Australian Government
Australian Institute of Health and Welfare

Alcohol and other drug treatment services in Australia: early insights

Web report | Last updated: **14 Apr 2023** | Topic: Alcohol & other drug treatment services

About

Alcohol and other drug treatment services in Australia: early insights presents key statistics about Australia's publicly funded alcohol and other drug treatment services and their clients. *Early insights* is a companion report to the data and analysis presented in *Alcohol and other drug treatment services in Australia: annual report*.

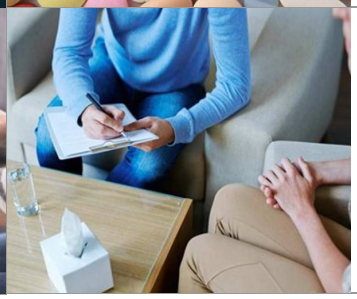
Cat. no: HSE 242

- Data cubes
- Archived content
- Related material

Findings from this report:

- Of the 228,500 AOD treatment episodes provided, counselling was the most common treatment type (36%).
- Alcohol remains the most common principal drug of concern for which clients sought treatment.
- Around 131,000 clients sought AOD treatment in 2021–22.
- 1,274 publicly funded alcohol and other drug treatment agencies provided treatment services to clients in 2021–22.

Summary

The 4 most common drugs clients sought treatment for were alcohol, amphetamines, cannabis and heroin in 2021–22.			1,274 publicly funded alcohol and other drug treatment agencies provided treatment services to clients in 2021–22.
Around 131,000 clients sought AOD treatment in 2021–22.			Counselling was the most common AOD treatment type, accounting for over 1 in 3 (36%) treatment episodes in 2021–22.

Alcohol and other drug (AOD) treatment agencies across Australia provide a range of services and support to people receiving treatment for their own drug use, as well as for their families and friends. These key findings present high-level information for 2021–22 about publicly funded AOD treatment services, the people they treated, and the treatment provided.

Summary

On this page:

Who provides publicly funded alcohol and other drug treatment services?

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. Treatment services are delivered in 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 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.

In 2021–22, 1,274 publicly funded alcohol and other drug treatment agencies provided services in Australia.

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 (Figure AODTSAGENCIES.1).

Over the last 10 years, there have been increases in the total number of AOD treatment agencies (from 714 in 2012–13 to 1,274 in 2021–22). See the Alcohol and other drug treatment services NMDS Data Quality Statement, 2021–22 for further information.

Service sector

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 (Figure AODTSAGENCIES.1).

Figure AODTSAGENCIES.1: Treatment agencies, by sector and state and territory, 2012–13 to 2021–22

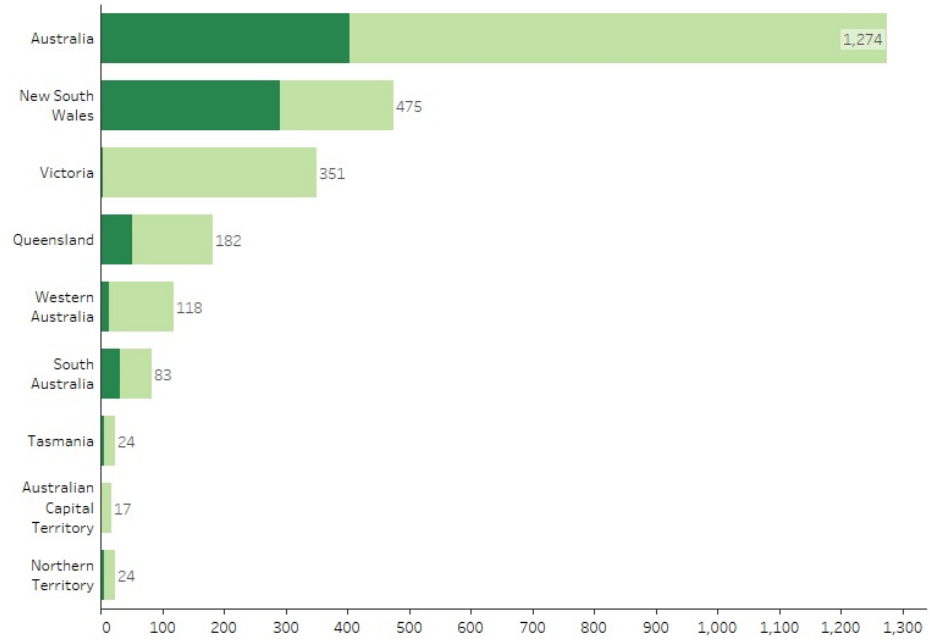
The horizontal bar chart shows the number and proportion of alcohol and other drug treatment agencies by sector (government and non-government) and state and territory.

In 2021–22, Australia had 1,274 agencies; New South Wales had 475 agencies; Victoria had 351 agencies; Queensland had 182 agencies; Western Australia had 118 agencies; South Australia had 83 agencies; the Australian Capital Territory had 17 agencies; Tasmania had 24 agencies and the Northern Territory had 24 agencies.

Nationally in 2021–22, over 2 in 3 (68.4%) AOD treatment agencies were non-government. Across states and territories, the proportion of non-government AOD agencies ranged from 38.7% of agencies in New South Wales to 99.1% of agencies in Victoria.

Select year:
2021-22

Select measure:
(•) Number of agencies
( ) Per cent



Sector (click to highlight):
Government Non-government

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

See notes >

Summary

On this page:

Who uses alcohol and other drug treatment services?

Around 131,000 people received publicly funded treatment or support for alcohol and other drug use.

Alcohol and other drug (AOD) treatment agencies across Australia provide a range of services and support to people receiving treatment for their own drug use, as well as for their families and friends.

Profile of clients

In 2021–22, among people receiving alcohol and other drug treatment:

- Publicly funded AOD treatment services provided treatment to about 131,000 clients across Australia.
- 3 in 5 people (60%) who received treatment or support for alcohol or drug use were male.
- Of the 93% of clients receiving treatment for their own alcohol or drug use, over half were aged 20–39 (52%) and over 3 in 5 people (62%) were male.
- Of the remaining 6.8% of clients who sought support for someone else's drug use, nearly half were aged 30–49 (47%) and over 2 in 5 clients were female (45%).
- Less than one percent (0.8%) of all clients reported a sex of 'Other', which includes people who reported sex as indeterminate, intersex or non-binary. The 2018–19 collection included 'Other' as a value for the client's sex for the first time (Figure AODTS CLIENTS.1).

