



NADA
network of alcohol and
other drugs agencies



UNIVERSITY
OF WOLLONGONG
AUSTRALIA

NADAbase Snapshot Report 19/20

Time frame: 1st July 2019 to 30th June 2020

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Background: The snapshot provides an overview of the data that was collected within the NADAbase during the 2019-2020 financial year. The snapshot is divided into three sections: (1) description of participants who entered treatment using the NSW Alcohol and Other Drugs Treatment Services (AODTS) Minimum Data Set (MDS), (2) description of participants who completed at least one NADAbase Client Outcome Management System (COMS) survey, and (3) a summary of client outcomes during this period using NADAbase COMS.

Section 1. MDS:

This section presents an overview of the NSW AODTS Minimum Data Set (MDS) data collected during this period across the NGO sector.

1.1 Demographics: During this period 20,762 unique commencement assessments were completed (64% male, 35% female). About 22% of participants identified as being of Aboriginal and/or Torres Strait Islander. Most participants were born in Australia (88%) and reported that English was their preferred language (98%). Almost half of all participants were accessing temporary benefits as their primary source of income (46%). See Table 1 for further descriptions.

Table 1. MDS demographic information for participants who entered treatment during the 2019-20 financial year.

	N	%	Mean	SD
Age (years)			33.1	12.7
Gender				
Male	13283	64.0		
Female	7340	35.4		
Transgender female	12	.1		
Transgender male	17	.1		
Non binary / indeterminate	15	.1		
Intersex	12	.1		
Not stated	89	.4		
Indigenous status				
Neither Aboriginal or Torres Strait Islander	15542	74.9		
Aboriginal but not Torres Strait Islander Origin	3975	19.1		
Aboriginal and Torres Strait Islander	233	1.1		
Torres Strait Islander but not Aboriginal Origin	73	.4		
Not stated	939	4.5		
Sexuality				
Straight or heterosexual	10489	50.5		
Lesbian, gay, homosexual	383	1.8		
Bisexual	314	1.5		
Queer	28	.1		
Not stated	4686	22.6		
Not asked	4862	23.4		
Country of birth¹				
Australia	18265	88.0		
New Zealand	428	2.1		
England	217	1.0		
Vietnam	115	.6		
Fiji	94	.5		
Iran	81	.4		

South Africa, Republic of	78	.4
Philippines	73	.4
Lebanon	71	.3
Bahrain	63	.3
United States	52	.3
India	42	.2
Ireland, Republic of	46	.2
Samoa	44	.2
Sudan	44	.2
Thailand	44	.2
Scotland	33	.2
China	30	.1
Not stated	216	1.0
Other	726	3.5
Preferred language¹		
English	20243	97.5
Aboriginal language, so described	65	.3
Arabic	58	.3
Persian, excluding Dari	51	.2
Vietnamese	48	.2
Not stated	82	.4
Other	215	1.0
Principle source of income		
Temporary benefits (e.g. sickness, unemployment)	9597	46.2
Pension	2223	10.7
Full-time employment	1899	9.1
No income	1183	5.7
Part-time employment	951	4.6
Dependent on others	733	3.5
Other	378	1.8
Student allowance	479	2.3

Retirement fund	61	.3
Not stated/not known/described	3258	15.7

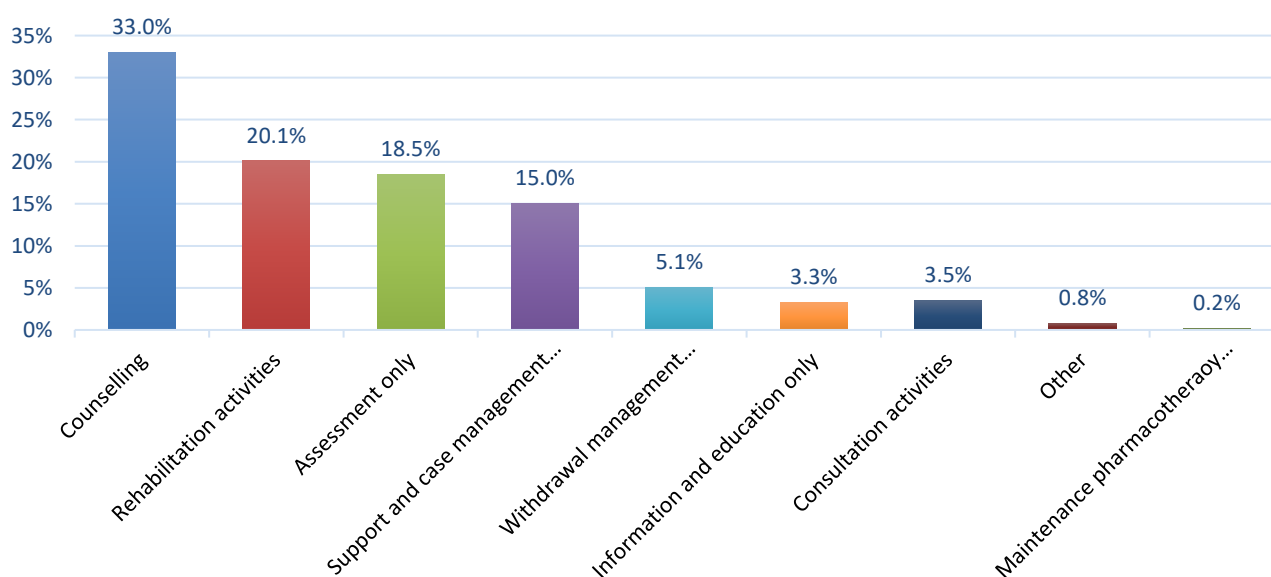
Accommodation

Rented house or flat	9250	44.6
Privately owned house or flat	5091	24.5
Not known	2316	11.2
Other	858	4.1
No usual residence/homeless	1082	5.2
Prison/detention centre	685	3.3
Alcohol or other drug treatment residence	413	2.0
Hostel/supported accommodation	403	1.9
Boarding house	292	1.4
Shelter / refuge	293	1.4
Caravan on serviced site	50	.2
Psychiatric hospital	29	.1

Notes. County of birth or preferred language listed if 30 or more participants¹.

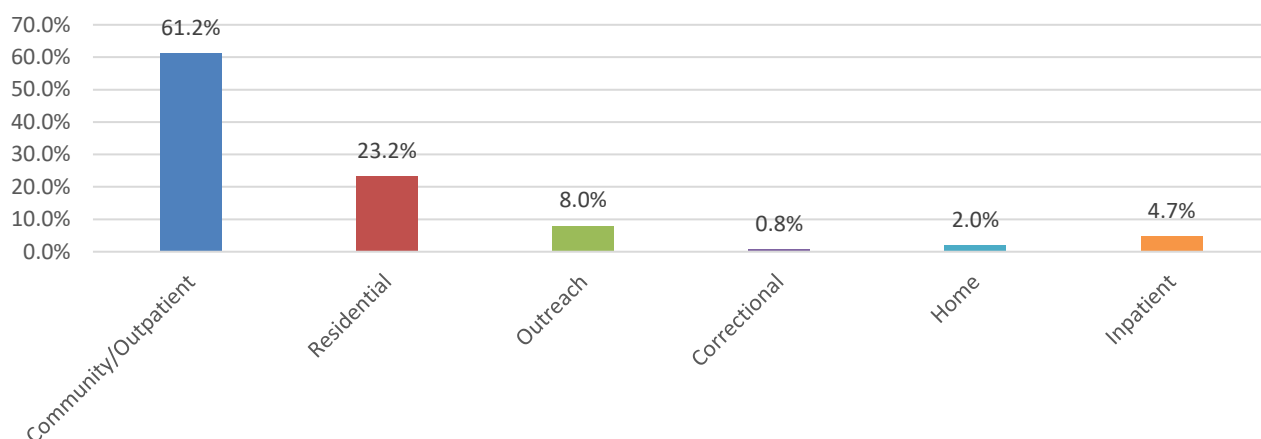
1.2 Main treatment type: Figure 1 provides a description of the main treatment type for people during this period. Counselling (33%), rehabilitation activities (20%), and assessment only (19%) were the three most common main treatment types.

Figure 1. Main Treatment Type



1.3 Service delivery setting. Figure 2 provides a summary of the primary service delivery settings. Community / outpatient (61%) and residential (23%) were the most highly endorsed treatment settings.

Figure 2. Service delivery setting



1.4 Substances of Concern: All participants were asked to nominate their primary substance of concern (see Figure 3). Amphetamines (including methamphetamines) were the highest endorsed primary substance of concern (33%), followed by alcohol (30%) and cannabinoids (18%). Participants were also asked to nominate any other substances of concern (see Figure 4). If applicable, participants could nominate multiple other substances of concern. Cannabinoids (27%) were the most highly endorsed ‘other drug of concern’. This was followed by nicotine (26%), alcohol (14%), and amphetamines (14%). Figures 5 and 6 present the primary substance of concern based on Indigenous status and gender respectively. These figures include the 4 most highly endorsed primary substances of concern.

