Alcohol and other drug treatment services in Australia annual report

Web report | Last updated: **21 Jun 2023** | Topic: Alcohol & other drug treatment services

About

In 2021–22, around 131,000 people aged 10 and over received treatment from alcohol and other drug treatment services. The four most common drugs that led clients to seek treatment were alcohol (42% of episodes), amphetamines (24%), cannabis (19%) and heroin (4.5%). The median age of clients was 37 years.

Cat. no: HSE 250

- State and territory summaries
- Impact of COVID-19
- Data

Findings from this report:

- Treatment agencies provided around 228,500 treatment episodes to an estimated 131,000 people aged 10 and over
- 3 in 5 people who received treatment were male (60%) and over half (52%) were aged 20–39
- Alcohol remains the most common principal drug of concern for which clients sought treatment
- Of the 228,500 AOD treatment episodes provided, counselling was the most common treatment type (36%)

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COVID-19 impact

COVID-19 impact on alcohol and other drug treatment services

Key Findings

Alcohol and Other Drug (AOD) treatment services reported changes in service usage and impacts on treatment provision in response to the COVID-19 pandemic. Nationally, a comparison of quarterly trends in AOD treatment episodes across the four main waves of COVID-19 waves from 2018–19 to 2021–22 showed:

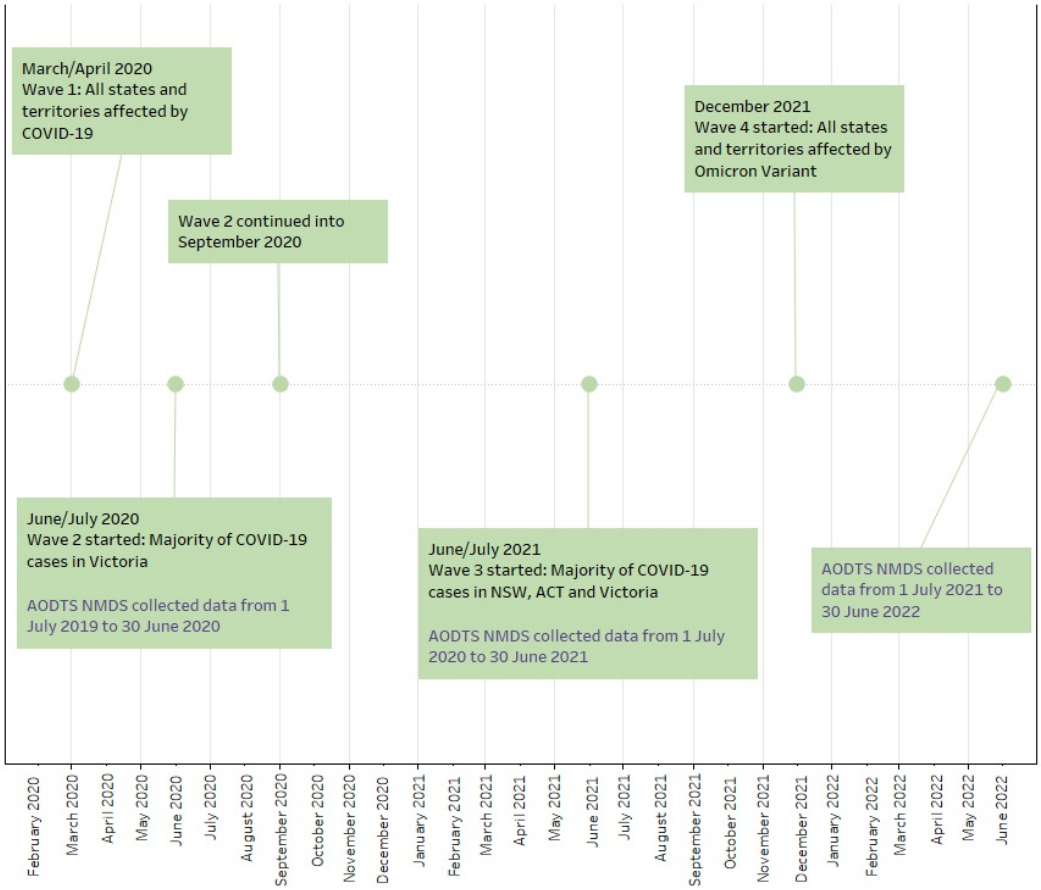
- decreases in rehabilitation during Apr–Jun 2020 continued to Jun 2022 due to ongoing public health restrictions which reduced availability of treatment places
- the initial increases in counselling between Apr–Dec 2020 were followed by declines to Jun 2022
- more changes in treatment episodes for rehabilitation and counselling were observed in *Major cities* and *Inner regional* areas than other areas
- more changes in treatment delivered in residential, home, and outreach settings were observed in *Major cities* and *Inner regional* areas than other areas
- the quarterly pattern of AOD treatment shows that for most AOD treatments the total number of episodes continued to remain lower in 2021–22 compared with pre-pandemic levels (2018–19).

In response to the COVID-19 pandemic, a range of public health regulations were introduced in Australia from mid-March 2020 to limit the spread of COVID-19. These public health regulations were extended in late March 2020 with all non-essential services ordered to temporarily close by the Australian Government.

International and domestic border restrictions and a suite of public health restrictions continued into 2022, which resulted in a slower progression of COVID-19 cases in Western Australia.

Figure COVID 1: Key COVID-19 dates from 2020 to 2022 and AODTS NMDS collection periods from 2020 to 2022

The flow chart shows that Wave 1 of the COVID-19 pandemic started in March/April 2020 (affecting all states and territories), Wave 2 started in June/July 2020 and continued into September 2020 (with most COVID-19 cases in Victoria), Wave 3 started in June/July 2021 (with most cases in NSW, ACT and Victoria), and Wave 4 started in December 2021 (the Omicron variant, affecting all states and territories). The AODTS NMDS 2021–22 collection includes all closed episode data up to 30 June 2022.



Title: Figure COVID 1: Key COVID-19 dates from 2020 to 2022 and AODTS NMDS collection periods from 2020 to 2022
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Access to alcohol and other drug treatment

A total of 228,451 treatment episodes were provided to people for their own or someone else's alcohol and/or drug use in 2021–22, decreasing by 6% from the previous year (242,980 in 2020–21). The number of clients treated by publicly funded AOD treatment services similarly decreased (6.3% from 139,271 clients in 2020–21 to 130,525 in 2021–22). Taking into consideration population growth, this equates to 619 clients per 100,000 people in 2020–21, falling to 576 clients per 100,000 people in 2021–22.

From March 2020 onwards, states and territories reported that specialised treatments provided by AOD services were affected by the introduction of public health regulations. This included social distancing measures, which led to a reduction in the availability of treatment services as the number of people that could be accommodated or assessed across treatment settings was reduced to comply with this public health guideline. In response to the health regulations, treatment services adapted practices such as expanding access to online services and telehealth appointments.

Health regulations continued into 2021–22 and viewing quarterly trends provides insights into how services continued to adapt treatment practices. Nationally, the general pattern of AOD treatment showed an initial drop across most main treatments in wave one (Apr–Jun 2020) followed by increases in subsequent months before decreasing again in waves three and four (Apr–Dec 2021). This quarterly pattern shows that, for most treatments, the total number of closed treatment episodes remained lower in 2021–22 compared with previous years of the COVID-19 pandemic.

The type of main AOD treatment and where it is delivered are closely linked. For example:

- Adapting service delivery for treatment types such as assessments, counselling, and support and case management to better suit online or offsite (home) treatment settings. The increased reporting of 'other' treatment settings may reflect agencies adapting to telephone/video conference consultations.
- Treatment types provided by outreach services were limited due to the face-to-face nature of this service delivery.
- An increase in treatment types provided in non-residential treatment settings and the decreases in other delivery settings reflects services adapting to provide some treatments in different settings.
- Rehabilitation is mainly provided in a residential setting; decreases in bed-based rehabilitation service settings were due to continued public health restrictions, which reduced client capacity and thus availability of treatment places.
- Changes in treatment provided and where it was delivered during the four waves of COVID-19 were more noticeable in *Major cities* and *Inner regional* areas than other areas. The greater volume of clients and services in these areas contributed to these changes.

Note that the trends have been identified nationally and by remoteness areas; individual jurisdiction trends may differ.

Technical notes: Reporting of Alcohol and other drug treatment services quarterly data

The collection period for the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) is by financial year. To examine the impact of the pandemic, closed treatment episode data from 2018–19, 2019–20, 2020–21 and 2021–22 were analysed by quarterly periods and compared.

Comparison of quarterly financial year episode data allows for data collected for the four main waves of COVID-19 to be compared across 2018–19 (prior to COVID-19), 2019–20, 2020–21 and 2021–22 collection periods (Figure COVID 1).

Financial year data include treatment episodes that ended within the period and excludes those that were ongoing or new (not closed) within the reporting year. This will lead to an underestimation of the number of treatment episodes presented in this analysis. Quarters are presented as financial year quarters in this analysis; Q1=Jul–Sep, Q2=Oct–Dec, Q3=Jan–Mar, Q4=Apr–Jun.

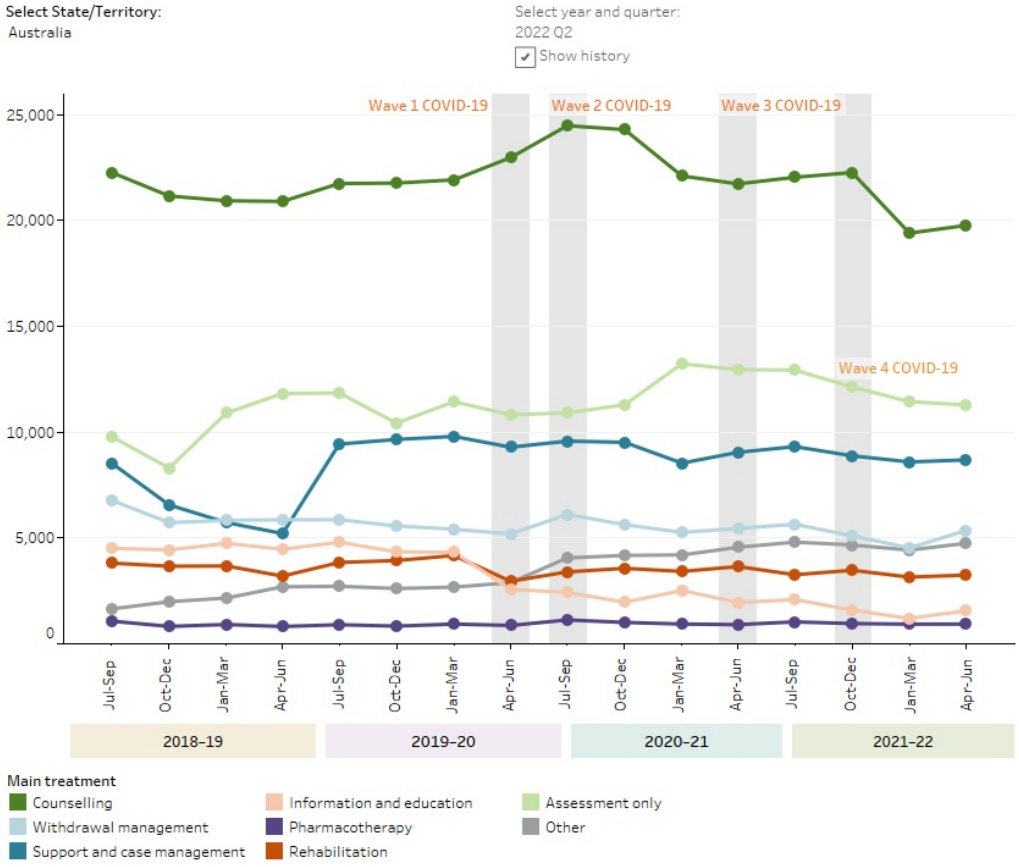
For further information, see Key terminology and glossary.

COVID-19 impact

Nationally, between 2018–19 and 2021–22, there were notable changes in AOD treatment service types, particularly services providing treatment in tailored physical settings.

Figure COVID TREATMENT 1 : Treatment episodes, by main treatment type, state and territory, quarterly data, 2018-19 to 2021-22

The line graph shows that counselling remained the most common main treatment type between July–September 2018 and April–June 2022. Treatment episodes for counselling increased from 21,833 in January–March 2020 (pre-COVID) to 22,936 in April–June 2020 (Wave 1), peaking at 24,443 episodes in July–September 2020 (Wave 2) before decreasing to 22,228 episodes in Oct-Dec 2021 (Wave 4). Assessment only remained the second most common main treatment type across the period (11,254 episodes in April–June 2022). A filter allows the user to view data for Australia or by state/territory.



Title: Figure COVID TREATMENT 1: Treatment episodes, by main treatment type, state and territory, quarterly data, 2018–19 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables COVID.3-COVID.11.
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See notes >

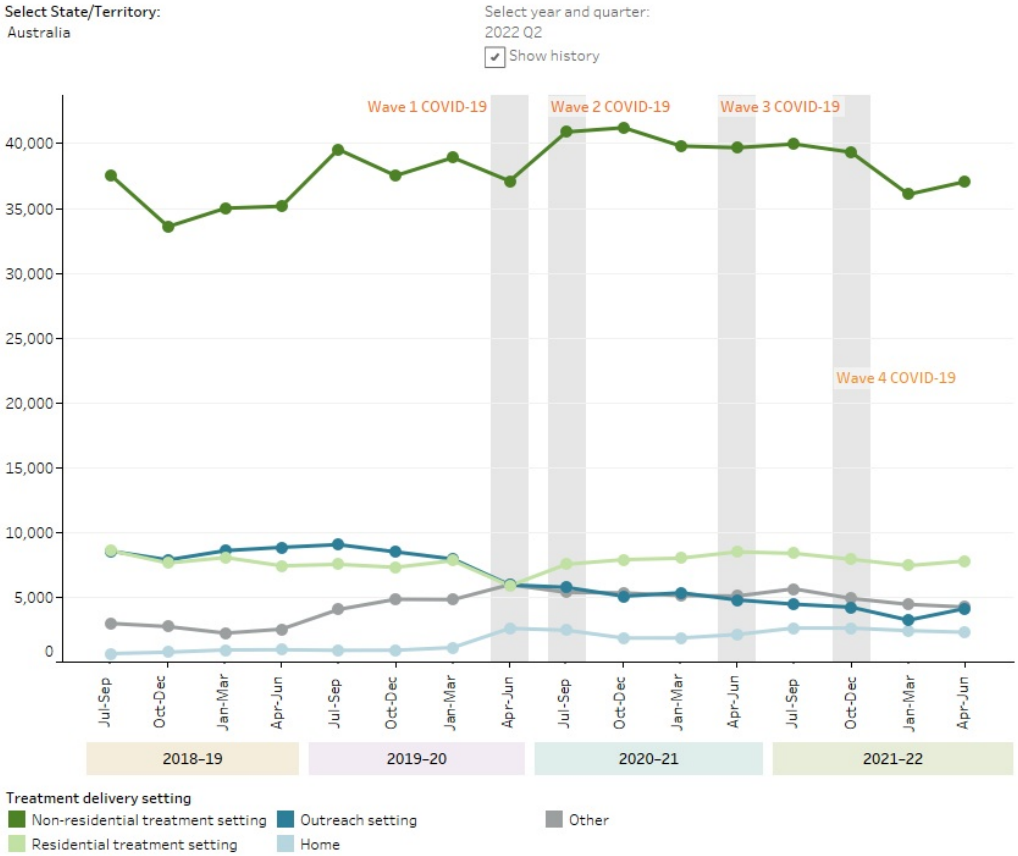
- **Counselling:**
  - Treatment episodes showed notable increases between Apr–Dec 2020, coinciding with the first and second waves of the pandemic before declining to pre-pandemic levels in Jan–Jun 2022.
  - Despite AOD services adapting (for example, increased telehealth services), a decrease in episodes from Jan 2021 indicates additional constraints to service delivery. Such constraints may include client ability to access telehealth services, as well as impacts on the workforce with service staff illness, vacancies, or turnover.
- **Rehabilitation:**
  - Most rehabilitation treatment is provided in residential settings. Bed-based residential units were operating at reduced capacity between 2020 and 2022 in some states and territories to ensure social distancing guidelines were met.
  - From Apr–Jun 2020, there was a drop in treatment episodes for rehabilitation as a main treatment, coinciding with the first wave of the pandemic. Numbers remained slightly lower than pre-pandemic levels from Jul 2020 to Jun 2022.

COVID-19 impact

Some types of AOD treatment provided to clients require specific settings. For example, withdrawal (detox) and rehabilitation treatment service types are mostly provided in residential settings, whereas counselling and support and case management can be provided in most settings.

Figure COVID DELIVERYSETTING 1: Treatment episodes, by treatment delivery setting, state and territory, quarterly data, 2018-19 to 2021-22

The line graph shows that non-residential treatment settings remained the most common delivery setting between July–September 2018 and April–June 2021. Episodes provided in non-residential treatment settings fluctuated over the period, decreasing from 38,883 episodes in January–March 2020 (pre-COVID) to 37,072 in April–June 2020 (Wave 1). Episodes then increased to 40,857 in July–September 2020 (Wave 2) but then decreased to 39,646 in April–June 2021 (Wave 3) and 39,296 in Oct-Dec 2021 (Wave 4). A filter allows the user to view data for Australia or by state/territory.



Title: Figure COVID DELIVERYSETTING 1: Treatment episodes, by treatment delivery setting, state and territory, quarterly data, 2018–19 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables COVID.12-COVID.20.
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A comparison of national quarterly trends in AOD service delivery settings between 2018–19 and 2021–22 showed variation and the implementation of public health restrictions. For example:

- for **Residential treatment settings:**
  - there was a drop in treatment episodes in Apr–Jun 2020, which coincided with the first wave of the pandemic
  - treatment episodes over the next 2 years to Jun 2022 steadily increased to pre-pandemic treatment levels, indicating easing of localised lockdown restrictions in some states and territories as well as AOD services adapting to health restrictions.
- for **Outreach settings:**
  - there was a notable decrease in Apr–Jun 2020 treatment episodes, coinciding with the first wave of the pandemic
  - treatment episodes remained lower than pre-pandemic levels from Jun 2020 to Jun 2022, coinciding with the second, third and fourth waves of the pandemic
  - most AOD services, which normally provided in-person visits, discontinued face-to-face contact with clients and moved to telehealth options.

- for **Home settings:**
  - there was a substantial increase in treatment episodes provided from Apr–Jun 2020, coinciding with the first wave of the pandemic. This may reflect AOD services providing telehealth services in the home
  - treatment episodes remained higher than pre-pandemic levels between Jun 2020 and Jun 2022 (Figure COVID DELIVERYSETTING 1, tables COVID.13–COVID.21).

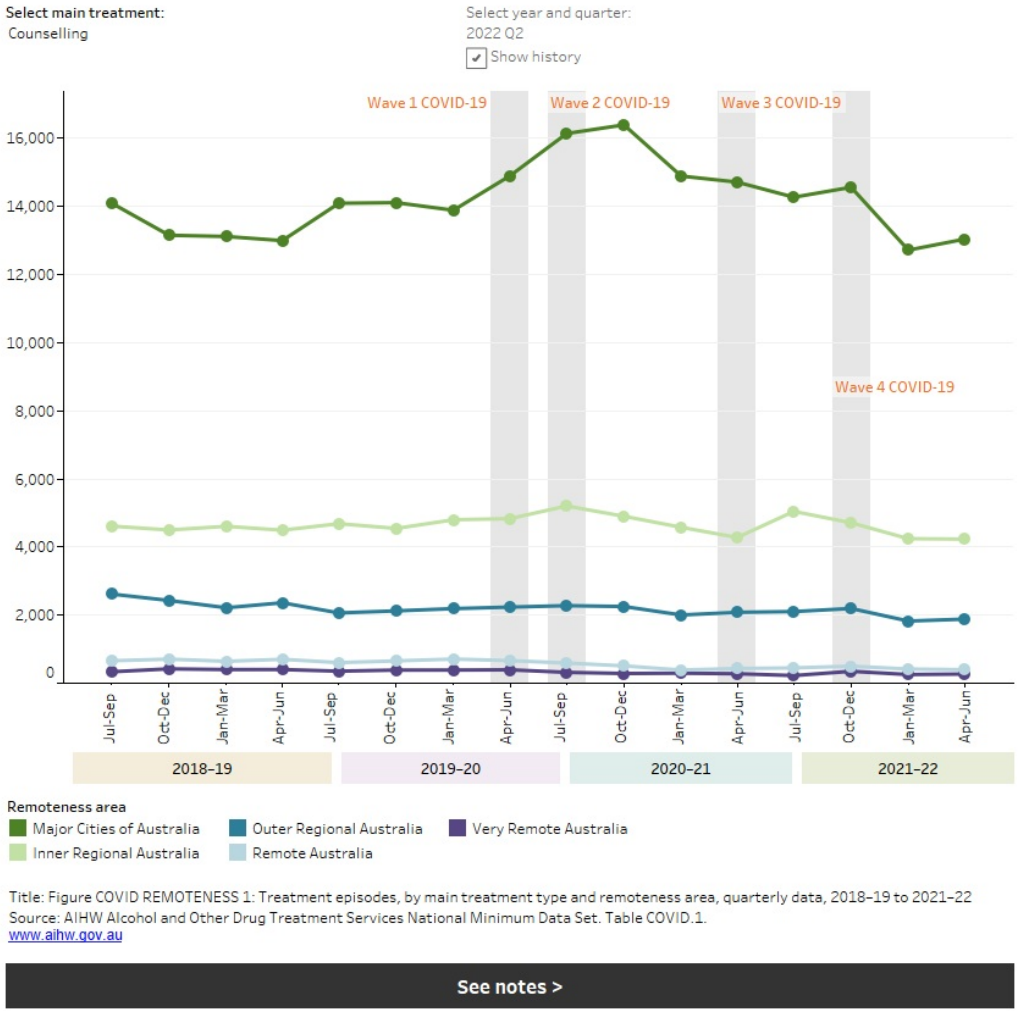
COVID-19 impact

Nationally, between 2018–19 and 2021–22, there were notable changes in AOD treatment types delivered within remoteness areas, particularly AOD treatment requiring clients to attend tailored physical settings.

Remoteness area of treatment episodes was based on the location of the treatment service (see technical notes for further information).

Figure COVID REMOTENESS 1: Treatment episodes, by main treatment type and remoteness area, quarterly data, 2018-19 to 2021-22

The line graph shows the number of episodes with counselling as the main treatment type, by remoteness area. Most episodes were provided in Major cities across the period July–September 2018 to April–June 2021. The number of counselling episodes in Major cities increased from 13,870 in January–March 2020 (pre-COVID) to 14,882 in April–June 2020 (Wave 1) and 16,122 in July–September 2020 (Wave 2). Episodes then decreased 14,695 in April–June 2020 (Wave 3), decreasing further to 13,019 episodes in Apr-Jun 2022. A filter allows the user to view data for each main treatment type.



Title: Figure COVID REMOTENESS 1: Treatment episodes, by main treatment type and remoteness area, quarterly data, 2018–19 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table COVID.1.
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Main treatment across remoteness areas

Changes in trends for main treatment delivered within remoteness areas are likely to be associated with the main waves of the COVID-19 pandemic:

- for **Counselling:**
  - provided in *Major cities* and *Inner regional* areas, episodes increased from Apr–Sep 2020, coinciding with the first and second waves of the pandemic
  - these increases continued into Oct–Dec 2020 before decreasing to pre-pandemic levels in Jan-Jun 2022
  - decreases in episodes from Jan 2021 indicates additional constraints to service delivery, such as, impacts on the workforce with service staff illness, vacancies, or turnover.

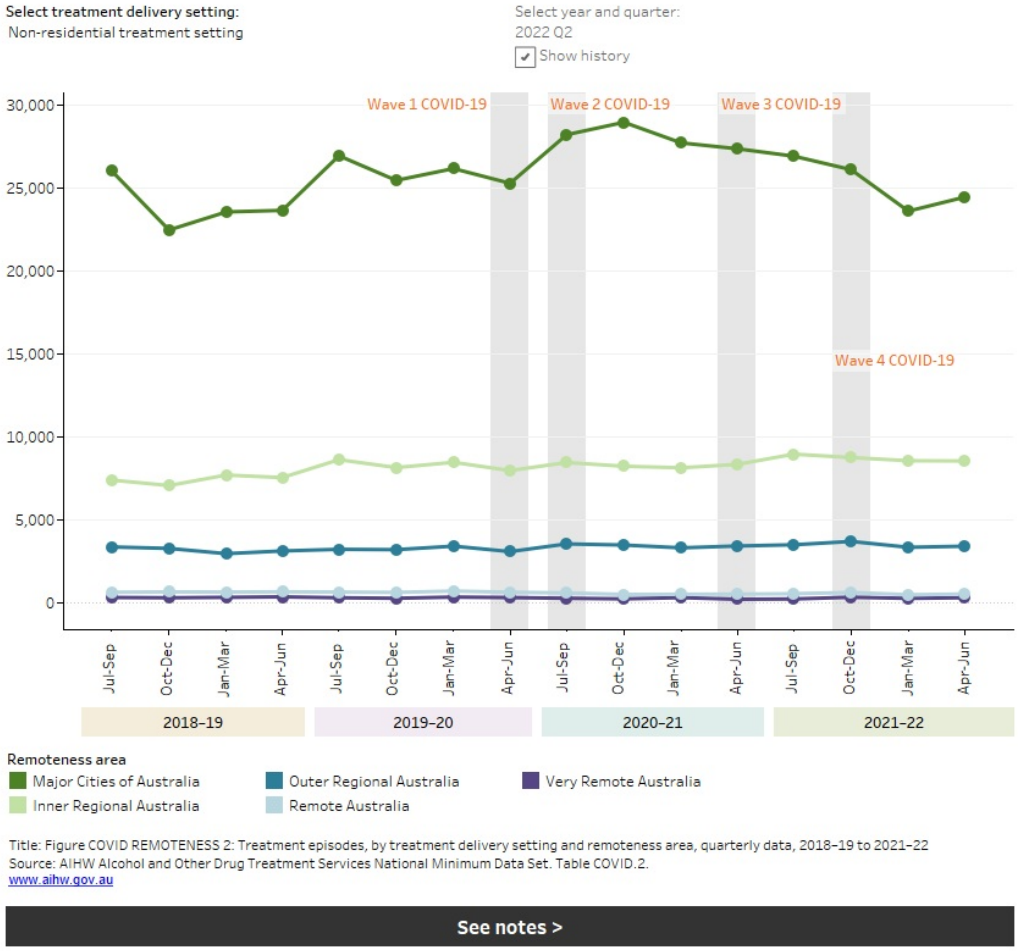
- for **Rehabilitation:**
  - there was a drop in treatment episodes provided in all remoteness areas in wave one and wave two (Apr–Dec 2020). Since then, treatment episodes have increased, although the magnitude of the initial decrease and rate of the subsequent increase differs in each remoteness area
  - for example, treatment episodes provided *Major cities* saw sharp decreases at the beginning of each COVID wave (particularly from Jan–Jun 2020 and Apr–Jun 2021)
  - treatment episodes remained low from Oct 2020 to Jun 2022 in *Major cities* and as at Apr–Jun 2022, had not returned to pre-pandemic levels. This decrease reflects the continuation of health regulations and localised lockdown measures limiting bed capacity for services.

Treatment delivery settings across remoteness areas

Some AOD treatment delivery settings in remoteness locations were impacted more than others during the onset of COVID-19 and associated public health measures.

Figure COVID REMOTENESS 2: Treatment episodes, by treatment delivery setting and remoteness area, quarterly data, 2018-19 to 2021-22

The line graph shows that most treatment episodes provided in non-residential treatment settings occurred in *Major cities* across the period June–September 2018 to April–June 2021. The number of episodes provided in non-residential settings in *Major cities* overall decreased from 26,113 in January–March 2020 to 25,228 in April–June 2020 (Wave 1), then increased in Waves 2 and 3 (28,154 in July–September 2020 and 27,307 in April–June 2021, respectively). Episodes decreased to 26,048 in Oct-Dec 2021 (Wave 4) and 24,390 in Apr-Jun 2022. A filter allows the user to view data for each treatment delivery setting.



Title: Figure COVID REMOTENESS 2: Treatment episodes, by treatment delivery setting and remoteness area, quarterly data, 2018–19 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table COVID.2.
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Changes observed in AOD treatment settings within remoteness areas include:

- **Residential treatment settings:**
  - located in *Major cities* were most impacted, with a sharp decrease in treatment episodes between Jan–Jun 2020 coinciding with the first wave of the pandemic
  - treatment episodes also decreased in *Major cities* and *Inner regional areas* from Apr–Dec 2021, following waves three and four of the pandemic
  - bed-based residential units were operating at reduced capacity between 2020 and 2022 in some states and territories to ensure social distancing guidelines were met.

- for **Outreach settings:**
  - treatment episodes provided in *Major cities*, *Inner regional* and *Outer regional* areas showed notable decreases in Apr–Jun 2020, coinciding with the first wave of the pandemic
  - this decrease continued from Jul 2020 to Jun 2022, and closed treatment episodes have not yet returned to pre-pandemic levels as at June 2022
  - most services providing in-person visits discontinued face-to-face contact with clients, moving to telehealth options (Figure COVID REMOTENESS 2, Table COVID.2).
- **Home settings:**
  - located in *Major cities* and *Inner regional* areas showed the greatest increases in Apr–Jun 2020 compared with previous time periods, coinciding with the first wave of the pandemic. *Major cities* experienced another large increase in episodes provided from Jul–Sept 2021, just after the third wave of the pandemic
  - this reflects services adapting for example, to telehealth services located in *Major cities* and *Inner regional* areas. Episodes decreased between Dec 2020 and Jun 2022 but remain higher than pre-pandemic episodes (Figure COVID REMOTENESS 2, tables COVID.12–COVID.20).

COVID-19 impact

On this page:

Summary information provided by states and territories, regarding the AODTS NMDS data collection:

New South Wales

From 2019–20 to 2021–22, the ongoing impact of COVID has seen:

- services use telehealth, primarily telephone or video conferencing for group sessions
- staff turnover and sickness impacting ability to deliver services, including increased workload as well as additional tasks (for example, ongoing cleaning)
- some treatment services (such as withdrawal management and residential rehabilitation services) were impacted due to social distancing rules and continued to have limited occupancy rates and bed capacity in both non-government and government services. These constraints meant services had to reduce the availability of treatment places
- constraints to service delivery also had an impact on data collection including less timely data uploads due to staff working from home. Local health districts also reported unexpected data system loading issues
- risk management practices and PPE increased workloads for staff and mask wearing was a barrier to engaging with clients and seeing non-verbal cues
- some services closed, which increased the workload of services that remained open
- all home visits/ external (outreach) service visits were suspended for a period of time
- difficulty accessing technology for some clients
- new client assessments decreased as treatment places were limited
- access for agencies regarding ICT infrastructure and internet capacity highlighted a divide for regional and rural services; weak connectivity contributed to potential decline of some service delivery
- some local health districts reported workforce and service delivery issues, which may have impacted the number of closed episodes
- regional and rural services were less affected; however, access to metropolitan services by rural clients was affected.

Victoria

The impact of COVID from 2019–20 to 2021–22 saw the majority of providers move to telehealth service provision, discontinuing face-to-face contact with clients unless they were receiving residential withdrawal and rehabilitation services.

Impacts on residential withdrawal and rehabilitation services included:

- bed based units operating at reduced bed capacity during lockdowns, ensuring social distancing requirements were met. Occupancy across all residential services fell compared to pre-COVID as a result of social distancing requirements
- COVID-19 restrictions also reduced the number of referrals and increased the number of admission cancellations to residential withdrawal and rehabilitation services
- wait times between referrals and admissions also increased due to reduced capacity. Leave and visitors were prohibited during residential stays to decrease risk
- services reduced the number of referrals and increased the number of admission cancellations.

While the number of non-residential withdrawal episodes increased slightly between 2019–20 and 2020–21, during extensive COVID-19 lockdowns non-residential withdrawal service contacts included an electronic process rather than face-to-face, which may have been coded as ‘other’ setting rather than a non-residential treatment facility setting.

Queensland

From 2019–20 to 2021–22, the impact of COVID-19 has seen:

- a decrease in closed treatment episodes across all treatment types for the period of Mar–Jun 2020, particularly for counselling and information and education

- there was also a decrease in the reporting of diversion referrals from the justice system due to public restrictions being in place and restricted operation of the Magistrates Courts. From March to August 2020, most police and court diversion appointments were scheduled to occur by telephone, with only a few providers offering face-to-face appointments. In 2020–21, diversion referral episodes from the justice system increased compared to 2019–20, potentially due to the easing of public restrictions
- in January 2022, there was a lockdown in Queensland and services continued to provide treatment episodes via different modes of delivery. There was a drop in appointments for the Police Drug Diversion Program, Illicit Drugs Court Diversion Program and Drug and Alcohol Assessment Referral Program. Diversion treatment episodes (and hence AODTS interventions) also decreased between financial years; however, this may be for a number of reasons (including COVID lockdown).

Western Australia

As a result of COVID–19, services offered more telehealth appointments and organisations continued to report COVID impacted service delivery from 2019–20 to 2021–22. Examples include:

- inability to recruit staff due to border restrictions
- staff sickness and isolation periods affecting workforce availability
- staff not being vaccinated in line with government requirements
- residential services were required to close beds at times due to government public health restrictions, which may result in less episodes at some agencies
- decreased bed capacity across residential services, including rehabilitation and withdrawal services.

South Australia

From 2019–20 to 2021–22, the impacts for treatment service delivery due to COVID-19 included:

- a proportion of counselling services shifted from face-to-face appointments to telehealth and telephone clinical support to clients in treatment
- there was decreased bed capacity across residential services and withdrawal services, reducing the amount of people accessing these services
- medically assisted treatment for Opioid Dependence prescription review periods were increased from 3 to 6 months during COVID restrictions
- Drug and Alcohol Services SA (DASSA) were asked to implement a Work from Home (WFH) mandate
- eligibility criteria for entry into DASSA's inpatient withdrawal management facility was reviewed during COVID-19, resulting in cannabis and amphetamine withdrawal management clients being referred to outpatient services and SA's non-government sector.

Tasmania

COVID-19 restrictions in Tasmania from 2019–20 to 2021–22 saw:

- an overall reduction in the number of closed AOD treatment episodes in Tasmania from April 2020, as a result of COVID-19 restrictions
- rehabilitation and counselling episodes decline over the April to June 2020 period and face-to-face outreach services moved to providing telehealth services. From mid-July 2020, in-person service delivery resumed from a telehealth model; however, social-distancing measures remained. This resulted in a minor reduction in capacity for some bed-based services
- inpatient withdrawal units were operating at reduced capacity for the entire 2021–22 period due to COVID-19 restrictions
- a small decrease in the average new referrals (episode) totals for non-residential settings was noted in July 2020, potentially due to client hesitancy to access health settings. However, this temporary trend reversed by August 2020
- reduced face to face appointments on site with preference for services to be conducted through telehealth and phone.

Australian Capital Territory

As a result of COVID-19 restrictions from 2019–20 to 2021–22:

- services slowed intake into residential withdrawal programs, which slowed admission to rehabilitation programs and decreased bed capacity in residential rehabilitation and withdrawal services
- services shifted to telehealth services and online programs (for example, face-to-face programs, including group programs, were suspended, or reconvened online)
- staff illness and absence affected programs during both the lockdown period and other parts of the year, requiring staff to isolate at home if unwell and to take time off work
- agency staff relocated to working from home
- reductions in service operating hours
- ceased or reduced intake of new clients to residential and non-residential treatment services.

Northern Territory

From 2019–20 to 2021–22:

- COVID-safe procedures in residential rehabilitation resulted in a decrease in the number of people that could be accommodated in each facility (for example, one person per room) to ensure social distancing guidelines were adhered to. While different service types were impacted in different ways, no service completely closed during this time. There was short-term reduction in capacity, but this eased quickly to business-as-usual once services learnt how to operate under the new COVID environments
- outreach services increased to compensate for reduced residential services.

Clients

On this page:

People may receive treatment for their own or someone else's alcohol or drug use (see Key terminology and glossary). Characteristics of all clients are described below, including clients' principal drugs of concern by age group and clients receiving treatment in multiple collection years.

The Alcohol and Other Drug Treatment Services (AODTS) collection captures information on treatment services accessed by clients. It does not measure the underlying need for treatment or level of problematic alcohol or drug use in the community. Changes in client numbers may be due to clients' access to treatment, treatment availability and/or funding available for alcohol and other drug treatment services.

Key findings

In 2021–22:

- around 131,000 people aged 10 and over received treatment for their own or someone else's alcohol and/or drug use from publicly funded AOD treatment services. This equates to 576 clients per 100,000 people
- around 228,500 treatment episodes were provided to clients
- an average of 1.7 treatment episodes were provided to people receiving treatment for their own alcohol or drug use
- 6 in 10 people were male (60%), and over half (52%) were aged 20–39
- 1 in 6 (18%) people aged 10 and over identified as Aboriginal and/or Torres Strait Islander
- of the clients receiving treatment in 2021–22, 47% had previously received treatment at some point since 2017–18.

In the 5 years to 2021–22:

- around 469,000 Australians received treatment for alcohol or drug use, some having received treatment across multiple years
- there has been a 14% increase in client numbers from 2013–14, from around 114,400 to 131,000. Adjusting for population growth, this equates to an increase in the rate of service use from 564 clients per 100,000 population to 576 over this period.

Characteristics of clients

The number of people treated by publicly funded alcohol and other drug treatment agencies increased from 114,436 in 2013–14 to 130,525 in 2021–22 (14% increase). When taking population growth into consideration, the rate of people accessing services has also increased from 564 clients per 100,000 population in 2013–14 to 576 clients per 100,000 population in 2021–22 (Figure AODTS CLIENTS 1, Table SCR.21). Of the clients receiving treatment in 2021–22, 47% had previously received treatment at some point since 2017–18 (Table SCR.28).

In 2021–22, 124,165 people received treatment for their own alcohol or drug use and 12,536 sought treatment in relation to someone else's alcohol or drug use. Around 1 in 20 (4.7% or 6,176) clients sought treatment for their own as well as someone else's alcohol or drug use in 2021–22 (Table SCR.27).

Figure CLIENTS 1: AODTS clients and treatment episodes, by state and territory, 2013–14 to 2021–22

The line chart shows that there were 576 clients per 100,000 population in Australia in 2021–22, decreasing from 619 clients per 100,000 population in 2021–22. Across the period 2013–14 to 2021–22, the rate of clients was highest in the Northern Territory (1,530 per 100,000 in 2021–22) and lowest in New South Wales (399 per 100,000 in 2021–22). A filter allows the user to view by rate of clients, number of clients or number of treatment episodes.

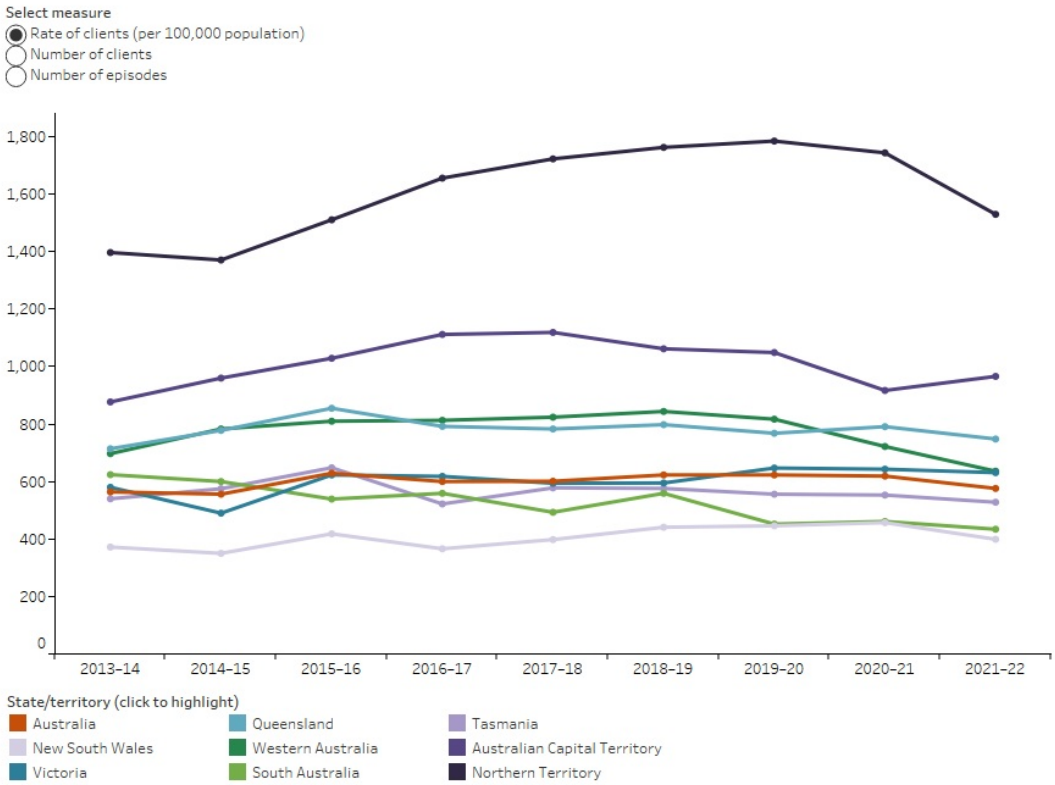

Figure CLIENTS 1: AODTS clients and treatment episodes, by state and territory, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SCR.21.
http://www.aihw.gov.au

See notes >

Client profile

In 2021–22:

- most people (93% or 121,700 clients) received treatment for their own alcohol or drug use; these clients were more likely to be male (62%)
- in contrast, of the 6.8% (or 8,800 clients) people who received treatment for someone else's alcohol or drug use, over 2 in 5 were female (45% or 4,000 clients) (15% or 1,400 reported not stated for sex) (Tables SC.1-2)
- the rate of all clients receiving AOD services was highest for those that lived in *Very remote* areas (1,600 per 100,000 people) and lowest for those in *Major cities* (484 per 100,000; Table SCR.29)
- almost 4 in 5 (79% or 103,200 clients) people received treatment at a single agency, 14% attended 2 agencies, and 6.7% of clients received treatment at 3 or more agencies (Table SCR.23).

See Key terminology and glossary for further information on how clients are counted in this report.

Age and sex

Clients who received treatment for their own alcohol or drug use tended to be younger than those who received treatment for someone else's alcohol or drug use.

In 2021–22, client characteristics revealed:

- the majority of all clients were male (60% or 78,700 clients) and over half (52% or 67,600 clients) were aged 20–39
- just over 3 in 5 (62% or 75,900 clients) of people receiving treatment for their own alcohol or drug use were aged under 40, compared with over half (54% or 4,700 clients) of those who sought treatment for someone else's alcohol or drug use
  - of the 75,900 people aged under 40 who received treatment for their own alcohol or drug use, 1 in 10 (10% or 12,300 clients) were 10–19 years of age
- people aged 60 and over accounted for 5.2% (or 6,300) of clients who received treatment for their own alcohol or drug use, compared with 10% (or 900) of clients who sought treatment for someone else's alcohol or drug use (Figure CLIENTS 2, Table SC.3).

Figure CLIENTS 2: Proportion of clients by client type, sex, and age group, 2013-14 to 2021-22

The butterfly bar chart shows that, among all clients, the most common age group for both male and female clients in 2021–22 was 30–39 (27.3% of males and 26.5% of females), followed by 20–29 (24.6% of males and 24.2% of females). A filter allows the user to view data for all clients, clients seeking treatment for their own drug use, or clients seeking treatment for someone else's drug use. Buttons allow the user to navigate to bar charts presenting trend data disaggregated by sex, age group and client type.

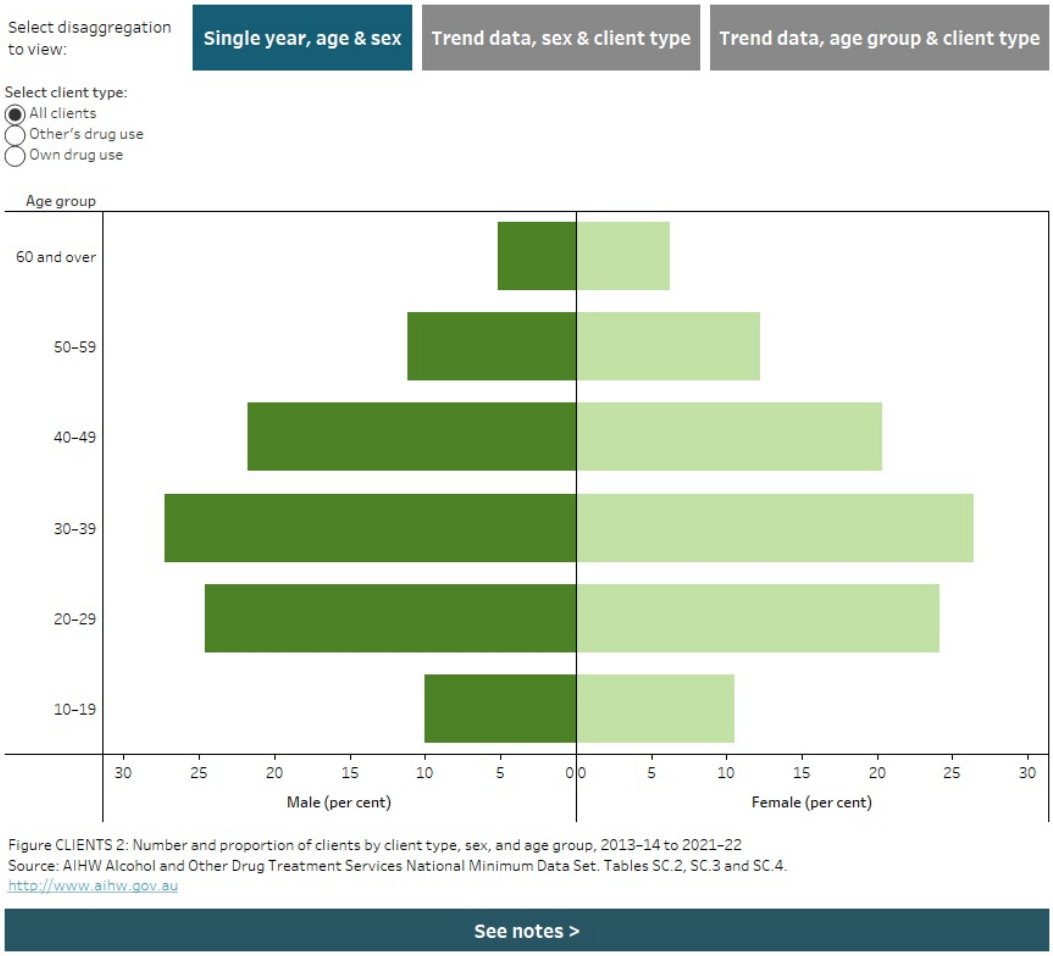

Figure CLIENTS 2: Number and proportion of clients by client type, sex, and age group, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables SC.2, SC.3 and SC.4.
http://www.aihw.gov.au

See notes >

Client service use over multiple years

Nationally since 2017–18, 468,996 people have received AOD treatment, some in more than one year (Figure CLIENTS 3, Table SCR.28).

Over the 5 years to 2021–22:

- the majority received treatment in a single year (71%):
  - 69,788 (15%) of people received treatment for the first time in 2021–22
  - a further 261,822 (56%) of people received treatment in only 1 of the 4 collection periods (excluding 2021–22).
- 3 in 10 (29%) of people received treatment in more than one year.

Figure CLIENTS 3: Client service use over multiple years, 2017–18 to 2021–22

The pie chart shows the proportion of clients who received treatment in a single year only, 2 of the 5 years, 3 of the 5 years, 4 of the 5 years or all 5 years between 2017–18 and 2021–22. Most clients received treatment in a single year only (14.9% for 2021–22), 15.3% received treatment in 2 years, 5.5% in 3 years, 1.9% in 4 years and 0.9% received treatment in all 5 years.

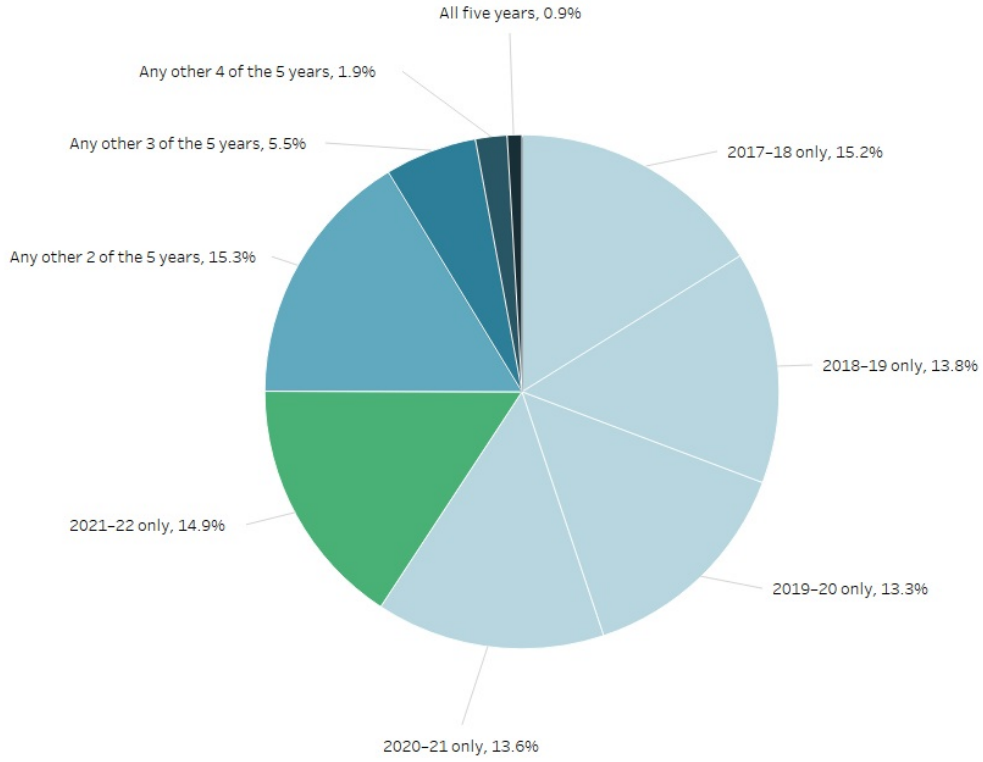

Figure CLIENTS 3: Client service use over multiple years, 2017–18 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set Table. Table SCR.28.
http://www.aihw.gov.au

See notes >

Clients and drugs of concern

AOD treatment services provide treatment for the drug that is of most concern to the client, which is referred to as their principal drug of concern.

Different age groups sought treatment for different principal drugs of concern. For people who received treatment for their own alcohol or drug use in 2021–22:

- Alcohol was the most common principal drug of concern in the older age groups: just under two-thirds of people aged 50–59 (64%) and over three-quarters of people aged 60 and over (77%) received treatment for alcohol as a principal drug of concern
- Amphetamines were the most common principal drug of concern for those aged 20–29 and 30–39 (25% and 33%, respectively).
- Cannabis was the most common principal drug of concern in young clients: 3 in 5 people aged 10–19 (61%) (Figure CLIENTS 4, Table SC.13).

Figure CLIENTS 4: Clients who received treatment for their own drug use, by age group and principal drug of concern, 2013–14 to 2021–22

The stacked horizontal bar chart shows that the most common principal drug of concern (PDOC) differed with age in 2021–22. Cannabis was the most common PDOC for clients aged 10–19 (61.4% of clients) or 20–29 (31.3%). Amphetamines was the most common PDOC for clients aged 30–39 (32.9%), and alcohol was the most common principal drug of concern among clients aged 40–49 (49.3% of clients), 50–59 (63.6%) or 60+ (76.8%). A filter allows the user to view different years of data.

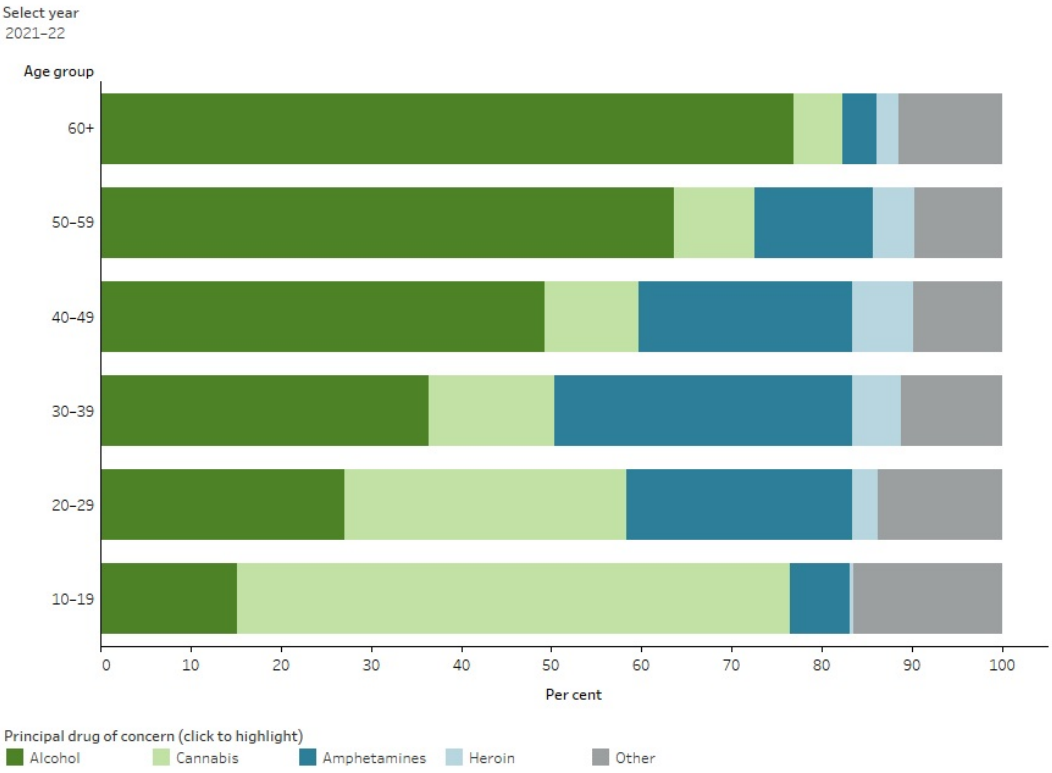

Figure CLIENTS 4: Clients who received treatment for their own drug use, by age group and principal drug of concern, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SC.13.
http://www.aihw.gov.au

See notes >

The age and sex profiles of the clients varied by principal drug of concern. For people who received treatment for their own alcohol or drug use in 2021–22:

- where heroin was the principal drug of concern, people aged over 30 (83% of clients) were the most likely to receive treatment. Among these clients, 35% were aged 30–39 and 33% were aged 40–49 (Table SC.13)
- over half (56%) of all people receiving treatment for codeine as the principal drug of concern were female
- males were nearly 6 times more likely to receive treatment for cocaine as a principal drug of concern than females (83% of episodes for males; 14% for females) (Table SC.12)
- 3 in 4 (75%) clients receiving treatment for volatile solvents as a principal drug of concern were Aboriginal and/or Torres Strait Islander (Table SC.14).

Usual accommodation type for client

The collection of information about a person's usual type of accommodation where they lived prior to the start of their AOD treatment enables AOD services to identify people who may be vulnerable, such as those from custodial settings or people at risk of homelessness. This information may help identify people living in a public place or experiencing homelessness, supporting the 'no exit to homelessness' policy where agencies can only discharge a client to safe, stable housing (Department of Social Services 2020).