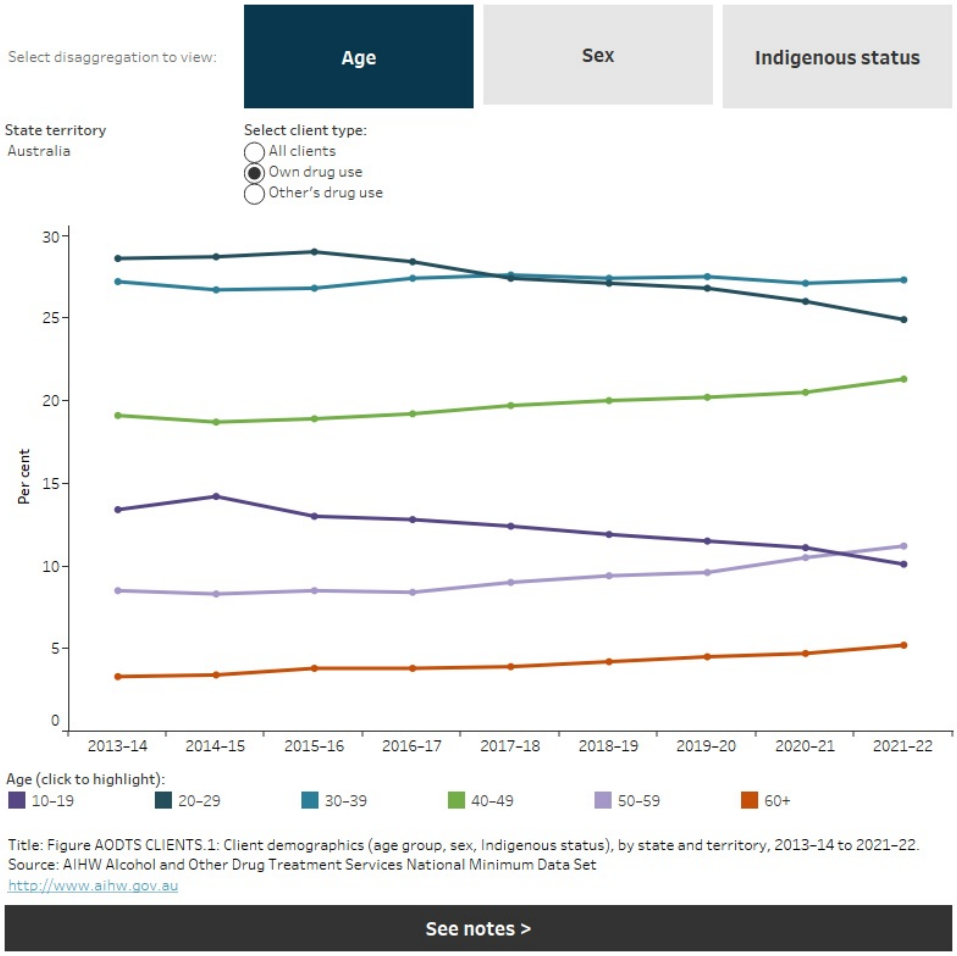
Note that data may have been impacted by continued COVID–19 restrictions in some states and territories which included changes to modes of treatment delivery. See How has COVID-19 impacted on alcohol and other drug treatment services? for further information.

Figure AODTS CLIENTS.1: Client demographics (age group, sex, Indigenous status), by state and territory, 2013-14 to 2021-22

The line graph shows proportions of clients receiving treatment from alcohol and drug treatment services by age group and client type. Nationally, the distribution of clients by age group has remained consistent from 2013–14 to 2021–22. In 2021–22, 10.1% of clients receiving treatment for their own drug use were aged 10–19, 24.6% were aged 20–29, 27.2% were aged 30–39, 21.3% were aged 40–49, 11.5% were aged 50–59 and 5.5% were aged over 60.

The first horizontal stacked bar graph shows proportions of clients receiving treatment from alcohol and drug treatment services by sex and client type. In 2021–22, 61.9% of clients receiving treatment for their own drug use were male, 35.0% were female and 3.2% were another sex or not stated. Among clients receiving treatment for other's drug use, 38.7% were male, 45.4% were female and 15.9% were another sex or not stated. Among all clients, 60.3% of clients were male, 35.7% of clients were female and 4.0% were another sex or not stated.

The second horizontal stacked bar graph shows proportions of clients receiving treatment from alcohol and drug treatment services by Indigenous status and client type. In 2021–22, 18.4% of clients receiving treatment for their own drug use were Indigenous, 78.7% were non-Indigenous and 2.9% were not stated. Among clients receiving treatment for other's drug use, 9.4% were Indigenous, 84.5% were non-Indigenous and 6.1% were not stated. Among all clients, 17.8% of clients were Indigenous, 79.1% of clients were non-Indigenous and 3.1% were not stated.



Indigenous Australians

In 2021–22, Indigenous Australians accounted for 18% (23,169) of people aged 10 and over receiving treatment or support for their own or someone else's alcohol or other drug use (Figure AODTS CLIENTS.1):

- One in 6 Indigenous Australian clients (22,338 or 18%) received treatment for their own alcohol or drug use.
- Around 1 in 10 (831 or 9.4%) Indigenous Australian clients received treatment for someone else's alcohol or drug use.
- Indigenous Australians were nearly 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 population compared with 497) (age standardised rate ratio for clients aged 10 and over).

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.

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).

Client trends

The number of people aged 10 and over receiving alcohol and other drug treatment rose by 14% from 2013–14 to 2021–22.

Over the past 9 years, the number of people treated by publicly funded alcohol and other drug treatment agencies increased by 14% between 2013–14 (114,436) and 2021–22 (130,525).

The number of clients in treatment represents 564 per 100,000 people in 2013–14, rising to 576 per 100,000 people in 2021–22 (Figure AODTS CLIENTS.2).