Figure 3. Primary substance of concern

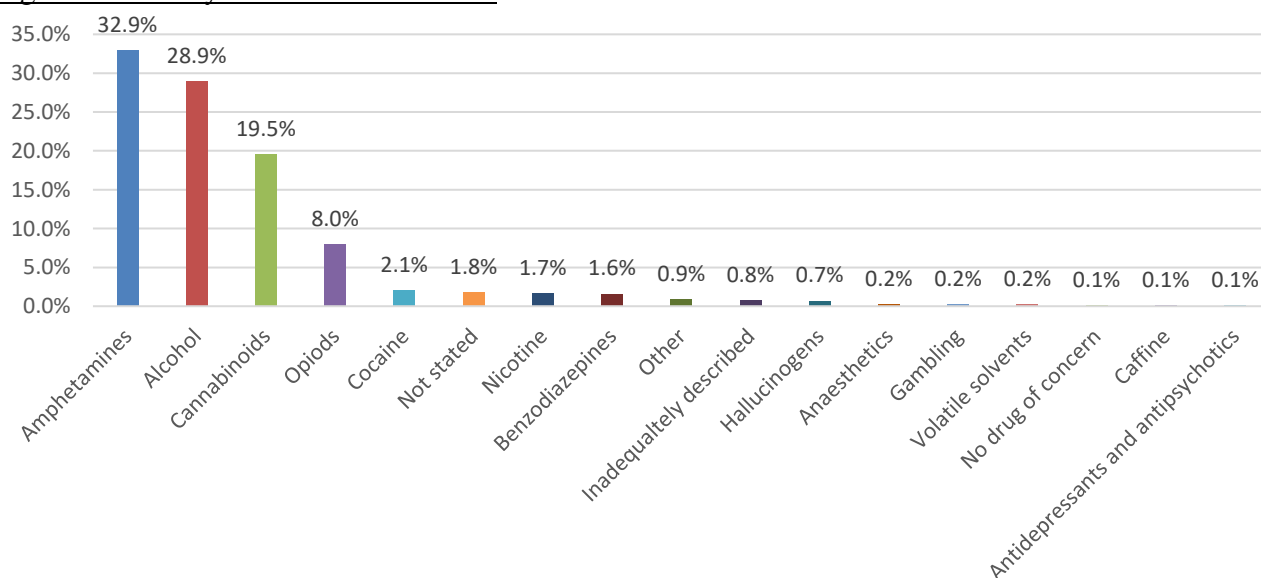


Figure 4. Other substances of concern

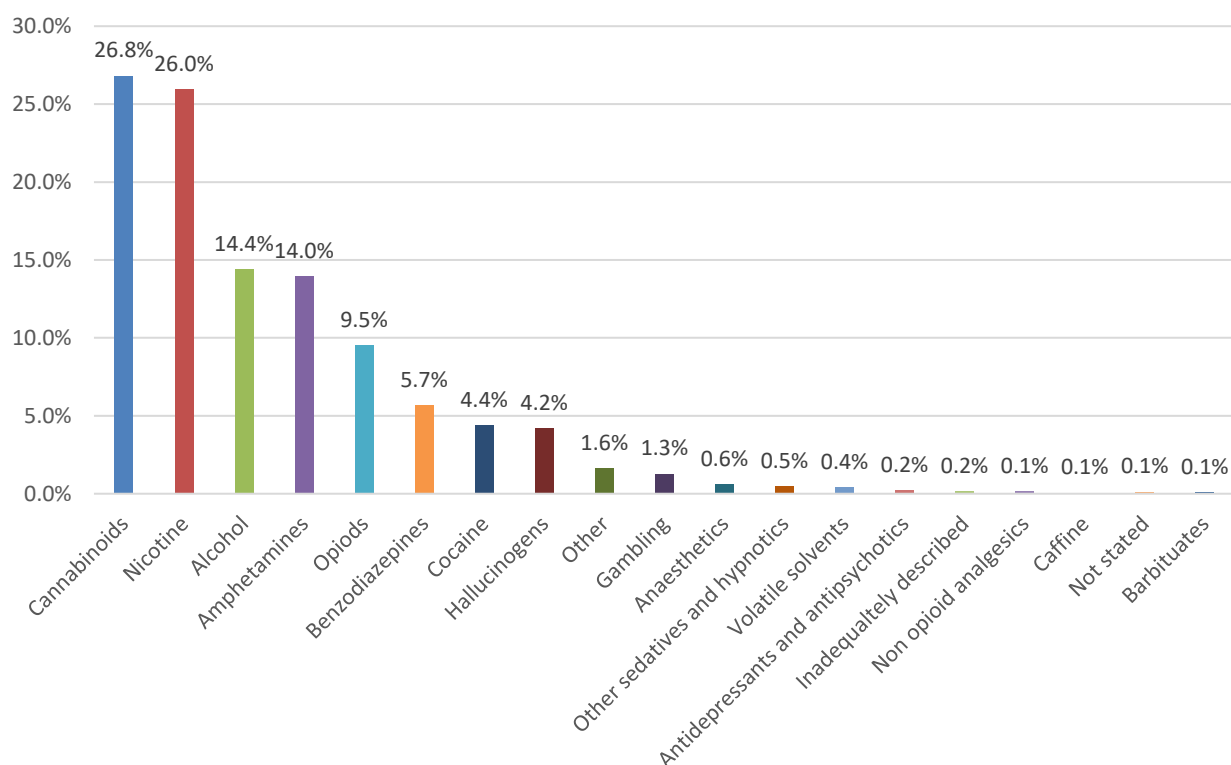


Figure 5: Primary drug of concern by Indigenous status

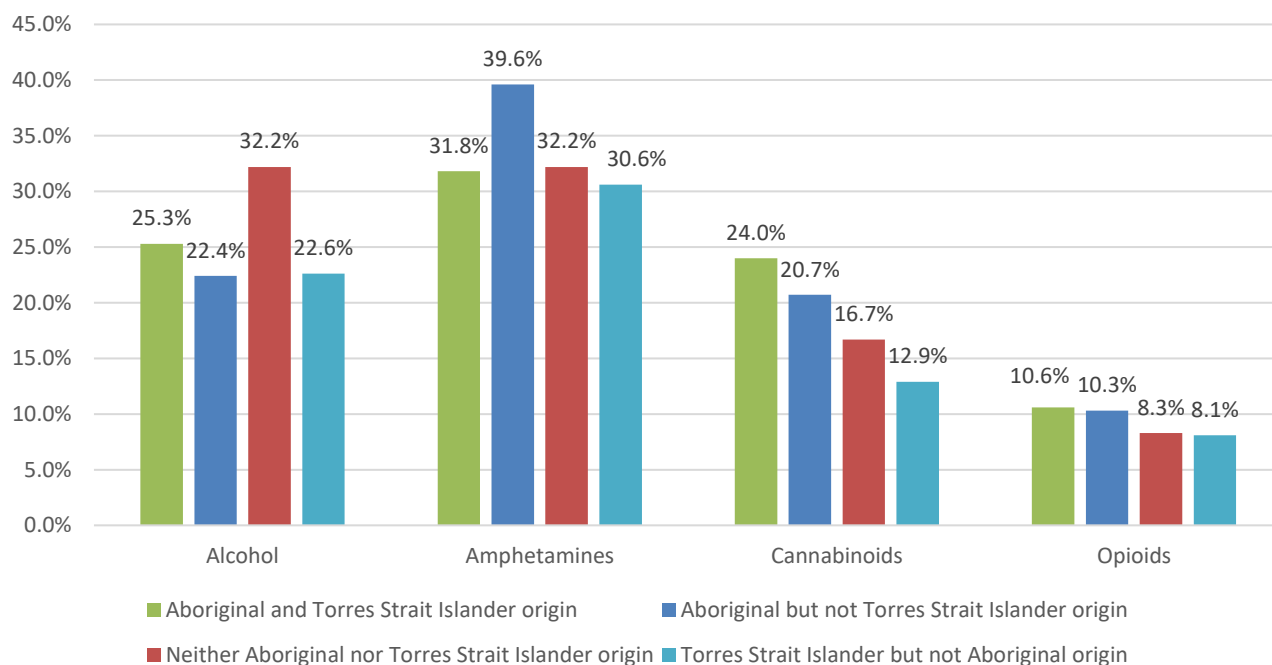
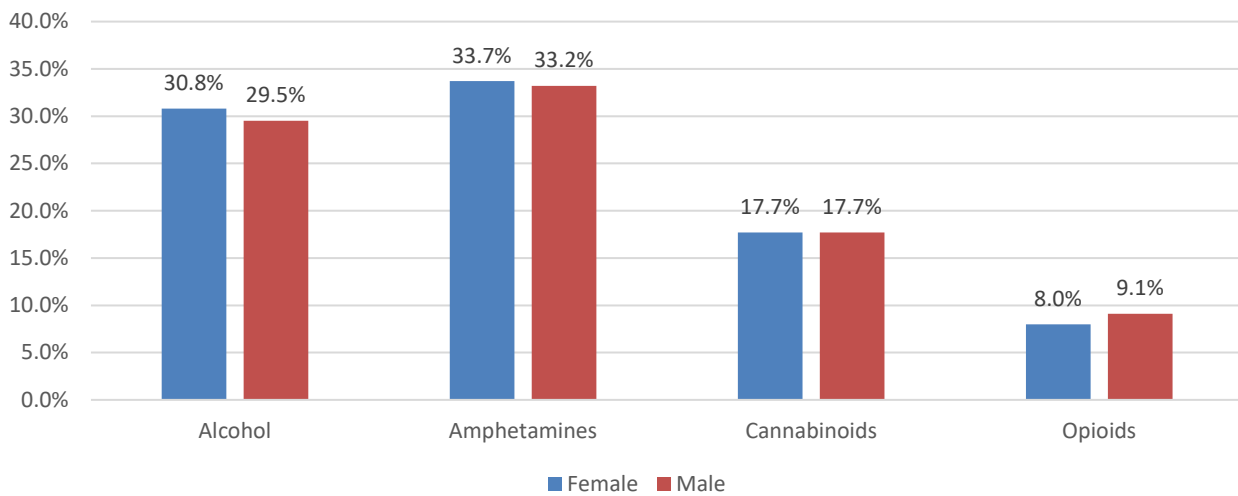
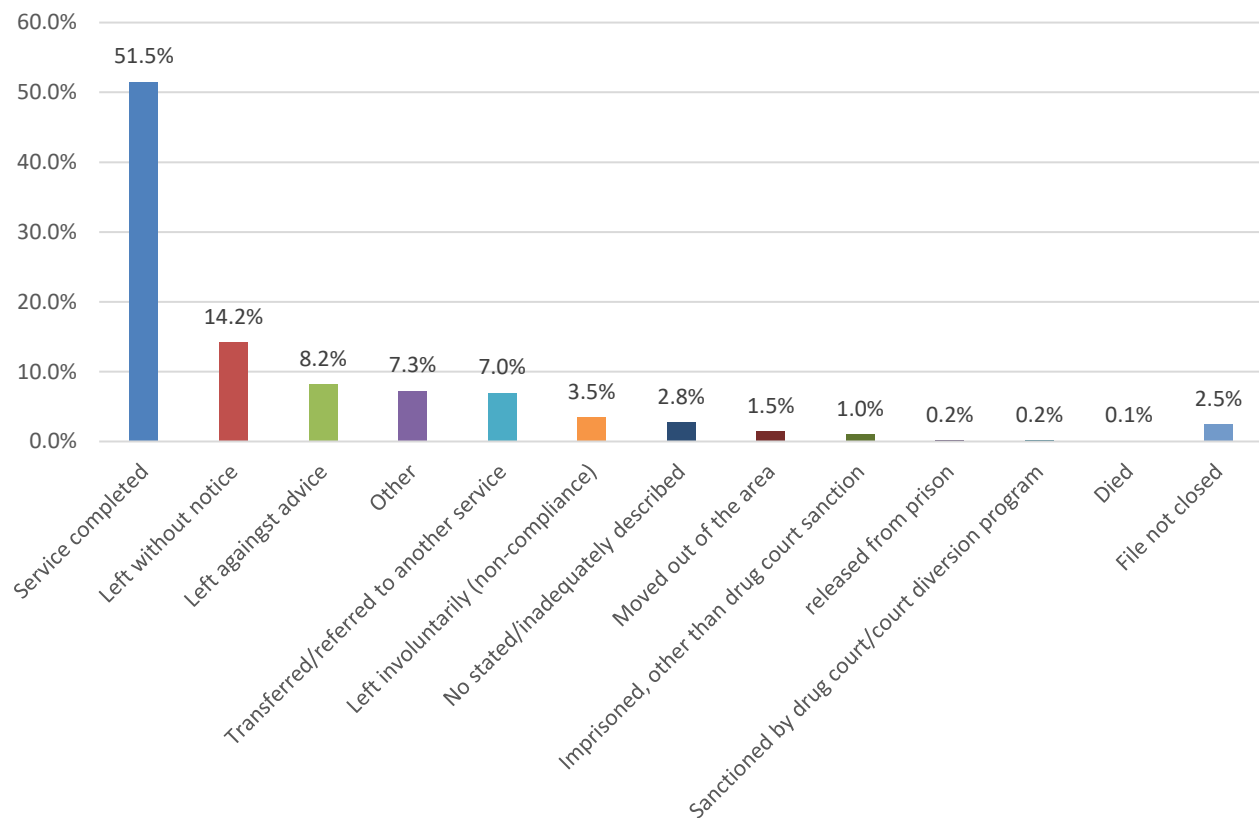


