



**NADA**  
network of alcohol and  
other drugs agencies



UNIVERSITY  
OF WOLLONGONG  
AUSTRALIA

# NADAbase Snapshot Report

## 2021-2022

February 2023

The Network of Alcohol and other Drugs Agencies (NADA) is the peak organisation for the non government alcohol and other drugs sector in NSW. We represent 80 organisational members that provide services in over 100 locations across NSW. They provide a broad range of services including health promotion and harm reduction, early intervention, treatment and continuing care programs. Together, we improve the health and wellbeing of people who use, or have used, alcohol and other drugs across the NSW community.

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NADA proudly acknowledges Aboriginal and Torres Strait Islander people as the Traditional Custodians of the lands and waters throughout Australia. Our office stands on the land of the Gadigal people of the Eora Nation. We recognise, respect and value the deep and continuing connection of Aboriginal and Torres Strait Islander people to land, water, community and culture. We look to and celebrate Aboriginal and Torres Strait Islander people for their cultural guidance, leadership and expertise.

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## EXECUTIVE SUMMARY

### Objective

This report presents the most recent state-wide results of the minimum dataset and outcome data, where available, for specialist non government (NGO) alcohol and other drugs (AOD) treatment services. The report focusses on the period 1 July 2021 to 30 June 2022.

### Methods

The data is sourced from NADAbase, an online client data repository system. The report describes the people who accessed the NGO AOD services, and people who completed an outcome measure using NADA COMS [severity of dependence (SDS) scores, levels of psychological distress (K10 scores) and quality-of-life (QoL) scores] and Australian Treatment Outcomes Profile (ATOP). It also compares the average trends of outcome measures (NADA COMS and ATOP, separately) across each 30-day time points after a baseline assessment for different groups of people and different treatment settings. The timepoints are estimated as intervals instead of a fixed time point, i.e. a 30-day timepoint includes any time from 15 days to 45 days, as completed assessments varied widely across services. The estimates for the relative distributions of outcome measures were obtained from data available for each time point.

### Results

For services who input data into NADAbase between 2021-2022, 18,420 people accessed 219 NGO AOD services in NSW for at least one episode of care. Alcohol was the most common substance of concern across all groups of people except for Aboriginal and Torres Straits Islander people who nominated methamphetamine (including amphetamine). The distributions of outcome measures for NADA COMS (average SDS scores, average K10 scores and average QoL scores) and ATOP, varied by sex, Aboriginal and Torres Straits Islander identification and treatment settings across 30-day, 60-day, 90-day and 120-day time point after their first baseline assessment.

### Conclusion

This is the first NADAbase snapshot that presents findings on ATOP data. This report highlights two opportunities for improvement in the NGO AOD sector. First, NADAbase is a very useful resource for the sector, yet the challenge remains to promote routine use of outcome measures that supports and informs clinical care and benchmarking for people who access treatment at specialist NGO AOD services. Second, this descriptive snapshot provides exploratory data on which future research should focus on, i.e. priority populations including women and Aboriginal and Torres Strait Islander people, to better understand factors that may support better outcomes when people accessing an NGO AOD service.

## GLOSSARY OF TERMS

AOD	Alcohol and other Drug
AODTS	Alcohol and other Drug Treatment Services
ATOP	Australian Treatment Outcome Profile
BBV	Blood-borne virus
COMS	Client Outcome Measurement System
EUROHIS-QoL8	8-item EUROHIS Quality of Life measure
K10+	Kessler 10 plus
MDS	Minimum dataset
NADA	Network of Alcohol and other Drugs Agencies
NADAbase	An online database, accessible only by NADA members
NGO	Non government organisation
NMDS	National Minimum Data Sets
NSW	New South Wales
ROM	Routine outcome monitoring
SDS	Severity of Dependence Scale

## INTRODUCTION

This report provides a snapshot of data that was submitted through NADABase for the period 1 July 2021 to 30 June 2022. The report first outlines the methods and key terms that are used to identify and analyse the data collected in NADABase. NADABase is an online client data repository system that collects episode of care and outcome data from specialist non government organisations (NGO) alcohol and other drug treatment services that are members of NADA (Network of Alcohol and Other Drugs Agencies). NADA is a peak body for almost 80 organisational members that provide services in over 100 locations across NSW and the ACT. They provide specialist services including alcohol and other drugs (AOD) health promotions, early prevention, treatment and continuing programs. There are 219 unique services that input their data into NADABase.