Usual accommodation type for the client prior to treatment is reported for selected jurisdictions: New South Wales, Queensland, Western Australia, South Australia, Australian Capital Territory and the Northern Territory. As data quality improves additional jurisdictional data will be reported. The following analysis includes 60% of all treatment episodes (137,338) (Figure CLIENTS 5, Table OV.13).

In 2021–22, treatment episodes reporting the usual accommodation type for AOD clients from selected states and territories revealed in all selected jurisdictions:

- the most common accommodation prior to the start of treatment was independent residential accommodation (e.g., private residence, boarding house, private hotel or informal housing). Independent residential accommodation ranged from 51% in the Northern Territory to 89% in Western Australia
- the Northern Territory reported the highest proportion of episodes with usual accommodation types as custodial (prison/remand centre/youth training centre) (18%) and supported independent living (16%)
- South Australia reported the highest proportion of episodes with usual accommodation types as none/homeless/public place (9.9%) (Figure CLIENTS 5; Table OV.13).

Figure CLIENTS 5: Treatment episodes by client's accommodation type prior to treatment service, selected states and territories, 2017–18 to 2020–21

The stacked horizontal bar chart shows client accommodation type prior to treatment service for New South Wales, Queensland, Western Australia, South Australia and the Northern Territory in 2021–22. Independent residential accommodation was the most common accommodation type prior to treatment service across all included states/territories, ranging from 51.0% of clients in the Northern Territory to 89.0% in Western Australia. A filter allows the user to view different years of data.

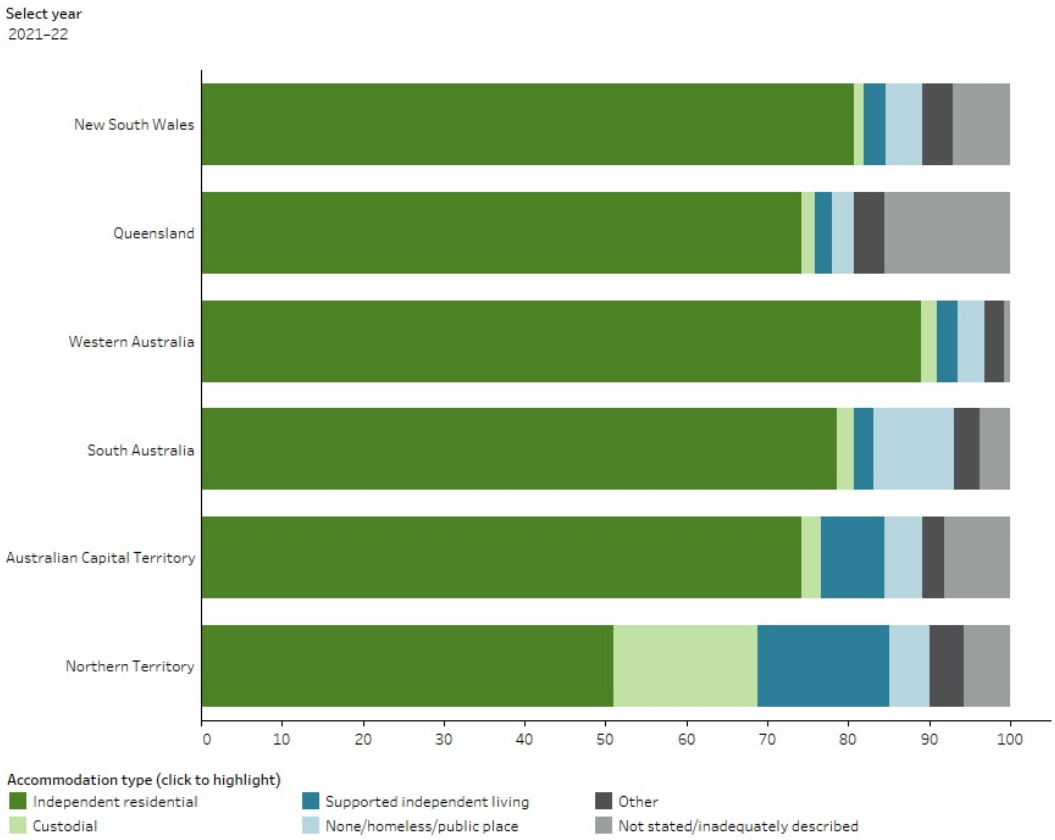

Figure CLIENTS 5: Treatment episodes by client's accommodation type prior to treatment service, selected states and territories, 2017–18 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment National Minimum Data Set. Table OV.13.
http://www.aihw.gov.au

See notes >

References

DSS (Department of Social Services) 2020. National Housing and Homelessness Agreement. Canberra: DSS. Viewed 1 July 2020.

Clients

On this page:

In 2021–22, Aboriginal and Torres Strait Islander Australians accounted for 18% (23,746) of people aged 10 and over receiving treatment or support for their own or someone else's alcohol or other drug use (Table SCR.26).

Nationally, the rate of Indigenous Australian people receiving treatment remains high:

- in 2021–22, the crude rate of Indigenous Australians receiving treatment for alcohol or drug use was 3,420 per 100,000 people
- the rate of Indigenous Australians receiving treatment for alcohol or drug use has increased over time, from 2,829 per 100,000 people in 2013–14 to 3,420 in 2021–22 (crude rate for clients aged 10 and over)
- in 2021–22, Indigenous Australians were more than 7 times as likely to receive treatment for alcohol or drug use as non-Indigenous Australians after adjusting for differences in age structure (3,354 per 100,000 people compared with 497 per 100,000; age standardised rates for clients aged 10 and over) (Figure INDIGENOUS 1, Table SCR.26).

Figure INDIGENOUS 1: Estimated number and rate of clients, by Indigenous status, 2013–14 to 2021–22

The line graph shows that between 2013–14 to 2021–22, the age-standardised rate of clients was consistently higher for Indigenous Australians than non-Indigenous Australians. In 2021–22, the age-standardised rate of clients was 3,354 per 100,000 population for Indigenous Australians, compared with 497 per 100,000 for non-Indigenous Australians. A filter allows the user to view data for age-standardised rate, crude rate or number of clients.

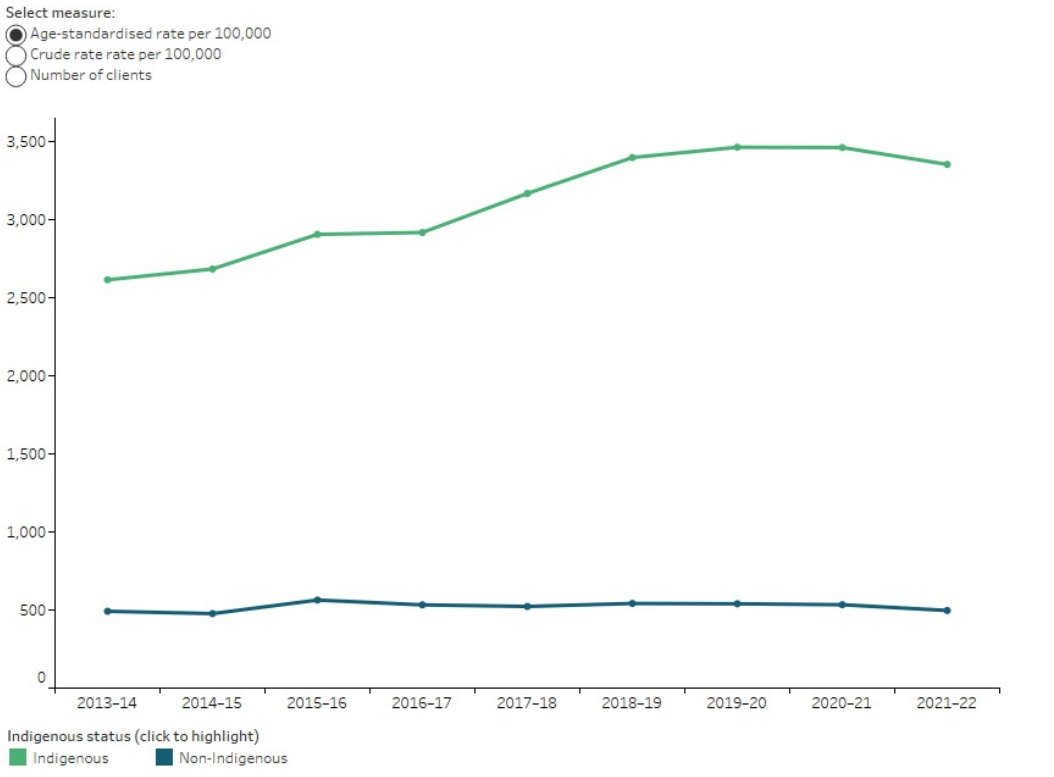

Figure INDIGENOUS 1: Estimated number and rate of clients, by Indigenous status, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SCR.26.
http://www.aihw.gov.au

See notes >

Client profile

In 2021–22:

- just under 1 in 5 (18% or 22,338) people who received treatment for their own alcohol or drug use were Indigenous Australians aged 10 and over
- around 1 in 10 (9.4% or 831) people who sought treatment for someone else's alcohol or drug use were Indigenous Australians
- three in 5 (60%) Indigenous clients were male and just under 2 in 5 (39%) were female
- over 7 in 10 (72%) Indigenous clients were aged 10 to 40 years
- Indigenous status was not reported for 3.1% of clients (Figure INDIGENOUS 2, tables SC.8–SC.10).

Figure INDIGENOUS 2: Proportion of Indigenous Australians by sex and age group (10 years and over), 2021–22

The butterfly bar chart shows that the most common age group for both male and female Indigenous Australian clients in 2021–22 was 20–29 (30% of both males and females), followed by 30–39 (28% of males and 30% of females). Buttons allow the user to navigate to a stacked bar chart presenting trend data disaggregated by Indigenous status and client type.

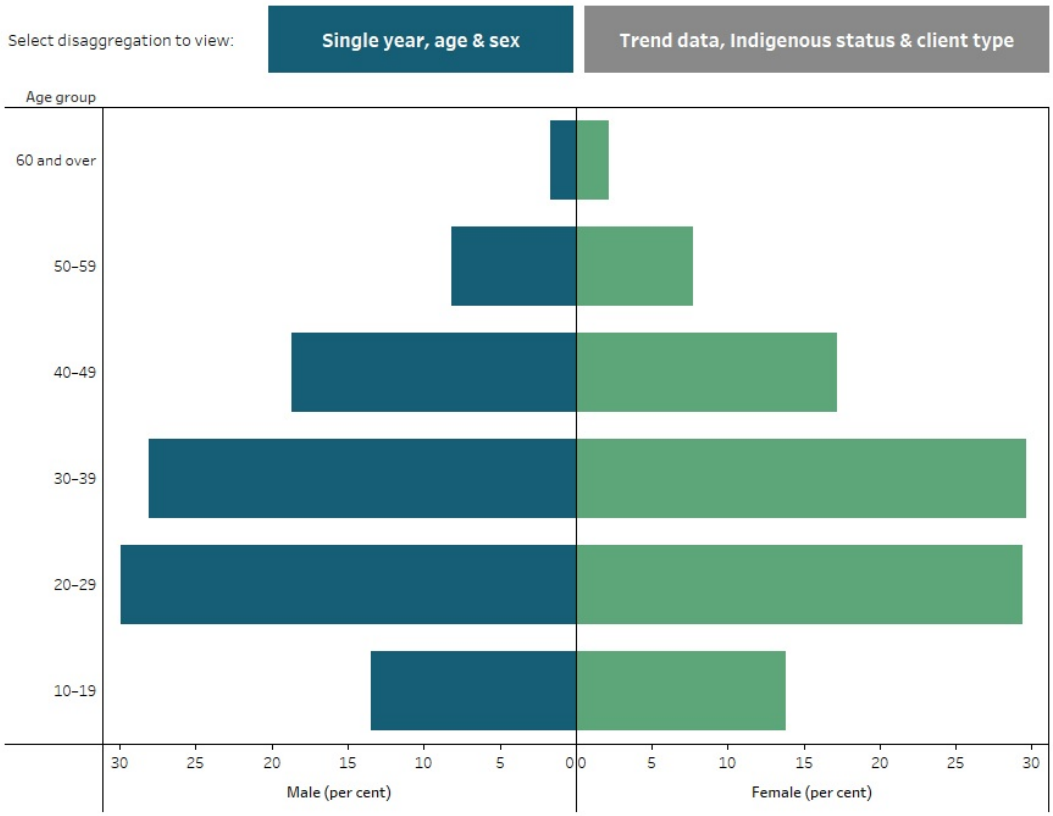

Figure INDIGENOUS 2: Proportion of Indigenous Australian AODTS clients by sex, age group (10 years and over) and client type, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SC.8 and SC.10.
http://www.aihw.gov.au

See notes >

Principal drug of concern

The main principal drugs of concern that led Indigenous Australians to seek treatment were alcohol (36%), amphetamines (24%), cannabis (24%), heroin (4.9%) (Figure INDIGENOUS 3, Table SC.14).

Nationally, the crude rate of Indigenous Australians receiving treatment for alcohol decreased from 1,299 per 100,000 people in 2013–14 to 1,255 in 2021–22. Over the same period, the rate of Indigenous Australians receiving treatment for amphetamines more than doubled, from 399 per 100,000 people to 905 per 100,000 people.

In 2021–22, after adjusting for differences in age-structure, Indigenous Australians were:

- nine times as likely to receive treatment for heroin (age standardised rate ratio) as non-Indigenous Australians (202 per 100,000 compared with 22 per 100,000)
- seven and 8 times as likely to receive treatment for alcohol or amphetamines (respectively) as non-Indigenous Australians
- seven times as likely to receive treatment for cannabis as non-Indigenous Australians (Figure INDIGENOUS 3, Table SCR.26).

Figure INDIGENOUS 3: Proportion and rate of Indigenous Australian AODTS clients, by principal drug of concern, 2013-14 to 2021-22

The visualisation includes 2 charts. The top chart is a stacked horizontal bar chart that shows the most common principal drug of concern among Indigenous Australian clients in 2021–22 was alcohol (35.9%), followed by amphetamines (24.2%). The bottom chart is a line chart that shows that alcohol has remained the most common principal drug of concern among Indigenous Australian clients across the period 2013–14 to 2021–22. Two filters for the bottom chart allow the user to view data for Indigenous or non-Indigenous clients and as a crude or age-standardised rate.

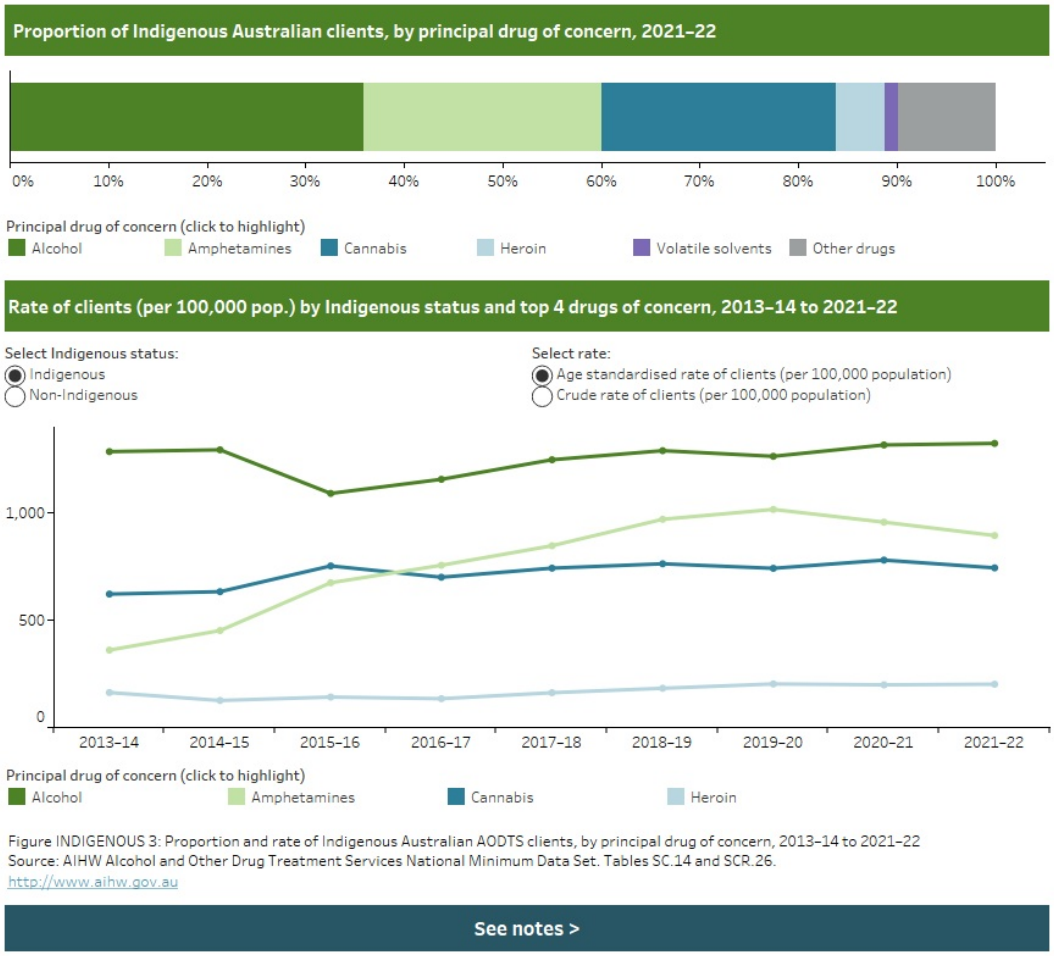

Figure INDIGENOUS 3: Proportion and rate of Indigenous Australian AODTS clients, by principal drug of concern, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables SC.14 and SCR.26.
http://www.aihw.gov.au

See notes >

Main treatment

For the 22,338 Indigenous Australians receiving treatment for their own alcohol or drug use, counselling was the most common main treatment type (42%), followed by assessment only (22%). Similarly, for Indigenous Australians seeking treatment for another person's alcohol or drug use, counselling was the most common treatment type (36%), followed by support and case management (33%; Table SC.20).

The referral and setting varied by treatment type for Indigenous Australian clients:

- most referrals for Indigenous Australian clients into treatment were from a family member or a self-referral
- Indigenous Australians who received withdrawal management (52%) or pharmacotherapy (61%) as a treatment type were most likely to be referred by a family member or a self-referral
- over one-quarter (27%) of all referrals for Indigenous Australians into treatment were from a health service
- the majority of Indigenous Australians received counselling (85%) or pharmacotherapy (94%) in a non-residential setting
- just under three-quarters (73%) of Indigenous Australians received rehabilitation and over two-thirds (68%) received withdrawal management in residential settings (Figure INDIGENOUS 4 and INDIGENOUS 5, tables SC.23 and SC.24).

Figure INDIGENOUS 4: Proportion of Indigenous Australian AODTS clients, by main treatment type and referral source for all clients, 2021-22

The stacked horizontal bar chart shows that the 2 most common sources of referral for Indigenous Australian AODTS clients were self/family and health service. This was consistent across all main treatment types. The proportion of clients who were referred via self/family ranged from 24.7% of clients receiving assessment only as the main treatment type to 60.6% for clients receiving pharmacotherapy. The proportion of clients who were referred via a health service ranged from 19.7% for clients receiving rehabilitation to 35.9% for clients receiving information and education.

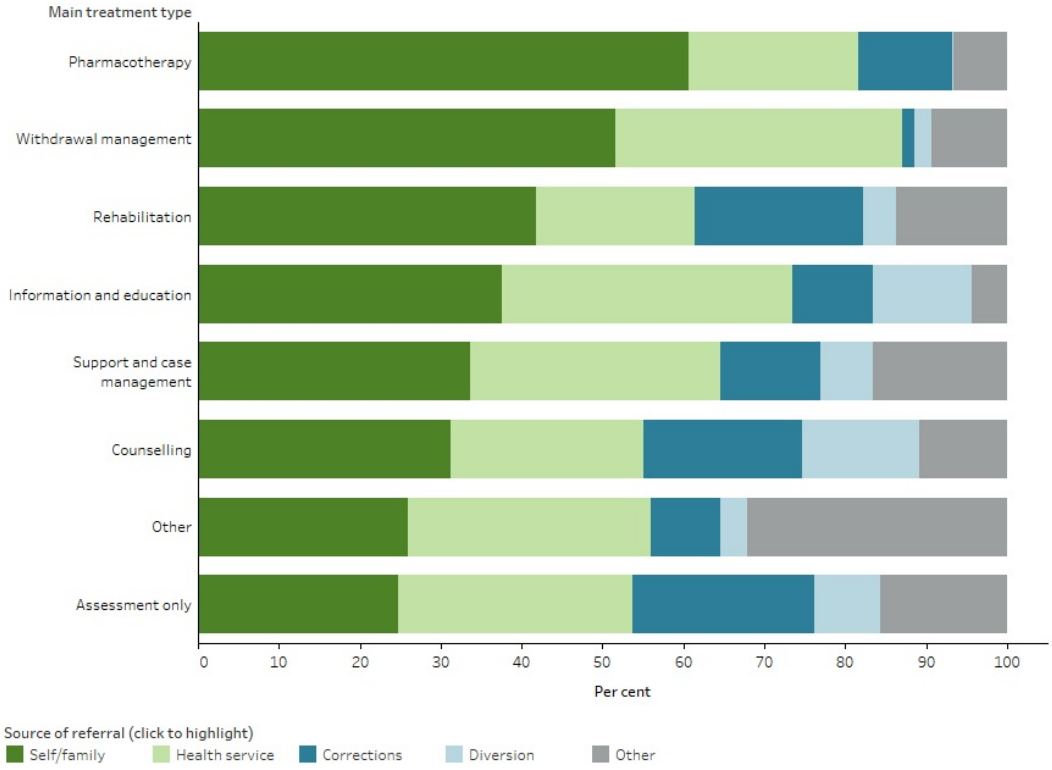

Figure INDIGENOUS 4: Proportion of Indigenous Australian AODTS clients, by main treatment type and referral source for all clients, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SC.24.
http://www.aihw.gov.au

See notes >

Figure INDIGENOUS 5: Proportion of Indigenous Australian AODTS clients, by main treatment type and delivery setting for all clients, 2021-22

The stacked horizontal bar chart shows that non-residential treatment settings were the most common delivery setting among Indigenous Australian clients receiving counselling, support and case management, assessment only, pharmacotherapy, information and education, or 'Other' as the main treatment type in 2021–22 (ranging from 51.3% to 93.9% of clients). Residential treatment settings were the most common delivery setting for clients receiving withdrawal management or rehabilitation (67.7% and 73.1% of clients, respectively).

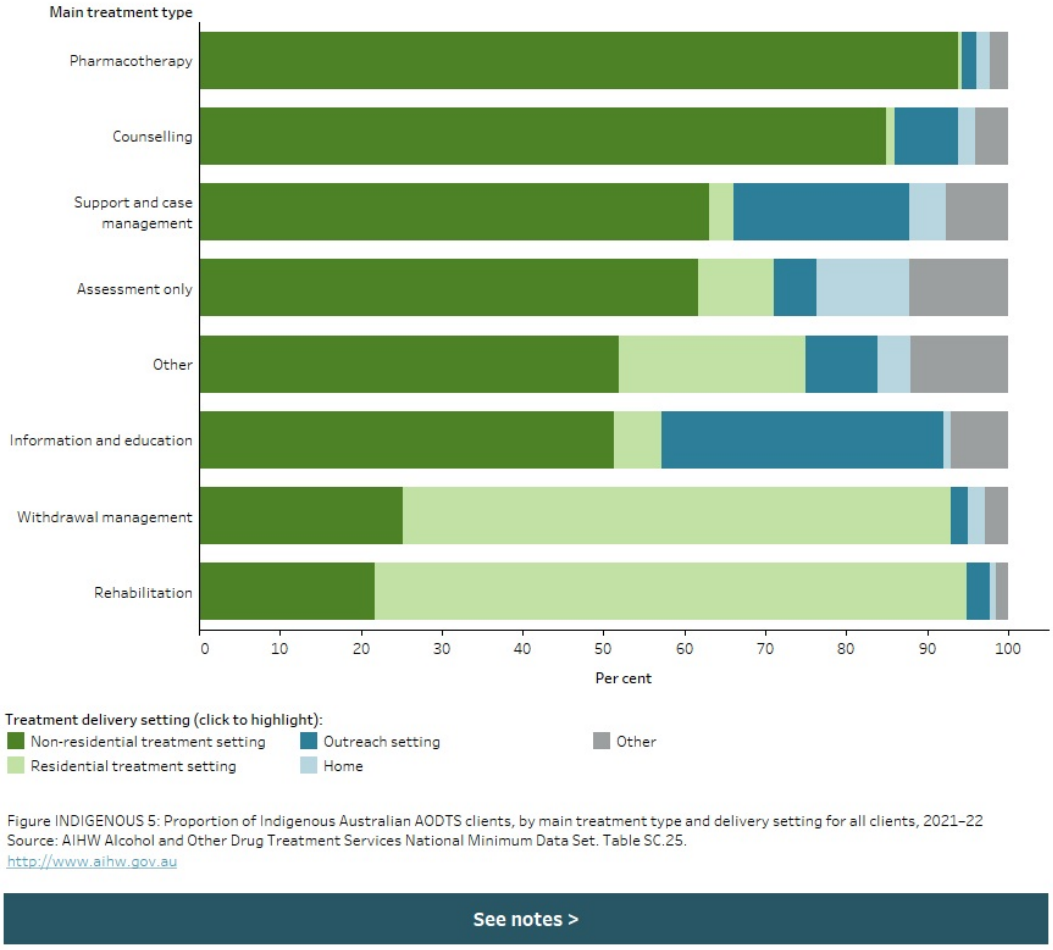

Figure INDIGENOUS 5: Proportion of Indigenous Australian AODTS clients, by main treatment type and delivery setting for all clients, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SC.25.
http://www.aihw.gov.au

See notes >

Australian Government-funded Aboriginal and Torres Strait Islander AOD reporting

The Australian Government funds primary healthcare services and substance use services specifically for Indigenous Australians. These services previously reported via the Australian Government-funded Aboriginal and Torres Strait Islander substance use services, via the Online Services Report (OSR) data collection. The substance use services program was transferred to the Department of Prime Minister and Cabinet and then to the National Indigenous Australians Agency and ceased in 2019.

The National Agreement on Closing the Gap noted that funding for First Nations Alcohol and Other Drugs (AOD) services and support will increase by up to $66 million to 2024–25, in addition to current funding. First Nations' AOD Treatment Services funded under the Indigenous Advancement Strategy (IAS) currently assists around 75 providers to deliver 90 activities. The Commonwealth also provides AOD treatment services and prevention, research and communication activities through the Drug and Alcohol Program (DAP) and funding to Primary Health Networks (PHNs), with nearly 30% of PHN funding allocated for First Nations specific treatment services (National Indigenous Australians Agency 2022).

References

National Indigenous Australians Agency (NIAA) 2022. Commonwealth Closing the Gap Annual Report 2022. Canberra: Commonwealth of Australia.

Drugs of concern

On this page:

People may seek alcohol and other drug (AOD) treatment services for use of one or several substances (including alcohol). The principal drug of concern (PDOC) is the main substance that the client stated led them to seek treatment. Clients can also nominate up to 5 additional drugs of concern, though these are not necessarily the subject of any treatment within the episode.

This section presents information on treatment episodes provided to clients for their own AOD use only. It is assumed that only the person using a substance themselves can accurately report their principal drug of concern. Therefore, these data are not collected for people who are seeking treatment for someone else's drug use.

This section focuses on treatment episodes provided for alcohol, amphetamines, cannabis and heroin as the PDOC. These 4 drugs were consistently the most common principal drugs of concern across Australia in the 10-year period up to 2021–22. For detailed information on each drug of concern, refer to the technical notes.

Key findings

In 2021–22:

- The most common principal drug of concern was alcohol (42% or 87,300 episodes), followed by amphetamines (24%), cannabis (19%) and heroin (4.5%).
- 4 in 5 treatment episodes for amphetamines were for methamphetamine as the principal drug of concern (80% or 39,900 episodes).

Over the 10-year period to 2021–22:

- The top 4 principal drugs of concern have remained consistent with amphetamines replacing cannabis as the second most common principal drug of concern from 2015–16.
- Alcohol remains the most common principal drug of concern, increasing from 63,800 to 87,300 episodes over this period.
- Treatment episodes for amphetamines as the principal drug of concern almost tripled between 2012–13 and 2019–20 (22,300 to 61,000), although this has declined since then (49,700 in 2021–22).
- Treatment episodes for heroin as a principal drug of concern fell from 8.3% to 4.5% (or 12,800 to 9,400 episodes).

Drugs of concern and treatment provided

In 2021–22, over 9 in 10 treatment episodes provided to clients were for their own AOD use (92% or 209,953 episodes) (Table OV.1). Among these episodes:

- The most common principal drugs of concern were alcohol (42% of treatment episodes), amphetamines (24%), cannabis (19%) and heroin (4.5%) (Table Drg.1).
- Clients reported at least 1 additional drug of concern in over one quarter of treatment episodes (28%).
  - The number of additional drugs reported was most commonly 1 (18% of episodes) or 2 drugs (6.7%).
  - Cannabis (11% of episodes), nicotine (9.1%) and alcohol (7.2%) were the most common additional drugs of concern (tables Drg.1, Drg.2, Drg.3).
- For the 4 most common principal drugs of concern, the most common treatment setting was non-residential treatment facilities (ranging from 63% to 72%) (Table Drg.8).

In the 10 years to 2021–22, the total number of treatment episodes for clients' own drug use increased from 155,151 to 209,953 episodes (Table OV.1). Among these episodes across the period:

- Alcohol remained the most common principal drug of concern each year, and treatment episodes increased by 37% over this period (from 63,800 to 87,300 episodes). The proportion of treatment episodes for alcohol in relation to all other drugs of concern fluctuated, falling from 41% in 2012–13 to 32% in 2015–16, before rising to 42% in 2021–22.
- Treatment episodes for amphetamines as a principal drug of concern more than doubled since 2012–13 (22,300 to 49,700 episodes), although this has declined since 2019–20.
  - 4 in 5 (80%) episodes for amphetamines were for methamphetamine as the principal drug of concern, increasing from 18% since 2012–13 (from 4,050 to 39,900 episodes).
- Treatment episodes for heroin as the principal drug of concern fell from 8.3% to 4.5% (or 12,800 to 9,400 episodes).
- Treatment episodes for cannabis fluctuated, peaking at 45,000 episodes in 2015–16. In relation to all other drugs of concern, cannabis treatment episodes were most prominent in 2014–15 when they constituted 24% of all episodes (Table Drg.5).

Fluctuations in certain principal drug treatment episodes in particular years may be due to administrative anomalies in the data. For example, the drop in all treatment episodes in the 2014–15 and 2016–17 collection years may be partly related to system changes resulting in under-reporting or partial reporting of the number of episodes in some jurisdictions (See the Data quality statement for further details).

Figure DRUGS 1: Closed treatment episodes for own alcohol or drug use, by principal drug of concern and additional drugs of concern, 2021-22

Note: Totals might not add to 100% due to rounding.

Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Dataset Tables Drg1 and Drg.2.

Explore drugs of concern:

- Alcohol
- Amphetamines
- Cannabis
- Heroin

- Pharmaceuticals
- Selected other drugs

Drugs of concern

Alcohol: client demographics and treatment

On this page:

In 2021–22, alcohol was reported as a drug of concern (either principal or additional) in almost half of all treatment episodes (49% or 102,382 episodes) (Table Drg.5).

Alcohol was the most common principal drug of concern:

- in over 2 in 5 treatment episodes (42% or 87,300 episodes) in 2021–22 (Table Drg.5)
- it has remained the most common PDOC since 2012–13
- with an overall increase in the number of alcohol-related treatment episodes (from 63,700 to 87,300 episodes), between 2012–13 and 2021–22
- the proportion of treatment episodes for alcohol in relation to all other drugs of concern fluctuated, falling from 41% in 2012–13 to 32% in 2015–16, before rising in 2021–22 (Table Drg.1).

In 2021–22, at least 1 additional drug of concern was recorded in over 1 in 5 alcohol-related treatment episodes (22% or 19,500 episodes) (Table Drg.2). The most common additional drugs of concern were cannabis (37% or 10,300 episodes), nicotine (27% or 7,400 episodes) and amphetamines (17% or 4,800 episodes) (Table Drg.3). These drugs may not have been the subject of any treatment in the episode.

For information on alcohol use and harms, please see:

- Tobacco, alcohol and other drugs in Australia: Alcohol
- National Drug Strategy Household Survey 2019 (Chapter 3: Alcohol)

Client demographics

In 2021–22, 48,400 clients received treatment for their own use of alcohol as a principal drug of concern. Of these clients:

- 3 in 5 were male (61% of clients) (Table SC.9).
- 1 in 2 were aged either 30–39 (25% of clients) or 40–49 (26%) (Table SC.10). This was consistent for both males and females (Figure ALCOHOL 1).
- One in 6 were Indigenous Australians (17% or 8,000 clients) (Table SC.11). This represents a rate of 1,255 Indigenous clients per 100,000 population (crude rate) (Table SCR.26).

Figure ALCOHOL 1: Clients with alcohol as the principal drug of concern, by sex and age group, 2021–22

The butterfly bar chart shows that in 2021–22, male clients receiving treatment for alcohol as the principal drug of concern were most likely to be aged 40–49 (26.1%) or 30–39 (25.3%). This was similar for female clients (26.7% aged 40–49 and 24.2% aged 30–39).

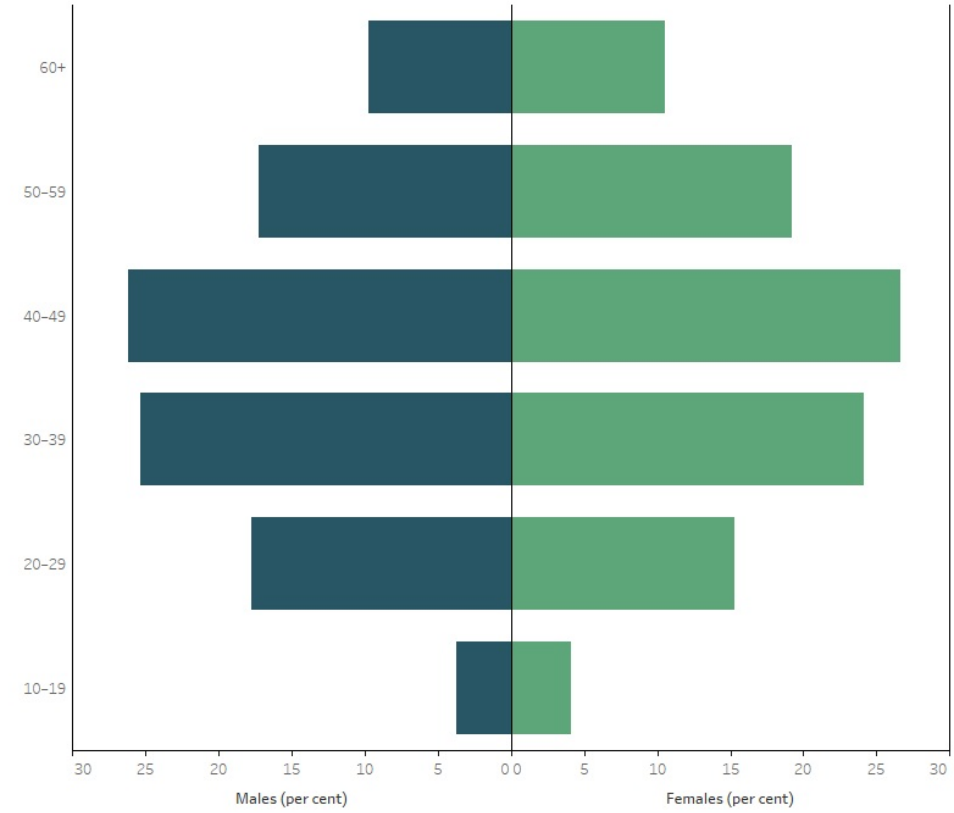

Figure ALCOHOL 1: Clients with alcohol as the principal drug of concern, by sex and age group, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

See notes >

Treatment

In 2021–22, 87,334 treatment episodes were provided to clients for alcohol as the principal drug of concern (Table Drg.5).

Among alcohol-related treatment episodes in 2021–22:

- The most common source of referral was self or family (41% or 36,000 episodes), followed by health services (39%) (Figure ALCOHOL 2; Table Drg.13).
  - Across the 10 years to 2021–22, referral from a health service increased while referral from the criminal justice system (diversion) fell.
- The most common main treatment type was counselling (35% or 30,800 episodes), followed by assessment only (22%) and withdrawal management (14%) (Figure ALCOHOL 2, Table Drg.18).
  - Counselling, withdrawal management and assessment only remained the most common treatment types across the 10 years to 2021–22, although the proportion of episodes for each treatment type varied over time.
- Almost 2 in 3 episodes were provided in non-residential treatment settings (66% of episodes). A further 17% were provided in residential treatment settings and 6.8% were provided in outreach settings (Table Drg.20).
- The median duration of treatment episodes was just over 4 weeks (29 days) (Table Drg.21). One in 3 (34%) treatment episodes lasted 2 days to 1 month, and 26% lasted 1–3 months (Table OV.12).
- Over 3 in 5 episodes ended with a planned completion (62% of episodes), while 20% ended unexpectedly (that is, the client ceased to participate against advice, without notice or due to non-compliance) (Figure ALCOHOL 2; Table Drg.19).

Figure ALCOHOL 2: Treatment episodes with alcohol as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012-13 to 2021-22

The line graph shows that counselling was the most common main treatment type among treatment episodes for alcohol across the 10 years to 2021–22, accounting for 30,832 episodes in 2021–22. Withdrawal management and assessment only remained the second and third most common main treatment types across the period. Filters allow the user to view data as the number or proportion (per cent) of episodes for main treatment type, reason for cessation or source of referral.

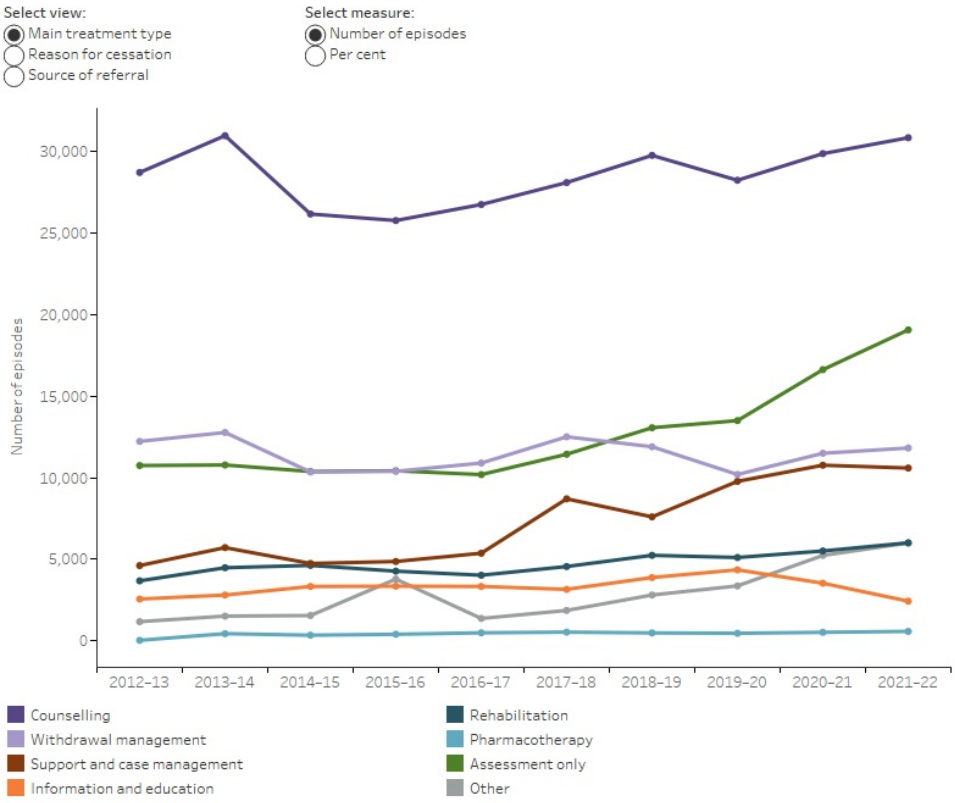

Figure ALCOHOL 2: Treatment episodes with alcohol as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables Drg.12, Drg.13 and Drg.18.
http://www.aihw.gov.au

See notes >

Drugs of concern

Amphetamines: client demographics and treatment

On this page:

In 2021–22, amphetamines were reported as a drug of concern (either principal or additional) in 3 in 10 treatment episodes (30% or 62,711 episodes) (Table Drg.5).

Classification of amphetamines in the AODTS NMDS

AODTS NMDS data for amphetamines correspond to the Australian Standard Classification of Drugs of Concern (ASCDC) for the general 'amphetamines' classification, in which methamphetamine is a sub-classification (ABS 2011).

The ASCDC is set up with 3 levels of classification which includes the broad group (e.g., Stimulants and hallucinogens), narrow group and base-level categories (which are the most detailed). Data available in the AODTS NMDS report the narrow group 'amphetamines' classification. Base-level categories within this narrow group include:

- Amphetamine
- Dexamphetamine
- Methamphetamine
- Amphetamine analogues
- Amphetamines, not elsewhere classified (n.e.c)
- Amphetamines not further defined (n.f.d).

Changes to coding for methamphetamines has been difficult due to jurisdictional differences in client management systems, and the use of only broad or narrow group coding by some agencies. This has improved over time due to advancements in workforce training, agency coding practices and new system updates.

Data on different forms of amphetamines—methamphetamine specifically—have not been separately reported over time due to the nature of the classification structure used in this collection. Information on methamphetamines as a principal drug of concern was reported for the first time in the 2019–20 Alcohol and Other Drug Treatment Services in Australia annual report.

Amphetamines were the second most common principal drug of concern, recorded in almost 1 in 4 treatment episodes (24% or 49,694 episodes) (Table Drg.4).

Amphetamines have remained the second most common principal drug of concern:

- since 2015–16, when it surpassed cannabis for the first time (Table Drg.5)
- with treatment episodes more than doubling since 2012–13 (22,300 to 49,700 episodes), although this has declined since 2019–20
- in relation to all other drugs of concern, treatment episodes steadily rose between 2012–13 (14%) and 2019–20 (28%) but declined in 2021–22 to 24% (Table Drg.1).

In 2021–22, 2 in 5 amphetamine-related treatment episodes had at least 1 additional drug of concern recorded (37% or 18,200 episodes) (Table Drg.2). The most common additional drugs of concern were cannabis (34% or 10,300 episodes), alcohol (21% or 6,400 episodes) and nicotine (19% or 5,700 episodes) (Table Drg.3). These drugs may not have been the subject of any treatment in the episode.

For information on amphetamine use and harms, please see:

- Tobacco, alcohol and other drugs in Australia: Meth/amphetamine and other stimulants
- National Drug Strategy Household Survey 2019 (Chapter 4: Illicit use of drugs)

Client demographics

In 2021–22, 27,490 clients received treatment for amphetamines as the principal drug of concern. Of these clients:

- 3 in 5 were male (61% of clients) (Table SC.9).
- almost 3 in 5 were aged either 20–29 (25% of clients) or 30–39 years (33%) (Table SC.10). This was consistent for both males and females (Figure AMPHET 1).

- 1 in 5 were Indigenous Australians (20% or 5,400 clients) (Table SC.11). This represents a rate of 905 Indigenous clients per 100,000 population (crude rate) (Table SCR.26).

Figure AMPHET 1: Clients with amphetamines as the principal drug of concern, by sex and age group, 2021–22

The butterfly bar chart shows that in 2021-22, clients receiving treatment for amphetamines as the principal drug of concern were most likely to be aged 30–39 (39.4% of male clients; 40.2% of female clients).

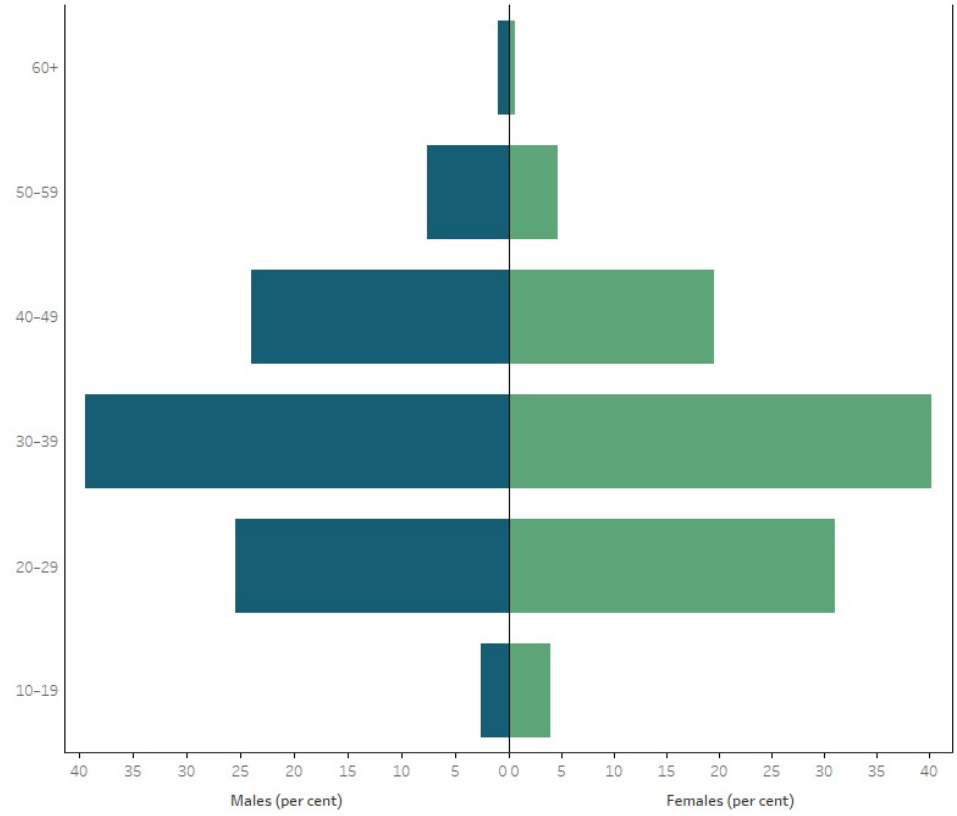

Figure AMPHET 1: Clients with amphetamines as the principal drug of concern, by sex and age group, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

See notes >

Treatment

In 2021–22, 49,694 treatment episodes were provided to clients for amphetamines as the principal drug of concern (Table Drg.4).

Among amphetamine-related treatment episodes in 2021–22:

- The most common source of referral were self/family (37% or 18,200 episodes), followed by health services (26%) (Figure AMPHET 2; Table Drg.37).
- The most common main treatment type were counselling (38% of episodes), followed by assessment only (23%) (Figure AMPHET 2; Table Drg.36). This is consistent with previous years, although the proportion of counselling episodes has fluctuated in the 10 years to 2021–22.
- Over 3 in 5 treatment episodes took place in a non-residential treatment facility (63% of episodes) (Table Drg.38).
- The median duration of treatment episodes was just over 5 weeks (36 days) (Table Drg.39). Episode duration varied by main treatment type, with the longest median duration being around 11 weeks (78 days) for counselling (Table Drg.41). Nearly 3 in 10 (27%) treatment episodes lasted 1 to 3 months; a further 26% lasted 2–29 days (Table OV.12).
- Around 1 in 2 episodes ended with a planned completion (52% of episodes), while 25% ended unexpectedly (Figure AMPHET 2; Table Drg.38).

Figure AMPHET 2: Treatment episodes with amphetamines as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012-13 to 2021-22

The line graph shows that counselling was the most common main treatment type among treatment episodes for amphetamines across the 10 years to 2021–22, rising from 9,934 episodes in 2012–13, peaking at 24,701 episodes in 2019-20 and falling to 18,653 episodes in 2021–22. Assessment only remained the second most common main treatment types across the period, accounting for 11,400 episodes in 2021–22. Filters allow the user to view data as the number or per cent of episodes for main treatment type, reason for cessation or source of referral.

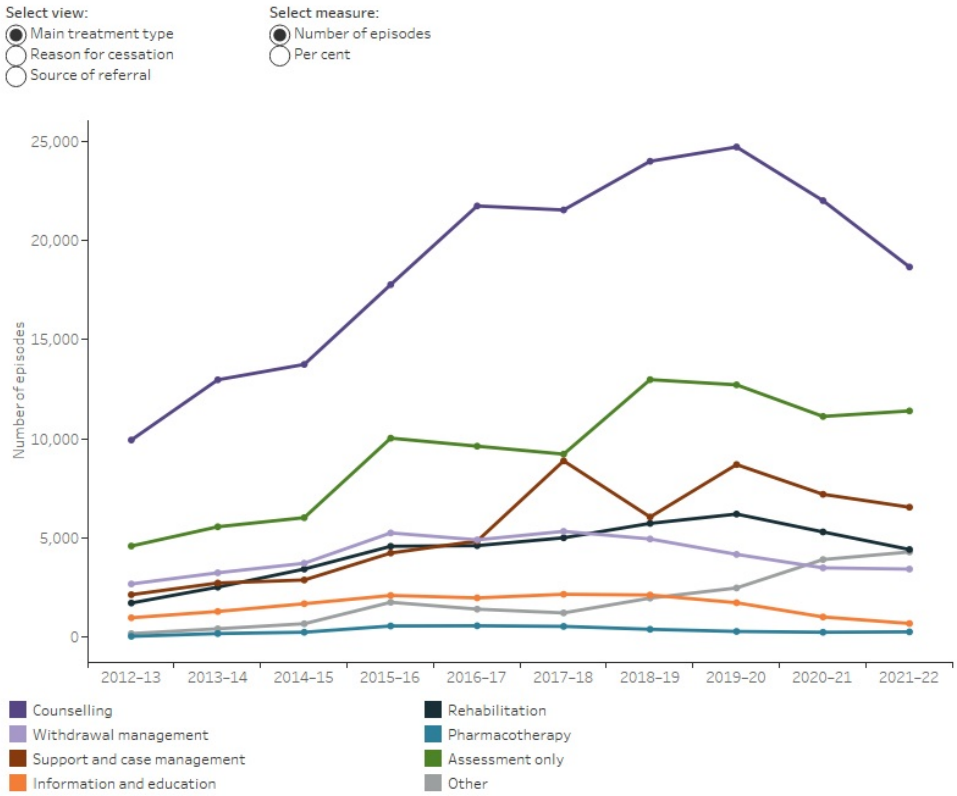

Figure AMPHET 2: Treatment episodes with amphetamines as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables Drg.12, Drg.13 and Drg.36.
http://www.aihw.gov.au

See notes >

Methamphetamine-related treatment episodes

In 2021–22, 4 in 5 (80%) amphetamine-related treatment episodes were for methamphetamine as the principal drug of concern (Table Drg.5). Treatment episodes increased from 18% to 80% since 2012–13 (from 4,050 to 39,912 episodes) (Figure AMPHET 3).

The rise in reported episodes for methamphetamine may be due to a combination of factors, including improvements in agency coding practices for methamphetamine, treatment system updates and increases in funded treatment services.

Figure AMPHET 3: Treatment episodes with amphetamines as the principal drug of concern, by amphetamine type, 2012–13 to 2021–22

The line graph shows that methamphetamine has remained the most common amphetamine type among treatment episodes for amphetamines since 2015–16, when it overtook ‘Amphetamines not further defined’. Methamphetamine accounted for 39,912 treatment episodes in 2021–22. A filter allows the user to view data as the number or per cent of episodes.

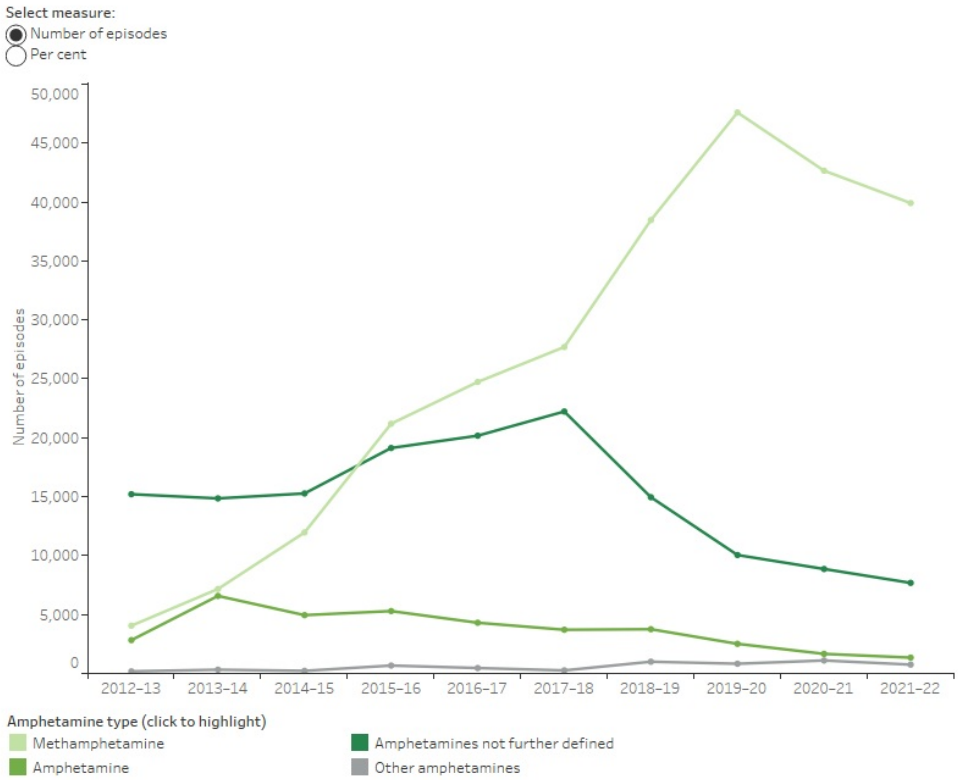

Figure AMPHET 3: Treatment episodes with amphetamines as the principal drug of concern, by amphetamine type, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Drg.5.
http://www.aihw.gov.au

See notes >

Method of use

How does a client's method of use relate to the form of amphetamine used?

A client's usual method of administering their principal drug of concern may indicate the form of drug used, particularly for amphetamines. For example:

- Clients who report smoking or inhaling amphetamines are most likely to be using amphetamines in crystal form.
- Clients who report ingesting or snorting are most likely to be using a powder form.
- Clients who report injecting amphetamines may be using any form of amphetamines, as each form (base, crystal and powder) can be injected. However, recent data from the Illicit Drug Reporting System (an annual survey of people who inject drugs) indicate that crystal and powder are the most common forms used among people who inject methamphetamine (Sutherland et al. 2022).

Among all amphetamine-related treatment episodes in 2021–22, smoking/inhaling was the most common method of use (50% of episodes), followed by injecting (33%) (Figure AMPHET 4; Table Drg.6). This was similar for methamphetamine (52% and 36% for smoking/inhaling and injecting, respectively) (Table Drg.6).

Between 2012–13 and 2021–22:

- The number of episodes where clients reported smoking/inhaling amphetamines increased from 8,400 episodes in 2012–13 to 25,000 episodes in 2021–22 (Figure AMPHET 4; Table Drg.6). This declined from 29,200 episodes in 2020–21, reflecting an overall decline in treatment episodes for amphetamines in the past two years.
- The number of episodes where clients injected amphetamines more than doubled between 2012–13 to 2019–20 (from 10,000 to 22,375 episodes), falling to 16,300 in 2021–22 (Figure AMPHET 4; Table Drg.6).