Figure 6: Primary drug of concern by gender



1.5 Reasons for leaving treatment: Figure 7 provide a summary of the reasons that people left treatment. The highest endorsed response was ‘service completed’ (53%). This was followed by ‘left without notice’ (15%), and ‘left against advice’ (8%). For about 5% of participants, it was unclear why the person left treatment as the categories ‘other’ or ‘not stated’ were selected.

Figure 7. Reason for leaving treatment

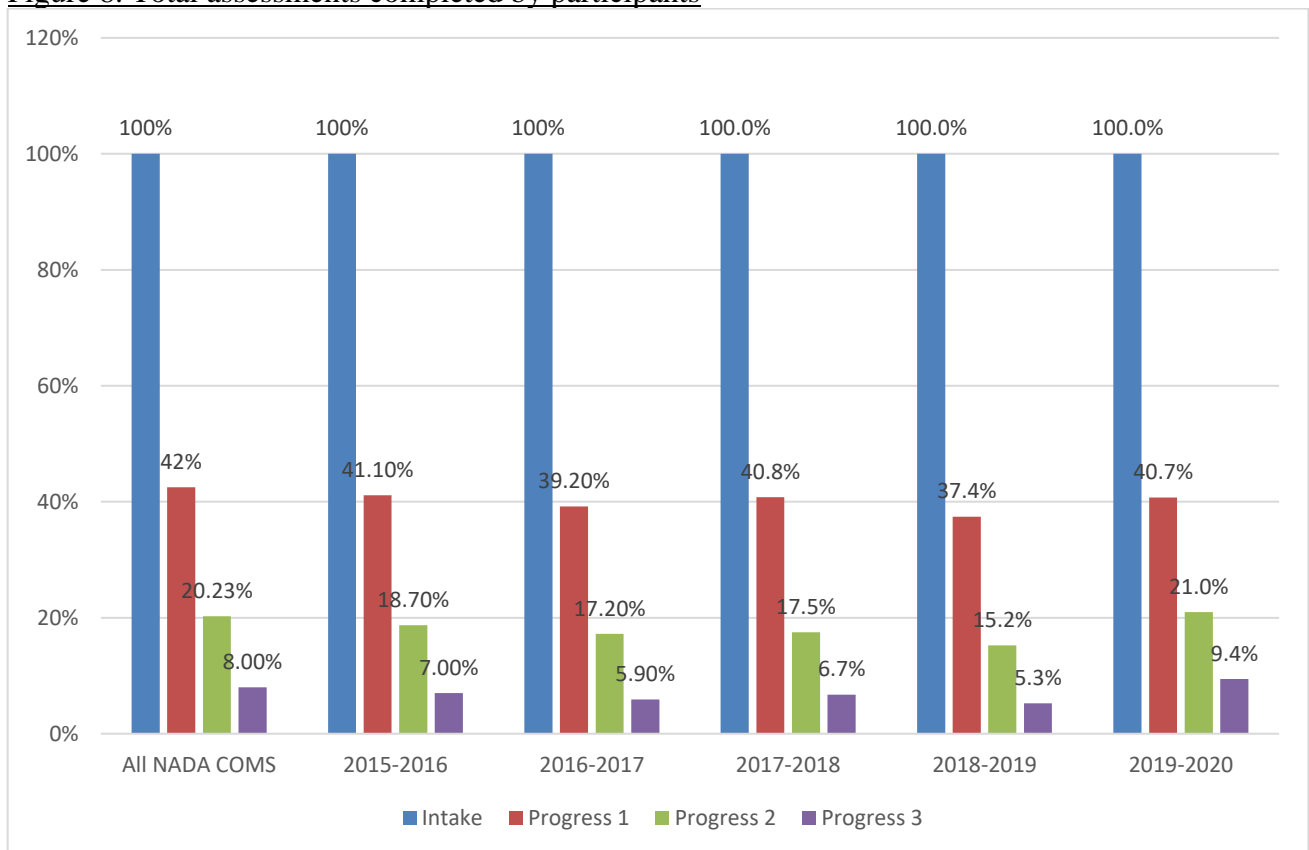


Section Two: COMS

This section provides an overview of the total NADA COMS assessments completed during the period. It also provides an overview of the participants who entered treatment during this period and completed at least one NADA COMS.

2.1 Total COMS completed: Figure 8 provides an overview of the total number of COMS assessments that have been completed across the life of NADA COMS (i.e. All NADA COMS), and for the period 2015-2016, 2016-2017, 2017-2018, 2018-2019, and 2019-2020.

Figure 8. Total assessments completed by participants



2.2 Proportion of COMS assessments completed: To examine the pattern of survey completion in more detail, further analysis was conducted to examine the proportion of people who completed multiple assessments during their treatment. Analysis focused on people who had stayed in treatment for 30-days or more (Figure 9), 60-days or more (Figure 10), and 90-days or more (Figure 11). Each figure compares the total number of assessments completed by all participants (blue bars), people who were attending residential activities (red bar) or counselling (green bars).