Between 2020–21 and 2021–22 the number of clients decreased by 6% (from 139,271 to 130,525). Factors contributing to this decrease include:

- Impacts on service delivery due to COVID-19 including, border restrictions, staff sickness/isolation periods, staff vacancies, staff turnover, staff reallocation to manage health service responses to COVID-19, residential services required to close beds or reduce bed based occupancy at times due to health restrictions or reassignment.
- And general 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).

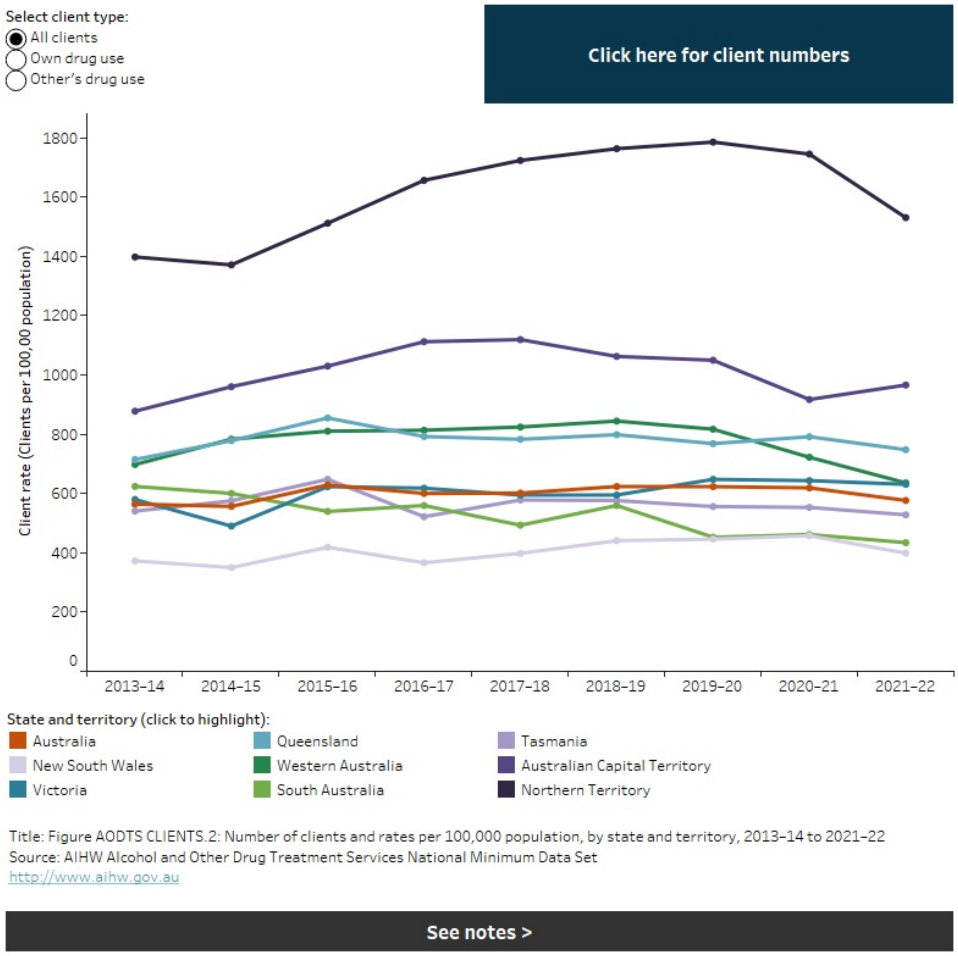
Figure AODTS CLIENTS.2: Number of clients and rates per 100,000, by state and territory, 2013-14 to 2021-22

The line chart shows client rates per 100,000 population by state and territory and client type.

Client rates for alcohol and/or drug use in Australia fluctuated from 564 clients per 100,000 population in 2013–14 to 576 clients per 100,000 population in 2021–22. Rates in each state in 2021–22 were: 399 clients per 100,000 population in New South Wales; 631 clients per 100,000 population in Victoria; 748 clients per 100,000 population in Queensland; 636 clients per 100,000 population in Western Australia; 434 clients per 100,000 population in South Australia; 528 clients per 100,000 population in Tasmania; 966 clients per 100,000 population in the Australian Capital Territory; and 1,530 clients per 100,000 population in the Northern Territory.

A filter allows the user to view by rate of clients and number of clients.

The second line chart shows client numbers for alcohol and/or drug use in Australia. There were 130,525 clients in 2021–22, an increase from 114,436 clients in 2013–14. Across the period 2013–14 to 2021–22, the number of clients was highest in the Victoria (36,375 clients in 2021–22) and lowest in Tasmania (2,684 clients in 2021–22).



Title: Figure AODTS CLIENTS.2: Number of clients and rates per 100,000 population, by state and territory, 2013–14 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
http://www.aihw.gov.au

See notes >

References

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

Summary

On this page:

What drugs do people seek treatment for?

People may seek AOD treatment services when experiencing problematic use with one or more drugs. Most people have one drug that is of greater concern for them, and their treatment will typically focus on this drug; this is referred to as the principal drug of concern. Clients who use more than one drug can also report additional drugs of concern.

Principal drug of concern

The most common principal drug of concern that led people to seek treatment was alcohol.

For people who received treatment for their own alcohol or drug use in 2021–22:

- Over 2 in 5 (42%) treatment episodes were for alcohol, followed by amphetamines (24%), cannabis (19%) and heroin (4.5%). This pattern was similar for both males and females, and Indigenous Australians (Figure AODTS PDOC.1).
- Where amphetamines (49,694 episodes) was reported as a principal drug of concern in 2021–22, 4 in 5 (80%) treatment episodes were for methamphetamines.