This snapshot then compares the findings with the overall data collected since 2012, where available.

The snapshot describes key findings from the following three sections:

1. description of people who entered treatment using the National and New South Wales (NSW) Alcohol and Other Drugs Treatment Services (AODTS) Minimum Data Set (MDS)
2. description of people who completed at least one NADABase Client Outcome Management System (COMS) assessment, and changes in COMS scores over time in treatment episode, stratified by Aboriginal and Torres Straits Islander identification, sex and treatment settings
3. description of people who completed at least one Australian Treatment Outcomes Profile (ATOP) assessment that was included in the NADABase, and changes in ATOP scores over time in treatment episode.

The report concludes with a brief discussion on the key findings and its implications for the NGO AOD sector.

## METHODS

### Data source

NADAbase is an online client data repository system that collects data from specialist non-government alcohol and other drug treatment services located across New South Wales (NSW) . It reports the minimum dataset (MDS)<sup>1</sup> for AODTS from NGO within the context of the clients who engaged with the services provided by the organisations. This snapshot focuses on clients' data submitted in NADAbase for NSW AODTS MDS for the period 1 July 2021-30 June 2022.

### People and episodes

The following criteria define the people who access treatment and their respective episodes in accessing the AOD NGO services and are adapted from the AIHW guidelines<sup>1</sup>.

The data are from predominantly publicly funded NGO organisations in NSW that provide one or more specialist AOD treatment services. This included people who were assessed for treatment for their own, or another person's, alcohol or other drug use. All people were aged 10 years or older at the start of the treatment episode. Although information relating to sex, gender, sexuality, and variation of sex were introduced on 1 July 2022, historic mapping was carried out on data collected prior to 1 July 2022.

An episode refers to a period of contact between a person and a treatment provider where there was a defined start (commencement) and end (cessation) dates. As defined by the AIHW reporting guideline<sup>1</sup>, a treatment episode may be closed for the following reasons: (1) treatment is completed, (2) when there has been no further contact between the client and treatment provider for 3 months, (3) where there is a change in the main treatment type, principal drug of concern or delivery setting, or (4) where treatment is ceased.

This report includes all episode's data that were closed in 2021–2022. For people who had multiple closed episodes data submitted through NADAbase during the 2021-2022 period, the most recent assessment is included in this report. Similarly, for comparison across the years, i.e., 2019-2020 and 2020-2021, the most recent assessment for that year is included in this report. This contrasts with

the previous snapshots which included the earliest assessments for episodes that commenced within that year.

## **Measures of outcomes**

NADAbase also collects outcome data as part of the COMS. Currently, submission of COMS data through NADAbase is not required for the NGO AOD sector, however, reporting of COMS data is mandated for some services who have contractual requirements with funding bodies. In this report, the COMS include health and quality of life measures. Broadly, the COMS encompasses two parts, the comprehensive, older set of survey instruments, collectively known as the NADA COMS<sup>2</sup> and the brief, newer survey of ATOP<sup>3</sup>.

The NADA COMS was first introduced in 2010<sup>2</sup> and underwent substantial expansion in 2019 after consultations with NADA members, a research review and various inputs from the project's expert advisory committee. It includes information on the following standardised measures:

1. Blood-borne virus (BBV) Exposure Risk Taking (Four items)
2. Drug and alcohol use (i.e. days of use in the past 30-days) and substance dependence (Substance Dependence Scale (SDS); Six items),
3. Psychological health (Kessler-10 Plus (K10); 14 items), and
4. Physical health and social functioning (the EUROHIS-Quality of Life (EQoL, condensed from the abbreviated World Health Organisation (WHO) QOL-BREF; Eight items).

The ATOP<sup>3</sup> was introduced in 2018 into NADAbase. This measure aligns with other outcome domains contained in NADA COMS and is used by 17 organisations. The ATOP is a clinical review tool that measures recent substance use, and the overall health and well-being of people accessing the AOD treatment (22 items)<sup>3</sup>. The ATOP outcome measures in this report comprise data on:

1. Drugs use (include injecting behaviour), (Two items)
2. Psychological health (One item),
3. Physical health (One item), and
4. Quality of life (One item).



## **Analyses**

For sections (1), (2) and (3), the results describing the demographics of people accessing the services were analysed at the individual level.

Descriptive data are reported as number (percentage) and mean (standard deviation). A person's age at the time of assessment was calculated using the time difference between date of episode commencement and the date of birth. The proportion of people with and without outcomes assessment are reported with descriptive statistics.