Figure 9. Proportion of COMS progress assessments completed for people who stayed in treatment for 30-days or more

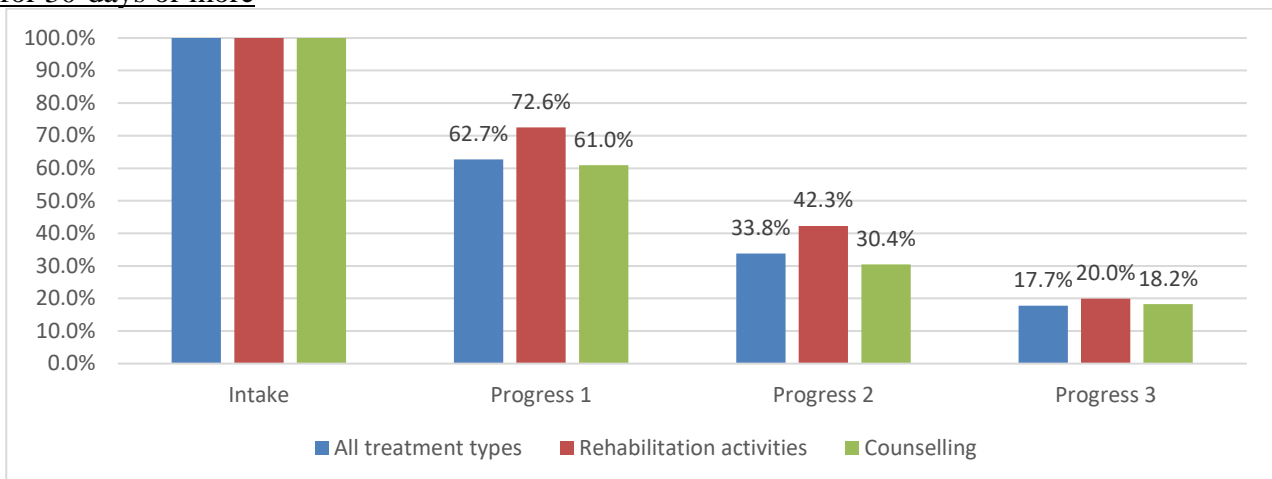


Figure 10. Proportion of COMS progress assessments completed for people who stayed in treatment for 60-days or more

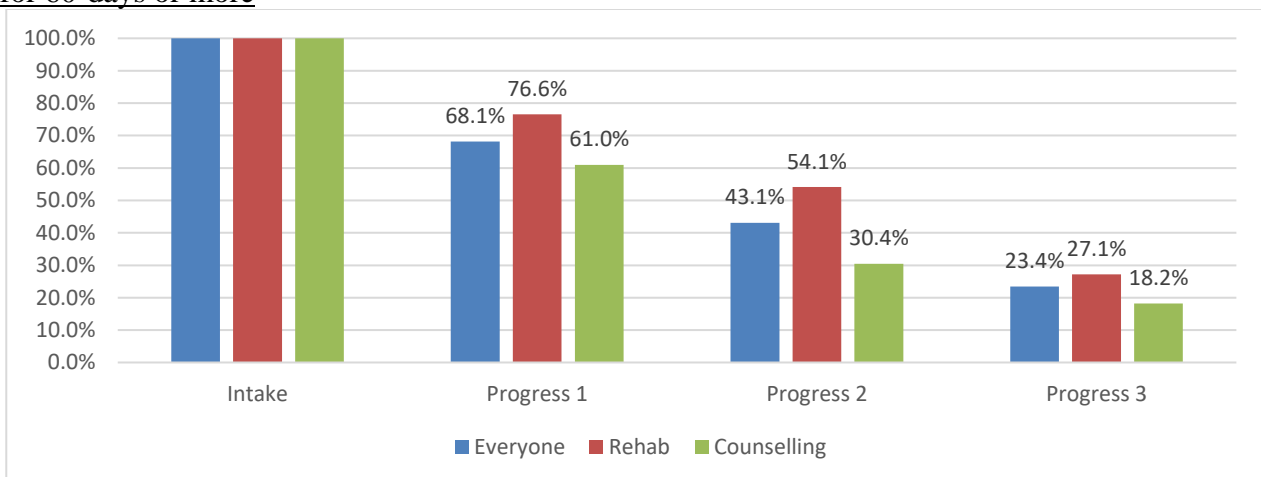
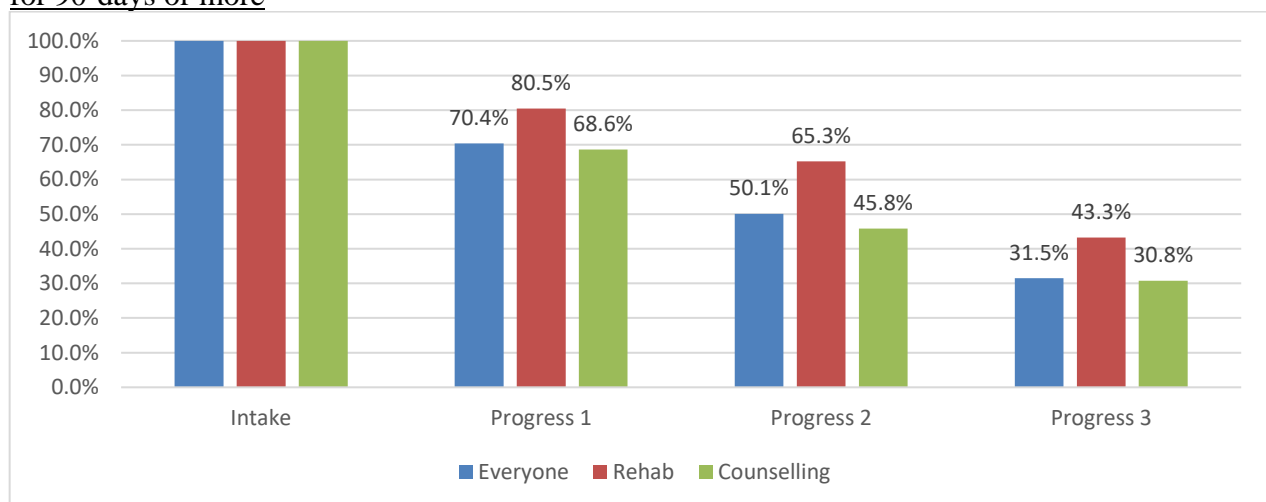


Figure 11. Proportion of COMS progress assessments completed for people who stayed in treatment for 90-days or more



2.1 Demographics: During the 2019 - 2020 period 5669 unique commencement intake assessments were completed (65% male, 35% female). About 22% of participants identified as being Aboriginal and/or Torres Strait Islander decent. Most participants were born in Australia (89%) and reported that English was their preferred language (96%). Forty-four percent of all participants were accessing temporary benefits as their primary source of income. See Table 2 for further descriptions.

Table 2. Demographic information for the first COMS assessment occasion.

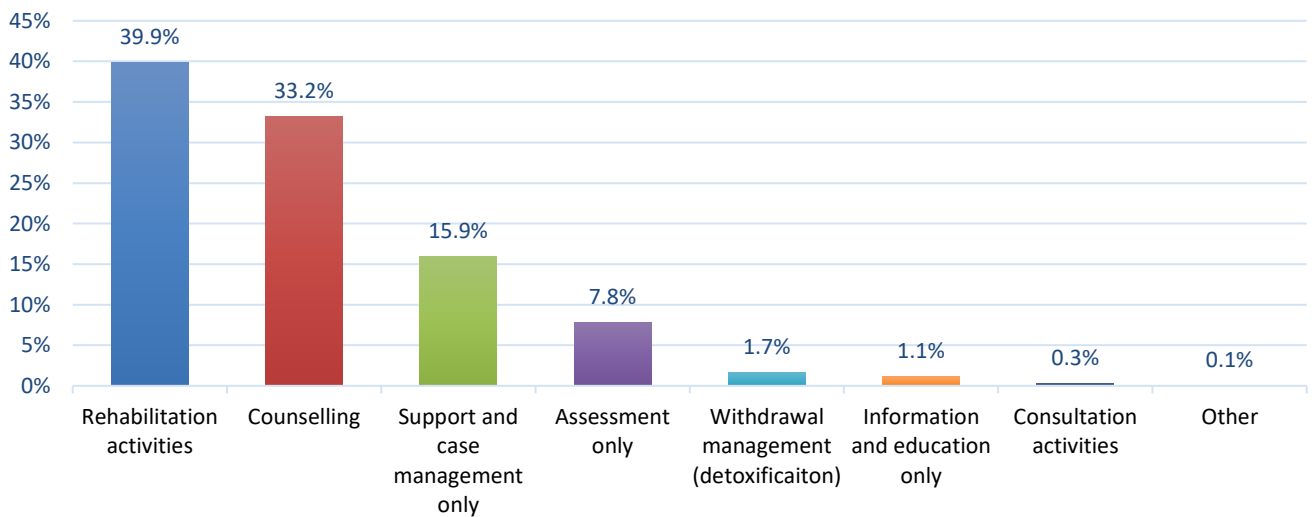
	N	%	Mean	SD
Age (years)			31.6	12.0
Gender				
Male	3662	64.6		
Female	1978	34.9		
Transgender female	4	.1		
Not stated	8	.1		
Non binary / indeterminate	5	.1		
Transgender male	10	.2		
Intersex	2	.0		
Indigenous status				
Neither Aboriginal or Torres Strait Islander	4283	75.6		
Aboriginal but not Torres Strait Islander Origin	1093	19.3		
Aboriginal and Torres Strait Islander	95	1.7		
Torres Strait Islander but not Aboriginal Origin	10	.2		
Not stated	188	3.3		
Sexuality				
Straight or heterosexual	2853	50.3		
Lesbian, gay, homosexual	153	2.7		
Bisexual	73	1.3		
Queer	10	.2		
Not stated	1686	29.7		
Not asked	894	15.8		
Country of birth				
Australia	5044	89.0		