Figure AMPHET 4: Treatment episodes with amphetamines as the principal drug of concern, by method of use, 2012-13 to 2021-22

The line graph shows that 'Smokes or inhales' has remained the most common method of use among treatment episodes for amphetamines since 2014–15, when it overtook 'Injects' for the first time. 'Smokes or inhales' was the method of use in 25,024 episodes for amphetamines in 2021–22, while 'Injects' was the second most common method of use in 16,314 episodes.

Figure AMPHET 4: Treatment episodes with amphetamines as the principal drug of concern, by method of use, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Drg.35.
http://www.aihw.gov.au

See notes >

The rise in treatment episodes between 2013–14 and 2019–20 where clients report injecting amphetamines may be related to several factors, including increases in treatment episodes overall, and particularly for people who might have been injecting amphetamines and heroin interchangeably (AIHW 2015).

Additionally, increases in treatment episodes for smoking methamphetamine from 2010 onwards is associated with increased importation of high purity crystalline methamphetamine into Australia (Degenhardt et al. 2017). National Drug and Alcohol Research Centre (NDARC) analysis of AODTS NMDS data indicates this greater availability of crystalline methamphetamines is reflected in the increased number of episodes identifying smoking as a method of use (McKetin et al. 2021).

Treatment episodes for methamphetamines where smoking was the method of use was primarily provided to among younger clients (median age 30 years), who were more likely to receive main treatment types of assessment only or support and case management (McKetin et al. 2021).

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ABS 2011. Australian Standard Classification of Drugs of Concern, 2011. ABS cat. no. 1248.0. Canberra: ABS.

AIHW 2015. Trends in methylamphetamine availability, use and treatment, 2003–04 to 2013–14. Drug treatment series no. 26. Cat. no. HSE 165. Canberra: AIHW

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McKetin R, Chrzanowska A, Man N, Peacock A, Sutherland R & Degenhardt L. 2021. Trends in treatment episodes for methamphetamine smoking and injecting in Australia, 2003–2019. Drug and Alcohol Review.

Sutherland R, Uporova J, King C, Jones F, Karlsson A, Gibbs D, et al. 2022. Australian Drug Trends 2022: Key Findings from the National Illicit Drug Reporting System (IDRS) Interviews, Sydney: National Drug and Alcohol Research Centre, University of New South Wales, accessed 3 April 2023.

Drugs of concern

Cannabis: client demographics and treatment

On this page:

In 2021–22, cannabis was reported as a drug of concern (either principal or additional) in nearly 1 in 3 treatment episodes (31% or 64,309 episodes) (Table Drg.4).

Cannabis was the third most common principal drug of concern:

- in nearly 1 in 5 treatment episodes (19% or 40,200 episodes) (Table Drg.4) and this has remained consistent since 2015–16, when cannabis was surpassed by amphetamines as the second most common PDOC
- in the 10 years to 2021–22, treatment episodes for cannabis fluctuated, peaking at 45,000 episodes in 2015–16
- in relation to all other drugs of concern cannabis treatment episodes were most prominent in 2014–15 when they constituted 24% of all episodes (Table Drg.5).

In 2021–22, 3 in 10 cannabis-related treatment episodes had at least 1 additional drug of concern recorded (30% or 12,000 episodes) (Table Drg.2). The most common additional drugs of concern were alcohol (32% or 5,800 episodes), amphetamines (23% or 4,300 episodes) and nicotine (23% or 4,200 episodes) (Table Drg.3). These drugs may not have been the subject of any treatment within the episode.

For information on cannabis use and harms, please see:

- Tobacco, alcohol and other drugs in Australia: Cannabis
- National Drug Strategy Household Survey 2019 (Chapter 4: Illicit use of drugs)

Client demographics

In 2021–22, 25,989 clients received treatment for cannabis as the principal drug of concern. Of these clients:

- over 3 in 5 were male (62% of clients) (Table SC.9)
- around 2 in 3 people were aged either 10–19 (29% of clients) or 20–29 years (37%) (Table SC.10). This was consistent for both males and females (Figure CANNABIS 1)
- around 1 in 5 were Indigenous Australians (20% or 5,300 clients) (Table SC.11). This represents a crude rate of 873 Indigenous clients per 100,000 population (Table SCR.26).

Figure CANNABIS 1: Clients with cannabis as the principal drug of concern, by sex and age group, 2021–22 (per cent)

The butterfly bar chart shows that male clients receiving treatment for cannabis as the principal drug of concern were most likely to be aged 10–19 (30.3% of clients) or 20–29 (35.4%) in 2021–22. This was similar for female clients (28.1% aged 10–19 and 38.1% aged 20–29).

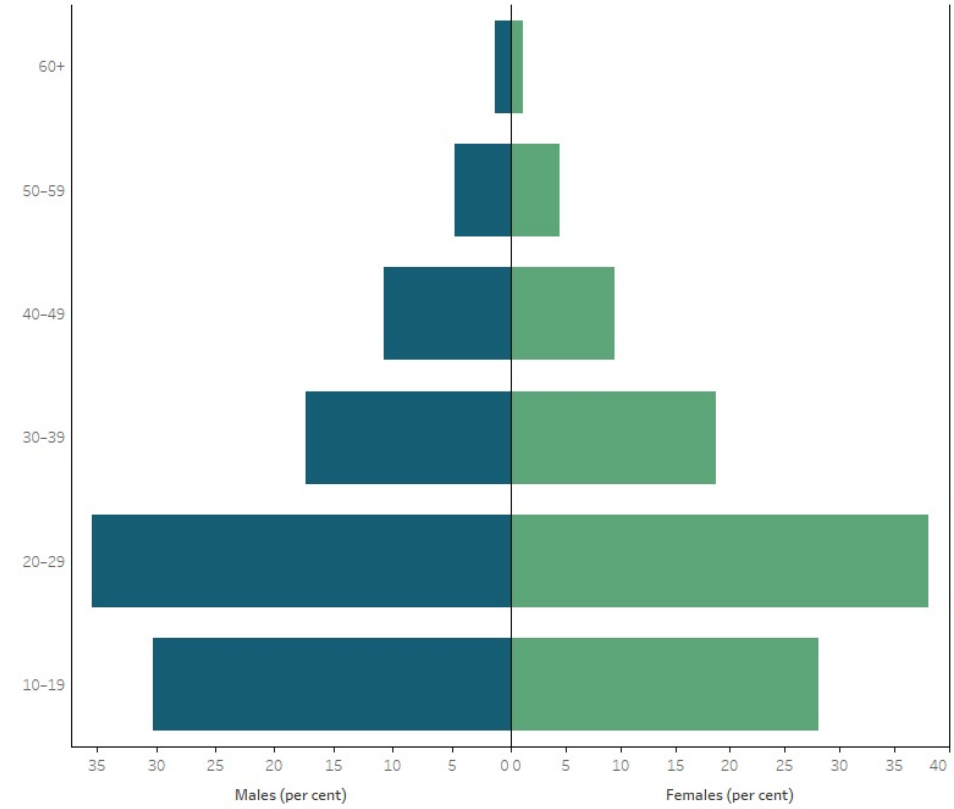

Figure CANNABIS 1: Clients with cannabis as the principal drug of concern, by sex and age group, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

See notes >

Treatment

In 2021–22, 40,210 treatment episodes were provided to clients for cannabis as the principal drug of concern (Table Drg.4).

Among cannabis-related treatment episodes in 2021–22:

- The most common sources of referral were health services and self/family (both around 29% of episodes), followed by diversion from the criminal justice system (20%) (Figure CANNABIS 32 Table Drg.28). For more information on diversion clients, see Source of referral and diversion clients.
- The most common main treatment type was counselling (47% of episodes), followed by assessment only (16%) (Figure CANNABIS 2, Table Drg.27). Counselling remained the most common main treatment type between 2012–13 and 2021–22.
- 7 in 10 treatment episodes took place in a non-residential treatment facility (70% of episodes) (Table Drg.29).
- The median duration of treatment episodes was just under 4 weeks (26 days) (Table Drg.30).
- Over 3 in 5 episodes ended with a planned completion (62% of episodes), while 21% ended unexpectedly (Figure CANNABIS 2, Table Drg.29).

Figure CANNABIS 2: Treatment episodes with cannabis as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012–13 to 2021–22

The line graph shows that counselling was the most common main treatment type among treatment episodes for cannabis across the 10 years to 2021–22, rising from 14,735 episodes in 2012–13 to 18,846 in 2021–22. Assessment only was the second most common main treatment type in 2021–22 (6,523 episodes), though this fluctuated over time. Filters allow the user to view data as the number or per cent of episodes for main treatment type, reason for cessation or source of referral.

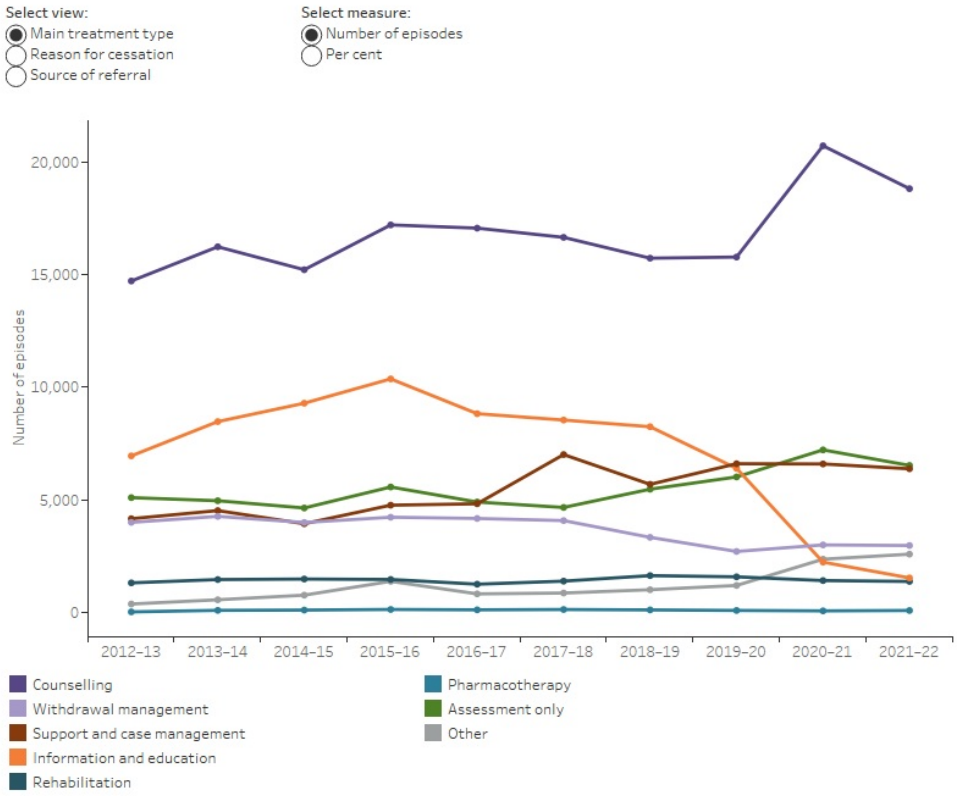

Figure CANNABIS 2: Treatment episodes with cannabis as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables Drg.12, Drg.13 and Drg.27.
http://www.aihw.gov.au

See notes >

Clients referred via diversion programs

Diversion treatment programs

Throughout Australia, diversion programs have been developed to divert people who were apprehended or sentenced for minor drug offences away from the criminal justice system into drug treatment. Treatment services range from short-term assessment, information or education sessions to longer-term treatments such as counselling and withdrawal management. For more information, refer to Diversion programs in Australia data and the Key terminology and glossary.

Most treatment episodes provided to clients diverted from the criminal justice system are for cannabis, followed by amphetamines. Clients who are referred via diversion may also receive other treatment episodes with a source of referral other than diversion.

In 2021–22, around 1 in 8 clients receiving treatment for their own drug use were referred via police or court diversion programs (12% or 14,343 clients) (Table SC.13).

Among these clients:

- around half reported cannabis as the principal drug of concern (49% of clients) (SC.13)
  - 23% of these clients also received AOD treatment following referral through other sources, such as from a health service or self/family (Table OV.14)
- 1 in 5 treatment episodes for cannabis as the principal drug of concern were provided to clients who had been referred via diversion programs (20% or 8,200 episodes) (Table Drg.28).

Clients who are referred to AOD treatment via diversion (diversion clients) may receive multiple treatment episodes during a collection period. Some diversion clients may receive treatment with a different source of referral (non-diversion episodes) in addition to the episode where they were referred via diversion (diversion episodes).

In 2021–22, of the 25,144 treatment episodes provided to these clients:

- Cannabis (50%) was the most common principal drug of concern for diversion-related treatment episodes.
- Amphetamines (33%) was the most common principal drug of concern for subsequent non-diversion-related episodes (Figure CANNABIS 4, Table OV.14).

Figure CANNABIS 3: Client diversion referrals for own drug use by selected principal drug of concern and client diversion episode type, 2021–22

The stacked horizontal bar graph shows that cannabis was the most common principal drug of concern (PDOC) among treatment episodes provided to clients referred via diversion in 2021–22 (50.1% of episodes). By comparison, amphetamines was the most common PDOC among non-diversion episodes provided to diversion clients (32.8% of episodes) and alcohol was the most common PDOC among non-diversion episodes provided to non-diversion clients (45.3%).

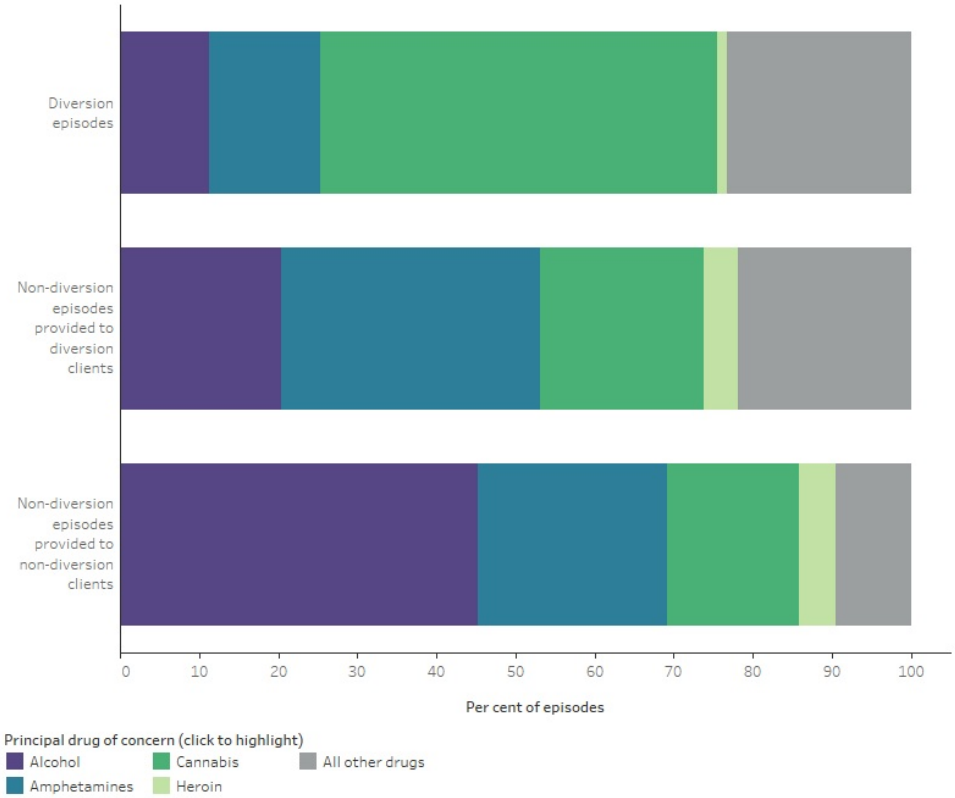

Figure CANNABIS 3: Client diversion referrals for own drug use by selected principal drug of concern and client diversion episode type, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table OV.14.
http://www.aihw.gov.au

See notes >

Drugs of concern

Heroin: client demographics and treatment

On this page:

In 2021–22, heroin was reported as a drug of concern (either principal or additional) in 5.7% of all treatment episodes (12,043 episodes) (Table Drg.4).

Heroin was the fourth most common principal drug of concern:

- in 4.5% of all treatment episodes (9,400 episodes) (Table Drg.4).
- This has remained consistent across the 10 years to 2021–22, although the proportion of heroin-related episodes has declined from a peak of 8.3% (12,800 episodes) in 2012–13 (Table Drg.5).

In 2021–22, over 1 in 3 heroin-related treatment episodes listed at least 1 additional drug of concern (36% or 3,400 episodes) (Table Drg.2). The most common additional drugs of concern were amphetamines 33% or 1,900 episodes), cannabis (19% or 1,100 episodes) and nicotine (15% or 850 episodes) (Table Drg.3). These drugs may not have been the subject of any treatment within the episode.

Treatment for heroin use in the AODTS NMDS collection

People who seek treatment for heroin use have several options for treatment, including withdrawal programs (called detoxification) and abstinence-based treatment (for example, residential rehabilitation in a therapeutic community) (O'Brien 2004).

In Australia, one of the most common treatments for heroin use is opioid pharmacotherapy treatment (also known as opioid agonist therapy). Opioid pharmacotherapy involves replacing opioid drugs, including heroin, with a longer-lasting, medically prescribed opioid.

Agencies whose sole function is to prescribe or provide dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. Data from these agencies are captured in the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection (AIHW 2023). For more information, please see the 2022 NOPSAD report.

For information on heroin use and harms, please see:

- Tobacco, alcohol and other drugs in Australia: Illicit opioids, including heroin
- National Drug Strategy Household Survey 2019 (Chapter 4: Illicit use of drugs)
- National Opioid Pharmacotherapy Statistics Annual Data collection

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Client demographics

In 2021–22, 5,242 clients received treatment for heroin as the principal drug of concern. Of these clients:

- Over 2 in 3 were male (68% of clients) (Table SC.9).
- Over 2 in 3 were aged either 30–39 (35% of clients) or 40–49 (33%) (Table SC.10). This was consistent for both males and females (Figure HEROIN 1).
- Over 1 in 5 were Indigenous Australians (21% or 1,100 clients) (Table SC.11). This represents a crude rate of 187 Indigenous clients per 100,000 population (Table SCR.26).

Figure HEROIN 1: Clients with heroin as the principal drug of concern, by sex and age group, 2021–22

The butterfly bar chart shows that in 2021-22, male clients receiving treatment for heroin as the principal drug of concern were most likely to be aged 40-49 (34.5%) followed by 30-39 (33.4%). Female clients were most likely to be aged 30-39 (37.1%) followed by 40-49 (28.7%).

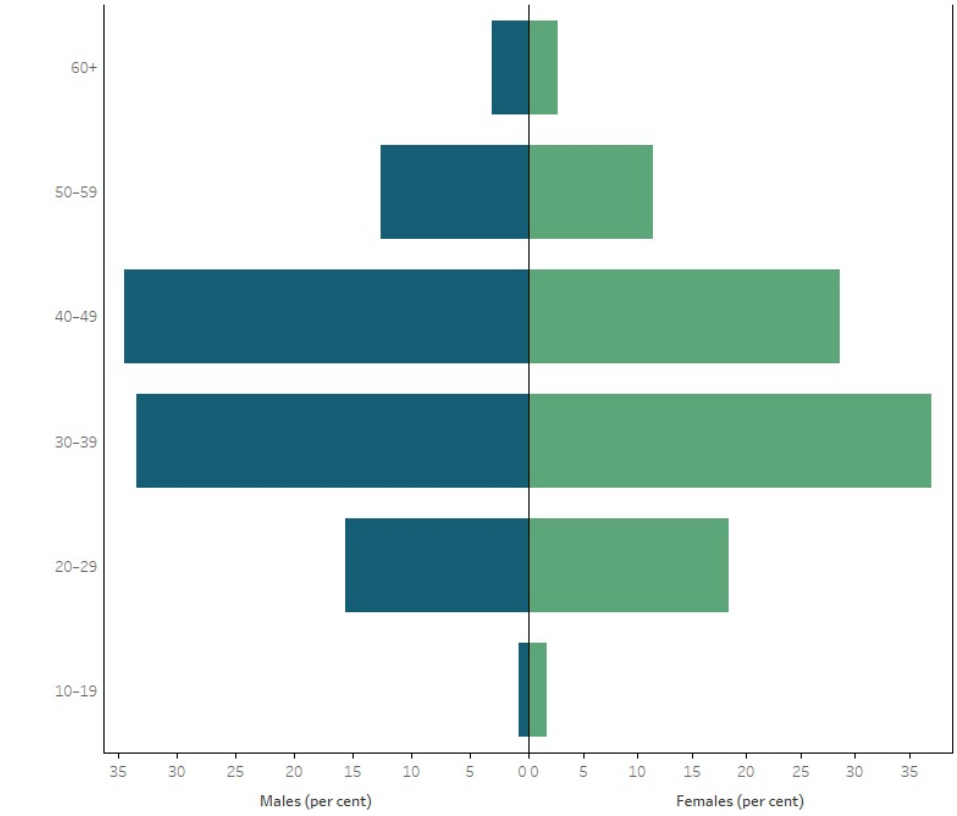


Figure HEROIN 1: Clients with heroin as the principal drug of concern, by sex and age group, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

See notes >

Treatment

In 2021–22, 9,396 treatment episodes were provided to clients for heroin as the principal drug of concern (Table Drg.4).

Among heroin-related treatment episodes in 2021–22:

- The most common source of referral was self/family (43% of episodes), followed by health services (28%) (Figure HEROIN 2, Table Drg.55).
- The most common main treatment type was counselling (21% of episodes), followed by assessment only (21%) and pharmacotherapy (19%) (Figure HEROIN 2, Table Drg.54).
- In the 10 years to 2021–22, main treatment types for heroin have fluctuated:
  - Treatment episodes for withdrawal management decreased from 22% to 6.8% (or from around 2,800 to 640 episodes).
  - Conversely, pharmacotherapy episodes increased from 7.8% to 19% (or from around 1,000 to 1,800 episodes). Fluctuations in pharmacotherapy treatment episodes over time can be attributed to changes to jurisdictional coding practices and systems, resulting in under-reporting of pharmacotherapy at the national level.
- Over 7 in 10 treatment episodes took place in a non-residential treatment facility (72% of episodes) (Table Drg.56).
- The median duration of treatment episodes was around 1 month (30 days) (Table Drg.58).
- 3 in 5 treatment episodes ended with a planned completion (60% of episodes), while just under 1 in 5 (19%) ended unexpectedly (Figure HEROIN 2; Table Drg.56).

Figure HEROIN 2: Treatment episodes with heroin as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012-13 to 2021-22

The line graph shows that counselling has been the most common main treatment type among treatment episodes for cannabis for most of the 10 years to 2021–22. The number of counselling episodes has fallen from 4,209 in 2012–13 to 1,949 in 2021–22. Other treatment types fluctuated across time, with assessment only becoming the most common treatment type in 2021–22 (1,983 episodes). Filters allow the user to view data as the number or per cent of episodes for main treatment type, reason for cessation or source of referral.

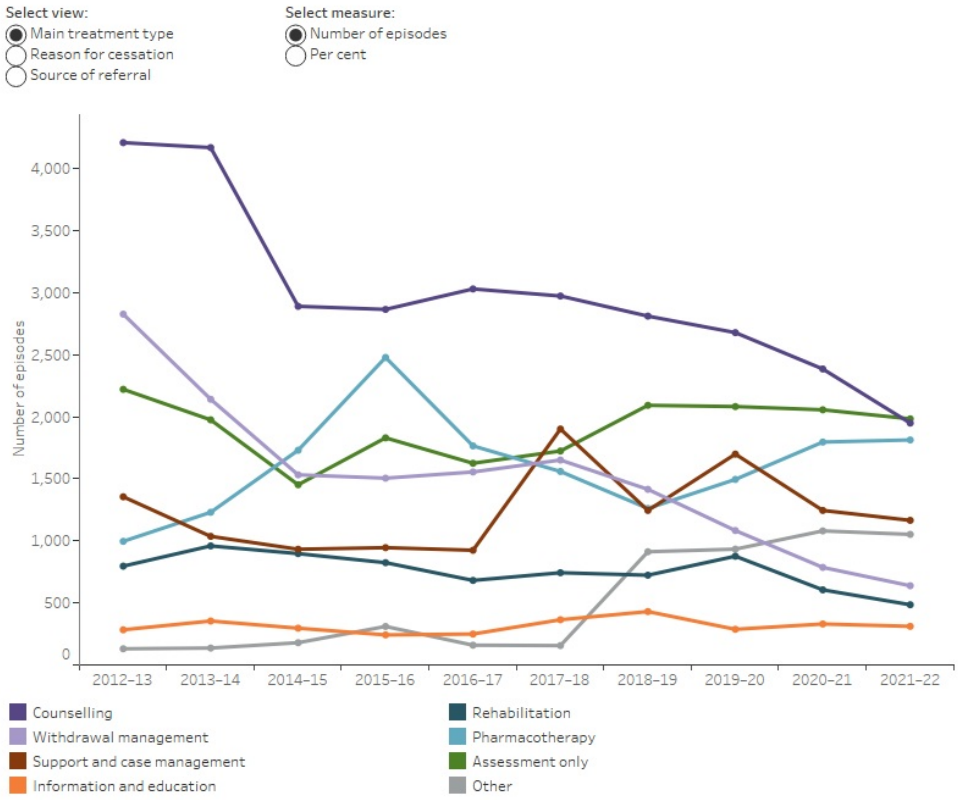


Figure HEROIN 2: Treatment episodes with heroin as the principal drug of concern, by main treatment type, reason for cessation or source of referral, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables Drg.12, Drg.13 and Drg.54.
http://www.aihw.gov.au

See notes >

In 2021–22, injecting remained the most common method of use in heroin-related treatment episodes (71% of episodes) (Table Drg.6). Clients reported injecting drugs in the past 3 months in nearly 1 in 2 treatment episodes (46% of episodes). In a further 11% of episodes, clients reported that they last injected 3–12 months ago (Table Drg.52).

Between 2012–13 and 2021–22 the proportion of treatment episodes where clients reported that they had never injected drugs increased 4-fold, rising from 5.4% (696 episodes) to 20% (1,900 episodes) (Table Drg.52).

References

AIHW (2023) *National Opioid Pharmacotherapy Statistics Annual Data collection*, AIHW, Australian Government, accessed 20 April 2023.

O'Brien S 2004. Treatment options for heroin and other opioid dependence: a guide for families and carers. Canberra: Department of Health and Ageing.

Drugs of concern

Pharmaceuticals: client demographics and treatment

On this page:

In 2021–22, pharmaceuticals were reported as a drug of concern (either principal or additional) in 10.0% of all treatment episodes (21,185 episodes) (Table Drg.87).

- Pharmaceuticals were the principal drug of concern in 5.0% of treatment episodes (10,400 episodes) (Table Drg.87). This proportion relative to all drugs of concern has declined from 7.2% in 2012–13 (11,100 episodes).
- In the 10 years to 2021–22, pharmaceuticals were generally more likely to be reported as an additional rather than principal drug of concern. However, in 2021–22 the proportion of episodes with pharmaceuticals as an additional drug of concern has declined to 5.1%, (Table Drg.87).
- The most common additional drugs of concern reported with pharmaceuticals were amphetamines (22% or 1,400 episodes), cannabis (21% or 1,300 episodes) and alcohol (15% or 920 episodes) (Figure DRUGS 1, Table Drg.88).

Classification of pharmaceutical drugs in the AODTS NMDS

Pharmaceuticals are drugs that are available from a pharmacy—over the counter or by prescription—including opioids (such as codeine and oxycodone) and benzodiazepines (such as diazepam). Some pharmaceutical drug use is for non-medical purposes (Department of Health 2017).

Pharmaceuticals are not listed as a broad drug group in the Australian Standard Classification of Drugs of Concern (ASCDC) classification. In the AODTS NMDS report, the 'pharmaceuticals' drug classification includes the following 10 drug types: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics. Refer to the Technical notes and Key terminology and glossary for more information.

For information on pharmaceutical drug use and harms, please see:

Tobacco, alcohol and other drugs in Australia: Pharmaceuticals

National Drug Strategy Household Survey 2019 (Chapter 5: Non-medical use of pharmaceuticals)

Pharmaceuticals by drug type

In 2021–22, opioids and benzodiazepines accounted for 3 in 4 episodes provided for a pharmaceutical drug as the PDOC (76% or 7,934 episodes) (Table Drg.87). 'Opioids' includes codeine, morphine, buprenorphine, oxycodone, methadone and other opioids.

- Opioids as a group were a principal drug of concern in 2.2% of all treatment episodes and an additional drug of concern in 1.3% (4,700 and 2,600 episodes, respectively). Buprenorphine (1,400 episodes), methadone (950) and oxycodone (740) were the most common principal drug types recorded in opioid-related treatment episodes.
- Benzodiazepine was a principal drug of concern in 1.5% of treatment episodes and an additional drug of concern in 2.3% (3,200 and 4,800 episodes, respectively).

Over the 10 years to 2021–22:

- The number of treatment episodes with pharmaceuticals as the principal drug of concern decreased slightly, from 11,100 to 10,500 episodes. Relative to all other principal drugs of concern, the proportion of episodes for pharmaceuticals fell from 7.2% to 5.0%.
- The number of treatment episodes for benzodiazepines initially decreased from 2,400 episodes from 2012–13 to 1,700 episodes in 2015–16, increasing to 3,200 in 2021–22.
- The number of episodes for opioids peaked at 7,700 in 2013–14 before falling to 4,700 episodes in 2021–22 but fluctuated over time by drug type (Figure PHARMS 1; Table Drg.87).

Figure PHARMS 1: Treatment episodes with pharmaceuticals as the principal drug of concern, by selected principal drugs of concern, 2012–13 to 2021–22

The line graph shows that amongst pharmaceutical drugs, benzodiazepines were the most common principal drug of concern for most years in the 10-year period to 2021–22, increasing from 2,377 episodes in 2012–13 to 3,212 episodes in 2021–22.

Filters allow the user to toggle between viewing episode data on pharmaceutical drugs by pharmaceutical drug type, or in relation to the

5 most common principal drugs of concern in the AODTS NMDS. Filters also allow the user to toggle between the number and proportion of episodes.

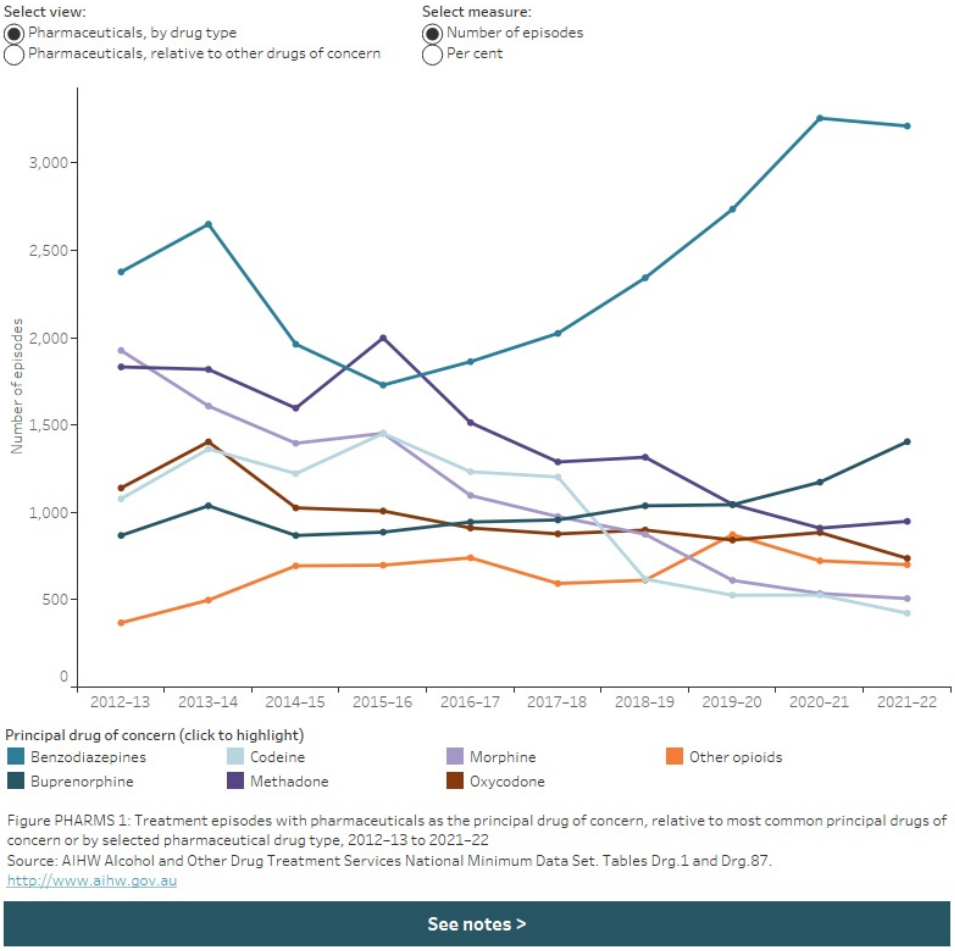


Figure PHARMS 1: Treatment episodes with pharmaceuticals as the principal drug of concern, relative to most common principal drugs of concern or by selected pharmaceutical drug type, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables Drg.1 and Drg.87.
http://www.aihw.gov.au

See notes >

Client demographics

In 2021–22, around 6,155 clients received treatment for any pharmaceutical drug as the principal drug of concern (Table SC.30). Of these clients:

- 3 in 5 were male (61% of clients). The proportion of male clients ranged from 42% for codeine to 88% for steroids (Table SC.30).
- Over 1 in 2 were aged either 20–29 (25% of clients) or 30–39 (29%). The proportion of clients in each age group varied by PDOC:
  - Clients receiving treatment for benzodiazepines had the highest proportion of people aged 10–19 (19% of clients).
  - Most clients receiving treatment for opioids were aged either 30–39 or 40–49, ranging from 52% for oxycodone to 64% for buprenorphine (Table SC.31).
- Around 1 in 7 were Indigenous Australians (15% of clients). The proportion of Indigenous clients was highest for buprenorphine (29% of clients) (Table SC.32).

Treatment

In 2021–22, around 10,445 treatment episodes were provided to clients for pharmaceuticals as the principal drug of concern (Table Drg.87).

- The most common sources of referral were self/family (40% of episodes) and health services (39%). This was relatively consistent across drug types, but diversion was the most common referral source for steroid-related treatment episodes (33% of episodes) (Table Drg.90).
- The most common main treatment types were assessment only (30% of episodes) and counselling (22%) (Figure PHARMS 3; Table Drg.89).
- Most episodes took place in non-residential treatment facilities (74% of episodes); this was the most common treatment setting across drug types (Figure PHARMS 3; Table Drg.92).
- Three in 5 treatment episodes ended with a planned completion (60% of episodes; ranging from 49% for morphine as the PDOC to 76% for steroids). Just under 1 in 5 episodes ended unexpectedly (19%) (Figure PHARMS 2; Table Drg.91).

Figure PHARMS 2: Treatment episodes with selected pharmaceutical drugs as the principal drug of concern, by main treatment type, treatment delivery setting or reason for cessation, 2021–22

The stacked horizontal bar chart shows that in 2021–22 assessment only was the most common main treatment type among most episodes for pharmaceutical drugs with the exception of benzodiazepines, ranging from 26.0% for methadone to 49.3% for buprenorphine. Counselling was the most common main treatment type in episodes where benzodiazepines (28.9% of episodes) was the principal drug of

concern. A filter allows the user to view data for main treatment type, reason for cessation or treatment delivery setting.

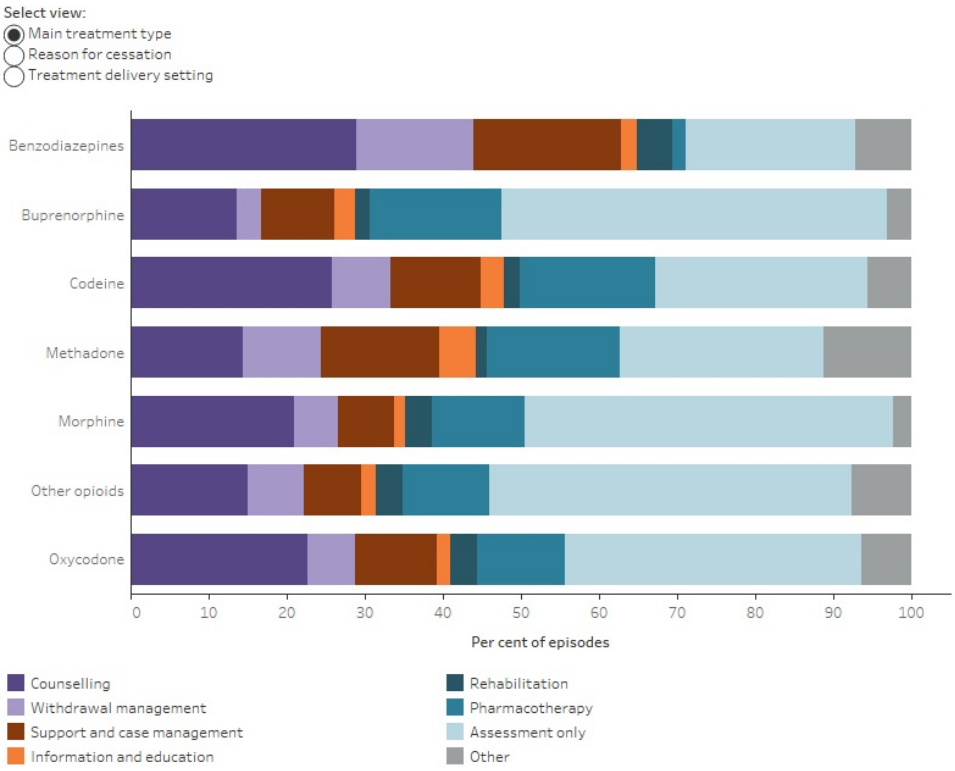


Figure PHARMS 2: Treatment episodes with selected pharmaceuticals as the principal drug of concern, by main treatment type, reason for cessation or treatment delivery setting, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables Drg.89, Drg.91 and Drg.92.
http://www.aihw.gov.au

See notes >

References

ABS 2011. Australian Standard Classification of Drugs of Concern, 2011. ABS cat. no. 1248.0. Canberra: ABS.

Department of Health 2017. National Drug Strategy 2017-2026. Canberra: Commonwealth of Australia.

Drugs of concern

Selected other drugs: client demographics and treatment

On this page:

In addition to the most common principal drugs of concern, the AODTS NMDS report includes information on selected other drug types: nicotine, ecstasy and cocaine. These drugs may be commonly used in the community or linked to increased risk of harm. Treatment captured through the AODTS NMDS for these drugs may be less prominent than for other drugs as they are relatively uncommon, or people who use them are less likely to seek treatment than people who use other drugs. See the Key terminology and glossary for further information.

Together, nicotine, ecstasy and cocaine have contributed around 2–3% of all treatment episodes each year since 2012–13 (tables Drg.1, Drg.5). Individually, the proportion of treatment episodes for each of these drugs has remained at less than 2% per year across the period (Table SD.9).

Nicotine, ecstasy and cocaine are more likely to be reported as an additional rather than principal drug of concern. For example, nicotine was reported as a principal drug of concern in only 1.2% of treatment episodes in 2021–22 but was an additional drug of concern in 9% of episodes (Table Drg.5).

For information on selected other drug use and harms, please see:

Tobacco, alcohol and other drugs in Australia: Tobacco

Tobacco, alcohol and other drugs in Australia: Meth/amphetamine and other stimulants

National Drug Strategy Household Survey 2019 (Chapter 2: Tobacco smoking; Chapter 4: Illicit use of drugs)

Nicotine

In 2021–22, nicotine was reported as a drug of concern (either principal or additional) in 10% of all treatment episodes (21,659 episodes) (Table Drg.5). In 2021–22:

- Nicotine was the principal drug of concern in just 1.2% of treatment episodes (2,400 episodes) (tables Drg.1, Drg.5). This proportion has remained relatively stable since 2012–13 (1.7% or 2,600 episodes) (Table Drg.5).
- Nicotine was an additional drug of concern in just under 1 in 10 treatment episodes (9.1% or 19,200 episodes) (Table Drg.4). Most treatment episodes with nicotine as an additional drug of concern were for alcohol (38% of episodes), amphetamines (30%) or cannabis (22%) as the principal drug of concern (Table Drg.3).

The low proportion of episodes for nicotine as the principal drug of concern in the AODTS NMDS collection may be due to the existence of numerous alternative support options within the community (for example, general practitioners, pharmacies, helplines, and web services). Additionally, people may view AOD treatment services as being most appropriate for drug use that is beyond the expertise of general practitioners. However, therapy to quit smoking is becoming an integral part of some AOD services as a parallel treatment with other drugs of concern.

Client demographics

In 2021–22, 1,820 clients received treatment for nicotine as the principal drug of concern (Table SC.9). Of these clients:

- over 1 in 2 were male (52% of clients) (Table SC.12)
- over 1 in 2 were aged either 10–19 (35% of clients) or 20–29 (18%) years (Table SC.13)
- over 1 in 5 were Indigenous Australians (22% or 410 clients) (Table SC.14).

Treatment

In 2021–22, 2,449 treatment episodes were provided to clients for nicotine as the principal drug of concern.

Among nicotine-related episodes in 2021–22:

- The most common source of referral was health service (36% of episodes), followed by self/family (28%) (Table Drg.46).
- The most common main treatment types were counselling (32% of episodes and assessment only (27%) (Table Drg.45).

- Almost 4 in 5 treatment episodes took place in a non-residential treatment facility (79% of episodes), and 9.4% took place in an outreach setting (Table Drg.47).
- The median duration of these treatment episodes was 25 days (Table Drg.48). Nearly half of all episodes (47%) lasted between 2 days and 3 months, while nearly 3 in 10 (29%) lasted less than 1 day (Table OV.12).
- Almost 3 in 4 episodes ended with a planned completion (72% of episodes), while 13% ended unexpectedly (Table Drg.47).

Ecstasy

In 2021–22, ecstasy was reported as a drug of concern (either principal or additional) in 1.1% of all treatment episodes (2,238 episodes) (Table Drg.4). In 2021–22:

- Ecstasy was the principal drug of concern in 0.2% of treatment episodes (480 episodes) (Table Drg.5). This proportion has remained relatively stable since 2012–13 (0.7% or around 1,010 episodes) (Table Drg.5).
- Ecstasy was an additional drug of concern in 0.8% of treatment episodes (1,750 episodes), down from 3.3% in 2012–13 (5,140 episodes) (tables Drg.4 and Drg.5). Most treatment episodes with ecstasy as an additional drug of concern were for cannabis (36% of episodes), amphetamines (26%) or alcohol (23%) (Table Drg.3).

Client demographics

In 2021–22, 350 clients received treatment for ecstasy as the principal drug of concern. Among these clients:

- 7 in 10 were male (71% of clients) (Table SC.12)
- over 4 in 5 were aged 10–19 (32% of clients) or 20–29 (50%) (Table SC.13)
- around 1 in 8 were Indigenous Australians (13%) (Table SC.14).

Treatment

In 2021–22, 480 treatment episodes were provided to clients for ecstasy as the principal drug of concern (Table Drg.4). The median duration of these treatment episodes was just over 1 week (8 days), down from 26 days the previous year (Table Drg.75). Almost half of all episodes ended within 1 day (45% of episodes) and over 1 in 3 (35%) lasted between 2 days and 3 months (Table OV.12).

Among ecstasy-related treatment episodes in 2021–22:

- The most common source of referral was diversion from the criminal justice system (34% of episodes), followed by health service (28%) (Table Drg.73).
- The most common main treatment types were counselling (51% of episodes) and withdrawal management (14%) (Table Drg.72).
- Almost three-quarters of treatment episodes took place in a non-residential treatment setting (74% of episodes) (Table Drg.74).
- Just over 7 in 10 treatment episodes ended with a planned completion (73% of episodes), while 18% ended unexpectedly. The proportion of episodes with a planned completion ranged from 63% for episodes with rehabilitation as the main treatment to 93% for information and education (Table Drg.74).

Cocaine

In 2021–22, cocaine was reported as a drug of concern (either principal or additional) in 2.3% of all closed treatment episodes (4,808 episodes) (Table Drg.4). In 2021–22:

- Cocaine was the principal drug of concern in 1.0% of treatment episodes (2,200 episodes), rising from 0.3% of episodes in 2012–13 (512 episodes) (Table Drg.5).
- Cocaine was an additional drug of concern in 1.3% of treatment episodes (2,600 episodes). This has remained relatively stable since 2012–13 (1.6%), although the number of treatment episodes increased from 2,200 to 3,300 across the period (Table Drg.5). Most treatment episodes with cocaine as an additional drug of concern were for alcohol (41% of episodes), amphetamines (28%) or cannabis (18%) (Table Drg.3).

Client demographics

Around 1,600 clients received treatment for cocaine as the principal drug of concern in 2021–22 (Table SC.12). Among these clients:

- over 4 in 5 were male (83% of clients) (Table SC.12)
- over 1 in 2 were aged 20–29 years (52% of clients) and a further 29% were aged 30–39 (Table SC.13)
- less than 1 in 10 (7.2%) were Indigenous Australians (Table SC.14).

Treatment

In 2021–22, around 2,180 treatment episodes were provided to clients for cocaine as the principal drug of concern (Table Drg.4). The median duration of these treatment episodes was just over 5 weeks (37 days), up from 29 days the previous year (Table Drg.84). Around 1 in 4 episodes ended within 1 day (25% of episodes) and 49% lasted between 2 days and 3 months (Table OV.12).

Among cocaine-related treatment episodes in 2021–22:

- The most common source of referral was self/family (36% of episodes), followed by diversion (22%) and health services (19%) (Table Drg.82).
- The most common main treatment types were counselling (53% of episodes) and assessment only (19%) (Table Drg.81).

- Four in 5 treatment episodes took place in non-residential treatment facilities (80% of episodes) (Table Drg.83).
- Nearly 2 in 3 treatment episodes ended with a planned completion (65% of episodes), while 18% ended unexpectedly. Planned completions were most likely where the main treatment type was information and education (89% of episodes) (Table Drg.82).

Treatment provided

On this page:

There are a number of treatment types available to assist people experiencing problematic drug use, most of which aim to reduce the harm of drug use through services such as counselling or information and education. Additionally, some treatments use abstinence-oriented interventions to aid in short-term cessation or reduction of heavy or prolonged alcohol or other drug use in a safe, structured and supportive environment, to assist clients in developing skills to facilitate substance-free lifestyles.

Key findings

In 2021–22:

- around 228,500 treatment episodes were provided to 131,000 clients
- clients received an average of 1.8 treatment episodes nationally
- 92% (210,000) of all treatment episodes were provided to people receiving treatment for their own drug use while a further 8.1% (18,500) were for someone else's alcohol or drug use
- counselling was the most common treatment type provided to all clients in 2021–22 (36% of all treatment episodes), followed by assessment only (21%)
- for someone else's alcohol or drug use the most common treatment type was support and case management (39% of treatment episodes), followed by counselling (36%).

Over the 10-year period to 2021–22:

- counselling has remained the most common treatment type for all clients, ranging between 42% in 2012–13 and 36% in 2021–22
- withdrawal management for own drug use fell from 16% to 9.0%, moving from the third to the fourth most common treatment
- support and case management has become the third most common treatment for all clients, increasing from 9.2% of episodes in 2012–13 to 15% in 2021–22.

Treatment types

People can receive treatment for their own or someone else's alcohol or drug use (see Key terminology and glossary). Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not available for people seeking treatment for someone else's alcohol or drug use.

In 2021–22, a total of 228,451 treatment episodes were provided to 130,525 people for their own or someone else's alcohol or drug use; clients received an average of 1.8 treatment episodes each (Table SCR.21):

- between 2012–13 and 2020–21, treatment episodes increased by 41% (from 162,362 to 242,980)
- between 2020–21 and 2021–22, treatment episodes decreased by 6.0%.

Clients own drug or alcohol use and clients seeking support for someone else's alcohol or drug use

In 2021–22:

- over 9 in 10 treatment episodes (92% or 209,953) were provided for a client's own alcohol or drug use, and 8.1% (18,498) of treatment episodes were in relation to someone else's alcohol or drug use (Table Trt.2)
- around 124,165 people received treatment for their own alcohol or drug use and 12,536 people sought treatment in relation to someone else's alcohol or drug use (Tables SCR.27)
- among clients receiving treatment for their own alcohol or drug use:
  - counselling was the most common main treatment type followed by assessment only across all age groups
  - one in 5 (20%) of clients aged 10–19 received support and case management as a treatment type
  - older clients aged 40 and over were more likely to receive withdrawal management as a main treatment type (8-9%)
- among clients seeking support for someone else's alcohol or drug use, the age of clients varied by main treatment type:
  - over half of clients aged 40–49 (52%) and over 3 in 5 clients aged 50–59 (65%) and 60 and over (72%) received counselling for someone else's alcohol or drug use.
  - almost 2 in 5 clients aged 10–19 (39%) and 20–29 (35%) received support and case management for someone else's alcohol or drug use (Figure TREATMENTCLIENTS 1, Table SC.22).

Figure TREATMENTCLIENTS 1: Clients, by client type, main treatment type and age group, 2021-22

The stacked horizontal bar chart shows that in 2021-22, counselling was the most common main treatment type provided to all clients across all age groups, ranging from 39.3% for all clients aged 60+ years to 49.3% for all clients aged 10–19 years. A filter allows the user to view data for all clients, clients seeking treatment for their own drug use or clients seeking treatment for someone else's drug use.

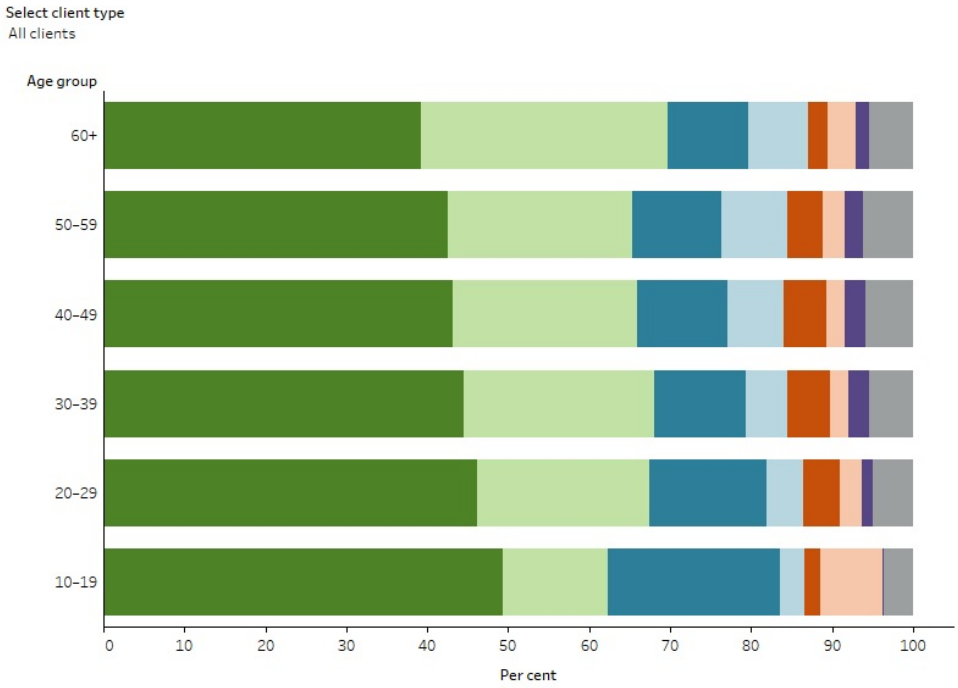


Figure TREATMENTCLIENTS 1: Clients by client type, main treatment type and age group, 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SC.19.
http://www.aihw.gov.au

See notes >

For treatment episodes provided for a client's own alcohol or drug use over the 10-year period to 2021–22:

- counselling has remained the most common treatment type, ranging between a high of 41% of episodes in 2012–13 and 2013–14 to a low of 35% in 2015–16. In 2021–22, 37% (76,700) episodes had counselling as the main treatment
- the proportion of episodes with withdrawal management as main treatment dropped from 16% in 2012–13 to 9.8% (20,500 episodes) in 2021–22.

For treatment episodes provided for those seeking support for someone else's alcohol or drug use over the 10-year period to 2021–22:

- until 2021–22, counselling was the most common treatment type, ranging between a high of 73% of episodes in 2016–17 and 43% in 2019–20. In 2021–22 the proportion of counselling as the main treatment type decreased to 36%
- in 2021–22, support and case management became to the most common main treatment, quadrupling in the 10 years to 2021–22, from 11% in 2012–13 to 39% in 2021–22 (Figure TREATMENTCLIENTS 2, Table Trt.3).

Figure TREATMENTCLIENTS 2: Number of treatment episodes, by client type and main treatment type, 2012-13 to 2021-22

The line graph shows that counselling has remained the most common main treatment type among episodes provided to all clients across the period 2012–13 to 2021–22, accounting for 36.5% of episodes in 2021–22. In 2021–22, assessment only was the second most common main treatment type (20.9% of episodes), followed by support and case management (15.5%). A filter allows the user to view data for all clients, clients seeking treatment for their own drug use or clients seeking treatment for someone else's drug use.

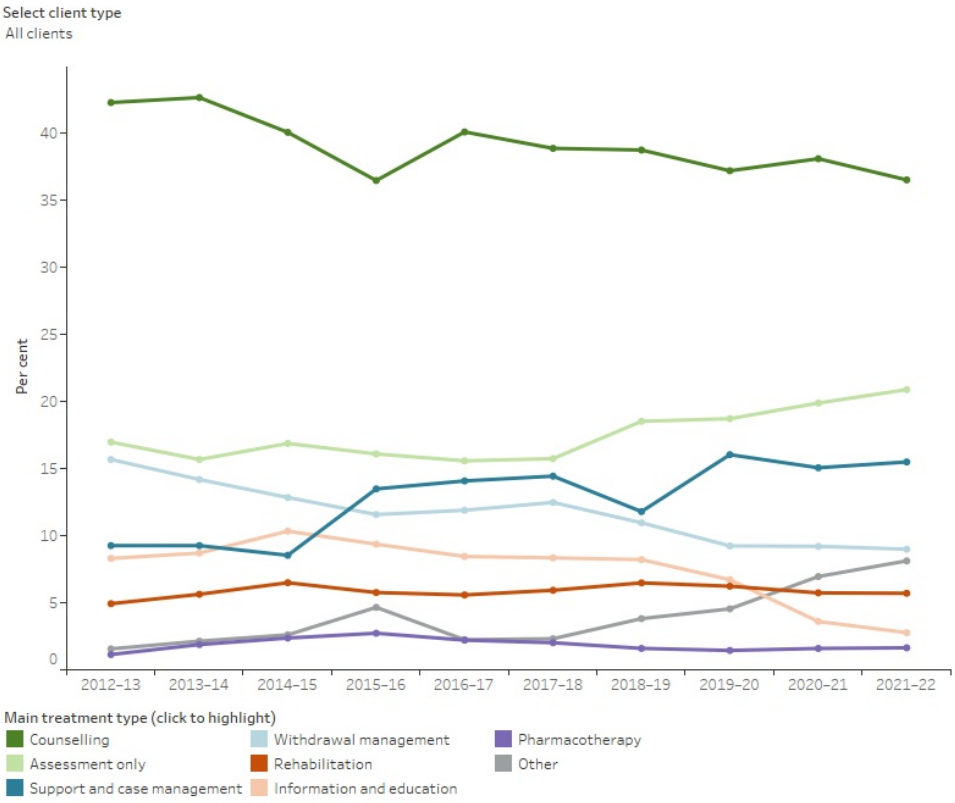


Figure TREATMENTCLIENTS 2: Treatment episodes, by client type and main treatment type, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Trt.3.
http://www.aihw.gov.au

See notes >

Explore treatment provided:

- Assessment only
- Counselling
- Information and education
- Pharmacotherapy
- Rehabilitation
- Support and case management
- Withdrawal management
- Other main treatment

Treatment provided

Although all service providers would normally include an assessment component in all treatment types, assessment only episodes are those for which only an assessment has been provided to the client. Assessment interventions aim to reduce immediate or short-term harms; engage and support people; and refer people into treatment. For more information on assessment only see glossary.