For sections (2) and (3), where data is available, comparison across subgroups were carried out for outcome measures. As such, the results from the outcomes analyses are pooled from different people at a time point i.e. the same people may not necessarily completed an assessment at each time point. The sub-group analyses were carried out to examine whether differences were observed for people who were in treatment after 30 days, 60 days, 90 days, 120 days, 150 days and 180 days after the initial assessment. As the assessment measures were inconsistently collected at standard times by the organisations, the outcome data were grouped according to the period in which they were completed. The person's first assessment was included (commencement). Outcomes assessments completed before 14-days were not included, as it was considered that people would not have received a 'sufficient dose' of treatment to meaningfully interpret changes over time.

The grouped time periods were baseline, 30-day (14 days to 29 days), 60-day (30 days to 59 days), 90-day (60 days to 89 days), 120-day (90 days to 119 days), and where data is available, 150-day (120 days to 149 days) and 180-day (150 days to 179 days). This grouping of time period was also applied to the definition of stages of which the assessments were carried out, i.e. baseline, Progress 1 that corresponded to 30-day time period, Progress 2 that corresponded to 60-day time period, Progress 3 that corresponded to 90-day time period, Progress 4 that corresponded to 120-day time period and Progress 5 that corresponded to 150-day time period. If a person had completed two outcome assessments during a period, the most recent assessment was included in the analysis. People with missing data were excluded from analyses on a variable-by-variable basis.

All statistical analyses were conducted in SPSS statistical software version 28.0 (IBM) and Excel spreadsheet software version 16.0 (Microsoft).

## RESULTS

The results are presented in three sections:

- Section 1 provides a cross-sectional summary of all MDS data that was collected from 1 July 2021 to 30 June 2022.
- Section 2 presents data that was collected as part of the NADA COMS. It begins by cross-sectionally describing the people that completed at least one NADA COMS assessment, describes completion rates of NADA COMS assessments across treatment episodes, and presents changes in NADA COMS scores over time in treatment's episode.
- Section 3 includes information for people who completed at least one ATOP assessment. It begins by cross-sectionally describing the people that completed at least one ATOP, describes completion rates of ATOP assessments across treatment episodes, and presents changes in ATOP scores over time in treatment's episode.

### Section One: Demographics

From 1 July 2021 to 30 June 2022, 18,420 unique baseline assessments were completed (61% male, 38% female). The average age was 34.3 years (SD 12.90). About 23% of people identified as being Aboriginal and Torres Strait Islander. The majority were Australia-born (90%) and reported that English was their preferred language (98%). Almost half of all people were accessing temporary benefits as their primary source of income (47%). Table 1 illustrates the characteristics of people who accessed NGO AOD services, 2021-2022.

**Table 1 Baseline characteristics of people who accessed NGO AOD services, 2021-2022**

	N, 18,420	%
Age, years		
Younger than 18	1,688	9.2
18-29	5,651	30.7
30-39	4,916	26.7
40-49	3,686	20.0
50-59	1,815	9.9
Older than 60	664	3.6
Aboriginal and Torres Strait Islander		
Neither Aboriginal nor Torres Strait Islander	13,383	72.7
Aboriginal but not Torres Strait Islander	3,984	21.6
Torres Strait Islander but not Aboriginal	50	0.3
Aboriginal and Torres Strait Islander	186	1.0

	<b>N, 18,420</b>	<b>%</b>
Not stated	817	4.4
<b>Sex</b>		
Male	11,309	61.4
Female	7,022	38.1
Not stated or inadequately described	81	0.4
Another term	8	0.1
<b>Gender</b>		
Man or male	11,166	60.6
Woman or female	6,872	37.5
Non-binary	25	0.1
Trans man	20	0.1
Trans woman	21	0.1
Not stated or inadequately described or prefer not to answer	206	1.1
Missing*	110	0.6
<b>Sexuality</b>		
Straight or heterosexual	7,874	42.7
Lesbian, gay, homosexual	328	1.8
Bisexual	281	1.5
Another term	51	0.3
Unknown	<5	0.0
Prefer not to answer	<5	0.0
Not stated or inadequately described	9,880	53.6
<b>Language*</b>		
English	18,102	98.3
Arabic	43	0.2
Vietnamese	34	0.2
Aboriginal English	33	0.2
Persian	27	0.1
Others	181	0.9
<b>Country of birth**</b>		
Australia	16,490	89.5
New Zealand	356	1.9
England	201	1.1
Not Stated	101	0.5
Inadequately Described	74	0.4
Vietnam	68	0.4
Fiji	66	0.4
South Africa	63	0.3
Lebanon	57	0.3
Iran	54	0.3
United States of America	53	0.3
Philippines	46	0.2
Ireland	40	0.2
India	37	0.2