New Zealand	133	2.3
England	58	1.0
Vietnam	28	.5
Fiji	23	.4
Iran	21	.4
Lebanon	20	.4
Other	342	6.0
Preferred language		
English	5461	96.3
Other	208	3.7
Principle source of income		
Temporary benefits (e.g. sickness, unemployment)	2502	44.1
Pension (e.g. aged, disability)	986	17.4
Dependant on others	496	8.7
Full-time employment	479	8.4
No-income	384	6.8
Part-time employment	347	6.1
Student allowance	159	2.8
Retirement fund	10	.2
Other	118	2.1
Not known	188	3.3
Usual Accommodation		
Rented house or flat	3108	54.8
Privately owned house or flat	1236	21.8
Prison / detention centre	140	2.5
No usual residence / homeless	316	5.6
Hostel / supported accommodation	113	2.0
Shelter or refuge	124	2.2
Boarding house	135	2.4
AOD treatment residence	109	1.9

Caravan on a serviced site	21	.4
Psychiatric hospital	13	.2
Other	106	1.9
Unknown	248	4.4

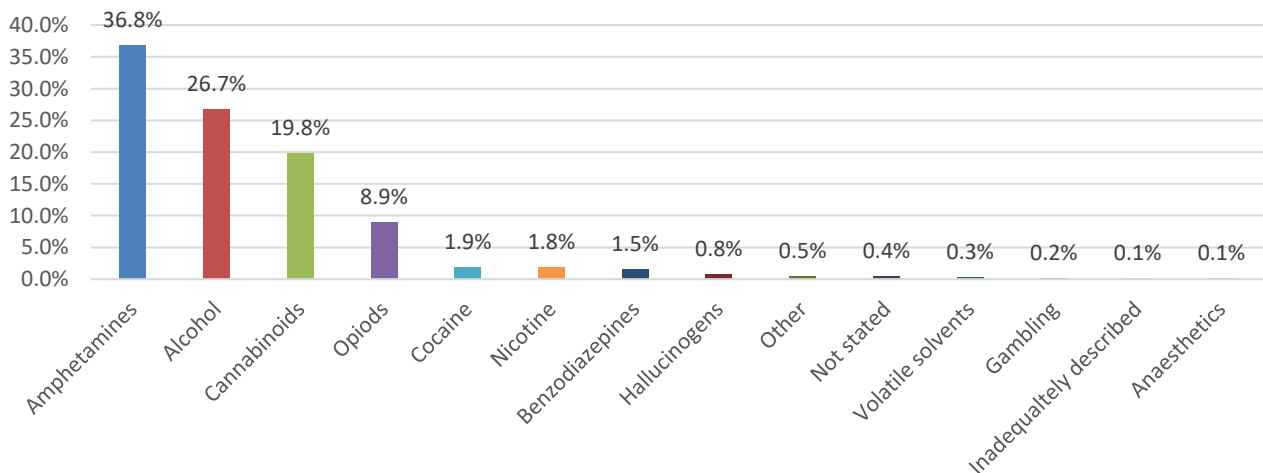
2.2 Main treatment type: Of the participants who entered treatment during the period, 40% were attending rehabilitation activities (see Figure 12). This was followed by people accessing counselling (33%) and people attending for support and case management (16%).

Figure 12. Main Treatment Type



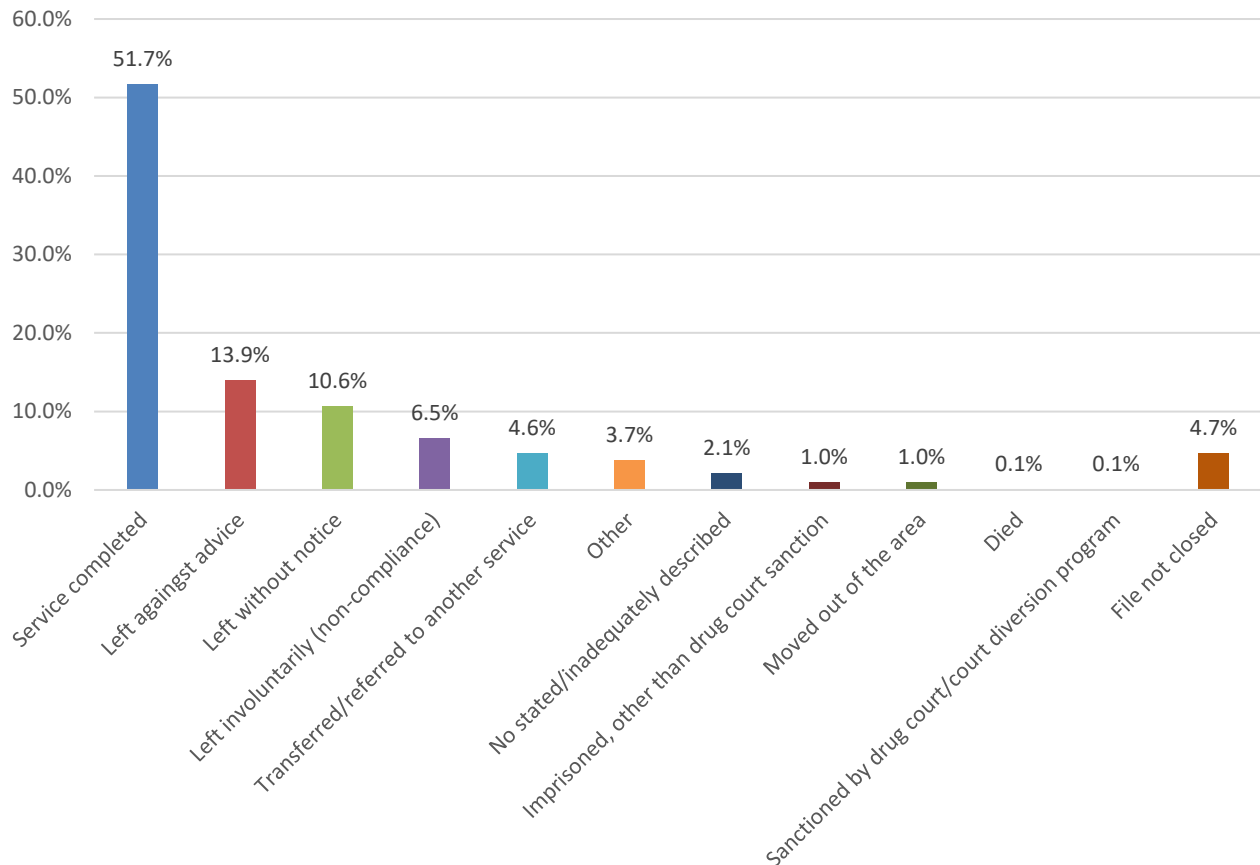
2.3 Substances of Concern: All participants were asked to nominate their primary substance of concern. Amphetamines was rated the highest endorsed substance (37%), followed by alcohol (27%) and cannabinoids (20%; see Figure 13).

Figure 13. Primary substance of concern



2.4 Reasons for leaving treatment: Figure 14 provide a summary of the reasons that people left treatment. The most common reasons were that the person had completed treatment (52%) or they had left against advice (14%).

Figure 14. Reason for leaving treatment



Injecting Drug Use: Participants were asked to indicate when they last “injected or hit up” any drug. As highlighted in Table 3, 57% of the participants had ‘never injected’ any drugs. Of those participants who had “injected or hit up” drugs in the last 3-months (n = 995, 56%), 273 (27%) had shared needles and 277 (28%) had shared injection equipment during this period. One hundred and thirty-one participants (13%) who reported injecting during the previous 3-months also reported that they overdosed in the previous 3-months.

Table 3. Description of injecting drug use.

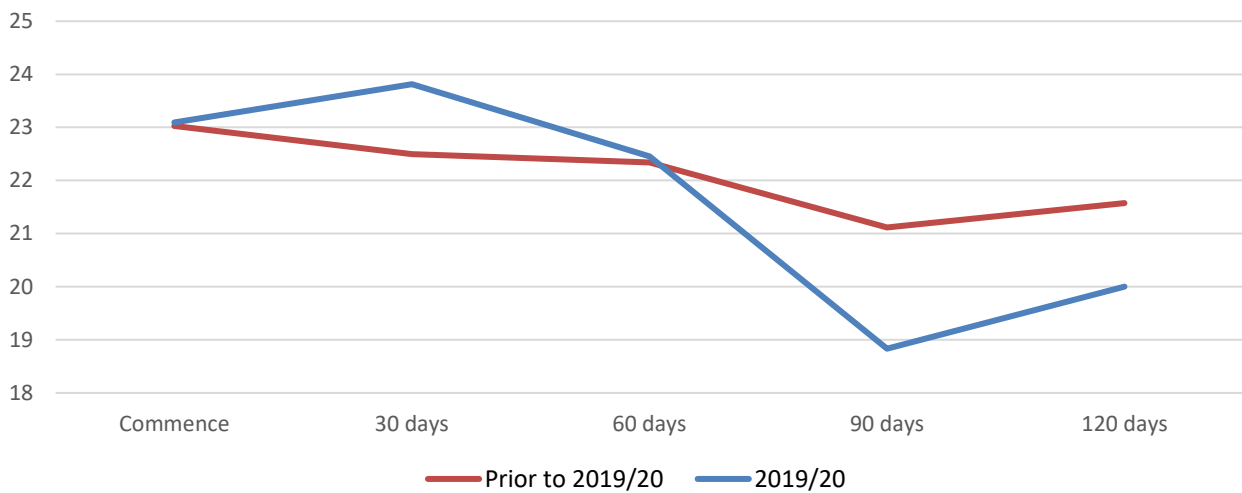
	N	%
When did you last inject/hit up any drug		
Never injected	3223	56.9
Last three months	995	17.6
More than 3 but less than 12 months ago	441	7.8
12 months ago or more	348	6.1
Not stated	55	1.0

Section Three: Client Outcome Data

The remaining figures present a comparison of the outcome data over time for gender, Indigenous status and service setting (i.e., counselling, rehabilitation and case management). Each of the figures provides a comparison between participants who accessed treatment prior to 30th June 2019, and participants that accessed treatment during the current period (i.e., from 1st July 2019 to 30th June 2020).