In 2021–22:

- over 1 in 5 (21% or 47,662) of all treatment episodes were reported as an assessment only
  - over 1 in 5 (22%) of treatment episodes for people receiving help for their own alcohol or drug use received assessment only as a main treatment.
  - among those seeking help for someone else's alcohol or drug use, 8.2% of episodes had an assessment only.
- assessment only treatment episodes were most commonly provided to people whose principal drug of concern was either alcohol (41%) or amphetamines (25%) (tables Trt.3, Trt.32).

Client profile

In 2021–22, among clients whose main treatment was assessment only:

- more than 3 in 5 (63%) people who received an assessment for their own alcohol or drug use were male
- more than half (55%) of people who received assistance for someone else's alcohol or drug use were male
- almost 1 in 5 (18%) people who received an assessment for their own alcohol or drug use and around 1 in 10 (9.7%) of people who sought support for someone else's alcohol or drug use identified as Indigenous Australians (tables SC.18, SC.21).

Treatment provided

Counselling is the most common treatment type for problematic alcohol or other drug use. Psycho-social counselling refers to evidence-informed talking therapies, aimed at helping the person develop skills (whether that be psychological skills, and/or practical skills) to reduce alcohol or other drug consumption and/or harms, in line with the person's own goals. For more information on counselling see glossary.

In 2021–22:

- counselling was reported as a main treatment type in 36% (83,326) of all treatment episodes
  - almost 2 in 5 (37%) treatment episodes for people receiving support for their own alcohol or drug use involved counselling as the main treatment, a decline from 38% in 2020–21
  - for treatment episodes where the client sought support for someone else's drug use, more than 1 in 3 (36%) episodes involved counselling as the main treatment type, a decline from 44% in 2020–21.
- among clients seeking treatment for their own alcohol or drug use, counselling as a main treatment was most commonly provided where the principal drug of concern was alcohol (40%), cannabis (25%), or amphetamines (24%) (Tables Trt.3, Trt.16).

Client profile

In 2021–22, for clients whose main treatment was counselling:

- more than 3 in 5 (62%) people receiving counselling for their own alcohol or drug use were male, while more than half (53%) of people seeking treatment for someone else's alcohol or drug use were female (19% of those who sought treatment for someone else's alcohol or drug use did not have their sex reported)
- over half (54%) of people receiving counselling for their own alcohol or drug use were aged 20–39, while over half (56%) of people who sought counselling for someone else's alcohol or drug use were aged 40 and over
- for people receiving treatment for their own alcohol or drug use, 18% identified as Indigenous Australians, compared with 6.8% of people who received counselling for someone else's alcohol or drug use (tables SC.18–20).

Treatment profile

Counselling treatment is provided for a client's own alcohol or drug use, as well as those seeking support for someone else's alcohol or drug use.

Over the 10-year period to 2021–22 for clients who received counselling:

- treatment episodes for counselling were longer than all other treatment types, ranging between a median length of 53 and 70 days; in 2021–22 the median length was 71 days (over 10 weeks) (Table OV.11).
- for their own alcohol or drug use, the proportion of treatment episodes that ended within 1 month fell from 33% to 27%
- for someone else's alcohol or drug use, the proportion of treatment episodes ending within 1 month fell from 40% to 20%. In contrast, the proportion lasting 3 to 6 months increased from 16% in 2012–13 to 26% in 2021–22 (Table Trt.21).

Treatment provided

Information and education can be provided to clients as written information or a psycho-educational intervention program. See glossary for further information.

In 2021–22, information and education as a main treatment was reported for 2.8% (6,321) of all treatment episodes (where clients sought treatment for their own or someone else's alcohol or drug use).

Most information and education episodes were provided to clients whose principal drug of concern was alcohol (42%) or cannabis (26%) (tables Trt.3, Trt.42).

Client profile

In 2021–22, for clients whose main treatment was information and education:

- more than 3 in 5 people receiving information and education for their own alcohol or drug use were male (65%), while more people who sought support for someone else's alcohol or drug use were female (59%)
- seven in 10 (70%) of all people receiving information and education for their own alcohol or drug use were aged 10–39 (27% of clients aged 10–19, 23% aged 20–29 and 20% aged 30–39). In contrast, almost 3 in 5 (58%) people who sought treatment for someone else's alcohol or drug use were aged 40 or over
- almost 3 in 10 (28%) people receiving treatment for their own alcohol or drug use identified as Indigenous Australians, compared with 17% of people seeking treatment for someone else's alcohol or drug use (tables SC.18–20).

Treatment profile

Among treatment episodes in 2021–22 with information and education as the main treatment, more than 2 in 5 (44%) of treatment episodes lasted 1 day for clients receiving treatment for their own alcohol or drug use. For those seeking treatment for someone else's use, this proportion was 15% (Table Trt.44).

Over the 10-year period to 2021–22, among clients who received information and education:

- for their own alcohol or drug use: the proportion of treatment episodes that lasted 1 day decreased from 82% in 2012–13 to 44% in 2021–22. These recent decreases were likely due to COVID-19 restrictions and reductions in service delivery from 2019–20 onwards
- for someone else's alcohol or drug use: the proportion of treatment episodes that lasted one day decreased from 77% in 2012–13 to 15% in 2021–22
- for all clients: the proportion of treatment episodes for lasting from 2 days to 3 months increased from 15% in 2012–13 to 51% in 2021–22 (Table Trt.44).

It is important to note that information and education treatment trends are influenced by differences in jurisdictional program practices over time.

Treatment provided

There are several medications (pharmacotherapies) used to treat dependence on alcohol, tobacco and other drugs. These pharmacotherapies can be prescribed for a short, medium or long-term duration, depending on the person's goals.

In the AODTS NMDS, only episodes where pharmacotherapy was either an additional treatment, or where it was the main treatment with an additional treatment provided, are included. Episodes where pharmacotherapy was the main treatment only and no additional treatment was provided are excluded. Pharmacotherapy is only available to people receiving treatment for their own drug use. As most pharmacotherapy services are outside the scope of the AODTS NMDS, the data presented here are a substantial under-representation.

More information on opioid pharmacotherapy in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics (NOPSAD). The latest data from the National Opioid Pharmacotherapy Statistics indicate that on a snapshot day in 2022, over 55,700 people received pharmacotherapy for opioid dependence (AIHW 2023).

For services that were in scope of the AODTS NMDS in 2021–22:

- pharmacotherapy treatment accounted for 1.8% (3,739) of total episodes for a client's own alcohol or drug use
- of these episodes, 23% (1,117) reported pharmacotherapy as an additional treatment (tables Trt.4, Trt.54).

Client profile

In 2021–22, for clients whose main treatment was pharmacotherapy:

- almost 7 in 10 (69%) people receiving treatment for their own alcohol or drug use were male
- around two-thirds (64%) of all people were aged 30–49 and 18% were aged 50 and over (tables SC.21–23)
- almost 1 in 5 (18%) people identified as Indigenous Australians (tables SC.18–20).

Treatment profile

For treatment episodes involving pharmacotherapy for a client's own alcohol or drug use:

- over half (51%) of episodes lasted over 3 months, of which almost 1 in 5 (18%) lasted over 12 months. An additional 20% of episodes lasted 2–29 days
- where pharmacotherapy treatment was provided as a main treatment type, the most common principal drugs of concern were heroin (48%) and alcohol (16%) (tables Trt.55, Trt.59).

References

AIHW (2023) *National Opioid Pharmacotherapy Statistics Annual Data collection*, AIHW, Australian Government, accessed 20 April 2023.

Treatment provided

Rehabilitation is an intensive treatment program that integrates a range of services and therapeutic activities, including counselling, behavioural treatment, social and community living skills, relapse prevention and recreational activities. This type of treatment is not available for people seeking treatment for someone else's alcohol or drug use. See glossary for further information on Rehabilitation.

In 2021–22, for a client's own alcohol or drug use:

- more than 1 in 20 (6.2% or 13,016) treatment episodes included rehabilitation as the main treatment type
- the most common principal drugs of concern were alcohol (46%) or amphetamines (34%) (tables Trt.3, Trt.47).

Client profile

In 2021–22, for clients whose main treatment was rehabilitation:

- two in 3 (63%) people were male
- over 1 in 3 people were aged 30–39 (32%), followed by people aged 20–29 (25%)
- around 3 in 10 (28%) of people identified as Indigenous Australians (tables SC.18–20).

Treatment profile

Among rehabilitation treatment episodes for a client's own alcohol or drug use:

- more than 1 in 3 (35%) episodes lasted 1–3 months, while a further 31% lasted between 2-29 days in 2021–22
- over the 10-year period to 2021–22, the duration of episodes of rehabilitation remained relatively stable, which may be related to rehabilitation treatment programs lasting a set period of time (Table Trt.52)
- in the 10 years to 2021–22, the median treatment duration for clients' own alcohol or drug use use was highest in 2016–17 at 53 days and has fallen to 42 days in 2021–22 (Table OV.11).

Treatment provided

Support includes activities such as providing emotional support to a client who occasionally calls an agency worker. 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 encompasses assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007). See glossary for further information on support and case management.

In 2021–22:

- around 1 in 7 (15% or 35,351) treatment episodes reported a main treatment of support and case management
  - over 1 in 7 (13%) treatment episodes included support and case management for clients' own alcohol or drug use
  - around 2 in 5 (39%) treatment episodes were for clients seeking treatment for someone else's alcohol or drug use
- most support and case management treatment episodes for a client's own alcohol or drug use were for people whose principal drug of concern was alcohol (38%), amphetamines (23%) or cannabis (23%) (tables Trt.3, Trt.37).

Client profile

In 2021–22, for clients whose main treatment was support and case management:

- three in 5 (59%) clients were male
- more than 2 in 3 (68%) people receiving treatment for either their own or someone else's alcohol or drug use were aged 10–39
- for people receiving treatment for their own alcohol or drug use, 19% identified as Indigenous Australians, compared with 12% of people who received support and case management for someone else's use (tables SC.18–20).

Treatment profile

Among support and case management treatment episodes for clients' own alcohol or drug use and someone else's alcohol or drug use:

- the proportion of episodes lasting 1 day was higher for clients receiving treatment for someone else's alcohol or drug use (65%) than for their own alcohol or drug use (13%)
- Most (78%) treatment episodes for support and case management lasted from one day to 3 months.

Over the 10-year period to 2021–22:

- for clients receiving treatment for their own alcohol or drug use, treatment episodes lasting one day increased from 9% in 2012–13 to 13% in 2021–22, while episodes lasting one to 3 months fell from 35% in 2012–13 to 30% in 2021–22
- the proportion of treatment episodes for someone else's alcohol or drug use that lasted 1 day rose substantially from 2012–13 (12%) to 2018–19 (87%) before falling in 2021–22 (65%)
- median treatment duration for own alcohol or drug use dropped over this period from 47 days to 38 days since 2012–13, and for someone else's alcohol or drug use median treatment duration dropped from 36 days to 1 day (tables Ov.11, Trt.39).

References

Vanderplaschen W, Wolf J, Rapp R & Broekaert E 2007. Effectiveness of different models of case management for substance-abusing populations. Journal of Psychoactive Drugs 39(1):81–5

Treatment provided

Withdrawal management (detoxification) includes medicated and non-medicated treatment in a residential or non-residential setting, to help manage, reduce or stop the use of a drug of concern. This type of treatment is not available for people seeking treatment for someone else's alcohol or drug use). See glossary for further information on withdrawal management.

In 2021–22:

- one in 10 (9.8% or 20,509) treatment episodes for a client's own alcohol or drug use involved withdrawal management as the main treatment
- of these, most treatment episodes were for alcohol (58%) or amphetamines (17%) (tables Trt.3, Trt.24).

Client profile

In 2021–22, for clients whose main treatment was withdrawal management:

- almost 3 in 5 (58%) of all people receiving treatment for their own alcohol or drug use were male
- one-quarter (25%) of clients were aged 30–39 and 27% were aged 40–49
- around 1 in 8 (14%) people identified as Indigenous Australians (tables SC.18–20).

Treatment profile

Among withdrawal management treatment episodes as a main treatment type:

- seven in 10 treatment episodes (70%) lasted 229– days, followed by 1 in 7 (14%) treatment episodes lasting 1 day
- over the 10-year period to 2021–22, median treatment duration has remained stable at 8 days since 2012–13 (tables Ov.11, Trt.29).

Treatment provided

Other main treatment types are modes of treatment that do not fit the descriptions of the main treatment types. Examples of other main treatment types may be living skills classes, outdoor therapy, relapse prevention and safe using or drug use reduction education and support.

In 2021–22:

- other treatment accounted for 8.1% (18,527) of all treatment episodes
- of these episodes, 27% (6,700) reported other treatment as an additional treatment (tables Trt.4, Trt.61)
- most other treatment episodes for a client's own alcohol or drug use were for alcohol (38%), amphetamines (27%) or cannabis (16%) (tables Trt.4, Trt.61, Trt.63).

Over the 10-year period to 2021–22:

- for clients receiving treatment for their own alcohol or drug use, most episodes lasted less than one month (ranging from 42% in 2021–22 to 73% of episodes in 2015–16)
  - episodes lasting 1 to 3 months increased from 22% in 2012–13 to 32% in 2021–22
  - episodes lasting one day fell from 28% in 2012–13 to 13% in 2021–22
- the proportion of other treatment episodes for someone else's alcohol or drug use that lasted 2–29 days increased from 11% in 2012–13 to 23% in 2021–22, and episodes lasting one to 3 months increased from 29% to 43% since 2012–13
- median treatment duration for other treatment ranged from 36 days to 54 days for all clients for most years between 2012–13 and 2021–22, with the exception of 2015–16 (19 days) (tables Ov.11, Trt.68).

Treatment referral and completion

Treatment referrals are part of interventions that aim to reduce immediate or short-term harms from AOD use, engage and support people affected, and connect people to treatment services where required. As part of care, case management co-ordination involves ongoing treatment planning, goal setting, review and facilitation for the client to achieve their goals, including a supported referral and system navigation support to other services. It includes ensuring links are made with health or social welfare services, and that care is coordinated across care settings and systems (Department of Health 2019).

Key findings

In 2021–22:

- self/family was the most common source of referral (37%)
- three in 4 (76%) episodes ended within 3 months
- around 3 in 5 (58%) treatment episodes had an expected/planned completion
- the median duration of episodes for a clients' own alcohol or drug use and for someone else's alcohol or drug use was 5 weeks (35 and 37 days, respectively).

Over the 10-year period to 2021–22:

- source of referral episodes for self/family decreased from 42% in 2012–13 to 37% in 2021–22
- the proportion of episodes with an expected completion decreased from 63% to 58%.

In 2021–22, for all clients:

- the most common source of referral was self/family (37% or 83,607 episodes) followed by health services (32% or 73,383 episodes):
  - this referral pattern was consistent for most treatment types
  - health services were the most common referral source for withdrawal management (46%), other treatment (41%), information and education (40%) and assessment only (34%) (Table Trt.11).
- diversion referrals fell from 17% to 8% over the same period (Table Trt.11).
- diversion as a referral source was most common for ecstasy (33%) and cannabis (20%) (Table Drg.13).

The most common sources of referral for a client's own alcohol or drug use and someone else's alcohol or drug use were similar in 2021–22:

- self/family (37%) was most common for a client's own alcohol or drug use, followed by health service (32%)
- self/family (36%) was most common for clients receiving treatment for someone else's alcohol or drug use, followed by health services (30%).

Over the 10-year period to 2021–22, treatment episodes where the referral source was:

- self/family decreased from 42% in 2012–13 to 37% in 2021–22
- health services increased from 24% to 32% over this time (tables Trt.10, Trt.11).

The source of referral varied according to clients' principal drug of concern. For example, in the 10 years to 2021–22, among episodes for a client's own alcohol or drug use (Figure TREATMENT 1):

- where alcohol was the principal drug of concern, referrals from health service increased from 28% in 2012–13 to 39% in 2021–22
- where amphetamines were the principal drug of concern, referrals from health service increased from 19% to 26%, while referrals for self/family decreased from 43% to 37%
- where cannabis was the principal drug of concern, the proportion of diversion (police or court diversion program) referrals increased from 2012–13 (32%) to 2014–15 (38%) before falling to 20% in 2021–22
- where a referral came from an 'other' referral source, treatment episodes increased from 7.6% in 2012–13 to 16% in 2019–2020, then decreased to 12% in 2021–22.

Figure TREATMENT 1: Treatment episodes for own drug use, by principal drug of concern and referral source, 2012-13 to 2021-22

The line graph shows the proportion of episodes by source of referral among treatment episodes with alcohol as the principal drug of concern. Self/family was the most common source of referral in most years between 2012-13 and 2021-22, accounting for 41.2% of episodes in 2021-22. A filter allows the user to view data for different principal drugs of concern.

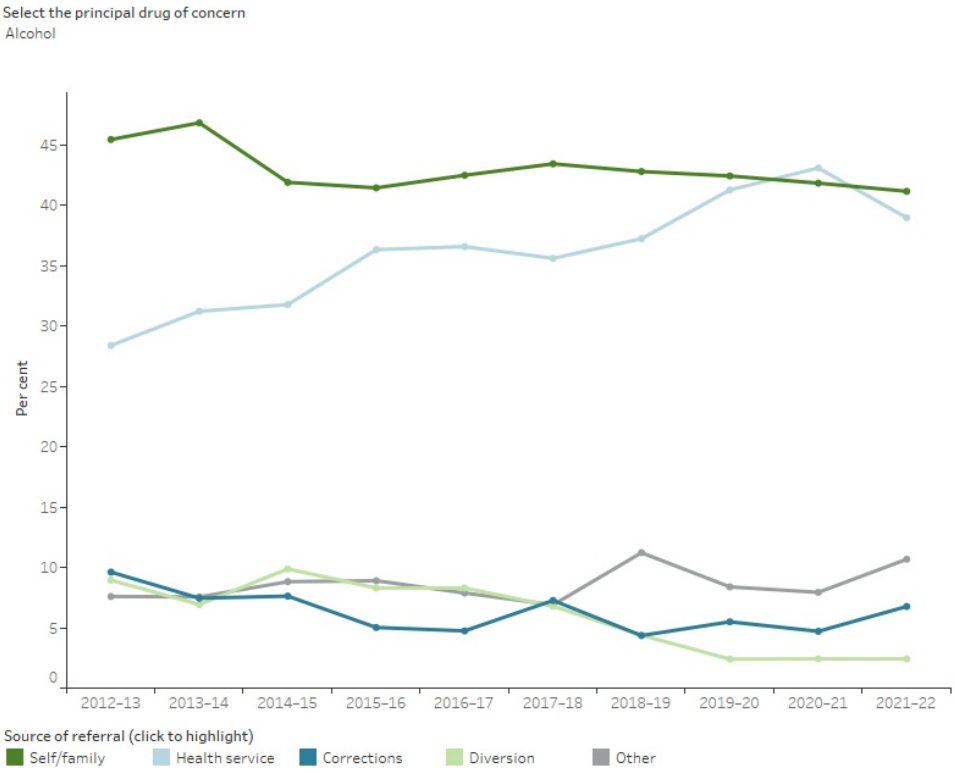


Figure TREATMENT 1: Treatment episodes for own drug use, by principal drug of concern and referral source, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Drg.13.
http://www.aihw.gov.au

See notes >

References

Department of Health 2019. National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–29. Canberra: Department of Health. Viewed 23 April 2021.

Treatment referral and completion

In 2021–22:

- around 3 in 4 treatment episodes ended within 3 months, both for clients receiving treatment for their own alcohol or drug use and for someone else's alcohol or drug use (76% and 75%, respectively) (Table Ov.9)
- the median duration of treatment episodes was around 4 weeks (29 days) for both for clients' own alcohol or drug use and for clients receiving support for someone else's alcohol or drug use (Table Ov.10)
- for clients' own alcohol or drug use, counselling had the longest median duration (70 days), while assessment only had the shortest (3 days) (Figure DURATION 1) (Table Ov.11).

Over the 10 years to 2021–22:

- treatment episodes ending within 3 months has remained the most common duration for client's own alcohol or drug use (76%).
- for clients' own alcohol or drug use, the median duration of treatment episodes fluctuated, from a low of 16 days in 2015–16, to a high of 29 days in 2021–22:
  - these trends were driven primarily by changes in the duration of support and case management episodes
  - the median duration of counselling has increased from 54 days to 71 days over this period (Figure DURATION 1)
- for clients seeking support for someone else's alcohol or drug use, the median duration fluctuated more widely, rising from a low of 14 days in 2018–19 to a high of 37 days in 2020–21, falling to 29 days in 2021–22 (tables Trt.12, Ov.11). This fluctuation was driven primarily by decreases in support and case management treatment duration.

Figure DURATION 1: Median duration of treatment episodes, by client type and main treatment type, 2012-13 to 2021-22

The line graph shows that the median duration of treatment episodes provided to all clients was longest for episodes with counselling as the main treatment type across most years between 2012–13 and 2021–22. In 2021–22, counselling episodes had a median duration of 71 days, compared with 42 days for rehabilitation and 47 days for 'other' main treatment types. A filter allows the user to view data for all clients, clients seeking treatment for their own drug use or clients seeking treatment for someone else's drug use.

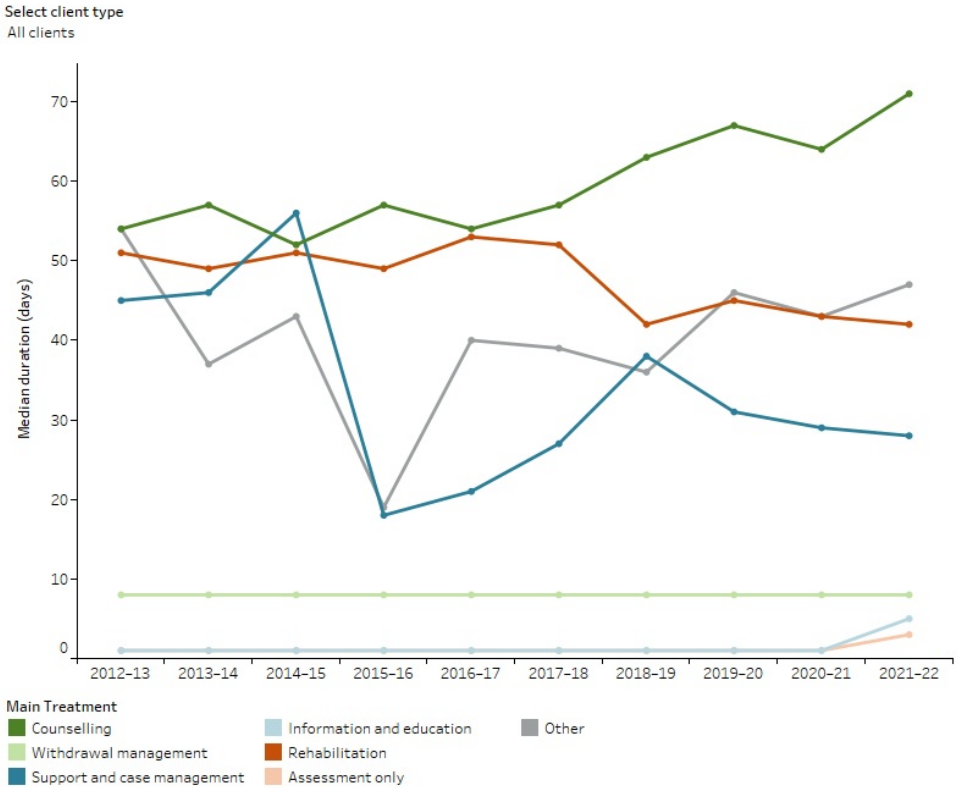


Figure DURATION 1: Median duration of treatment episodes, by client type and main treatment type and median duration, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table OV.11.
http://www.aihw.gov.au

See notes >

Treatment referral and completion

Reasons for clients no longer receiving treatment from an AOD treatment service include:

- expected completions (for example, treatment program completed)
- unplanned completions (for example, the client ceased to participate in the treatment program without notice)
- administrative completion (for example, client transferred to another service provider) (see Key terminology and glossary).

In 2021–22:

- treatment episodes for a client's own alcohol or drug use:
  - almost 3 in 5 (58%) treatment episodes ended as expected (planned) completions
  - around 1 in 5 (20%) of treatment episodes ended due to an unplanned completion (Table Trt.8).
- This pattern differed slightly for clients who received support for someone else's alcohol or drug use; the proportion of treatment episodes that ended due to unplanned completion was lower (12%) than for a client's own alcohol or drug use (Figure COMPLETION 1, Table Trt.8).

Figure COMPLETION 1: Treatment episodes, by client type and reason for cessation, 2012-13 to 2021-22

The stacked horizontal bar graph shows that most treatment episodes in 2021–22 ended with an expected/planned completion, regardless of client type. Treatment episodes provided to clients for their own drug use were more likely to end with an expected completion than were episodes provided to clients for someone else's drug use 59.3% compared with 45.1%, respectively). 37.8% of episodes provided to clients for other's drug use ended for other reasons, compared to 12.1% of episodes for clients' own drug use. A filter allows the user to view data for different years.

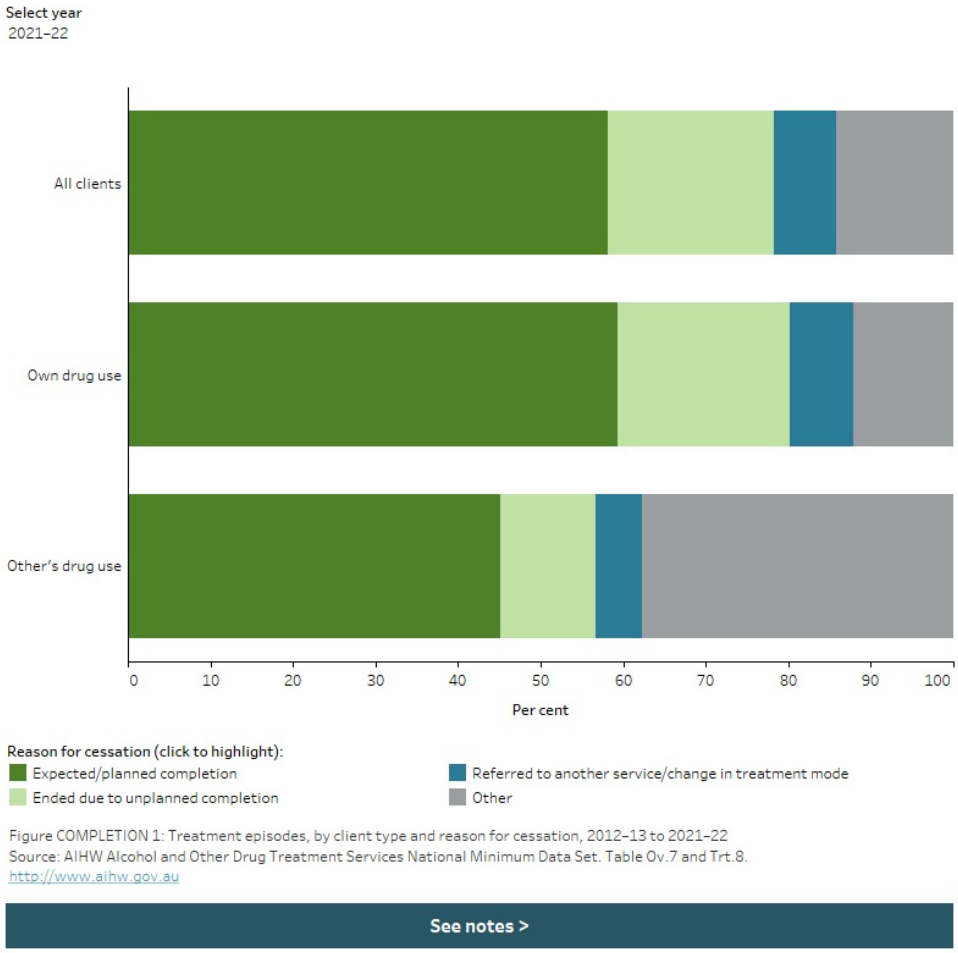


Figure COMPLETION 1: Treatment episodes, by client type and reason for cessation, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Ov.7 and Trt.8.
http://www.aihw.gov.au

See notes >

In 2021–22, completion of treatment for a client's own alcohol or drug use varied by principal drug of concern. For example, treatment episodes for:

- the most common principal drugs of concern had expected completion proportion ranging from 63% for cannabis to 52% for amphetamines
- ecstasy (73%) and nicotine (72%) as the principal drugs of concern had the highest proportion of episodes ending with an expected completion

- other stimulants and hallucinogens had the highest proportion of episodes for unplanned completions (26%), followed by amphetamines (25%), oxycodone (24%) and morphine (23%) (Table Drg.14, Figure COMPLETION 2).

Figure COMPLETION 2: Treatment episodes for selected drugs, by principal drug of concern and reason for cessation, completion, 2014-15 to 2021-22

The stacked horizontal bar chart shows that expected/planned completion was the most common reason for cessation in treatment episodes for all selected principal drugs of concern in 2021–22. The proportion of episodes that ended with an expected completion ranged from 49.1% for morphine as the principal drug of concern to 72.5% for ecstasy (MDMA). A filter allows the user to view data for different years.

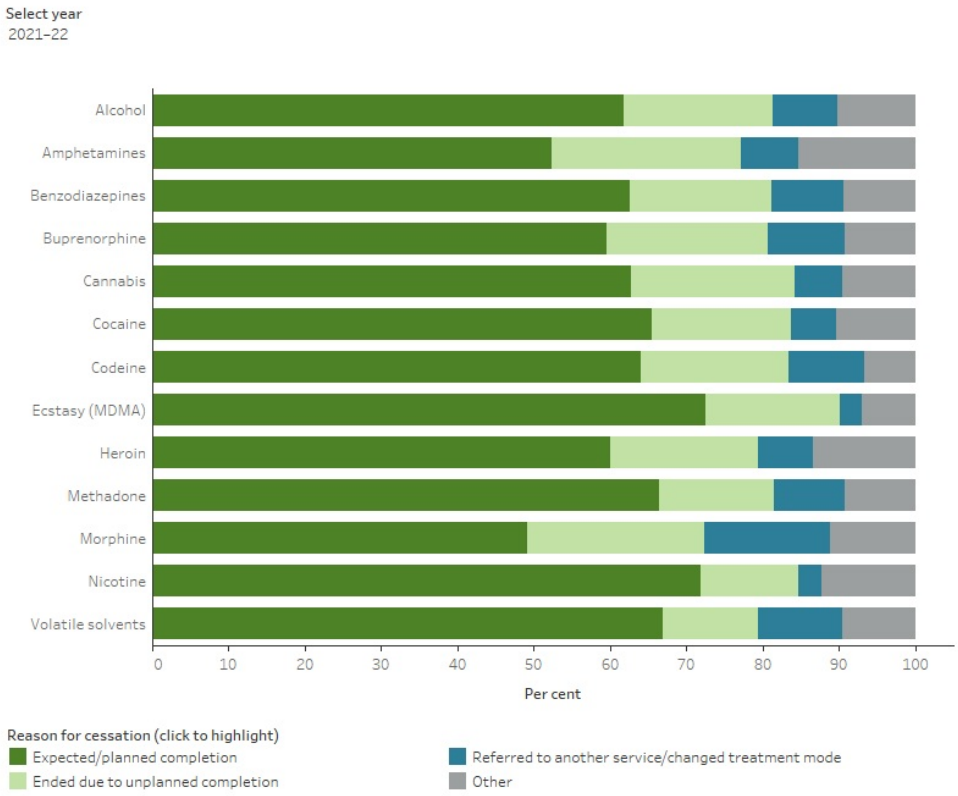


Figure COMPLETION 2: Treatment episodes for selected drugs, by principal drug of concern and reason for cessation, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Drg.12.
http://www.aihw.gov.au

See notes >

Over the 10 years to 2021–22, for a client's own alcohol or drug use, the proportion of treatment episodes that ended in an expected completion decreased overall, falling by 4 percentage points to 59% (Table Ov.7):

- where alcohol was the principal drug of concern, around 3 in 5 episodes ended with an expected completion (ranging from 62% to 66% between 2012–13 and 2021–22)
- where amphetamines were the principal drug of concern, the proportion of treatment episodes with an expected completion decreased 62% in 2015–16 to 52% in 2021–22
- where cannabis was the principal drug of concern, the proportion of treatment episodes with an expected completion decreased from 73% in 2016–17 to 63% in 2021–22
- where heroin was the principal drug of concern, the proportion of treatment episodes with an expected completion ranged between 53% and 61% between 2012–13 and 2021–22 (Table Drg.12).

Over the 10 years to 2021–22, for someone else's alcohol or drug use:

- the proportion of treatment episodes with an expected completion fell from 75% in 2012–13 to 45% in 2021–22
- conversely, 'other' as a reason for ceasing treatment increased from 11% in 2012–13 to 38% in 2021–22 (Table Ov.7).

Agencies

The Australian Government and state and territory governments fund non-government and government agencies to provide a range of alcohol and other drug (AOD) treatment services (see Key terminology and glossary). Treatment services are delivered in both residential and non-residential settings, and often include treatments such as detoxification, rehabilitation, counselling and pharmacotherapy.

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) contains a subset of information on publicly funded AOD treatment agencies and their service delivery outlets. An agency can have more than one service delivery outlet, located in different areas (see Policy Framework for details of collection scope).

Key findings

In 2021–22:

- around 1,300 publicly funded agencies provided data about their treatment services to the AODTS NMDS
- over 2 in 3 (68%) agencies were non-government
- nearly 3 in 5 (56%) agencies were located in *Major cities*
- nationally, counselling was the most common main treatment type provided by agencies across all remoteness areas.

Nationally, over the 10-year period to 2021–22, the total number of publicly funded agencies providing AOD treatment almost doubled from 714 in 2012–13 to around 1,274 in 2021–22.

In 2021–22, 1,274 publicly funded AOD treatment agencies reported to the AODTS NMDS. The number of agencies in each jurisdiction ranged from 17 in the Australian Capital Territory to 475 in New South Wales. The number of agencies reporting to the AODTS NMDS in 2021–22 decreased from 1,279 in 2020–21.

Over the last 10 years, the total number of AOD treatment agencies almost doubled (from 714 in 2012–13 to 1,274 in 2021–22). This has been driven by increases in New South Wales, Victoria, Queensland, and Western Australia. The expansion in the sector has seen a growth in the number of non-government AOD treatment services (from 397 in 2012–13 to 871 in 2021–22). The expansion has included new funding arrangements for existing AOD programs to increase service capacity, expand collaboration across agencies and deliver new treatment services. See the Alcohol and other drug treatment services NMDS Data Quality Statement, 2021–22 for further information.

Explore agencies:

- Service sector
- Location of agencies

Agencies

A mix of government and non-government agencies deliver publicly funded AOD treatment services. Nationally in 2021–22, over two-thirds (68%) of AOD treatment agencies were non-government, and these agencies provided 73% of all treatment episodes. In the decade from 2012–13, the proportion of non-government services has increased from 56% to 68% nationally.

Across most of Australia in 2021–22, the majority of AOD treatment agencies were non-government services, with proportions ranging from 61% in South Australia to 99% in Victoria. The exception was New South Wales, where the majority (61%) of AOD treatment agencies were government services (Figure AGENCIES 1).

In 2021–22, almost 3 in 5 (56%) agencies were located in *Major cities*. Seven in 10 (70%) agencies located in *Major cities* were non-government agencies, compared with 63% in 2017–18 (tables Agcy.1, Agcy.3).

Figure AGENCIES 1: Publicly funded AOD treatment agencies by service sector and state or territory, 2012-13 to 2021-22

The horizontal bar chart shows that 68.4% of treatment agencies in Australia were non-government in 2021–22. New South Wales had the highest proportion of government agencies (61.3%), while Victoria had the highest proportion of non-government agencies (99.1%). A filter allows the user to view different years of data.

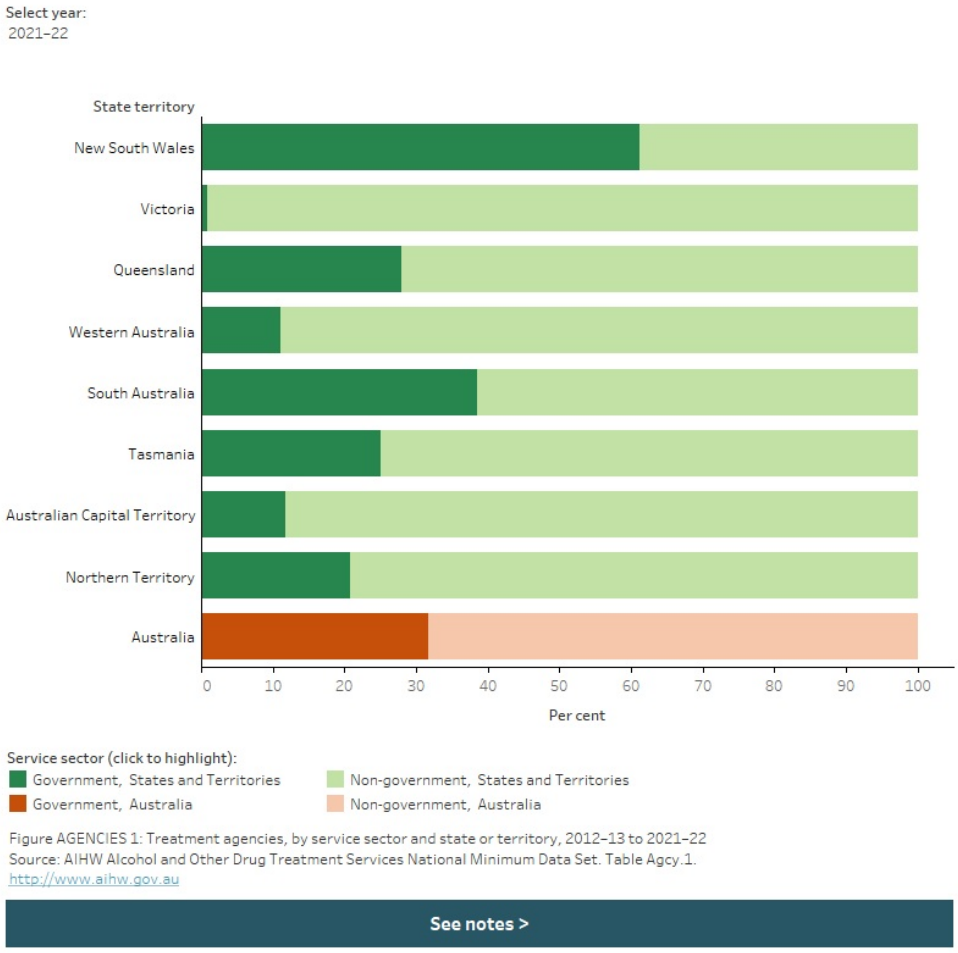


Figure AGENCIES 1: Treatment agencies, by service sector and state or territory, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Agcy.1.
http://www.aihw.gov.au

See notes >

Agencies

In 2021–22:

- Nearly 3 in 5 (56% or 711) treatment agencies were located in *Major cities* and a quarter (26% or 326) were in *Inner regional* areas. Agencies in these two areas provided 89% of all treatment episodes (Figure AGENCIES REMOTENESS 1, tables Agcy.3–Agcy.4).
- Relatively few treatment agencies were located in *Remote* (2.8% or 35) and *Very remote* areas (2.6% or 33). Agencies in these two areas provided 2.6% of all treatment episodes.
- This pattern was similar across most states and territories, except for Northern Territory where half (50%) of all agencies were located in *Remote* (32%) and in *Very remote* (17%) areas, with the other half in *Outer regional* (50%) areas (Table Agcy.3).

Over the 10-year period to 2021–22:

- Nationally, the total number of agencies has increased, rising from 714 agencies in 2012–13 to 1,274 agencies in 2021–22.
- The majority of agencies were located in *Major cities*; this trend was similar for most states and territories but does not apply to the Northern Territory and Tasmania, which do not have *Major cities* as a remoteness area.

Figure AGENCIES REMOTENESS 1: Treatment agencies by remoteness area and state or territory, 2017–18 to 2021–22

The horizontal bar chart shows that most agencies in New South Wales (61.8%), Victoria (60.6%), Queensland (45.1%), Western Australia (56.6%), South Australia (46.8%) and the Australian Capital Territory (100%) were located in *Major cities*. Tasmania and Northern Territory do not have any areas classified as *Major cities*. Most agencies in Tasmania were located in *Inner regional* areas (58.3%) and most agencies in the Northern Territory were located in *Outer regional* areas (50.0%). A filter allows the user to view different years of data.

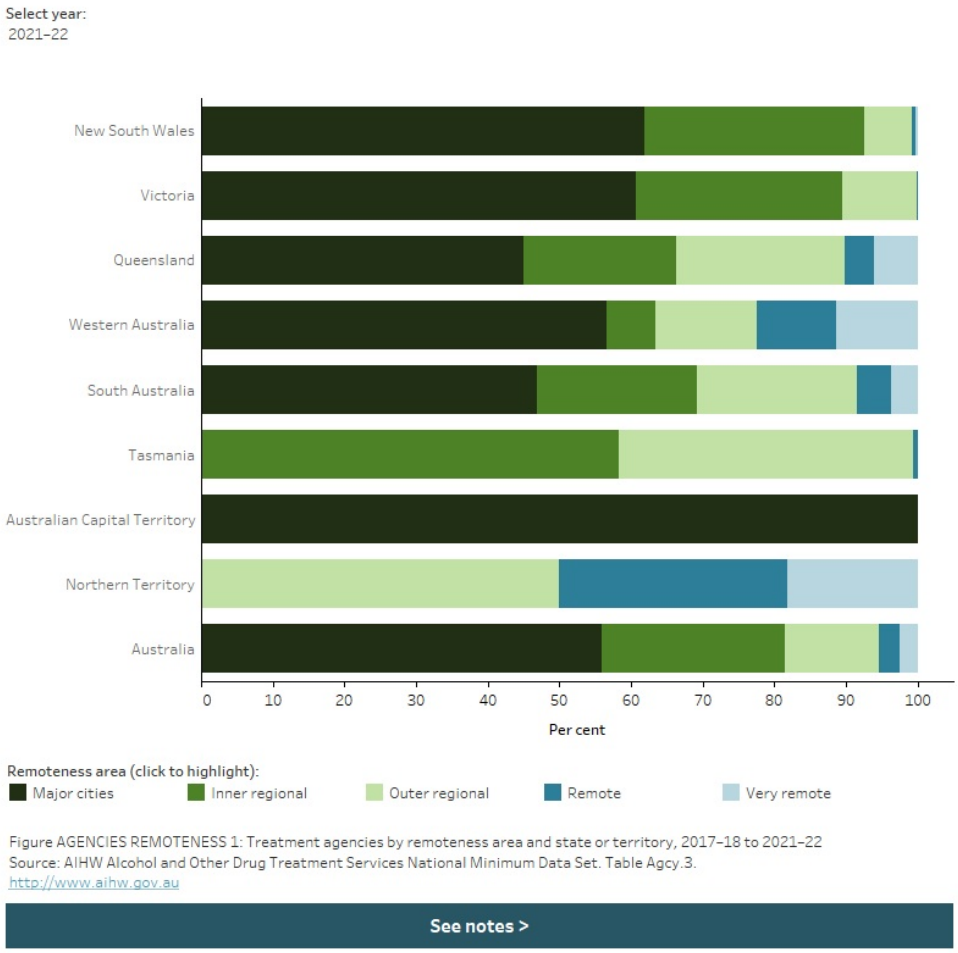


Figure AGENCIES REMOTENESS 1: Treatment agencies by remoteness area and state or territory, 2017–18 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Agcy.3.
http://www.aihw.gov.au

See notes >

Treatment type delivery varied by agency remoteness. Nationally, in 2021–22:

- Counselling was the most common main treatment type provided by treatment agencies across all remoteness areas.
- The proportion of treatment episodes for counselling ranged from as high as 46% in *Remote* areas to 36% in *Inner regional* areas (Figure AGENCIES REMOTENESS 2; Table Agcy.6).

The delivery of main treatment types also varied by agency remoteness at a jurisdictional level. In 2021–22:

- Agencies across all remoteness areas in New South Wales most commonly provided counselling, ranging from 55% of treatment episodes in *Outer regional* areas to 16% in *Very remote* areas.
- In Victoria, agencies in *Major cities* most commonly provided counselling and support and case management (24% and 22% of episodes, respectively). *Inner regional* and *Outer regional* agencies most commonly provided assessment only (27%) and counselling (35%), respectively.
- In Queensland, almost 1 in 2 (47%) episodes provided in *Remote* areas were assessment only.
- Around 9 in 10 episodes in *Remote* and *Very remote* areas of Western Australia were counselling (89% and 94% respectively)
- In South Australia, support and case management was more likely to be provided in more remote areas (ranging from 7.2% in *Inner Regional* to 31% in *Outer regional*) compared to *Major cities* (3.1%), while *Major cities* had a higher proportion of withdrawal management episodes (19%).
- In the Northern Territory, assessment only was the most common treatment provided in *Outer regional* areas (59%), while information and education was most common in *Very remote* areas (49%) (Figure AGENCIES REMOTENESS 2; Table Agcy.6).

Note that remoteness categories are derived by applying a correspondence based on the agency's Statistical Area level 2 code (SA2). See technical notes for information on how this affects the reporting of the number of agencies in a particular remoteness category.

Figure AGENCIES REMOTENESS 2: Treatment episodes by states and territories, treatment type and remoteness of agency 2018-19 to 2021-22

The horizontal bar chart shows that nationally in 2021–22, counselling was the most common main treatment type in all remoteness areas, ranging from 35.6% of episodes in *Inner regional* areas to 46.2% of episodes in *Remote* areas. Filters allow the user to view data for different years and by state/territory.

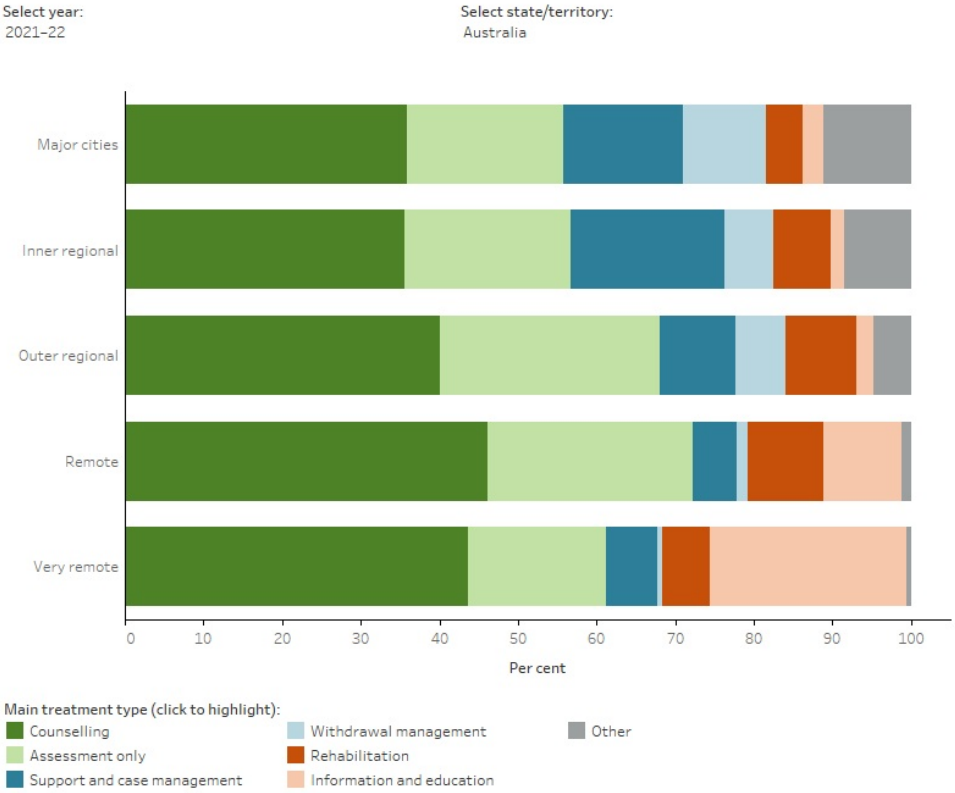


Figure AGENCIES REMOTENESS 2: Treatment episodes by remoteness area of agency, main treatment type and state or territory, 2018–19 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table Agcy.6.
http://www.aihw.gov.au

See notes >

State and territory summaries

On this page:

This section presents key state and territory findings on specialist alcohol and other drug (AOD) treatment services, the people they treat, and the treatment they provided in 2021–22.

The technical notes page provides details on the data, with further information available in the Alcohol and other drug treatment services NMDS 2021–22 Quality Statement. In addition, a series of state and territory *supplementary tables* accompanying the annual report are also available.

Key findings

In 2021–22:

- around 1,300 publicly funded agencies provided services for clients seeking AOD treatment in Australia, ranging from 17 in the Australian Capital Territory to 475 in New South Wales
- **alcohol** was the most common principal drug of concern for all states and territories; Northern Territory (65%), Tasmania (49%), Western Australia (46%), New South Wales (43%), Australian Capital Territory (43%), South Australia (41%), Queensland (39%) and Victoria (39%) (nationally 42% of treatment episodes)
- **amphetamines** were the second most common principal drug of concern in most states except for Queensland and Northern Territory. Treatment episodes for amphetamines ranged from 20% in the Australian Capital Territory to 31% in South Australia (nationally the second most common drug of concern; 24%)
- **counselling** was the most common main treatment type nationally (36%), and the most common in all states except the Northern Territory.

Over the period 2012–13 to 2021–22:

- the **number of publicly funded agencies** rose from 714 to 1,274 in 2021–22, a change that was largely driven by increases in New South Wales (from 245 to 475) and Victoria (from 129 to 351)
- **alcohol, amphetamines, cannabis and heroin** were the most common principal drugs of concern in 6 of the 8 states and territories
- **counselling** was the most common main treatment type across most states and territories during this period.

State and territory client rates

Nationally, the rate of clients receiving specialist AOD treatment was 576 per 100,000 people in 2021–22, the lowest rate since 2015–16 (Table SCR.21). The rate of clients treated by publicly funded AOD treatment agencies in each state and territory varied over time. (Figure CLIENTS 1).

Figure CLIENTS 1: AODTS clients and treatment episodes, by state and territory, 2013–14 to 2021–22.

The line chart shows that there were 576 clients per 100,000 population in Australia in 2021–22, decreasing from 619 clients per 100,000 population in 2021–22. Across the period 2013–14 to 2021–22, the rate of clients was highest in the Northern Territory (1,530 per 100,000 in 2021–22) and lowest in New South Wales (399 per 100,000 in 2021–22). A filter allows the user to view by rate of clients, number of clients or number of treatment episodes.

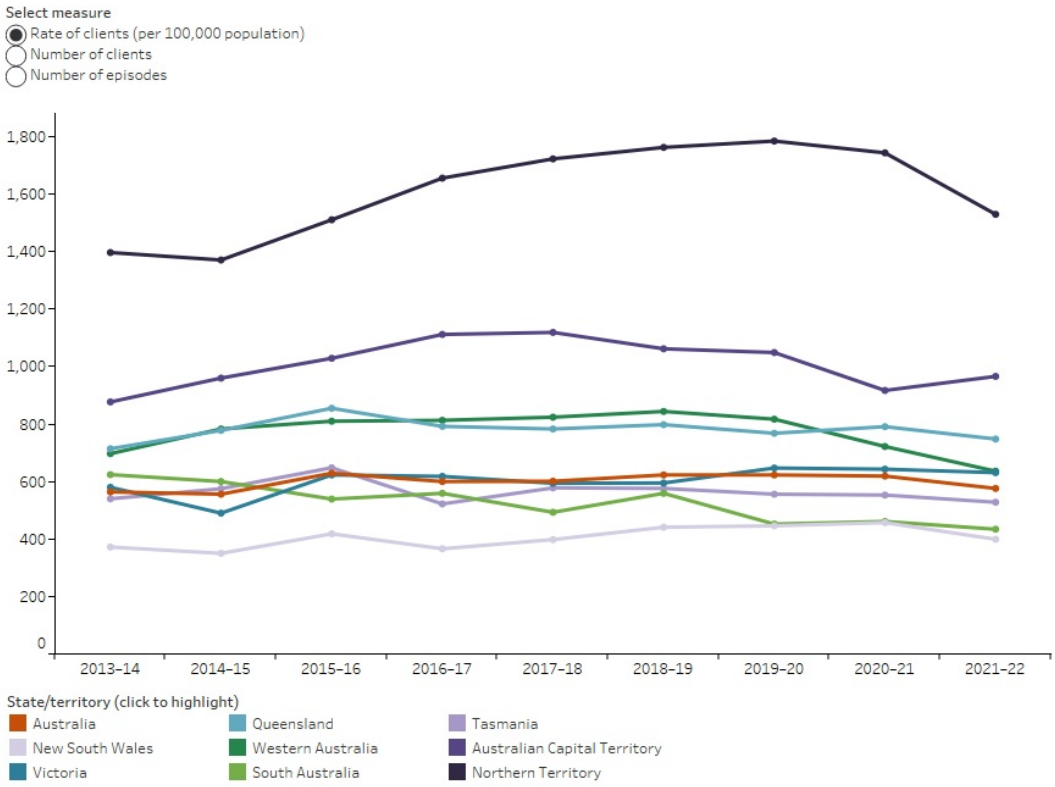


Figure CLIENTS 1: AODTS clients and treatment episodes, by state and territory, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SCR.21.
http://www.aihw.gov.au

See notes >

Over the period from 2013–14 to 2021–22, in 4 of 8 states and territories, the rate of clients remained consistently higher than the rate of clients nationally:

- in the **Northern Territory**, the rate of clients increased from 1,397 clients per 100,000 in 2013–14 to 1,530 per 100,000 in 2021–22
- in the **Australian Capital Territory**, the rate of clients ranged from 877 clients per 100,000 in 2013–14 to 1,119 per 100,000 in 2017–18, falling to 966 clients per 100,000 in 2021–22
- in **Western Australia**, the rate of clients increased between 2013–14 and 2019–20 from 697 per 100,000 to 817 per 100,000, then falling to 636 clients per 100,000 in 2021–22
- in **Queensland,** the rate of clients fluctuated from 714 clients per 100,000 in 2013–14 up to 855 per 100,00 in 2015–16, falling to 748 clients per 100,000 in 2021–22.

For more information see the Data quality statement.

