **all vulnerable cohorts had poorer AOD treatment and housing outcomes** – compared with AODT-only and SHS-only populations.

1 Introduction

There is a wealth of research that shows a strong link between alcohol and other drug misuse, and homelessness. Indeed, those people facing both challenges are often found to have the most persistent and challenging circumstances (Johnson & Chamberlain 2008; Scutella et al. 2014). Given the nature of both these issues, it is difficult to determine the full extent to which they overlap. Journeys Home, a longitudinal survey of over 1,500 people conducted over approximately 3 years to examine housing stability and homelessness in Australia, found that in the previous 6–12 months:

- over half (57%) of respondents consumed alcohol at risky levels
- nearly two-fifths (39%) had used illicit drugs
- about 1 in 14 (7%) had injected drugs (Scutella et al. 2014).

Similarly, the Journeys Home project found that the longer a person was homeless, the more likely they were to have used drugs or consumed alcohol at risky levels. Researchers for the Journeys Home project concluded that, to ensure effective and appropriately targeted services across these sectors, more information was needed on the extent and nature of substance use among different homeless populations.

Ensuring that people dealing with issues, like drug and alcohol misuse, do not exit support services into homelessness has been an objective under the National Partnership on Homelessness since its inception in 2009 (COAG 2009). In investigating how integrated homelessness, mental health and drug and alcohol services are, Flatau and others (2013) found that clients of well-integrated services have more positive outcomes.

Both the Specialist Homelessness Services collection (SHSC) and the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) are national data collections held by the AIHW. Analysis of SHSC data alone identified that, between 1 July 2011 and 31 December 2013, 41,755 (44%) of clients reported having a drug and/or alcohol issue (AIHW 2014). Through identifying clients of both homelessness and alcohol and other drug treatment (AODT) services, this report aims to provide a picture of the intersection of these 2 issues on a national scale.

1.1 How SHSC and AODTS data were matched

In order to analyse the circumstances of clients of both homelessness and drug treatment services, AIHW linked data from the:

- Specialist Homelessness Services Collection (2011–12, 2012–13, 2013–14)
- Alcohol and Other Drug Treatment Services NMDS (2012–13, 2013–14).

Linkage was carried out between these data by using a statistical linkage key, known as an SLK-581.

Box 1.1: What is the SLK-581?

The SLK-581 is a code which uses selected letters from a person's first and last names together with their sex and date of birth to produce a statistical linkage key or SLK. We can then use this SLK to link an individual's data across data sources without ever viewing their personal details.

AIHW operates under strict privacy obligations under section 29 of the Australian Institute of Health and Welfare Act 1987. To ensure the privacy of individuals, AIHW does not obtain access to the underlying data from which the statistical linkage key is created. All data in this project have had personal identifying details removed to ensure that no individual can be identified by either their circumstances or characteristics.

The SLK-581 was introduced for the AODTS NMDS from 2012–13, whereas the SHSC has contained the SLK-581 from 2011–12. Therefore, information was only available from 2012–13 and 2013–14 in the AODTS NMDS for this report.

It is important to note that, while these data sets contain a significant number of people across Australia, they do not represent a complete picture. Firstly, they only represent those people who have presented for, and received a service from, an SHS or from a publicly-funded specialised AODTS; and secondly, neither the SHSC nor the AODTS collections cover all possible avenues through which a person may receive services.

See Appendix A for further information on the linkage process, the scope and coverage of both collections, and how clients are referred to these services.

Supplementary tables accompany this release, they are available online and referenced throughout the report as Table S.x.

1.2 Overview of key findings

The linking of the AODTS NMDS (2012–13 to 2013–14) and SHSC (2011–12 to 2013–14) national data sets identified nearly 40,000 clients across the study period (referred to as ‘the matched group’). These clients represented a significant proportion of both AODTS (21%) and SHS (8%) clients, which supports other national (Teesson et al. 2003, Johnson & Chamberlain 2008) and international studies (CIHI 2007) that have indicated a significant overlap between problematic alcohol and other drug use and homelessness.

The analysis of client characteristics and service outcomes among this matched group revealed a population experiencing multiple levels of disadvantage – greater than either of the single service groups (AODT-only and SHS-only groups – see Box 2). This report found that matched clients were more likely to be living alone; to be seeking SHS assistance because of an itinerant lifestyle; to receive more frequent, yet shorter, periods of support and fewer nights of accommodation overall than SHS-only clients. Additionally, these matched clients were more likely to have multiple drugs (see Glossary) for which they required treatment and to be already homeless when seeking assistance, compared with AODT-only clients. Matched clients were more likely to seek SHS assistance for health reasons and problematic drug and alcohol use, compared with SHS-only clients. Those in the matched population have complex circumstances, suggesting they have fewer support networks: their complex circumstances and vulnerabilities mean that they are at higher risk of being less connected with the community and therefore at higher risk of social exclusion.

Box 1.2: Key definitions

Matched clients

In this report, ‘matched clients’ refers to those clients who were identified in both the AODTS NMDS and SHSC data sets.

AODT-only and SHS-only clients

The comparative client groups in this report – AODT-only and SHS-only clients – are those clients who were identified in only 1 of the source data sets. These client groups exclude matched clients.

Age

Clients in the AODTS NMDS are 10 and over, whereas SHSC includes clients of all ages. Therefore, the following client groups are 10 and over:

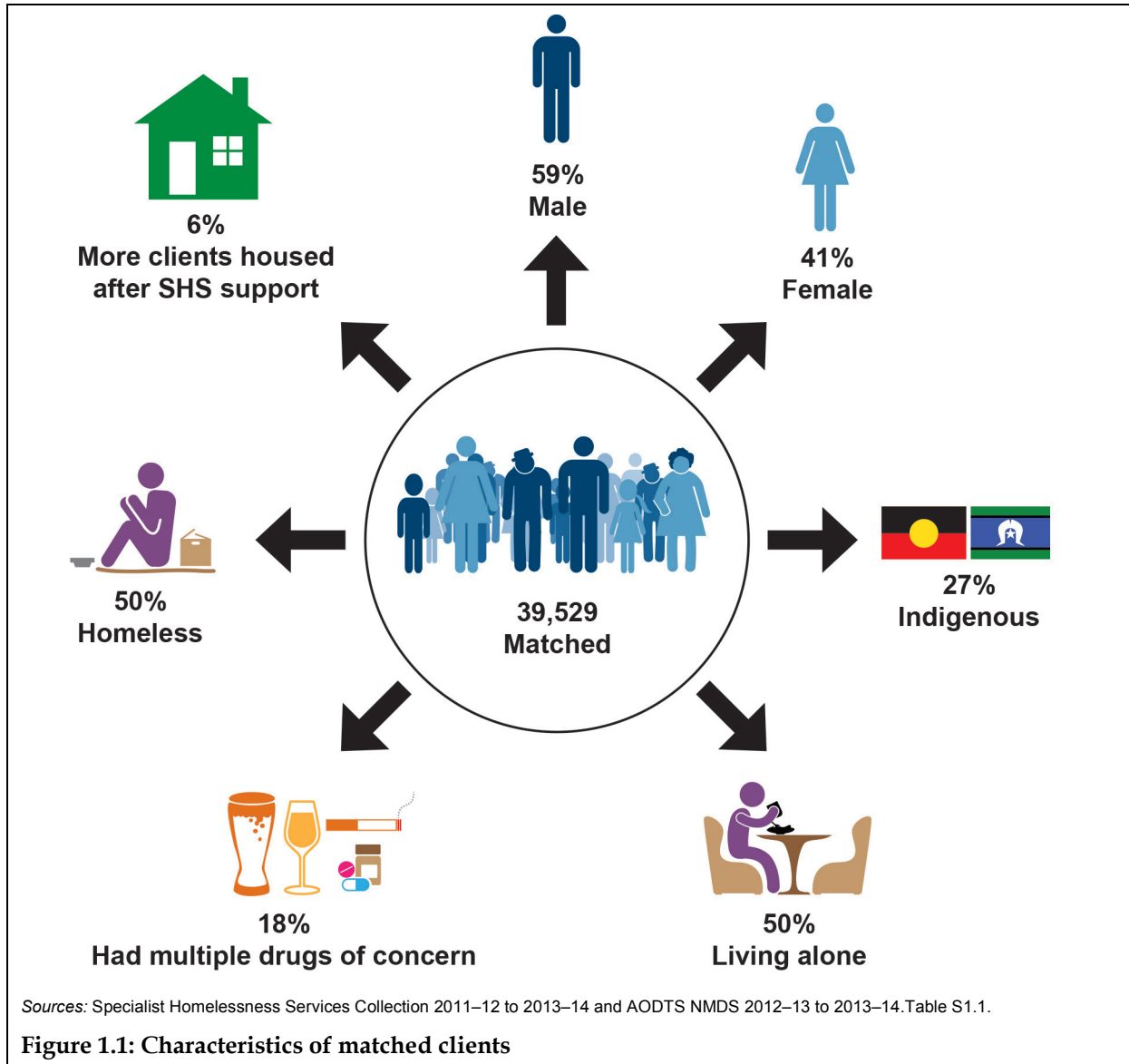
- Matched clients; all AODT-only clients; mental health clients (matched, AODT-only and SHS-only clients); and domestic and family violence clients (matched, AODT-only and SHS-only clients).
- All SHS-only clients include all age groups.

Homeless and at risk of homelessness

In this report, homelessness status has been examined (See Glossary for detailed definition). Clients are defined as being either ‘homeless’ or ‘at risk of homelessness’ (referred to as ‘at risk’).

Overall, those matched clients showed some interesting patterns when compared with clients receiving only 1 form of service. Generally, in demographic terms, they appeared to be more similar to AODT-only clients than to the SHS-only clients. For example, males

represented 59% of the matched group, compared with 71% in the AODT-only group and just 40% in the SHS-only group. Clients in the matched group were more likely to be living as a lone person and not have children in their care, compared with SHS-only clients (50% compared with 28%). Employment rates among the matched clients were low (6% compared with 13%).



Indigenous clients were over-represented among the matched cohort, when compared with both the SHS-only and AODT-only population groups. Around 27% of matched clients were Indigenous, compared with 22% of SHS-only and just 13% of AODT-only clients.

Matched clients appeared to present with more complex service needs and generally received more days of support and treatment: matched clients received an average of 146 days of AOD treatment over the period 2012–13 to 2013–14, compared with 103 days for AODT-only clients; and an average of 132 days of SHS support, compared with 98 days for SHS-only clients. Interestingly, despite receiving more days of SHS support, matched clients received fewer nights of accommodation on average (92 nights) when compared with SHS-only clients (108 nights). They also returned for support more often, receiving an

average of 2.2 AOD treatment episodes, compared with 1.5 for AODT-only clients, and 3.8 SHS support periods compared with 2.1 for SHS-only clients.

Matched clients were more likely to be homeless, compared with the SHS-only population (50% compared with 40%) and to experience poorer housing outcomes – with just over 1 in 2 (55%) matched clients housed at the end of SHS support, compared with 65% of the SHS-only population.

Clients may be receiving AOD treatment for 1 or multiple drugs of concern (see Glossary for definition of multiple drugs of concern). Treatment for multiple drugs of concern was nearly 3 times as likely among the matched clients than among AODT-only clients, with nearly 1 in 5 (18%) of the matched clients receiving treatment for multiple drugs, compared with just 7% of the AODT-only group. Matched clients were almost twice as likely as AODT-only clients to be in treatment for heroin (see Table S1.1).

Overview of key findings for vulnerable cohorts within the matched population

Extensive research, such as that undertaken in the Journeys Home project, indicates that certain groups within the population are at greater risk of homelessness (Scutella et al. 2014) and of developing harmful drug use behaviours. Many of the risks associated with homelessness and harmful drug use behaviours are shared between these groups.

To understand whether additional comorbidities and vulnerabilities exist within this already vulnerable population of matched clients, we identified 4 cohorts for analysis. They are clients who:

- have a current mental health issue
- are experiencing domestic and family violence
- are young clients aged 15–24
- are older clients, aged 50 and over.

Many of the people in these 4 cohorts belong to more than 1 vulnerable group (see Figure 1.2 and Table 1.1). That is, the cohorts are not mutually exclusive. Over three-quarters (76%) of matched clients experienced these additional vulnerabilities, emphasising the complexities surrounding this group.

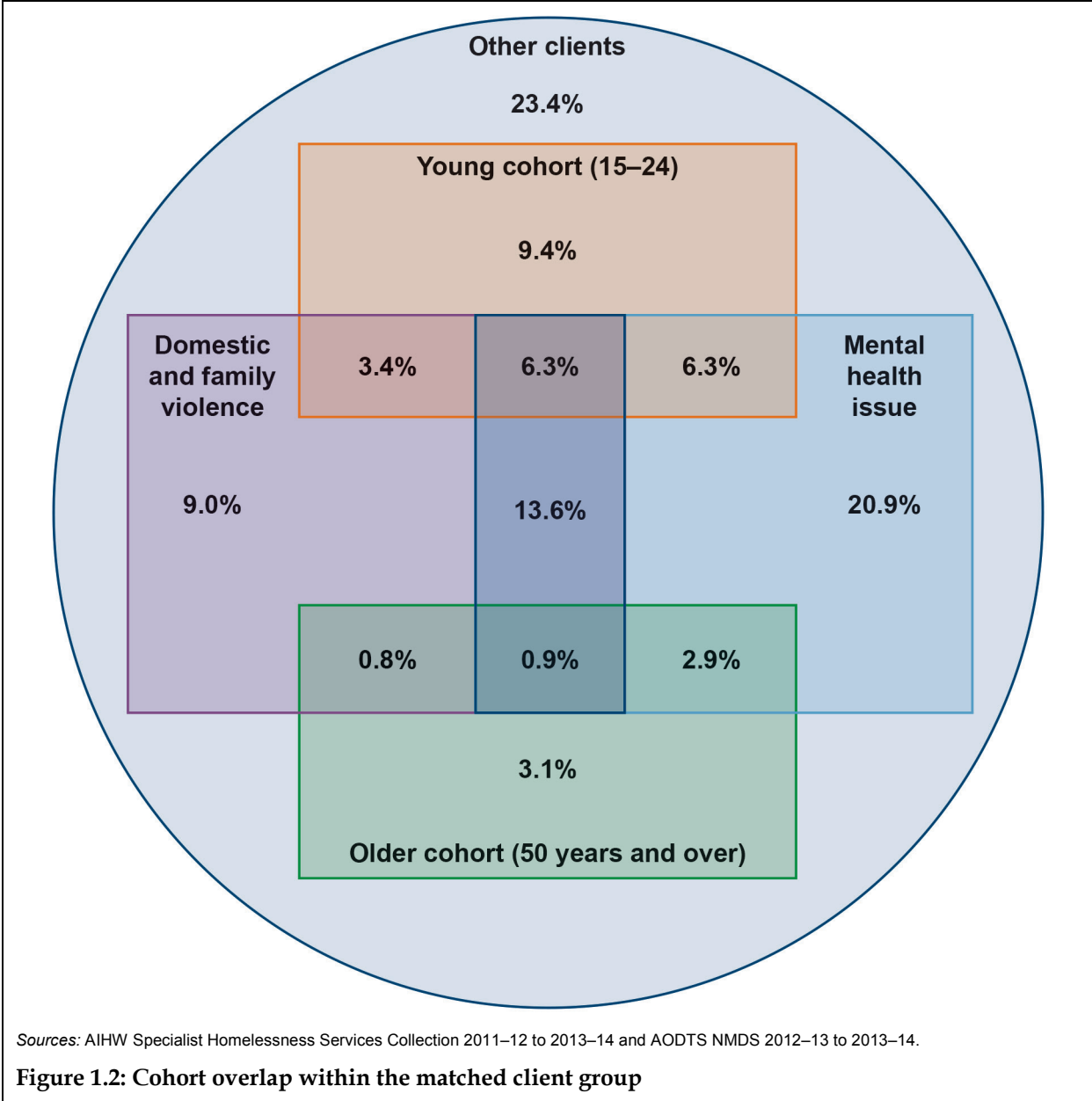
Table 1.1: Overview of cohort populations

Cohort	Matched clients	SHS-only clients	AODT-only clients
All	39,529	450,033	151,644
Mental health	20,091	98,692	..
Domestic and family violence (total)	13,439	133,945	..
Male	3,671	19,032	..
Female	9,768	114,913	..
Young (15–24 years)	10,035	101,195	41,394
Older (50 years and over)	3,042	53,362	21,015

.. not applicable.

Note: Mental health and domestic and family violence clients cannot be identified in the AODT population.

Analysis of key groups vulnerable to both homelessness and substance misuse revealed considerable overlap, particularly in conjunction with mental health and domestic and family violence. Over three-quarters of matched clients (76%) had at least 1 additional risk factor, and in the largest 2 cohorts, the overlap was substantial – with 1 in 5 (21% of clients) having experienced both domestic and family violence as well as a current mental health issue (see Figure 1.2).



There were a number of similarities in service experiences between these 2 cohorts – influenced, to some extent, by the overlap in clients. Both cohorts received the most AOD treatment episodes, the longest treatment durations, and had short-but-frequent spells of SHS support, spanning the longest support durations. The recurrent, persistent service engagement of these 2 cohorts over the 3-year study illustrates that these clients appear to ‘churn’ in and out of services with each crisis encountered. This in turn highlights the level of difficulty faced in assisting these people to achieve long-term outcomes.

At both the younger and older ends of the life course, those in the matched group presented to services with greater needs relating to health and wellbeing. While matched clients who were younger or older were both highly likely to be living alone and homeless, the drugs for which they received treatment were quite different – older clients having issues with alcohol specifically, but younger clients using multiple drugs, particularly cannabis, alcohol and amphetamines.

The analysis highlights the potential for further research based on longitudinal analysis of both the AODTS NMDS and SHSC data sets. With 45% of matched clients having multiple episodes of AOD treatment greater than 140 days and 40% of matched SHS clients receiving support spanning more than 180 days during the study period, there is great potential to monitor the changing circumstances of this group of people over time. Future longitudinal analysis could provide a better understanding of the likelihood of successful outcomes for clients presenting with particular characteristics and provided with different AOD treatments and SHS services and levels of support.

2 Clients with a current mental health issue

Key findings

The matched clients in the mental health cohort:

- represented 1 in 2 matched clients (20,091, or 51%), making it the largest of all the cohorts analysed
- were more likely than any other cohort to be in treatment for multiple drugs of concern (21%).

Matched clients in the mental health cohort had poorer housing outcomes and appeared to have more barriers to overcome compared with SHS-only clients with a current mental health issue or all AODT-only clients:

- They had more AOD treatment episodes (2.4 compared with 1.5 for AODT-only) as well as more SHS support periods (5.3 compared with 3.3 for SHS-only).
- They were the most likely of all cohorts to need (82%) and be provided (77%) with accommodation, but spent fewer nights, on average, in accommodation than SHS-only clients with a current mental health issue (107.8 compared with 134.4).
- They were more likely than any other cohort to be moving from place to place, with no fixed abode (21% itinerant).
- They were the equal most likely cohort to still be receiving support at the end of the study period, at around half (51%) of clients.

The Australian Government's national approach to reducing homelessness identifies untreated mental health and substance use disorders as one of the main pathways into homelessness and has prioritised these vulnerable groups (COAG 2009). Research from the Journeys Home project has identified both mental health and substance misuse as 'typical' pathways into homelessness (Chamberlain & Johnson 2011).

Much of the literature indicates that there is a high comorbidity of mental health and substance misuse (for example, CIHI 2007), with the general consensus being that, when they occur together, the impact is negative and people are at greater risk of social and economic disadvantage.

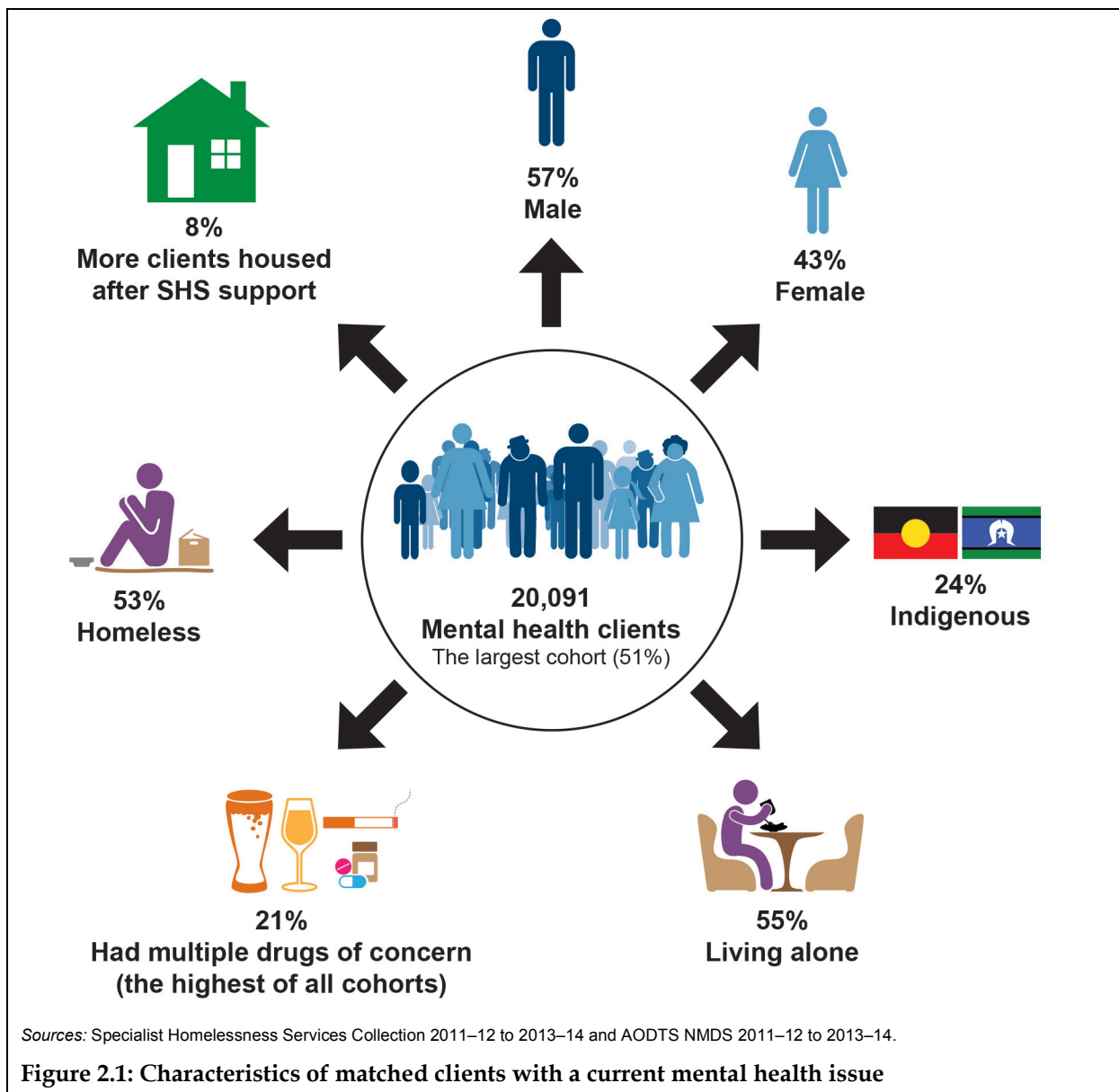
The National Survey of Mental Health and Wellbeing found that, while 1 in 5 Australians will experience a mental illness during their life time, among those who have also ever experienced homelessness, the prevalence of mental illness is 1 in 2 (54%) – about 3 times the rate of those who have never experienced homelessness (Slade et al. 2009).

Specialist homelessness agencies are supporting a growing number of people experiencing a current mental health issue. Over the 4 years to 2014–15, there has been a 40% increase in the number of clients presenting with a current mental health issue (AIHW 2015). Both this group of clients and those presenting to SHS agencies with drug and alcohol use issues have been identified as being particularly vulnerable to homelessness (AIHW 2014).

Box 2.1: Identifying clients with a current mental health issue

Clients with a current mental health issue have been identified in this report by using information provided in the SHSC and includes only clients aged 10 and over (see Glossary for more details). There is currently no information available in the AODTS NMDS to determine a person's mental health status. As such, only those clients receiving AODTS that also receive SHS can be identified as having a current mental health issue. Any comparisons made with clients receiving AODT only cannot distinguish between clients who do, or do not, have a current mental health issue.

Analysis of matched clients during the study period identified 20,091 clients aged 10 and over – 51% or just over half – who reported having a current mental health issue (Figure 2.1).



2.1 Client characteristics

Mental health is a major issue for clients who received both AODTS and SHS services. Over half (51%) of the matched clients reported experiencing a current mental health issue. By comparison, just over 1 in 5 (22%) of SHS-only clients identified having a current mental health issue.

Nearly a quarter (24%) of matched clients with a current mental health issue were Indigenous, compared with 16% receiving SHS-only and 13% receiving AODT-only services.

Matched clients with a current mental health issue were more likely to be homeless than SHS-only clients with a current mental health issue (53% compared with 47%) (see Figure 2.1). They were also more likely to be unemployed, less likely to be in the labour force and more likely to be living alone, compared with clients in the general SHS-only population (see Table S2.2).

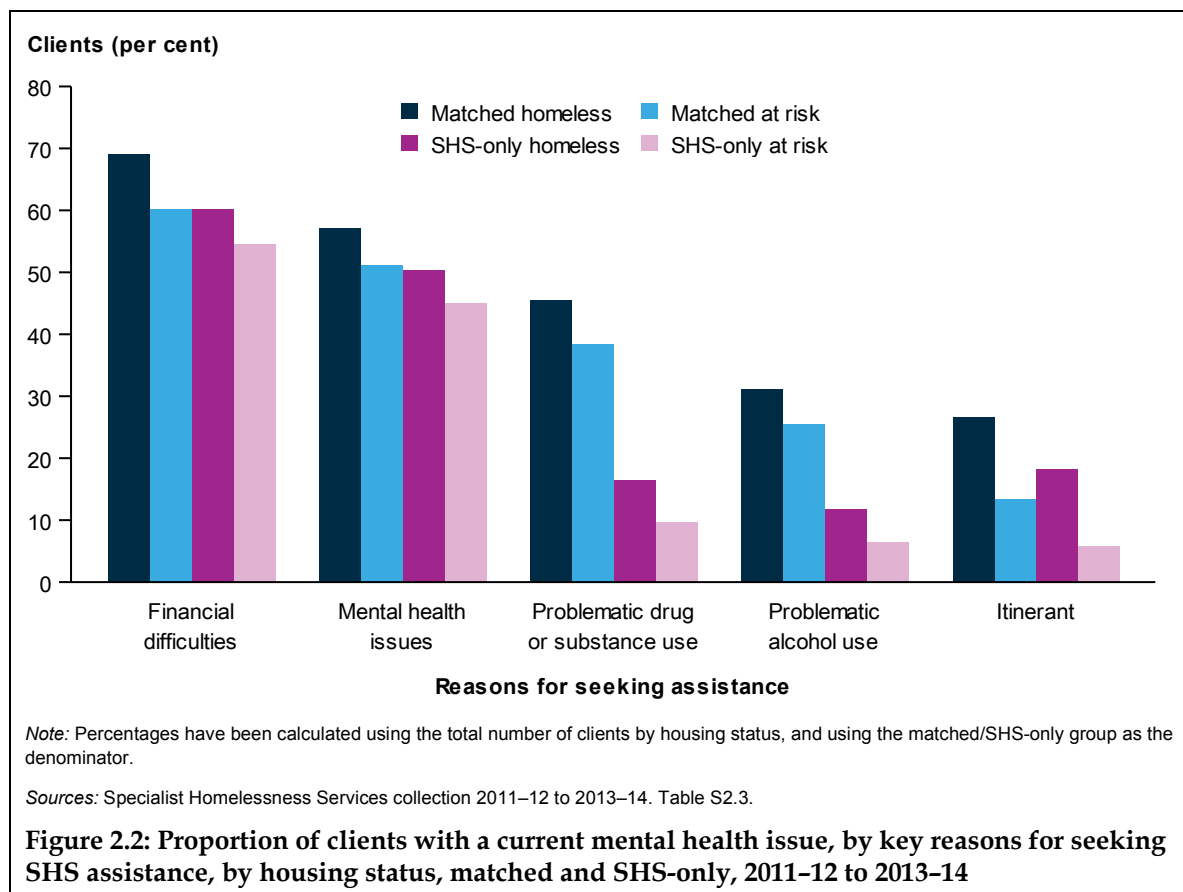
2.2 Why did these clients seek SHS assistance?

The pathways into homelessness can be many and varied and the reasons clients seek assistance can highlight major risk factors for homelessness. SHS clients can identify a number of reasons, as well as a 'main' reason, for seeking assistance, thus capturing the range of situations clients find themselves in. Because a client's housing situation has the potential to influence their reason(s) for seeking assistance, reasons were reported according to a client being either 'homeless' or 'at risk of homelessness' (see Glossary for housing status definitions).

In both the matched and the SHS-only groups, the main reason clients with a current mental health issue gave for seeking SHS support was largely associated with their housing circumstances. When all the reported reasons for seeking assistance were examined, clients in the matched group reported considerably more reasons for seeking assistance, compared with clients in the SHS-only group (Figure 2.2). This suggests that those clients in the matched group were experiencing multiple levels of disadvantage.

Compared with SHS-only clients with a current mental health issue, clients in the matched group with a current mental health issue were:

- more likely to identify 'accommodation' as a reason for seeking assistance (76% compared with 65% for the SHS-only clients)
- more likely to identify 'unemployment' (29% compared with 19%) and 'financial difficulties' (65% compared with 57%) as reasons for seeking assistance
- far more likely to seek assistance for health-related reasons, such as mental health issues (54% compared with 47%); problematic drug use (42% compared with 13%); or alcohol use (28% compared with 9%)
- more than 3 times as likely to seek assistance due to a transition from custodial arrangements (14% compared with 4%)
- almost twice as likely to be itinerant, with no fixed address (21% compared with 12%). (See Glossary for SHSC definition of 'itinerant'.)



These reasons indicate that clients in the matched group who are experiencing a current mental health issue are also likely to have associated health issues (potentially related to their substance misuse). There are high rates of itinerancy in this group, which could indicate a lack of social and community engagement (see Table S2.3).

2.3 Which drugs were they using?

Comorbidity of mental disorders and substance use disorders is not uncommon. This interaction suggests that for those struggling with mental illness, the risk of alcohol or drug misuse is increased.

Compared with those in the AODT-only group, clients in the matched group with a current mental health issue were:

- three times more likely to be receiving treatment for more than 1 drug of concern (see Glossary) (21% compared with 7% for AODT-only clients with a current mental health issue)
- more likely to receive treatment for amphetamines (22% compared with 15%)
- more than twice as likely to be receiving treatment for heroin (13% compared with 6%)
- almost twice as likely to be receiving treatment for pharmaceuticals (12% compared with 7%) (see Table 2.1).