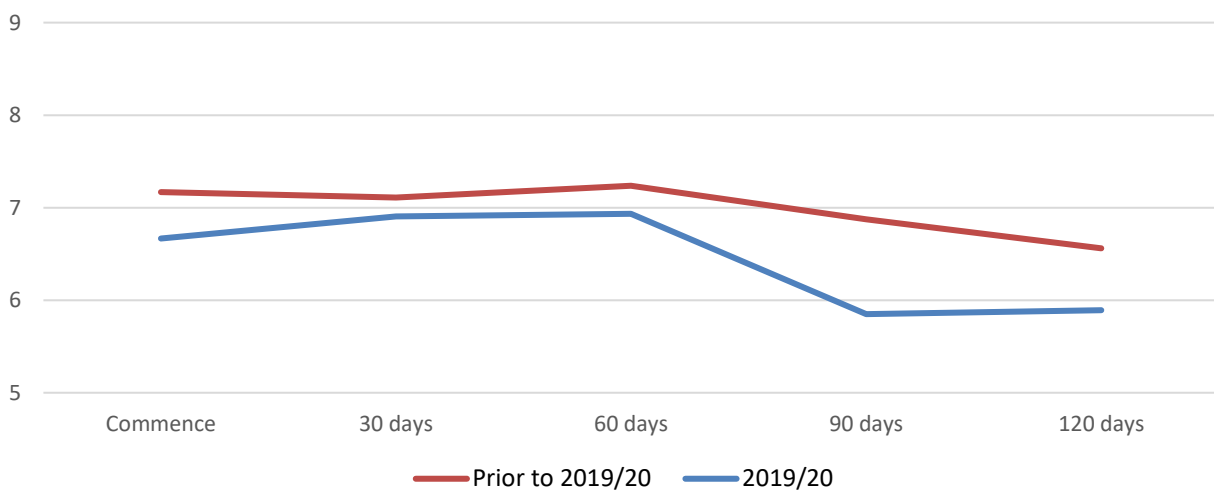
As the assessment measures are not consistently completed at standard times by the organisations, the outcome data were grouped according to the period in which they were completed. The persons first assessment was included (commencement). COMS surveys completed before 14-days were not included, as it was considered that participants would not have received a ‘sufficient dose’ of treatment to meaningfully interpret changes over time. The time periods were commencement, 30-days (14-days to 29-days), 60-days (30 days to 59-days), 90-days (60-days to 89-days) and 120-days (90-days to 190-days). If a participant had completed two assessments during a period, the latest assessment was included in the analysis. As the same participants have not necessarily completed an assessment at each of these periods of time and the data is grouped across a large range of different services, it is important to consider the following graphs as average trends. As demonstrated across all the comparisons, symptom distress (measured by the Kessler-10) tended to demonstrate a consistent reduction over time (i.e., decreases in K10 scores). Substance dependence (measured by the Substance Dependence Scale) tended to increase initially (i.e., scores increased), and then gradually reduce (i.e., scores decreased). Quality of life (measured by the EUROHIS World Health Organisation Quality of Life Scale) tended to show rapid improvements in the initial stages of treatment (i.e., increases in scores) and then tended to maintain those improvements over time. However, see the following Figures for individual sub-group differences.

Figure 15. Symptom distress (K10)



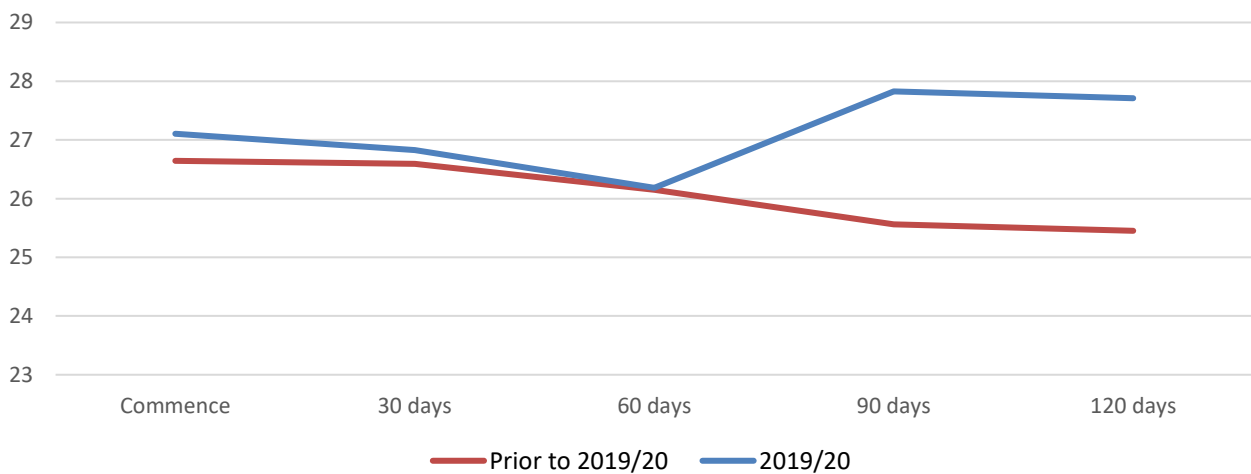
Note. Client improvements are demonstrated by reductions in K10 scores

Figure 16. Substance dependence



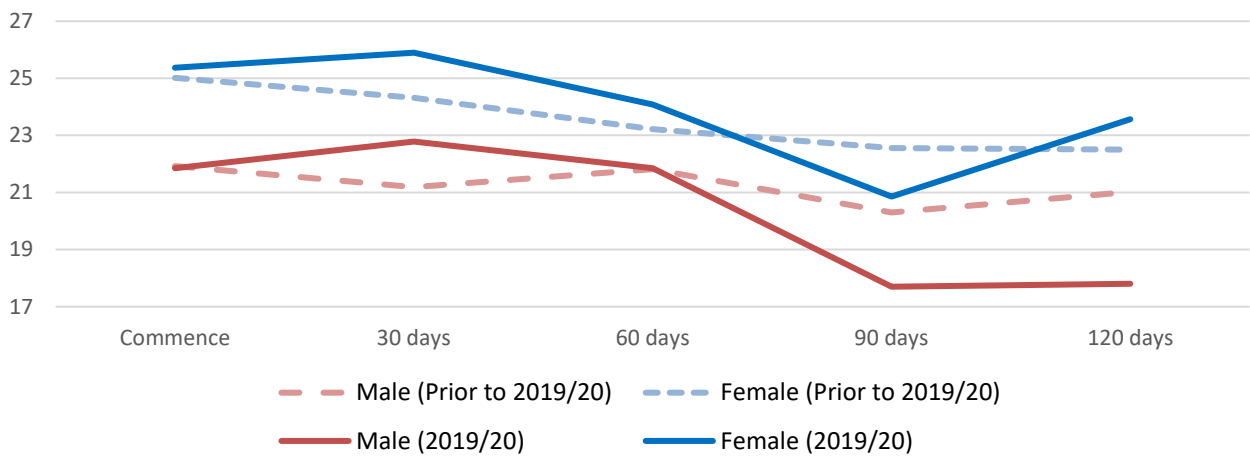
Note. Client improvements are demonstrated by reductions in SDS scores

Figure 17. Quality of life (QOL)



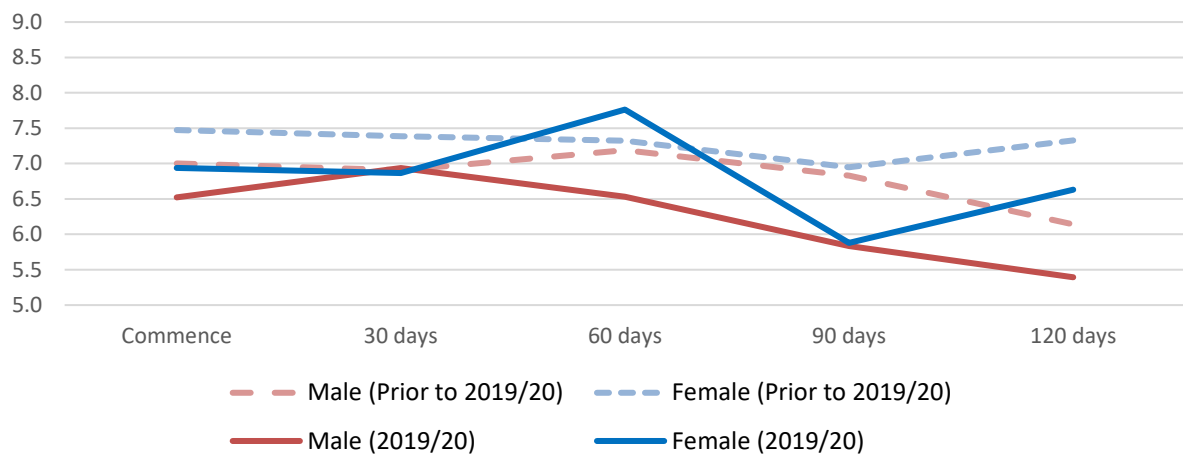
Note. Client improvements are demonstrated by increases in QOL scores