Explore state and territory summaries:

- New South Wales
- Victoria
- Queensland
- Western Australia
- South Australia
- Tasmania
- Australian Capital Territory
- Northern Territory
- Technical notes - state and territory summaries

State and territory summaries

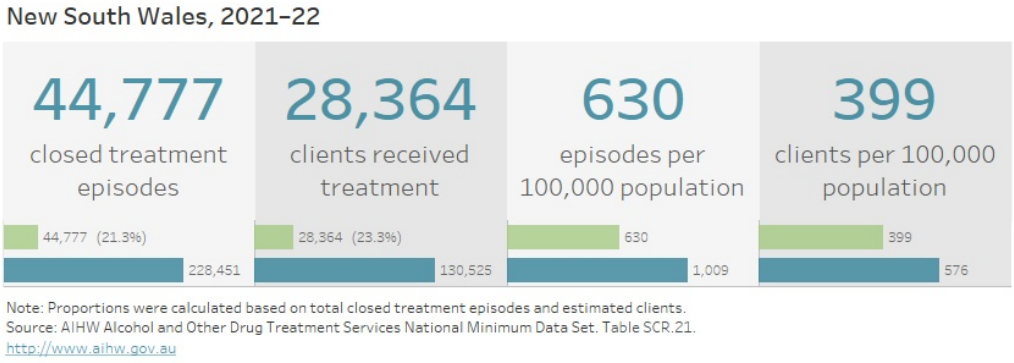
On this page:

In 2021–22, 475 publicly funded alcohol and other drug treatment agencies in New South Wales provided 44,777 treatment episodes to 28,364 clients (tables ST NSW.1, Agcy.1, SCR.21).

New South Wales reported:

- the number of treatment episodes decreased by 14% between 2020–21 and 2021–22 (51,800 and 44,800 episodes, respectively), although over the 10 years since 2012–13 there has been a 6% increase in treatment episodes (35,300 episodes) (Table ST NSW.2)
- more clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (399 clients per 100,000 population compared with 372 per 100,000, respectively)
- client numbers have increased from 24,200 in 2013–14 to 28,400 in 2021–22 (Table SCR.21).

The visualisation shows that 51,451 closed treatment episodes were provided to an estimated 31,549 clients in New South Wales in 2019–20. This equates to a rate of 723 episodes and 443 clients per 100,000 population, which is lower than the national rate (1,064 episodes and 624 clients per 100,000 population).



Note: Proportions were calculated based on total closed treatment episodes and estimated clients.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SCR.21.
http://www.aihw.gov.au

In 2021–22, most clients in New South Wales attended 1 agency (78% of clients) (Table SCR.23). Clients received an average of 1.6 treatment episodes, similar to the national average (1.8 episodes) (Table SCR.21).

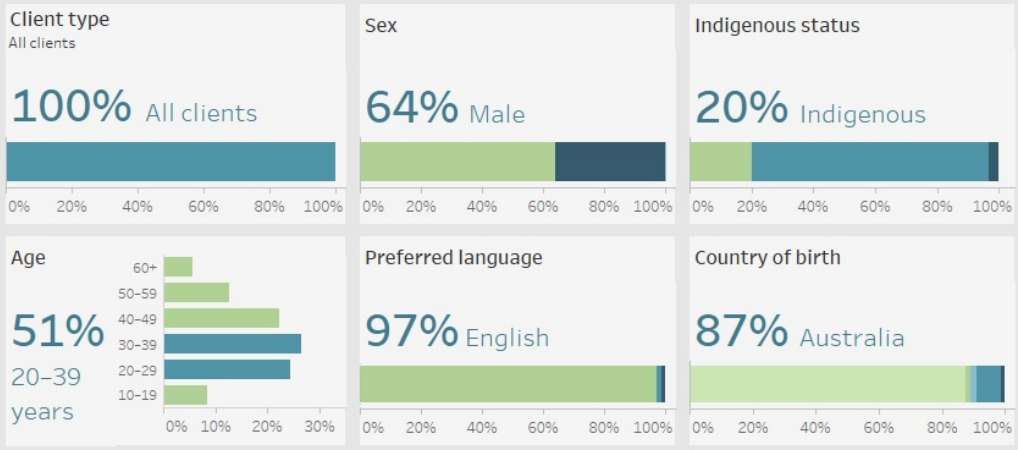
Client demographics

In 2021–22:

- nearly all (98%) clients in New South Wales received treatment for their own alcohol or drug use, of which almost 2 in 3 people were male (64%) (Figure NSW 1)
- females were more likely to receive treatment for someone else's drug use than males (56% of female clients compared with 43% of male clients)
- Over half (51%) of all clients were aged 20–39 years
- 1 in 5 (20%) of all clients identified as Indigenous Australians, consistent with the national proportion (18%)
- the majority (87%) of all people were born in Australia and nearly all (97%) reported English as their preferred language (tables SC.4, SC NSW.1–3, SC NSW.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2019–20, nearly all (98%) clients in New South Wales received treatment for their own drug use. Of these clients, around two-thirds (66%) were male, 52% were aged 20–39, and 18% were Indigenous Australians. Nearly all clients (97%) listed English as their preferred language and most (87%) were born in Australia.

Figure NSW 1: AODTS clients by client type and selected demographics, New South Wales, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables SC NSW.1–3 and SC NSW.21–22.
http://www.aihw.gov.au

Patterns of service use

Over the period 2017–18 to 2021–22, 104,500 clients received treatment in New South Wales (Table SCR.28). Of these clients, the majority received treatment in a single year (70% or 73,500):

- 15,100 (14%) received treatment for the first time in 2021–22
- a further 58,400 (56%) received treatment in only one of the five collection periods (excluding 2021–22).

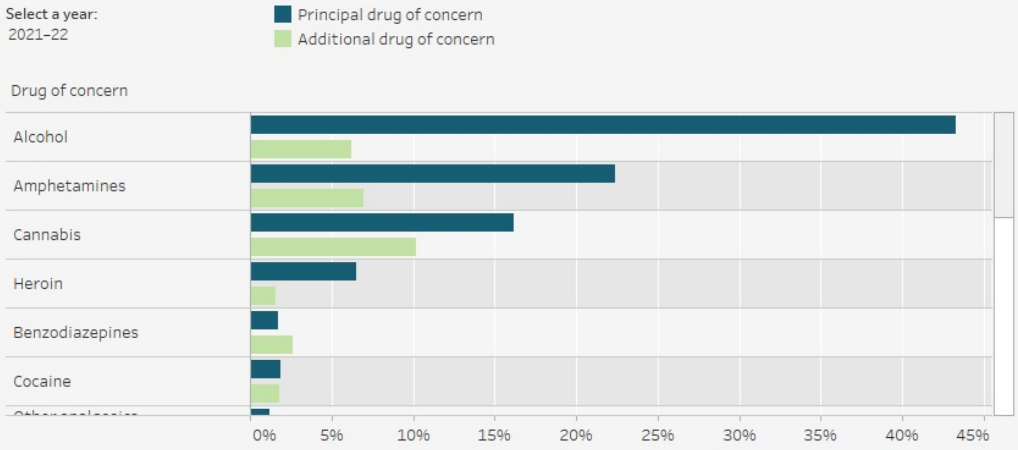
Drugs of concern

In 2021–22, among clients in New South Wales receiving treatment for their own alcohol or drug use:

- alcohol was the most common principal drug of concern (43% or 19,100 episodes)
- amphetamines as a principal drug of concern accounted for over 1 in 5 episodes (22% or 9,900), followed by cannabis (16% or 7,200) (Figure NSW 2, Table ST NSW.6).

The grouped horizontal bar chart shows that, in 2020–21, alcohol was the most common principal drug of concern in treatment episodes provided to clients in New South Wales for their own drug use (40.6%). This was followed by amphetamines (22.5%), cannabis (16.3%), and heroin (6.9%). Nicotine and cannabis were the most common additional drugs of concern (10% and 9.9% of episodes, respectively), followed by amphetamines (6.9%) and alcohol (6.1%).

Figure NSW 2: Proportion of treatment episodes for own drug use, by drug of concern, New South Wales, 2021–22 (per cent)



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST NSW 7.
http://www.aihw.gov.au

In 2021–22, for clients receiving treatment for their own use of amphetamines:

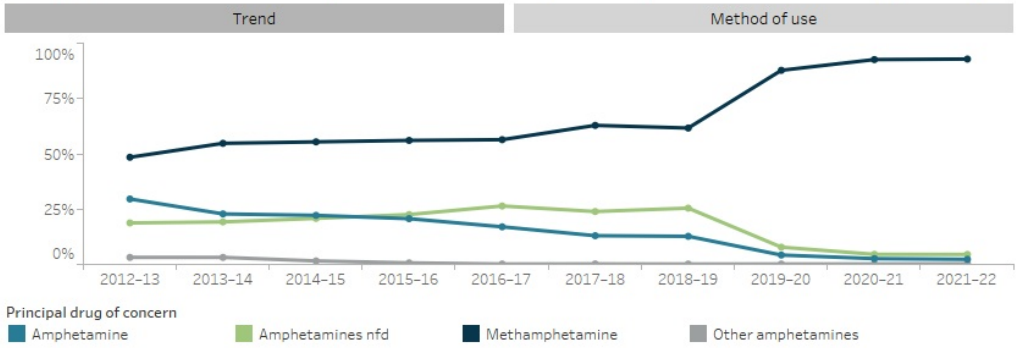
- methamphetamine was reported as a principal drug of concern in 93% of treatment episodes (Table Drg.4)
- in half (50%) of the treatment episodes where methamphetamine was the principal drug of concern, smoking was the most common method of use, followed by injecting (39%) (Figures NSW 3a, 3b).

Some jurisdictions are working with service providers to encourage more specific reporting of amphetamine use (i.e. to reduce the use of ‘amphetamines not further defined’ code where possible).

The line graph shows that, between 2011–12 and 2020–21, methamphetamine has remained the most common drug of concern among amphetamine-related treatment episodes for clients' own drug use. The proportion of methamphetamine-related episodes increased from 45.1% of amphetamine-related episodes in 2011–12 to 92.6% in 2020–21.

The stacked horizontal bar chart shows the method of use for treatment episodes related to clients' own use of methamphetamine, amphetamine, amphetamines not further defined, and other amphetamines in New South Wales in 2020–21. Smoking was the most common method of use across all amphetamine codes (ranging from 37.5% to 52.6% of episodes).

Figure NSW 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), New South Wales (per cent)



Notes:
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. ST NSW.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes).

In 2021–22, when the client reported additional drugs of concern, nicotine and cannabis were the most common additional drugs of concern (11% and 10% of episodes, respectively), followed by amphetamines (7.0%) and alcohol (6.2%) (Table ST NSW.7).

Over the period 2012–13 to 2021–22 New South Wales was consistent with national trends:

- alcohol remained the most common drug of concern, although there was variation in treatment episode numbers during this time, fluctuating from 14,700 to 19,100 episodes over this period; the proportion of alcohol treatment episodes relative to all other drugs of concern, declined from 43% in 2012–13 to 37% in 2016–17, rising to 43% again in 2021–22 (Figure NSW 2, Table ST NSW.6)
- amphetamines were the second most common principal drug of concern in 2021–22 and have increased since 2013–14 (from 14% or 4,700 episodes to 22% or 9,900 episodes)
  - within the amphetamines group, methamphetamine was reported as the principal drug of concern in almost half (48%) of episodes in 2012–13, rising to 63% in 2017–18 before a considerable increase to 93% in 2021–22 (Figure NSW 3a)
  - the rise in episodes may be related to increases in funded treatment services and/or improvement in agency coding practices for methamphetamines (Figure NSW 2, Table ST NSW.6)
- cannabis is the third most common principal drug of concern, decreasing from 21% to 16% in 2021–22 (Figure NSW 2, Table ST NSW.6).

Treatment

In 2021–22, for treatment episodes in New South Wales:

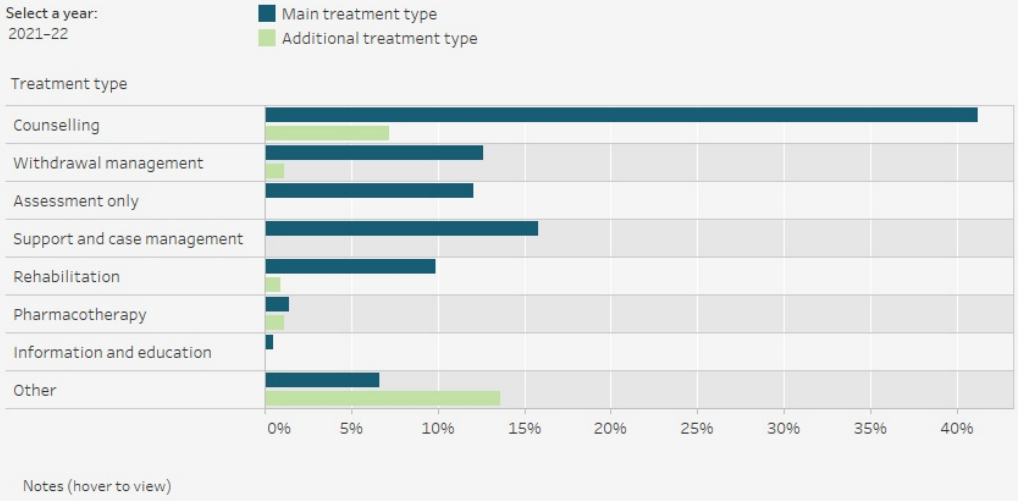
- counselling was the most common main treatment provided (41% of episodes), followed by support and case management (16%) and withdrawal management (13%)
- where an additional treatment was provided as a supplementary to the main treatment, 'other' treatment (13.6%) was the most common, followed by counselling (7.2%) (Table ST NSW.13). See technical notes for further information on calculating proportions for additional treatment type.

Over the period 2012–13 to 2021–22:

- counselling remained the most common treatment type for all episodes relative to other treatment types, rising from 36% (12,600 episodes) in 2012–13 to 42% (16,100) in 2016–17, dropping to 41% (18,500) in 2021–22
- withdrawal management episodes have fallen in the 10 years to 2021–22 from 18% (6,200 episodes) to 13% (5,600 episodes) (tables ST NSW.13, NSW.15).

The grouped horizontal bar chart shows that, in 2020–21, the most common main treatment type provided to clients in New South Wales for their own drug use was counselling (40.0% of episodes). This was followed by withdrawal management (14.4%) and support and case management (14.1%). 'Other' was the most common additional treatment type (8.0%), followed by counselling (6.8%).

Figure NSW 4: Proportion of treatment episodes, by treatment type, New South Wales, 2021–22



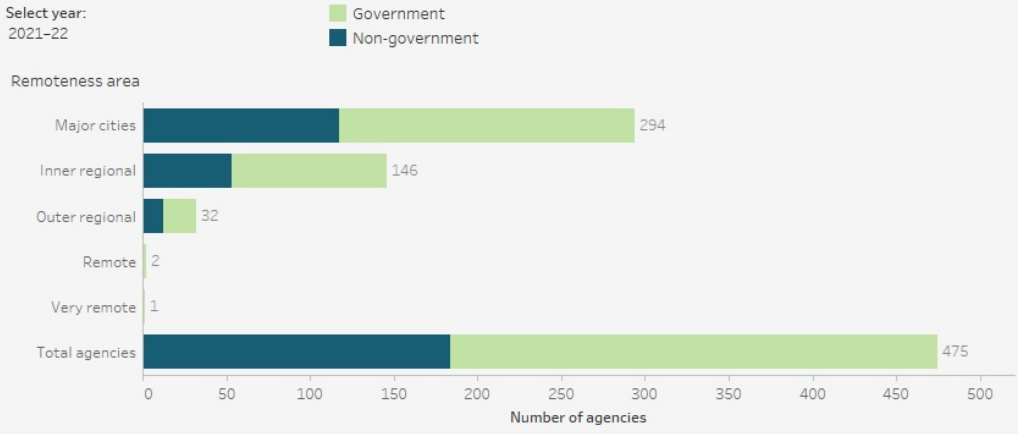
Agencies

In 2021–22, in New South Wales:

- over 6 in 10 (61%) AOD agencies were government treatment agencies
- the majority (62%) of the 475 publicly funded treatment agencies were located in *Major cities*, followed by *Inner regional* areas (31%)
- agencies located in *Major cities* provided almost 2 in 3 (65%) of all treatment episodes
- less than 1% of treatment agencies were located in *Remote* or *Very remote* areas – these provided less than 1% of all treatment episodes (176 episodes)
- across all remoteness areas, the majority of agencies were government agencies, ranging from 60% in *Major cities* to 100% in *Very remote* areas (Figure NSW 5, tables Agcy.1, Agcy.3–4).

In the period 2012–13 to 2021–22, the number of publicly funded treatment agencies in New South Wales rose from 245 to 475 (Table Agcy.1). The horizontal bar chart shows that most treatment agencies in New South Wales in 2021–22 were located in *Major cities* (294 agencies), followed by *Inner regional areas* (146 agencies) and *Outer regional areas* (32 agencies). 3 treatment agencies were located in *Remote* and *Very remote* areas. Of the total 475 treatment agencies, 61.3% 291agencies) were government agencies.

Figure NSW 5: Number of agencies, by remoteness area and sector, New South Wales, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

State and territory summaries

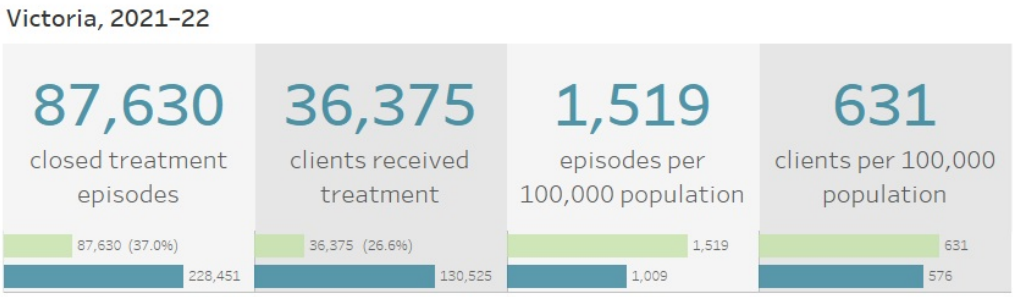
- **On this page:**
- Client demographics
- Drugs of concern
- Treatment
- Agencies

In 2021–22, 351 publicly funded alcohol and other drug treatment agencies in Victoria provided 87,630 treatment episodes to 36,375 people (tables Agcy.1, SCR.21).

Victoria reported:

- a 2.6% decrease in treatment episodes (from 90,000 in 2020–21 to 87,600 in 2021–22). Factors contributing to this decrease include, general and administrative impacts on services and data collection (e.g. changes in funding for services, partial reporting of data during the financial year, and services with no closed treatment episodes as treatment was ongoing).
- a 55% increase (56,400 episodes) in treatment episodes since 2012–13 (Table ST VIC.2)
- more clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (631 clients per 100,000 population compared with 580 per 100,000, respectively)
- a 13% increase in clients from 2017–18 (33,000) peaking in 2019–20 (37,400), then decreasing by 2.7% (36,400) in 2021–22 due to COVID-19 impacts and state-wide system changes. Client numbers increased gradually from 2013–14 (29,500) (Table SCR.21).

The visualisation shows that 87,630 treatment episodes were provided to 36,375 clients in Victoria in 2021–22. This equates to a rate of 1,519 episodes and 631 clients per 100,000 population, which is higher than the national rate (1,009 episodes and 576 clients per 100,000 population).



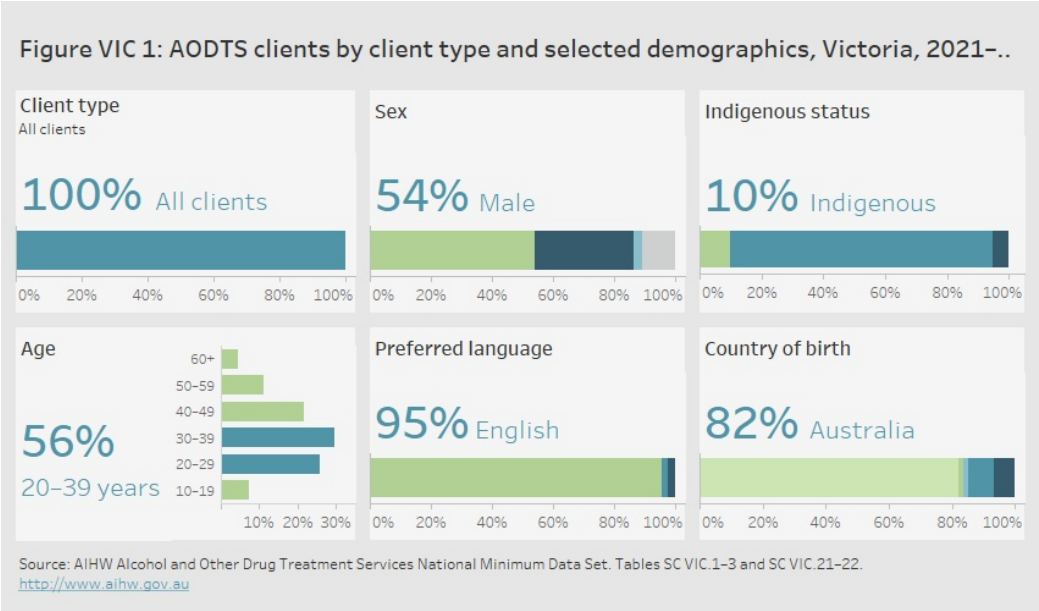
In 2021–22, nearly 7 in 10 (71%) clients in Victoria attended 1 agency and received an average of 2.4 treatment episodes, which is higher than the national average of 1.8 treatment episodes (tables SCR.21, SCR.23). This is due to the methods used in Victoria's data collection system, where each type of treatment (regardless of main or additional treatment) results in a separate treatment episode (see Data Quality Statement for further information).

Client demographics

In 2021–22:

- over 8 in 10 (83% or 30,300) clients in Victoria received treatment for their own alcohol or drug use, of which over 1 in 2 (56%) people were male (Figure VIC 1, tables SC VIC.1, SCR.27)
- 2.7% (960) of all clients reported sex as 'other', the highest proportion reported across all states and territories in the collection period. This category was collected for the first time in 2018–19 (Table SC VIC.1)
- nearly 3 in 5 (56%) of all people were aged 20–39 years
- 10% of all clients identified as Indigenous Australians, which is lower than the national proportion (18%)
- the majority (82%) of all clients were born in Australia and mostly (95%) reported English as their preferred language (tables SC VIC.1–3, SC.4, SC VIC.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2021–22 in Victoria, 54% of all clients were male, 56% were aged 20–39 and 10% were Indigenous Australians. Nearly all clients (95%) listed English as their preferred language and most (82%) were born in Australia.



Patterns of service use

Over the period 2017–18 to 2021–22, 113,700 people received treatment in Victoria. Of these clients, the majority received treatment in a single year (64% or 73,200):

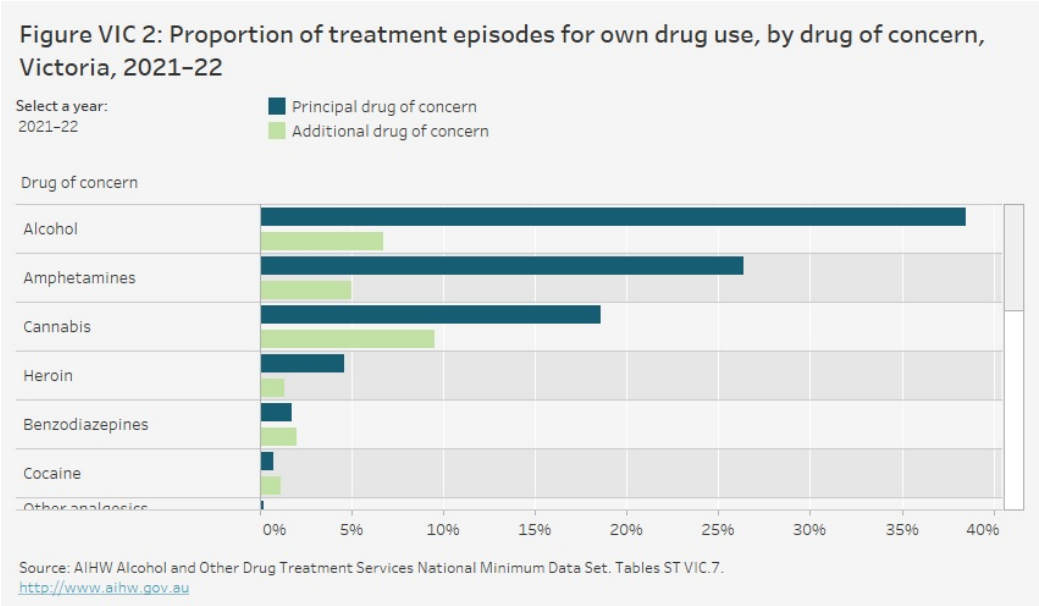
- 17,800 (16%) received treatment for the first time in 2021–22
- a further 55,400 (49%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

Drugs of concern

In 2021–22 for clients in Victoria receiving treatment for their own alcohol or drug use:

- alcohol was the most common principal drug of concern, accounting for 39% (27,900) of treatment episodes
- amphetamines (26% or 19,100 episodes) were the second most common principal drug of concern, followed by cannabis (19% or 13,500) (Figure VIC 2, Table ST VIC.6).

The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in Victoria for their own drug use (38.5%). This was followed by amphetamines (26.4%), cannabis (18.6%), and heroin (4.6%). Cannabis was the most common additional drug of concern (9.5% of episodes), followed by nicotine (7.6%) and alcohol (6.7%).



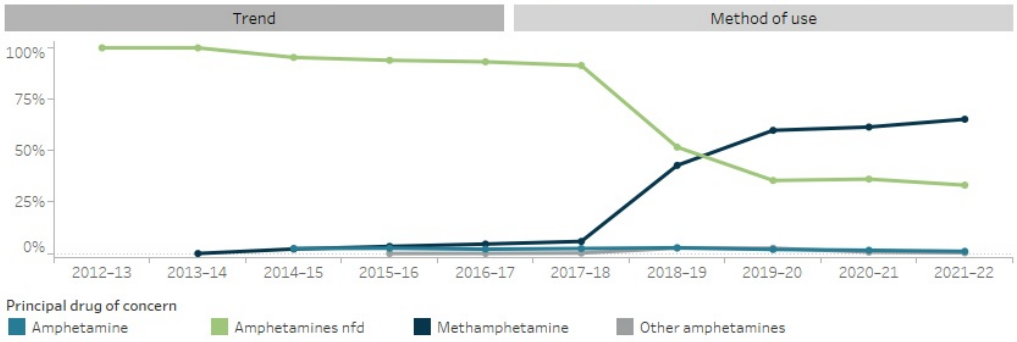
In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern in over 3 in 5 (65%) of treatment episodes (Figure VIC 3a)
- smoking was the most common method of use in 58% of episodes where methamphetamine was the principal drug of concern, followed by injecting (18%) (Figure VIC 3b).

Victoria is working with service providers to encourage more specific reporting of amphetamine use (for example, to reduce the use of ‘amphetamines not further defined’ code where possible).

The line graph shows that, from 2012–13 to 2018–19, 'amphetamines not further defined' was the most common drug of concern among amphetamine-related treatment episodes for clients' own drug use. In 2019–20, methamphetamine became the most common drug of concern. The proportion of episodes for amphetamines not further defined decreased from 2017–18 (91% of amphetamine-related episodes) to 2021–22 (33.3%), while episodes increased for methamphetamines (from 5.9% to 65.3%). Buttons allow the user to navigate to data on method of use.

Figure VIC 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), Victoria (per cent)



Notes
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST VIC.6.
http://www.aihw.gov.au

In 2019–20, Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This proportion decreased in 2020–21 (2.1%), due to work with service providers by the Victorian Agency for Health Information to encourage more specific reporting of drug of concern. In 2021–22, this remains low, 4.7% of treatment episodes. For more information see the Data quality statement.

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes). In 2021–22, when the client reported additional drugs of concern, cannabis was the most common (9.5% of episodes), followed by nicotine and alcohol (7.6% and 6.7%, respectively) (Table ST VIC.7).

Over the period 2012–13 to 2021–22:

- alcohol was the most common principal drug of concern for treatment episodes except in 2019–20 when amphetamines were the most common principal drug of concern (28% and 29% respectively):
  - the proportion of episodes ranged from 42% in 2012–13 to 28% in 2019–20, before increasing to 39% in 2021–22
  - the number of episodes fell 26% from 21,500 in 2012–13 to 15,800 in 2014–15, rising to 27,900 episodes in 2021–22 (Figure VIC 2, Table ST VIC.7).
- amphetamines were the second most common principal drug of concern (26% or 19,100 episodes). The proportion of episodes with a principal drug of concern for amphetamines increased from 13% in 2012–13 to peak at 30% in 2018–19, decreasing in 2021–22 (26%):
  - within the amphetamines group, methamphetamine was reported as the principal drug of concern for the first time in 2014–15 (2.2% of episodes). This was followed by a large increase in 2018–19 (43%) and 2021–22 (65%) (Figure VIC 3a)
  - the rise in episodes for methamphetamine is due mainly to improvements in agency coding practices for methamphetamines, although some of the increase in episodes could be related to increases in funded treatment services.
- the proportion of treatment episodes for cannabis decreased from 22% in 2012–13 to 19% in 2021–22 (Figure VIC 2, Table ST VIC.7).

Treatment

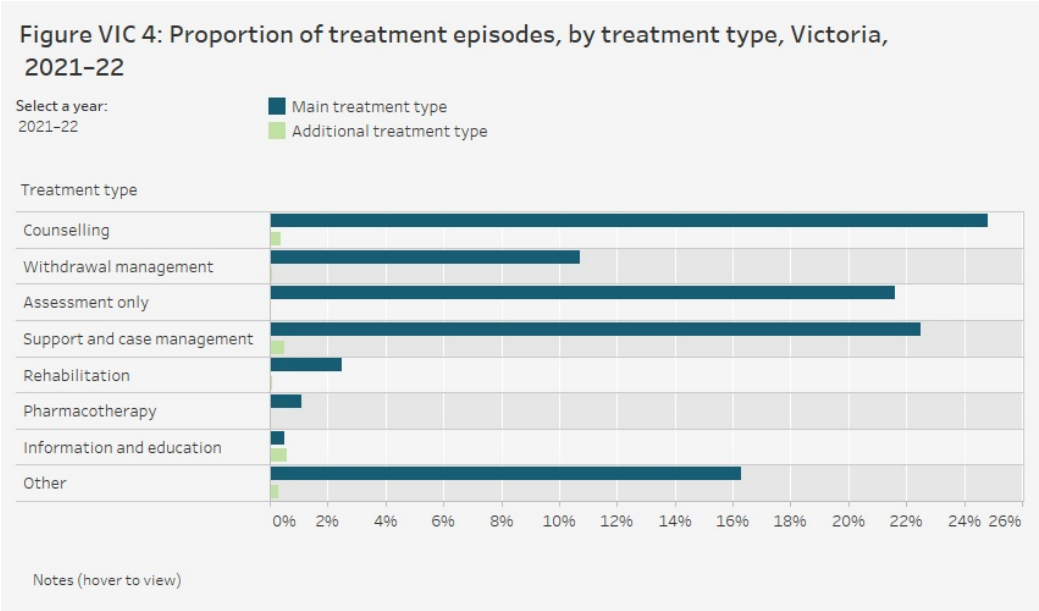
In 2021–22, counselling was the most common treatment type (25% of episodes) followed by support and case management (23%) (Figure VIC 4, Table ST VIC.13).

The majority of services who submit AODTS NMDS data use the Victorian Alcohol and Drug Collection (VADC), which does not differentiate between main and other treatment types. A small proportion of services who submit AODTS NMDS data use their own data collection systems, which do differentiate between main and other treatment types.

Over the period from 2012–13 to 2021–22:

- counselling remained one of the most common main treatments for all episodes in 2021–22 (25%), though this proportion has halved since 2012–13 (53%)
- support and case management as a main treatment increased from 13% in 2012–13, peaking in 2015–16 (30%) and falling to 23% in 2021–22
- withdrawal management decreased from 21% to 11% and 'other' treatment increased from 0.6% to 16% over the same period (Figure VIC 4, Table ST VIC.13).

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in Victoria for their own drug use was counselling (24.8% of episodes). This was followed by support and case management (22.5%), and assessment only (21.6%). Information and education was the most common additional treatment type (0.6%), followed by support and case management (0.5%).



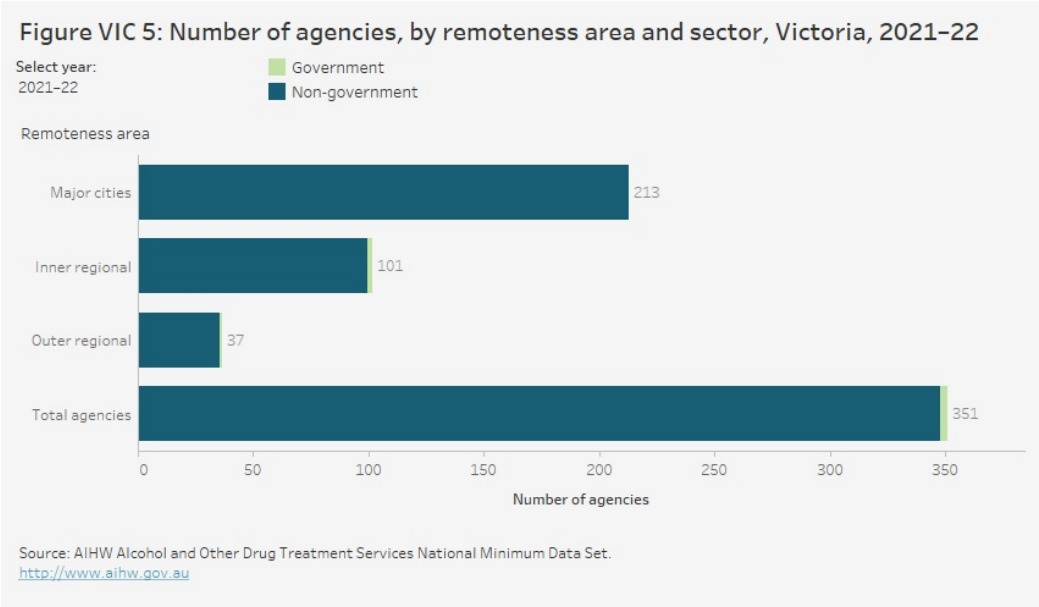
Agencies

In 2021–22, in Victoria:

- only 3 of the 351 AOD agencies that received public funding were government treatment agencies
- over 6 in 10 (61%) treatment agencies were located in *Major cities*, followed by *Inner regional* areas (29%) (Figure VIC 5; Table Agcy.3)
- Victoria does not have any areas classified as *Remote* or *Very remote*.

In the period from 2012–13 to 2021–22, the number of publicly funded treatment agencies in Victoria increased from 129 in 2012–13 to 404 in 2018–19, dropping to 351 in 2021–22 (Table Agcy.1).

The increase in agency numbers over time in Victoria is attributed to counting each location of a service delivery outlet, which may be located in different areas for a single agency.
The horizontal bar chart shows that most treatment agencies in Victoria were located in *Major cities* (213 agencies), followed by *Inner regional areas* (101 agencies) and *Outer regional areas* (37 agencies) in 2021–22. Of the total 351 treatment agencies, 99.1% (348 agencies) were non-government agencies.



State and territory summaries

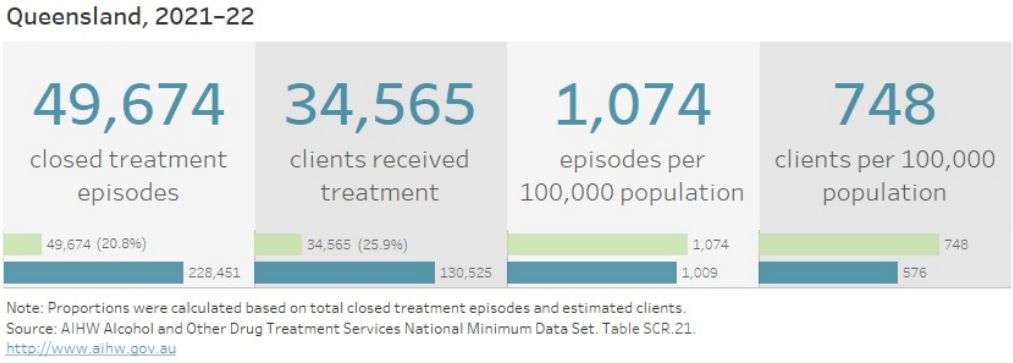
On this page:

In 2021–22, 182 publicly funded alcohol and other drug treatment agencies in Queensland provided 49,674 treatment to 34,565 clients (tables Agcy.1, SCR.21).

Queensland reported:

- a 1.9% decrease in treatment episodes from 50,600 in 2020–21 to 49,700 in 2021–22, and a 63% increase in treatment episodes since 2012–13 (30,600) (Table ST QLD.2)
- more clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (748 clients per 100,000 population compared with 714 per 100,000, respectively)
- client numbers increased from 29,000 in 2013–14 to 34,600 in 2021–22 (Table SCR.21).

The visualisation shows that 49,674 treatment episodes were provided to 34,565 clients in Queensland in 2021–22. This equates to a rate of 1,074 episodes and 748 clients per 100,000 population, which is higher than the national rate (1,009 episodes and 576 clients per 100,000 population).



In 2021–22, most (85%) clients in Queensland attended 1 agency, and received an average of 1.4 treatment episodes, which is lower than the national average of 1.8 treatment episodes (tables SCR.21, SCR.23).

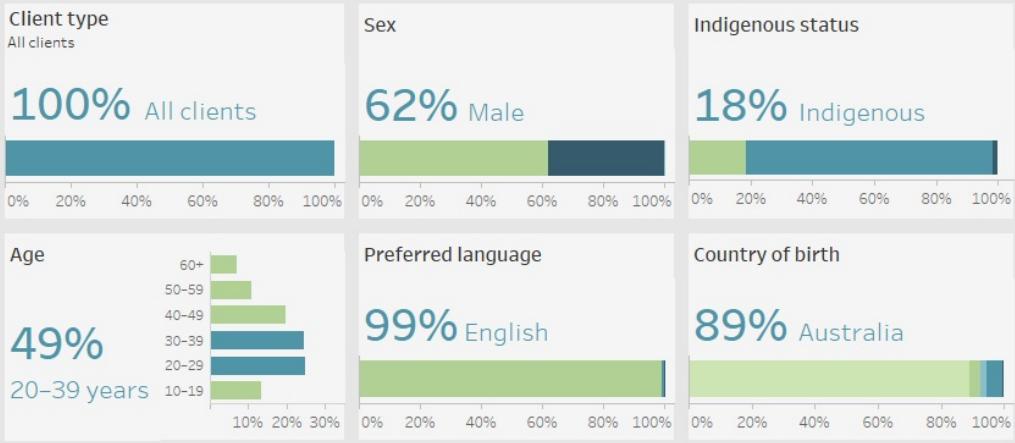
Client demographics

In 2021–22:

- nearly all (97%) clients in Queensland received treatment for their own alcohol or drug use, of which over 6 in 10 (63%) people were male (Figure QLD 1)
- clients seeking treatment for someone else's alcohol or drug use were more likely to be female (around 2 in 3 or 66%)
- one in 2 (50%) people were aged 20–39 years, and 13% were aged 10–19 years which is higher than the national proportion (10%)
- about 1 in 5 (19%) of all clients identified as Indigenous Australians, which is consistent with the national proportion (18%)
- the majority (89%) of all clients were born in Australia and nearly all (99%) reported English as their preferred language (tables SC QLD.1–3, SC.3–4, SC QLD.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2021–22 in Queensland, 62% of all clients were male, 49% were aged 20–39 and 18% were Indigenous Australians. Nearly all clients (99%) listed English as their preferred language and most (89%) were born in Australia.

Figure QLD 1: AODTS clients by client type and selected demographics, Queensland, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables SC QLD.1–3 and SC QLD.21–22.
http://www.aihw.gov.au

Patterns of service use

Over the period 2017–18 to 2021–22, 131,000 clients received treatment in Queensland. Of these clients, the majority received treatment in a single year (77% or 101,000):

- 21,000 (16%) received treatment for the first time in 2021–22
- a further 80,100 (61%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

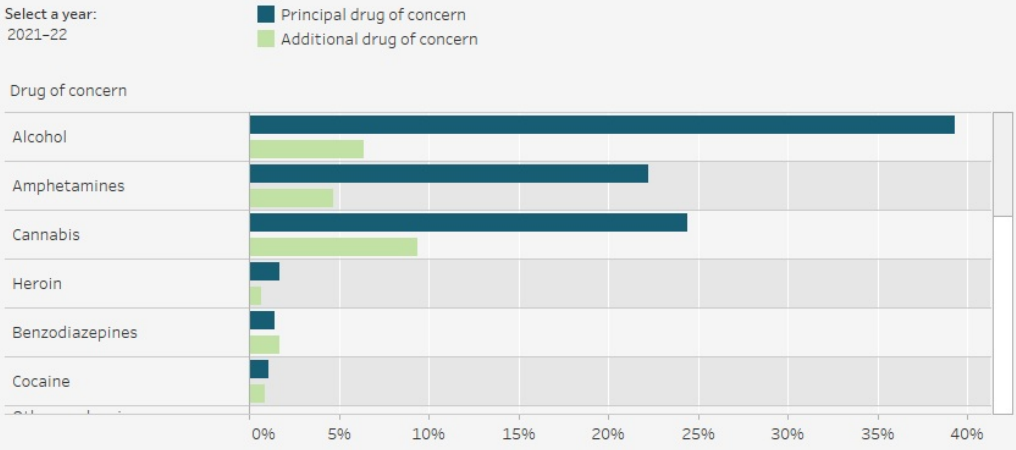
Drugs of concern

In 2021–22, for clients in Queensland receiving treatment episodes for their own alcohol or drug use:

- alcohol was the most common principal drug of concern (39% or 19,100 episodes) (Figure QLD 2, Table ST QLD.6)
- cannabis was the second most common principal drug of concern (24% or 11,800 episodes), followed by amphetamines (22% or 10,800). In Queensland, the level of cannabis reported as the principal drug of concern is a result of the police and illicit drug court diversion programs operating in the state (Table ST QLD.12).

The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in Queensland for their own drug use (39.3%). This was followed by cannabis (24.4%) and amphetamines (22.2%). Cannabis was the most common additional drug of concern (9.4% of episodes), followed by alcohol (6.4%) and amphetamines (4.7%).

Figure QLD 2: Proportion of treatment episodes for own drug use, by drug of concern, Queensland, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST QLD.7.
http://www.aihw.gov.au

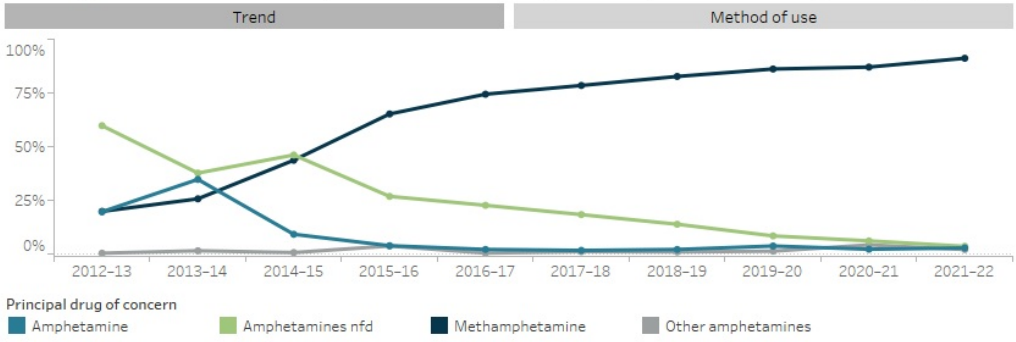
In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern in over 9 in 10 (91%) treatment episodes (Figure QLD 3a)
- in almost half (48%) of treatment episodes where methamphetamine was the principal drug of concern, injecting was the most common method of use, followed by smoking (39%) (Figure QLD 3b).

Queensland is working with service providers to encourage more specific reporting of amphetamine use (i.e. to reduce the use of ‘amphetamines not further defined’ code where possible).

The line graph shows that, from 2012–13 to 2014–15, 'amphetamines not further defined' was the most common drug of concern among amphetamine-related treatment episodes for clients' own drug use. In 2015–16, methamphetamine became the most common drug of concern. The proportion of episodes for amphetamines not further defined decreased from 2014–15 (46.2% of amphetamine-related episodes) to 2021–22 (3.7%), while episodes increased for methamphetamines (from 43.7% to 91.2%). Buttons allow the user to navigate to data on method of use of amphetamines.

Figure QLD 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2011–12 to 2021–22) or method of use (2021–22), Queensland (per cent)



Notes
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST QLD.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes). When clients reported additional drugs of concern, cannabis was the most common additional drug (9.4% of episodes), followed by alcohol (6.4%) and nicotine (5.2%) (Table ST QLD.7).

Over the period 2012–13 to 2021–22:

- alcohol was the most common principal drug of concern from 2012–13 to 2014–15, and in 2018–19 replaced cannabis as the most common principal drug of concern (Table ST QLD.7)
  - the proportion of episodes for alcohol as a principal drug of concern increased from 37% in 2012–13 to 39% in 2021–22, relative to all other principal drugs of concern. However, the number of treatment episodes almost doubled over this period from 10,700 episodes to 19,100.
- cannabis was the second most common principal drugs of concern, with treatment episodes increasing from 34% in 2012–13, peaking at 39% in 2015–16 and falling to 24% in 2021–22. From 2012–13 to 2021–22, treatment episodes increased from 10,050 to 11,800
- the proportion of episodes for amphetamines as a principal drug of concern doubled since 2012–13 (11% to 22%), with the number of treatment episodes increasing from 3,200 to 10,800 over this period
  - within the amphetamines group, methamphetamine was reported as the principal drug of concern in 20% of episodes in 2012–13, rising to 65% in 2015–16, then 91% in 2021–22 (Figure QLD 3a)
  - The rise in episodes where methamphetamines were the principal drug of concern may be related to increases in funded treatment services and improvements in agency coding practices for methamphetamines.
- the proportion of treatment episodes in Queensland where cannabis was the principal drug of concern was higher than the national proportion in 2021–22 (24% compared with 19%) (Table Drg.1). This trend has been consistent for the 10-year period.

Treatment

Changes to AOD reporting in Queensland

In 2020–21, Queensland Health transitioned to an integrated public AOD and mental health system for reporting. Due to the use of this integrated system, there was an improvement in the capability to report assessment only as a main treatment type. This resulted in increases in treatment episodes with assessment only as a main treatment type and is considered as a more accurate representation of the treatment being provided by the sector.

Prior to 2020–21, treatment episodes provided to people diverted into AOD services by police and court diversion programs were recorded as information and education. This resulted in a high proportion of information and education treatment episodes in Queensland. From 2020–21, the police and court diversion programs are now reported as counselling which is a more accurate representation of the treatment being provided. See Data Quality Statement for further information.

In 2021–22, for treatment episodes in Queensland:

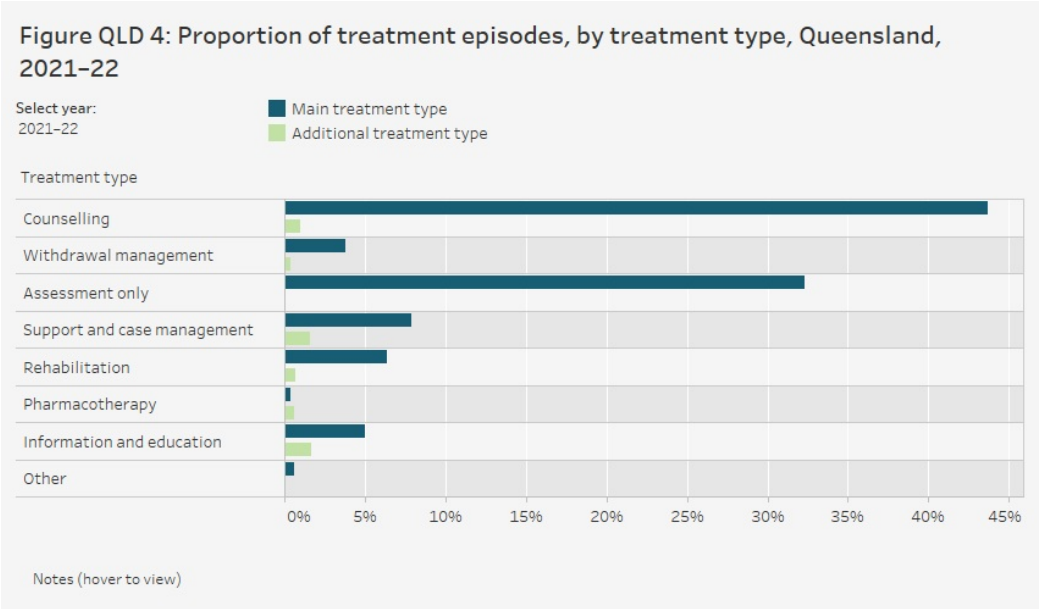
- counselling was the most common main treatment (44% of episodes), followed by assessment only (32%) (Figure QLD 4)

- the proportion of episodes for information and education as a main treatment dropped 16 percentage points from 2019–20 (21%) to 5.0% in 2021–22. This was due to a review of coding practices which resulted a large proportion of episodes previously coded as information and education being coded as counselling (Table ST QLD.13)
- where an additional treatment was provided as supplementary to the main treatment, information and education (1.7%) was also the most common type of additional treatment, followed by support and case management (1.6%). See technical notes for further information on calculating proportions for additional treatment type.

Over the period 2012–13 to 2021–22:

- the proportion of all treatment episodes where counselling was the main treatment type increased from 33% in 2012–13 to 44% in 2021–22. Counselling replaced information and education as the most common treatment in 2016–17
- the proportion of withdrawal management as a main treatment type decreased since 2012–13, dropping from 9.7% down to 3.8% in 2021–22.

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in Queensland for their own drug use was counselling (43.7% of episodes). This was followed by assessment only (32.3%) and support and case management (7.9%). Information and education was the most common additional treatment type (1.7%), followed by counselling (1.6%).



Agencies

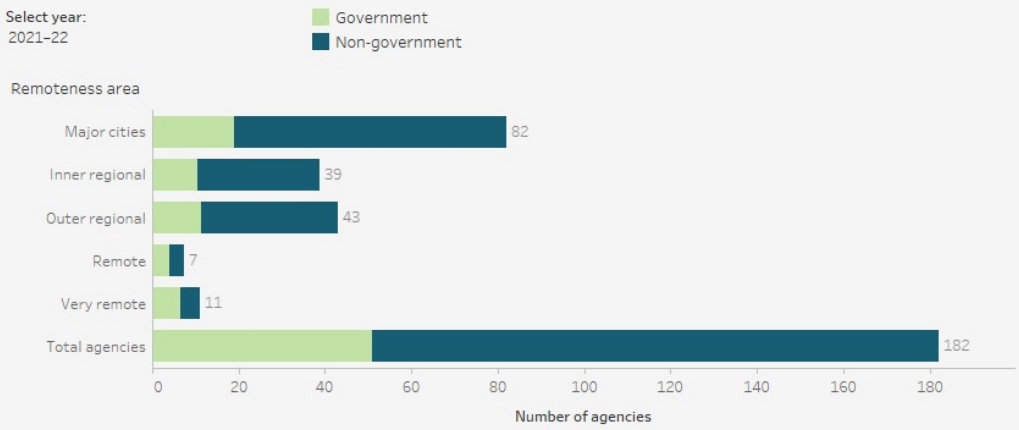
In 2021–22, in Queensland:

- more than 7 in 10 (72%) AOD agencies that received public funding were non-government treatment agencies (Table Agcy.1)
- almost half (45%) of the 182 treatment agencies were located in *Major cities*, followed by *Outer regional* (24%) and *Inner regional* (21%) areas
- around 1 in 10 (9.9%) of all government treatment agencies were located in *Remote* and *Very remote* areas (Figure QLD 5; Table Agcy.3).

In the 10 years to 2021–22, the number of publicly funded treatment agencies in Queensland steadily increased from 133 in 2012–13 to 194 in 2019–20, falling to 182 in 2020–21 and 2021–22. The recent change in agency numbers is attributed to a review of the agency coding structure in the public sector. As a result, there have been significant agency identifier changes which have been constructed to align with the Queensland Health Corporate Reference Database System, providing a more accurate representation of number of agencies reporting at the service outlet level (Table Agcy.1).

The horizontal bar chart shows that most treatment agencies in Queensland were located in *Major cities* (82 agencies), followed by *Outer regional areas* (43 agencies) and *Inner regional areas* (39 agencies) in 2021–22. 18 agencies were located in *Remote* and *Very remote* areas. Of the total 182 treatment agencies, 72% (131 agencies) were non-government agencies.

Figure QLD 5: Number of agencies, by remoteness area and sector, Queensland, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

State and territory summaries

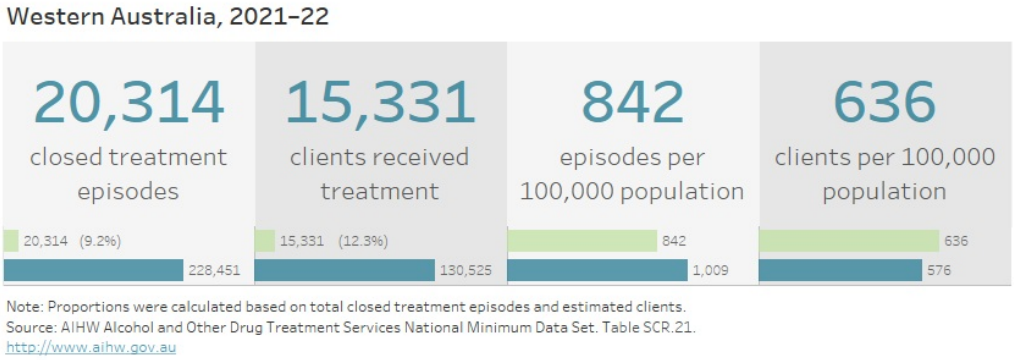
On this page:

In 2021–22, 118 publicly funded alcohol and other drug treatment agencies in Western Australia provided 20,314 treatment episodes to 15,331 clients (tables Agcy.1, SCR.21).

Western Australia reported:

- an 8.7% decrease in treatment episodes from 22,200 in 2020–21 to 20,300 in 2021–22, and a 1.5% decrease in episodes since 2012–13 (20,600) (Table ST WA.2)
- less clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (636 compared with 697 per 100,000 population, respectively)
- client numbers increased from 2013–14 (15,146) to 2018–19 (19,300), decreasing to 15,300 in 2021–22 (Table SCR.21).

The visualisation shows that 22,245 treatment episodes were provided to 17,195 clients in Western Australia in 2020–21. This equates to a rate of 957 episodes and 740 clients per 100,000 population, compared with the national rate of 1,079 episodes and 618 clients per 100,000 population.