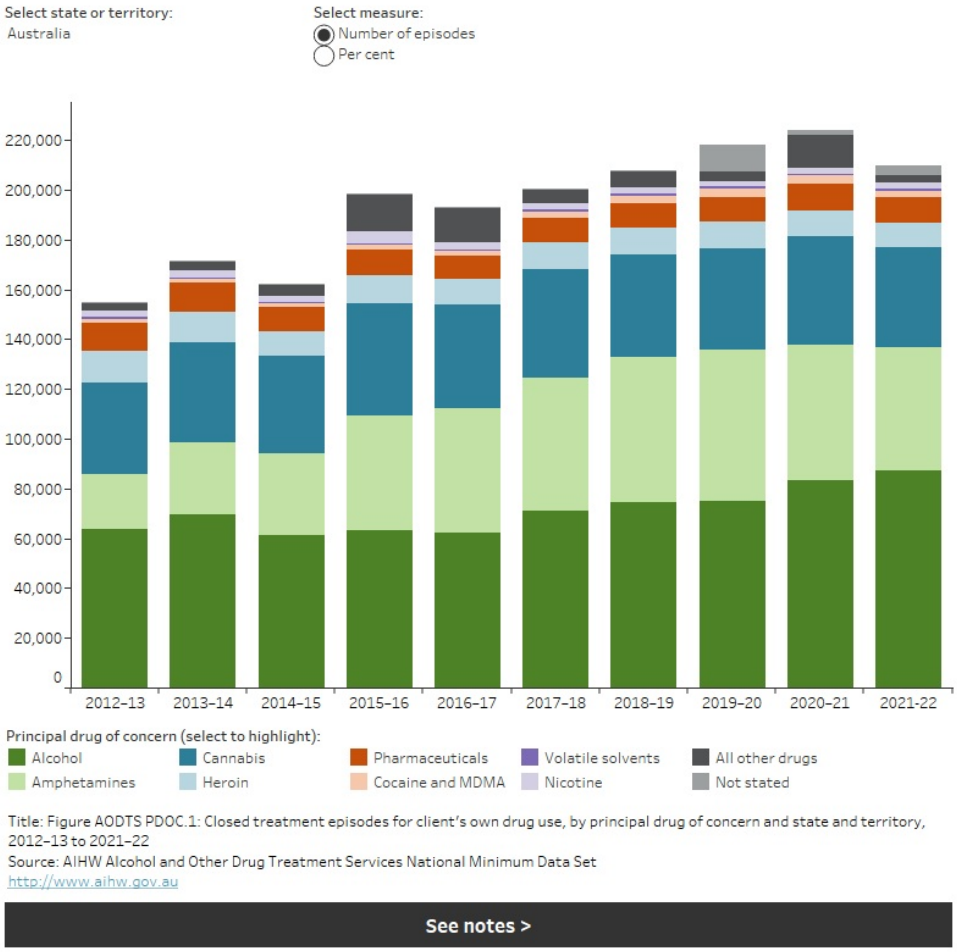
There was variation across age groups in the most common principal drugs of concern:

- Alcohol was the most common principal drug of concern for older clients. Alcohol was the principal drug of concern for 49% of those aged 40–49; 64% of those aged 50–59; and 77% of people aged 60 and over.
- Cannabis was the most common principal drug of concern treated in young people, with 3 in 5 people aged 10–19 (61% of treatment episodes) receiving treatment for cannabis.
- Amphetamines was the most common principal drug of concern for 1 in 3 people aged 30–39 (33%) and 1 in 4 aged 20–29 (25%).

Figure AODTS PDOC.1: Closed treatment episodes for client's own drug use, by principal drug of concern and state and territory, 2012–13 to 2021–22

The stacked bar graph shows the closed treatment episodes for clients' own drug use by principal drug of concern and state and territory, from 2012–13 to 2021–22. Between 2012–13 and 2021–22, the number of treatment episodes increased from 155,151 episodes in 2012–13 to 209,953 episodes in 2021–22.

The four most common drugs of concern have remained consistent through this period. In 2021–22, 87,334 (41.6%) of closed treatment episodes had alcohol as the principal drug of concern (slightly increasing from 63,755; 41.1% in 2012–13); 49,694 (23.7%) of episodes had amphetamines (more than doubling from 22,265; 14.4% in 2012–13); 40,210 (19.2%) of episodes had cannabis (increasing from 36,560; 23.6% in 2012–13); and 9,396 (4.5%) had heroin (falling from 12,817; 8.3% in 2012–13).



Methamphetamines

Methamphetamines as a principal drug of concern (coded within amphetamines) has been relatively stable at around 4 in 5 treatment episodes in this amphetamines group over the past 3 years; 2019–20 (78% or 47,599 episodes), 2020–21 (79% or 42,659 episodes), and 2021–22 (80% or 39,912 episodes) (Figure AODTS PDOC.2).

Over the last 10 years, treatment episodes for amphetamines and amphetamines *not further defined* decreased as coding practices improved in reporting treatment for methamphetamines. The rise in reported episodes for methamphetamines can be attributed to a range of factors including improvements in agency coding, treatment system updates and increases in funded treatment services.

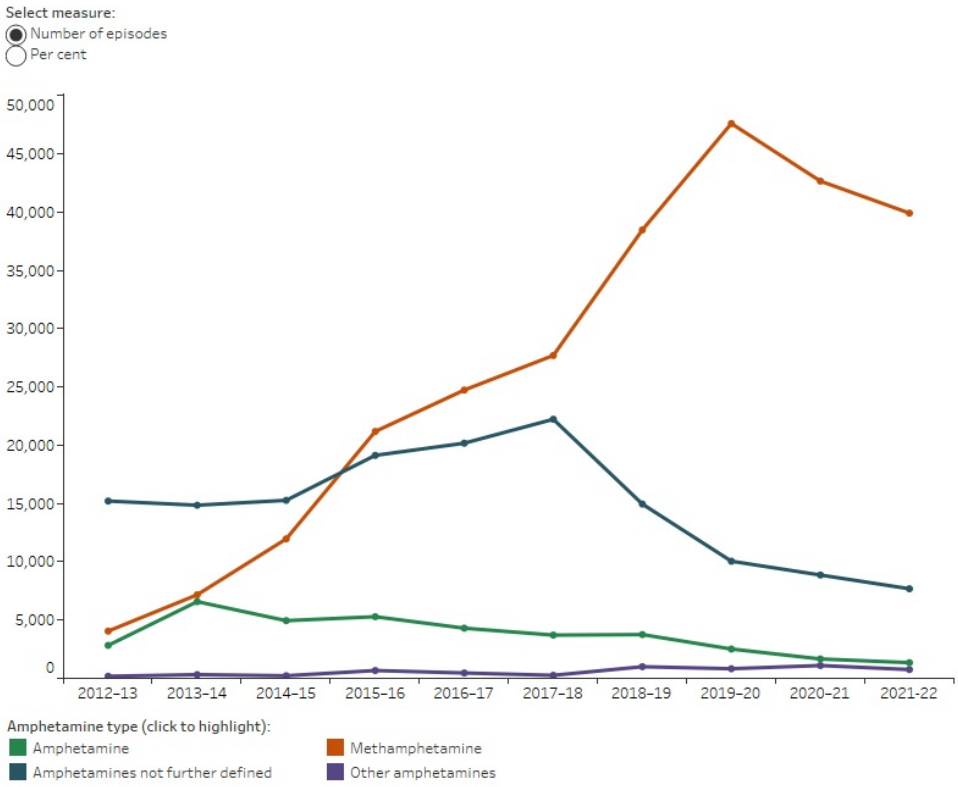
Figure AODTS PDOC.2: Closed treatment episodes for client's own drug use for Amphetamines, by (ASCDC) codes, 2012-13 to 2021-22