Table 2.1: Matched clients with a current mental health issue and AODT-only clients, by principal drug of concern, 2012–13 to 2013–14

Drugs of concern	Matched mental health clients			AODT-only ^(b)
	Homeless	At risk	All matched ^(a)	
Alcohol	40.4	40.4	40.2	38.7
Cannabis	28.5	28.8	29.0	28.0
Amphetamine	22.0	21.4	21.7	15.1
Heroin	12.8	12.5	12.5	5.7
Pharmaceuticals	12.8	11.8	12.2	6.6
Other drug	6.2	6.1	6.4	7.2
Clients with multiple drugs	20.8	20.0	20.6	6.9
Average number of drugs per client	1.3	1.3	1.3	1.1
Number of clients	9,102	7,915	20,091	151,644

(a) 'All' includes clients whose homeless status was not reported.

(b) Clients with a current mental health issue have been identified in the matched population. There is no way to identify AODT-only clients who have a current mental health issue.

Source: AODTS NMDS 2012–13 to 2013–14.

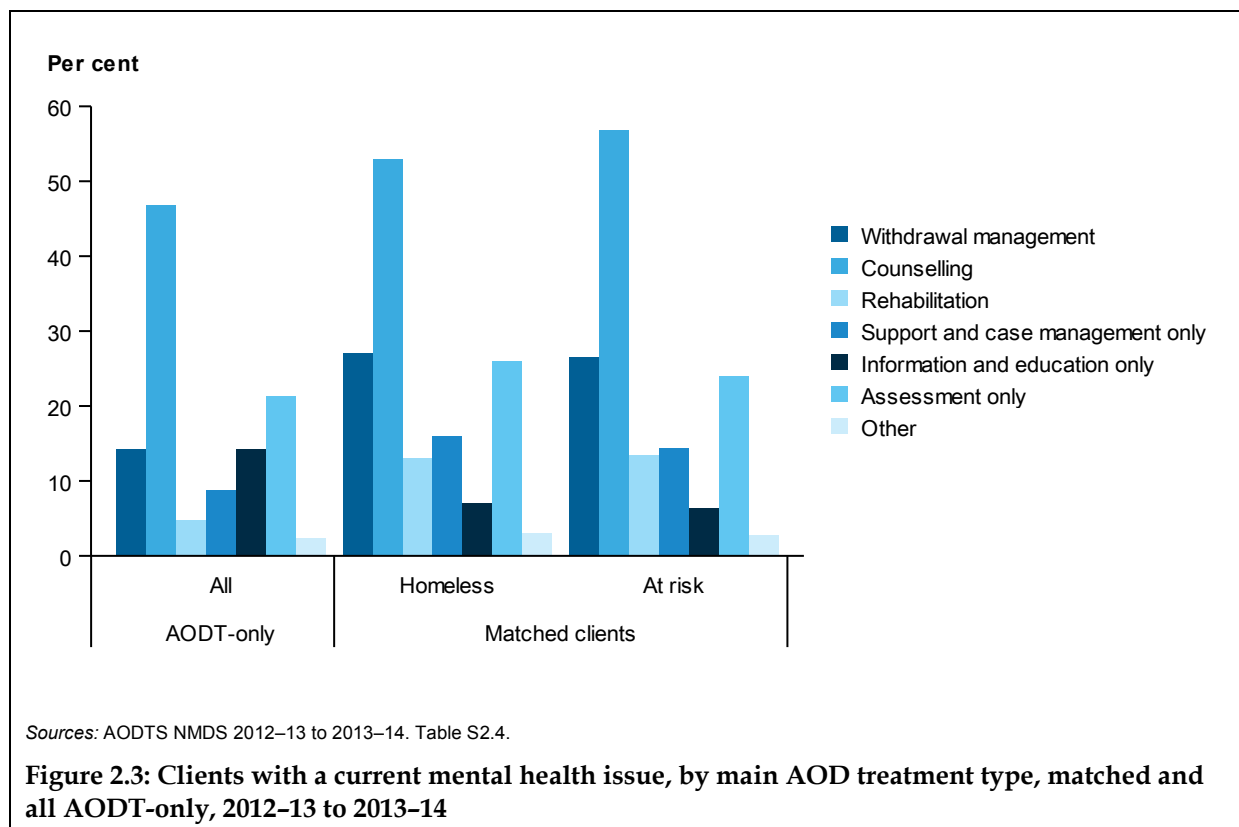
2.4 What services and support did they receive?

AOD Treatment type and setting

Counselling was the most common treatment type provided in AOD treatment services overall. This was also the most common treatment received by those clients with a current mental health issue in the matched group (see Figure 2.3 and Table S2.5).

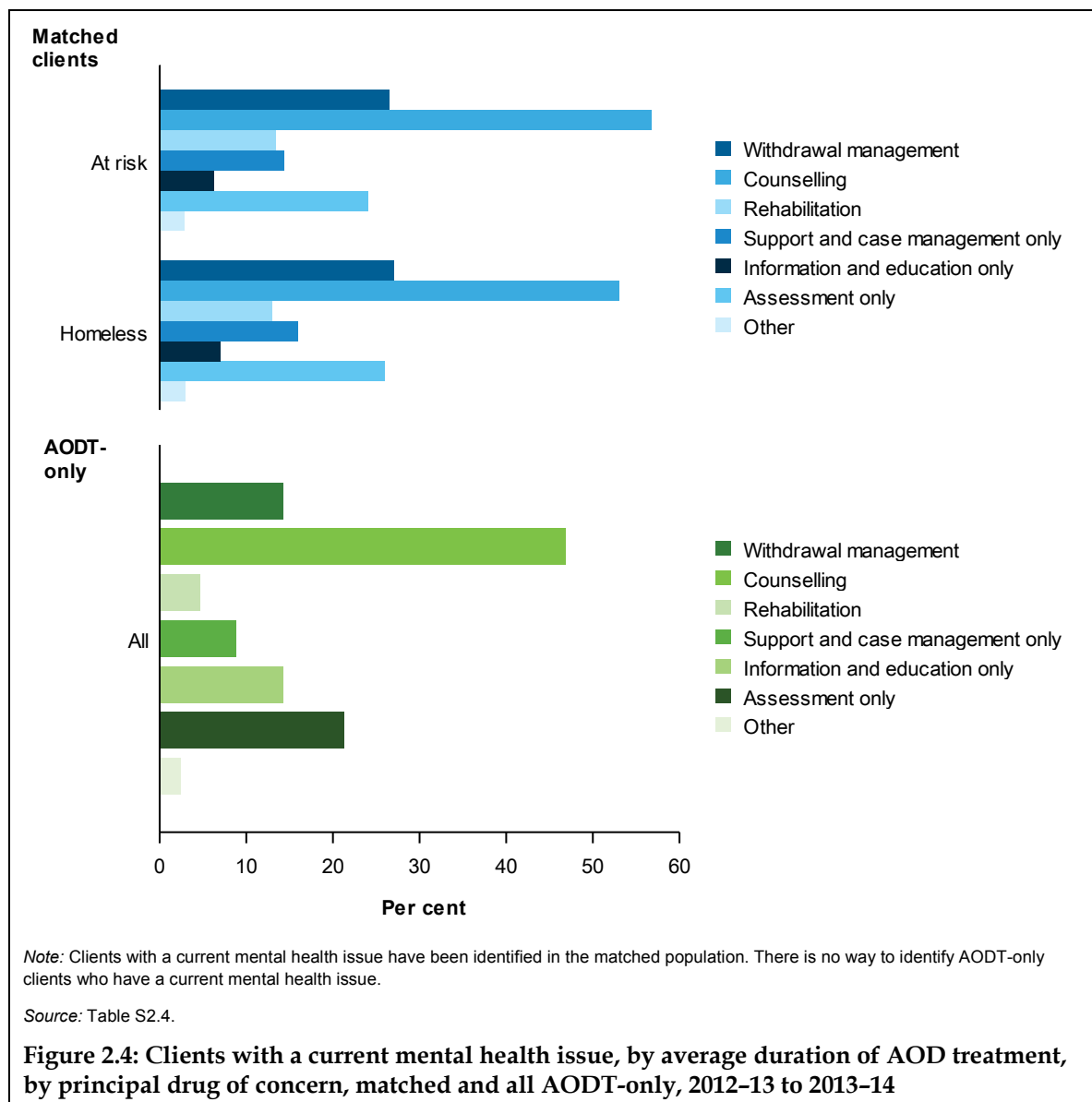
Compared with those in the AODT-only group, clients with a current mental health issue in the matched group were:

- more likely to be receive counselling (56% compared with 47% for AODT-only clients with a current mental health issue)
- almost twice as likely to receive withdrawal treatment (27% compared with 14%)
- almost twice as likely to receive rehabilitation (13% compared with 5%)
- less likely to be receive information and education only (6% compared with 14%).



How long did their AOD treatment last?

On average, clients with a current mental health issue in the matched group spent longer in treatment compared with all AODT-only clients – 156 days compared with 103 days (see Table S2.4). Clients in the matched group who were at risk of homelessness generally spent longer in treatment than those who were already homeless (164 days compared with 147) (see Figure 2.4).



Compared with the AODT-only population, clients with a current mental health issue in the matched group received:

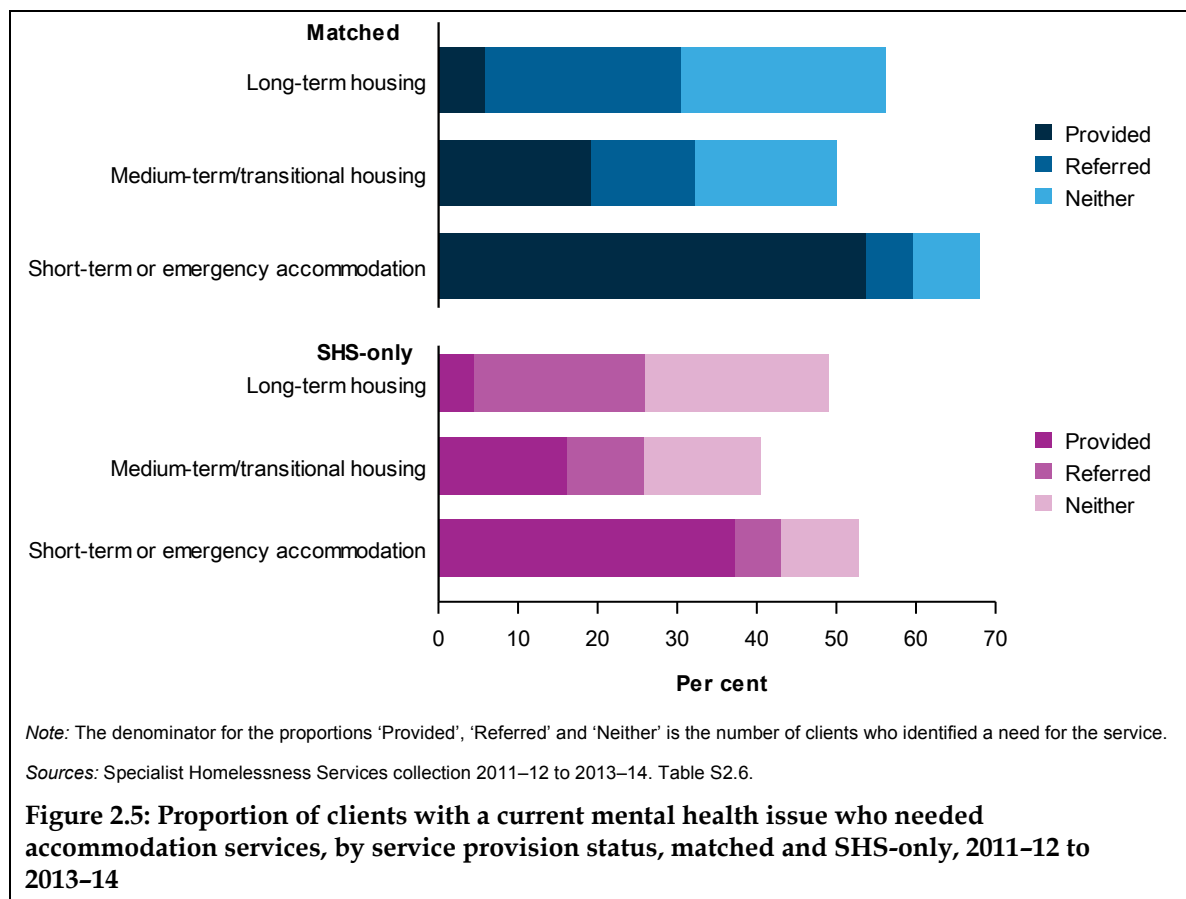
- more days of treatment on average (156 days compared with 103 days for all AODT-only clients). Those at risk of homelessness in the matched group received the greatest average number of days overall (164 days)
- almost twice the number of average treatment days for cannabis (113 days compared with 63 days)
- fewer treatment days for heroin on average (188 days compared with 242) – with homeless clients in the matched group receiving the fewest days of all client groups who were treated for heroin (171 days)
- more treatment days for alcohol on average (137 days compared with 101).

What SHS services did they need?

SHS agencies offer a wide range of programs and services for those without the resources or support to deal with a housing crisis. While the primary focus of support is on providing stable housing or assisting clients to remain housed, agencies also provide many other services targeting the underlying barriers to improvements in housing. Service needs range from requiring basic support and assistance (such as meals, shower facilities, laundry and transport) to those addressing more complex needs including specialised services such as health and medical services and professional legal or financial services.

Clients in the matched group with a current mental health issue needed more assistance from specialist homelessness agencies covering a greater range of services than those SHS-only clients did. This increased need for services included both general and specialist service types.

Accommodation was needed by most SHS clients with a current mental health issue, however, as Figure 2.5 illustrates, those clients in the matched group were more likely than SHS-only clients to request this service.

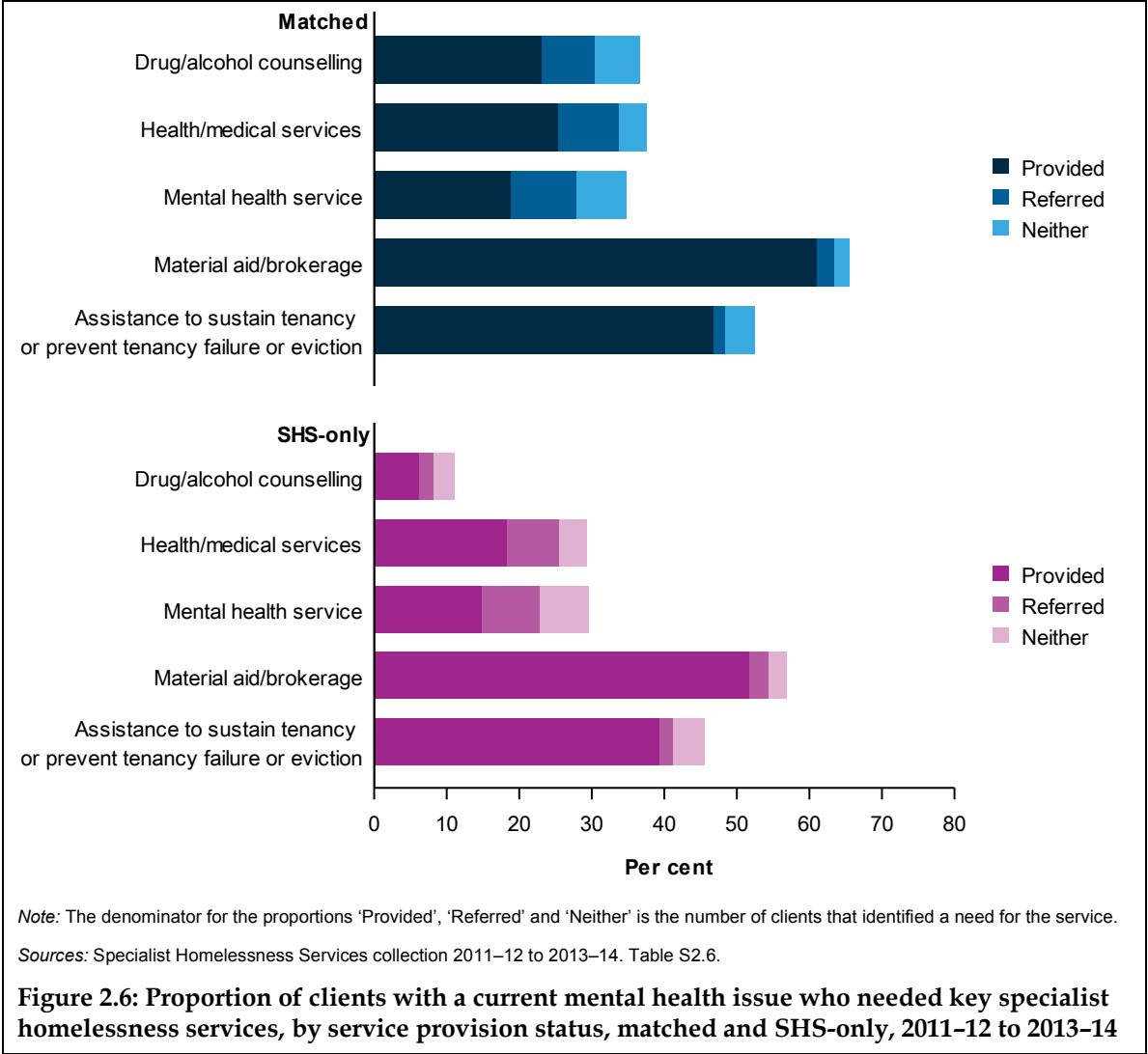


More than 8 in 10 (82%) clients in the matched group who presented to an SHS agency needed accommodation of some type, with over three-quarters (77%) receiving the requested service. Over two-thirds of these clients (68%) needed short-term or emergency accommodation. By contrast, 7 in 10 clients in the SHS-only group (71%) needed some form of accommodation, with two-thirds receiving it (67%). Just over half (53%) needed short-term or emergency accommodation.

Compared with those in the SHS-only group with a current mental health issue, clients in the matched group with a current mental health issue were more likely to request:

- specialist medical/health services (38% compared with 29%) and to receive those services (68% compared with 63%)
- psychological, psychiatric and mental health services (40% compared with 38%) and to receive those services (55% compared with 51%)
- drug/alcohol counselling services (37% compared with 11%) and to receive those services (63% compared with 56%)
- basic assistance services, such as meals (49% compared with 37%); laundry/shower facilities (42% compared with 30%); and transport (51% compared with 40%) – with over 90% of these requests able to be met.

Figure 2.6 illustrates some key differences in service needs between clients in the matched and SHS-only groups. For a complete list of service needs and their provision status, see Table S2.6. Overall more clients in the matched group approached SHS agencies in need of basic subsistence, reflecting the high level of itinerancy in this group.



How much SHS support did these clients receive?

Clients in the matched group with a current mental health issue received more frequent support, delivered over longer durations of time, than SHS-only clients with a current mental health issue.

On average, over the 3 years examined, clients in the matched group with a current mental health issue had 5.3 support periods and received a total of 178.8 days of support (see Table 2.2). (See Glossary for details on calculating total days of support). By comparison, over the same period, those SHS-only clients with a current mental health issue received 3.3 support periods and 157.4 days of support.

Table 2.2: SHS support characteristics of clients with a current mental health issue, by housing status, matched and SHS-only, 2011–12 to 2013–14

	Matched mental health clients			SHS-only mental health clients		
	All	Homeless	At risk	All	Homeless	At risk
Average support periods	5.3	5.4	4.7	3.3	3.5	3.0
Average support days	178.8	178.7	167.5	157.4	166.2	143.0
Support periods (% of clients)						
1 support period	21	22	25	36	35	40
5–9 support periods	24	24	22	16	16	14
10 or more periods	14	14	11	5	6	4
Support days (% of clients)						
5 days or fewer	11	11	13	17	16	19
180–630 days	29	29	27	24	24	22
Over 630 days	5	5	4	5	5	4
Active support (average days per support period)	34	33	36	47	48	48
Duration ⁽²⁾ (% of clients)						
5 days or fewer	11	11	12	16	16	18
180–630 days	35	33	34	30	29	28
Over 630 days	22	22	19	13	14	12
Clients receiving accommodation (%)	63	70	54	47	59	35
Accommodation (average nights)	107.8	109.2	100.9	134.4	133.7	132.2

Notes

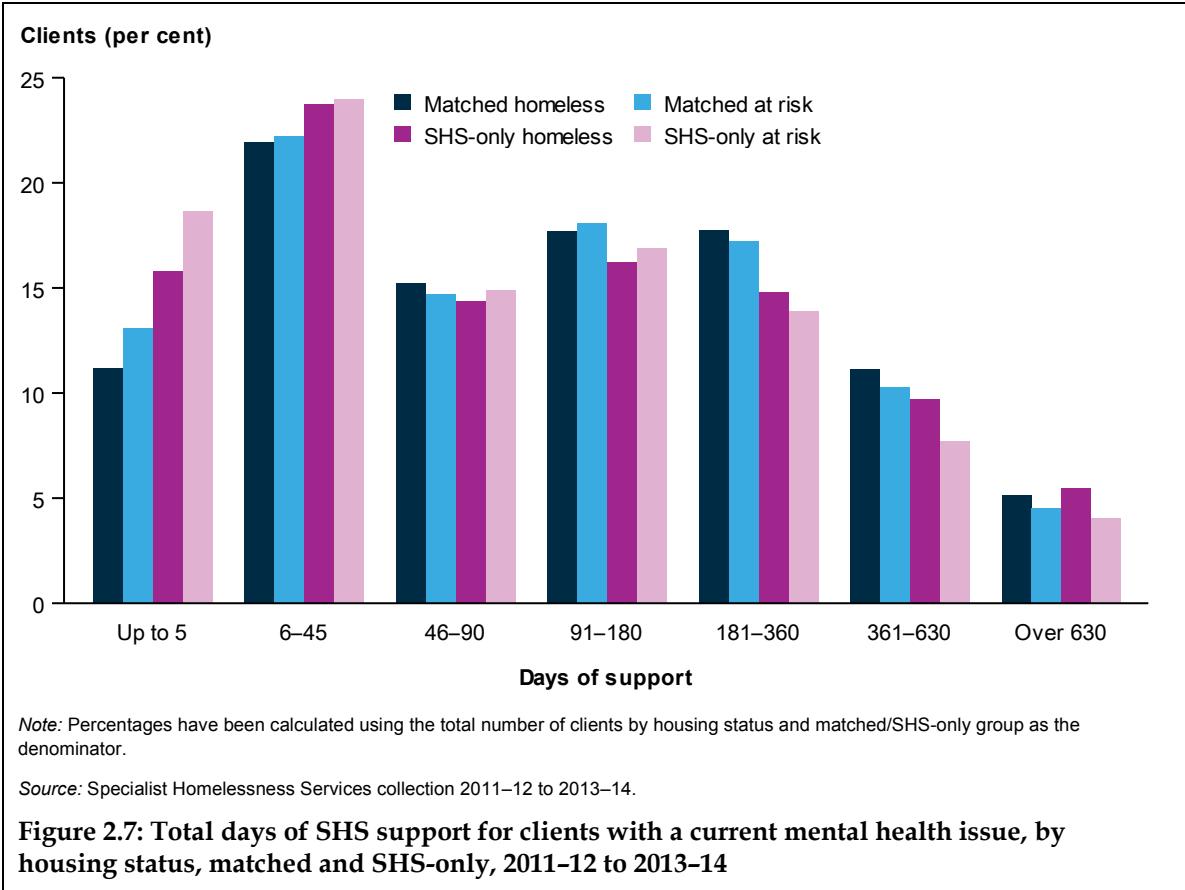
1. Support periods, days and nights are calculated using a start date of 1 July 2011–12 and an end date of 30 June 2013–14.
2. 'Duration' is calculated as the number of days between the first day of the first support period and the last day of the last support period within the study period. It includes only clients with closed support at the end of the study period.
3. All clients include clients whose housing status was not known.

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

Matched clients presenting as homeless (53% of the matched mental health cohort) received, on average, the most support periods (5.4 per client) and the greatest number of support days (an average of 178.7). By comparison, SHS-only clients at risk of homelessness (53% of the SHS-only mental health group) received the least support: an average of 3.0 support periods and 143.0 days of support.

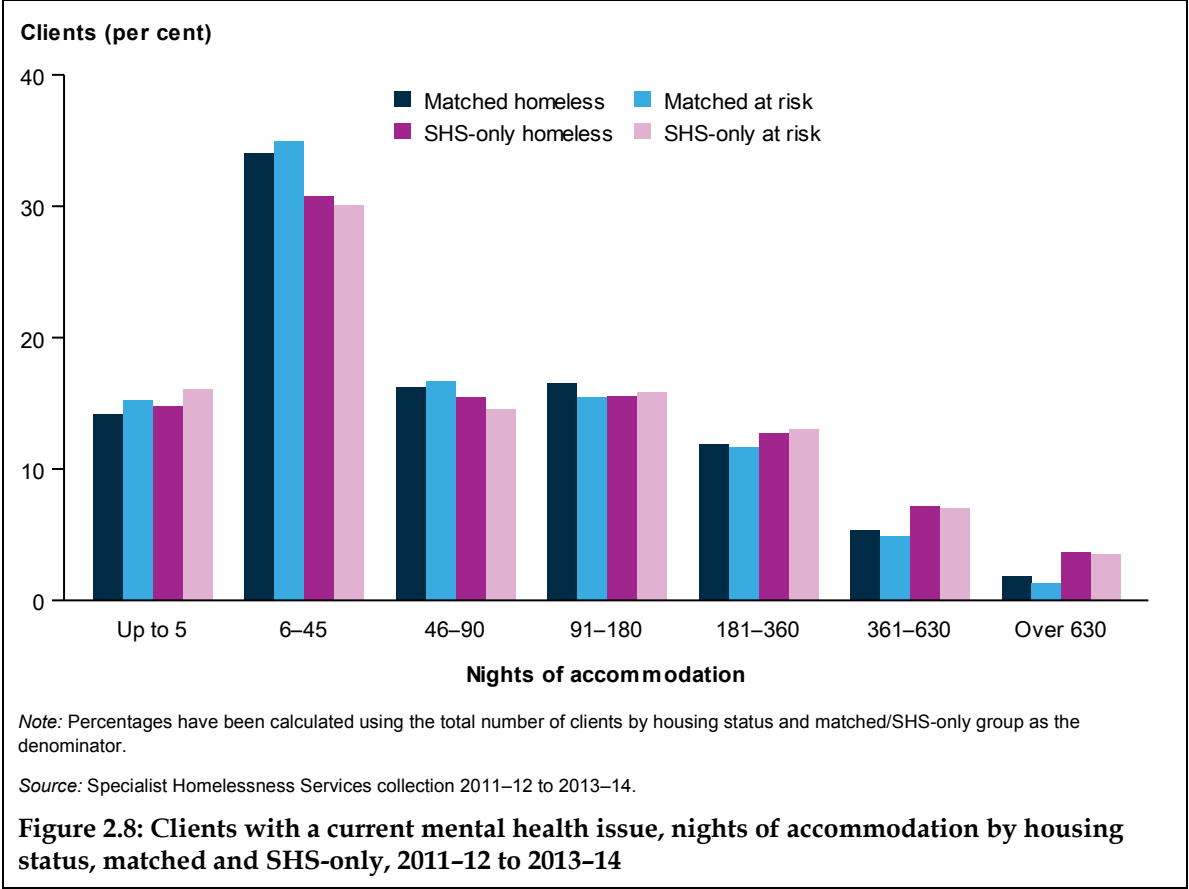
Compared with those in the SHS-only group (Figure 2.7), clients with a current mental health issue in the matched group were more likely to:

- receive more days of support (178.8 days compared with 157.4 on average)
- receive more support periods (5.3 periods compared with 3.3 on average), with homeless clients in the matched group receiving the greatest number of all (5.4)
- receive more than 1 support period (79% compared with 64%)
- receive 5 or more support periods (38% compared with 21%)
- have shorter support periods on average (34 days compared with 47 days)
- receive accommodation (63% compared with 47%), yet be accommodated for fewer nights (107.8 nights compared with 134.4).



The short-but-frequent service engagement pattern of matched clients with a current mental health issue affects the effectiveness of service delivery and is indicative of clients less committed to behavioural changes (Garcia 2005). The tendency for these clients to have fewer nights in accommodation is shown in the distribution of accommodation nights (see Figure 2.8). About 1 in 2 (49%) clients in the matched group spent up to 45 nights in accommodation over the study period, which was slightly higher than the proportion

observed in the SHS-only group (46%). However, while 1 in 4 (24%) clients in the SHS-only group were accommodated for over 180 nights, just under 1 in 5 (19%) of the matched clients were accommodated for that amount.



Clients with a current mental health issue in the matched group experienced housing instability and substance misuse issues as well as mental health issues. This combination of complex circumstances and high levels of accommodation provision, in shorter durations, highlights the potential difficulty experienced by specialist homelessness services in accommodating these high needs clients.

2.5 What were the outcomes for clients?

Why did their AOD treatment end?

Overall, most episodes of AOD treatment ended under expected circumstances (see Glossary for details of expected completion). Clients with a current mental health issue in the matched group and in the AODT-only population had similar rates of expected treatment completion. However, clients with a current mental health issue in the matched group were more likely than those in the AODT population to have their treatment end:

- unexpectedly (40% compared with 26%)
- due to imprisonment (3% compared with 1%).

What were their SHS housing circumstances and outcomes following support?

Box 2.2: How are housing outcomes measured?

To measure improvements in housing circumstances, the housing situation of a client is recorded at both the beginning and end of their SHS support. Housing outcomes can only be analysed when the period of support has finished; for this reason, only clients whose support was not ongoing at the end of the 3-year study were included in the analysis. For about half of the matched group (51%), and for 38% of the SHS-only clients, support remained ongoing at the end of 2013–14 and these clients have been excluded from this section of the analysis.

Just over half (55%) of clients in the matched group with a current mental health issue began support homeless – higher than the proportion of clients in the SHS-only group (49%). At the end of support from specialist homelessness agencies, more clients in both groups were housed. However, clients with a current mental health issue who were in the matched group were less likely to end support in stable housing (53% of matched clients compared with 61% of SHS-only clients).

Specialist homelessness agencies assist clients either presenting homeless into stable housing or assist clients at risk of homelessness to remain housed. (See Glossary for housing status definitions.) Table 2.3 compares the housing circumstances of both the matched and SHS-only groups at the beginning and end of support.