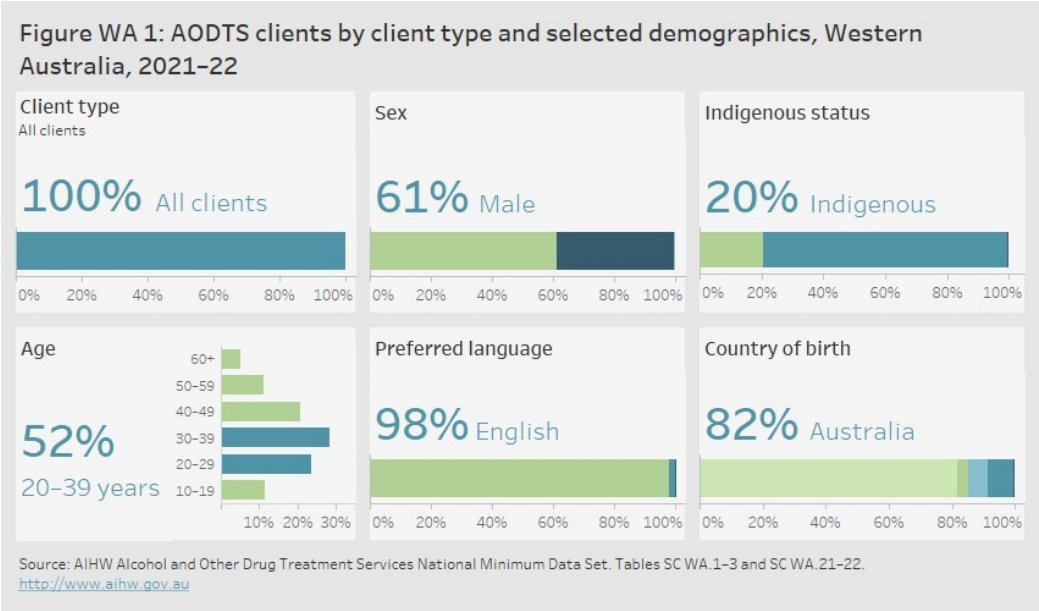
In 2021–22, most (85%) clients in Western Australia attended 1 agency, and received an average of 1.3 treatment episodes, which is lower than the national average of 1.8 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2021–22:

- most (94%) clients in Western Australia received treatment for their own alcohol or drug use, of which 2 in 3 (64%) were male (Figure WA 1)
- almost 8 in 10 people seeking treatment for someone else's alcohol or drug use were female (78%)
- over half (54%) of the people receiving treatment for their own alcohol or drug use were aged 20–39 years; in contrast, people seeking treatment for someone else's alcohol or drug use were more likely to be aged 50 and over (50%)
- 1 in 5 (20%) of all clients identified as Indigenous Australians, which is higher than the national proportion (18%)
- the majority (82%) of all clients were born in Australia and nearly all (98%) reported English as their preferred language (tables SC WA.1–3, SC.4, SC WA.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2020–21, just under two-thirds (62%) of all clients were male, 54% were aged 20–39 and 22% were Indigenous Australians in Western Australia. Nearly all clients (99%) listed English as their preferred language and most (83%) were born in Australia.



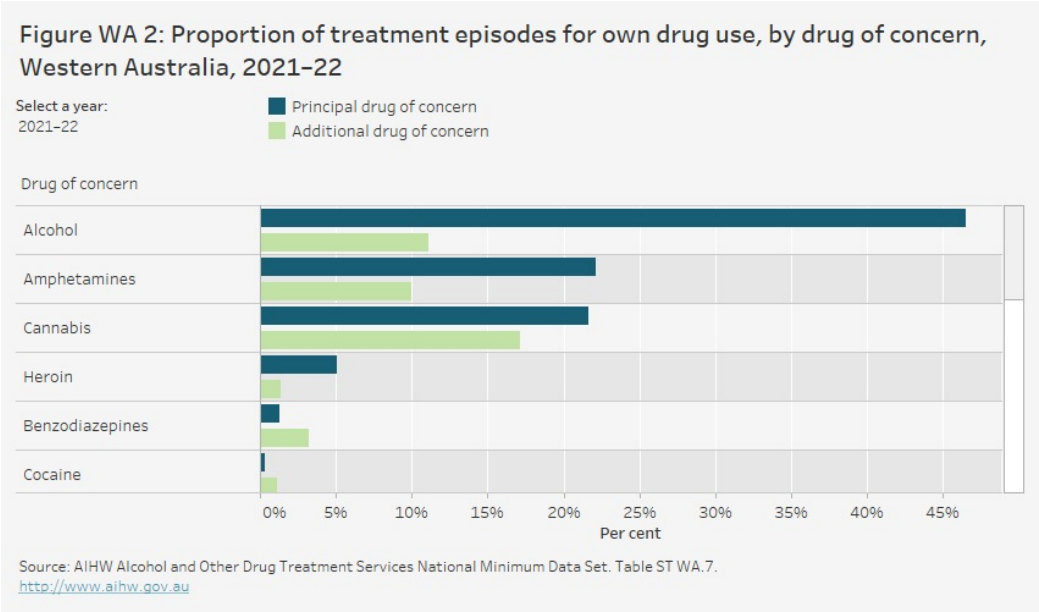
Patterns of service use

Over the period 2017–18 to 2021–22, 65,200 clients received treatment in Western Australia. Of these clients, the majority received treatment in a single year (73% or 47,900):

- 8,700 (13%) received treatment for the first time in 2021–22
- a further 39,100 (60%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

Drugs of concern

In 2021–22, for clients in Western Australia receiving treatment episodes for their own alcohol or drug use, alcohol was the most common principal drug of concern (46% or 9,000 episodes), followed by amphetamines (22% or 4,300) (Figure WA 2, Table ST WA.6).
The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in Western Australia for their own drug use (46.5%). This was followed by amphetamines (22.1%) and cannabis (21.6%). Cannabis was the most common additional drug of concern (17.1% of episodes), followed by alcohol (11.1%) and amphetamines (10.0%).

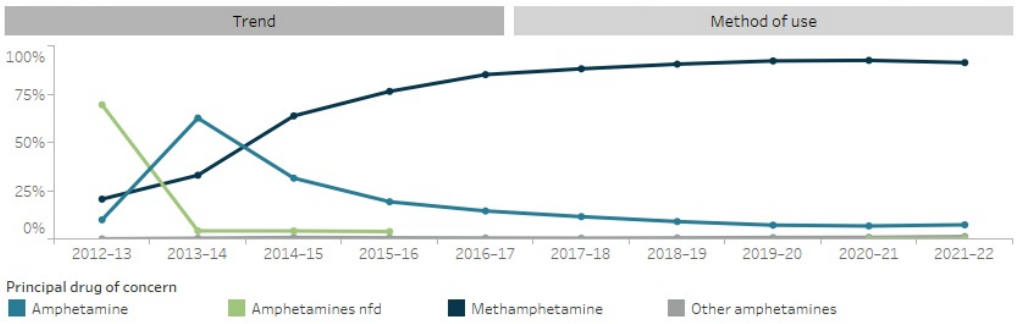


In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern in over 9 in 10 (91%) treatment episodes
- in over half of treatment episodes where methamphetamine was the principal drug of concern, injecting was the most common method of use (52%), followed by smoking (43%) (Figures WA 3a, WA 3b).

The line graph shows that, from 2012–13 to 2013–14, amphetamine and ‘amphetamines not further defined’ were the most common drugs of concern among amphetamine-related treatment episodes for clients’ own drug use. In 2014–15, methamphetamine became the most common drug of concern. The proportion of episodes for methamphetamine increased from 20.6% in 2012–13 to 91.3% in 2021–22. Buttons allow the user to navigate to data on amphetamines by method of use.

Figure WA 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), Western Australia (per cent)



Notes
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Amphetampines nfd were not reported from 2016–17 to 2019–20.
4. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST WA.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode (see technical notes).

In 2021–22, when the client reported additional drugs of concern, cannabis was the most common additional drug (17% of episodes), followed by nicotine and alcohol (both 11%) and amphetamines (10%) (Table ST WA.7).

Over the period 2012–13 to 2021–22:

- the proportion of treatment episodes for alcohol as a principal drug of concern relative to all other principal drugs of concern fell from 39% (7,700) in 2012–13 to 29% in 2016–17 (6,700), rising to 46% (9,000 episodes) in 2021–22
- the proportion of treatment for amphetamines as a principal drug of concern increased from 20% in 2012–13, peaking at 36% in 2016–17 then falling to 22% in 2021–22 (Table ST WA.6)
  - within the amphetamines group, methamphetamine was reported as the principal drug of concern in 21% of episodes in 2012–13, rising to 91% in 2021–22 (Figure WA 3a)
- cannabis remained relatively steady between 2012–13 and 2021–22, ranging from 23% of treatment episodes in 2012–13, peaking at 25% in 2013–14 and falling to 22% in 2021–22.

Treatment

In 2021–22, for treatment episodes in Western Australia, counselling was the most common main treatment (66% of episodes), followed by support and case management 11% (Figure WA 4, Table ST WA.13).

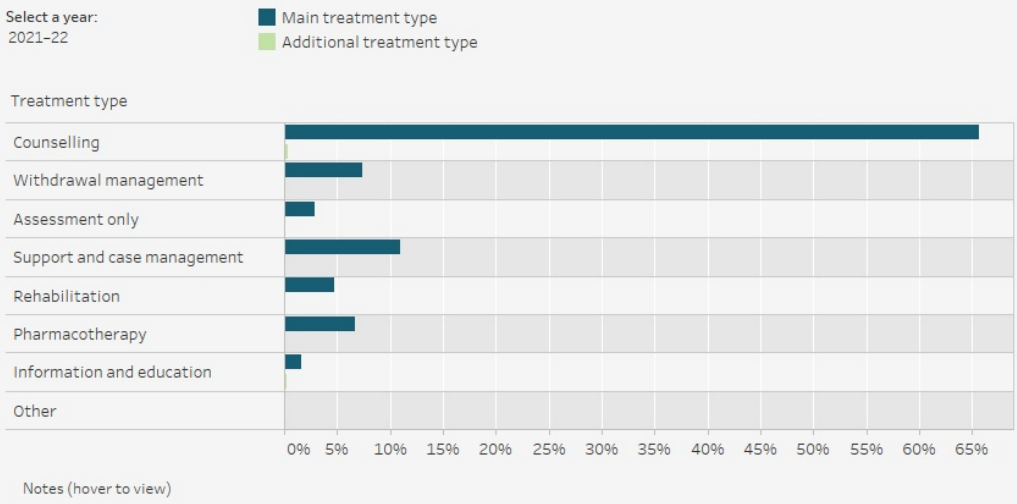
The majority of services who submit AODTS NMDS data use Western Australia's data collection system, which does not differentiate between main and other treatment types. A small proportion of services who submit AODTS NMDS data use their own data collection systems, which do differentiate between main and other treatment types.

Over the period 2012–13 to 2021–22:

- counselling remained the most common main treatment for all episodes. The proportion of episodes where counselling was a main treatment type remained substantially higher in Western Australia than nationally over the period, ranging from 60% to 71% in Western Australia compared with 36% to 43% nationally (tables ST WA.13, Trt.3)
- the next most common main treatment types were support and case management (4.5% to 11% of episodes) and withdrawal management (5.6% to 14%).

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in Western Australia for their own drug use was counselling (65.6% of episodes). This was followed by support and case management (11.0%) and withdrawal management (7.4%).

Figure WA 4: Proportion of treatment episodes, by treatment type, Western Australia, 2021–22



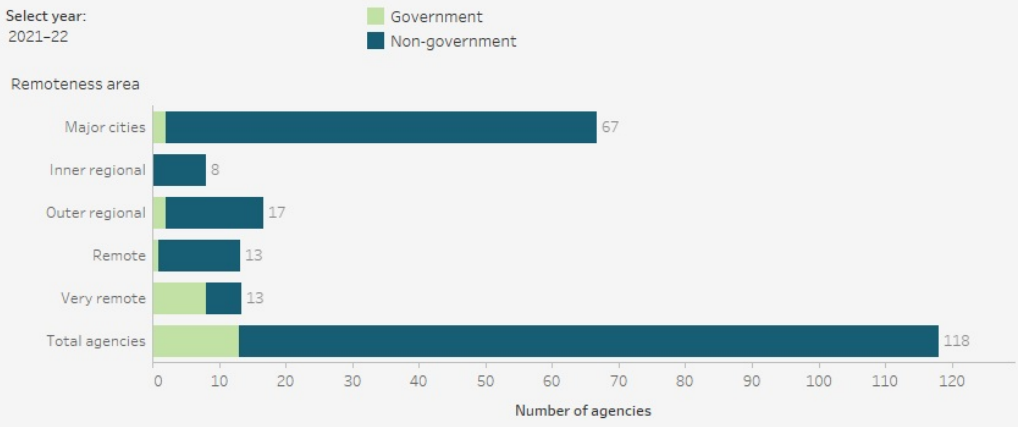
Agencies

In 2021–22, in Western Australia:

- just under 9 in 10 (89%) AOD agencies that received public funding were non-government treatment agencies (Table Agcy.1)
- almost 3 in 5 (57%) of the 118 treatment agencies were located in *Major cities* (Figure WA 5, Table Agcy.3)
- *Very remote* areas were the only areas where there were more government than non-government agencies (8 and 5, respectively).

In the 10 years to 2021–22, the number of publicly funded treatment agencies in Western Australia rose from 68 to 118 (Table Agcy.1). The horizontal bar chart shows that most treatment agencies in Western Australia were located in *Major cities* (67 agencies), followed by *Outer regional areas* (17 agencies) and *Remote and Very remote areas* (13 agencies each) in 2021–22. 8 agencies were located in *Inner regional* areas. Of the total 119 treatment agencies, 89% (105 agencies) were non-government agencies.

Figure WA 5: Number of agencies, by remoteness area and sector, Western Australia, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

State and territory summaries

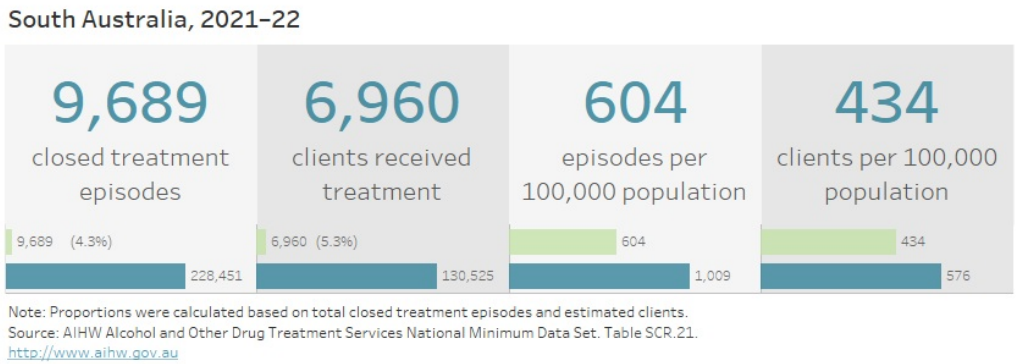
On this page:

In 2021–22, 83 publicly funded alcohol and other drug treatment agencies in South Australia provided 9,689 treatment episodes to just 6,960 clients (tables Agcy.1, SCR.21).

South Australia reported:

- a decrease in treatment episodes since 2013–14, falling from 13,200 to 9,799 episodes in 2021–22 (Table ST SA.2)
- fewer clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (434 clients per 100,000 population compared with 624 per 100,000, respectively)
- client numbers decreased from 9,200 in 2013–14 to 7,000 in 2021–22 (Table SCR.21).

The visualisation shows that 9,689 treatment episodes were provided to 6,960 clients in South Australia in 2021–22. This equates to a rate of 604 episodes and 434 clients per 100,000 population, lower than the national rate (1,009 episodes and 576 clients per 100,000 population).



In 2021–22, most (86%) clients in South Australia attended 1 agency, and received an average of 1.4 treatment episodes, which is lower than the national average of 1.8 treatment episodes (tables SCR.21, SCR.23).

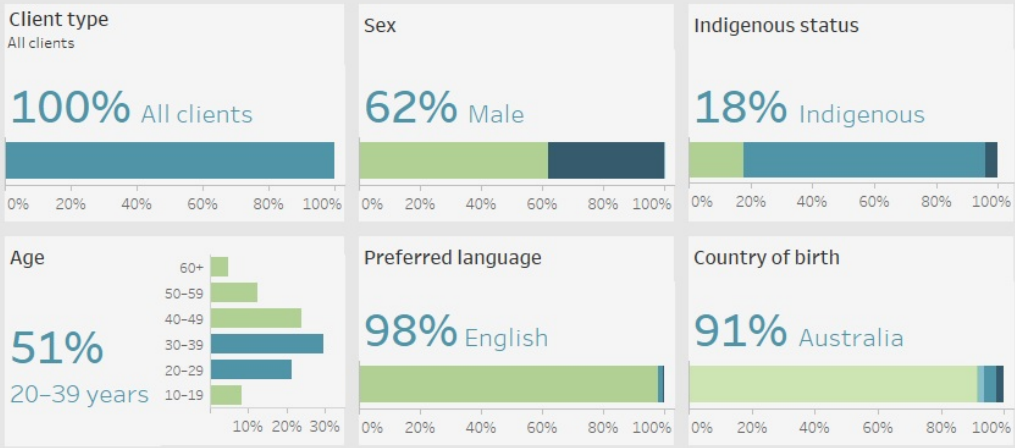
Client demographics

In 2021–22:

- nearly all (over 99%) clients in South Australia received treatment for their own alcohol or drug use, of which over 3 in 5 (62%) people were male (Figure SA 1)
- 2 in 3 people seeking treatment for someone else's alcohol or drug use were female (67%)
- over half (53%) of all people were aged 30–49 years
- over 1 in 6 (18%) people identified as Indigenous Australians, which is consistent with the national proportion (18%)
- the majority (91%) of clients were born in Australia and nearly all (98%) reported English as their preferred language (tables SC SA.1–3, SC.4, SC SA.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2021–22 in South Australia, just under two-thirds (62%) of all clients were male, 51% were aged 20–39 and 18% were Indigenous Australians. Nearly all clients (98%) listed English as their preferred language and most (91%) were born in Australia.

Figure SA 1: AODTS clients by client type and selected demographics, South Australia, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Tables SC SA.1–3 amd SC SA.21–22.
http://www.aihw.gov.au

Patterns of service use

Over the period 2017–18 to 2021–22, 28,400 clients received treatment in South Australia. Of these clients, the majority of clients received treatment in a single year (76% or 21,700):

- 4,200 (15%) received treatment for the first time in 2021–22
- a further 17,500 (62%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

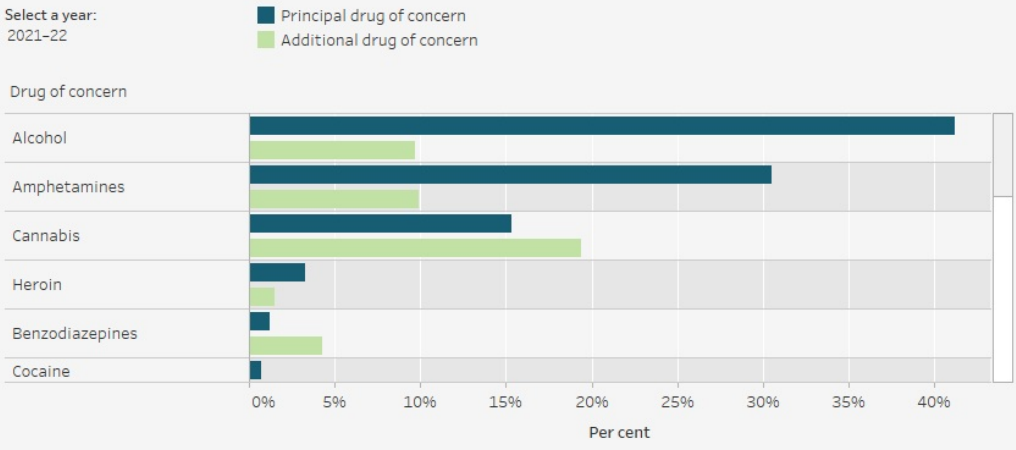
Drugs of concern

In 2021–22, for clients in South Australia receiving treatment episodes for their own alcohol or drug use:

- alcohol was the most common principal drug of concern for clients (41% or 4,000 episodes) (Figure SA 2)
- amphetamines accounted for one-third of treatment episodes (31% or 2,900), followed by cannabis (15% or 1,500).

The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in South Australia for their own drug use (41.2%). This was followed by amphetamines (30.5%) and cannabis (15.3%). Cannabis was the most common additional drug of concern (19.4% of episodes), followed by amphetamines (9.9%) and alcohol (9.7%).

Figure SA 2: Proportion of treatment episodes for own drug use, by drug of concern, South Australia, 2021–22



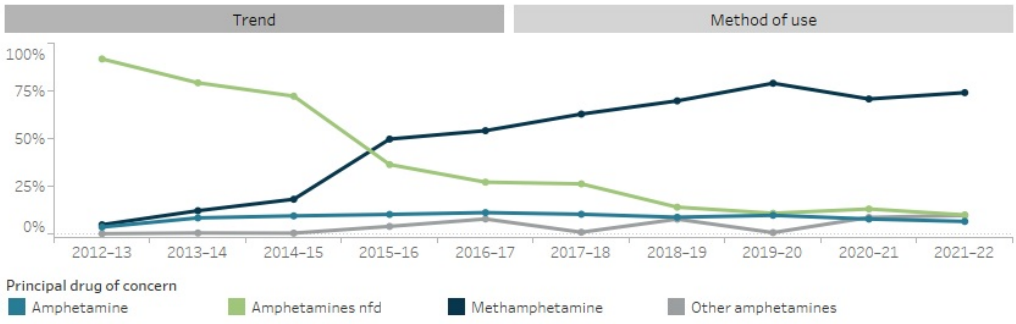
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST SA.7.
http://www.aihw.gov.au

In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern in approximately 74% of treatment episodes (Figure SA 3a)
- where methamphetamine was the principal drug of concern, smoking was the most common method of use in 59% of treatment episodes, followed by injecting (33%) (Figure SA 3b).

The line graph shows that, from 2012–13 to 2014–15, ‘amphetamines not further defined’ was the most common drug of concern among amphetamine-related treatment episodes for clients’ own drug use. In 2015–16, methamphetamine became the most common drug of concern. The proportion of episodes for methamphetamine increased from 4.7% in 2012–13 to 74.1% in 2021–22, while episodes for amphetamines not further defined decreased from 91.8% to 9.9% over the same period. Buttons allow the user to navigate to data on amphetamines by method of use.

Figure SA 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), South Australia (per cent)



Notes
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST SA.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes).

In 2021–22, when clients reported additional drugs of concern, nicotine was the most common (22% of episodes), followed by cannabis (19%) (Table ST SA.7).

Over the period 2012–13 to 2021–22:

- alcohol was the most common principal drug of concern over this period, from 38% of episodes in 2012–12, falling to 27% in 2016–17, increasing to 41% in 2021–22 (Table ST SA.7)
- amphetamines have remained the second most common principal drug of concern have increased over this period, from 24% in 2012–13 to 34–37% of episodes between 2016–17 and 2019–20, before falling to 31% in 2021–22. Amphetamine treatment episodes increased over this period from 2,700 in 2012–13, peaking at 4,300 in 2018–19, falling to 3,000 in 2021–22
  - for episodes where amphetamines were the principal drug of concern, the proportion of treatment episodes with methamphetamines has increased more than 15-fold since 2012–13 (from 4.7% to 79% in 2019–20, slightly falling to 74% in 2021–22 (Figure SA 3a)
  - the rise in episodes may be related to increases in funded treatment services and/or improvement in agency coding practices for methamphetamines.

The proportion of treatment episodes for amphetamines as a principal drug of concern has been consistently higher in South Australia than the national proportion (31% and 24% respectively in 2021–22). This is related to a state government legislated program regarding assessments provided under a Police Drug Diversion initiative. The program results in comparatively high proportions of engagement with methamphetamine users.

In addition, due to the Cannabis Expiation Notice legislation in South Australia, adult simple cannabis offences are not diverted to treatment and so are not included in the data (see the Data Quality Statement).

Treatment

In 2021–22, for treatment episodes in South Australia:

- counselling was the most common main treatment (40% of episodes), followed by assessment only (23%) and withdrawal management (15%) (Figure SA 4, Table ST SA.13)
- where an additional treatment was provided as a supplementary to the main treatment, support and case management (16%) was the most common additional treatment, followed by counselling (9.3%). See technical notes for further information on calculating proportions for additional treatment type.

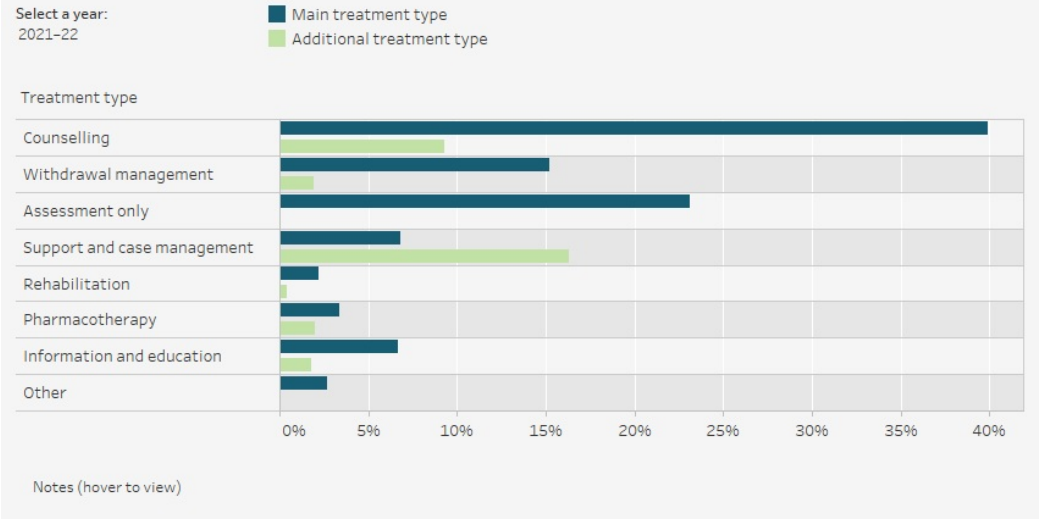
Over the period 2012–13 to 2021–22:

- counselling as main treatment has doubled in the 10 years to 2021–22 (from 20% of treatment episodes in 2012–13 to 40%)
- the proportion of episodes with rehabilitation as main treatment fell from 8.6% to 2.2%
- the proportion of episodes where assessment only was the main treatment has almost halved since 2012–13, falling from 43% to 23% in 2021–22. However, assessment only in South Australia remained considerably higher than the national proportion (ranging from 16% to 21%) (tables ST SA.13, Trt.4).

The high proportion of treatment episodes where assessment only is the most common treatment type relates in part to the SA Police Drug Diversion Initiative (PDDI).

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in South Australia for their own drug use was counselling (39.9% of episodes). This was followed by assessment only (23.1%) and withdrawal management (15.2%). Support and case management was the most common additional treatment type (16.3% of episodes), followed by counselling (9.3%).

Figure SA 4: Proportion of treatment episodes, by treatment type, South Australia, 2021–22



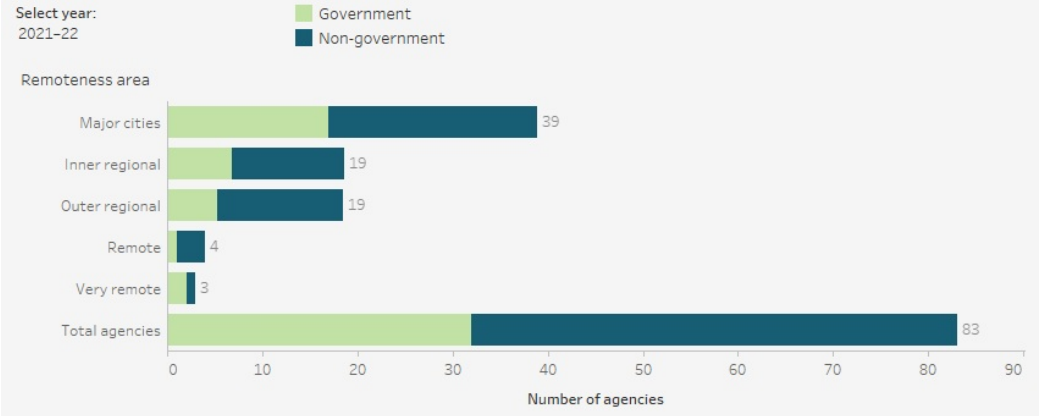
Agencies

In 2021–22, in South Australia:

- 3 in 5 (61%) of 83 AOD agencies that received public funding were non-government treatment agencies
- around half (47%) of all treatment agencies were located in *Major cities*, followed by *Outer regional areas* (23%) and *Inner regional areas* (23%) (Figure SA 5, Table Agcy.3)
- In *Very Remote* areas 2 of 3 treatment agencies (67%) were government organisations.

Over the 10 years to 2021–22, the number of publicly funded treatment agencies in South Australia decreased from 93 to 83 (Table Agcy.1). The horizontal bar chart shows that most treatment agencies in South Australia were located in *Major cities* (39 agencies), followed by *Outer regional* and *Inner regional* areas (19 agencies each) in 2021–22. 4 agencies were located in *Remote* areas and 3 agencies were located in *Very remote* areas. Of the total 83 treatment agencies, 61% (51 agencies) were non-government agencies.

Figure SA 5: Number of agencies, by remoteness area and sector, South Australia, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

State and territory summaries

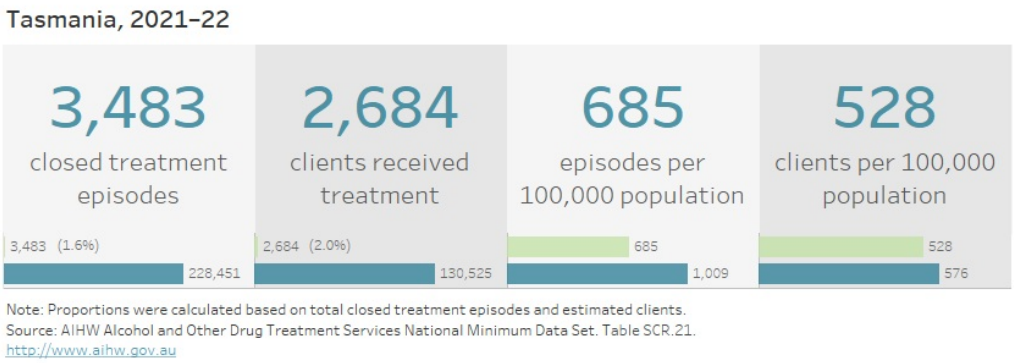
On this page:

In 2021–22, 24 publicly funded alcohol and other drug treatment agencies in Tasmania provided provided 3,483 treatment episodes to 2,684 clients (tables Agcy.1, SCR.21).

Tasmania reported:

- a 9.7% decrease in treatment episodes from 3,900 in 2020–21 to 3,500 in 2021–22, and a 49% increase in treatment episodes since 2013–14 (2,300) (Table ST TAS.2)
- less clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (528 clients per 100,000 population compared with 540 per 100,000, respectively)
- client numbers increased from 2,400 in 2013–14 to 2,700 in 2021–22 (Table SCR.21).

The visualisation shows that 3,483 treatment episodes were provided to 2,684 clients in Tasmania in 2021–22. This equates to a rate of 685 episodes and 528 clients per 100,000 population, lower than the national rate (1,009 episodes and 576 clients per 100,000 population).



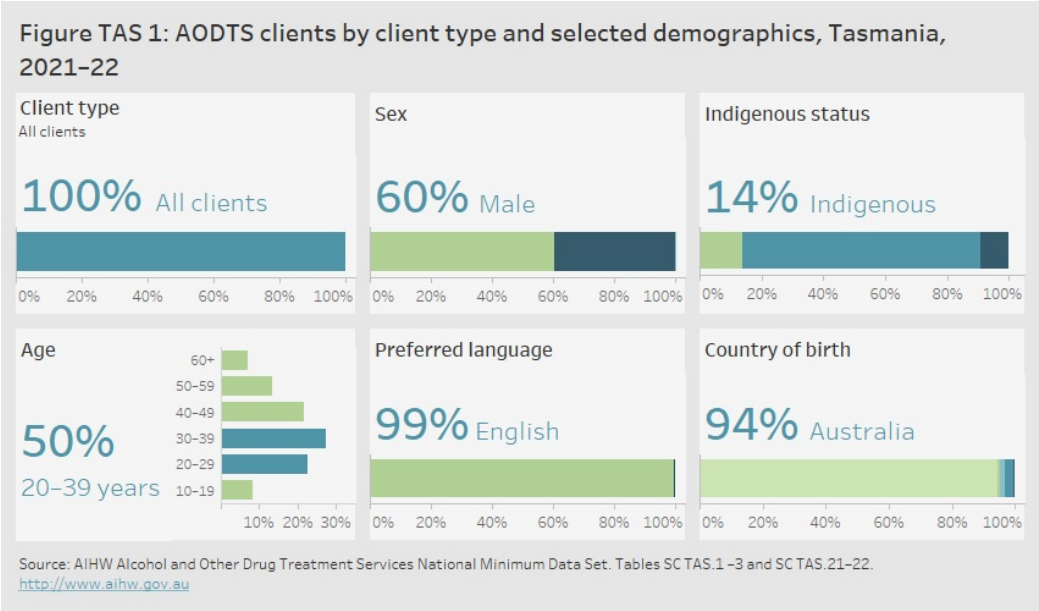
In 2021–22, most (86%) clients in Tasmania attended 1 agency, and received an average of 1.3 treatment episodes, which is lower than national average of 1.8 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2021–22:

- most (94%) clients in Tasmania received treatment for their own alcohol or drug use, of which 3 in 5 (62%) people were male (Figure TAS 1)
- people seeking treatment for someone else's alcohol or drug use were most likely to be female (71%)
- half (51%) of all clients were aged 20–39 years
- around 1 in 7 (14%) of all clients identified as Indigenous Australian, which is lower than the national proportion (18%)
- the majority (94%) of all clients were born in Australia and nearly all (99%) reported English as their preferred language (tables SC Tas.1–3, SC.4, SC TAS.21–22).

The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in Tasmania for their own drug use (48.8%). This was followed by amphetamines (21.5%) and cannabis (17.9%). Cannabis was the most common additional drug of concern (16.3% of episodes), followed by amphetamines (9.1%) and alcohol (7.6%).



Patterns of service use

Over the period 2017–18 to 2021–22, 9,900 clients received treatment in Tasmania. Of these clients, the majority received treatment in a single year (74% or 7,300):

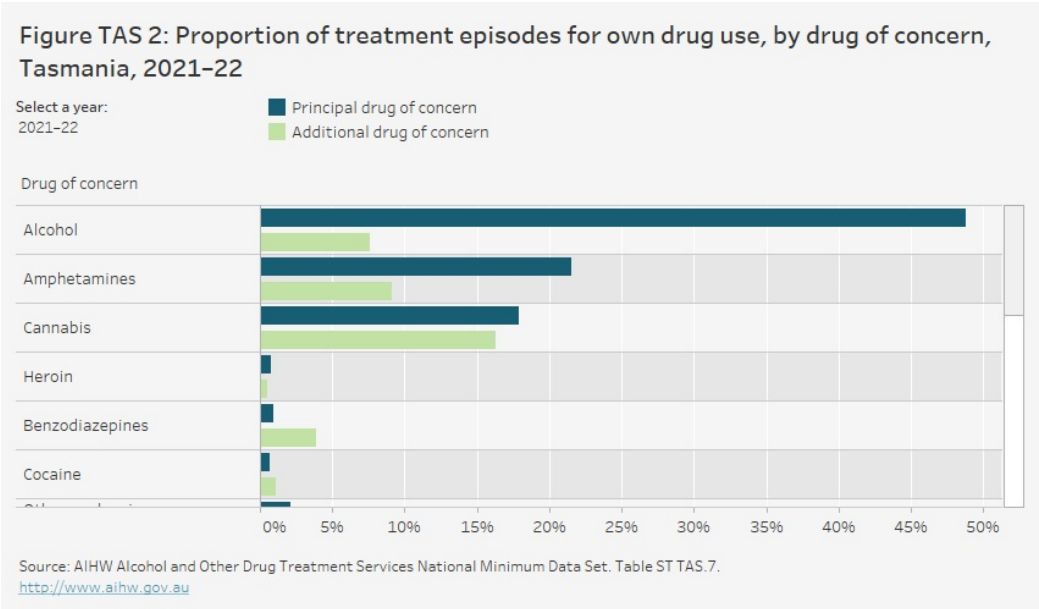
- 1,600 (16%) received treatment for the first time in 2021–22
- a further 5,700 (58%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

Drugs of concern

In 2021–22, for clients in Tasmania receiving treatment episodes for their own alcohol or drug use:

- alcohol was the most common principal drug of concern (49% or 1,600 episodes) (Figure TAS 2, Table ST TAS.7)
- amphetamines as a principal drug of concern accounted for 1 in 4 treatment episodes (22% or 710 episodes).

The grouped horizontal bar chart shows that, in 2020–21, alcohol was the most common principal drug of concern in treatment episodes provided to clients in Tasmania for their own drug use (44.8%). This was followed by amphetamines (24.9%) and cannabis (17.5%). Cannabis was the most common additional drug of concern (16.9% of episodes), followed by amphetamines (9.1%) and alcohol (8.3%).

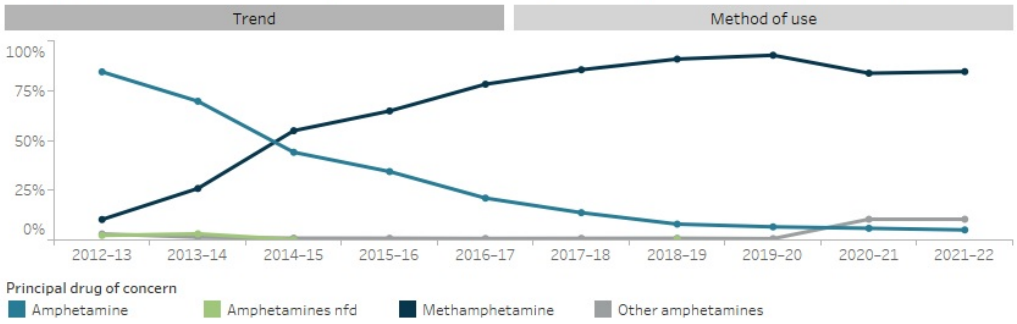


In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern in over 8 in 10 (85%) treatment episodes (Figure TAS 3a)
- in almost half (47%) of treatment episodes where methamphetamine was a principal drug of concern, injecting was the most common method of use, followed by smoking (39%) (Figure TAS 3b).

The line graph shows that, from 2012–13 to 2013–14, amphetamine was the most common drug of concern among amphetamine-related treatment episodes for clients' own drug use. In 2014–15, methamphetamine became the most common drug of concern. The proportion of episodes for methamphetamine increased from 10.3% in 2012–13 to 84.5% in 2021–22, while episodes for amphetamine decreased from 84.4% to 5.1% over the same period. Buttons allow the user to navigate to data for amphetamines by method of use.

Figure TAS 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), Tasmania (per cent)



Notes:
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Amphetamines nfd were not reported from 2015–16 onwards.
4. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST TAS.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes).

In 2021–22, when the client reported additional drugs of concern, cannabis was the most common additional drug of concern (16% of episodes), followed by amphetamines (9%), alcohol and nicotine (both 8%) (Table ST TAS.7).

Over the period 2012–13 to 2021–22:

- alcohol was the most common principal drug of concern, increasing from 39% of episodes in 2012–13 (840 episodes) to 49% (1,600) in 2021–22 (Table ST TAS.7)
- treatment episodes for amphetamines increased from 12% (263 episodes) to 22% (710) over the period
- treatment episodes for cannabis decreased from 30% (638 episodes) to 18% (591). While the number of treatment episodes increased, the proportion in relation to all principal drugs of concern decreased
- within the amphetamines group, methamphetamine was reported as the principal drug of concern in 3% of episodes in 2012–13, rising to 93% in 2019–20, falling to 85% in 2021–22 (Figure TAS 3a). The rise in episodes may be related to increases in funded treatment services and/or improvement in agency coding practices for methamphetamines.

Treatment

In 2021–22, for treatment episodes in Tasmania:

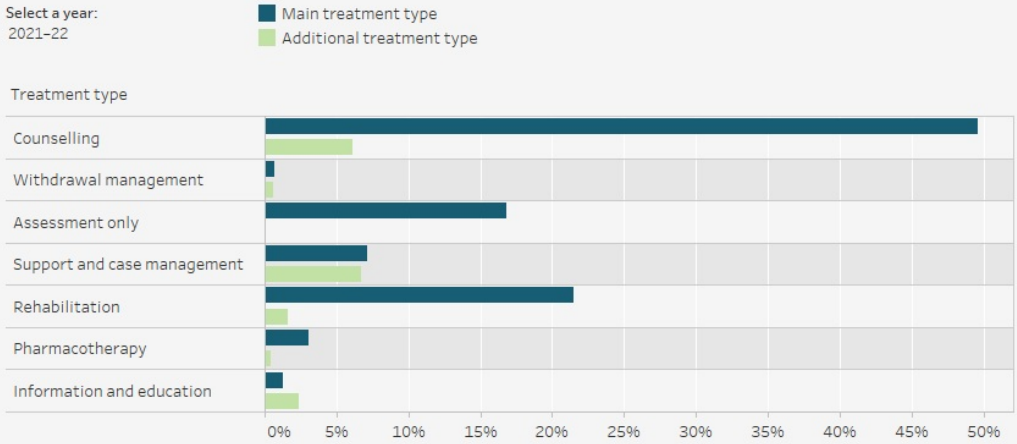
- counselling was the most common main treatment (50% of episodes), followed by rehabilitation (21%) (Figure TAS 4, Table ST TAS.13)
- where an additional treatment was provided as a supplementary to the main treatment, support and case management (6.7%) was the most common type of additional treatment, followed by counselling (6.1%) and information and education (2.4%). See technical notes for further information on calculating proportions for additional treatment type.

Over the period 2012–13 to 2021–22:

- counselling remained the most common main treatment, with the proportion of episodes peaking at 62% in 2013–14, falling to 37% in 2016–17, before fluctuating between 48% to 50% from 2018–19 onwards
- rehabilitation increased from 2012–13 (6%) peaking in 2016–17 (24%) before decreasing in 2021–22 (21%); the proportion of episodes for rehabilitation is higher than the national proportion over this period (ranging from 4.9–6.5%) (tables ST TAS.13, Trt.1).

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in Tasmania for their own drug use was counselling (49.6% of episodes). This was followed by rehabilitation (21.5%) and assessment only (16.8%). Support and case management was the most common additional treatment type (6.7% of episodes), followed by counselling (6.1%).

Figure TAS 4: Proportion of treatment episodes, by treatment type, Tasmania, 2021–22



Note

Agencies

Tasmania only has the geographical classifications of *Inner regional*, *Outer regional* and *Remote* areas.

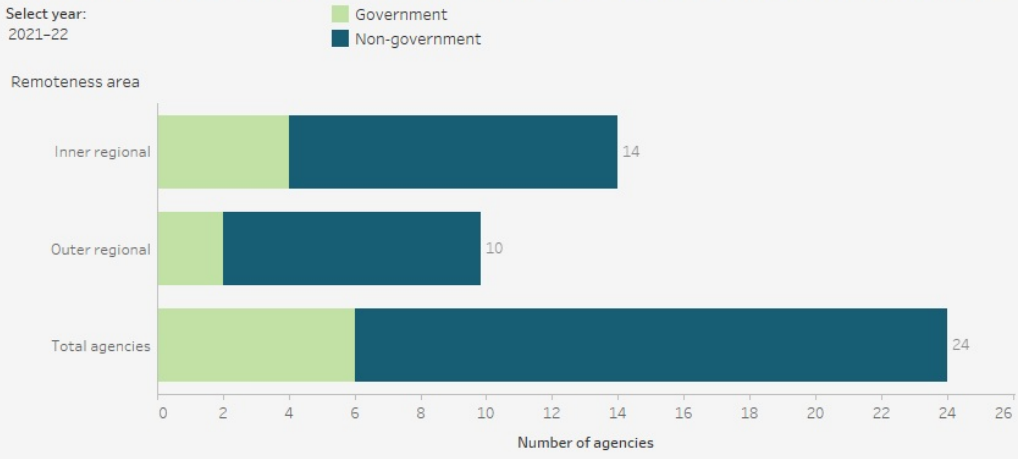
In 2021–22, in Tasmania:

- three-quarters (75%) of the 24 AOD agencies that received public funding were non-government treatment agencies
- 58% of agencies were located in *Inner regional* areas, followed by *Outer regional* (42%) (Figure TAS 5, Table Agcy.3)
- agencies located in *Inner regional* and *Outer regional* areas were more likely to be non-government organisations.

In the 10 years to 2021–22, the number of publicly funded treatment agencies in Tasmania rose from 17 in 2012–13 to 24 in 2021–22 (Table Agcy.1).

Note that remoteness categories are derived by applying a correspondence based on the agency's Statistical Area level 2 code (SA2). Not all SA2 codes fit neatly within a single remoteness category, and a ratio is applied to reapportion each SA2 to the applicable remoteness categories. As a result, it is possible that the number of agencies in a particular remoteness category is not a whole number. After rounding, this can result in there being '<0.5%' agencies in a remoteness area, due to the agency's SA2 partially crossing into the remoteness area. See technical notes for further details.
The horizontal bar chart shows that most treatment agencies in Tasmania were located in Inner regional areas (14 agencies), followed by Outer regional areas (10 agencies) in 2021–22. Of the total 24 treatment agencies, most (18 agencies) were non-government agencies.

Figure TAS 5: Number of agencies, by remoteness area and sector, Tasmania, 2021–22



Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set.
http://www.aihw.gov.au

State and territory summaries

On this page:

In 2021–22, 17 publicly funded alcohol and other drug treatment agencies in the Australian Capital Territory provided 6,931 treatment episodes to more than 3,838 clients (tables Agcy.1, SCR.21).

The Australian Capital Territory reported:

- a 57% increase in treatment episodes between 2012–13 to 2021–22, from 4,400 episodes to 6,900 episodes (Table ST ACT.2)
- more clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (966 clients per 100,000 population compared with 877 per 100,000, respectively)
- client numbers increased from 2,900 in 2013–14 to 4,000 in 2019–20, then fell to 3,800 in 2021–22 (Table SCR.21).

The visualisation shows that 6,931 treatment episodes were provided to 3,838 clients in the Australian Capital Territory in 2021–22. This equates to a rate of 1,744 episodes and 966 clients per 100,000 population, which is higher than the national rate (1,009 episodes and 576 clients per 100,000 population).

Note: Proportions were calculated based on total closed treatment episodes and estimated clients.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SCR.21.
http://www.aihw.gov.au

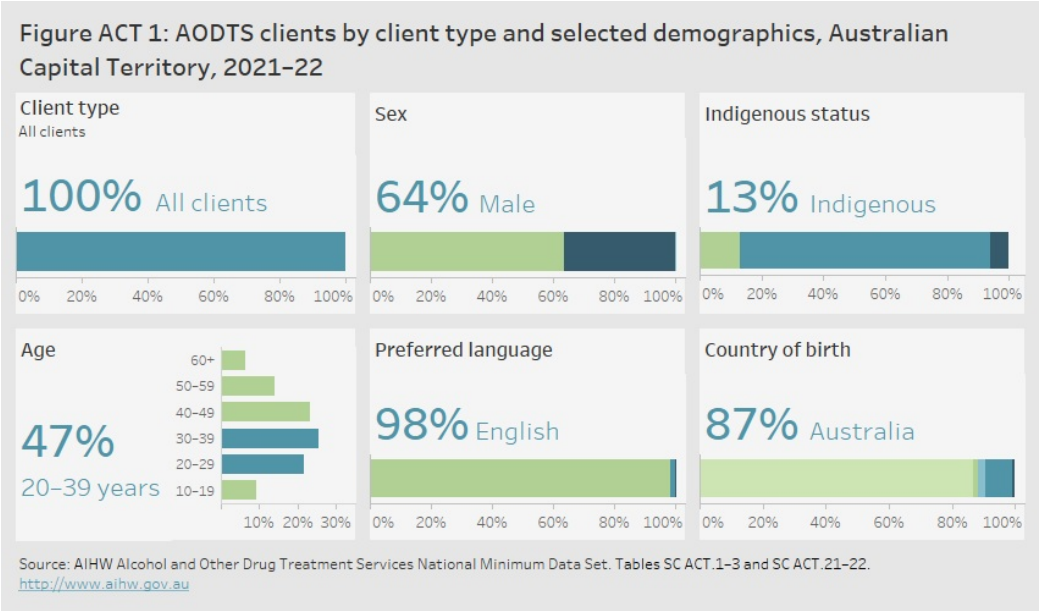
In 2021–22, most (76%) clients in the Australian Capital Territory attended 1 agency, and received an average of 1.8 treatment episodes, the same as the national average of 1.8 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2021–22:

- nearly all (97%) clients in the Australian Capital Territory received treatment for their own alcohol or drug use, of which almost 2 in 3 (65%) people were male (Figure ACT 1)
- people seeking treatment for someone else's alcohol or drug use were mostly female (73%)
- one in 2 (48%) of all clients were aged 20–39 years
- over 1 in 8 (13%) of all clients identified as Indigenous Australians, which is lower than the national proportion (18%)
- the majority (87%) of all clients were born in Australia and nearly all (98%) reported English as their preferred language (tables SC ACT.1–3, SC.4, SC ACT.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2021–22 in the Australian Capital Territory, just under two-thirds (64%) of all clients were male, 47% were aged 20–39 and 13% were Indigenous Australians. Nearly all clients (98%) listed English as their preferred language and most (87%) were born in Australia.



Patterns of service use

Over the period 2017–18 to 2021–22, 13,200 clients received treatment in the Australian Capital Territory. Of these clients, the majority received treatment in a single year (70% or 9,300):

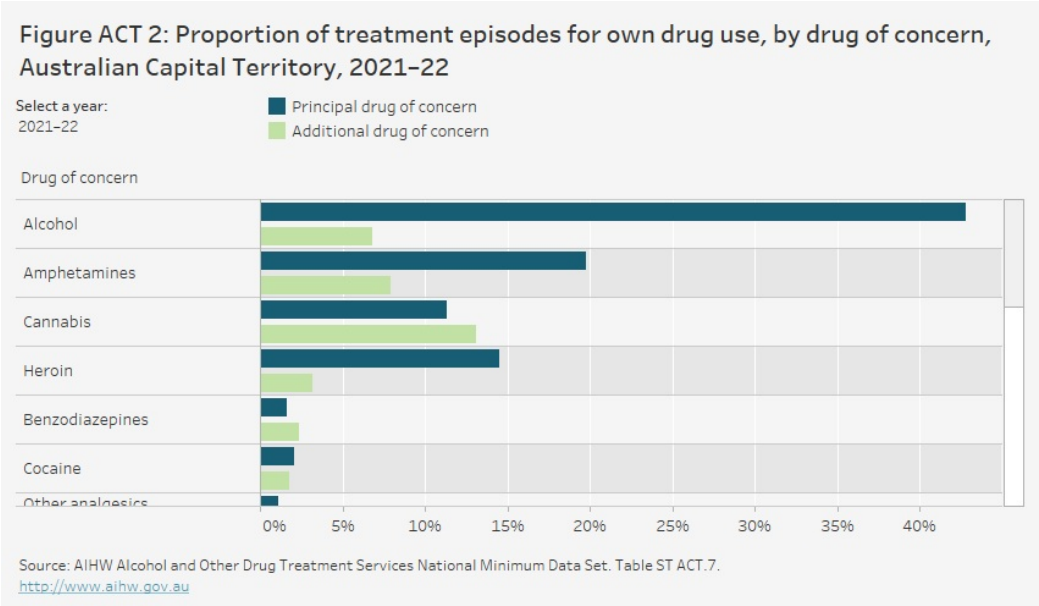
- 1,900 (14%) received treatment for the first time in 2021–22
- a further 7,400 (56%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

Drugs of concern

In 2021–22, for clients in the Australian Capital Territory receiving treatment episodes for their own alcohol or drug use:

- alcohol was the most common principal drug of concern for clients (43% or 2,900 episodes) (Figure ACT 2, Table ST ACT.7)
- amphetamines accounted for 1 in 5 (20% or 1,300) treatment episodes.

The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in the Australian Capital Territory for their own drug use (42.8%). This was followed by amphetamines (19.8%), heroin (14.5%) and cannabis (11.3%). Cannabis was the most common additional drug of concern (13.1% of episodes), followed by nicotine (11.1%) and amphetamines (7.9%).



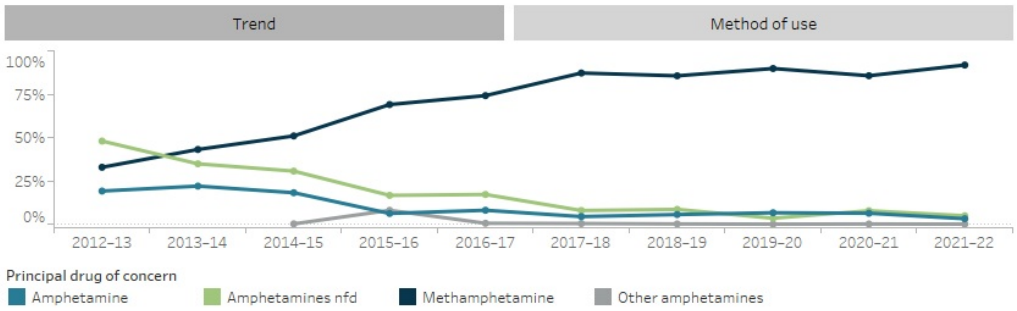
In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern for over 9 in 10 (92%) treatment episodes (Figure ACT 3a)
- in almost half (44%) of the treatment episodes where methamphetamine was the principal drug of concern, injecting was the most common method of use, followed by smoking (36%) (Figure ACT 3b).

Some jurisdictions are working with service providers to encourage more specific reporting of amphetamine use (i.e. to reduce the use of ‘amphetamines not further defined’ code where possible).

The line graph shows that in 2012–13, amphetamines not further defined was the most common drug of concern among amphetamine-related treatment episodes for clients' own drug use. In 2013–14, methamphetamine became the most common principal drug of concern within the amphetamines group. The proportion of methamphetamine-related episodes increased from 32.9% of amphetamine-related episodes in 2012–13 to 91.8% in 2021–22, while the proportion of episodes for amphetamines not further defined decreased from 48.0% to 4.9% over the same period. Buttons allow the user to navigate to data on amphetamines by method of use.

Figure ACT 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), Australian Capital Territory (per cent)



Notes
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST ACT.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes).

In 2021–22, when the client reported additional drugs of concern, cannabis was the most common additional drug (13%), followed by nicotine (11%) (Table ST ACT.7).

Over the period 2012–13 to 2021–22:

- alcohol was the most common principal drug of concern relative to all other drugs accounting for almost half (47%) of episodes in 2012–13 and falling to 43% of episodes in 2021–22 (Table ST ACT.7)
- the proportion of episodes with amphetamines as the principal drug of concern increased from 11% in 2012–13 to peak in 2016–17 (25%), before falling to 20% in 2021–22. The number of treatment episodes fluctuated from 496 in 2012–13 to 1,626 in 2016–17, down to 1,345 in 2021–22
  - within the amphetamines group, methamphetamine was reported as the principal drug of concern in 33% of episodes in 2012–13, rising to 92% in 2021–22 (Figure ACT 3a)
  - the rise in episodes may be related to increases in funded treatment services and/or improvement in agency coding practices for methamphetamines
- The proportion of heroin as a principal drug of concern fell from 16% in 2012–13 to 8–9% between 2014–15 and 2017–18, before rising to 14% in 2021–22 (higher than the national proportion of 4.5%) (Table Drg.5).