The line graph shows that, among closed treatment episodes for client's own drug use for amphetamines, methamphetamines have been the most common drug of concern since 2012–13. In 2021–22, there were 39,912 (80.3%) episodes with methamphetamines as a principal drug of concern, a large increase from 4,050 (18.2%) episodes in 2012-13.

The number and proportion of episodes with amphetamines not further defined has fallen from 15,210 episodes (68.3%) in 2012–13 to 7,685 episodes (15.5%) in 2021–22.

The number and proportion of episodes with amphetamine has fluctuated, peaking in 2013–14 (6,579 episodes or 22.7%) and falling to 1,345 episodes (2.7%) in 2021–22.

The number and proportion of episodes with other amphetamines has increased from 177 episodes in 2012–13 (0.8%) to 752 episodes in 2021–22 (1.5%).



Title: Figure AODTS PDOC.2: Closed treatment episodes for client's own drug use for Amphetamines, by ASCDC codes, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
http://www.aihw.gov.au

See notes >

Summary

On this page:

What treatments do people receive?

Many types of treatment are available in Australia to assist people experiencing problematic drug use, aiming to reduce the harm of drug use through services such as counselling or education. Additionally, some treatments use abstinence-oriented interventions to aid in short-term cessation or reduction of heavy and/or prolonged alcohol or other drug use, to assist clients in developing skills to facilitate substance-free lifestyles.

In 2021–22:

- A total of 228,451 treatment episodes were provided to people for their own or someone else's alcohol or drug use.
- Clients received an average of 1.8 treatment episodes nationally.
- Treatment episodes increased by 41% since 2012–13 (from 162,362) but decreased by 6.0% from the previous year (242,980 in 2020–21).

What are the treatment types?

Counselling continues to be the most common treatment provided.

In 2021–22:

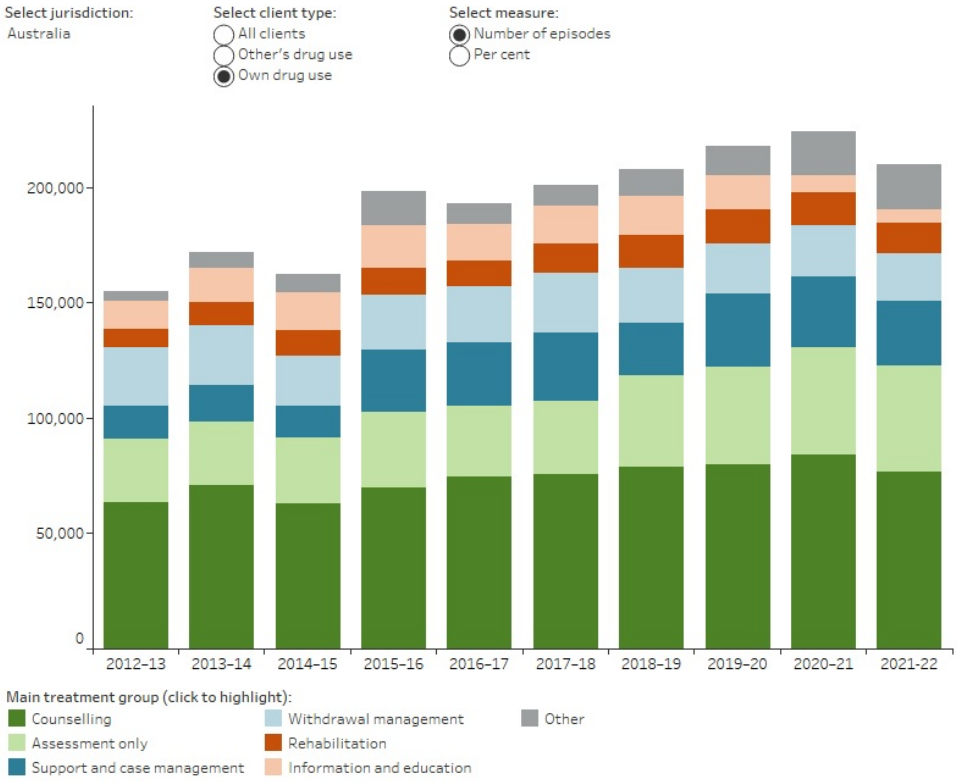
- Counselling continued to be the most common main treatment type, comprising of over 1 in 3 (36%) of all treatment episodes, followed by Assessment only (21%) and support and case management (15%).
- Among people who sought support for their own drug or alcohol use, just under 2 in 5 (37%) received counselling as their main treatment and 1 in 5 received an assessment only (22%).
- Among people who sought support for someone else's drug use, under 2 in 5 (39%) received support and case management and over 1 in 3 (36%) received counselling as their main treatment (Figure TREATMENTCLIENTS.1).