Figure 18. Symptom distress (K10): Women and Men



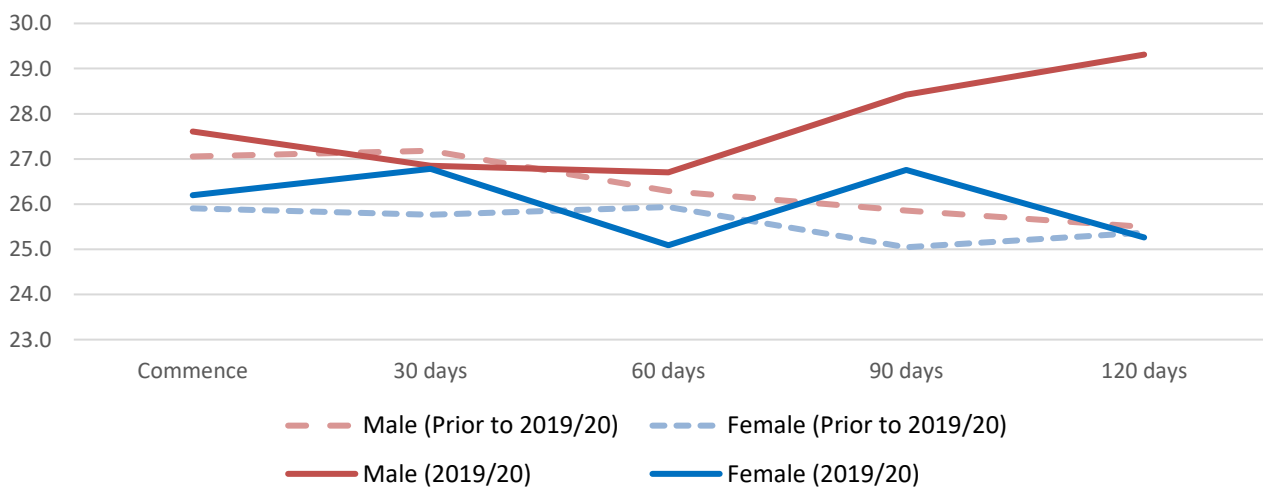
Note. Client improvements are demonstrated by reductions in K10 scores

Figure 19. Severity of Dependence (SDS): Women and Men



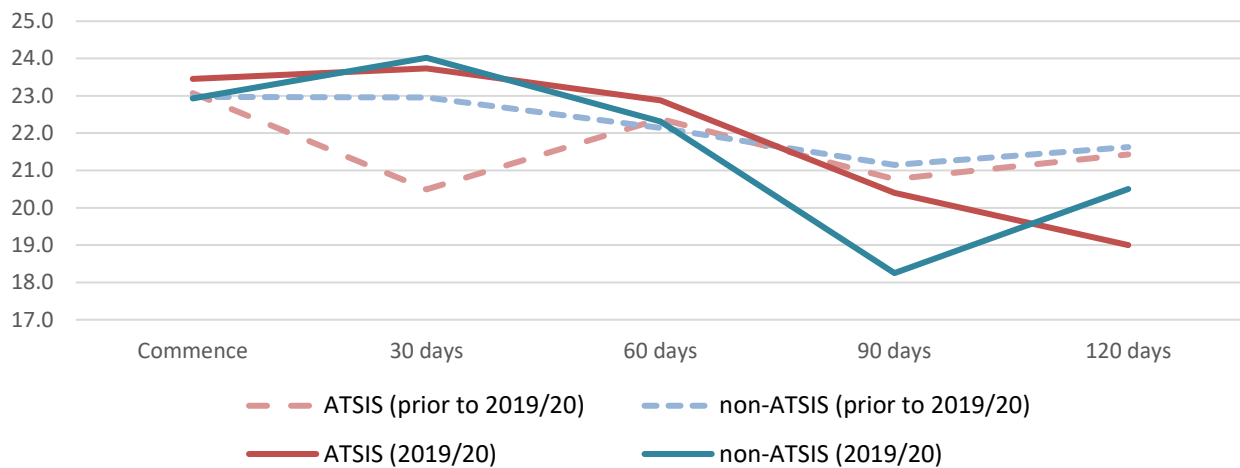
Note. Client improvements are demonstrated by reductions in SDS scores

Figure 20. Quality of Life (QOL): Women and Men



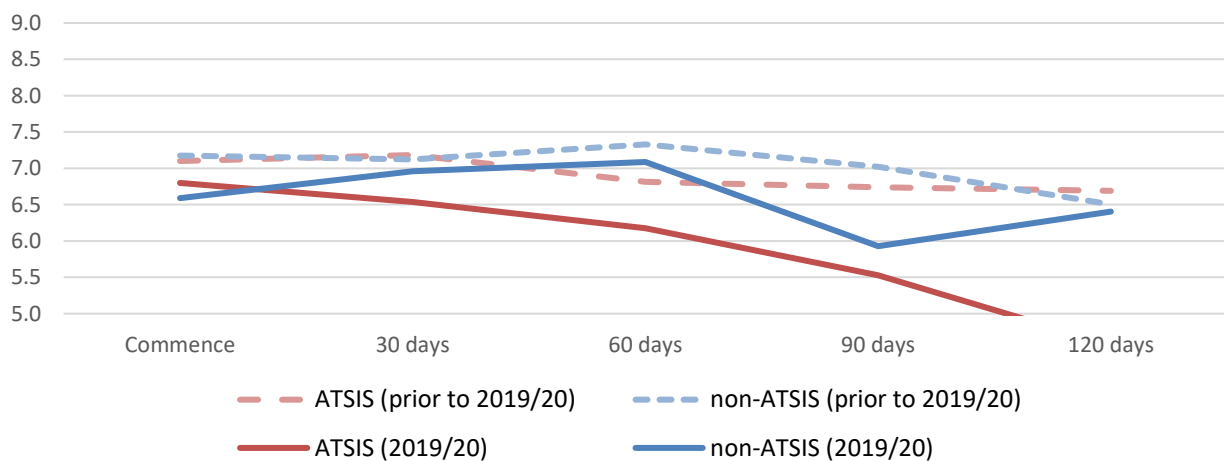
Note. Client improvements are demonstrated by increases in QOL scores

Figure 21. Symptom distress (K10): ATSI and non-ATSI



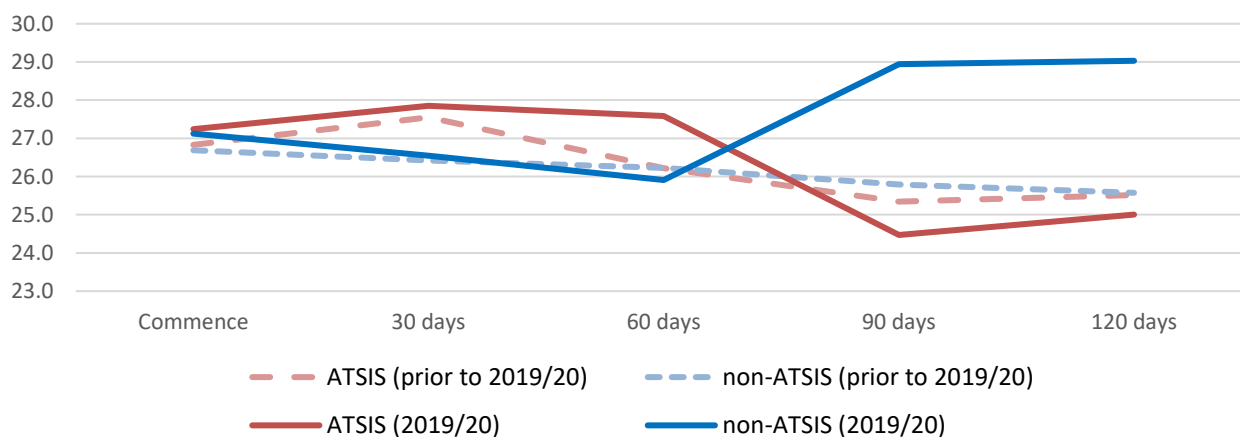
Note. Client improvements are demonstrated by reductions in K10 scores