Table 2.3: Clients with a current mental health issue, by housing status at the beginning and end of support, matched and SHS-only, 2011–12 to 2013–2014

Housing circumstance	Matched mental health clients (%)		SHS-only mental health clients (%)	
	Start	End	Start	End
No shelter or improvised/inadequate dwelling	18.7	10.6	14.0	7.9
Short-term emergency accommodation	20.5	26.3	19.1	21.1
House, townhouse or flat—couch surfer or with no tenure	15.8	10.3	15.4	9.7
<i>Total homeless</i>	<i>54.8</i>	<i>47.1</i>	<i>48.5</i>	<i>38.6</i>
Public or community housing—renter or rent free	10.6	20.9	12.0	22.9
Private or other housing—renter, rent free or owner	22.8	23.3	34.6	35.4
Institutional settings	11.9	8.8	5.0	3.1
<i>Total at risk of homelessness</i>	<i>45.2</i>	<i>52.9</i>	<i>51.5</i>	<i>61.4</i>

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

On presentation, clients with a current mental health issue in the matched group were:

- more likely than SHS-only clients with a mental health issue to have been 'rough sleeping' (19% compared with 14%) (see Glossary for definition)
- more than twice as likely to have been in an institutional setting (12% compared with 5%)
- less likely to own or be privately renting their home (23% compared with 35%).

Following support, housing outcomes improved for those in the matched cohort. However, 47% of clients in the matched cohort ended their support, and yet remained homeless. When matched clients with a current mental health issue were compared with SHS-only clients also experiencing a current mental health issue, they:

- were more likely to finish SHS support in short-term or emergency accommodation (26% compared with 21%)
- experienced a 10 percentage point improvement in social housing rates following support, from 11% to 21%
- were still more likely to be rough sleeping following support (11% compared with 8%) – however, the rate of rough sleeping fell from 1 in 5 (19%) to around 1 in 10 (11%) over this 3-year period.

The ability to exit homelessness was not equal among all clients. Figure 2.9 illustrates this by comparing the housing circumstances of clients at the end of support (y-axis), based on their housing situation at the beginning of support (x-axis). Clients who began support homeless, (as shown in the upper panel) were either supported into different forms of housing (purple shades), or despite support, remained homeless (blue shades).

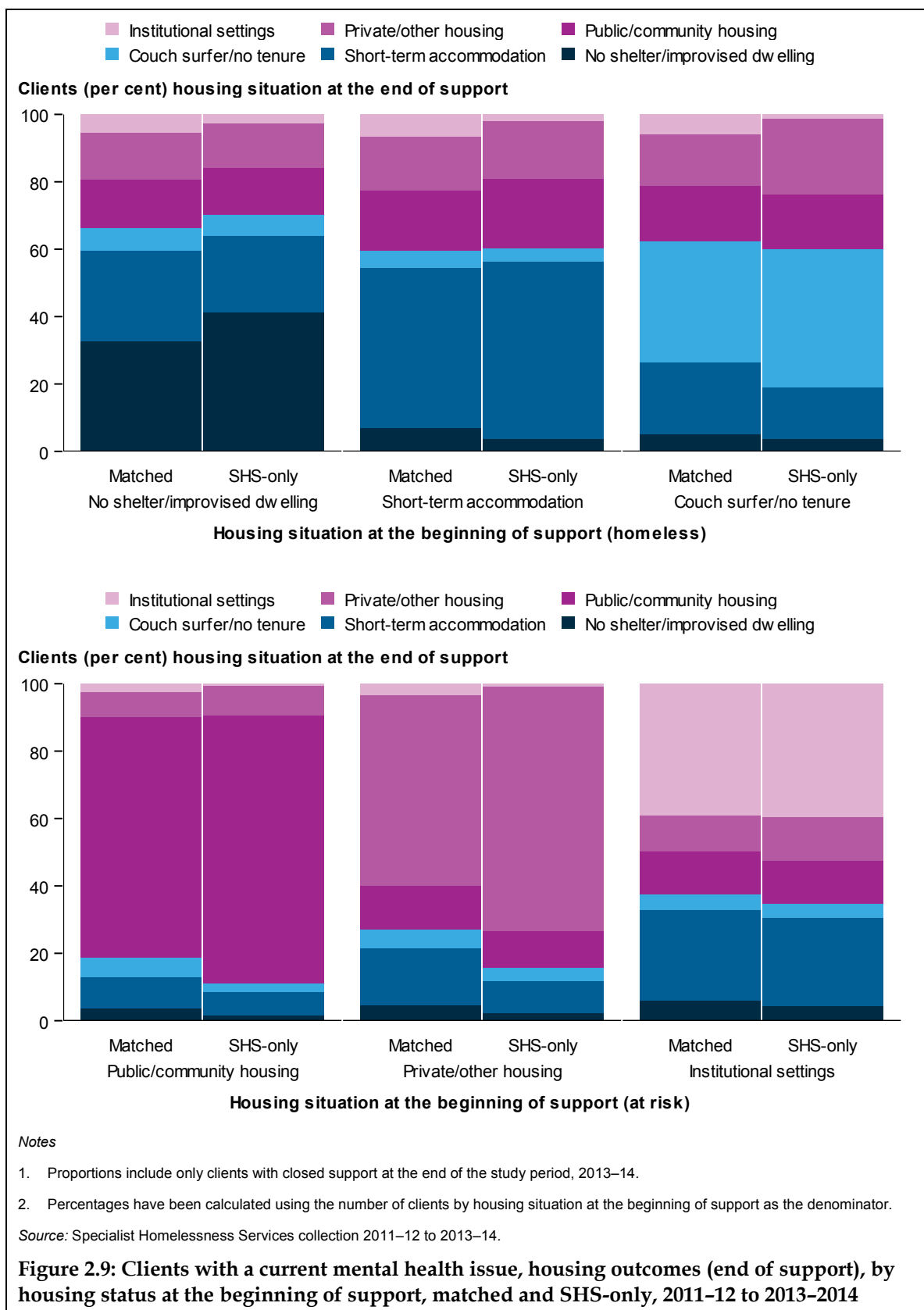
Compared with SHS-only clients with a current mental health issue, matched clients with a current mental health issue who began support homeless were:

- less likely to remain 'rough sleeping' (33% compared with 41%)
- more likely to be living in an institutional setting following support.

Clients who began support housed (lower panel) were assisted to remain housed (purple shades), or despite support, became homelessness (blue shades).

Of clients who began support housed, matched clients were less likely than those in the SHS-only group to remain in:

- their public and community housing following support.
- private housing following support.



2.6 What does this tell us?

The addition of substance misuse to mental health issues adds more complexity to the lives of matched clients and their greater vulnerability is reflected in their AOD treatment, specialist homelessness service needs and housing outcomes.

Just over half (51%) of matched clients reported a current mental health issue. This was much higher than among SHS-only clients (22%) – which suggests a considerable overlap between substance misuse, mental health issues and housing instability for this group.

Around 1 in 4 (24%) matched clients were Indigenous, nearly twice the proportion for the AODT-only group (13%) and higher than the SHS-only group (16%).

Matched clients were much more likely to have multiple drugs of concern (21% compared with 7% AODT-only). Compared with AODT-only clients, there were noticeably more matched clients receiving treatment for amphetamines (22% compared with 15%); heroin (13% compared with 8%); and pharmaceuticals (12% compared with 7%).

Matched clients had poorer housing outcomes and appeared to have more barriers to overcome than SHS-only and AODT-only clients. Matched clients had more AOD treatment episodes as well as more SHS support and they were using a broader range of drugs. The very high need in the matched group for basic assistance services such as meals, laundry, shower facilities and transport reflects a vulnerable client group where everyday activities are challenging, and provides evidence of the greater difficulties for independent living in this group.

3 Clients who have experienced domestic and family violence

Key Findings

Matched clients experiencing domestic and family violence:

- were the second largest cohort analysed – around 1 in 3 (34%) of matched clients
- were the only cohort where there was a higher proportion of females than males (73% and 27%, respectively)
- had the highest rate of Indigenous clients of all cohorts (33%)
- had more AOD treatment episodes (2.2 compared with 1.5 for AODTS-only clients) as well as more SHS support periods (5.1 compared with 2.6 for SHS-only clients); they were equally the most likely to still be receiving SHS support at the end of the study period (51%)
- had more clients receiving treatment for amphetamines than any other cohort, and female clients had the highest rate of overall (22% matched female clients).

Together, these findings indicate that poorer drug treatment and housing outcomes are achieved by matched clients experiencing domestic and family violence compared with SHS-only clients experiencing domestic and family violence and by AODT-only clients.

Nearly 3 million Australians over the age of 15 have experienced some form of partner violence, or physical or sexual violence from another family member in their lifetime (ABS 2013).

Domestic and family violence is a major cause of homelessness in Australia. A large majority of victims are women and their children, although men may also be victims. The violence experienced removes the sense of safety and belonging within the home, and leaving a violent situation usually requires leaving the family home (Chamberlain & Johnson 2011).

Drug and alcohol use is often associated with domestic and family violence, for both perpetrators and victims. A survey of perceptions of domestic violence in Australia found that people thought drug and alcohol use was a common cause of domestic violence (Cale & Breckenridge 2015). Similarly, a global meta-analysis of domestic and family violence conducted by the World Health Organization found that alcohol use and violence are associated in both women's experience of intimate partner violence and subsequent alcohol use; and in alcohol use and subsequent intimate partner violence (WHO 2013). Of the 6 longitudinal studies examined in the WHO analysis, all showed positive associations between intimate partner violence and incident alcohol use (although not all were statistically significant) (WHO 2013).

Given the associations of both homelessness and drug and alcohol use with domestic and family violence, it is important to determine the extent to which these 2 issues overlap for people experiencing domestic and family violence. Analysis of clients receiving SHS in 2015 found that more than 1 in 10 (13%) had both experienced domestic and family violence and reported problematic drug or alcohol use (AIHW 2015).

Further, given that most victims of domestic violence are women and children (although men may also be victims), to explore any differences between females and males, analyses have been further broken down by sex.

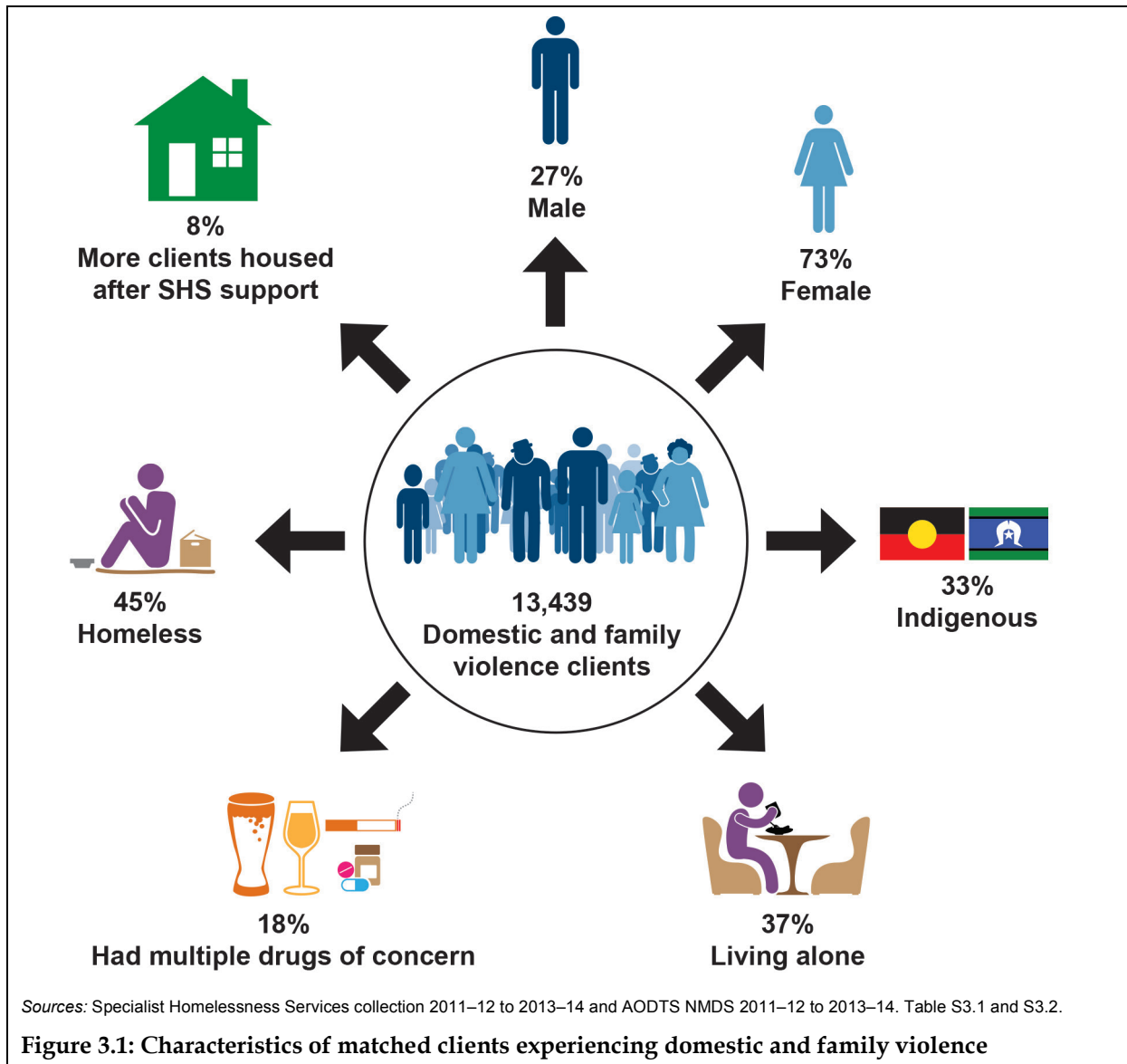
Box 3.1: Identifying clients who have experienced domestic and family violence

Clients experiencing domestic and family violence have been determined in this report by using information provided in the SHSC. (See Glossary for more details.) The matched clients experiencing domestic and family violence have been compared with SHS-only clients experiencing domestic and family violence. For comparability, SHSC clients aged 10 and over experiencing domestic and family violence were compared with matched and AODT-only clients.

There is currently no information available in the AODTS NMDS to determine a person's experiences with domestic and family violence, so any comparisons made with clients receiving AOD treatment only cannot distinguish between clients who are, or are not, experiencing domestic and family violence. As a result, only those clients receiving AODTS who also receive SHS can be identified as experiencing domestic and family violence.

While SHSC agencies mainly assist people who are victims of domestic and family violence, they may also assist perpetrators of violence who are seeking assistance (and therefore may appear within the data in this report). The SHSC is not able to separately identify these clients.

There were 13,439 matched clients identified who experienced domestic and family violence between the years 2011-12 to 2013-14 (Figure 3.1).



3.1 Client characteristics

Domestic and family violence were significant issues for both the matched and SHS-only groups, with around a third of both groups experiencing domestic and family violence.

Unlike the other cohorts examined in this report, those experiencing domestic and family violence were far more likely to be female than male (73% compared with 27%).

There were very high rates of Indigenous clients in the matched group experiencing domestic and family violence and this was highest for females, with 33% of Indigenous female clients and 31% of male clients experiencing domestic and family violence, compared with 13% for both female and male AODT-only clients and 21% of female and 22% male SHS-only clients (see Table S3.2).

The median age of matched male and female clients experiencing domestic and family violence was similar to those in the AODT-only population. The median ages of clients experiencing domestic and family violence in the SHS-only group were different to those in

the matched group, because of the larger proportion of children 10–17 in the SHS-only population: the median age of males was 19 and 45% of males were aged 10–17. (By contrast, only 13% of male clients in the matched group were in this age group and the median age was 29.) Female median ages were similar (matched 31 and SHS-only 32 years, respectively) as were the proportions of female clients aged 10–17 (matched 6% and SHS-only 11%, respectively).

Matched clients experiencing domestic and family violence were more than twice as likely to be living alone as those in the SHS-only group (37% compared with 21%) and much less likely to be employed (7% compared with 19%) (see Table S3.2).

3.2 Why did these clients seek SHS assistance?

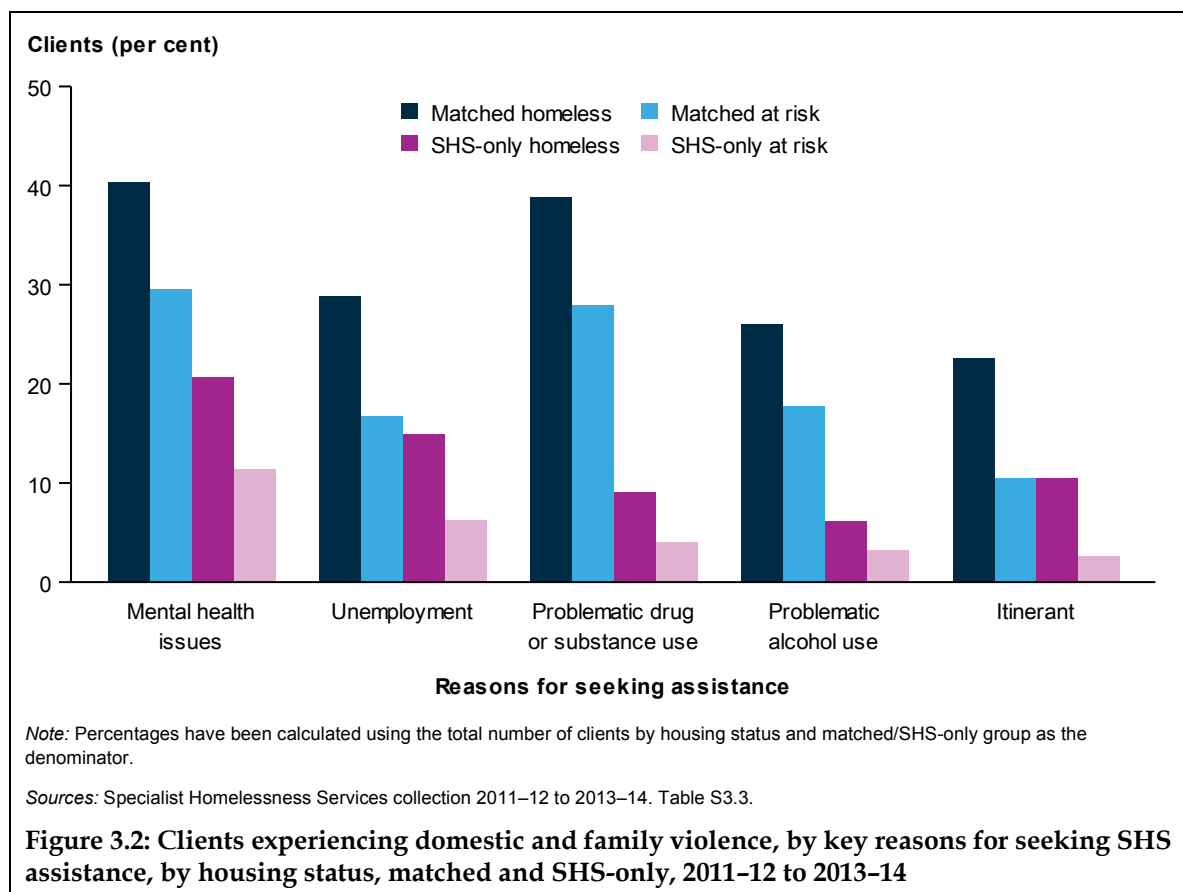
For clients in the matched and SHS-only groups, the overwhelming reason for seeking assistance from specialist homelessness agencies was due to their violent situation. Four in 10 (41%) matched clients reported domestic and family violence as the main reason for seeking assistance with even more clients in the SHS-only group seeking services primarily because of domestic and family violence (66%).

When all the reasons for seeking assistance were examined, clients in the matched group reported many more reasons than clients in the SHS-only group and some significant differences were observed between these groups (see Figure 3.2 and Table S3.3).

Compared with SHS-only clients experiencing family and domestic violence, clients in the matched group experiencing domestic and family violence were:

- more than twice as likely to identify ‘health’ as a reason for seeking assistance (52% compared with 20%), particularly mental health issues (33% compared with 13%)
- three times as likely to be itinerant (15% compared with 5%)
- far more likely to identify problematic drug use (32% compared with 5%) or alcohol use (21% compared with 4%)
- more likely to identify ‘unemployment’ (21% compared with 8%) as a reason for seeking assistance
- more likely to seek assistance following a transition from custodial arrangements (8% compared with 1%).

This indicates that clients in the matched group are not only experiencing domestic and family violence, but are experiencing far greater difficulties and complexities than domestic and family violence clients in the SHS-only group.



3.3 Which drugs were they using?

Matched clients experiencing domestic and family violence were more likely than all AODT-only clients to be treated for more than 1 principal drug of concern, and of those clients in the matched group, males were more likely than females to have multiple drugs of concern (20% compared with 17%) (see Table 3.1).

For most drugs, there were higher proportions of both male and female clients in the matched group compared with all AODT-only clients. Clients in the matched group were, overall, more likely to receive treatment for:

- amphetamines (21% compared with 15%), with females more likely than males (22% compared with 19%)
- pharmaceuticals (10% compared with 7%), with females more likely than males (11% compared with 7%)
- heroin (10% compared with 6%).

Table 3.1: Clients experiencing domestic and family violence, by principal drug of concern, matched and all AODT-only, 2012–13 to 2013–14

Drugs of concern	Matched domestic and family violence clients (%)			AODT-only
	Males	Females	All matched	
Alcohol	44.2	38.2	39.9	38.7
Cannabis	36.4	27.9	30.2	28.0
Amphetamine	19.0	21.6	20.9	15.1
Heroin	9.1	9.1	9.1	5.7
Pharmaceuticals	6.6	11.1	9.9	6.6
Other drugs	6.7	6.8	6.8	7.2
Number of clients	3,696	9,739	13,439	151,644
<i>Number of clients with a multiple PDOC</i>	<i>741</i>	<i>1,631</i>	<i>2,372</i>	<i>10,417</i>

Note: Clients experiencing domestic and family violence have been identified in the matched population. There is no way to identify AODT-only clients who have, or have not, experienced domestic and family violence.

Source: AODTS NMDS 2012–13 to 2013–14.

3.4 What services and support did they receive?

AOD Treatment type and setting

Counselling – regardless of gender, housing status or experiences with domestic and family violence – was the main treatment type received by AODT clients overall (see Table S3.4). This was also the most common treatment received by both female and male clients experiencing domestic and family violence in the matched group.

Clients experiencing domestic and family violence in the matched group, when compared with those all AODT-only clients, were more likely to receive:

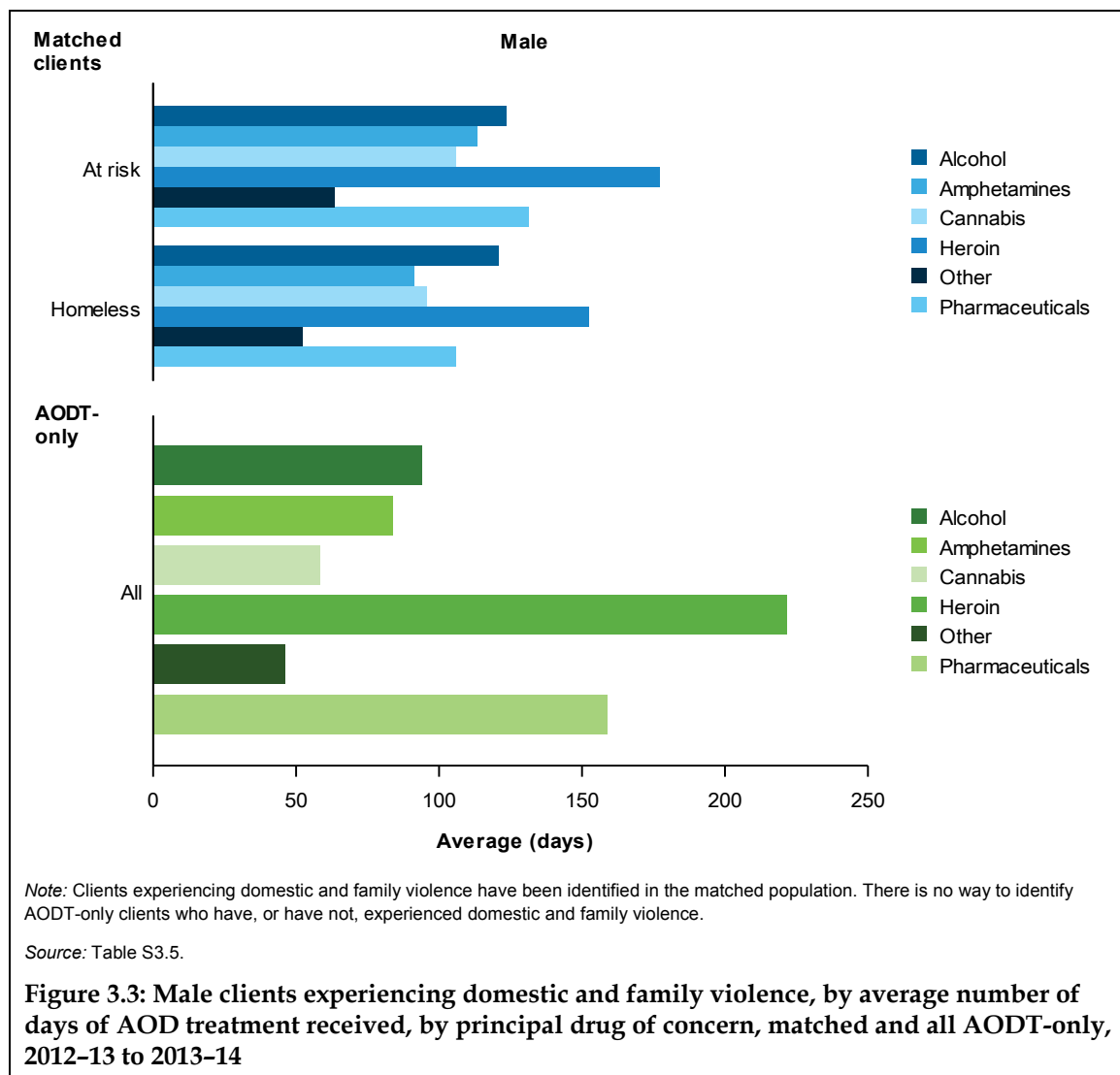
- counselling (58% compared with 47% in the AODT-only group)
- withdrawal services (22% compared with 14%)
- rehabilitation (10% compared with 5%).

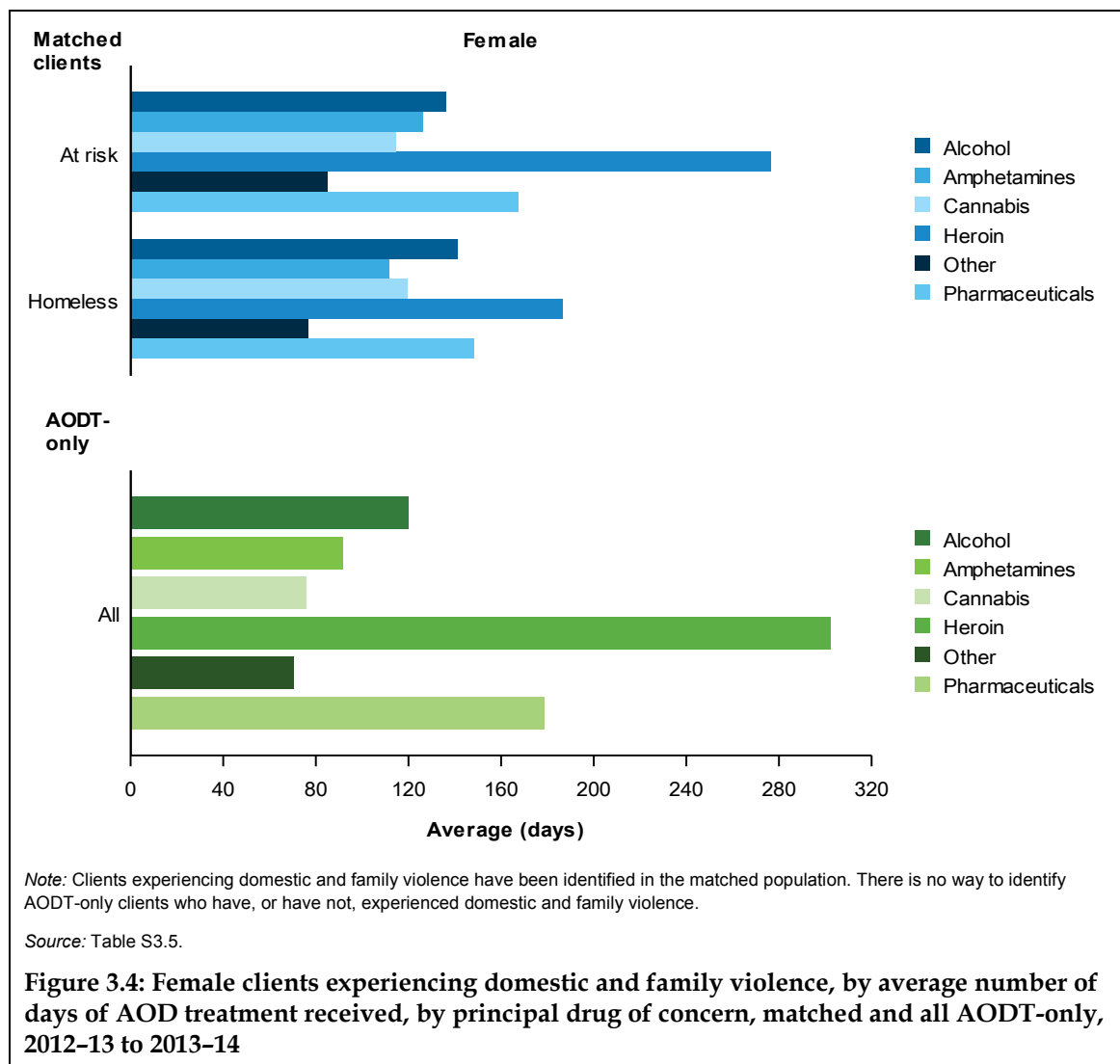
Across all treatment types, there were similar proportions of female and male matched clients who had experienced domestic and family violence; slightly higher for female clients in all cases except for assessment-only services (24% of males compared with 19% of females).

How long did their AOD treatment last?

Clients in the matched group experiencing domestic and family violence spent longer, on average, in treatment than clients in the AODT-only group – 153 days compared with 103 days (see Figures 3.3, 3.4 and Table S3.5). Similarly, they received a greater number of treatment episodes on average than clients in the AODT-only group (2.2 treatment episodes compared with 1.5).

Overall, clients receiving treatment for heroin received the most days of AOD treatment. This was highest for female clients in the AODT-only group (an average of 300 days) compared with the matched group who had experienced domestic and family violence, who were at risk of homelessness (an average of 272 days).