Figure TREATMENTCLIENTS.1: Closed treatment episodes, by main treatment type, client type and state and territory, 2012–13 to 2021–22

The stacked bar graph shows the closed treatment episodes for clients' own drug use by main treatment type, client type and state and territory, from 2012–13 to 2021–22. Counselling has remained the most common treatment type in Australia in this time, with counselling being provided in 76,731 episodes (36.5%) for clients' own drug use and 6,613 episodes (35.7%) for others' drug use in 2021–22.

Among clients seeking treatment for their own drug use in Australia in 2021–22, assessment only (46,145 episodes, 22.0%), support and case management (28,064 episodes, 13.4%) and withdrawal management (20,509 episodes, 9.8%) were the next most common treatment types.

Among clients seeking treatment for their other's drug use in Australia in 2021–22, support and case management (7,287 episodes, 39.4%), assessment only (1,517 episodes, 8.2%) and information and education (512 episodes, 2.8%) were the next most common treatment types.



Title: Figure TREATMENTCLIENTS.1: Closed treatment episodes, by main treatment type, client type and state and territory, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
http://www.aihw.gov.au

See notes >

Treatment delivery setting

Over 2 in 3 treatment episodes were provided in a non-residential treatment setting.

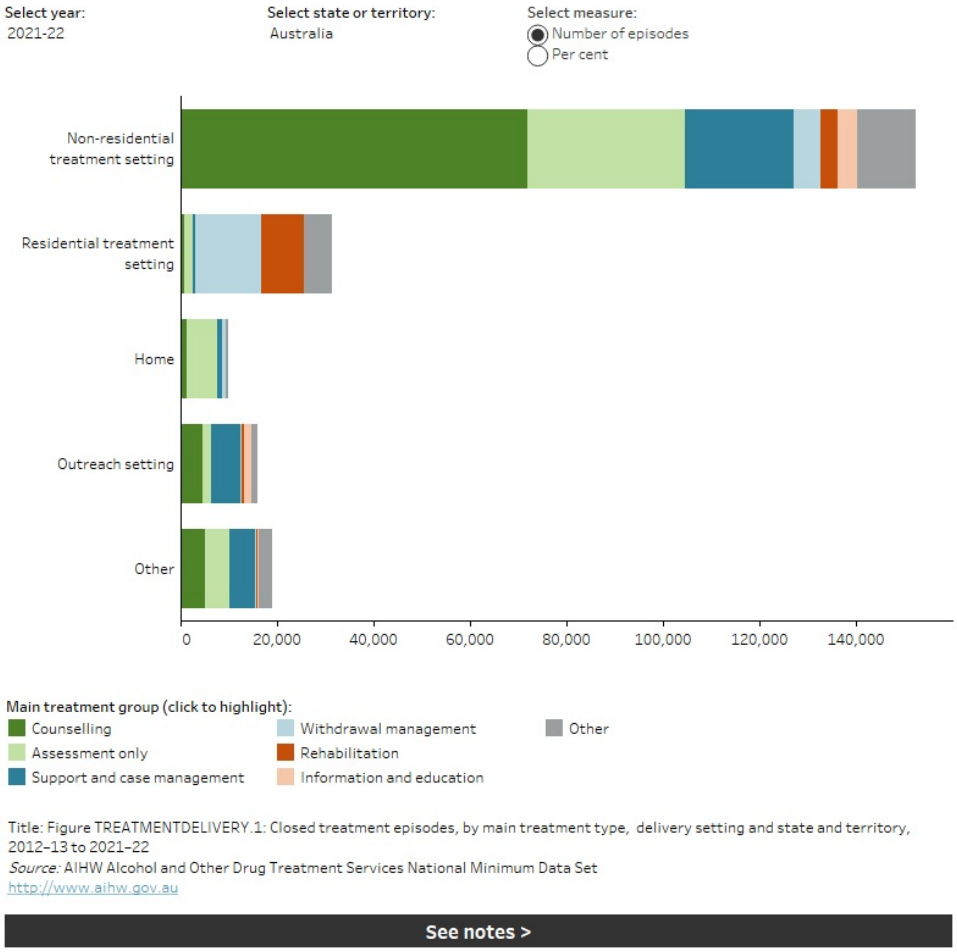
Nationally, in 2021–22:

- Around 2 in 3 treatment episodes were provided in a non-residential treatment setting (67% of episodes), such as community-based Non-Government Organisations (NGOs) and hospital outpatient services.
- The next most common settings were residential treatment settings (14%), which allow clients to stay in a facility that is not their home or usual place of residence, other (8.4%) and outreach settings (6.9%) (such as mobile/outreach alcohol and other drug treatment service providers) (Figure TREATMENTDELIVERY.1).

Figure TREATMENTDELIVERY.1: Closed treatment episodes, by main treatment type, delivery setting and state and territory, 2012-13 to 2021-22

The horizontal stacked bar graph shows the number of closed treatment episodes by main treatment type, delivery setting and state and territory. Most treatment episodes were delivered in non-residential treatment settings.

In 2021–22, the most common treatments by setting in Australia were: counselling (71,953 episodes, 47.2%) in non-residential settings; withdrawal management (13,714 episodes, 43.7%) was most common in residential settings; assessment only (6,355 episodes, 64.8%) in home settings; counselling (4,591 episodes, 28.9%) in outreach settings; and support and case management (5,315 episodes, 27.8%) in other settings.



Length of treatment

Clients whose principal drug of concern was amphetamines spent one of the longest periods in treatment, with a median duration of 36 days.

In 2021–22, the median treatment duration across all treatment episodes was over 4 weeks (29 days). The duration of treatment episodes varied by main treatment type and principal drug of concern:

- Among all clients, the median duration was 71 days for clients receiving counselling.
- For people who sought support for their own drug or alcohol use, the median duration was 42 days for rehabilitation, 38 days for support and case management, 8 days for withdrawal management, and 3 days for assessment only.
- Among the four most common principal drugs of concern, median treatment duration was longest for amphetamines (36 days), followed by heroin (30 days), alcohol (29 days) and cannabis (26 days).

What are the common reasons for ceasing treatment?