Figure 22. Substance dependence (SDS): ATSI and non-ATSI



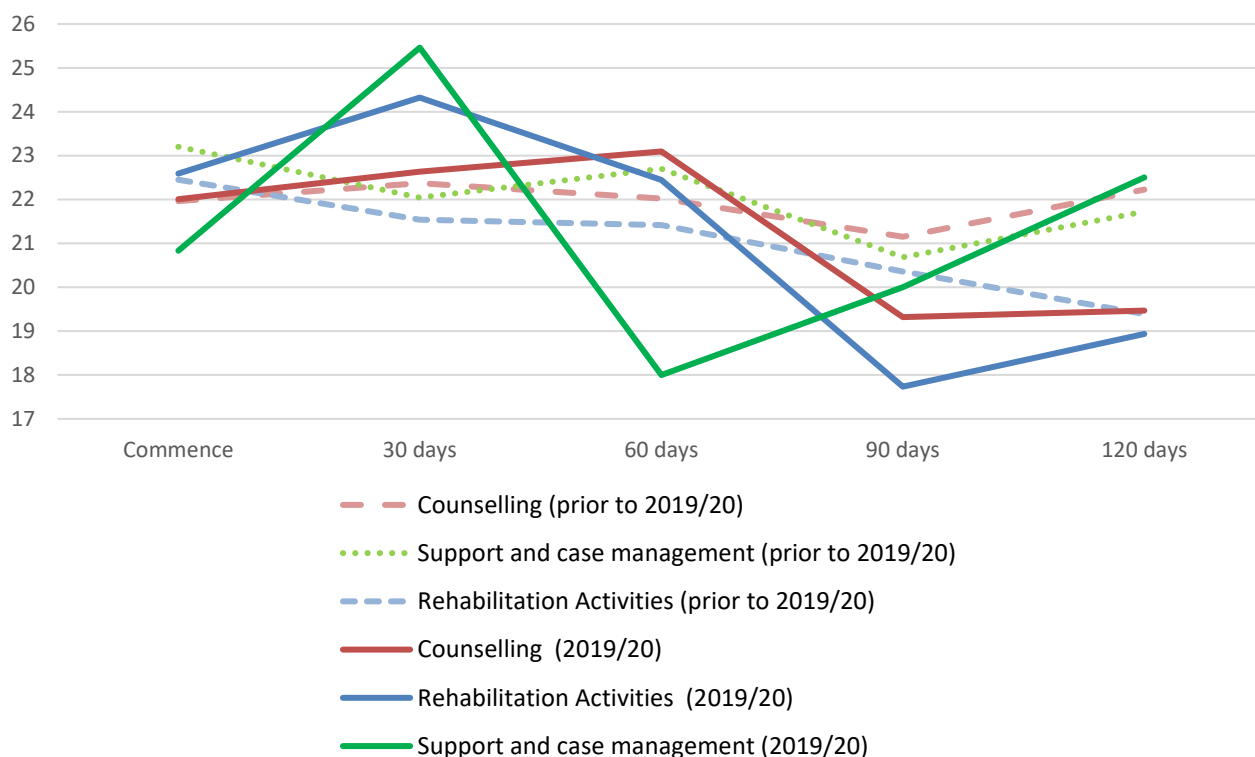
Note. Client improvements are demonstrated by reductions in SDS scores

Figure 23. Quality of Life: ATSI and non-ATSI



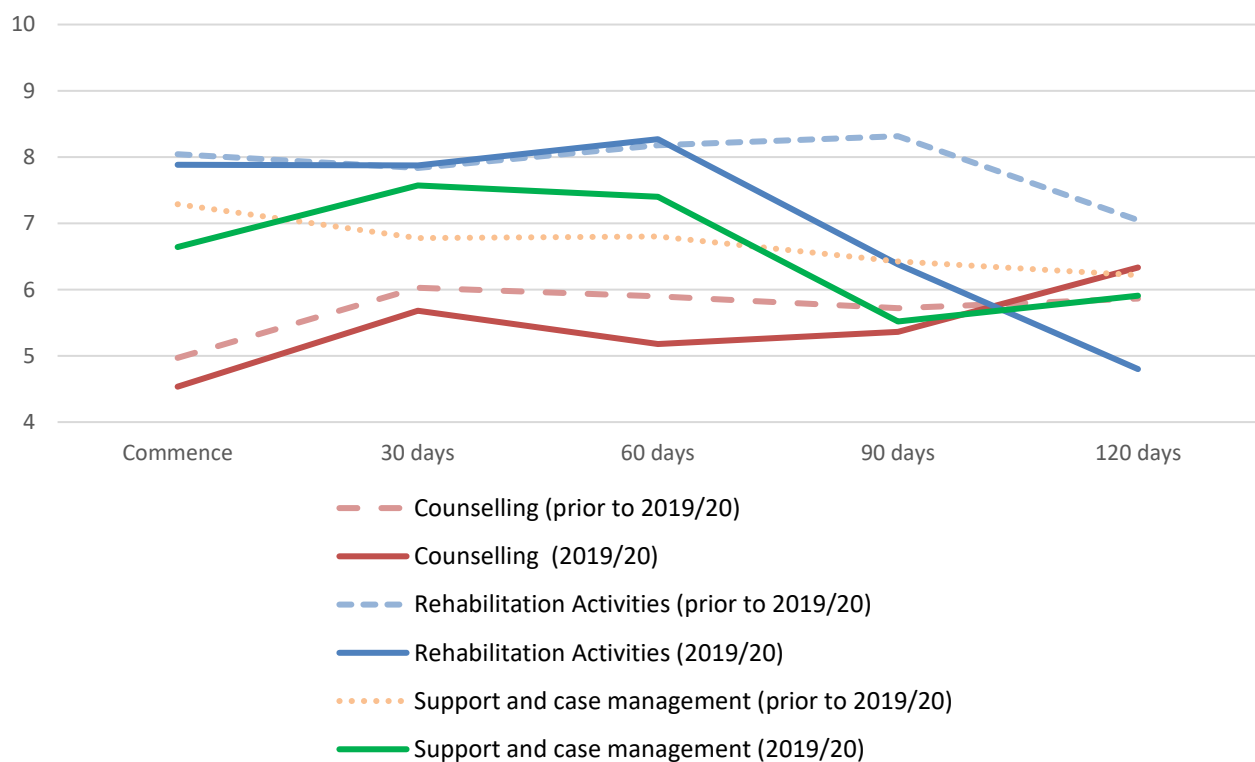
Note. Client improvements are demonstrated by increases in QOL scores

Figure 24. Symptom distress (K10): Service settings



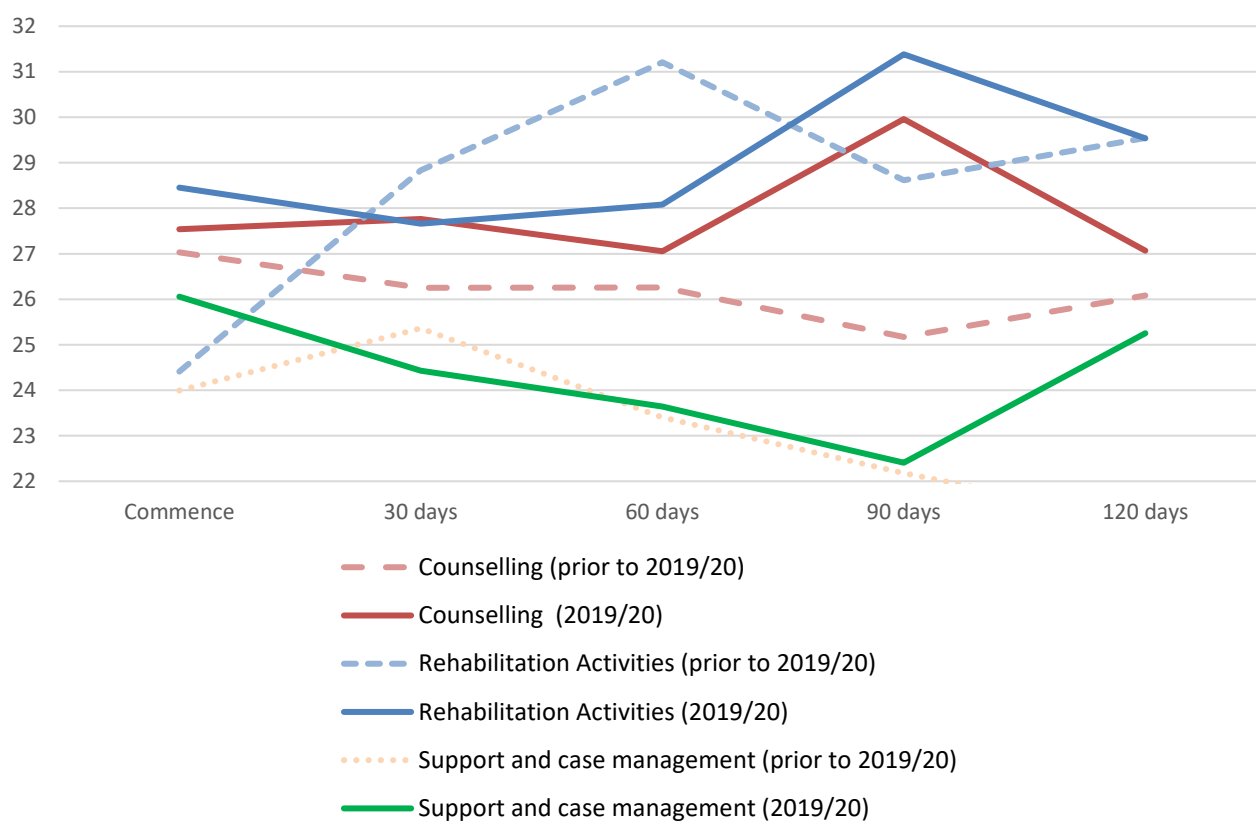
Note. Client improvements are demonstrated by reductions in K10 scores

Figure 25. Substance dependence (SDS): Service setting



Note. Client improvements are demonstrated by reductions in SDS scores

Figure 26. Quality of life: Service setting



Note. Client improvements are demonstrated by increases in QOL scores