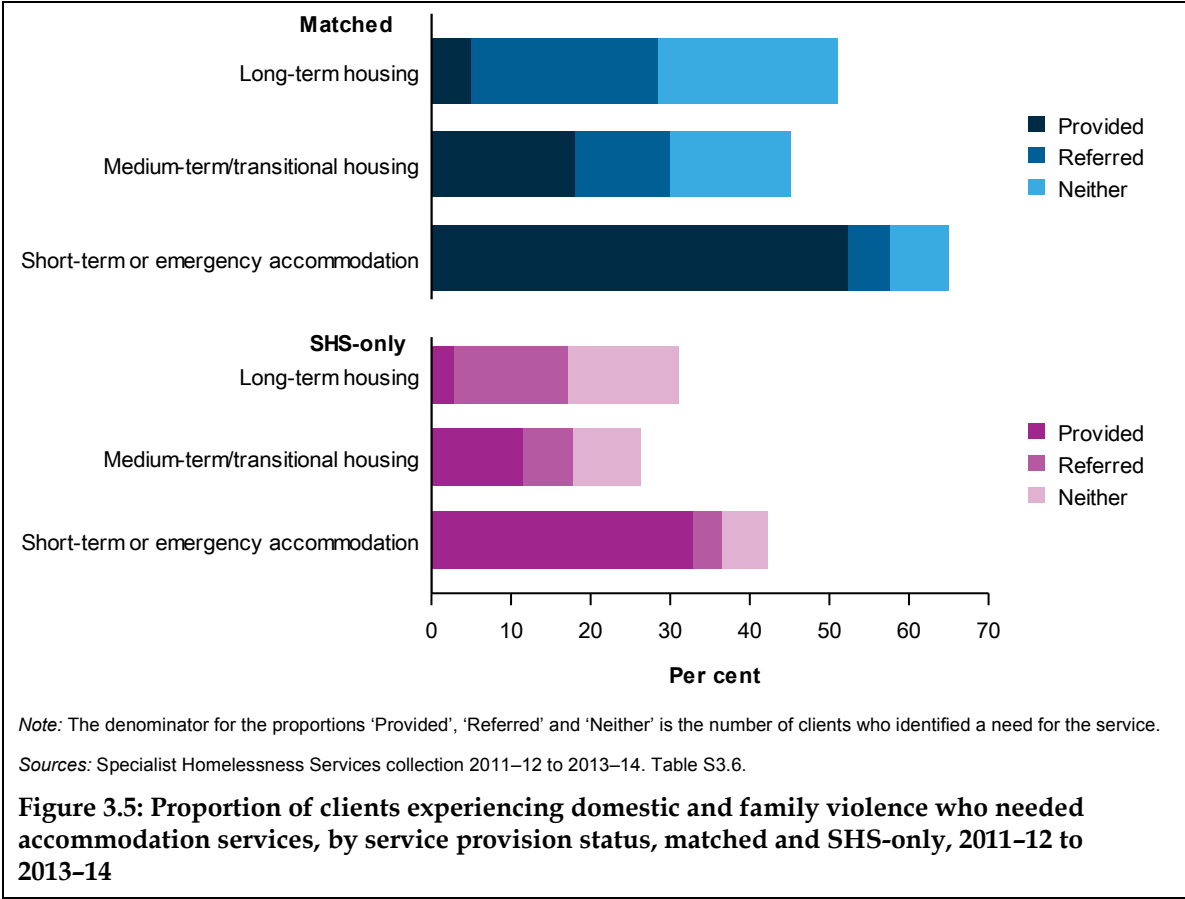




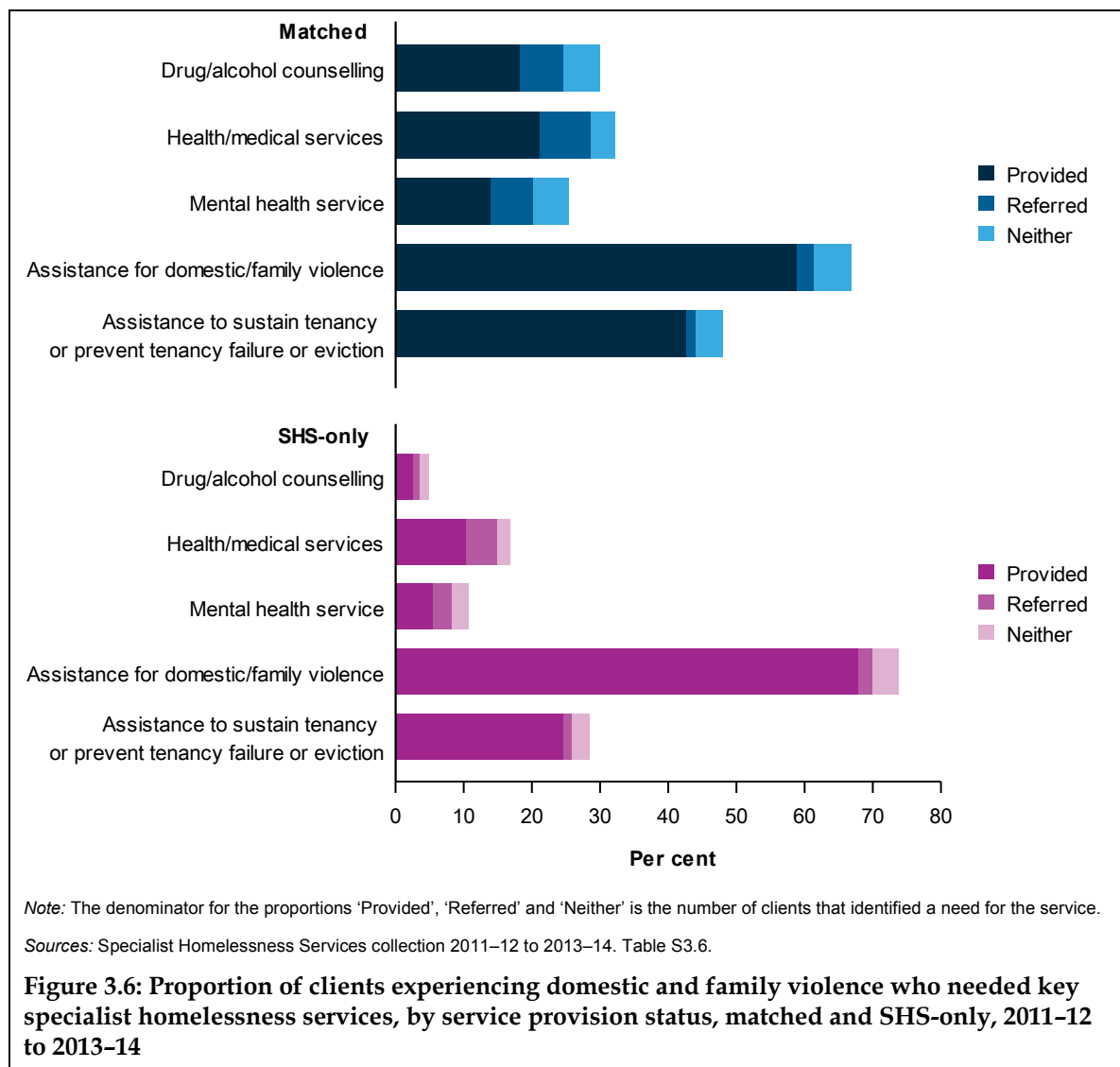
What SHS services did they need?

In addition to recording the main and additional reasons for seeking assistance, SHS agencies also assess and record all services a client needs, receives or that were referred to another service provider. While general levels of need were highest among clients in the matched group who were experiencing domestic and family violence, there were some differences in the levels of need recorded.

Among clients who were experiencing domestic and family violence, a larger proportion (76%) of clients from the matched group needed accommodation services, compared with 54% of those in the SHS-only group (see Table S3.6). Regardless of their housing situation on presentation, short-term or emergency accommodation was needed by most clients across both groups (matched 65% and SHS-only 42%) (see Figure 3.5).



Assistance for domestic and family violence was needed by more clients in the domestic and family violence cohort than by any other cohort examined (see Figure 3.6). However, the proportion of clients needing this service was slightly higher for SHS-only clients (74%) compared with the matched group (67%).



Compared with SHS-only clients experiencing family and domestic violence, clients in the matched group experiencing domestic and family violence were:

- more than twice as likely to need mental health services (25% compared with 11%)
- six times as likely to need drug and alcohol services (30% compared with 5%)
- more likely to need health or medical services (32% compared with 17%)
- more likely to request assistance with challenging social and behavioural problems (35% compared with 19%)
- more likely to request court support (29% compared with 22%)
- more likely to request basic services such as meals (45% compared with 28%) or laundry services (39% compared with 24%).

For both matched and SHS-only groups experiencing domestic and family violence, males were:

- more likely to need accommodation (84% of males in the matched group compared with 73% of females; 69% of SHS-only males compared with 51% of females)

- more likely to identify a need for mental health services (36% of males in the matched group compared with 27% of females; 21% of SHS-only males compared with 14% of females)
- more likely to need assistance for challenging social behaviour (47% of males in the matched group compared with 31% of females; 32% of SHS-only males compared with 16% of females)
- more likely to need assistance for drug and alcohol counselling (40% of males in the matched group compared with 26% of females; 11% of SHS-only males compared with 4% of females).

This increased need for accommodation could reflect the experience of men leaving the home following a violent incident and having perhaps fewer family and support networks to draw on in a time of crisis.

How much SHS support did these clients receive?

On average, clients experiencing domestic and family violence in the matched group had 5.1 support periods and received a total of 180.7 days of support over the 3-year study. By comparison, clients experiencing domestic and family violence in the SHS-only group received half the number of support periods (2.6) and a total of 115.8 days (see Table 3.2). (See Glossary for details on calculating total days of support). These figures were similar for males and females.

Table 3.2: SHS support characteristics of clients experiencing domestic and family violence, by housing status and sex, matched and SHS-only, 2011–12 to 2013–14

	Matched domestic and family violence clients					SHS-only domestic and family violence clients				
	All	Male		Female		All	Male		Female	
		Home-less	At risk	Home-less	At risk		Home-less	At risk	Home-less	At risk
Average support periods	5.1	5.9	4.7	5.1	4.6	2.6	3.2	2.3	3.1	2.4
Average support days	180.7	193.7	167.6	207.4	163.0	115.8	158.6	126.7	164.2	98.7
Support periods (% of clients)										
1 support period	23	20	29	20	25	48	40	53	39	51
5–9 support periods	24	24	20	26	23	11	13	9	15	10
10 or more periods	13	16	12	13	11	3	5	2	4	2
Support days (% of clients)										
5 days or fewer	13	9	15	9	16	26	15	24	15	30
180–630 days	29	34	28	32	26	18	24	19	25	15
Over 630 days	5	6	4	7	5	3	5	4	5	2
Active support (average days per support period)	36	33	36	40	36	45	50	54	54	41

(continued)

Table 3.2 (continued): SHS support characteristics of clients experiencing domestic and family violence, by housing status and sex, matched and SHS-only, 2011–12 to 2013–14

	Matched domestic and family violence clients					SHS-only domestic and family violence clients				
	All	Male		Female		All	Male		Female	
		Home-less	At risk	Home-less	At risk		Home-less	At risk	Home-less	At risk
Duration ⁽²⁾ (% of clients)										
5 days or fewer	15	10	17	10	28	18	17	26	18	32
180–630 days	32%	37%	33%	34%	22%	30%	27%	22%	27%	20%
Over 630 days	22%	19%	18%	24%	9%	21%	12%	8%	13%	8%
Clients receiving accommodation (%)	60	75	56	72	39	51	66	41	63	30
Accommodation (average nights)	105.5	116.2	105.6	114.3	109.7	88.6	125.8	119.7	124.6	91.4

Notes

1. Support periods, days and nights are calculated using a start date of 1 July 2011–12 and an end date of 30 June 2013–14.
2. 'Duration' is calculated as the number of days between the first day of the first support period and the last day of the last support period within the study period. Includes only clients with closed support at the end of the study period.
3. All clients include clients whose housing status was not known.

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

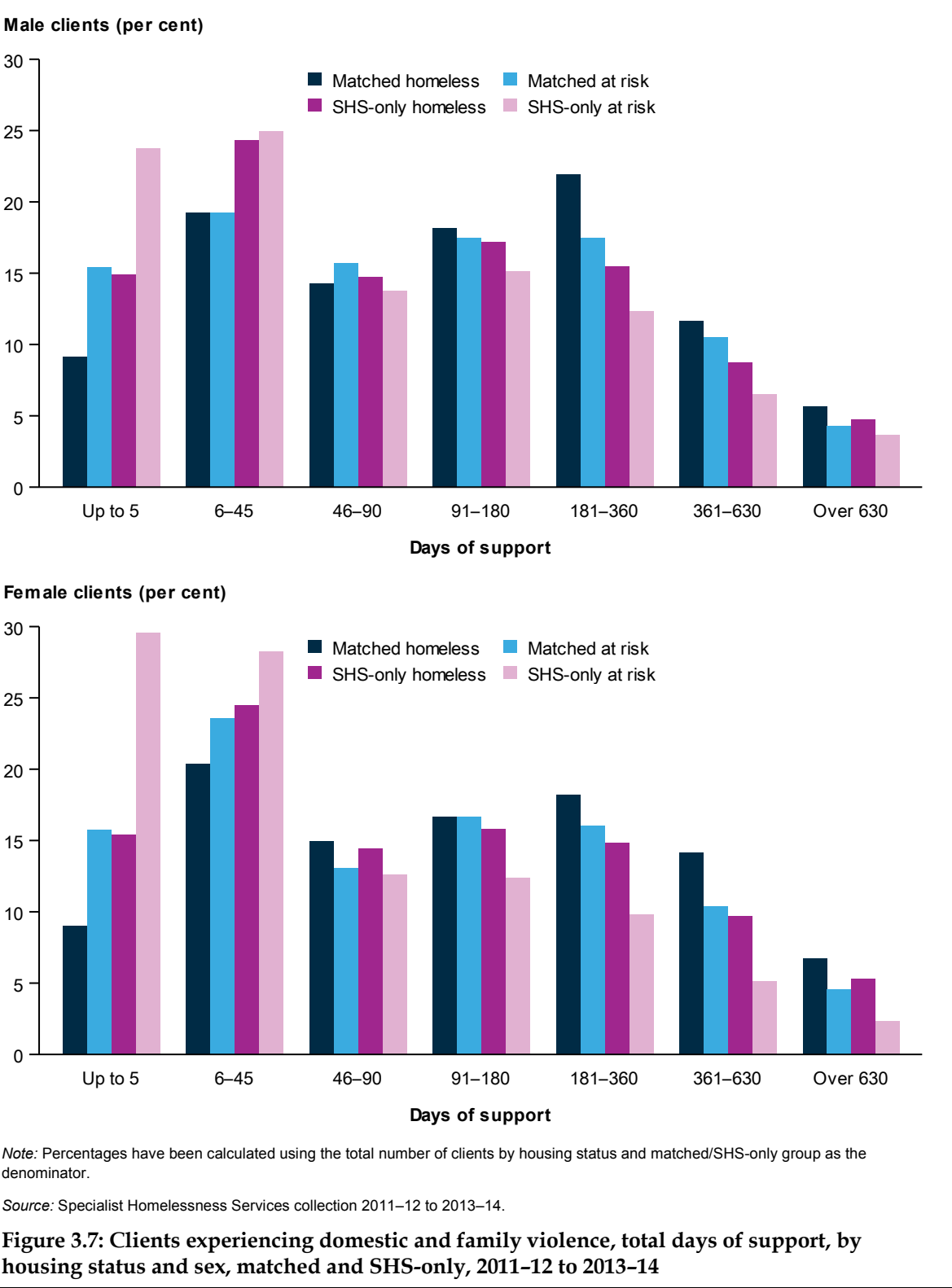
Compared with those in the SHS-only group, clients experiencing domestic and family violence in the matched group:

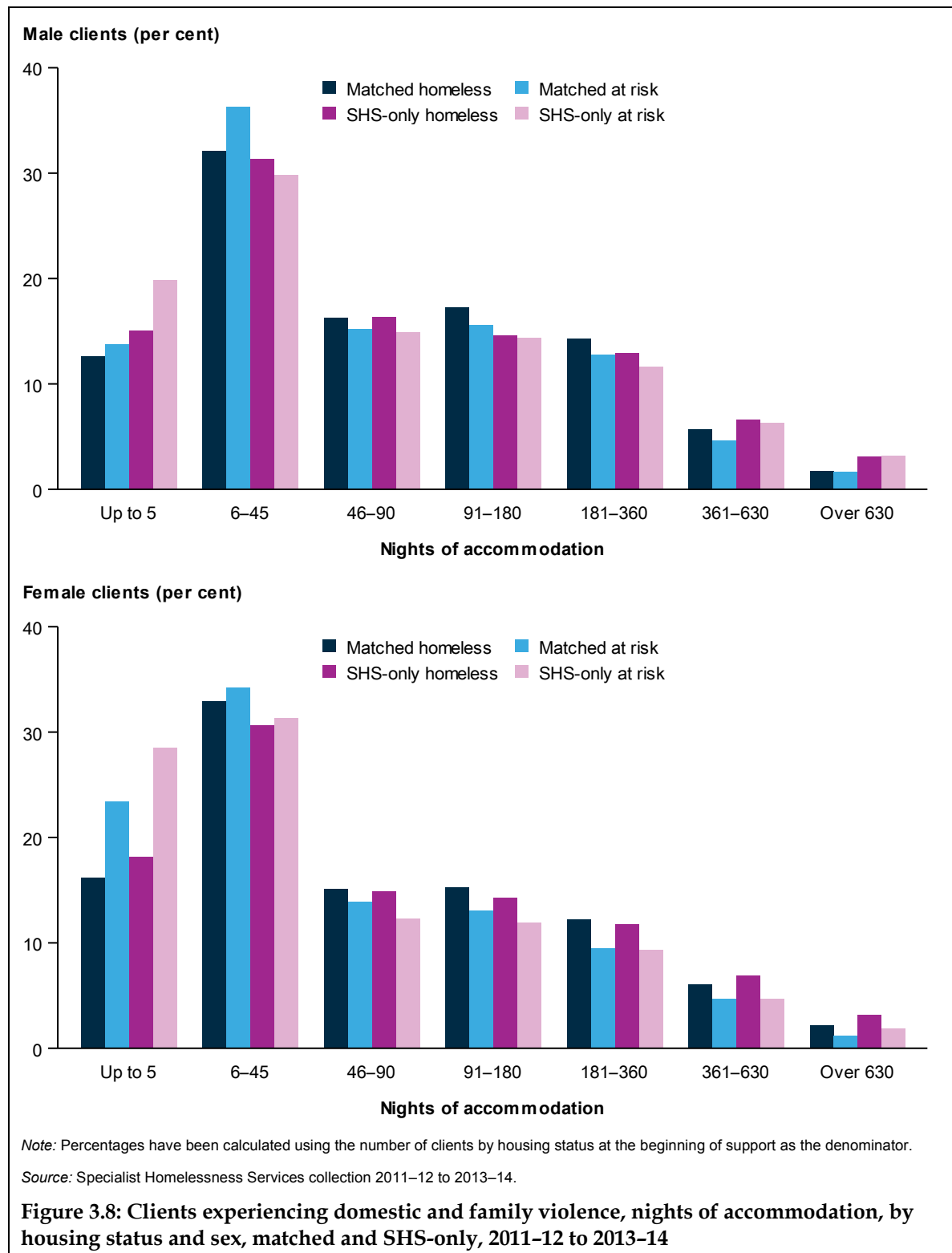
- received twice the average number of support periods (5.1 compared with 2.6), with homeless males in the matched group receiving the greatest average number of support periods (5.9)
- were less likely to receive just 1 support period (23% compared with 48%)
- were more than twice as likely to receive 5 or more support periods (37% compared with 14%)
- were more likely to receive support totalling greater than 180 days (35% compared with 21%). Homeless females and males in the matched group were most likely of all to receive over 180 days of total support (both 39%)
- were more likely to receive accommodation (60% compared with 39%), with homeless males in the matched group most likely of all (75%)
- received fewer total nights of accommodation on average (105.5 compared with 109.7)
- were more than twice as likely to be supported over a 630-day time span (22% compared with 9%).

Figures 3.7 and 3.8 compare the patterns of support days and accommodation nights, respectively, of male and female clients experiencing domestic and family violence.

These analyses illustrate that clients in the matched group experiencing domestic and family violence received greater numbers of support periods, but that these support periods tended to be shorter. Male homeless clients in the matched group had the shortest, but most frequent, contact with SHS agencies. Such a pattern of engagement suggests these clients are

less committed to changing their lifestyle behaviour (Garcia 2005). Clients in the matched group experiencing domestic and family violence also received fewer nights of accommodation. This seems to indicate that, while their need for accommodation was high and those needs were largely met, these clients had greater difficulty in maintaining that accommodation or remaining accommodated.





3.5 What were the outcomes for clients?

Why did their AOD treatment end?

Overall, for the majority of matched clients and all AOD-only clients, support ended under expected circumstances. (See Glossary for definition of ‘expected cessation’.) However, there was a higher proportion of matched clients experiencing domestic and family violence where support ended under unexpected circumstances. This was highest for:

- female clients who were homeless (43%)
- male clients who were at risk of homelessness (40%).

What were their SHS housing circumstances and outcomes following support?

The analysis of housing outcomes requires a client to have a closed support period. A significant number (51%) of clients experiencing domestic and family violence in the matched group were still being supported by specialist homelessness agencies at the end of the study period. By comparison, 72% of domestic and family violence clients in the SHS-only group were not in support at the end of the study period and their housing outcomes have been included in the assessment.

Housing circumstances of the groups examined were fairly similar between those in the matched group and those in the SHS-only group. However, what Table 3.3 illustrates is that clients experiencing domestic and family violence in the matched group, both males and females, were more likely to be homeless both on presentation and following support than those in the SHS-only group.

Table 3.3: Clients experiencing domestic and family violence, by housing status at the beginning and end of support, matched and SHS-only, 2011–12 to 2013–2014

Housing circumstance	Matched domestic and family violence clients (%)				SHS-only domestic and family violence clients (%)			
	Males		Females		Males		Females	
	Start	End	Start	End	Start	End	Start	End
No shelter or improvised/ inadequate dwelling	21.4	12.1	9.2	4.8	13.2	6.8	5.1	2.5
Short-term or emergency accommodation	17.7	25.8	18.9	20.3	19.9	23.8	16.1	15.9
House, townhouse or flat—couch surfer or with no tenure	18.7	10.3	14.5	10.0	16.3	10.7	13.0	8.6
<i>Total homeless</i>	<i>57.8</i>	<i>48.2</i>	<i>42.6</i>	<i>35.0</i>	<i>49.5</i>	<i>41.2</i>	<i>34.2</i>	<i>27.0</i>
Public or community housing—renter or rent free	9.8	17.9	19.4	30.3	10.9	18.9	13.7	20.8
Private or other housing—renter, rent free or owner	24.5	27.4	33.2	31.6	36.9	38.2	51.2	51.7
Institutional settings	8.0	6.5	4.8	3.2	2.7	1.8	0.9	0.5
<i>Total at risk of homelessness</i>	<i>42.2</i>	<i>51.8</i>	<i>57.4</i>	<i>65.0</i>	<i>50.5</i>	<i>58.8</i>	<i>65.8</i>	<i>73.0</i>

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

When males and females in the matched group who had experienced domestic and family violence were compared with those in the SHS-only group:

- males in the matched group had the highest rate of rough sleeping, with 1 in 5 (21%) rough sleeping on presentation. This was twice the rate among females in the matched group (9%) and higher than male SHS-only clients (13%)
- males in the matched group were most likely to 'couch surf', with just under 1 in 5 (19%) presenting with no tenure. This was higher than in all other groups.

Following support, housing outcomes for homeless males and females of both the matched and SHS-only groups improved. Table 3.3 shows that for homeless clients, following support:

- they were less likely to be homeless, and overall homelessness rates across all groups fell—however clients in the matched group were still more likely to be homeless than SHS-only clients
- males in the matched group were more likely than females to end their support in short-term or emergency accommodation, both in the matched and SHS-only groups.

When comparing males and females at risk of homelessness in the matched group who have experienced domestic and family violence, with males and females in the SHS-only group:

- females across all groups were more likely to be housed on presentation than males. Those clients in the SHS-only group were, again, more likely to be housed, with 66% of SHS-only females housed on presentation
- almost 1 in 5 (19%) of females in the matched group were living in social housing on presentation. This is double the rate of matched males (10%) and higher than both males and females in the SHS-only group (11% and 14%, respectively).

Following support, housing outcomes improved for males and females at risk of homelessness in both the matched and SHS-only groups. Table 3.3 shows that following support, for clients at risk of homelessness:

- females were more likely to be housed than males
- those in the SHS-only group were more likely than those in the matched group to be housed
- there were significant increases in the proportions of clients housed in social housing, with matched males rising from 10% to 18% and matched females rising from 19% to 30% over the duration of the study.

The pathway from homelessness to secure housing is not the same for everyone. Figures 3.9 and 3.10 show the housing circumstances of male and female clients, respectively, at the end of support, depending on their circumstances at the beginning of support (blue for homeless and purple for housed). In the upper panel, clients began support homeless and in the lower panel, clients began housed.

Figure 3.9 shows that, compared with males in the SHS-only group, matched male clients who began support:

- homeless (upper panel) were more likely to be housed at the end of support but also more likely to be living in institutional settings
- housed (lower panel) were less likely to remain housed in private or public and community housing.

Compared with females in the SHS-only group matched female clients who began support:

- homeless (upper panel) were more likely to be housed following support
- housed (lower panel) were less likely to remain housed in private or public and community housing.

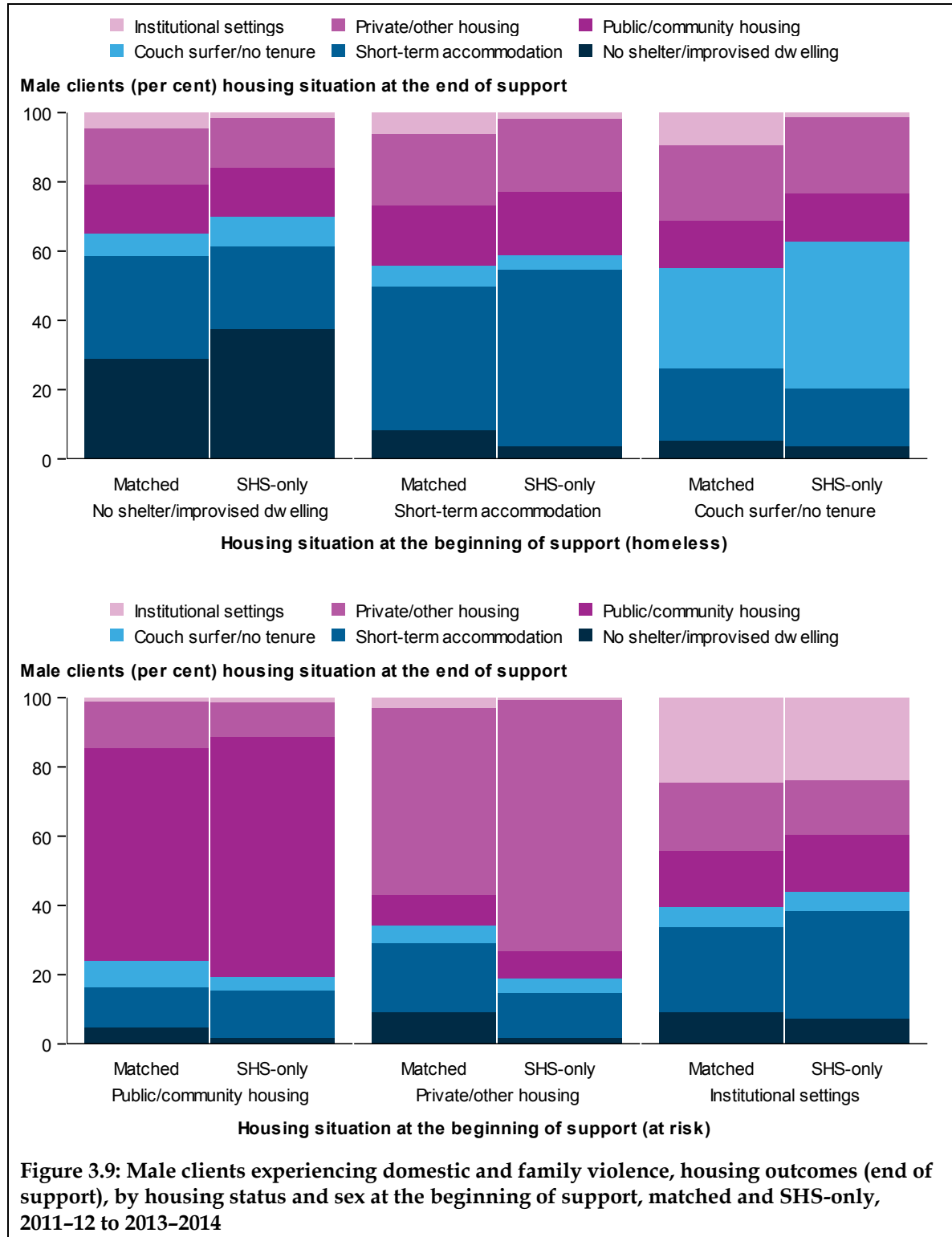
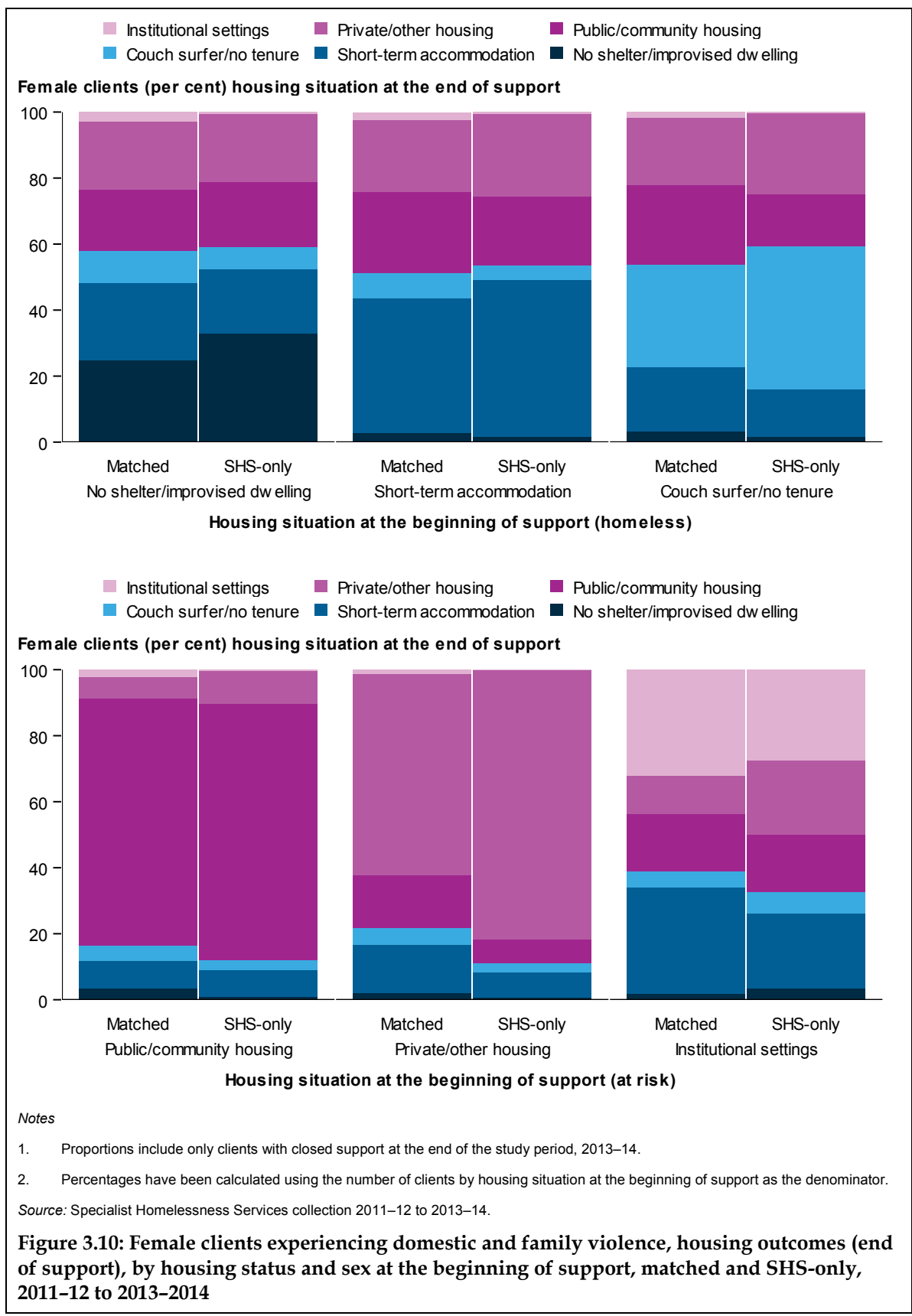


Figure 3.9: Male clients experiencing domestic and family violence, housing outcomes (end of support), by housing status and sex at the beginning of support, matched and SHS-only, 2011-12 to 2013-2014



3.6 What does this tell us?

This cohort was the only cohort where there was a higher proportion of females than males (73% and 27%, respectively). Matched clients experiencing domestic and family violence were also the most likely, compared with all other cohorts, to be single parents with children (26%) and the most likely to be Indigenous (33%).