Treatment

In 2021–22, for treatment episodes in the Australian Capital Territory:

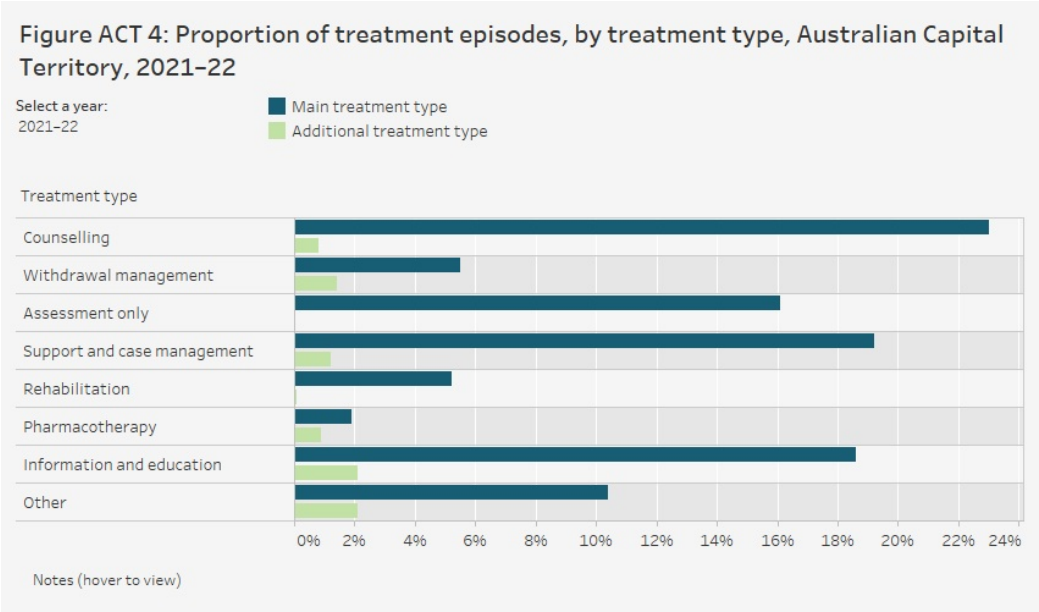
- counselling was the most common main treatment (23% of episodes) (Figure ACT 4, Table ST ACT.13)
- support and case management was the second most common treatment (19%), followed by information and education (19%)
- where an additional treatment was provided as a supplementary to the main treatment, information and education (2.1%) was the most common additional treatment. See technical notes for further information on calculating proportions for additional treatment type.

Over the period 2012–13 to 2021–22:

- the proportion of episodes with information and education as main treatment ranged from 22% in 2012–13 to 32% in 2017–18, before decreasing to 19% in 2021–22 (ST ACT.13)
- counselling became the most common main treatment type in 2021–22; in the 10 years prior, the proportion of episodes with counselling as main treatment ranged from 17% in 2012–13 to 28% in 2018–19, before decreasing to 23% in 2021–22
- compared to national proportions, fewer treatment episodes provided in the ACT had counselling as main treatment over the 10 years to 2021–22 (ranging from 17% to 28% in the ACT, compared with 36% to 43% nationally)
- conversely, more treatment episodes in the ACT had information and education as main treatment (ranging from 16% to 32% in the ACT compared with 4% to 10% nationally) (tables ST ACT.13, Trt.3).

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in the Australian Capital Territory for their own drug use was counselling (23.0% of episodes). This was followed by support and case management (19.2%) and information and education (18.6%). Information and education and other treatments were the most common additional treatment types

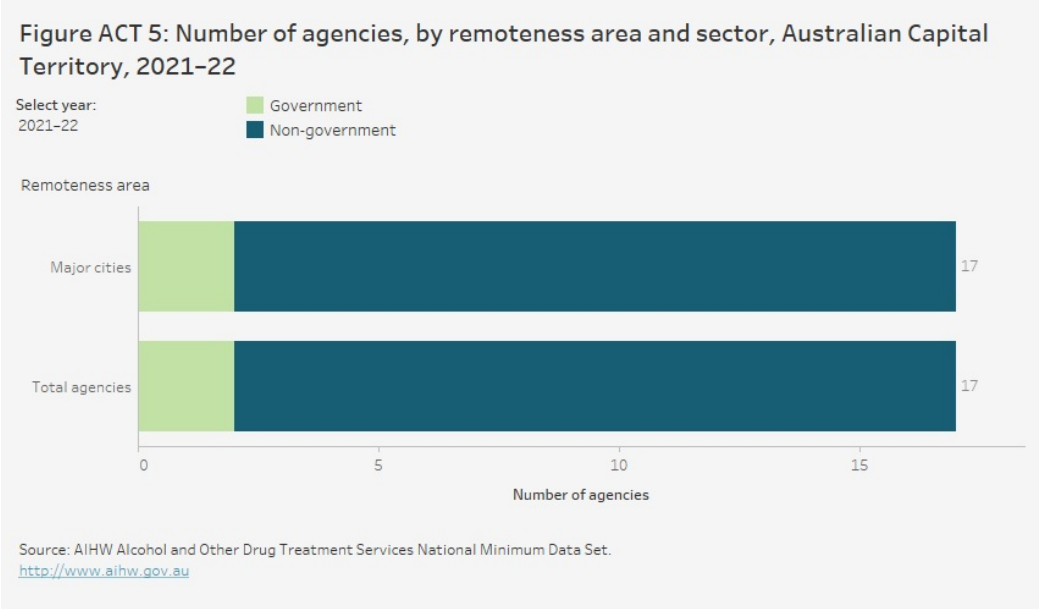
(2.1% of episodes each).



Agencies

The Australian Capital Territory only has the one geographical classification of *Major city*, and the majority of treatment agencies are non-government organisations (88%) (Figure ACT 5, Table Agcy.3).

Over the period 2012–13 to 2021–22, the number of publicly funded treatment agencies rose from 10 to 17 agencies (Table Agcy.1).
The horizontal bar chart shows that all treatment agencies in the Australian Capital Territory were located in *Major cities* in 2021–22. Of the total 17 treatment agencies, most (15 agencies) were non-government agencies.



State and territory summaries

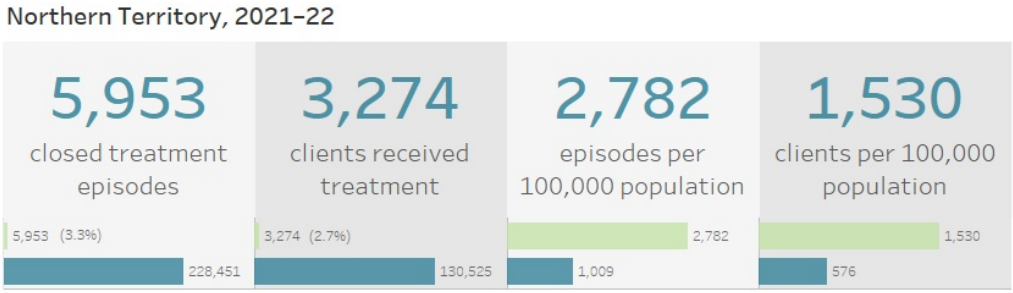
On this page:

In 2021–22, 24 publicly funded alcohol and other drug treatment agencies in the Northern Territory provided provided 5,953 treatment episodes to 3,274 clients (tables Agcy.1–2, SCR.21).

The Northern Territory reported:

- a 25% decrease in treatment episodes from 8,000 in 2020–21 to 6,000 in 2021–22, and a 64% increase in treatment episodes since 2012–13 (3,600) (Table ST NT.2)
- more clients are using AOD services in 2021–22 than 2013–14, after adjusting for population growth (1,530 clients per 100,000 population compared with 1,397 per 100,000, respectively)
- client numbers increased from 2,870 in 2013–14 to 3,776 in 2019–20 then dropped to 3,274 in 2021–22 (Table SCR.21).

The visualisation shows that 5,953 treatment episodes were provided to 3,274 clients in the Northern Territory in 2021–22. This equates to a rate of 2,782 episodes and 1,530 clients per 100,000 population, which is higher than the national rate (1,009 episodes and 576 clients per 100,000 population).



Note: Proportions were calculated based on total closed treatment episodes and estimated clients.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table SCR.21.
http://www.aihw.gov.au

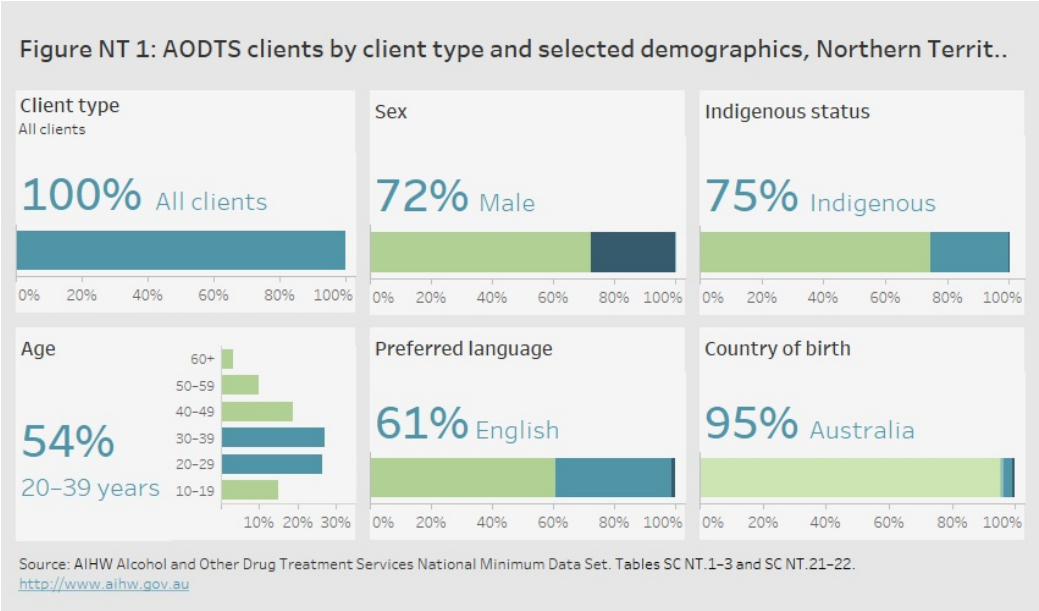
In 2021–22, most (81%) clients in the Northern Territory attended 1 agency, and received an average of 1.8 treatment episodes, which is the same as the national average of 1.8 treatment episodes (tables SCR.21, SCR.23).

Client demographics

In 2021–22:

- most (99%) clients in the Northern Territory received treatment for their own alcohol or drug use, of which over 7 in 10 (73%) people were male (Figure NT 1)
- people seeking treatment for someone else's alcohol or drug use were more likely to be female (55%)
- over half (54%) of all people were aged 20–39 years, and 15% of people were aged 10–19 years which is higher the national proportion (10%)
- 3 in 4 (75%) of all clients identified as Indigenous Australians, more than 4 times higher than the national proportion (18%)
- nearly all (95%) people were born in Australia and over 3 in 5 (61%) reported English as their preferred language, with nearly 2 in 5 (38%) reporting Indigenous languages as their preferred language (tables SC NT.1–3, SC.3–4, SC NT.21–22).

The visualisation includes a series of horizontal bar graphs showing that, in 2021–22 in the Northern Territory, over two-thirds (72%) of all clients were male, 54% were aged 20–39 and 75% were Indigenous Australians. Around 3 in 5 (61%) listed English as their preferred language and most (95%) were born in Australia.



Patterns of service use

Over the period 2017–18 to 2021–22, 12,100 clients received treatment in the Northern Territory. Of these clients, the majority received treatment in a single year (67% or 8,100):

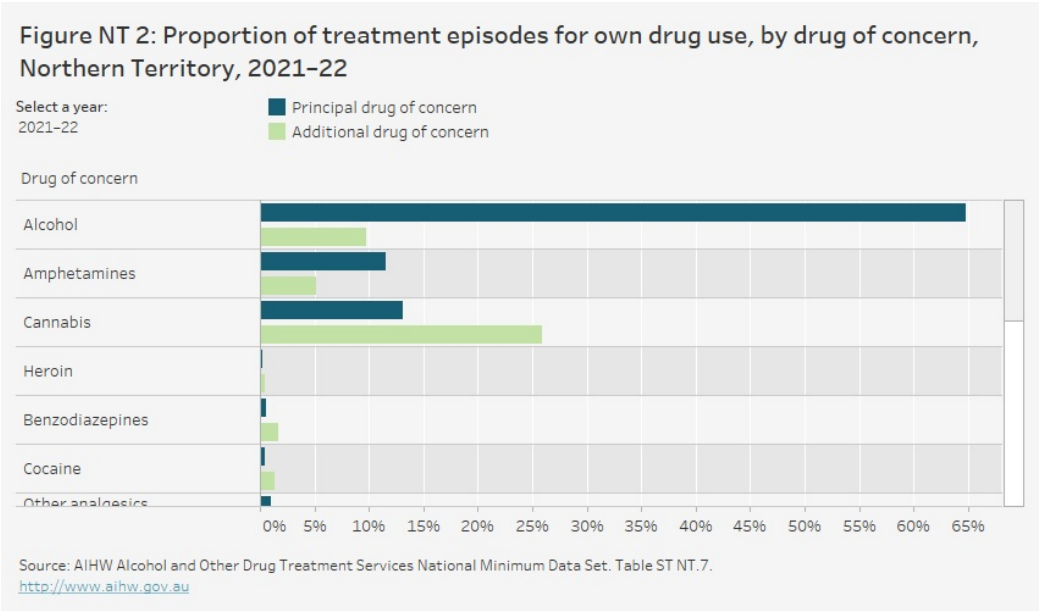
- 1,600 (14%) received treatment for the first time in 2021–22
- a further 6,500 (53%) received treatment in only one of the five collection periods (excluding 2021–22) (Table SCR.28).

Drugs of concern

In 2021–22, for clients in the Northern Territory receiving treatment episodes for their own alcohol or drug use:

- alcohol was the most common principal drug of concern for clients (65% or 3,800 episodes) (Figure NT 2, Tables ST NT.7)
- cannabis (13% or 770 episodes) and amphetamines (12% or 685 episodes) were the second and third most common principal drugs of concern
- volatile solvents (5.3% or 310 episodes) were the next most common principal drug of concern, with proportions higher than the national level (less than 1%) (Table Drg.1).

The grouped horizontal bar chart shows that, in 2021–22, alcohol was the most common principal drug of concern in treatment episodes provided to clients in the Northern Territory for their own drug use (64.8%). This was followed by cannabis (13.1%) and amphetamines (11.6%). Cannabis was the most common additional drug of concern (25.9% of episodes), followed by nicotine (15.5%) and alcohol (9.7%).

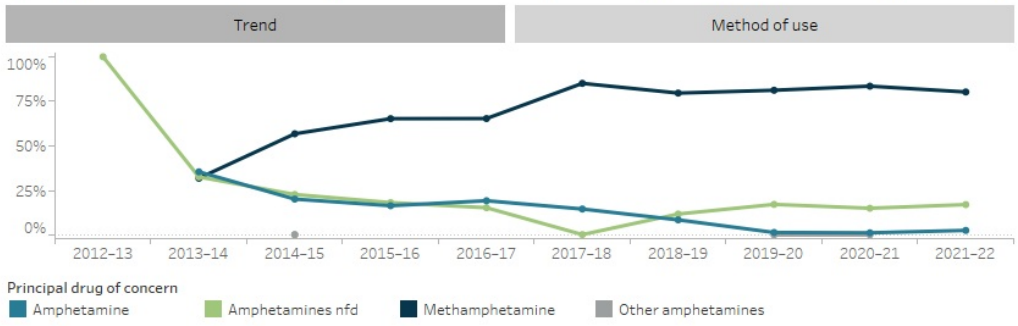


In 2021–22, for clients receiving treatment for their own use of amphetamines:

- methamphetamine was reported as a principal drug of concern in around 4 in 5 (80%) treatment episodes (Figure NT 3a)
- in just under half (46%) of treatment episodes where methamphetamine was a principal drug of concern, smoking was the most common method of use, followed by injecting (45%) (Figure NT 3b).

The line graph shows that, between 2012–13 and 2013–14, amphetamine and amphetamines not further defined were the most common drugs of concern among amphetamine-related treatment episodes for clients' own drug use. In 2014–15, methamphetamine became the most common principal drug of concern within the amphetamines group. The proportion of methamphetamine-related episodes increased from 31.9% of amphetamine-related episodes in 2013–14 to 80.3% in 2021–22, while the proportion of episodes for amphetamines not further defined decreased from 32.6% to 17.1% over the same period. Buttons allow the user to navigate to data on amphetamines by method of use.

Figure NT 3a: Proportion of treatment episodes for own drug use, by amphetamine group (2012–13 to 2021–22) or method of use (2021–22), Northern Territory (per cent)



Notes
1. Other amphetamines includes Dexamphetamine, Amphetamine analogues and Amphetamines nec.
2. Amphetamines nfd are amphetamines not further defined.
3. Other amphetamines not reported from 2015–16 to 2018–19.
4. Coding of methamphetamines has improved over time due to advancements in workforce training, agency coding practices and new system updates.
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set. Table ST NT.6.
http://www.aihw.gov.au

Clients can nominate up to 5 additional drugs of concern; these drugs are not necessarily the subject of any treatment within the episode (see technical notes).

In 2021–22, when the client reported additional drugs of concern, cannabis was the most common additional drug of concern (26% of episodes), followed by nicotine (15%) (Table ST NT.7).

Over the period 2012–13 to 2021–22:

- alcohol remained the most common principal drug of concern, increasing from 60% in 2012–13 (2,000 episodes) to peak at 72% in 2020–21 (5,500 episodes), falling to 65% (3,800 episodes) in 2021–22. The proportion of episodes for alcohol, relative to all other principal drugs of concern, remained consistently higher than the national proportion (for example, 65% compared with 42% nationally in 2021–22) (tables ST NT.7, Drg.1).
- treatment episodes for amphetamines as a principal drug of concern increased over this period (4.8% to 12%).
  - within the amphetamines group, treatment for methamphetamine as a principal drug of concern was reported as the principal drug of concern in 32% of episodes in 2013–14, rising to 85% in 2017–18, dropping to 80% in 2021–22 (Figure NT 3a)
  - the rise in methamphetamine episodes may be related to changes in the illicit drug market and/or changes in service provider practices.
- the proportion of treatment episodes for volatile solvents as a principal drug of concern decreased from 14% in 2012–13 to 5.3% in 2021–22 (Table Drg.1).

Treatment

In 2021–22, for treatment episodes in the Northern Territory:

- assessment only was the most common main treatment (46% of episodes), followed by counselling (17%) (Figure NT 4, Table ST NT.13)
- where an additional treatment was provided as a supplementary to the main treatment, counselling (8.6%) was the most common additional treatment, followed by support and case management (7.0%) (Table ST NT.13). See technical notes for further information on calculating proportions for additional treatment type.

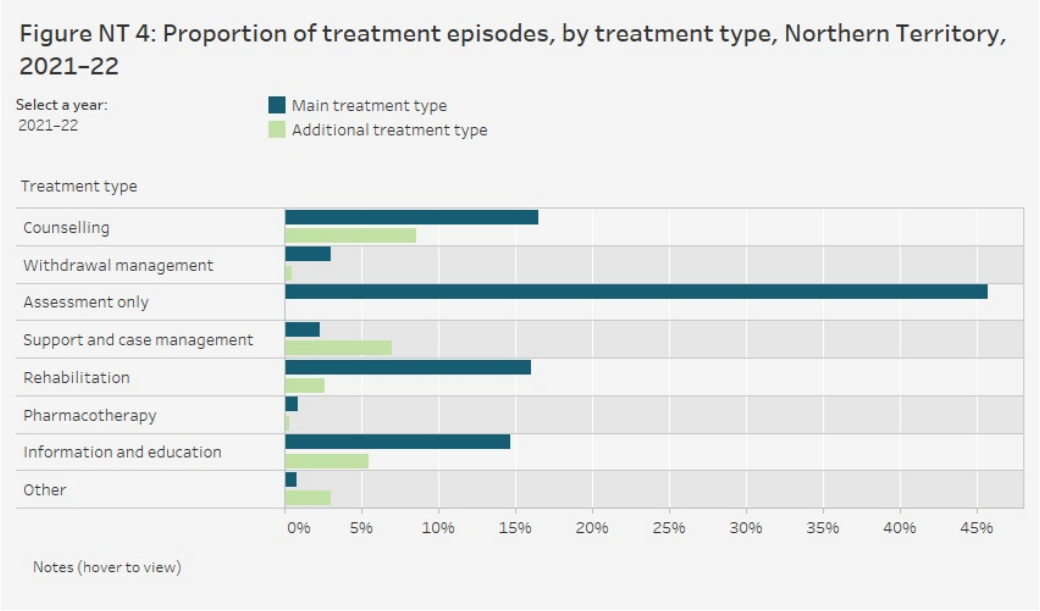
All agencies in the Northern Territory are required to complete a separate assessment only episode prior to the commencement of treatment. This is due to a policy of monitoring the volume of assessment work performed by agencies and understanding the relationship between assessment and subsequent treatment, particularly in relation to certain alcohol-related legislative-based programs. This policy was introduced in 2018 (reported in the 2017–18 collection year).

Over the period 2012–13 to 2021–22:

- assessment only remained the most common main treatment, although the proportion of episodes fluctuated (increasing from 44% in 2012–13 to 47% in 2017–18 before falling to 46% in 2021–22)
- the proportion of episodes where counselling was the main peaked at 25% in 2016–17, before halving to 13% in 2019–20 and rising to 17% in 2021–22

- the proportion of treatment episodes where rehabilitation was the main treatment fluctuated since 2012–13, rising from 15% to 25% in 2016–17 before falling to 16% in 2021–22 (Table ST NT.13).

The grouped horizontal bar chart shows that, in 2021–22, the most common main treatment type provided to clients in the Northern Territory for their own drug use was assessment only (45.7% of episodes). This was followed by counselling (16.5%) and rehabilitation (16.0%). Counselling was the most common additional treatment type (8.6% of episodes), followed by support and case management (7.0%).



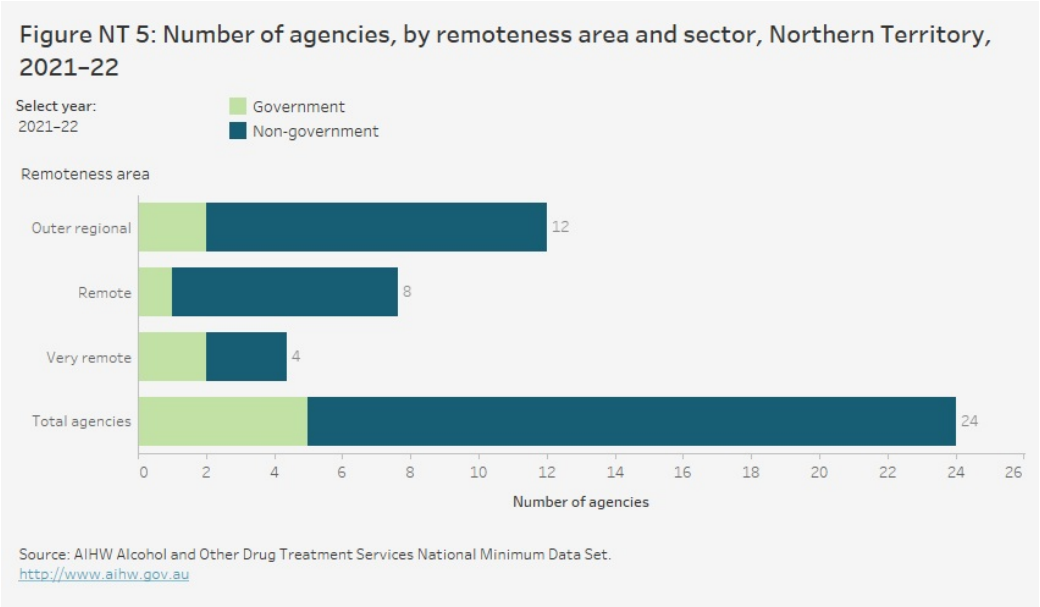
Agencies

The Northern Territory does not have any areas classified as *Major city* or *Inner regional*. It only has locations classified as *Outer regional*, *Remote* or *Very remote*.

In 2021–22:

- the majority of the 24 treatment agencies were in the non-government sector (79%)
- *Outer regional* areas contained the most treatment agencies (50%), followed by *Remote* areas (33%) (Figure NT 5, Table Agcy.3).

In the 10 years to 2021–22, the number of publicly funded treatment agencies rose from 19 to 24 (Table Agcy.1).
The horizontal bar chart shows that all treatment agencies in the Northern Territory were located in *Outer regional areas* (12 agencies), followed by *Remote areas* (8 agencies) and *Very remote areas* (4 agencies) in 2021–22. Of the total 24 treatment agencies, most (19 agencies) were non-government agencies.



State and territory summaries

On this page:

General notes

1. Data are subject to minor revisions over time.
2. Components of figures may not sum to totals due to rounding.

Client demographics

1. Data are based on client records with a valid Statistical Linkage Key (SLK-581).
2. Client data exists from the 2013–14 collection onwards.
3. The client data used in these visualisations is not imputed. Therefore, these numbers may differ from what have been previously published.
4. Rates are crude rates based on the Australian estimated resident population as at 31 December of the reference year. Rates for previous years may differ to those previously reported due to updated estimated resident populations.
5. Proportions are calculated based on overlapping unit record data sorted by state/territory. As clients can receive treatment in multiple states/territories within the same collection period, the number of clients for Australia is less than the summed number of clients for each state/territory. Therefore, the proportions by each state/territory may differ from those reported elsewhere as they are calculated from the summed number of clients in each state/territory.
6. The COVID-19 pandemic and the resulting Australian Government closure of the international border from 20 March 2020, caused significant disruptions to the usual Australian population trends. This report uses Australian Estimated Resident Population (ERP) estimates that reflect these disruptions.

   In the year July 2020 to June 2021, the overall population growth was much smaller than the years prior and in particular, there was a relatively large decline in the population of Victoria. ABS reporting indicates these were primarily due to net-negative international migration (National, state and territory population, June 2021 | Australian Bureau of Statistics (abs.gov.au)).

   Please be aware that this change in the usual population trends may complicate interpretation of statistics calculated from these ERPs. For example, rates and proportions may be greater than in previous years due to decreases in the denominator (population size) of some sub-populations.

Drugs of concern

1. Data are based on client records with a valid Statistical Linkage Key (SLK-581).
2. Client data exists from the 2013–14 collection onwards.
3. The client data used in these visualisations is not imputed. Therefore, these numbers may differ from what have been previously published.
4. Rates are crude rates based on the Australian estimated resident population as at 31 December of the reference year. Rates for previous years may differ to those previously reported due to updated estimated resident populations.
5. Proportions are calculated based on overlapping unit record data sorted by state/territory. As clients can receive treatment in multiple states/territories within the same collection period, the number of clients for Australia is less than the summed number of clients for each state/territory. Therefore, the proportions by each state/territory may differ from those reported elsewhere as they are calculated from the summed number of clients in each state/territory.
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   Please be aware that this change in the usual population trends may complicate interpretation of statistics calculated from these ERPs. For example, rates and proportions may be greater than in previous years due to decreases in the denominator (population size) of some sub-populations.
7. Unlike the principal drug of concern, additional/other drug/s of concern is not necessarily the subject of any treatment within the episode.
8. The proportion of episodes for an additional drug of concern is calculated by the number of closed treatment episodes for that particular additional drug (up to 5 drug types can be reported) divided by the total number of closed treatment episodes for clients receiving treatment for their own alcohol or drug use in the collection year.
9. The AODTS NMDS contains data on drugs of concern that are coded using the ABS's Australian Standard Classification of Drugs of Concern (ASCDC) (ABS 2011). Pharmaceuticals were grouped using the following 10 drug categories and ASCDC codes:

Table 1: Pharmaceutical drugs of concern, ASCDC codes and classifications

Drug Category	ASCDC CODE
Codeine	1101
Morphine	1102
Buprenorphine	1201
Oxycodone	1203
Methadone	1305
Benzodiazepines	2400–2499
Steroids	4000–4999
Other opioids	1100, 1199, 1200, 1299, 1300–1304, 1306–1399
Other analgesics	0005, 1000, 1400–1499
Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999

Jurisdictional notes regarding principal drug of concern

Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This is in part due to service providers adjusting to changes in reporting practices associated with the implementation of a new data collection system in 2019–20. In 2020–21, these drugs of concern were coded as 'Other drugs of concern' (14%) to realign with previous coding practices for Victoria. Victoria is working with service providers to encourage more specific reporting of drug of concern.

In Queensland, the level of cannabis reported as the principal drug of concern is a result of the police and illicit drug court diversion programs operating in the state.

South Australia reports a high proportion of treatment episodes where amphetamines are the principal drug of concern due to the SA Police Drug Diversion Initiative (PDDI). In addition, adult cannabis offences are not included in the PDDI due to the SA Cannabis Expiation Notice legislation.

Treatment

1. The proportion of episodes for an additional treatment type is calculated by the number of closed treatment episodes for that particular additional treatment type divided by the total number of closed treatment episodes for main treatment type in the collection year.
2. Rehabilitation, withdrawal management (detoxification), and pharmacotherapy are not available for clients who received treatment for someone else's alcohol or other drug use.
3. The main treatment type of 'other' includes pharmacotherapy. In 2019–20, changes were made to categories under Main Treatment; the word 'only' was removed from code 5 (support and case management) and code 6 (information and education). The removal of the word 'only' from support and case management and information and education, changed reporting rules for agencies; allowing agencies to be able to report and more accurately capture these items as an additional treatment in conjunction with a main treatment type. Main treatment code for 'Other' changed from 8 to 88.
4. Changes were also made to Other Treatment type (or additional treatment) categories, which added the codes 5 (Support and case management) and code 6 (Information and education) as categories to allow agencies to better reflect and record the current use of these treatment types in services. Other treatment type coding for the category 'Other' changed from 5 to 88.
5. In 2019–20 and 2020–21 and 2021–22, unprecedented restrictions related to the COVID-19 pandemic impacted delivery of some AOD services including withdrawal management, residential rehabilitation, counselling and face-to-face outreach services, which moved to providing telehealth services to ensure social distancing guidelines were met. Withdrawal and rehabilitation bed-based occupancy decreased compared to pre-COVID occupancy in most states.

Agencies

1. An agency's remoteness area is derived by applying an ABS Australian Statistical Geography Standard (ASGS) Remoteness Structure 2011 to Statistical Area Level 2 code (SA2) correspondence. Some SA2s are split between multiple remoteness areas. Where this is the case, the data are weighted according to the proportion of the population of the SA2 in each remoteness area. As a result, it is possible that the number of agencies in a particular remoteness area is not a whole number. After rounding, this can result in there being '<0.5' or '<0.5%' of agencies in a remoteness area due to the agency's SA2 partially crossing into the remoteness area.
2. The number of agencies by remoteness or sector may not sum to the total number of agencies due to rounding.
3. The number of agencies is not an accurate reflection of all in-scope AOD specialist treatment services in Australia, as some agencies fail to report data during a collection for various reasons. See the Alcohol and other drug treatment services NMDS 2021–22 data quality statement for further details.
4. In 2018–19, the AOD treatment agency counting methodology was revised to better reflect the number of unique AOD treatment service outlets. There is a level of agency duplication, due to agencies splitting out episode data related to the funding source for that program/service. A small number of agencies split their data submission according to state funded service episodes, which are reported to relevant state or territory departments; and Commonwealth funded service episodes are reported to a peak body or directly to the AIHW. This has resulted in the double counting of some services over time. This revision has been applied to all time-series; the main changes in data related to AOD service counts are from 2014–15 to 2017–18.
5. Data for SA2 only available for 2014–15 collection onwards.

For further Technical information regarding the AODTS NMDS see Annual report technical notes.

Data quality statement

AODTS NMDS 2021–22 data quality statement

Data

2021–22 States and territories (episodes) data tables

2021–22 Clients (states and territories) data tables

References

ABABS 2011. Australian Standard Classification of Drugs of Concern, 2011. ABS cat. no. 1248.0. Canberra: ABS.

Primary Health Network (PHN) Data

On this page:

In December 2015, the Australian Government announced the release of the *Australian Government Response to the National Ice Taskforce Final Report* (the Response). The Response underpinned the National Ice Action Strategy (NIAS), which was endorsed by the Council of Australian Governments (COAG) on 11 December 2016.

An evaluation of the NIAS commenced in January 2020 with the development of an Evaluation Framework. The evaluation itself commenced in June 2020 and was completed in March 2021. An interim report, submitted to the Department of Health in January 2021, included interim findings for selected NIAS activities. A final report was submitted July 2021 providing a comprehensive assessment including initiatives designed to achieve demand reduction, supply reduction and harm reduction across a wide range of sectors including government, community, law enforcement, justice and regulation, policy, and research.

The Australian Government has invested approximately $561 million over four years from 1 July 2016 in drug and alcohol treatment services, as part of a $713 million investment in reducing the impact of drug and alcohol misuse on individuals, families and communities under the *Drug and Alcohol Program*.

Approximately $412.1 million of this investment was provided to Primary Health Networks (PHNs) to commission locally based treatment in line with community need. This includes the $241.5 million committed under the NIAS. This funding was delivered through the Australian Government's *Drug and Alcohol Program* and aims to improve the access to, and effectiveness of drug and alcohol treatment services in the community.

In April 2020, the Australian Government announced an additional $6 million would be invested in online and phone support services for people experiencing substance issues during the COVID-19 pandemic.

The main source of data about specialist drug and alcohol treatment services in Australia is the Alcohol and Other Drug Treatment Services National Minimum Data Set (the AODTS NMDS), compiled on an annual basis from administrative data by the Australian Institute of Health and Welfare (AIHW).

PHN-commissioned specialist alcohol and other drug treatment providers collect data, in accordance with the AODTS NMDS, on in-scope specialist treatment services and provide it to the AIHW. Alcohol and other drug treatment agencies funded by PHN organisations under the *Drug and Alcohol Program* submitted data to the AODTS NMDS for the first time in 2016–17.

The following set of data visualisations present information at PHN geographic areas. The data presented are from all publicly funded AOD treatment services (which includes PHN-commissioned services) that have reported to the AODTS NMDS (see technical notes for more details).

PHNs are organisations that connect health services across a specific geographic area (PHN areas). There are 31 PHN areas that cover the whole of Australia with the boundaries defined by the Australian Government Department of Health. Some states/territories consist of a single PHN area, while others are made up of multiple PHN areas.

Alcohol and other drug treatment services dashboards

Click on the icon maps to explore the dashboards

- For the best experience use Chrome, Edge or Firefox browsers. For more information on browser compatibility, see Supported browsers
- Best viewed on a desktop, laptop or tablet.

Alcohol and other drug treatment agencies map, 2017-18 to 2021-22

Primary Health Network

Alcohol and other drug treatment map, 2017–18 to 2021–22

Primary Health Network

Principal drug of concern map, 2017–18 to 2021–22

Primary Health Network

Alcohol and other drug treatment

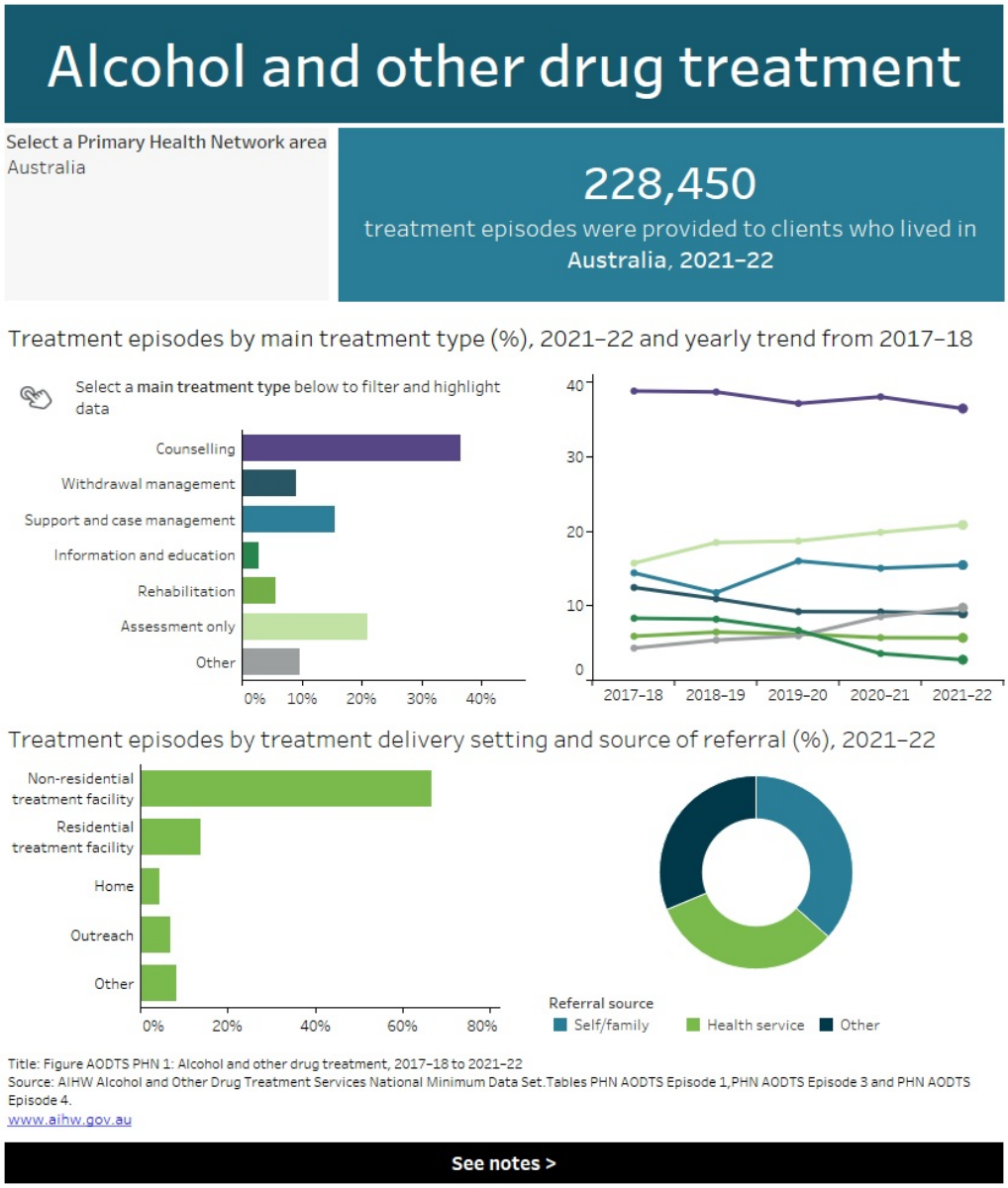
The following data visualisation shows:

- Treatment episodes, by PHN area of client and main treatment type, 2017–18 to 2021–22.
- Treatment episodes, by PHN area of client and source of referral, 2021–22.
- Treatment episodes, by PHN area of client and treatment delivery setting, 2021–22.

Figure AODTS PHN 1: Alcohol and other drug treatment, 2017–18 to 2021–22

The interactive data dashboard shows that there were 228,450 treatment episodes provided to clients in Australia in 2021–22. A horizontal bar chart and line graph show the proportion of treatment episodes by main treatment type in 2021–22 (bar chart) and between 2017–18 and 2021–22 (line graph). Counselling remained the most common main treatment type between 2017–18 and 2021–22, accounting for 36.5% of episodes in 2021–22.

A horizontal bar chart and a donut chart show the proportion of treatment episodes by treatment delivery setting in 2021–22. Most episodes were delivered in non-residential treatment settings (66.7%) and the most common sources of referral were self/family (36.6% of episodes) and health services (32.1%). A filter allows the user to view data for Australia or by Primary Health Network area.



Client demographics

The following data visualisation shows:

- Clients by PHN area of client, client type and sex, 2021–22.
- Clients by PHN area of client, client type and age group, 2021–22.
- Clients by PHN area of client, client type and Indigenous status, 2021–22.

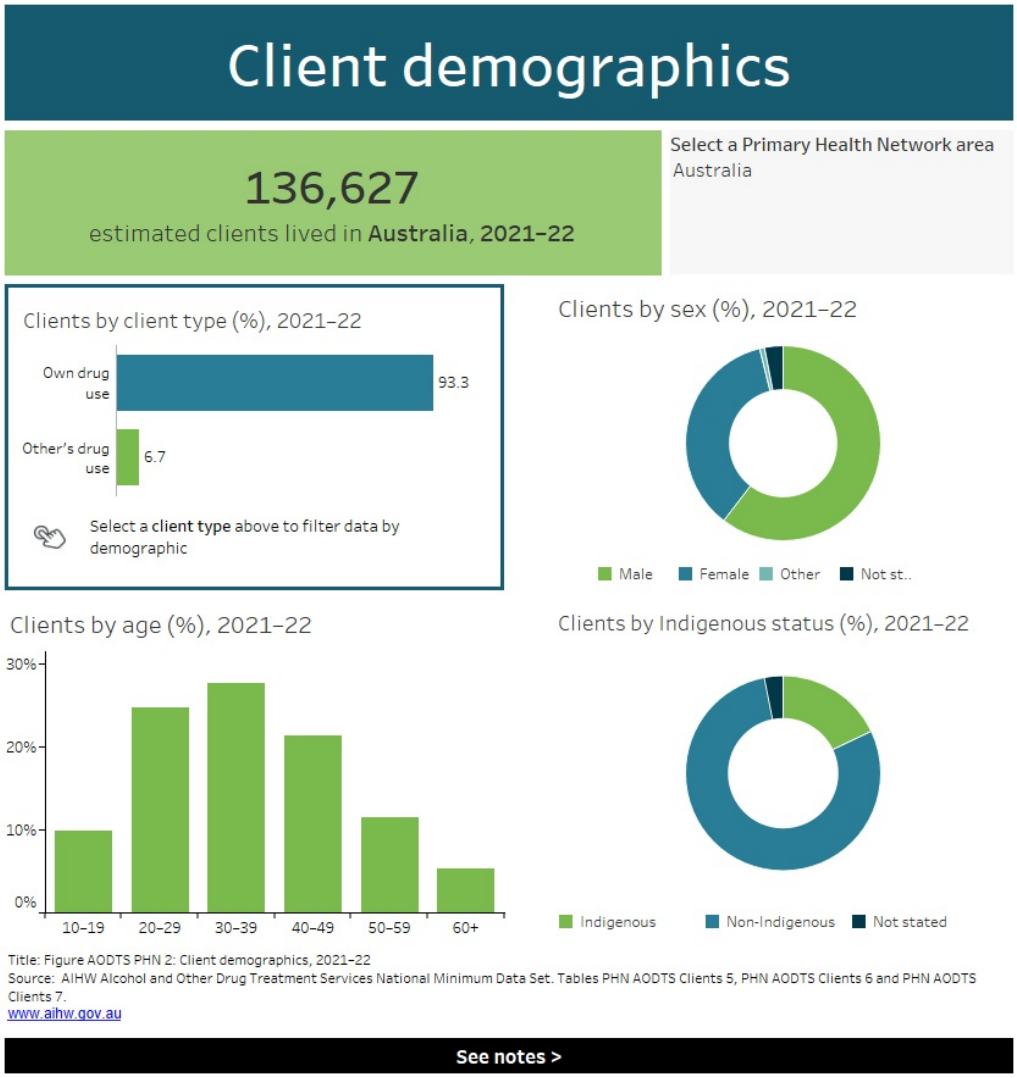
Figure AODTS PHN 2: Client demographics, 2021-22

The interactive data dashboard shows that there were 136,627 estimated clients in Australia in 2021–22. A horizontal bar chart shows that most clients in 2021–22 sought treatment for their own drug use (93.3%, compared with 6.7% of clients seeking treatment for someone else's drug use).

A vertical bar chart shows the proportion of clients by age group in 2021–22. Most clients were aged 30–39 (27.5%) or 20–29 (24.7%).

Two donut charts show the proportion of clients by sex and Indigenous status in 2021–22, respectively. Most clients were male (60.4%, compared with 35.7% for females) and 17.9% were Indigenous.

A filter allows the user to view data for Australia or by Primary Health Network area.



Principal drug of concern

The following data visualisation shows:

- Treatment episodes for clients who received treatment for their own drug use by PHN area of client and principal drug of concern, 2017–18 to 2021–22.
- Treatment episodes for clients who received treatment for their own drug use by PHN area of client and main treatment type, 2021–22.
- Treatment episodes for clients who received treatment for their own drug use by PHN area of client and source of referral, 2021–22.

Figure AODTS PHN 3: Principal drug of concern, 2017–18 to 2021–22

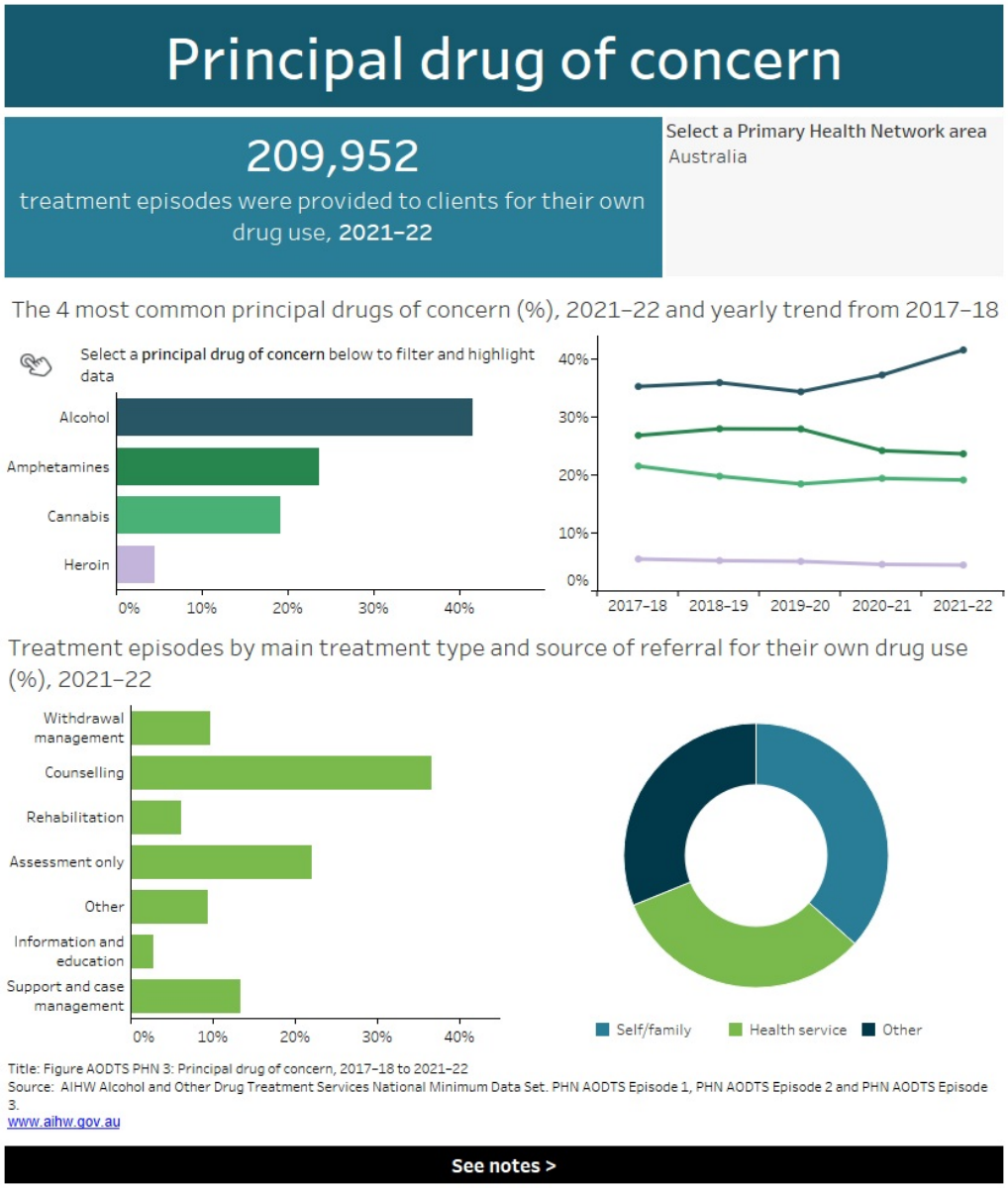
The interactive data dashboard shows that there were 209,952 treatment episodes provided to clients for their own drug use in Australia in 2021–22.

A horizontal bar chart and a line graph show the 4 most common principal drugs of concern among these episodes in 2021–22 (bar chart) and between 2017–18 and 2021–22 (line graph). Alcohol was the most common principal drug of concern across the period, accounting for 41.6% of episodes in 2021–22. This was followed by amphetamines (23.7% of episodes in 2021–22) and cannabis (19.2%).

A horizontal bar chart shows the proportion of treatment episodes provided to clients for their own drug use in 2021–22 by main treatment type. Counselling was the most common main treatment type (36.5% of episodes), followed by assessment only (22.0%).

A donut chart shows that proportion of treatment episodes by source of referral in 2021–22. The most common source of referral was self/family (36.6% of episodes), followed by health services (32.3%).

A filter allows the user to view data for Australia or by Primary Health Network.



Data tables

PHN AODTS NMDS data tables

Pharmacotherapy in Australia Data

Opioid pharmacotherapy is one of the main treatment options for dependence on opioid drugs, such as heroin and morphine. Treatment involves replacing the opioid drug of dependence with a legally obtained, longer-lasting opioid. In Australia, clients attend dosing point sites (for example, pharmacies) regularly to take the dose of their prescribed medication under the supervision of a pharmacist or other health professional.

Clients who receive pharmacotherapy treatment can be captured in various data sources. The two national sources presented in this report are:

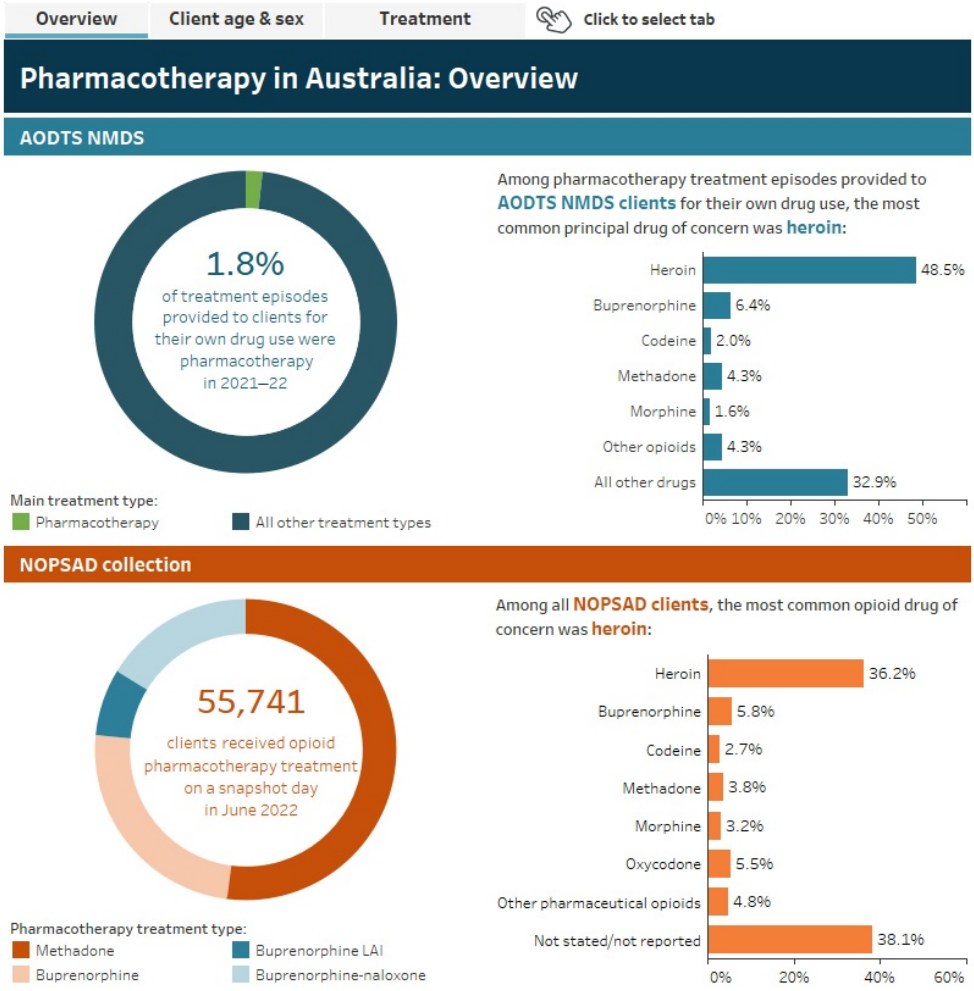
- Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS).
- National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) Collection.

Due to the specifications of these collections, it is not possible to directly compare or identify people who received pharmacotherapy treatment via dosing point site as well as treatment from a publicly funded alcohol and other drug (AOD) service (see technical notes for more details). However, exploring this information in parallel can provide a more detailed picture about pharmacotherapy treatment in Australia.
The interactive data dashboard provides an overview of pharmacotherapy treatment in AODTS NMDS in 2021–22 and in the NOPSAD collection on a snapshot day in June 2021 (NOPSAD data does not include Queensland).

In 2021–22, 1.8% of AODTS NMDS treatment episodes provided to clients for their own drug use involved pharmacotherapy as the main treatment type. Among these episodes, the most common principal drug of concern was heroin (48.5% of AODTS NMDS pharmacotherapy episodes).

On a snapshot day in June 2022, 55,741 clients received opioid pharmacotherapy in the NOPSAD collection. The most common pharmacotherapy treatment type was methadone (50.2% of clients) and the most common opioid drug of dependence was heroin (36.2% of NOPSAD clients).

Navigation buttons allow the user to navigate between the following tabs: Overview, Client age and sex, and Treatment.



Sources: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set (Tables Trt.2 and Trt.55), AIHW National Opioid Pharmacotherapy Statistics Annual Data Collection (Tables S4 and S10).
http://www.aihw.gov.au

Data tables

Data tables (AODTS NMDS)

Data tables (NOPSAD collection)

Diversion programs in Australia Data

On this page:

What are drug diversion programs?

In Australia, drug diversion treatment programs (diversion programs) divert people who have been apprehended or sentenced for a minor drugs offence from the criminal justice system. Diversions often result in clients being referred to drug treatment agencies, including publicly funded AOD treatment agencies captured in Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) data. Treatment services for clients referred via diversion programs range from short-term assessment (such as information or education sessions) to longer-term treatments (such as counselling or withdrawal management).

There are 2 key types of diversion programs in Australia that are captured in AODTS NMDS data:

- **Police diversion** occurs when an offence is first detected by a law enforcement officer. This typically applies for minor drug offences (for example, drug possession or use), often relating to cannabis. The offender may receive a caution or fine and will sometimes be required to attend mandatory drug assessment or education sessions.
- **Court diversion** occurs after a charge has been laid. It is usually applied for offences where criminal behaviour was related to drug use (for example, burglary or public order offence). Bail-based programs generally involve drug assessment and treatment, while pre- and post-sentence programs (such as drug courts) are aimed at repeat offenders and may involve more intensive treatment.

For more information on diversion programs, refer to the Key terminology and glossary.

Diversion has several objectives, including:

- Avoiding the negative labelling and stigma associated with criminal conduct and contact with the criminal justice system.
- Preventing further offending by minimising a person's contact with, and progression through, the criminal justice system.
- Reducing the number of people reaching the courts and prisons, thereby lightening the heavy caseload of courts and reducing delays as well as in costs of court processes and incarceration.
- Reducing unnecessary social controls.