In 2021–22, almost 3 in 5 (58%) of all treatment episodes ended in a planned or expected completion, and 1 in 5 (20%) treatment episodes ended due to an unplanned completion (Figure REASONCESSATION.1).

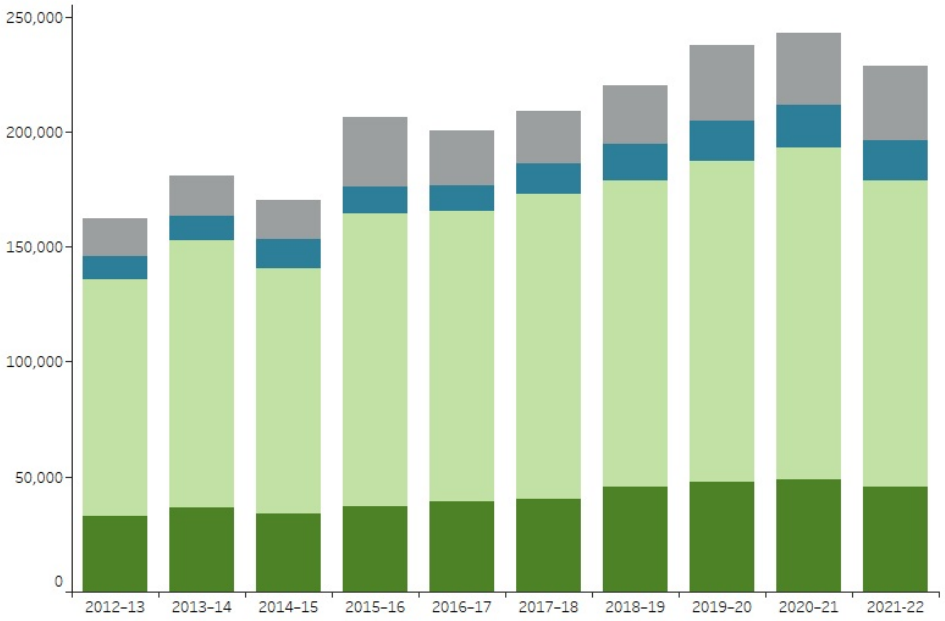
Figure REASONCESSATION.1: Closed treatment episodes, by reason for cessation and main treatment, 2012–13 to 2021–22

The stacked bar graph shows closed treatment episodes, by reason for cessation and main treatment, 2012–13 to 2021–22. Expected/planned completion has consistently remained the most common reason for cessation for all treatments in this time, increasing from 103,018 episodes (63.4%) in 2012–13 to 132,833 episodes (58.1%) in 2021–22.

Ending due to unplanned completion has remained the next most common reason for cessation for all treatments, increasing from 32,990 episodes (20.3%) in 2012–13 to 45,872 episodes (20.1%) in 2021–22.

Select treatment group:
All treatments

Select measure:
(•) Number of episodes
( ) Per cent



End reason (click to highlight):
- Ended due to unplanned completion
- Expected/planned completion
- Referred to another service/change in treatment mode
- Other

Title: Figure REASONCESSATION.1: Closed treatment episodes, by reason for cessation and main treatment, 2012–13 to 2021–22
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
http://www.aihw.gov.au

See notes >

Data cubes

On this page:

About the cubes

A data cube is a multidimensional representation of the data set. It allows the user to select, filter and arrange aggregated data by variables of interest using drag and drop functionality. Data generated from the cubes can be exported into Excel for data analysis and reporting.

Period covered

The cubes cover the period 2003–04 to 2021–22.

Counting unit

The counting unit is a 'closed treatment episode'. A closed treatment episode refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. As a unit of measurement, the 'closed treatment episode' used in the AODTS NMDS does not provide information on the number of clients who access publicly funded alcohol and other drug treatment, nor can it provide information on the extent of concurrent, sequential or recurrent service use.

Data items included in the data cubes

For a full list of the AODTS NMDS 2019–20 data items, and metadata about those items, download AODTS cube metadata.

Exclusions to the collection

- Agencies whose sole activity is to prescribe and/or dose for opioid pharmacotherapy maintenance treatment such as methadone.
- Halfway houses and sobering-up shelters, correctional institutions, health promotion services (for example, needle and syringe exchange programs).
- Alcohol and drug treatment units in acute care or psychiatric hospitals that only provide treatment to admitted patients.
- Private treatment agencies that do not receive government funding.

It should also be noted that:

- The number of Aboriginal and Torres Strait Islander (First Nations) clients may be under-estimated as most Australian Government funded First Nations substance-use services and health services that provide specialised treatment for alcohol and other drug use do not supply data under the AODTS NMDS. In addition, at the national level, a low percentage of clients did not state their Indigenous status (approximately 5% of all closed treatment episodes over time, ranging from 8,000 to 13,600 episodes over 10 years).
- On their own, the data do not provide measures of the incidence or prevalence of non-prescribed use of, or dependence on, alcohol or other drugs in the community. This is because not all persons who have alcohol or other drug dependence seek treatment, or they may seek treatment from non-publicly funded services.
- For remoteness area, components may not sum to number of treatment agencies as some treatment agencies are distributed among more than one remoteness area; in these cases, the largest ratio of the agency area is allocated to the remoteness area.
- 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 details.
- 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 that is related to the funding source for that program/service. Some agencies chose to split their data according to the funding source. For example, state funded service episodes are reported to the relevant state or territory department and the Commonwealth funded service episodes are separated and reported to a peak body or directly to the AIHW. This has resulted in some services being counted as two separate agencies over time. The revision was applied to all time-series, with AOD service counts from 2014–15 to 2017–18 affected.

Additional information

Across all years, the following data items in the cubes have been collapsed for confidentiality reasons:

- *Method of use* for principal drug of concern – Injects data has been collapsed into the *Other* category.

- *Source of referral* for treatment – corrections, police and court diversion data have been collapsed into the *Other* category.
- *Reason for cessation* of treatment – drug court, imprisoned and died have been collapsed into the *Other* category.

How do I use the cubes?

Data cubes allow the user to quickly select, filter and arrange aggregated data by variables of interest using the drag and drop functionality. Data generated from these cubes can be exported into Excel for data analysis and reporting.