Around 1 in 3 (34%) of matched clients reported experiencing domestic and family violence, not dissimilar to the rates for SHS-only clients (30%). However, the proportion of male clients in the matched group experiencing domestic and family violence was twice that of the SHS-only population (27% compared with 14%).

One in 3 (33%) of matched clients were Indigenous, much higher than in either the AODT-only (13%) or SHS-only groups (21%).

The pattern of drug use was similar for clients in the matched and AODT-only groups, but higher proportions of matched clients received treatment for each drug. This is reflected in matched clients being much more likely to have multiple drugs of concern (20% of males and 17% of females, compared with 7% and 6%, respectively). Amphetamines and pharmaceuticals were the only drugs for which there were more females (22% and 11%) than males (20% and 7%). The biggest difference across the 2 client groups was between female clients receiving treatment for amphetamines (22% of matched females and 13% of AODT-only females).

Clients in the matched group had more AOD treatment episodes and more frequent, but shorter, spells of SHS support spanning longer durations than clients in the AODT-only and SHS-only groups, respectively. These service characteristics reveal the dynamic and difficult nature of the interaction between service providers and clients with substance misuse issues, experiences of domestic and family violence and housing instability.

Housing outcomes were poorer for clients experiencing domestic and family violence in the matched group than SHS-only, particularly for those beginning support housed but at risk of homelessness. However, there were significant increases in the proportion of clients living in social housing following support. This reflects not only the assistance provided by agencies to obtain a stable housing outcome for their clients, but also the crucial role that social housing plays in accommodating those with multiple levels of disadvantage and vulnerability.

4 Young clients 15–24 years

Key Findings

Matched clients aged 15–24 years:

- were the most likely, of all cohorts, to present to an SHS agency homeless (54%), and for those whose support had ended, were most likely to be homeless (49%)
- were more likely to receive treatment for cannabis than for any other drug (52%), and were the only cohort where alcohol was not the most commonly reported drug of concern
- were more likely to receive treatment for multiple drugs of concern (18% compared with 7% of AODT-only clients)
- received many more days of AOD treatment and SHS support on average, compared with AODT-only and SHS-only clients (126 days in AOD treatment and 147.6 SHS support days, compared with 73 days in AOD treatment and 113.9 in SHS support)
- were the most likely of all cohorts to be ‘couch surfing’ when seeking SHS services (27%).

These findings highlight the complex and challenging situations young matched clients are faced with when entering both AOD treatment and homelessness services. It is unsurprising then, that achieving a stable housing outcome was more difficult for young matched clients than for any other cohort, with about 1 in 2 (49%) homeless at the end of their SHS support.

Young people are some of the most vulnerable people in our society. Traumatic and stressful experiences in the home, such as domestic and family violence and family conflict can often lead young people to develop drug and alcohol use issues, and result in them leaving the family home. Chamberlain and Johnson (2011) found that, of those surveyed, the key pathway into adult homelessness was from youth homelessness. Indeed, the Australian Government’s 2008 White Paper *The road home: a national approach to reducing homelessness* (FaHCSIA 2008) listed young people exiting care and protection or juvenile justice as a particularly vulnerable groups requiring prioritised attention.

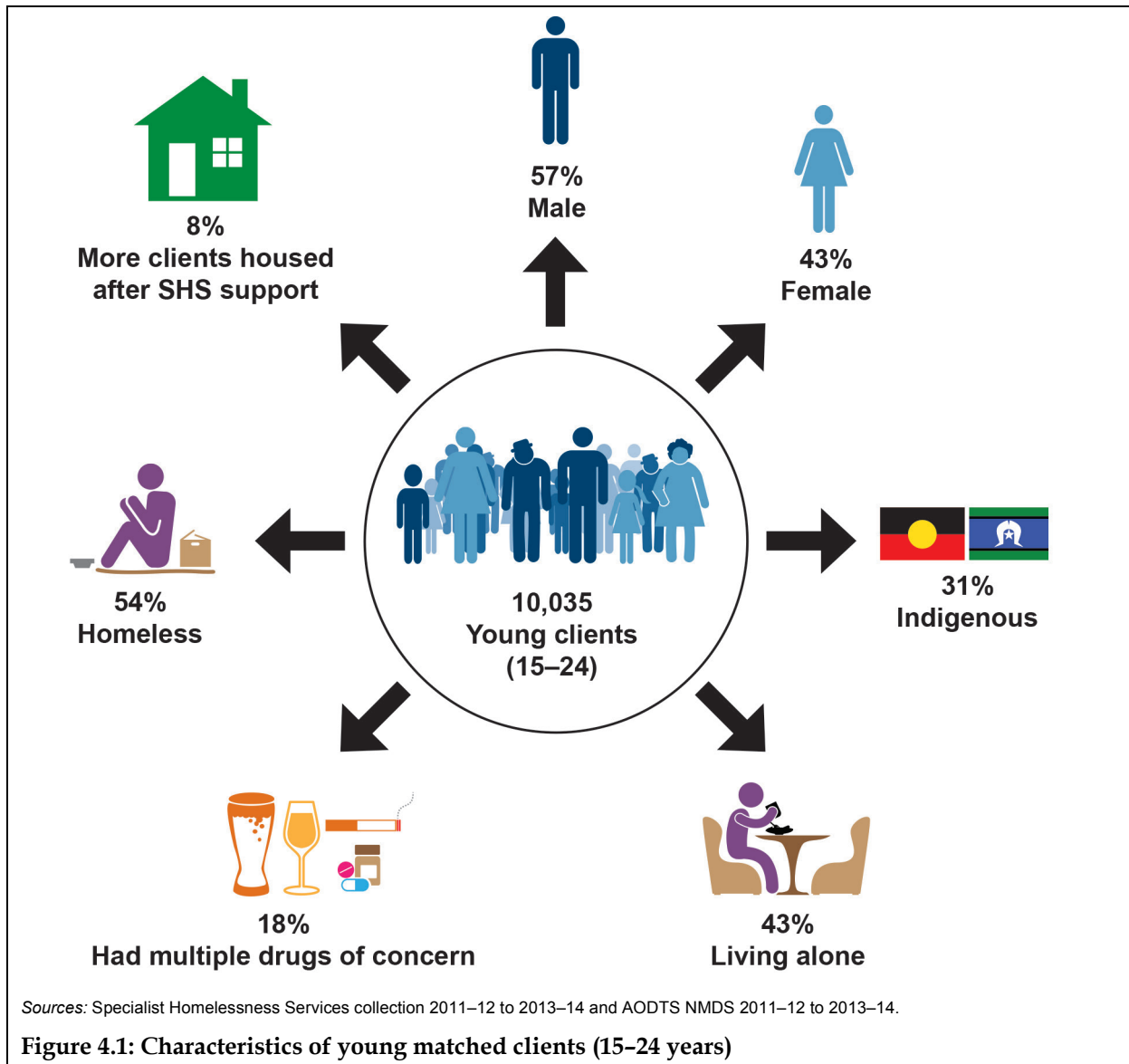
Previous research into the intersection of homelessness and AOD use among young people has indicated 2 key findings for young people: that young homeless people are more susceptible to developing AOD issues (as this is often the only way to be accepted among homeless sub-cultures); and that they are more likely to have long-term issues with homelessness (Chamberlain & Johnson 2011; Mallett et al. 2005).

The current evidence shows that young people are not only vulnerable to homelessness and AOD issues separately, but that one can often lead to the other, often resulting in poorer outcomes into their adult lives. As such, it is important to continue to investigate the issue and to make progress toward understanding the circumstances, service needs and outcomes of young people facing both of these issues.

Box 4.1: Identifying 'young people'

In this report, young people have been defined as clients who were aged 15–24 when first presenting for any service from July 2011 to June 2014. As information on a client's age is available in both data sets, it is possible to make comparisons with both SHS-only and AODT-only clients for young people.

There were 10,035 clients aged 15 to 24 identified in the linked data set for the years 2011–12 to 2013–14 (Figure 4.1).



4.1 Client characteristics

One in 4 (25%) of clients identified in the matched group were young people aged 15–24. This is slightly higher than the proportion in the SHS-only population, which was around 1 in 5 (22%) (see Table S4.1).

The proportion of male and female clients in the matched group fell between the SHS-only and AODT-only proportions. In the matched group, 57% of clients were male, compared with just over 1 in 3 (36%) in the SHS-only and over 7 in 10 (77%) in the AODT-only groups (see Table S4.2).

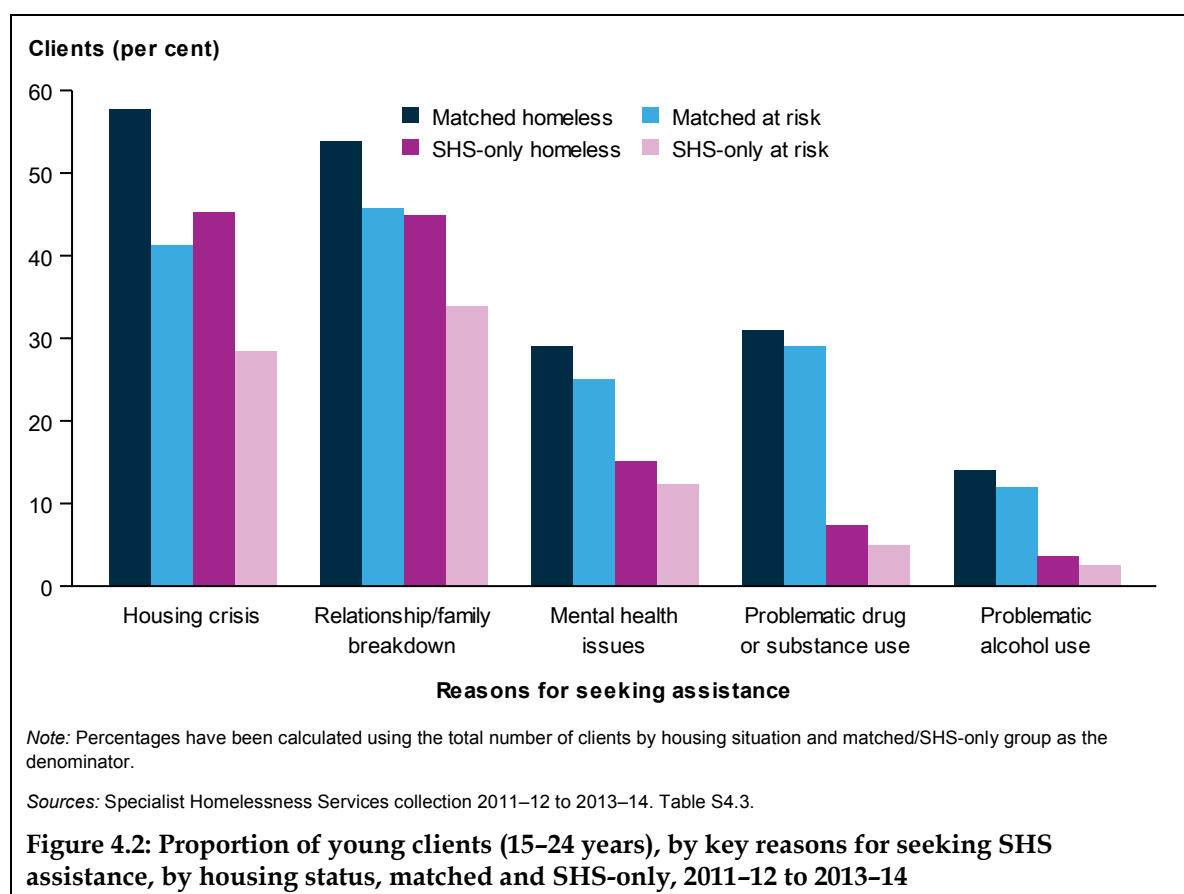
More than half (54%) of the young clients in the matched group were homeless upon presentation to the SHS agency (see Figure 4.1). This was higher than the rate of homelessness at presentation for SHS-only young clients (48%).

Young clients in the matched group were more likely than young clients in either the SHS-only or AODT-only groups to be Indigenous. Three in 10 (31%) of young people in the matched group were Indigenous, compared with 23% in the SHS-only and just 16% in the AODT-only groups. Those in the matched group were also more likely to be alone when they presented to SHS services, compared with young SHS-only clients (85% compared with 76%) and were also more likely to be unemployed (see Table S4.2).

4.2 Why did these clients seek SHS assistance?

Homelessness among young people can arise for a variety of reasons, with family breakdown and conflict being significant contributing factors (Barker 2012).

Irrespective of their housing situation, relationship and family breakdown, as the main reason for seeking assistance, was notably higher across all youth groups, compared with any other cohort examined. More than 1 in 10 young clients, across both the matched (13%) and SHS-only (12%) groups, reported relationship and family breakdown as the main reason for seeking assistance, which supports the view that at this life stage, family conflict is a major driver of youth homelessness.



When all reasons for seeking assistance were examined for the youth groups, other areas of socioeconomic disadvantage were revealed, and were more pronounced in the matched group (Figure 4.2 and Table S4.3). Young people in the matched group were more likely than young people in the SHS-only group to present to services due to:

- experiencing a ‘housing crisis’ (50% compared with 36%)
- family-related issues, such as relationship breakdown (50% compared with 38%) or ‘time out’ from family (33% compared with 24%)
- unemployment (23% compared with 13%) or employment difficulties (12% compared with 7%)
- health-related reasons (44% compared with 20%), such as mental health issues (27% compared with 13%) and medical issues (11% compared with 6%)
- problematic drug/substance use (30% compared with 6%) or alcohol use (13% compared with 3%)
- being itinerant (15% compared with 7%)
- transitioning from custodial arrangements (10% compared with 2%), foster care (4% compared with 1%) or other care arrangements (5% compared with 2%).

These reasons seem to indicate that difficulties with unemployment, as well as family or relationship difficulties, are compounding factors for these young people, making them particularly vulnerable to substance misuse and precarious housing.

4.3 Which drugs were they using?

Young people (across all groups) were the only client group where alcohol was not the most commonly reported principal drug of concern. More young clients (in both the matched and AODT-only groups) received treatment for cannabis than for any other drug (52% of matched clients and 50% of AODT-only clients).

There were more young people in the matched group than the AODT-only group who received treatment for:

- alcohol (28% compared with 25%)
- amphetamines (23% compared with 16%)
- multiple drugs of concern (18% compared with 7%) (See Table 4.1).

Table 4.1: Young clients (15–24 years), by drug of concern, matched and AODT-only clients, 2012–13 to 2013–14

Drugs of concern	Matched young clients (15–24 years)			AODT-only (%)
	Homeless (%)	At risk (%)	All matched (%)	
Alcohol	28.4	27.0	27.7	24.5
Cannabis	51.9	52.0	52.3	50.2
Amphetamine	23.4	22.4	22.9	15.6
Heroin	4.7	4.7	4.7	1.8
Pharmaceuticals	4.8	3.7	4.2	2.2
Other PDOCs	7.7	8.2	8.2	10.5
Clients with multiple PDOCs	19.0	16.8	18.4	7.0
Average number of PDOCs per client	1.2	1.2	1.2	1.1
Number of clients	4,319	3,647	10,035	41,394

Source: AODTS NMDS 2012–13 to 2013–14.

4.4 What services and support did they receive?

AOD Treatment type and setting

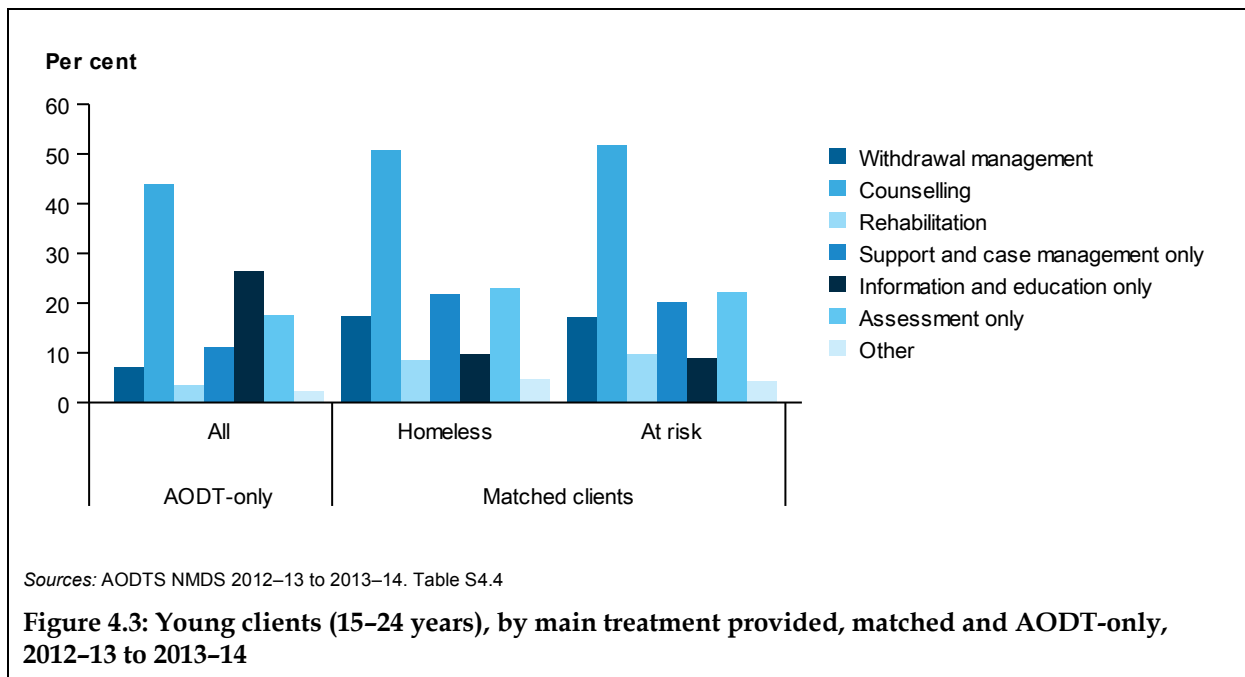
Counselling was the most common treatment type received for all clients in AOD treatment and it was also the most common treatment type provided to all young clients (see Table S4.4).

Compared with those in the AODT-only group, young clients in the matched group were:

- more likely to receive counselling (52% compared with 44%)
- much more likely to receive case management (22% compared with 11%)
- more likely to receive assessment only (21% compared with 18%)
- much less likely to receive information and education only (9% compared with 27%)
- more likely to receive treatment via outreach services (24% compared with 15%).

While the patterns of treatment settings were fairly consistent across all cohorts (with non-residential settings always being the second most commonly reported), treatment

received via outreach services was the second most common treatment setting reported for young clients in both groups. This is likely to have been influenced by higher proportions of young clients receiving assessment only and case management compared with other cohorts (see Figure 4.3), and these treatment types are commonly provided via outreach.

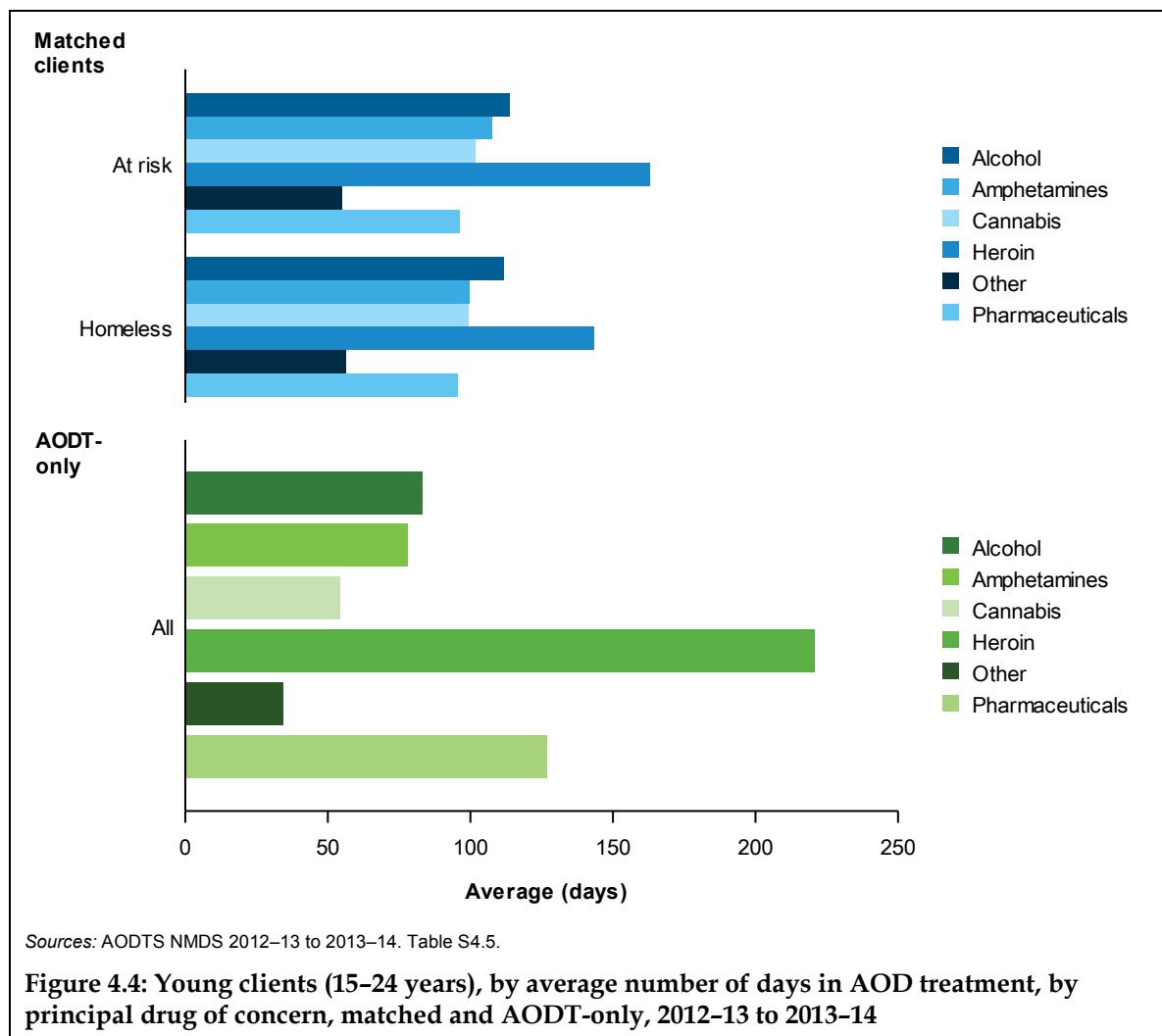


How long did their AOD treatment last?

On average, young clients in the matched group spent nearly twice as long in treatment as clients in AODT-only group – 126 days compared with 73 days. For matched clients, the average treatment duration was very similar for those who were homeless or at risk of homelessness (123 days compared with 127) (see Figure 4.4).

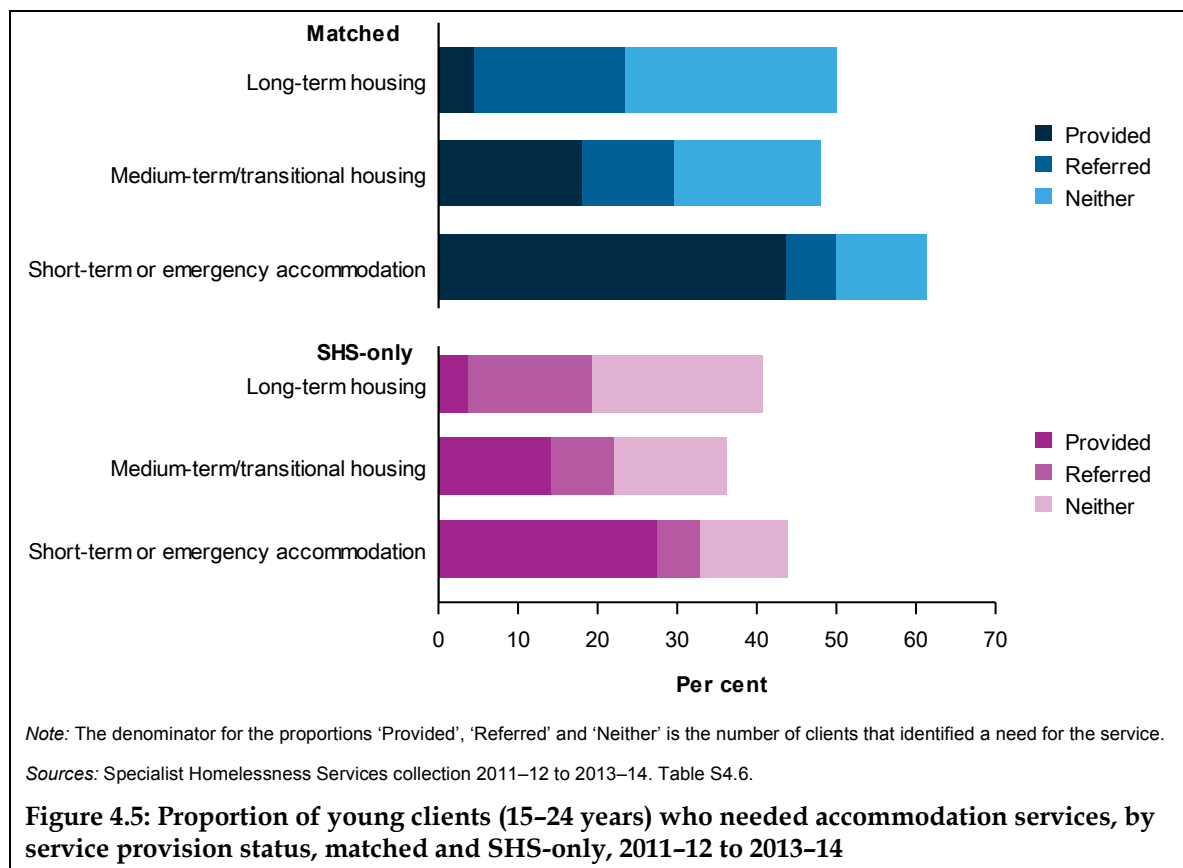
Compared with young clients in AODT-only population, young clients in the matched group received on average:

- more days in treatment overall (126 days compared with 73), with clients at risk receiving the greatest average number overall (127 days)
- fewer days of treatment for heroin (154 days compared with 221 days)
- fewer days of treatment for pharmaceuticals (101 days, compared with 127 days).



What SHS services did they need?