Providing appropriate interventions to those offenders who are in need of treatment or other services.

About the diversion client data visualisation

This interactive data visualisation is based on data from the AODTS NMDS about clients who are referred to treatment via police or court diversion programs. It includes all clients with a valid statistical linkage key (SLK) who received at least 1 treatment episode for their own drug use with diversion as the referral source in a given collection period (that is, financial year). In this visualisation:

- **Diversion clients** include all clients who were referred to treatment via a diversion program (police or court) in at least 1 treatment episode in the collection period. For example, where clients received more than 1 treatment episode in the same collection period, if at least 1 had a diversion referral source then they are counted as 'Diversion clients' for the purpose of this analysis.
- **Non-diversion clients** include all clients who did not receive any episodes with a diversion referral source in the collection period.

Police and court diversion clients counts are reported both separately and combined in this visualisation. The sum of clients for police and court diversion exceeds the total number of diversion clients reported due to overlap where, for example, clients received at least 2 treatment episodes with referrals from police and court diversion in the same collection period.

How do we count treatment episodes provided to diversion clients?

Standard AODTS NMDS reporting counts diversion treatment episodes as the total number of episodes in which the source of referral was listed as 'diversion'. For this feature diversion report, treatment episodes are counted as follows:

- **Treatment episodes provided to non-diversion clients** include all treatment episodes provided to non-diversion clients in the collection period.
- **Treatment episodes provided to diversion clients** include all treatment episodes provided to diversion clients (police or court). Where diversion clients received multiple treatment episodes in the collection period, all episodes related to these clients are counted as 'diversion treatment episodes' regardless of the referral source. For example, if a client received 2 treatment episodes in 2021–22 and 1 of these listed 'diversion' as the referral source, both episodes are counted as diversion treatment episodes even if the second episode did not list diversion as the referral source.

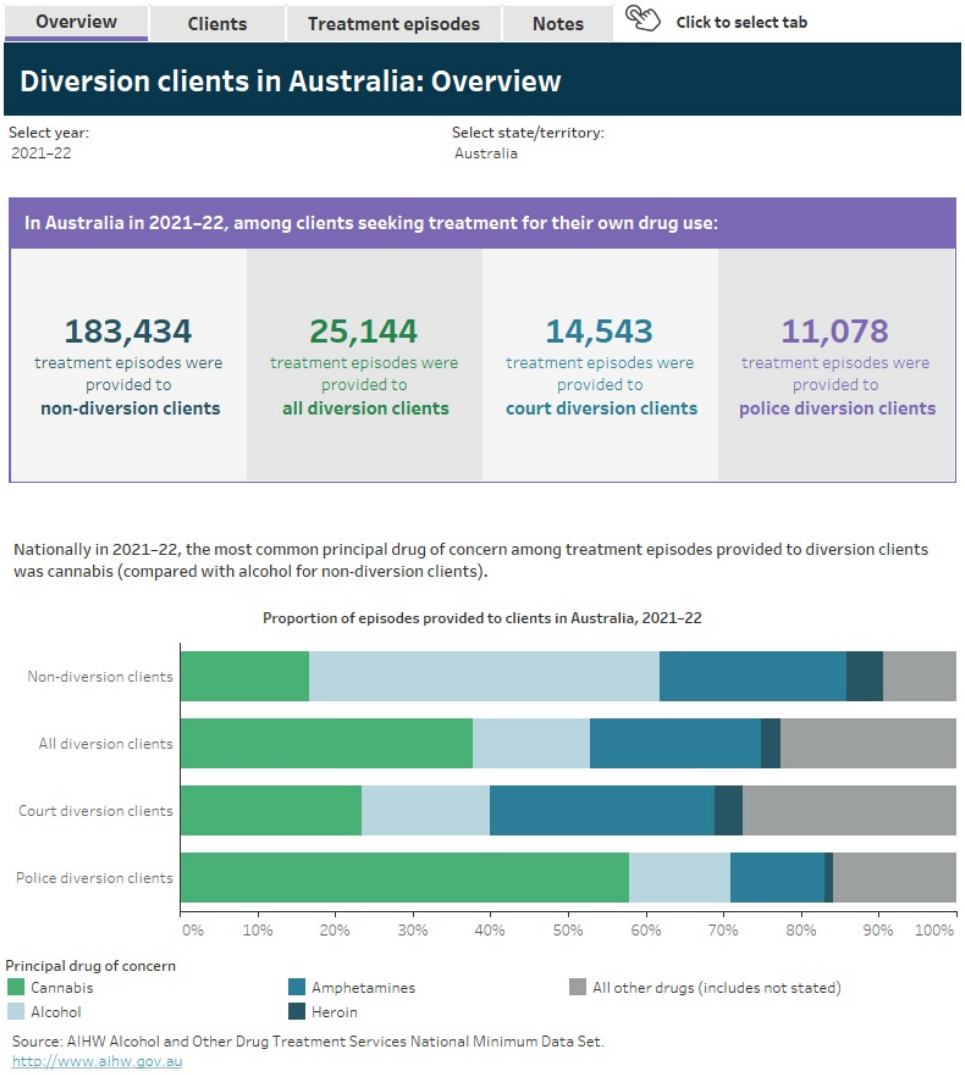
Treatment episodes in this visualisation are only included for clients with a valid SLK. The total number of treatment episodes reported is lower here than in the standard AODTS NMDS report, where all treatment episodes are counted regardless of client SLK.

The interactive data dashboard provides an overview of treatment episodes provided to diversion clients in Australia in 2021–22.

A series of tiles show that, in 2021–22, 183,434 treatment episodes were provided to non-diversion clients, 25,144 episodes were provided to all diversion clients, 14,523 episodes were provided to court diversion clients and 11,078 episodes were provided to police diversion clients.

A stacked horizontal bar graph shows that alcohol was the most common principal drug of concern (PDOC) in treatment episodes provided to non-diversion clients (45.3% of episodes), while cannabis was the most common PDOC among episodes provided to all diversion clients (37.8% of episodes). The proportion of episodes with cannabis as the PDOC was higher for police diversion clients (57.9% of episodes) than court diversion clients (23.4%).

Filters allow the user to view data by year (2017–18 to 2021–22) and by state or territory. Navigation buttons allow the user to navigate between the following tabs: Overview, Clients and Treatment episodes.



Technical notes

Technical notes

Policy framework for alcohol and other drugs and service response

On this page:

Drug use in Australia

Health impacts

The health impacts associated with alcohol and other drug (AOD) use include hospitalisation, mental health conditions, physical injury, overdose and mortality. Tobacco, alcohol and illicit drug use together account for 16.5% of the burden of disease in Australia (AIHW 2021).

Social impacts

The social impacts of AOD use in Australia include involvement in criminal activity, engagement in risky behaviours, victimisation and road trauma. In 2016, 1 in 10 (9.9%) recent drinkers and 15.1% of people who had recently used illicit drugs had driven while intoxicated (AIHW 2017). In 2019, 1 in 5 (21%) Australians aged 14 and over were victims of an alcohol-related incident and 10.5% were victims of an illicit drug-related incident (AIHW 2020).

Economic impacts

The use and misuse of licit and illicit drugs imposes a heavy financial cost on the Australian community. In recent years, the separate costs of tobacco ($136.9 billion in 2015–16), opioid ($15.76 billion in 2015–16), methamphetamine (over $5 billion in 2013–14) and alcohol use ($14.35 billion in 2010) in Australia have been estimated, utilising different methodologies (Whetton et al. 2021; Whetton et al. 2020; Whetton et al. 2019; Whetton et al. 2016).

Alcohol and tobacco are 2 of the most widely used drugs in Australia. The most recent 2019 National Drug Strategy Household Survey reported that of Australians aged 14 and over:

- 77% drank alcohol in the previous 12 months and 14.0% were current smokers (AIHW 2020).
- Around 1 in 6 (16.8%) drank at levels that increased the risk of alcohol-related harms over their lifetime (more than 2 standard drinks per day on average: NHMRC 2009), a decrease from 21% in 2001.
- 25% of people drank at levels that put them at an increased risk of accident or injury (more than 4 standard drinks in a session: NHMRC 2009) at least monthly. This is a decrease from 26% in 2016 and 30% in 2001.

In 2019, illicit drug use was relatively common among Australians aged 14 and over (AIHW 2020):

- 43% self-reported they had illicitly used a drug at some point in their life (including pharmaceuticals used for non-medical purposes) and 16.4% had done so in the last 12 months.
- Cannabis continued to be the most commonly used illicit drug with more than 1 in 3 (36%) having used it in their lifetime and 11.6% using it in the previous 12 months.
- Ecstasy and cocaine were the second and third most common illicit drugs used in a lifetime (12.5% and 11.2%, respectively) and in the last 12 months (3.0% and 4.2%, respectively).

The National Drug Strategy

Australia has had a coordinated approach to dealing with alcohol and other drugs since 1985. The National Drug Strategy (NDS) 2017–2026 is the 7th and latest iteration of the cooperative strategy between the Australian Government, state and territory governments, and the non-government sector. The NDS provides a framework that identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments – in partnership with service providers and the community – and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply, and harm reduction strategies.

The objective of the NDS

The NDS has an overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (NDSC 2017):

- **demand reduction:** to prevent the uptake and/or delay the onset of use of alcohol, tobacco, and other drugs; reduce the misuse of alcohol, tobacco, and other drugs in the community; and support people to recover from dependence through evidence-informed treatment
- **supply reduction:** to prevent, stop, disrupt, or otherwise reduce the production and supply of illegal drugs; and to control, manage, and/or regulate the availability of illegal drugs

- **harm reduction:** to reduce the adverse health, social and economic consequences of the use of drugs for consumers, their families, and the wider community.

The collection of treatment services data, for example in the AODTS NMDS, forms part of the evidence base reinforcing harm reduction actions in the strategy, which include (NDSC 2017):

- increasing access to pharmacotherapy treatment to reduce drug dependence and reduce the health, social, and economic harms to individuals and the community that arise from misuse of opioids
- monitoring emerging drug issues to provide advice to the health, law enforcement, education, and social services sectors to inform individuals and the community regarding risky behaviours
- developing and promoting culturally appropriate alcohol, tobacco, and other drug information and support resources for individuals, families, communities, and professionals in contact with people at increased risk of harm from alcohol, tobacco, and other drugs
- providing opportunities for intervention among high-prevalence or high-risk groups and locations, including the implementation of settings-based approaches to modify risk behaviours
- enhancing systems to facilitate greater diversion into health interventions from the criminal justice system, particularly for Aboriginal and Torres Strait Islander people, young people, and other at risk populations who may be experiencing disproportionate harm.

Alcohol and other drug treatment services

AOD treatment services provide support to people regarding their use of alcohol or drugs through a range of treatments. Treatment objectives can include reduction or cessation of substance use, as well as improving social and personal functioning. Treatment and assistance may also be provided to support the family and friends of people who have problems with alcohol or drug use. Treatment services include detoxification and rehabilitation, counselling, and pharmacotherapy, and are delivered in residential and non-residential settings.

In Australia, publicly funded treatment services for AOD use are available in all states and territories. Most of these services are funded by state and territory governments, while some are funded by the Australian Government. Information on publicly funded AOD treatment services in Australia, clients, and drug treatment are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS).

Other available data sources that support a more complete picture of AOD treatment in Australia include:

- the National Opioid Pharmacotherapy Statistics Annual Data collection
- the National Hospital Morbidity Database
- the Specialist Homelessness Services collection
- the National Prisoner Health Data collection.

The AODTS NMDS

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government organisations. Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed (see glossary).

Information on the following types of treatment are reported:

- assessment only
- counselling
- information and education
- pharmacotherapy
- rehabilitation
- support and case management
- withdrawal management (see glossary).

The AODTS NMDS collects data about services provided to people who are seeking assistance for their own alcohol or drug use and those seeking assistance for someone else’s alcohol or drug use.

Client information is collected at the episode level in the AODTS NMDS. Further details on the estimation of client numbers and the imputation methodology can be found in the technical notes.

Data collected by treatment agencies are forwarded to the relevant state and territory health departments, who then extract required data according the specifications in the AODTS NMDS. Data are submitted to the AIHW annually for national collation and reporting.

Coverage and data quality

Although the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government organisations, it is difficult to fully quantify the scope of AOD services in Australia.

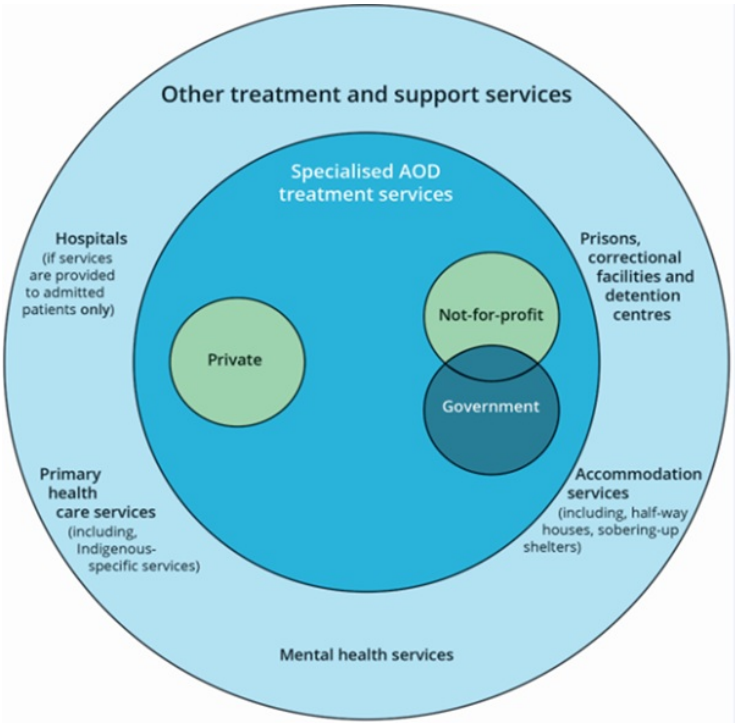
People receive treatment for alcohol and other drug-related issues in a variety of settings not in scope for the AODTS NMDS. These include:

- services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding
- alcohol and other drug treatment units in acute care or psychiatric hospitals that provide treatment only to admitted patients

- prisons, correctional facilities and detention centres
- primary health-care services, including general practitioner settings, community-based care, Indigenous Australian-specific primary health-care services and dedicated substance use services
- health promotion services (for example, needle and syringe programs)
- accommodation services (for example, halfway houses and sobering-up shelters) (Figure AODTS1).

In addition, agencies whose sole function is prescribing or providing dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. These data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection.

Figure AODTS1: Alcohol and other drug treatment and support services in Australia



Note: Those in scope for the AODTS NMDS are shaded darker blue.

The Australian Government funds primary healthcare services and substance use services specifically for Indigenous Australians. These services may be in scope for the AODTS NMDS but the majority of the services currently do not report to the NMDS. These services previously reported via the Australian Government-funded Aboriginal and Torres Strait Islander substance use services, via the Online Services Report (OSR) data collection. However, the substance use services program was transferred to the Department of Prime Minister and Cabinet and then to the National Indigenous Australian Agency. Since the cessation of the OSR data collection, the number of substance use services for Indigenous Australians in-scope and reporting to the AODTS NMDS has gradually increased.

The National Agreement on Closing the Gap noted that funding for First Nations Alcohol and Other Drugs (AOD) services and support will increase by up to $66 million to 2024–25, in addition to current funding. First Nations' AOD Treatment Services funded under the Indigenous Advancement Strategy (IAS) currently assists around 75 providers to deliver 90 activities. The Commonwealth also provides AOD treatment services and prevention, research and communication activities through the Drug and Alcohol Program (DAP) and funding to Primary Health Networks (PHNs), with nearly 30% of PHN funding allocated for First Nations specific treatment services (National Indigenous Australians Agency 2022).

In 2021–22, 95.3% (1,274) of in-scope agencies submitted data to the AODTS NMDS. Overall, from 2019–20 to 2020–21, there was a decrease of less than 1 percentage point (0.7%) in the proportion of in-scope agencies that reported to the collection. For the 2014–15 and 2015–16 reporting periods, sector reforms and system issues in some jurisdictions affected the number of in-scope agencies that reported. This led to an under-count of the number of closed treatment episodes reported for these years, so results, especially across reporting years, should be interpreted with caution.

Further details on scope, coverage and data quality are available from the AODTS NMDS 2021–22 Data Quality Statement.

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Technical notes

On this page:

For technical notes on the state and territory summaries refer to Technical notes - state and territory summaries.

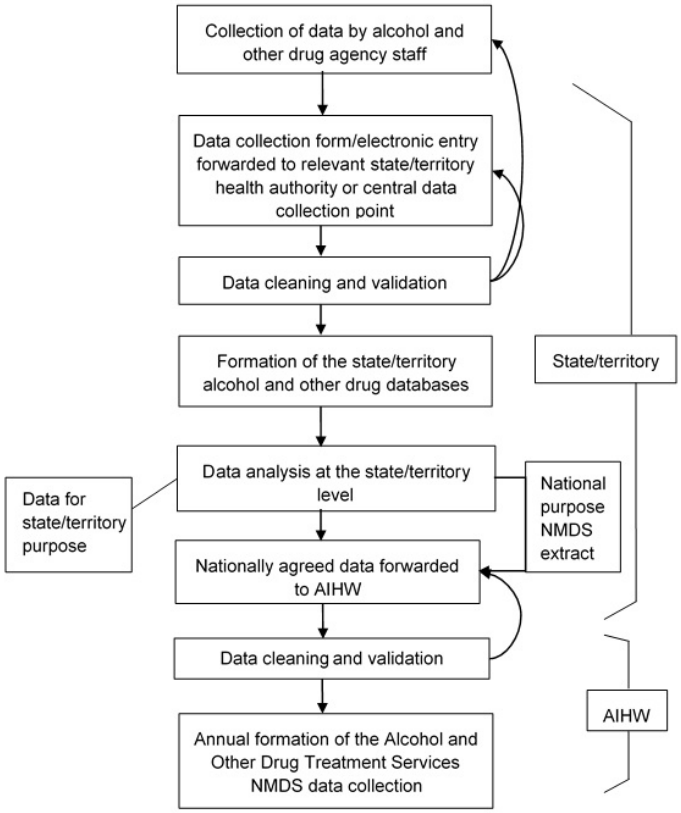
Age

Age is calculated as at the start of the episode.

Data collection process

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning and policy. Figure A1 shows the processes involved in constructing the national data.

Figure A1: Alcohol and other drug treatment data collection flowchart



Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's Australian Standard Classification of Drugs of Concern (ASCDC) (ABS 2011). In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	ASCDC codes	Category	Includes
Analgesics	1000–1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other opioids	Oxycodone, fentanyl, pethidine
		Other analgesics	Paracetamol
Sedatives and hypnotics	2000–2999	Alcohol	Ethanol, methanol and other alcohols
		Benzodiazepines	Clonazepam, diazepam and temazepam
		Other sedatives and hypnotics	Ketamine, nitrous oxide, barbiturates and kava
Stimulants and hallucinogens	3000–3999	Amphetamines	Amphetamine, dexamphetamine and methamphetamine
		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	Volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Cannabinoids	7000–7199	Cannabis	
Other	4000–6999 9000–9999	Other	Anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
Not stated	0000–0002	Not stated	

In this report, pharmaceutical drugs were grouped using 10 drug types, making up the pharmaceuticals group for the purposes of the analysis. These drugs correspond to the ASCDC codes and classifications (Table A2).

Table A2: Pharmaceutical drugs of concern, ASCDC codes and classifications

Drug category	ASCDC code	ASCDC classification (broad group and narrow group/s)	Drug description (ASCDC base level unit/s)
Codeine	1101	Analgesics Organic opiate analgesics	Codeine
Morphine	1102	Analgesics Organic opiate analgesics	Morphine

Buprenorphine	1201	Analgesics Semisynthetic opioid analgesics	Buprenorphine
Oxycodone	1203	Analgesics Semisynthetic opioid analgesics	Oxycodone
Methadone	1305	Analgesics Synthetic opioid analgesics	Methadone
Benzodiazepines	2400–2499	Sedatives and hypnotics Benzodiazepines	Benzodiazepines n.f.d., alprazolam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam, benzodiazepines n.e.c.
Steroids	4000–4999	Anabolic agents and selected hormones Anabolic androgenic steroids Beta2 agonists Peptide hormones, mimetics and analogues Other anabolic agents and selected hormones Not further defined	Anabolic agents and selected hormones n.f.d., anabolic androgenic steroids n.f.d., boldene, dehydroepiandrosterone, fluoxymesterone, mesterolone, methandriol, methenolone, nandrolone, oxandrolone, stanozolol, testosterone, anabolic androgenic steroids n.e.c., beta2 agonists n.f.d., eformoterol, fenoterol, salbutamol, beta2 agonists n.e.c., peptide hormones, mimetics and analogues n.f.d., chorionic gonadotrophin, corticotrophin, erythropoietin, growth hormone, insulin, peptide hormones, mimetics and analogues n.e.c., other anabolic agents and selected hormones n.f.d., sulfonylurea hypoglycaemic agents, tamoxifen, thyroxine, other anabolic agents and selected hormones n.e.c.
Other opioids	1100, 1199, 1200, 1299, 1300–1304, 1306–1399	Analgesics Organic opiate analgesics Semisynthetic opioid analgesics Synthetic opioid analgesics Not further defined	Organic opiate analgesics n.f.d., organic opiate analgesics n.e.c., semisynthetic opioid analgesics n.f.d., semisynthetic opioid analgesics n.e.c., synthetic opioid analgesics n.f.d., fentanyl, fentanyl analogues, levomethadyl acetate hydrochloride, meperidine analogues, pethidine, tramadol, synthetic opioid analgesics n.e.c.
Other analgesics	0005, 1000, 1400–1499	Analgesics Non-opioid analgesics Not further defined	Analgesics n.f.d., non-opioid analgesics n.f.d., acetylsalicylic acid, paracetamol, ibuprofen, non-opioid analgesics n.e.c.

Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999	Sedatives and hypnotics Anaesthetics Barbiturates Gamma-hydroxybutyrate (GHB) type drugs and analogues Other sedatives and hypnotics	Sedatives and hypnotics n.f.d., anaesthetics n.f.d., ketamine, nitrous oxide, phencyclidine, propofol, anaesthetics n.e.c., barbiturates n.f.d., amylobarbitone, methylphenobarbitone, phenobarbitone, barbiturates n.e.c., GHB-type drugs and analogues n.f.d., GHB, gamma-butyrolactone, 1,4-butanediol, GHB-type drugs and analogues n.e.c., other sedatives and hypnotics n.f.d., chlormethiazole, kava lactones, zopclone, doxylamine, promethazine, zolpidem, other sedatives and hypnotics n.e.c.

n.f.d—not further defined; n.e.c—not elsewhere classified.

Jurisdictional notes regarding principal drug of concern:

- Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This is in part due to service providers adjusting to changes in reporting practices associated with the implementation of a new data collection system in 2019–20. In 2020–21, these drugs of concern were coded as 'Other drugs of concern' (14%) to realign with previous coding practices for Victoria. Victoria is working with service providers to encourage more specific reporting of drug of concern.
- In Queensland, the proportion of cannabis episodes reported as the principal drug of concern is a result of the police and illicit drug court diversion programs operating in the state.
- South Australia reports a high proportion of treatment episodes where amphetamines are the principal drug of concern due to the SA Police Drug Diversion Initiative (PDDI). In addition, adult cannabis offences are not included in the PDDI due to the SA Cannabis Expiation Notice legislation.

Duration

Duration is calculated in whole days, and only for closed episodes.

Population rates

In this publication, crude rates were calculated using the ABS's estimated resident population at the midpoint of the data range: that is, rates for 2020–21 data were calculated using the estimated resident population at 31 December 2021.

The COVID-19 pandemic and the resulting Australian Government closure of the international border from 20 March 2020, caused significant disruptions to the usual Australian population trends. This report uses Australian Estimated Resident Population (ERP) estimates that reflect these disruptions.

In the year July 2020 to June 2021, the overall population growth was much smaller than the years prior and in particular, there was a relatively large decline in the population of Victoria. ABS reporting indicates these were primarily due to net-negative international migration (National, state and territory population, June 2021 | Australian Bureau of Statistics (abs.gov.au)).

Please be aware that this change in the usual population trends may complicate interpretation of statistics calculated from these ERPs. For example, rates and proportions may be greater than in previous years due to decreases in the denominator (population size) of some sub-populations.

Reason for cessation

The AODTS NMDS contains data on the reason an episode ended (reason for cessation). In this report, these reasons are grouped (Table A3), but data for the individual end reasons are available in the online supplementary tables.

A different method was used for grouping end reasons in reports released before 2014, so trend comparisons across reports should be made with caution. It is possible to compare data at the individual end reasons using the supplementary tables.

Table A3: Grouping of cessation reasons, by indicative outcome type

Outcome type	Reason for cessation
Expected/planned completion	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Ended due to unplanned completion	Ceased to participate against advice
	Ceased to participate without notice

	Ceased to participate due to non-compliance
Referred to another service/change in treatment mode	Change in main treatment type
	Change in delivery setting
	Change in principal drug of concern
	Transferred to another service provider
Other	Drug court or sanctioned by court diversion service
	Imprisoned (other than drug court sanctioned)
	Died
	Other
	Not stated

Remoteness area

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure 2016 (ABS 2016b) to analyse the proportion of AOD treatment agencies by remoteness area. This structure allows areas that share common characteristics of remoteness to be classified into broad geographic regions of Australia. These areas are:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Very remote*
- *Remote*

The remoteness structure divides each state and territory into several regions based on their relative access to services.

Examples of urban centres in each remoteness area are:

- *Major cities:* Canberra, Newcastle
- *Inner regional:* Hobart, Bendigo
- *Outer regional:* Cairns, Darwin
- *Remote: K*atherine, Mount Isa
- *Very remote:* Tennant Creek, Meekatharra.

For this report, the remoteness area of the agency was determined using the Statistical Area Level 2 (SA2) of the agency. Not all SA2 codes fit neatly within a single remoteness category, and a ratio is applied to reapportion each SA2 to the applicable remoteness categories. As a result, it is possible that the number of agencies in a particular remoteness category is not a whole number. After rounding, this can result in there being '<0.5%' agencies in a remoteness area, due to the agency's SA2 partially crossing into the remoteness area.

The Australian Statistical Geography Standard ASGS has replaced the Australian Standard Geographical Classification 2006 (ABS 2006), which was used in previous reports to calculate remoteness areas. Therefore, remoteness data for 2011–12 and previous years are not comparable with those for 2012–13 and subsequent years.

Service sectors

From 2008–09, agencies funded by the Department of Health under the Non-Government Organisation Treatment Grants Program (NGOTGP) were classified as non-government agencies. Before this, many of these agencies were classified as government agencies. As a result, trends in service sectors of agencies should be interpreted with caution.

Source of referral: diversion

Throughout Australia, there are programs that divert people who have been apprehended or sentenced for a minor drugs offence from the criminal justice system. Many of these diversions result in clients receiving drug treatment services, who have been referred to treatment agencies as part of a drug diversion program. Since the 1980s, Australian governments have supported programs aimed at diverting from the criminal justice system people who have been apprehended or sentenced with a minor drugs offence.

In Australia, drug diversion program come in two main forms:

- **Police diversion** occurs when an offence is first detected by a law enforcement officer. It usually applies for minor use or possession offences, often relating to cannabis, and can involve the offender being cautioned, receiving a fine and/or having to attend education or assessment sessions.
- **Court diversion** occurs after a charge is laid. It usually applies for offences where criminal behaviour was related to drug use (for example, burglary or public order offence). Bail-based programs generally involve assessment and treatment, while pre- and post-sentence programs (including drug courts) tend to involve intensive treatment and are aimed at repeat offenders.

Treatment

The number of closed treatment episodes for counselling as a main treatment type has remained the most common treatment type for all clients over all collection years. Fluctuations over time in closed treatment episodes for particular treatment types may be influenced by coding practices, increased funding or changes in treatment policies/ capacity to provide specialised alcohol and other drug treatment services, which may contribute to variation in treatment types over time.

Trends

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia*, due to data revisions.

Imputation methodology for AOD clients

From the inception of the AODTS NMDS, data have been collected only about treatment episodes provided by AOD treatment services. An SLK was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continuing to ensure the privacy of these individuals receiving treatment.

An imputation strategy for the collection was developed to correct for the impact of invalid or missing SLKs on the total number of clients. This strategy takes into account several factors relating to the number of episodes per client and makes assumptions relating to spread across agencies. It also takes into consideration the likelihood that an episode with a missing SLK relates to a client that has already been counted through other episodes with a valid SLK.

To ensure an accurate representation of the AODTS client population, imputation was applied to the 2012–13, 2013–14 and 2015–16 AODTS NMDS to account for the proportion of valid SLKs being less than 95% for these years. The national rate of valid SLKs for these years was largely affected by low proportions of valid SLKs in New South Wales.

Further information on imputation methodology for AOD clients

Attributing the number of clients to a set of records missing SLK

The AODTS NMDS collects information at the service record level. Service records are associated with individual clients through an SLK. There are a number of records that have missing or invalid SLK data that cannot be attributed to a client. This leads to an under-reporting of the total number of clients using the services, because some (but not all) of the records will belong to clients who are not observed via a valid SLK.

This document describes the method of using the available data—after making several assumptions about the behaviour of the whole population—to estimate the total number of clients.

Imputation groups

Imputation groups are formed to improve the performance of the estimates. The service records were grouped according to properties that are thought to influence the behaviour of clients and the quality of SLK data, and then the imputation was performed at this imputation group level.

Possible properties used to develop groups include location, provider size (measured by number of service records) and service type. The data are also grouped according to any subpopulations that are going to be reported upon, such as jurisdiction.

The final imputation groups were formed by balancing the often-competing priorities of having homogenous groups and the need to have groups large enough to ensure that the imputation is robust.

Assumptions and approximations

Assumption 1: randomness and independence

This imputation method assumes that whichever service provider a client attends for each incidence of service is random and independent of any other incidents of service the client may have. It is further assumed that the validity or otherwise of the SLK recorded on each service record is random, and independent of both the client and the service provider with which the record is associated.

Assumption 2: distribution of the number of service records per client

This method also assumes that the distribution of the number of records per client for all clients is similar to that observed using the subset of records with valid SLKs.

Approximation 1: no client has more than 10 service records

This imputation method uses the approximation that no client has more than 10 service records.

In order to implement this approximation, any clients observed to have more than 10 service records were treated as if they had only 10, and the proportion of clients with 10 service records calculated accordingly.

Notation

The definition of the notation used in this document is as follows:

N_t

: the (unknown) total number of clients

N_t'
: the imputed total number of clients

N_{SLK1}
: the number of clients observed using the records with a valid SLK

P_{SLK1}
: the proportion of clients with at least 1 service record with a valid SLK

P_{Ni}
: the (unknown) proportion of clients with
i
service records

P_{Ni}'
: the imputed proportion of clients with
i
service records

$P_{Ni,SLK1}$
: the proportion of clients with
i
service records as observed using records with valid SLKs

n_t
: the total number of service records

$n_t|N_t,P_{Ni}$
: the number of service records given the total number of clients and the proportions of clients with
i
service records,
i
= 1,2, ... 10

n_{SLK1}
: the number of service records with a valid SLK

n_{SLK0}
: the number of service records with an invalid SLK

p_{SLK0}
: the proportion of service records with an invalid SLK.

Methodology

Given Assumption 1 and Approximation 1, the proportion of clients who have at least 1 service record with a valid SLK is:

$$P_{SLK1} = \sum_{i=1}^{10} P_{Ni}\left(1 - p_{SLK0}^{i}\right)$$

Now:

$$N_{SLK1} = P_{SLK1} \times N_t$$

so it follows that the total number of clients is:

$$N_t = \frac{N_{SLK1}}{P_{SLK1}}$$

To resolve this equation for
N_t
the values of the
P_{Ni}
is required. These are unknown, given it is not possible to observe the whole population due to the records with invalid SLK values. This method imputes the unknown
P_{Ni}
using numerical methods, then uses these values to impute
N_t
.

The process starts with the distribution of number of records per client that were observed using the records with valid SLKs (
$P_{Ni,SLK1}$

). These values are then adjusted so that the following conditions are met.

Constraint 1

The sum of the imputed proportions is equal to 1. That is:

$$\sum_{i=1}^{10} P'_{Ni} = 1$$

Constraint 2

The imputed proportion of clients with 1 service record is less than or equal to the observed equivalent proportion among clients with records with valid SLKs. That is:

$$P'_{N1} \leq P_{N1,SLK1}$$

This constraint is used because some of the clients observed to have only 1 record will, in fact, have additional records with invalid SLKs. It is unlikely that the true proportion of clients with 1 service record is higher than that observed using records with valid SLKs.

Constraint 3

The total number of service records that the imputed total number of clients and the imputed distribution of records per client imply is equal to the observed number of service records.

That is:

$$n_t | N'_t, P'_{Ni} = N'_t \sum_{i=1}^{10} (i \times P'_{Ni}) = n_t.$$

This constraint is used to ensure that the imputed values are consistent with the observed number of records.

Penalty function

Under Assumption 2 we want to limit how much the imputed proportions differ from the proportions observed via the records with valid SLK data. To achieve this we use a penalty function that increases as the distance between the imputed and observed proportions increases. This function is defined to be:

$$f(P_{N1,SLK1}, P_{N2,SLK1}, \ldots, P_{N10,SLK1}, P'_{N1}, P'_{N2}, \ldots, P'_{N10}) = \sum_{i=1}^{10} \frac{(P'_{Ni} - P_{Ni,SLK1})^2}{P_{Ni,SLK1}}$$

Using numerical methods, the

$P'_{N1}, P'_{N2}, \ldots P'_{N10}$

are chosen such that the penalty function is minimised, subject to the 3 constraints.

The final step is to use the imputed proportions to calculate the imputed total number of clients:

$$N'_t = \frac{N_{SLK1}}{\sum_{i=1}^{10} P'_{Ni}(1 - p^i_{SLK0})}$$

The resulting number is then rounded to the nearest integer.

Discussion

This imputation technique uses available information to impute the total number of clients. The methodology takes into account the proportion of records with invalid SLK data and the distribution of the number of service records per client, as observed via the records with valid SLK data. It is apparent that the assumptions made do not hold for every client or service record. It is reasonable to expect that a client's attendance at a service provider will be affected by location and any prior contact they had with a provider. It should also be noted that some service providers failed to collect SLK for any service record during the reference period.

Despite the known cases where Assumption 1 does not hold, it is reasonable to hope that, across the population as a whole, the assumption is a reasonable representation of the populations of clients and service records.

It is believed that the impact of Approximation 1 will be small because, given Assumption 1, the chance that a client with more than 10 service records is not observed via a record with a valid SLK is extremely small. The chance diminishes as the proportion of records with an invalid SLK decreases and across jurisdictions the highest proportion observed is about 0.3. It should also be noted that the largest proportion of clients with 10 or more service records observed in the data at the jurisdiction level was only 0.007.

There are many different penalty functions that could be used in this imputation. The function used was chosen because, compared with the other penalty functions investigated, it produced imputed proportions that were generally as close or closer to the observed proportions. It also most consistently resulted in a distribution that was similar in shape to the observed distribution of the number of records per client.

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Technical notes

COVID-19

In 2021–22, restrictions related to the COVID-19 pandemic continued and impacted delivery of services including AOD treatment for withdrawal management and residential rehabilitation. The latter included closure of services for a period of time in some states. Withdrawal and rehabilitation bed-based occupancy decreased compared to pre-COVID-19 occupancy in most states. Counselling and face-to-face outreach services also moved to providing telehealth services to ensure social distancing and public health guidelines were met. The number of AOD referrals decreased and the number of admission cancellations increased for residential withdrawal and rehabilitation services. The majority of providers moved to a telehealth model and discontinued face-to-face contact with clients unless the client received withdrawal or rehabilitation services.

Summary information provided by states and territories, regarding the AODTS NMDS data collection:

New South Wales

During 2021–22, the impact of COVID has overall seen:

- services utilise telehealth, primarily telephone (metropolitan or rural and remote)
- services report an increased workload when staff on leave and also additional tasks (for example, ongoing cleaning)
- some services closed, which increased other workloads to services that still remained open with increase in referrals
- staff turnover and staff sickness impacting ability to deliver services
- some local health districts reported workforce and service delivery issues which may have impacted the number of closed episodes.

Victoria

The impact of COVID during 2021–22 included:

- bed based units were operating at reduced bed capacity during lockdowns, ensuring social distancing requirements are met. Occupancy across all residential services has fallen compared to pre-COVID as a result of social distancing requirements. Wait times between referrals and admissions have also increased due to reduced capacity. Leave and visitors have been prohibited during residential stays to decrease risk. This impacted withdrawal and rehabilitation main treatment types
- majority of providers have moved to a telehealth model, discontinuing face to face contact with clients unless they are receiving residential withdrawal and rehabilitation services
- reduced the number of referrals and increased the number of admission cancelations to residential withdrawal and rehabilitation services impacting withdrawal and rehabilitation main treatment types.

Queensland

In January 2022, there was a lockdown in Queensland and services continued to provide treatment episodes via different modes of delivery. There was a drop in appointments for the Police Drug Diversion Program, Illicit Drugs Court Diversion Program and Drug and Alcohol Assessment Referral Program (DAAR). The diversion treatment episodes (and hence AODTS interventions) also decreased between financial years, however this may be for a number of reasons (including COVID lockdown).

Western Australia

As a result of COVID-19, services offered more telehealth appointments and organisations continue to report COVID impacted service delivery. Examples include inability to recruit staff due to border restrictions, staff sickness and/or isolation periods for close contacts meant no coverage to operate at times, and staff not being vaccinated in line with government requirements. Residential services were required to close beds at times due to restrictions put in place by government which may result in less episodes at some agencies.

South Australia

During COVID-19 restrictions, a proportion of counselling services shifted from face-to-face appointments to telehealth and telephone clinical support to clients in treatment. There was also decreased bed capacity across residential services and withdrawal services reducing the amount of people accessing these services.

Tasmania

COVID-19 escalation management plan enacted to Tier 3 in quarters 3 and 4 of the 2021–22 financial year. This resulted in reduced face to face appointments on site with preference to be conducted through telehealth and phone. A slight reduction in new referrals was experienced. This reduction in consumers accessing services was common across many areas of the health system (for example, emergency departments). Inpatient withdrawal units were operating at reduced capacity for the entire 2021–22 period due to COVID-19 restrictions.

Australian Capital Territory

The ACT was in COVID-19 lockdown from August to October 2021. This lockdown slowed intake into residential withdrawal programs, which slowed admission to rehabilitation programs. Services shifted to non-contact programs (for example, face-to-face programs, including group programs, were suspended, or reconvened online or delivered by telephone or text). Staff illness and absence affected programs during

both the lockdown period and other parts of the year, requiring staff to isolate at home if unwell and to take time off work. In mid-August 2022 the ACT went into lock-down and further restrictions included restrictions impacting services.

Northern Territory

During 2021–22, COVID-safe procedures in residential rehabilitation resulted in a decrease in the number of people that could be accommodated in each facility (for example, one person per room). While different service types were impacted in different ways no service 'shut-shop' during this time. There was short-term reduction in capacity, but this eased quickly to business-as-usual once services learnt how to operate under the new COVID environments.

Policy, legislation and environmental changes

New South Wales

In 2019–20, a number of natural disasters impacted the 2019–20 NSW reporting period, including large areas of NSW experiencing unprecedented bushfires between October 2019 and March 2020, and in February 2020 some areas of NSW experienced flooding.

South Australia

South Australia reported a high proportion of episodes of treatment where amphetamines are the principal drug of concern and assessment only is the main treatment type. This is related to assessments provided under the Police Drug Diversion Initiative. This program is legislated in South Australia, unlike other jurisdictions, and therefore results in a higher percentage of assessment only services with high rates of engagement with methamphetamine users. In addition, due to the Cannabis Expiation Notice legislation in South Australia, adult simple cannabis offences are not diverted to treatment and so are excluded from the data.

The South Australian Police Drug Diversion initiative also saw a change in legislation from April 2019 [Statues Amendment (Drug Offences) Bill 2018, where youth are no longer diverted immediately for an Assessment. Adults who have been apprehended twice in four years are no longer eligible for an Assessment.

Northern Territory

As of 2018 all agencies; regardless of setting, are instructed to complete a separate assessment only episode prior to the commencement of treatment. This policy relates to monitoring the volume of assessment work performed by agencies, particularly in relation to certain alcohol-related legislatively-based programs.

Technical notes

Key terminology

Closed treatment episode

An episode of treatment for alcohol and other drugs is the period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

A treatment episode is considered closed where any of the following occurs: treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months; or there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS for a reporting year if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy (through an opioid substitution therapy program) and not receiving any other form of treatment that falls within the scope of the collection
- include only activities relating to needle and syringe exchange, or
- are for a client aged under 10.

Drugs of concern

The **principal drug of concern** is the main substance that the client stated led them to seek treatment from the AOD treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses of principal drug of concern. It is assumed that only the person using the substance themselves can accurately report principal drug of concern; therefore, these data are not collected from those who seek treatment for someone else's drug use.

Additional drugs of concern refers to any other drugs the client reports using in addition to the principal drug of concern. Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode.

All drugs of concern refers to all drugs reported by clients, including the principal drug of concern and any additional drugs of concern.

Reasons for cessation

The reasons for a client ceasing to receive a treatment episode from an AOD treatment service include:

- expected/planned completion: episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement
- ended due to unplanned completion: episodes where the client ceased to participate against advice, without notice or due to non-compliance
- referred to another service/change in treatment mode: 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.

Treatment types

Treatment type refers to the type of activity used to treat the client's alcohol or other drug problem. Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not available for clients seeking treatment for someone else's drug use. See glossary for more information on treatment types and definitions.

The **main treatment type** is the principal activity that is determined at assessment by the treatment provider to be necessary for the completion of the treatment plan for the client's alcohol or other drug problem for their principal drug of concern. One main treatment type is reported for each treatment episode. 'Assessment only', 'support and case management' and 'information and education' can be reported only as main treatment types.

In 2019–20, changes were made to categories under Main Treatment; the word 'only' was removed from support and case management and information and education. The removal of the word 'only' from support and case management and information and education, changed reporting rules for agencies; allowing agencies to be able to report and more accurately capture these items as an additional treatment in conjunction with a main treatment type.

Additional treatment types refer to other treatment types provided to the client, in addition to their main treatment type. Up to 4 additional treatment types can be reported. For example, a client may receive counselling as their main treatment and support and case management as an additional treatment. Up to four additional treatment types can be recorded for each client.

Note that Victoria and Western Australia do not supply data on additional treatment types. In these jurisdictions, each type of treatment (main or additional) results in a separate episode.

Glossary

additional drugs: Clients receiving treatment for their own drug use nominate a principal drug of concern that has led them to seek treatment and additional drugs of concern, of which up to 5 are recorded in the AODTS NMDS. Clients receiving treatment for someone else's drug use do not nominate drugs of concern.

additional treatment type: Clients receive 1 main treatment type in each episode and additional treatment types as appropriate, of which up to 4 are recorded in the AODTS NMDS.

agency: agencies included in the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) are publicly funded (at state, territory, or Australian Government level) government and non-government agencies that provide one or more specialist alcohol and other drug treatment services, whether residential or non-residential. Acute care hospitals or psychiatric hospitals are also included if they have specialist alcohol and other drug units that provide treatment to non-admitted patients (for example, outpatient services), as are Indigenous or mental health services if they provide specialist alcohol and other drug treatment.

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.

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.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGS replaced the ASGC in July 2011.

benzodiazepines: Also known as minor tranquillisers, these drugs are most commonly prescribed by doctors to relieve stress and anxiety, and to help people sleep. Common names include benzos, tranx, sleepers, downers, pills, serras (Serepax®), moggies (Mogadon®) and normies (Normison®).

client: an individual who is assessed and/or accepted for treatment for their own or someone else's alcohol or other drug use from an in-scope agency and who is aged 10 or older at the start of the treatment episode.

client type: The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person. Clients may seek treatment or assistance concerning their own alcohol and/or other drug use, or treatment and/or assistance in relation to the alcohol and/or other drug use of another person.

client counts:

Every client in the Alcohol and Other Drug Treatment Services National Minimum Dataset (AODTS NMDS) is assigned a statistical linkage key (SLK-581).

Clients are counted based on the number of SLK-581s in the AODTS NMDS.

National counts are based on the first time a client's SLK-581 appears in the AODTS NMDS. All clients are counted once.

State and territory counts are based on counting all SLK-581s for each client in the AODTS NMDS. This may result in clients being counted more than once. This is most common among clients who travel interstate for treatment. For example, clients who reside in Queanbeyan, NSW and travel to Canberra, ACT for treatment. This means that the total number of clients at the state or territory level can be greater than the national total.

This report uses both national and state and territory counts to describe trends at both national and jurisdictional levels, as well as movements between jurisdictions. For more information, refer to the supplementary table footnotes and the SLK-581 guide for use.

closed treatment episode: A period of contact between a client and a treatment provider, or team of providers. An episode is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months, when treatment is ceased (see reason for cessation) or there is a change in the main treatment type, principal drug of concern or delivery setting.

cocaine: A drug that belongs to a group of drugs known as stimulants. Cocaine is extracted from the leaves of the coca bush (*Erythroxylum coca*). Some of the common names for cocaine include C, coke, nose candy, snow, white lady, toot, Charlie, blow, white dust and stardust.

diversion client type: Clients who received at least 1 AOD treatment episode during a collection year resulting from a referral by a police or court diversion program. The 2 subtypes in this group are:

- diversion only clients—received treatment as a result of diversion referrals only
- diversion client with non-diversion episodes—received at least 1 treatment episode resulting from a diversion referral, but also received at least 1 treatment episode resulting from a non-diversion referral in a collection year.

ecstasy (MDMA): The popular street name for a range of drugs containing the substance 3, 4-methylenedioxymethamphetamine (MDMA)—a stimulant with hallucinogenic properties. Common names for ecstasy include Adam, Eve, MDMA, X, E, the X, XTC and the love drug.

GHB: stands for gamma hydroxybutyrate, which is a central nervous system depressant. Common names for GHB include, G, Grievous Bodily Harm, fantasy, liquid E, liquid ecstasy and blue nitro.

government 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.

heroin: One of a group of drugs known as opioids, which are strong painkillers with addictive properties. Heroin and other opioids are classified as depressant drugs. Common names for heroin include 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.

illicit drug use: Includes:

- the use of illegal drugs—drugs that are prohibited from manufacture, sale or possession in Australia, such as cannabis, cocaine, heroin and MDMA (ecstasy)
- misuse, non-medical or extra-medical use of pharmaceuticals—drugs that are available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse, such as opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids
- use of other psychoactive substances—legal or illegal, potentially used in a harmful way, such as kava, or inhalants such as petrol, paint or glue (but not including tobacco or alcohol).

licit drug use: The use of legal drugs in a legal manner, including tobacco smoking and alcohol consumption.

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

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

method of use for principal drug of concern: The client's usual method of administering the principal drug of concern as stated by the client. Includes: ingests, smokes, injects, sniffs (powder), inhales (vapour), other and not stated.

nicotine: The highly addictive stimulant drug in tobacco.

non-government agency: An agency that receives some government funding, but is not controlled by the government, and is directed by a group of officers or an executive committee. A non-government agency may be an income tax-exempt charity.

principal drug of concern: The main substance that the client stated led them to seek treatment from an alcohol and drug treatment agency.

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

- completed treatment—where the treatment was completed as planned
- a change in the main treatment type
- a change in the delivery setting
- a change in the principal drug of concern
- been transferred to another service provider—including where the service provider is no longer the most appropriate, and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services, or between residential services and a hospital—excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment
- ceased to participate against advice—here the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- ceased to participate without notice
- ceased to participate involuntarily—where the service provider stops the treatment due to non-compliance with the rules or conditions of the program
- ceased to participate at expiation—where the client has fulfilled their obligation to satisfy expiation requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment
- ceased to participate by mutual agreement—where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area
- been to a drug court or sanctioned by court diversion service—where the client is returned to court or jail due to non-compliance with the program
- been imprisoned (other than sanctioned by a drug court or diversion service)
- died.

The grouped categories used in the report for **reason for cessation**:

- referred to another service/change in treatment mode: 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
- ended due to planned completion: Includes episodes where the client completed treatment—ceased to participate at expiation or by mutual agreement

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

referral source: The source from which the client was transferred or referred to the alcohol and other drug treatment service.

standard drink: Contains 10 grams of alcohol (equivalent to 12.5 millilitres of alcohol). Also referred to as a full serve.

tobacco: A plant, *Nicotiana tabacum*, whose leaves are dried and used for smoking and chewing and in snuff. Its major pharmacologically active substance is the alkaloid nicotine (see nicotine).

treatment delivery setting: The main physical setting in which the type of treatment that is the principal focus of a client's alcohol and other drug treatment episode is actually delivered to a client (irrespective of whether or not this is the same as the usual location of the service provider).

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.

treatment type: The type of activity that is used to treat the client's alcohol or other drug use, which includes:

- assessment only—where only assessment is provided to the client (service providers would normally include an assessment component in all treatment types)
- counselling—can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
- information and education—where information and education is provided to the client (service providers would normally include an information and education component in all treatment types)
- pharmacotherapy—where the client receives another type of treatment in the same treatment episode and includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who experience dependence on 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 to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in several ways, including residential treatment services, therapeutic communities and community-based rehabilitation services
- support and case management—support includes helping a client who occasionally calls an agency worker for emotional support, while 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 help manage, reduce or stop the use of a drug of concern.

Technical notes

ABS	Australian Bureau of Statistics
ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
GHB	gamma hydroxybutyrate
MDMA	3, 4-methylenedioxymethamphetamine
NA	Not applicable
NDS	National Drug Strategy
NGOs	Non-Government Organisations
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
SLK	statistical linkage key
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Technical notes

General notes:

- The Australian Government commissioned Primary Health Networks (PHNs) from 1 July 2015, to provide funding for locally based AOD treatment services in line with community need. This funding is delivered through the Australian Government's *Drug and Alcohol Program,* and aims to improve the access to, and effectiveness of drug and alcohol treatment services in the community.
- Data presented in the dashboards are from all publicly funded AOD treatment services (which include PHN-commissioned services) that have reported to the AODTS NMDS.
- AOD treatment agencies funded by their PHN under the Australian Government Department of Health's Drug and Alcohol Program (DAP) submitted data to the AODTS NMDS for the first time in 2016–17.
- In these dashboards, data are presented from the 2017–18 collection year to show the trends in each PHN prior to the establishment of the boundaries.
- Financial year data from agencies include treatment episodes that ended within the period (closed treatment episodes) and excludes those that were ongoing or new (not closed) within the reporting year.

Agencies dashboard:

- The PHN of the agency was assigned based on the Statistical Area Level 2 (SA2) of the treatment agency using the Australian Bureau of Statistics' (ABS) SA2 2016 to Primary Health Network 2017 concordance file.
- As SA2 2016 boundaries may not correspond to PHN 2017 boundaries, some agencies may be captured in a neighbouring PHN including those in a neighbouring jurisdiction.

Main treatment for client dashboards:

- The PHN of the client was based on the postcode of the client using the Australian Bureau of Statistics' (ABS) Postal Area 2021 to Primary Health Network 2017 concordance file. Clients reporting an invalid postcode were assigned: 'PHN Unallocated' and removed from analysis. In 2021–22, 6,922 records contained invalid postcodes. Correspondence mappings may change over time and data may differ from what was previously published. The numbers presented here may also not correspond to those presented elsewhere based on this correspondence.
- Results with cell sizes less than 5 have been presented as '<5' (in some cases the value is null), due to this adjustment some values may not sum to the total or 100%.
- Data collection and reporting practices in Western Australia and Victoria are not directly comparable with data for other jurisdictions because every treatment type provided is reported as a separate episode.

Client demographics dashboard:

- Client numbers are based on records with a valid statistical linkage key (SLK-581).
- Client numbers are not comparable to client data published in the AODTS in Australia 2021–22 report; these dashboards present clients that attended treatment in multiple PHN locations in the collection year. The total client numbers at the PHN level are greater than the state/territory results due to finer geographic granularity of PHNs compared to the state/territory level.
- Results with cell sizes less than 5 have been presented as '<5' (in some cases the value is null), due to this adjustment some values may not sum to the total or 100%.
- Clients who lived in multiple PHN areas over the collection period are counted in each. Therefore, the total of clients is greater than the national distinct client total for 2021–22.

Principal drug of concern dashboards:

- The PHN of the client was based on the postcode of the client using the Australian Bureau of Statistics' (ABS) Postal Area 2021 to Primary Health Network 2017 concordance file. Clients reporting an invalid postcode were assigned: 'PHN Unallocated' and removed from analysis. In 2021–22, 6,393 records contained invalid postcodes. Correspondence mappings may change over time and data may differ from what was previously published. The numbers presented here may also not correspond to those presented elsewhere based on this correspondence.
- Results with cell sizes less than 5 have been presented as '<5' (in some cases the value is null), due to this adjustment some values may not sum to the total or 100%.

Jurisdiction-specific notes:

- Victoria reported comparatively high incidences of 'Not stated drugs' (15%) as the drug of concern. This is in part due to service providers adjusting to changes in reporting practices associated with the implementation of a new data collection system in 2019–20. In 2020–21, these drugs of concern were coded as 'Other drugs of concern' (14%) to realign with previous coding practices for Victoria. Victoria is working with service providers to encourage more specific reporting of drug of concern.
- In Queensland, the level of cannabis reported as the principal drug of concern is a result of police and illicit drug court diversion programs operating in the state.

- South Australia reports a high proportion of treatment episodes where amphetamines are the principal drug of concern due to the SA Police Drug Diversion Initiative (PDDI). In addition, adult cannabis offences are not included in the PDDI due to the SA Cannabis Expiation Notice legislation.

Technical notes

AODTS NMDS

The AODTS NMDS visualisations are based on episode data reported during the 2021–22 collection cycle, and contains information on treatment provided to clients by publicly funded AOD treatment services. Only episodes where pharmacotherapy was an additional treatment, or a main treatment with an additional treatment provided are included in the AODTS NMDS. Episodes where pharmacotherapy and no additional treatment was provided are excluded.

NOPSAD collection

The NOPSAD Collection visualisations are based on client data reported on a snapshot day in June 2022. This collection contains information on clients receiving opioid pharmacotherapy treatment, prescribers of opioid drugs and the dosing points that clients attend to receive their medication.

Data

Report editions

This release

Alcohol and other drug treatment services in Australia annual report | 21 Jun 2023

Previous releases

- Alcohol and other drug treatment services in Australia 2018–19 | **Publication** | 26 Jun 2020
- Alcohol and other drug treatment services in Australia 2017–18 | **Publication** | 25 Jul 2019
- Alcohol and other drug treatment services in Australia 2016–17 | **Publication** | 22 Jun 2018
- Alcohol and other drug treatment services in Australia 2015–16 | **Publication** | 28 Jun 2017
- Alcohol and other drug treatment services in Australia 2014–15 | **Publication** | 15 Jun 2016
- Alcohol and other drug treatment services in Australia 2013–14 | **Publication** | 18 Jun 2015
- Alcohol and other drug treatment services in Australia 2012-13 | **Publication** | 12 Aug 2014
- Alcohol and other drug treatment services in Australia 2011-12 | **Publication** | 28 Aug 2013
- Alcohol and other drug treatment services in Australia 2010-11: report on the National Minimum Data Set | **Publication** | 16 Nov 2012

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