When a data cube is opened, default dimensions are shown. To view other dimensions, right-click on the dimension to be replaced, and then select the 'Change' item. For example, to replace sex with country of birth right-click on sex and select 'Change Sex to'. Then select 'Country of birth' from the list.

If you wish to collate totals and present percentages, right-click on the table icon, where the data is displayed. This provides additional options for filtering the data. To hide dimensions right-click on the dimension name and select the 'Hide' menu item.

How do I export data from cubes?

The data can be exported to either to Excel or Word. Right-click the table area and select 'Export table' from the menu. Choose the number of rows you wish to export, and select either Excel or Word as your preference, or save as a tab or comma separated file. Name the file and save it in your preferred location.

Technical notes

Technical notes

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 16.1% 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 ($66.8 billion in 2017–18) 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 two 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). The AODTS NMDS is one of several NMDSs that collect data under the 2012 National Healthcare Agreement to inform policy and help improve service delivery (COAG 2012).

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 Key terminology and 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 Key terminology and 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 data and methods.

Data collected by treatment agencies are forwarded to the relevant state and territory health departments, who then extract required data according to 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.

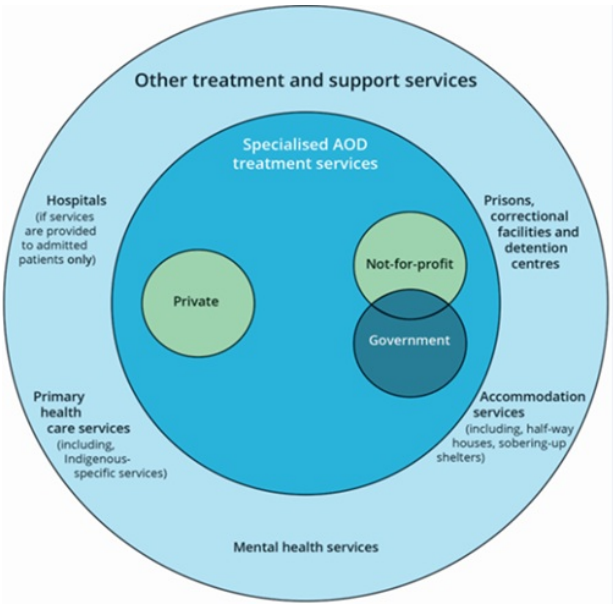
People receive treatment for alcohol and other drug-related issues in a variety of settings not in scope for the AODTS NMDS. These include:

- 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. TThese 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 subsequently transferred to the Department of Prime Minister and Cabinet and then to the National Indigenous Australians 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 specifc 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

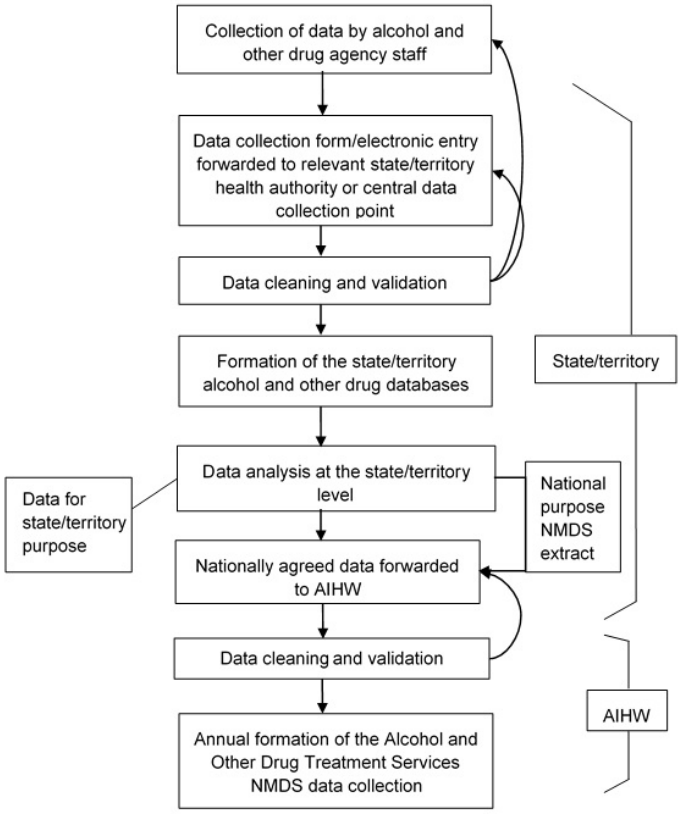
Age

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 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 se

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

Jurisdictional notes regarding principal drug of concern:

- 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.
- Victoria reported a high number of miscellaneous episodes coded as ‘Other drugs’ due to service provider reporting practices and limitations with the reporting system. This system was replaced in 2019–20. In 2019–20 and 2020–21, Victoria continued to report high levels of miscellaneous episodes coded as ‘Other drugs’ or ‘Not stated’ as principal drugs of concern due to service provider reporting practices with the new data reporting system.
- 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.

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 2021–22 data were calculated using the estimated resident population at 31 December 2021. Rates for previous years may differ to previously reported due to updated estimated resident population.

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*
- *Remote*
- *Inner regional*
- *Very remote*
- *Outer regional*

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* Katherine, 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 or 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. Data about the clients those episodes relate to have not been available at a national level. 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

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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.

References

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

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 lock down 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 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, unable to recruit staff due to border restrictions, staff sickness and/or isolation periods for close contacts meant no coverage to operate at times, 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 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. In mid-August 2022 the ACT went into lock-down and further restrictions, which 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 person 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.
- **other:** episodes that ended due to the client returning to court or jail due to non-compliance with a drug court program or sanctioned by court diversion service, imprisoned (other than drug court sanctioned), died, or reasons not elsewhere classified.

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.

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.

Other 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.

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: Includes:

- distinct clients—where the total number refers to the actual number of clients counted
- estimated clients—where the number of clients is estimated using imputed numbers (see imputation methodology).

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, or when treatment is ceased (see reason for cessation).

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

Notes

Data quality statement

Alcohol and Other Drug Treatment Services National Minimum Data Set 2021–22

Related material

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