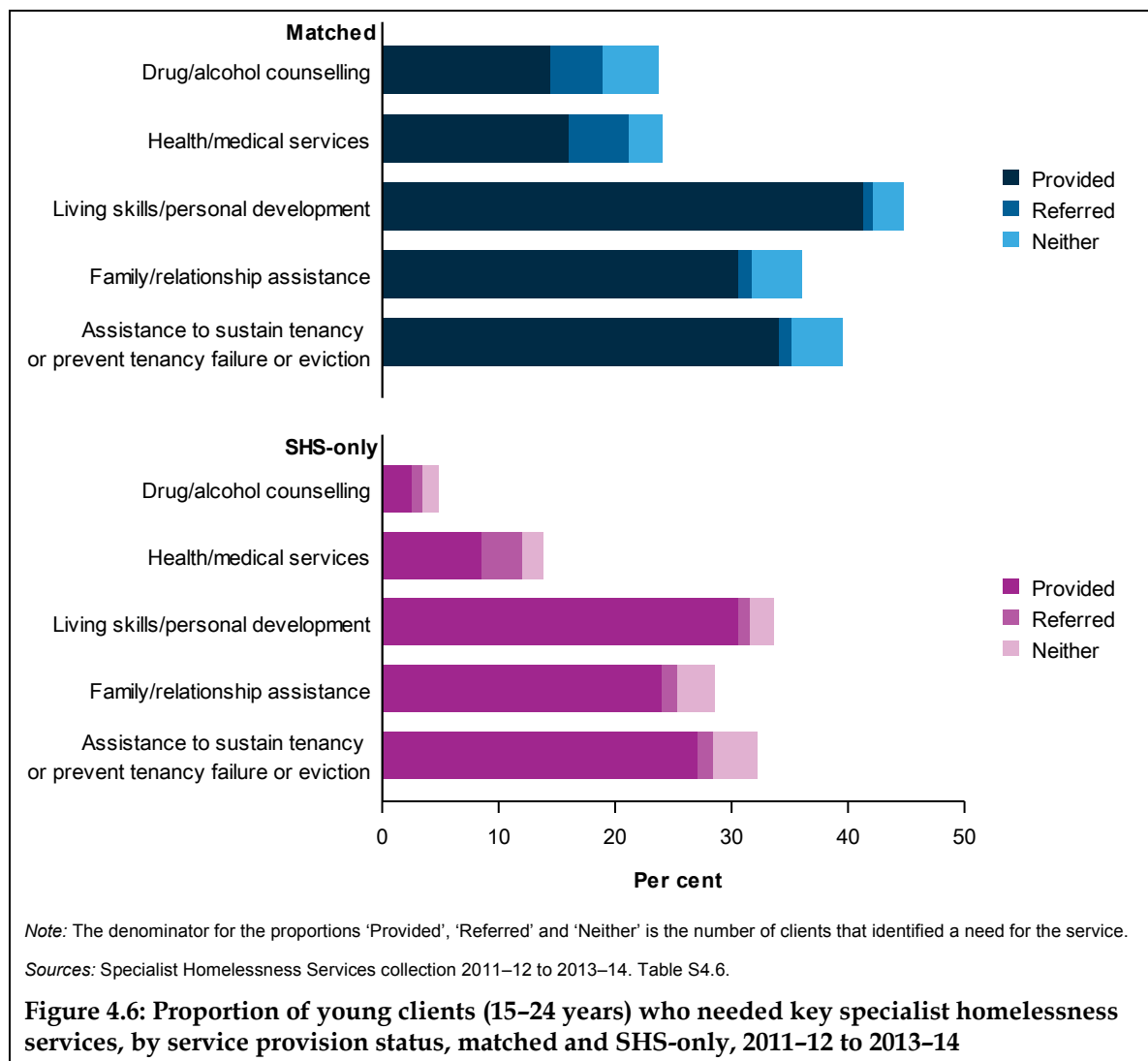
Young clients in the matched group needed more services overall than those in the SHS-only group. Almost 8 in 10 (78%) young clients in the matched group needed accommodation. Clients in both groups needed short-term or emergency accommodation the most (see Figure 4.5).



Across both groups, young clients who presented as homeless needed more accommodation than clients who presented at risk of homelessness. Of those young clients who presented as homeless, the matched group needed more accommodation (84%) than clients in the SHS-only group (78%).

Young people in the matched group, when compared with those in the SHS-only group were:

- more likely to request (78% compared with 65%) and receive (70% compared with 60%) accommodation services
- more likely to request (23% compared with 12%) and receive (55% compared with 51%) mental health services (see Figure 4.6)
- over 4 times as likely to request (24% compared with 5%) drug and alcohol counselling services and to receive them (61% compared with 53%)
- more likely to request (24% compared with 14%) and receive (67% compared with 62%) health and medical services
- more likely to request legal information (27% compared with 17%) and court support (19% compared with 10%).



How much SHS support did these clients receive?

Young clients (15–24) in the matched group received longer periods of support, over an extended duration, compared with clients in SHS-only, including more frequent contact with SHS agencies (Table 4.2).

Table 4.2: SHS support characteristics of young clients (15–24 years), by housing status, matched and SHS-only, 2011–12 to 2013–14

	Matched young clients			SHS-only young clients		
	All	Homeless	At risk	All	Homeless	At risk
Average support periods	3.7	3.9	3.5	2.3	2.4	2.1
Average support days	147.6	150.5	145.1	113.9	127.7	108.1
Support periods (% of clients)						
1 support period	36	34	40	54	50	56
5–9 support periods	17	18	16	8	9	8
10 or more support periods	7	8	7	2	2	2
Support days (% of clients)						
5 days or fewer	17	16	18	26	22	28
180–630 days	24	24	23	17	19	16
Over 630 days	4	4	4	3	3	3
Active support (average days per support period)	39	39	41	50	53	51
Duration ⁽²⁾ (% of clients)						
5 days or fewer	20	19	21	28	24	30
180–630 days	26	27	25	20	21	20
Over 630 days	13	14	12	8	8	7
Clients receiving accommodation (%)	54	59	48	38	48	31
Accommodation (average nights)	101.2	105.5	95.1	119.1	120.6	119.2

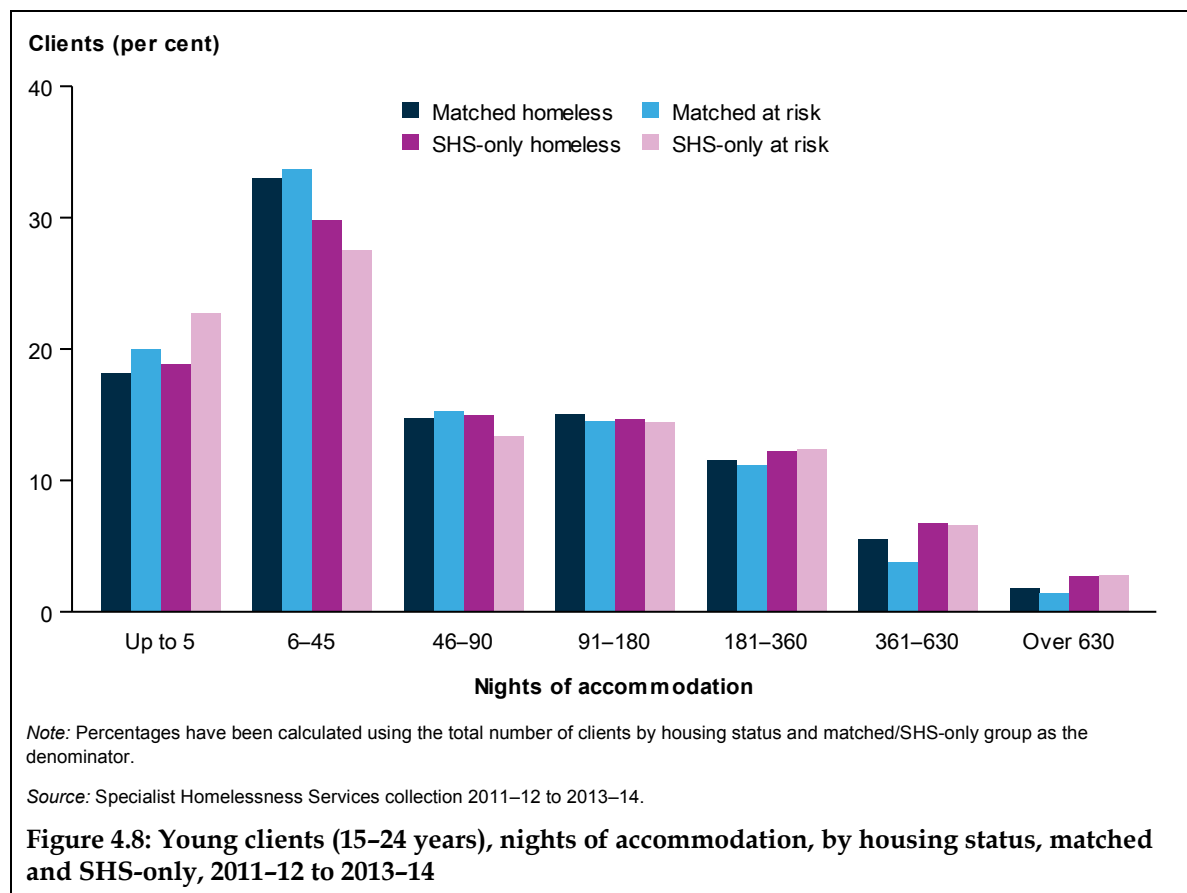
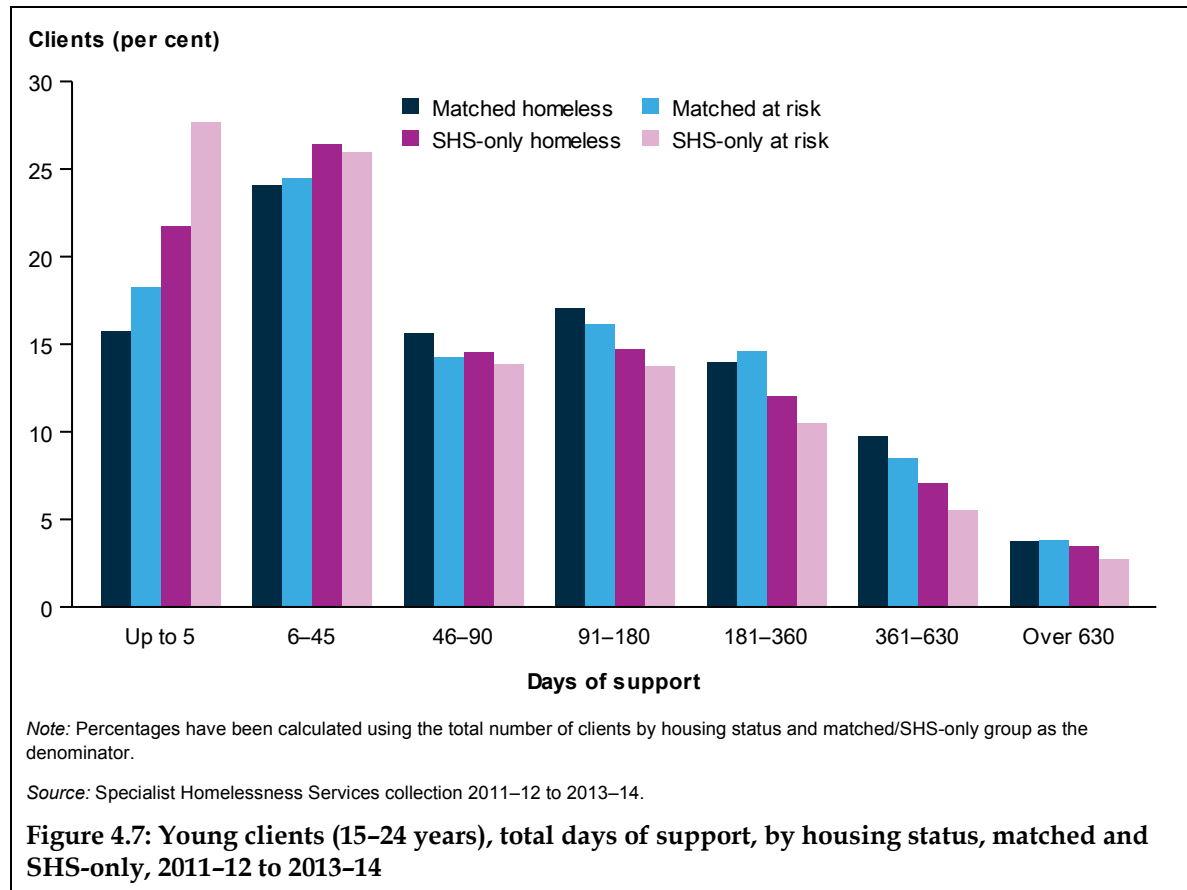
Notes

1. Support periods, days and nights are calculated using a start date of 1 July 2011–12 and an end date of 30 June 2013–14.
2. 'Duration' is calculated as the number of days between the first day of the first support period and the last day of the last support period within the study period. Includes only clients with closed support at the end of the study period.
3. 'All clients' includes 'not stated'.

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

Compared with young SHS-only clients, young people in the matched group:

- received a greater average number of support periods over the study period (3.7 compared with 2.3), with homeless young clients in the matched group receiving the highest number of all (an average of 3.9 support periods)
- received the greatest total days of support on average (147.6 compared with 113.9 days), and the greatest average number of support days (150.5) (Figure 4.7)
- were less likely to receive just 1 period of support (36% compared with 54%)
- were much more likely to receive 5 or more support periods (25% compared with 10%)
- had a greater number (3.7 compared with 2.3) of shorter support periods (39 days on average compared with 50 days)
- were more likely to be accommodated (54% compared with 38%), but for fewer nights on average (101.2 compared with 119.1 nights) (Figure 4.8).



4.5 What were the outcomes for clients?

Why did their AOD treatment end?

Overall, AOD treatment ended under expected conditions for young clients. (See Glossary for details of expected completion). Although, there were more clients in AOD treatment only whose treatment completion was expected compared with matched clients (76% compared with 68%).

However, by contrast, young clients in the matched group were more likely than the AODT-only group to have their treatment end:

- unexpectedly (37% compared with 22%)
- due to an administrative change (11% compared with 5%)
- due to imprisonment (3% compared with 1%).

What were their SHS housing circumstances and outcomes following support?

Specialist homelessness agencies assist young people to transition to safe and sustainable housing options.

A large proportion (39%) of young clients in the matched group was still being supported by specialist homelessness agencies at the end of the study period. The analysis of housing outcomes required a client to have closed support period, and consequently just 6 in 10 clients (61%) were included in the analysis. By comparison, nearly 8 in 10 (76%) of young clients in the SHS-only group were not in support at the end of the study period and their housing outcomes were assessed.

Over half (57%) of the young clients in the matched group presented to SHS agencies homeless (see Table 4.3). Further, young clients in the matched group were more likely to be homeless, both at the beginning and the end of their support, than young clients in the SHS-only group. They were also the most likely of the cohorts examined to be 'couch surfing' (27%).

Compared with those in the SHS-only group, on presentation young clients in the matched group:

- were more likely to be 'sleeping rough' (14% compared with 9%)
- experienced similar rates of living in short-term accommodation (17% compared with 16%), 'couch surfing' (27% compared with 26%) and living in social housing (8% compared with 9%)
- were less likely to be privately renting or to own their home (26% compared with 37%).

Following support, there were observable improvements in housing outcomes across both the young clients in the matched group and the SHS-only group, but compared with SHS-only clients, young clients in the matched group were still:

- more likely to be homeless, with just under half ending support in some kind of homelessness (49% compared with 42%)
- more likely to be housed in short-term or emergency accommodation (22% compared with 19%)

- less likely to be housed in private rental or owned accommodation (29% compared with 41%).

Table 4.3: Young clients (15–24 years), by housing status at the beginning and end of support, matched and SHS-only, 2011–12 to 2013–2014

Housing circumstance	Matched young clients		SHS-only young clients	
	Start	End	Start	End
No shelter or improvised/inadequate dwelling	13.5	7.8	9.1	5.1
Short-term emergency accommodation	16.8	22.0	16.5	18.8
House, townhouse or flat—couch surfer or with no tenure	26.9	19.4	26.1	17.9
<i>Total homeless</i>	<i>57.2</i>	<i>49.3</i>	<i>51.6</i>	<i>41.8</i>
Public or community housing—renter or rent free	8.5	15.0	9.4	15.8
Private or other housing—renter, rent free or owner	26.4	28.7	37.1	41.1
Institutional settings	7.9	7.1	1.8	1.3
<i>Total at risk of homelessness</i>	<i>42.8</i>	<i>50.7</i>	<i>48.4</i>	<i>58.2</i>

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

Figure 4.9 shows housing outcomes following support (y-axis) based on the housing circumstances of the young client when support commenced (x-axis).

Young clients beginning support homeless, shown in the upper panel, were either supported into different forms of housing (purple shades), or, despite the efforts of SHS agencies, remained homeless (blue shades).

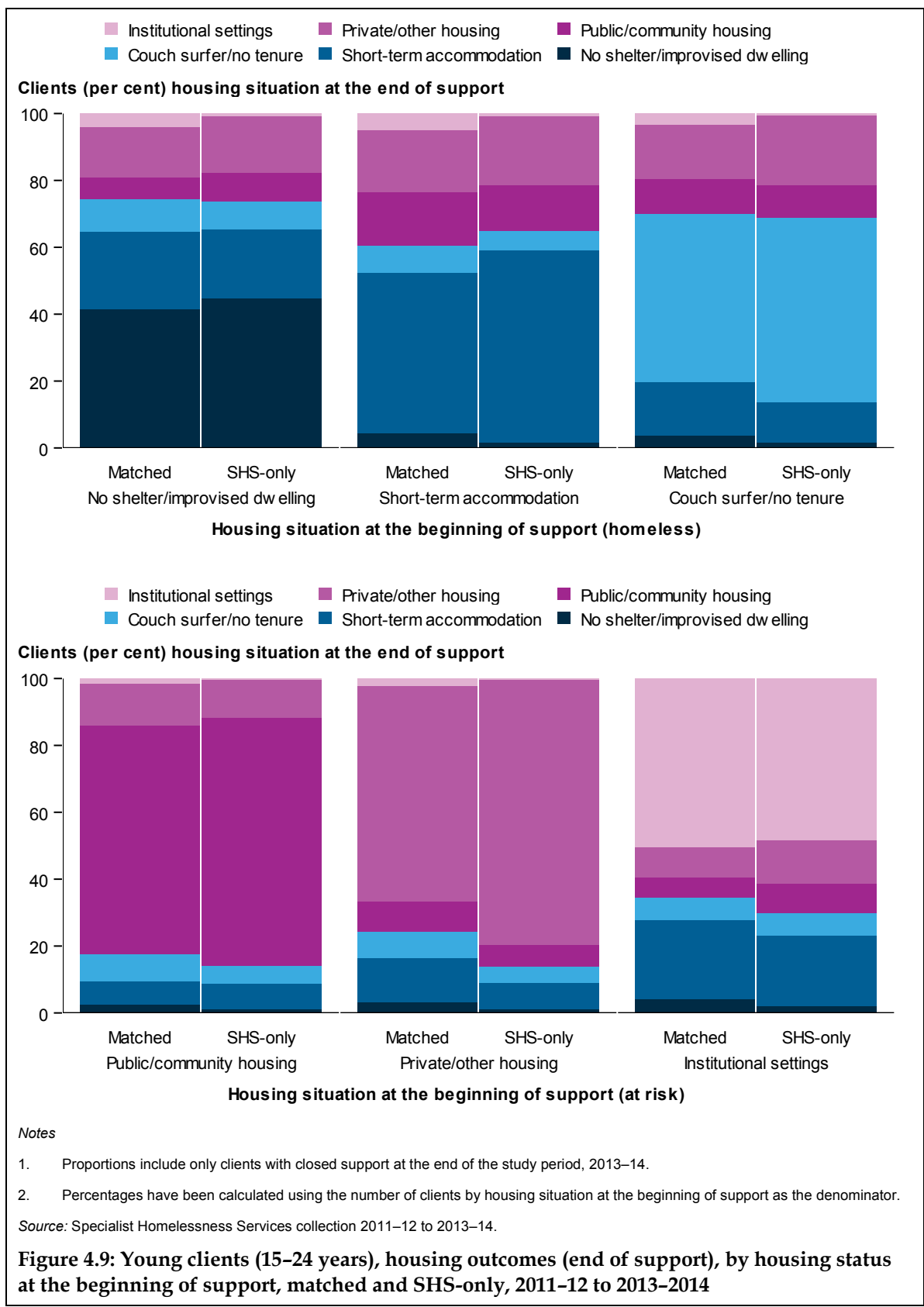
When comparing young matched clients who began support homeless (upper panel) with those in the SHS-only group, young matched clients were:

- just as likely to remain homeless when starting support either sleeping rough or couch surfing.
- more likely to be living in an institution following support.

Compared with those in the SHS-only group, young matched clients who began support housed (lower panel) were:

- less likely to remain housed in private and public and community housing following support
- more likely to become homeless when support was sought after being in an institution.

Even at this young age, the co-occurrence of drug and alcohol issues with homelessness is emerging, with young clients in the matched group generally ending support with poorer housing outcomes. Young clients beginning support in institutional settings were the most likely to exit into homelessness. Exiting homelessness was more difficult for young matched clients than for any other cohort, suggesting that they have fewer resources and networks to rely on in troubled times.



4.6 What does this tell us?

In general, young clients who have experienced both substance misuse and homelessness before the age of 25 appear more vulnerable than AODT-only or SHS-only clients at this age.

Young matched clients were the most likely, of all cohorts, to present to an SHS agency homeless (54%). These clients were also the most likely of the cohorts examined to be 'couch surfing' (27%) and to be unemployed (55%).

Around 1 in 3 (31%) of young matched clients were Indigenous, much higher than for either AODT-only (16%) or SHS-only clients (23%).

Eight in 10 (80%) of young matched clients aged 15-17 were alone when they approached specialist homelessness agencies, much higher than for SHS-only clients of this age (69%).

Young clients across all groups were more likely to receive treatment for cannabis than for any other drug – slightly more likely for matched clients (52%), than for AODT-only clients (50%). This was the only cohort for which alcohol was not the most commonly reported drug of concern. While most clients who are diverted from the justice system are in the age bracket 15-24, and receive treatment for cannabis (AIHW 2016), young matched clients were less likely to be diverted, compared with young AODT-only clients (26% and 45%, respectively).

These differences are possibly related to more matched clients than AODT-only clients having multiple drugs of concern (18% compared with 7%), and therefore, a greater number of treatment episodes (2.1 compared with 1.4 on average) than AODT-only clients.

Achieving a stable housing outcome was more difficult for matched young clients than for any other cohort, with about 1 in 2 (49%) homeless at the end of their SHS support.

5 Older clients 50 years and over

Key Findings

Matched clients aged 50 and over:

- were the most likely of all cohorts analysed to be male (68%) and living alone (69%)
- were the most likely of all cohorts to receive treatment for alcohol (68%), and the least likely to receive treatment for any other drug; less than 10% for any other drug of concern
- received many more days of AOD treatment and SHS support, on average, compared with AODT-only and SHS-only clients (160 days in AOD treatment and 126 SHS support days for matched clients aged 50 and over, compared with 108 days for those receiving AOD treatment only and 81 for those receiving SHS assistance only)
- were the least likely of all cohorts to receive accommodation (44%) and spent the fewest nights accommodated (88 nights on average).

Given that large proportions of older clients were living alone and receiving fewer nights' accommodation, it is not surprising they were more likely than SHS-only clients to end support homeless (39% compared with 30%).

As Australia's population ages, it is expected that the number of ageing Australians at risk of homelessness and of drug and alcohol misuse will grow. In 2008, the Australian Government identified homelessness among older Australians as a growing issue, highlighting that they often have complex issues, including mental illness resulting from problematic drug/alcohol use (FaHCSIA 2008). Results from the SHSC appear to confirm this, with the number of older clients receiving SHS increasing by 25% since the collection began in 2011–12.

Similarly, drug and alcohol issues are expected to increase in older Australians in 2 ways: firstly, as a consequence of the ageing population overall, and secondly, because 'Baby Boomers' have had higher rates of drug and alcohol use compared with previous generations, it is expected they will begin to experience associated issues as they age (Nicholas & Roche 2014).

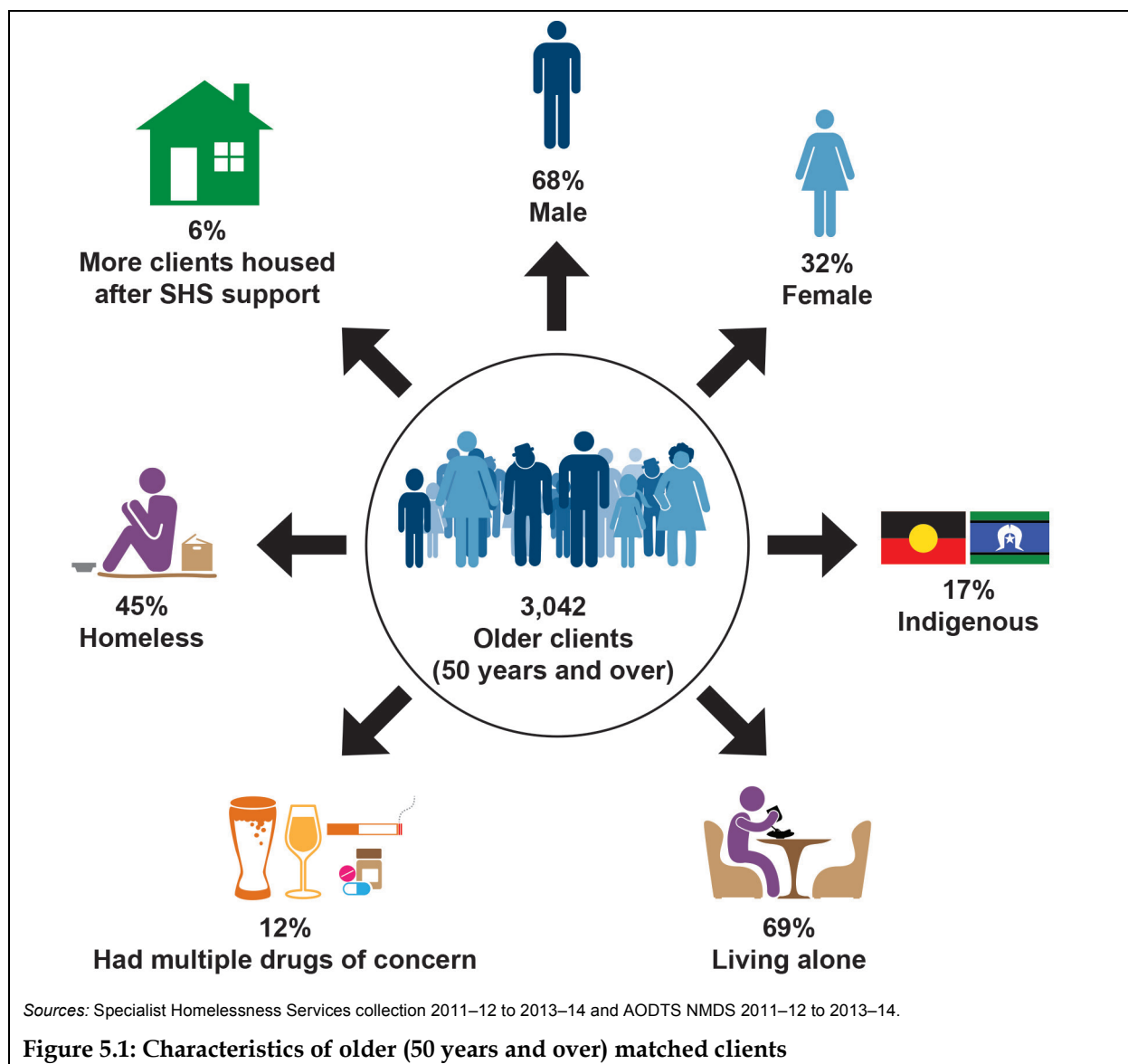
In the last 5 years, an ageing cohort of Australians receiving drug and alcohol treatment does appear to be emerging, with the proportion of treatment episodes for clients aged over 40 increasing from 26% in 2005–06 to 32% in 2014–15 (AIHW 2016).

As with younger people, older Australians who face both homelessness and drug/alcohol issues may be particularly vulnerable and experience poorer overall outcomes. With the numbers of older clients increasing in both collections it is important to understand the extent to which these issues overlap, to ensure an appropriate service and policy response.

Box 5.1: Identifying 'older' clients

It is difficult to put a fixed age on what constitutes 'older' – as Petersen and others (2014) highlight, it is particularly problematic given that the ageing process may vary from person to person depending on their life experiences. Petersen and others used the age range 55 years and over to ensure that people facing premature ageing are appropriately captured. In this report, the age range 50 and over has been used to attempt to capture people who may be ageing prematurely, but to also include the 'Baby Boomer' cohort. (See Glossary for definition.)

There were 3,042 clients aged 50 and over identified in the linked data set for the years 2011–12 to 2013–14 (Figure 5.1).



5.1 Client characteristics

Older clients in the matched group represent just 8% of the overall matched cohort. This was a smaller proportion of older clients than in either the SHS-only (12%) or AODT-only (14%) groups. Despite this, demographically they were quite different to clients receiving only 1 service.

The proportion of older male and female clients in the matched group differed from both the SHSC and AODTS collections. Just over two-thirds (68%) of older clients in the matched group were male, higher than the proportion in either the SHS-only (45%) and the AODT-only (60%) groups.

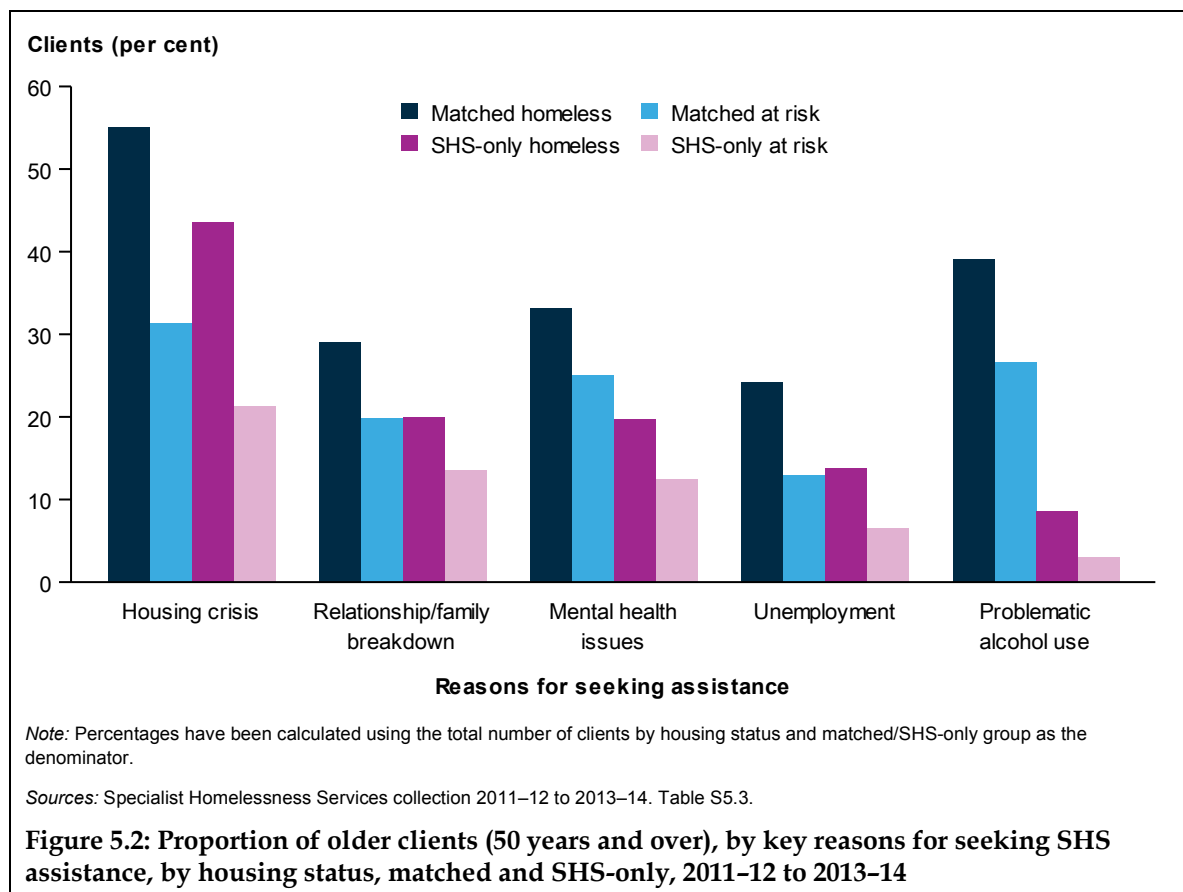
Just under half (45%) of the older clients in the matched group were homeless upon presentation to an SHS agency, higher than the rate of homelessness for older SHS-only clients (33%).

Older clients in the matched group were also more likely than those in either the SHS-only or AODT-only groups to be Indigenous. Around 17% of older clients in the matched group were Indigenous, compared with 13% in the SHS-only and just 6% in the AODT-only groups.

5.2 Why did these clients seek SHS assistance?

There are many drivers of homelessness for older persons. Homelessness NSW suggests that a significant lack of affordable housing, a shortage of public housing as well as a lack of appropriate care options for older people with complex needs, have compounded existing housing issues for older people (Homelessness Australia 2016). Those not yet old enough to access superannuation, or the age pension, may find themselves struggling to meet their housing costs.

The main reason older clients, in both the matched and SHS-only groups, approached SHS agencies for assistance was distinct from the reasons given by other cohorts. Housing crisis and financial difficulties were the main reasons for about a third of older clients (33% of matched clients compared with 35% of SHS-only).



When all reasons were considered (see Figure 5.2 and Table S5.3), older clients in the matched group, when compared with those older clients in the SHS-only group, were:

- more likely to seek assistance for ‘accommodation’ reasons (62% compared with 48%)
- more likely to seek assistance for a ‘housing crisis’ (42% compared with 27%)
- more likely to seek assistance for health-related services (56% compared with 29%), such as mental health services (28% compared with 14%) or medical services (27% compared with 19%)
- more likely to seek assistance because of employment difficulties (8% compared with 4%) or unemployment (17% compared with 8%)
- more than twice as likely to be itinerant (13% compared with 6%)
- more likely to seek assistance for problematic alcohol use (31% compared with 5%)
- less likely to seek assistance for family and domestic violence (18% compared with 23%), but were more likely to report relationship/family breakdown (23% compared with 15%) as a reason for seeking assistance.

These reasons seem to suggest that the breakdown of a relationship is a trigger for seeking assistance, as well as problematic alcohol, rather than other drug/substance use issues. The breakdown of a relationship makes older clients particularly vulnerable to homelessness, due to a significant reduction in income.

5.3 Which drugs were they using?

For each drug of concern there were higher proportions of older clients in the matched group than in the AODT-only group (see Table 5.1). Older clients in the matched group were also much more likely to receive treatment for multiple drugs than older clients in the AODT-only group (12% compared with 3%).

Alcohol was the drug older clients (in both the matched and AODT-only groups) were most likely to receive treatment for (66% compared with 60%), compared with other cohorts, older clients were much less likely to receive treatment for any other drug. No more than 10 per cent of clients in any of the older client groups received treatment for a drug of concern that was not alcohol (see Table 5.1).

Table 5.1: Older clients (50 years and over), by principal drug of concern, matched and AODT-only, 2012–13 to 2013–14

	Matched older clients (50 years and over)			AODT-only (%)
	Homeless (%)	At risk (%)	All matched (%)	
Alcohol	69.9	65.5	67.5	59.1
Cannabis	9.8	9.6	9.5	8.6
Amphetamine	5.7	6.4	5.9	2.9
Heroin	8.5	7.0	7.7	3.4
Pharmaceuticals	9.0	9.8	9.2	7.3
Other drugs	4.3	5.8	5.3	5.2
Clients with multiple PDOCs	15.4	9.4	11.6	2.9
Average number of PDOCs per client	1.1	1.11	1.1	1.04
Number of clients	1,150	1,412	3,042	21,015
<i>Number of reported PDOCs</i>	<i>1,233</i>	<i>1,471</i>	<i>3,193</i>	<i>18,189</i>

5.4 What services and support did they receive?

AOD Treatment type and setting

Older clients had similar patterns of treatment type, regardless of whether they were in the matched group or AODT-only group, with counselling being the most commonly provided treatment type for all older clients (see Table S5.4).

However, when compared with older clients in the AODT-only group, older clients in the matched group were:

- more likely to receive counselling (50% compared with 41%) (see Table S5.4)
- more likely to receive withdrawal (31% compared with 21%)
- slightly less likely to receive information and education only (5% compared with 6%).

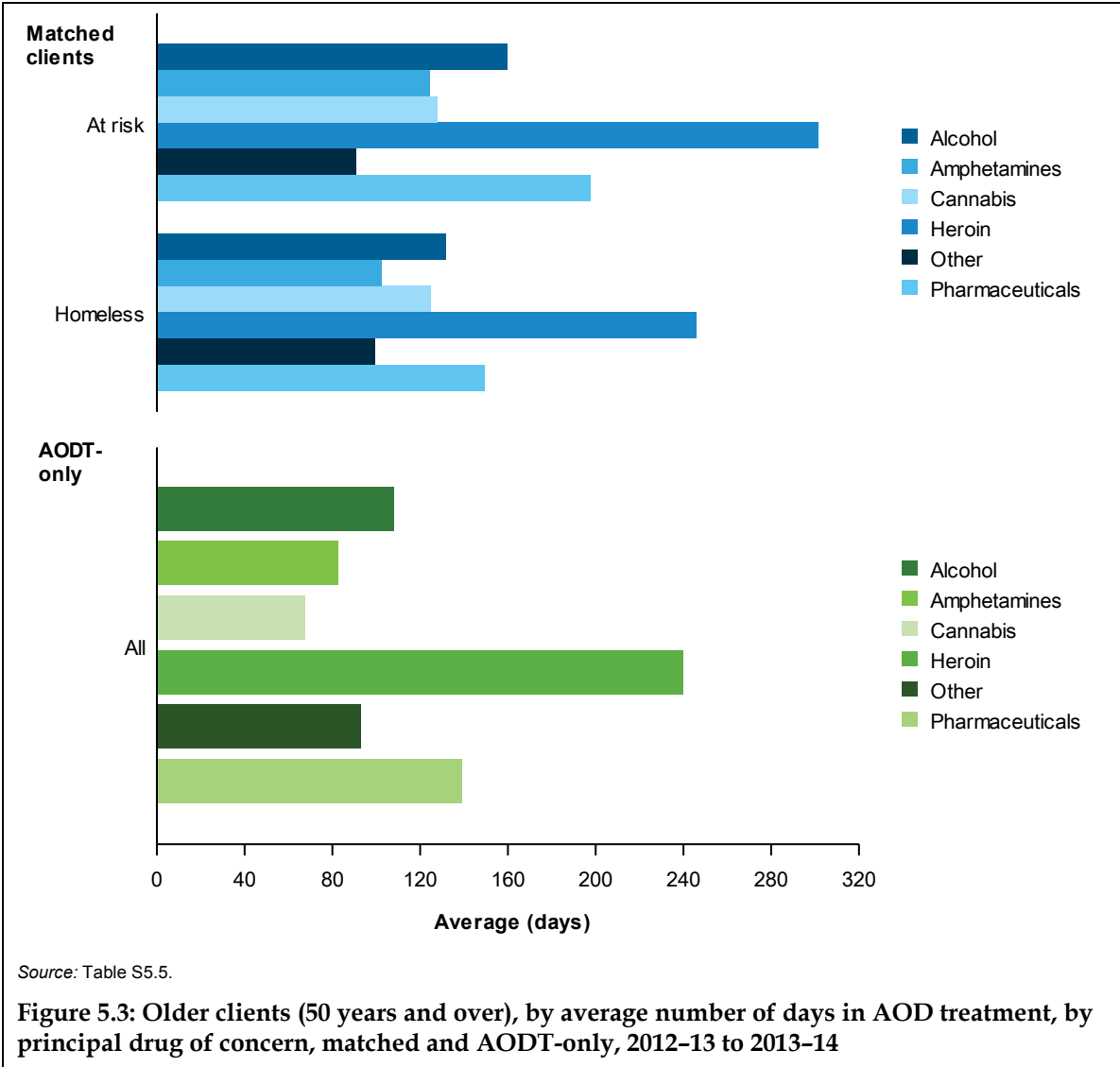
How long did AOD treatment last?

On average, older clients in the matched group spent longer in treatment than clients in the AODT-only group – 161 days compared with 108 days. For clients in both services there was some difference in the average treatment duration, with those who presented at risk of

homelessness spending longer in treatment than those who presented as already homeless (174 days compared with 148) (see Figure 5.3).

When compared with older clients in the AODT-only group, older clients in the matched group spent more days, on average, in treatment for:

- heroin (268 days compared with 240)
- pharmaceuticals (165 days compared with 139).

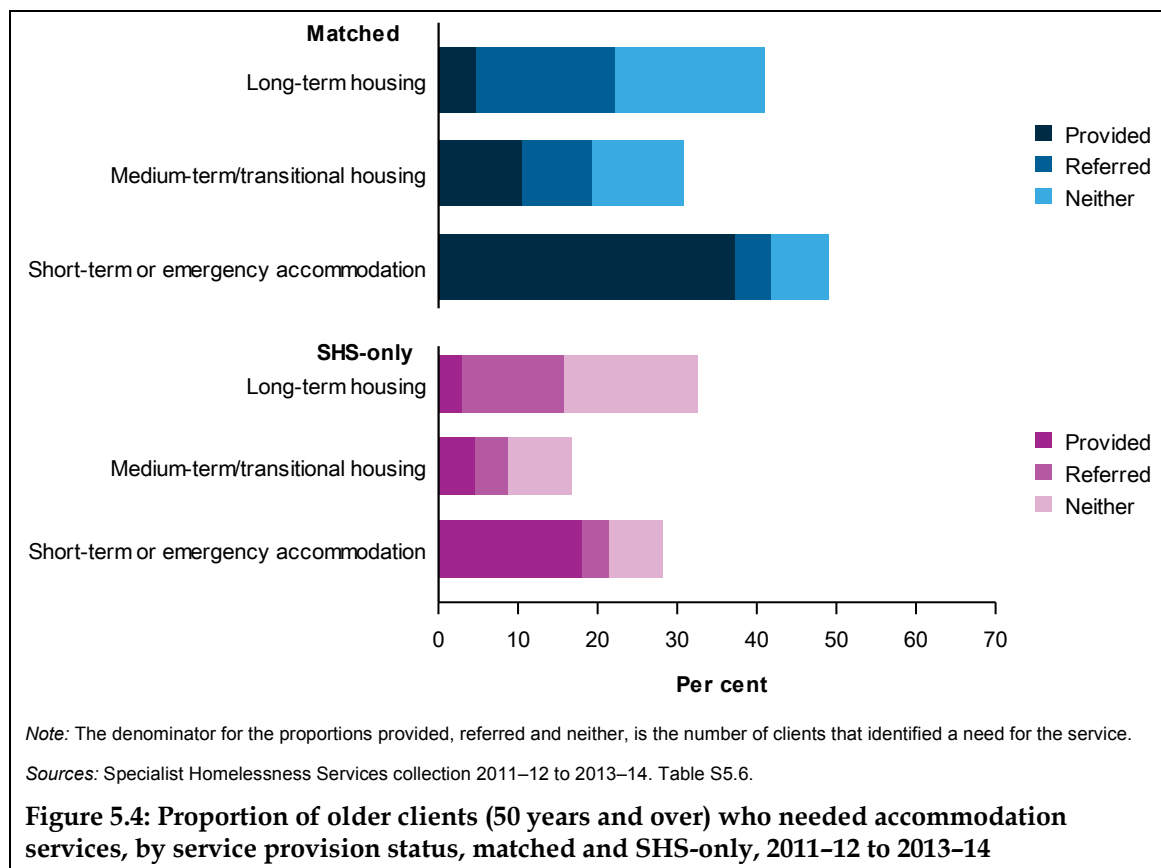


Source: Table S5.5.

Figure 5.3: Older clients (50 years and over), by average number of days in AOD treatment, by principal drug of concern, matched and AODT-only, 2012-13 to 2013-14

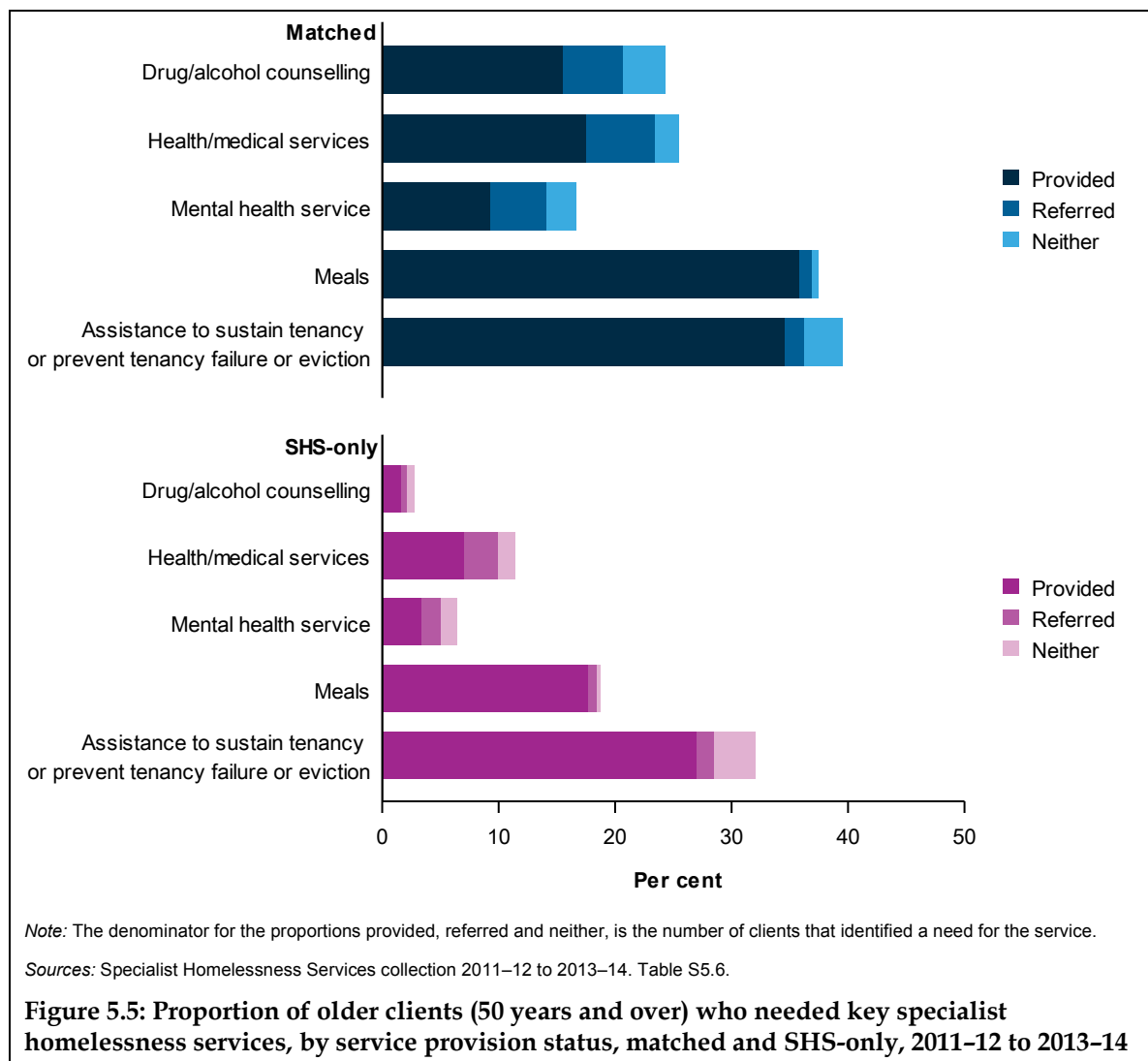
What SHS services did they need?

Compared with other cohorts, older clients in both matched and SHS-only groups were the least likely to need accommodation (66% and 47%, respectively). Where accommodation was needed, clients in the matched group were far more likely to need short-term or emergency accommodation (49%) compared with the SHS-only group (28%) (Figure 5.4).



When compared with older clients in the SHS-only group (Figure 5.5), older clients in the matched group were:

- more likely to need accommodation services (66% compared with 47%) and more likely to receive that service (68% compared with 48%)
- more likely to need mental health services (17% compared with 6%) and to receive that service (56% compared with 53%)
- eight times more likely to need drug and alcohol services (24% compared with 3%) and to receive that service (64% compared with 59%)
- twice as likely to need assistance to obtain or maintain a government pension/allowance (16% compared with 8%)
- around twice as likely to need basic assistance such as a meal (37% compared with 19%) or laundry facilities (33% compared with 15%)
- more likely to need assistance because of family and relationship breakdown (16% compared with 11%).



How much SHS support did these clients receive?

The support received by older clients in the matched group was distinct from those in SHS-only, particularly when the housing situation was examined.

Older clients in the matched group received more recurrent support over a longer duration than older clients in the SHS-only group (Table 5.2).

Table 5.2: SHS support characteristics of older clients 50 years and over, by housing status, matched and SHS-only, 2011–12 to 2013–14

	Matched older clients			SHS-only older clients		
	All	Homeless	At risk	All	Homeless	At risk
Average support periods	3.5	3.9	2.9	2.0	2.3	1.9
Average Support days	126.2	144.5	111.5	81.0	100.0	75.6
Support periods (% of clients)						
1 support period	39	34	45	59	54	61
5–9 support periods	15	19	12	6	8	5
10 or more periods	6	7	4	1	2	1
Support days (% of clients)						
5 days or fewer	23	19	26	37	30	39
180–630 days	19	22	17	11	14	10
Over 630 days	4	5	3	2	3	2
Active support (average days per support period)	36	37	38	40	43	40
Duration ⁽²⁾ (% of clients)						
5 days or fewer	24	19	26	36	31	38
180–630 days	26	29	23	17	19	16
Over 630 days	12	14	10	5	6	5
Clients receiving accommodation (%)	44	60	34	23	42	15
Accommodation (average nights)	87.9	90.1	83.3	105.6	101.1	116.4

Notes

1. Support periods, days and nights are calculated using a start date of 1 July 2011–12 and an end date of 30 June 2013–14.
2. 'Duration' is calculated as the number of days between the first day of the first support period and the last day of the last support period within the study period. Includes only clients with closed support at the end of the study period.
3. 'All clients' includes 'not stated'.

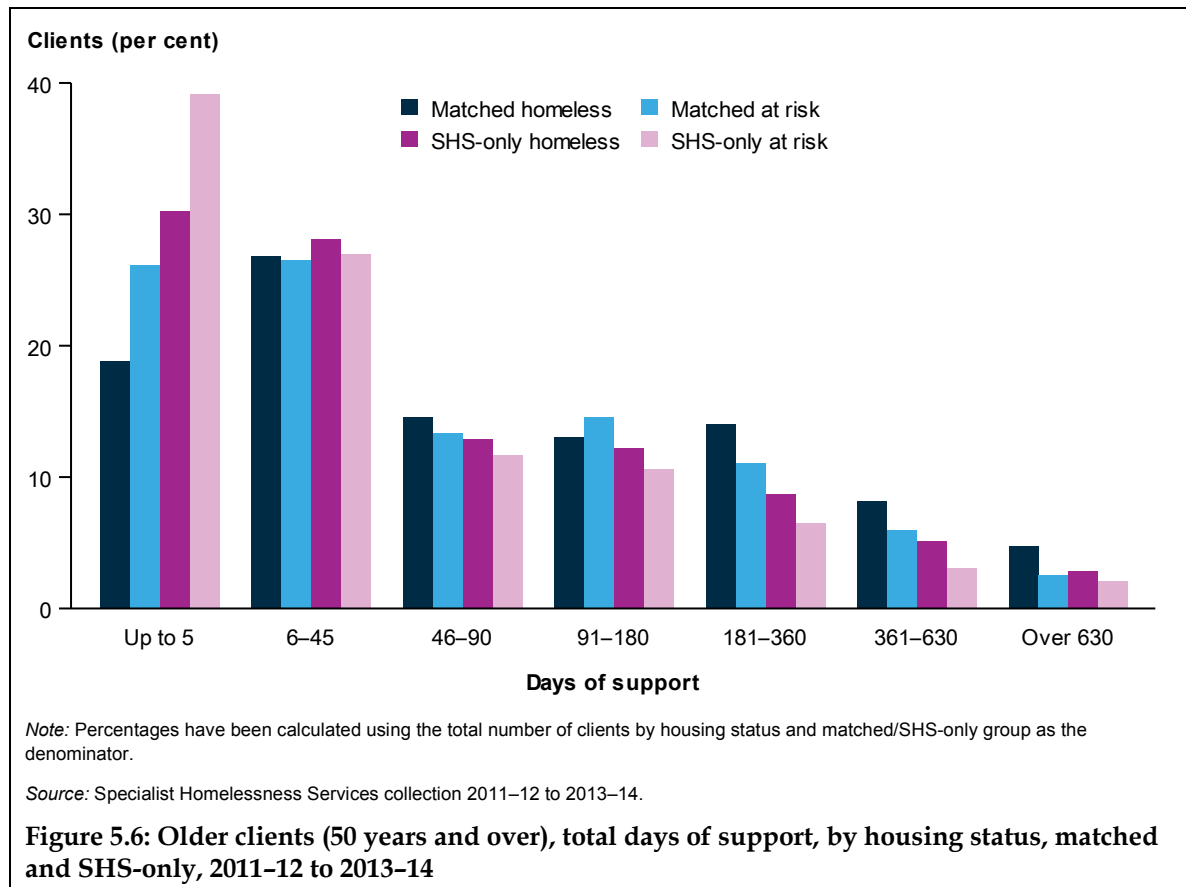
Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

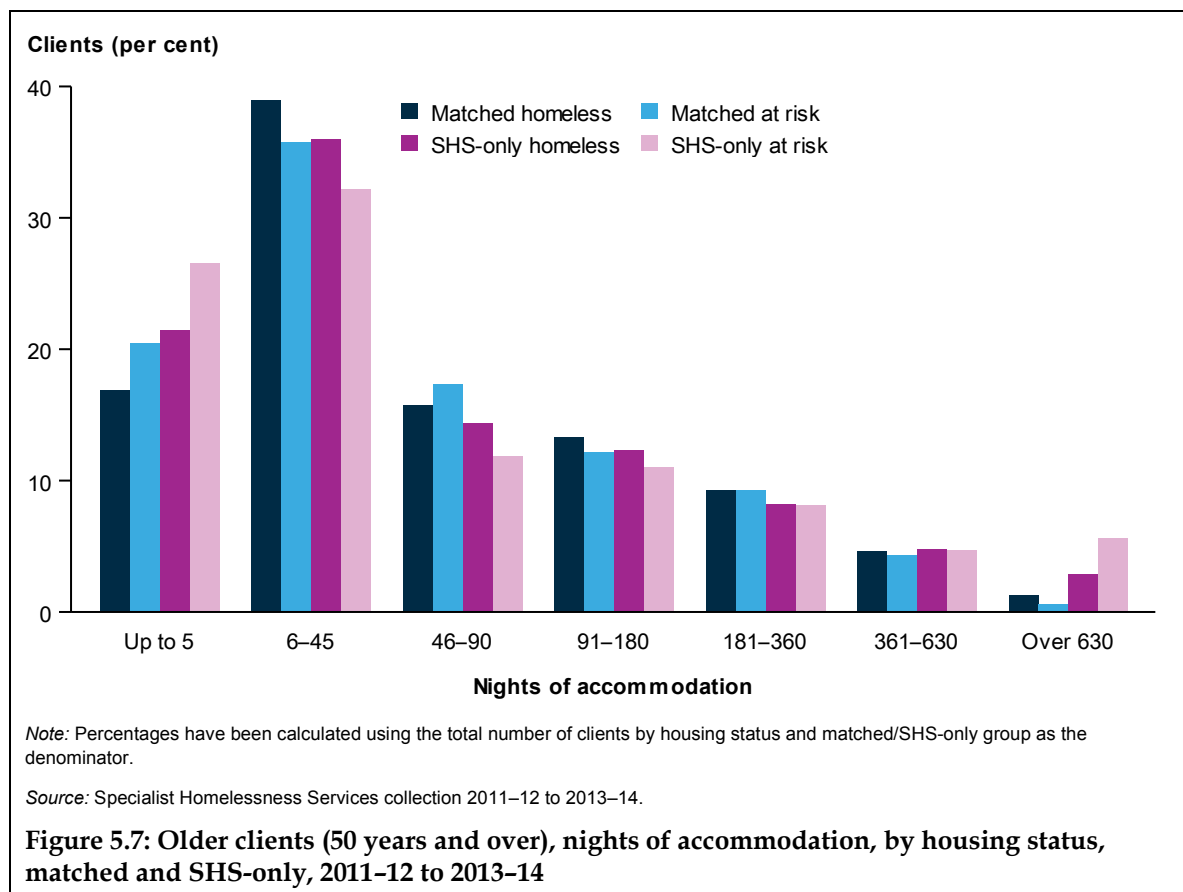
Compared with older SHS-only clients, older clients in the matched group:

- received a greater number of support periods over the study period (3.5 compared with 2.0 on average), with homeless older clients in the matched group receiving the highest of all (an average of 3.9 support periods)
- received the greatest total days of support (126.2 compared with just 81.0 on average). Older homeless clients in the matched group also received the greatest average number of support days (144.5)
- were less likely to receive just 1 period of support (39% compared with 59%)
- were 3 times as likely to receive 5 or more support periods (21% compared with 7%)

- were more likely to require more than 180 total days of support over the study period (22% compared with 13%)
- had shorter active support periods, averaging 36 days (compared with 40 days on average)
- were more likely to be accommodated (44% compared with 23%) – but for fewer nights on average (87.9 compared with 105.6).

Figures 5.6 and 5.7 illustrate the different patterns of support days and accommodation nights, respectively, for matched and SHS-only older clients (see Glossary for details on calculating total days of support).





5.5 What are the outcomes for clients?

Why did their AOD treatment end?

For the majority of older clients, treatment ended under expected conditions (see Table 5.3). As with other cohorts, older clients in the AODT-only group were more likely than matched clients to complete treatment in expected conditions, although the difference between matched and AODT-only clients was smaller than in any other cohort (75% and 72% respectively).

Older clients in the matched cohort were more likely than older AODT-only clients to have their treatment end:

- unexpectedly (29% compared with 20%)
- due to an administrative change (13% compared with 8%).

Of all matched clients, older matched clients were more likely than any other cohort to have treatment end under expected conditions, and the least likely to end treatment under unexpected conditions.

What were their SHS housing circumstances and outcomes following support?

Compared with older clients in the SHS-only group, older clients in the matched group were more likely to be still receiving support at the end of the 3-year study (31% compared with

19%, respectively) and therefore their housing outcomes could not be included in the analysis. (See Glossary for details).

Just under half (45%) of the older clients in the matched group presented to an SHS agency homeless (see Table 5.3). This was higher than the proportion of older clients in the SHS-only group, for which one-third (35%) of clients presented as homeless.

Compared with older clients in the SHS-only group, older clients in the matched group on presentation were:

- more likely to be ‘rough sleeping’ (19% compared with 13%) or living in short-term or emergency accommodation (17% compared with 13%)
- less likely to be living in private rental/own their home (28% compared with 44%)
- over 3 times more likely to be in an institutional setting (11% compared with 3%).

Following support, improvements in housing outcomes were achieved across both groups, yet older clients in the matched group were still more likely to be homeless at the end of support (39% compared with 30% in the AODTS group). There was almost a halving of ‘rough sleeping’ among the matched group, falling to 10% following support, and an increase in those in social housing tenancies, rising from 16% to 26%.

Table 5.3: Older clients (50 years and over), by housing status at the beginning and end of support, matched and SHS-only, 2011–12 to 2013–2014

Housing circumstance	Matched older clients		SHS-only older clients	
	Start	End	Start	End
No shelter or improvised/inadequate dwelling	18.9	10.2	13.1	8.3
Short-term or emergency accommodation	16.8	22.4	13.1	14.8
House, townhouse or flat—couch surfer or with no tenure	9.3	6.6	9.0	6.8
<i>Total homeless</i>	<i>45.0</i>	<i>39.2</i>	<i>35.2</i>	<i>29.9</i>
Public or community housing—renter or rent free	16.2	26.0	18.0	25.2
Private or other housing—renter, rent free or owner	27.7	27.9	43.6	42.5
Institutional settings	11.2	6.9	3.2	2.4
<i>Total at risk of homelessness</i>	<i>55.1</i>	<i>60.8</i>	<i>64.8</i>	<i>70.1</i>

Source: Specialist Homelessness Services collection 2011–12 to 2013–14.

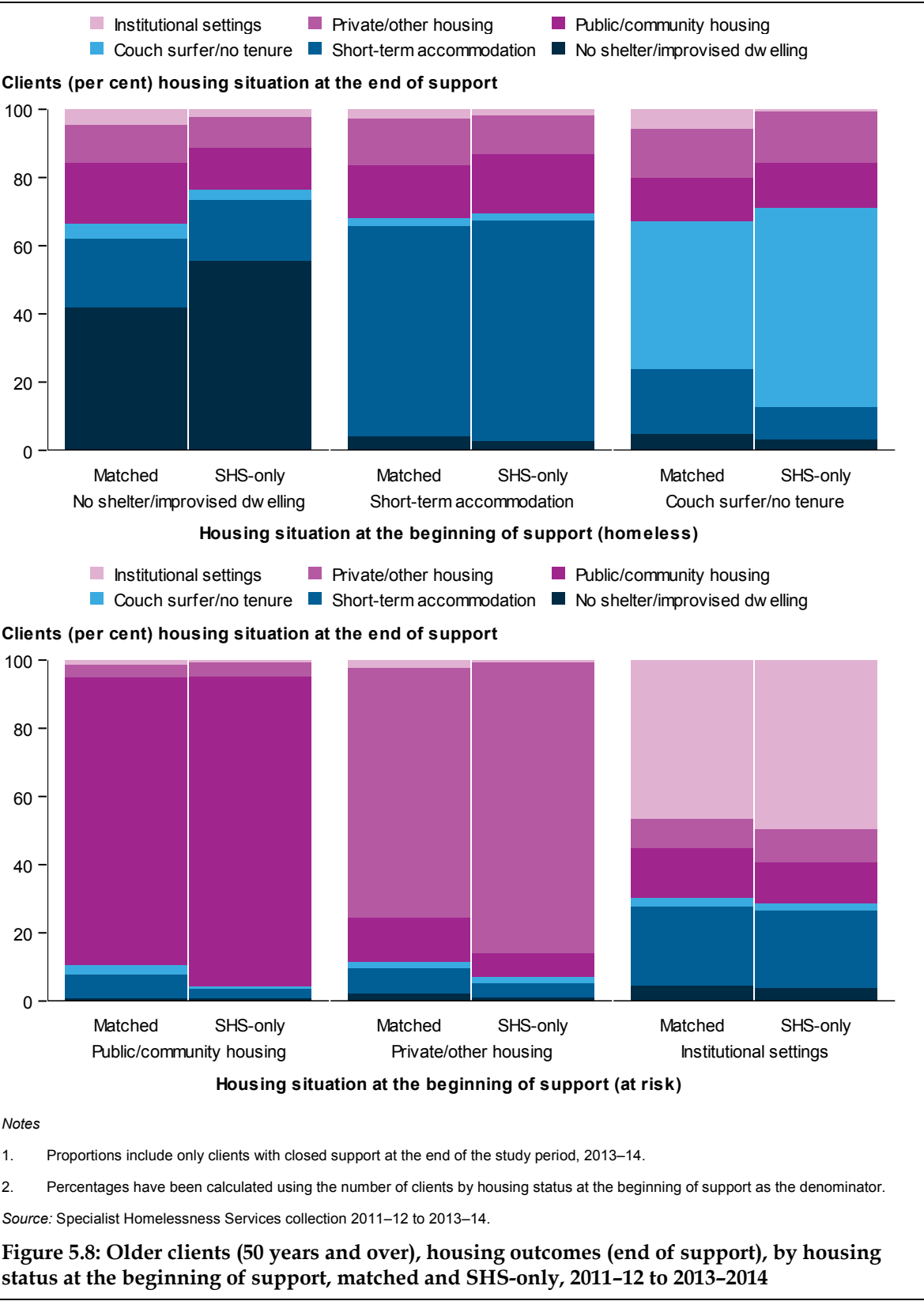
At the end of support more clients in both groups ended support housed, however, the ability to exit homelessness was not the same for all clients. Figure 5.8 illustrates this by tracking clients housing circumstances at the end of support (y-axis), based on their housing situation at the beginning of support (x-axis).

Comparing matched older clients who began support homeless with those in the SHS-only group, they were:

- more likely to be rough sleeping prior to support (18.9% compared with 13.1%)
- more likely to be living in institutions following support (6.9% compared with 2.4%).

For those older clients beginning support housed, specialist homelessness agencies were able to assist the vast majority of clients to remain housed (see Figure 5.8, lower panel). Matched older clients were less likely to remain in private and public and community housing than those in the SHS-only group.

The financial difficulties experienced by older matched clients, compounded by low employment rates and lack of family support (with 69% living alone), suggest possible reasons why these clients were far less likely to own or be living in private rental compared with SHS-only older clients.



5.6 What does this tell us?

The matched older cohort had the highest proportion of male clients (68%) compared with all other cohorts, and these clients were the most likely to live alone (69%).

Older clients in the matched group were younger, on average, and more likely to be living alone than older clients in AODT-only and SHS-only groups (54 years compared with 56 and 57, respectively, and 69% living alone compared with 56% SHS-only). More older matched clients were Indigenous than in the AODT-only and SHS-only groups (17%, compared with 6% and 13%, respectively).

Alcohol was the most common drug for which all older clients received treatment, although more common for matched clients (68%) than for AODT-only clients (59%). For each other drug, less than 10 per cent of clients in both the matched and AODT-only client groups received treatment for that drug.

Matched older clients were almost twice as likely as SHS-only clients to receive accommodation (44%, compared with 23%). Most of this was provided as short-term or emergency accommodation (matched 53%, compared with SHS-only 35%). However, on average, older matched clients were accommodated for fewer nights than older SHS-only clients (88 nights compared with 106 nights).

Matched older clients received many more days of AOD treatment and SHS support, on average, compared with AODT-only and SHS-only clients (receiving 160 days of AOD treatment and 126 SHS support days, compared with 108 treatment days received by AODT-only clients and 81 SHS support days received by SHS-only clients).

There were more older matched clients who began and ended their support homeless (45% and 39%), compared with older SHS-only clients (35% and 30%). However, older SHS-only clients who began support homeless had poorer housing outcomes. For example, a higher proportion of older SHS-only clients who began support sleeping rough were still sleeping rough when their support ended (56%, compared with 42% of older matched clients).

Appendix A: Data linkage, data gaps and limitations

Linkage

The AIHW is an accredited Commonwealth Integrating Authority. As an Integrating Authority the AIHW is responsible for ensuring data are managed and governed soundly and, in compliance with the *Privacy Act 1988*, ensuring data are kept and accessed securely. Further information on data linkage at the AIHW can be found at <<http://www.aihw.gov.au/data-linking/>>.

For this study, data from the SHSC and the AODTS NMDS were linked, with the dual aims of analysing the characteristics and circumstances of clients and of identifying vulnerable groups that access both these service types. SHSC data from July 2011 to June 2014 were linked to AODTS NMDS data covering July 2012 to June 2014.

Linkage was performed using a statistical linkage key, referred to as an SLK-581. The SLK-581 uses components of a person's first and last name, date of birth, and their sex to create an identifier. Further common information, specifically the postcode and state/territory of the client was also used to determine matches across the data sets. This method has been shown to be highly effective, with linkage quality that is comparable to name-based linkage strategies (AIHW 2011).

Table A1.1 presents the number of records successfully linked for this study. Twenty-one per cent of AODTS clients between 2012–13 and 2013–14 were able to be matched to a person who was an SHS client during 2011–12 and 2013–14.

Table A1.1: Summary of linked data

	Clients over study period	Clients identified and linked
AODTS NMDS	191,173	39,529 (21%)
SHSC	489,562	39,529 (8%)

Sources: AIHW Specialist Homelessness Services collection 1 July 2011–30 June 2014; AIHW AODTS NMDS 1 July 2012–30 June 2014.

Scope and coverage

While both the SHSC and AODTS NMDS cover a wide range of people experiencing issues with either homelessness, or with drug and alcohol use, they don't include all people who may be experiencing either of these issues within Australia. Both collections only capture those people who seek, and are provided with, services. Therefore, the study excluded people who were homeless, at-risk of homelessness, or experiencing drug and alcohol issues and did not receive SHS or AOD treatment during the reporting period covered for this report.

For AODTS specifically, there is a range of different services that are not included in the collection, including agencies that:

- do not receive any public funding
- primarily provide accommodation or overnight stays as their main function (for example, half-way houses and sobering-up shelters)

- are based in prisons or other correctional institutions
- provide services primarily concerned with health promotion (for example, needle and syringe programs)
- are located in acute care or psychiatric hospitals and provide treatment only to admitted patients.

Similarly, Aboriginal and Torres Strait Islander people are not fully represented in the AODTS NMDS. Some Indigenous Australians are captured via the *Online Services Report*, which collects information from Australian Government funded primary health care services and substance-use services specifically aimed at Indigenous Australians. For further information on the scope of the AODTS NMDS, see <[http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/201415/aodts-nmds/](http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/201415/aodts-nmnds/)>; and for further information on the scope of SHSC, see <<http://www.aihw.gov.au/homelessness/specialist-homelessness-services-2014-15/technical-information-glossary/>>.

Data quality and Indigenous Australians

Data about Indigenous Australians are affected by a number of issues, the most common being the under-identification of Indigenous people. This may happen when:

- people are not asked about their Indigenous status
- people are asked but in an inconsistent way
- information about a person's Indigenous status is recorded inaccurately.

Under-identification can vary across time, within data sets and within and between jurisdictions. In the SHSC, information on Indigenous status was not reported for 16% of the SHS-only population and 8% of the matched population during the study period. In the AODTS NMDS, Indigenous status was not reported for 6.2% of the AODT-only population and 5.8% of the matched population.

Incomplete data

As well as not covering all people experiencing issues with either homelessness or drug and alcohol use, both the AODTS NMDS and SHSC have incomplete data. That is, not all in-scope agencies submit data, and not all information sought from clients is answered. This means the data may not be completely representative of the populations they are collecting – of people receiving SHS or AOD treatment. How much this affects the representativeness of the data depends on how much information is missing, and how those people whose information was not collected are distributed among the relative populations. (That is, there would be less impact on the results if the people were evenly distributed among the populations, than if they were all from a particular sub-population, for example, younger males.)

Further data quality information can be found in the data quality statements available on the AIHW Metadata Online Registry (METeOR):

- The Specialist Homelessness Services collection data quality statement is available from <<http://meteor.aihw.gov.au/content/index.phtml/itemId/626455>>.
- The Alcohol and Other Drug Treatment Services NMDS data quality statement is available from <<http://meteor.aihw.gov.au/content/index.phtml/itemId/637860>>.

Glossary

Aboriginal or Torres Strait Islander: A person of Aboriginal and/or Torres Strait Islander descent who identifies as an Aboriginal and/or Torres Strait Islander.

active support: The average number of support days per support period. This measure gives an indication of the level of service engagement (Garcia 2005).

administrative cessation (see cessation reason): Includes episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

alcohol: A central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgement, coordination and balance more difficult.

alcohol and other drug (AOD) treatment agency: An agency that operates from the public accounts of the Australian Government or a state or territory government, is part of the general government sector, and is financed mainly from taxation.

amphetamines: Stimulants that include methamphetamine, also known as methylamphetamine. Amphetamines speed up the messages going between the brain and the body. Common names are speed, fast, up, uppers, louee, goey and whiz. Crystal methamphetamine is also known as ice, shabu, crystal meth, base, whiz, goey or glass.

AOD treatment episode: The period of contact between a client and a treatment provider or a team of providers. Each treatment episode has 1 principal drug of concern and 1 main treatment type. If the principal drug or main treatment changes, then a new episode is recorded.

Baby Boomer: Australia's 'Baby Boomers' were born between 1946 and 1966 during the post-war economic boom (ABS 2014).

calculating total length of support and total length of accommodation: To calculate support length and accommodation, every day (for length of support) or every night (for length of accommodation) the client received support or accommodation over the reporting period is added together. This means that the total number of days/nights presented for clients does not necessarily represent a consecutive number of days/nights the client received support/accommodation. For example, a client who received accommodation for 7 nights may have had 2 separate periods of accommodation: 1 for 5 nights and another for 2 nights.

clients experiencing domestic and family violence: Clients in the Specialist Homelessness Services collection (SHSC) were counted as 'experiencing domestic and family violence' if, any support period during the study period: if 'domestic and family violence' was reported as a reason they sought assistance; or if, during any support period, they required domestic or family violence assistance. The SHSC reports on all clients who experience domestic and family violence, both victims and perpetrators. The SHSC data are not able to distinguish between these 2 groups.

clients of AODT services: Clients may seek treatment or assistance concerning their own alcohol and/or other drug use, or support and/or assistance in relation to the alcohol and/or drug use of another person. The vast majority of AODT clients receive treatment for their own alcohol and/or drug use (for example, around 95% of clients treated in 2014–15). Information on drugs of concern is only collected for those clients who receive treatment for their own alcohol and/or other drug use.

clients of specialist homelessness services: A client is a person who receives a specialist homelessness service. A specialist homelessness service is assistance provided to a client aimed at responding to, or preventing, homelessness. A client can be of any age—children are also clients if they receive a service from a specialist homelessness agency.

clients with a current mental health issue: Clients with a current mental health issue were identified from the SHSC data set. SHS clients with a current mental health issue are identified as such if they meet any of these criteria:

- they indicated that at the beginning of a support period they were receiving services or assistance for their mental health issues (or had done so in the last 12 months)
- their formal referral source to the specialist homelessness agency was a mental health service
- they reported ‘mental health issues’ as a reason for seeking assistance
- their dwelling type, either a week before presenting to an agency, or when presenting to an agency, was as a psychiatric hospital or unit
- they had been in a psychiatric hospital or unit in the last 12 months
- at some stage during their support period, a need was identified for psychological services, psychiatric services or mental health services.

This analysis does not include clients aged under 10.

closed treatment episode: A period of contact between a client and a treatment provider or team of providers is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months, or when treatment is ceased (see ‘reason for cessation’).

drug/drug of concern/principal drug of concern: Any reference to drugs in this report refers to the main substance that the client stated led them to seek treatment from an alcohol and drug treatment agency.

expected cessation: Includes episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement.

heroin: One of a group of drugs known as opioids, which are strong pain-killers with addictive properties. Heroin and other opioids are classified as depressant drugs. Heroin is also known as smack, skag, dope, H, junk, hammer, slow, gear, harry, big harry, horse, black tar, China white, Chinese H, white dynamite, dragon, elephant, boy, home-bake or poison.

housing status (and other housing categories): All clients of Specialist Homelessness Services are considered to be either homeless or at risk of homelessness. Homelessness and ‘at risk’ status are assigned to those clients whose housing circumstances meet the specific criteria described below. Clients who did not provide sufficient information to make this assessment are excluded.

These categories are assigned to homeless and at risk categories as much as possible to align with the ABS statistical definition of homelessness (ABS 2012). However, there are some key areas where alignment may not occur. The ABS definition includes people living in severely crowded dwellings, but no specific question is asked in the SHSC on crowding, so this group cannot be separately identified.

Also, certain decisions are made by the ABS to exclude groups of people from the homeless count where they appear to have accommodation alternatives or there is a clear choice about the type of accommodation (for example, people who are travelling, people returning from overseas, certain owner builders or hobby farmers, and students living in halls of residence). However, if people in these circumstances become clients of specialist homelessness agencies, they are included here as either 'homeless' or 'at risk of homelessness', depending on their housing situation as reported.

Clients are considered to be 'homeless' if they are living in any of the following circumstances:

- No shelter or improvised dwelling: includes where dwelling type is 'no dwelling/street/park/in the open, motor vehicle, improvised building/dwelling, caravan, cabin, boat or tent'; or tenure type is 'renting or living rent-free in a caravan park'.
- Short-term temporary accommodation: dwelling type is 'boarding/rooming house, emergency accommodation, hotel/motel/bed and breakfast'; or tenure type is 'renting or living rent-free in boarding/rooming house, renting or living rent-free in emergency accommodation or transitional housing'.
- House, townhouse or flat (couch surfing or with no tenure): tenure type is 'no tenure'; or conditions of occupancy are 'living with relatives fee-free, couch surfing'.

Clients are considered to be 'at risk of homelessness' if they are living in any of the following circumstances:

- Public or community housing (renter or rent free): dwelling type is 'house/townhouse/flat' and tenure type is 'renter or rent-free public housing, renter or rent-free-community housing'.
- Private or other housing (renter, rent-free or owner): dwelling type is 'house/townhouse/flat' and tenure type is 'renter-private housing, life tenure scheme, owner-shared equity or rent/buy scheme, owner – being purchased/with mortgage, owner – fully owned, rent-free-private/other housing'.

identifying clients' needs for a service: The SHSC collects information on the needs of clients during their period of support from a specialist homelessness agency. Needs may be identified by the client and/or the service provider. Although this information is collected at the beginning of a support period, updated at the end of each month a client is supported and again at the end of each support period, each individual need is only recorded once in any collection month. For these analyses, a client's need for a service was recorded if the client needed that service at any time between 2011–12 and 2013–14. For example, a client was recorded as needing short-term or emergency accommodation if they were recorded as needing short-term or emergency accommodation in any collection month between 2011–12 and 2013–14, regardless of the number of months over which this need was recorded, or the number of times during over the reporting period they presented with this need.

Indigenous: A client is considered as Indigenous if, at any time in the reporting period, they identified as being of Aboriginal and/or Torres Strait Islander origin.

In the SHSC, information on Indigenous status is only provided with the explicit consent of the client to report this information. Consent is not required to collect Indigenous data in the AODTS NMDS.

itinerant: The client is moving from place to place or has no fixed address.

main treatment type: The principal activity that is determined, at assessment by the treatment provider, for treatment of the client's alcohol or other drug problem for the principal drug of concern.

median: The midpoint of a list of observations ranked from the smallest to the largest.

multiple drugs, multiple drugs of concern: where a client has more than one treatment episode (see treatment episode) in a reporting year, multiple drugs of concern refers to the number of different principal drugs of concern (see drugs of concern) a client has reported in that reporting year.

pharmaceuticals: A pharmaceutical is a drug that is available from a pharmacy, over the counter or by prescription, which may be subject to misuse (MCDS 2011). In the 2014–15 AODTS NMDS report, 10 different drug types were identified as making up the group 'pharmaceuticals' for the purposes of this analysis: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

reason for AOD cessation: The reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service.

referral source SHS: Clients can be formally referred to an SHS agency through any of the following sources: Specialist Homelessness Agency/outreach worker, telephone/crisis referral agency, Centrelink or employment service case worker, child protection agency, family and child support agency, hospital, mental health service, disability support service, drug and alcohol service, aged care service, social housing, youth/juvenile justice correctional centre, adult correctional facility, legal unit (including legal aid), school/other education institution, police, courts, Immigration department or asylum seeker/refugee support service, other agency (government or non-government), family and/or friends, other. Clients can also be informally referred.

SHS clients with a drug and/or alcohol use issue: Include those clients

- who reported they had been in rehabilitation in the last 12 months
- whose formal referral source to the specialist homelessness agency was a drug and alcohol service
- who reported 'problematic drug or substance use' or 'problematic alcohol use' as a reason for seeking assistance
- whose dwelling type either a week before presenting to an agency, or when presenting to an agency was rehabilitation
- who at some stage during their support period, were identified as needing drug and/or alcohol counselling.

sleeping rough: A term used to refer to those people who are:

- living in an improvised building or dwelling; or
- sleeping on the street, in a park or in the open.

specialist homelessness agency: A specialist homelessness agency is an organisation which receives government funding to deliver specialist homelessness services to a client. These can be either not-for-profit and for-profit agencies.

specialist homelessness services: A specialist homelessness service is assistance provided by a specialist homelessness agency to a client aimed at responding to, or preventing, homelessness. The specialist homelessness services in scope for this collection include accommodation provision; assistance to sustain housing; domestic/family violence services; mental health services; family/relationship assistance; disability services; drug/alcohol counselling; legal/financial services; immigration/cultural services; other specialist services; and general assistance and support.

support duration: The time (in days) between the first day of the first support period and the last day of the last support period in the study period, 2011–12 to 2013–14. This measure can only be calculated if the client is no longer receiving support, and therefore has a ‘closed’ support period.

support period: The period of time a client receives services from a specialist homelessness service agency is referred to as a ‘support period’. A support period begins the day the client receives a service and ends when either:

- the relationship between the client and the agency ends
- the client has reached the maximum amount of support the agency can offer
- a client has not received any services from the agency for a calendar month and there is no other ongoing relationship.

The end of the support period is the day the client last received service from the agency.

treatment type: The type of activity that is used to treat the client’s alcohol or other drug problem:

- **assessment only:** where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types
- **counselling:** the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
- **information and education only**
- **pharmacotherapy:** where the client receives another type of treatment in the same treatment episode. It includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse-prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the ‘withdrawal’ category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy

- **rehabilitation:** focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways, including residential treatment services, therapeutic communities and community-based rehabilitation services
- **support and case management only:** support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy
- **withdrawal management (detoxification):** includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

unexpected cessation: Includes episodes where the client ceased to participate against advice, without notice or due to non-compliance.

References

- ABS (Australian Bureau of Statistics) 2012. Information paper: a statistical definition of homelessness, 2012. ABS cat. no. 4922.0. Canberra: ABS. Viewed 27 July, 2016.
- ABS 2013. Personal safety, Australia, 2012. ABS cat no. 4906.0. Canberra: ABS.
- ABS 2014. Population by age and sex, regions of Australia, 2014. Cat. no. 3235.0. Canberra: ABS.
- AIHW (Australian Institute of Health and Welfare) 2011. Comparing an SLK-based and a name-based data linkage strategy: an investigation into the PIAC linkage. Data linkage series no. 11. Cat. no. CSI 11. Canberra: AIHW.
- AIHW 2014. Housing outcomes for groups vulnerable to homelessness: 1 July 2011 to 31 December 2013. Cat. no. HOU 274. Canberra: AIHW.
- AIHW 2015. Specialist homelessness services 2014–15. Canberra: AIHW. Viewed 1 August 2016, <<http://www.aihw.gov.au/homelessness/specialist-homelessness-services-2014-15/>>
- AIHW 2016. Alcohol and other drug treatment services in Australia 2014–15. Drug treatment series no. 27. Cat. no. HSE 173. Canberra: AIHW.
- Barker JD 2012. Social capital, homeless young people and the family. *Journal of Youth Studies* 15(6):730–743.
- Cale J & Breckenridge J 2015. Gender, age and the perceived causes, nature and extent of domestic and dating violence in Australian society. Sydney: University of NSW.
- Chamberlain C & Johnson G 2011. Pathways into adult homelessness. *Journal of Sociology* 49(1):60–77.
- CIHI (Canadian Institute for Health Information) 2007. Improving the health of Canadians: mental health and homelessness. Improving the health of Canadians 2007–2009 report series. Ottawa: CIHI.
- COAG (Council of Australian Governments) 2009. National Partnership Agreement on Homelessness. Canberra: Commonwealth of Australia.
- FaHCSIA (Families, Housing, Community Services and Indigenous Affairs) 2008. The road home: a national approach to reducing homelessness. Canberra: FaHCSIA.
- Flatau P, Conroy E, Thielking M, Clear A, Hall S, Bauskis A et al. 2013. How integrated are homelessness, mental health and drug and alcohol services in Australia? Melbourne: Australian Housing and Urban Research Institute.
- Garcia C 2005. Engaging the dually diagnosed homeless client. *Parity* 18(8):6–7.
- Homelessness Australia 2016. Homelessness and older people. Lyneham ACT: Homelessness Australia.
- Johnson G & Chamberlain C 2008. Homelessness and substance abuse: which comes first? *Australian Social Work* 61:342–56.
- Mallett S, Rosenthal D & Keys D 2005. Young people, drug use and family conflict: pathways into homelessness. *Journal of Adolescence* 28(2):185–99.

- Ministerial Council on Drugs Strategy (MCDS) 2011. National Drug Strategy 2010–2015. Canberra: Commonwealth of Australia.
- Nicholas R & Roche AM 2014. Information sheet 1: Why the growing use of alcohol and other drugs among older Australians needs attention. Adelaide: National Centre for Education and Training in Addiction (NCETA), Flinders University.
- Petersen M, Parsell C, Phillips R & White G 2014. Preventing first time homelessness amongst older Australians: final report. Melbourne: Australian Housing and Urban Research Institute.
- Scutella R, Chigavazira A, Killackey E, Herault N, Johnson G, Moschion J et al. 2014. Journeys home research report no. 4. Melbourne: University of Melbourne.
- Slade T, Johnston A, Oakley Browne MA, Andrews G & Whiteford H 2009. 2007 National Survey of Mental Health and Wellbeing: methods and key findings. *Australian and New Zealand Journal of Psychiatry* 43(7):594–6005.
- Teesson M, Hodder T & Buhrich N 2003. Alcohol and other drug use disorders among homeless people in Australia. *Substance Use & Misuse* 38(3–6):463–74.
- WHO (World Health Organization) 2013. Global and regional estimates of violence against women: prevalence and health effects of intimate partner violence and non-partner sexual violence. Geneva: WHO Press.

List of tables

Table 1.1:	Overview of cohort populations.....	5
Table 2.1:	Matched clients with a current mental health issue and AODT-only clients, by principal drug of concern, 2012-13 to 2013-14.....	12
Table 2.2:	SHS support characteristics of clients with a current mental health issue, by housing status, matched and SHS-only, 2011-12 to 2013-14.....	17
Table 2.3:	Clients with a current mental health issue, by housing status at the beginning and end of support, matched and SHS-only, 2011-12 to 2013-2014	20
Table 3.1:	Clients experiencing domestic and family violence, by principal drug of concern, matched and all AODT-only, 2012-13 to 2013-14.....	29
Table 3.2:	SHS support characteristics of clients experiencing domestic and family violence, by housing status and sex, matched and SHS-only, 2011-12 to 2013-14.....	34
Table 3.3:	Clients experiencing domestic and family violence, by housing status at the beginning and end of support, matched and SHS-only, 2011-12 to 2013-2014.....	38
Table 4.1:	Young clients (15-24 years), by drug of concern, matched and AODT-only clients, 2012-13 to 2013-14.....	47
Table 4.2:	SHS support characteristics of young clients (15-24 years), by housing status, matched and SHS-only, 2011-12 to 2013-14	52
Table 4.3:	Young clients (15-24 years), by housing status at the beginning and end of support, matched and SHS-only, 2011-12 to 2013-2014	55
Table 5.1:	Older clients (50 years and over), by principal drug of concern, matched and AODT-only, 2012-13 to 2013-14.....	62
Table 5.2:	SHS support characteristics of older clients 50 years and over, by housing status, matched and SHS-only, 2011-12 to 2013-14	66
Table 5.3:	Older clients (50 years and over), by housing status at the beginning and end of support, matched and SHS-only, 2011-12 to 2013-2014	69
Table A1.1:	Summary of linked data	72

List of figures

Figure 1.1: Characteristics of matched clients	4
Figure 1.2: Cohort overlap within the matched client group.....	6
Figure 2.1: Characteristics of matched clients with a current mental health issue	9
Figure 2.2: Proportion of clients with a current mental health issue, by key reasons for seeking SHS assistance, by housing status, matched and SHS-only, 2011–12 to 2013–14	11
Figure 2.3: Clients with a current mental health issue, by main AOD treatment type, matched and all AODT-only, 2012–13 to 2013–14.....	13
Figure 2.4: Clients with a current mental health issue, by average duration of AOD treatment, by principal drug of concern, matched and all AODT-only, 2012–13 to 2013–14.....	14
Figure 2.5: Proportion of clients with a current mental health issue who needed accommodation services, by service provision status, matched and SHS-only, 2011–12 to 2013–14.....	15
Figure 2.6: Proportion of clients with a current mental health issue who needed key specialist homelessness services, by service provision status, matched and SHS-only, 2011–12 to 2013–14.....	16
Figure 2.7: Total days of SHS support for clients with a current mental health issue, by housing status, matched and SHS-only, 2011–12 to 2013–14.....	18
Figure 2.8: Clients with a current mental health issue, nights of accommodation by housing status, matched and SHS-only, 2011–12 to 2013–14.....	19
Figure 2.9: Clients with a current mental health issue, housing outcomes (end of support), by housing status at the beginning of support, matched and SHS-only, 2011–12 to 2013–2014	22
Figure 3.1: Characteristics of matched clients experiencing domestic and family violence	26
Figure 3.2: Clients experiencing domestic and family violence, by key reasons for seeking SHS assistance, by housing status, matched and SHS-only, 2011–12 to 2013–14.....	28
Figure 3.3: Male clients experiencing domestic and family violence, by average number of days of AOD treatment received, by principal drug of concern, matched and all AODT-only, 2012–13 to 2013–14.....	30
Figure 3.4: Female clients experiencing domestic and family violence, by average number of days of AOD treatment received, by principal drug of concern, matched and all AODT-only, 2012–13 to 2013–14.....	31
Figure 3.5: Proportion of clients experiencing domestic and family violence who needed accommodation services, by service provision status, matched and SHS-only, 2011–12 to 2013–14.....	32
Figure 3.6: Proportion of clients experiencing domestic and family violence who needed key specialist homelessness services, by service provision status, matched and SHS-only, 2011–12 to 2013–14	33
Figure 3.7: Clients experiencing domestic and family violence, total days of support, by housing status and sex, matched and SHS-only, 2011–12 to 2013–14	36
Figure 3.8: Clients experiencing domestic and family violence, nights of accommodation, by housing status and sex, matched and SHS-only, 2011–12 to 2013–14	37

Figure 3.9: Male clients experiencing domestic and family violence, housing outcomes (end of support), by housing status and sex at the beginning of support, matched and SHS-only, 2011-12 to 2013-2014	40
Figure 3.10: Female clients experiencing domestic and family violence, housing outcomes (end of support), by housing status and sex at the beginning of support, matched and SHS-only, 2011-12 to 2013-2014	41
Figure 4.1: Characteristics of young matched clients (15-24 years)	44
Figure 4.2: Proportion of young clients (15-24 years), by key reasons for seeking SHS assistance, by housing status, matched and SHS-only, 2011-12 to 2013-14	46
Figure 4.3: Young clients (15-24 years), by main treatment provided, matched and AODT-only, 2012-13 to 2013-14	48
Figure 4.4: Young clients (15-24 years), by average number of days in AOD treatment, by principal drug of concern, matched and AODT-only, 2012-13 to 2013-14	49
Figure 4.5: Proportion of young clients (15-24 years) who needed accommodation services, by service provision status, matched and SHS-only, 2011-12 to 2013-14	50
Figure 4.6: Proportion of young clients (15-24 years) who needed key specialist homelessness services, by service provision status, matched and SHS-only, 2011-12 to 2013-14	51
Figure 4.7: Young clients (15-24 years), total days of support, by housing status, matched and SHS-only, 2011-12 to 2013-14	53
Figure 4.8: Young clients (15-24 years), nights of accommodation, by housing status, matched and SHS-only, 2011-12 to 2013-14	53
Figure 4.9: Young clients (15-24 years), housing outcomes (end of support), by housing status at the beginning of support, matched and SHS-only, 2011-12 to 2013-2014	56
Figure 5.1: Characteristics of older (50 years and over) matched clients	59
Figure 5.2: Proportion of older clients (50 years and over), by key reasons for seeking SHS assistance, by housing status, matched and SHS-only, 2011-12 to 2013-14	61
Figure 5.3: Older clients (50 years and over), by average number of days in AOD treatment, by principal drug of concern, matched and AODT-only, 2012-13 to 2013-14	63
Figure 5.4: Proportion of older clients (50 years and over) who needed accommodation services, by service provision status, matched and SHS-only, 2011-12 to 2013-14	64
Figure 5.5: Proportion of older clients (50 years and over) who needed key specialist homelessness services, by service provision status, matched and SHS-only, 2011-12 to 2013-14	65
Figure 5.6: Older clients (50 years and over), total days of support, by housing status, matched and SHS-only, 2011-12 to 2013-14	67
Figure 5.7: Older clients (50 years and over), nights of accommodation, by housing status, matched and SHS-only, 2011-12 to 2013-14	68
Figure 5.8: Older clients (50 years and over), housing outcomes (end of support), by housing status at the beginning of support, matched and SHS-only, 2011-12 to 2013-2014	70



There is much research to suggest a considerable overlap between people experiencing precarious housing, and drug and alcohol misuse. Linking client data from specialist homelessness services and alcohol and other drug treatment services, this report provides a picture of the intersection of these two issues on a national scale. It reveals a vulnerable population, in which Indigenous Australians and experiences of domestic and family violence and mental health issues were all over-represented. Their poorer drug treatment and housing outcomes highlight the level of difficulty faced in assisting these people to achieve long-term outcomes.