	N, 18,420	%
Others	714	4.0
Income		
Temporary benefit (including unemployment)	8,686	47.2
Full-time employment	2,354	12.8
Pension (including aged, disability)	2,182	11.8
Not stated/not known/inadequately described	2,088	11.3
Part-time employment	1,106	6.0
No income	693	3.8
Dependent on others	603	3.3
Other	378	2.1
Student allowance	254	1.4
Retirement fund	76	0.4
Accommodation		
Rented house or flat (public or private)	9,332	50.7
Privately owned house or flat	4,778	25.9
Not known	1,276	6.9
No usual residence/homeless	899	4.9
Other	528	2.9
Hostel/supported accommodation services	419	2.3
Prison/detention centre	384	2.1
Alcohol/other drug treatment residence	236	1.3
Shelter/refuge	234	1.3
Boarding house	208	1.1
Caravan on a serviced site	102	0.6
Psychiatric hospital	24	0.1

\*County of birth or preferred language listed if there were 5 or more people.

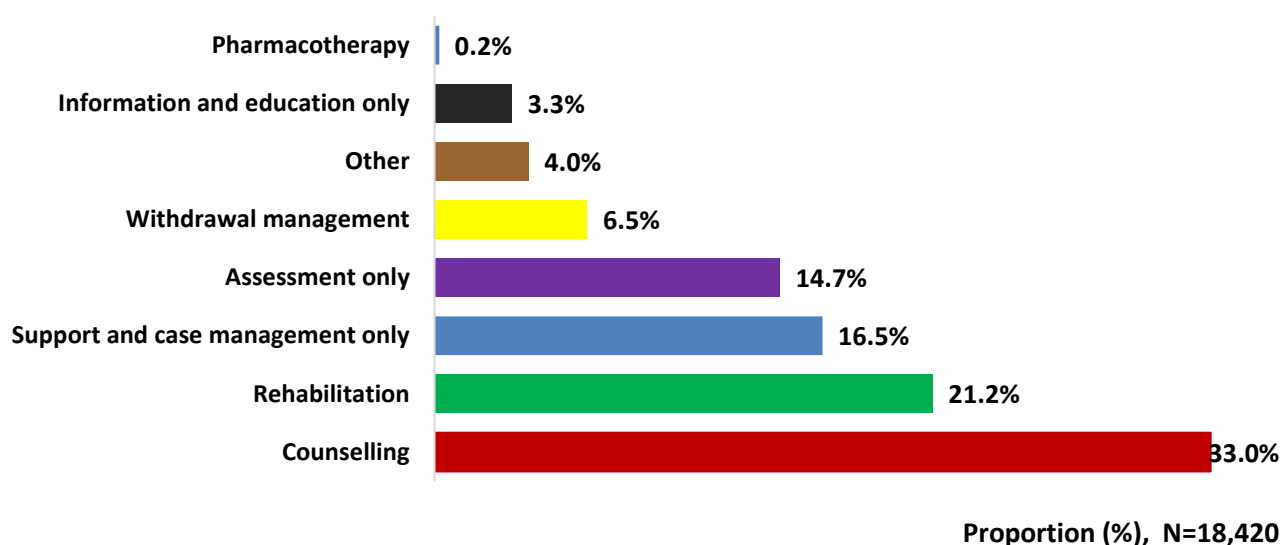
\*\*People with <5 were reported as such to reduce disclosure risk of de-identifying information. This refers to the recommended guideline by ABS to report aggregate data<sup>4</sup>

## Section One: Treatment settings

Of the 18,420 people who accessed the NGO AOD services from 1 July 2021 to 30 June 2022, the majority (93%) accessed treatment from the services located in NSW and 7% were from services located in Queensland.

Figure 1 describes the most common treatment provided to people accessing the NGO AOD services during this period. Counselling (33%), rehabilitation activities (21%), and support and case management (17%) were the three most common main treatment types.

**Figure 1 Primary services accessed by people across NGO AOD services, 2021-2022**



As shown in Table 2, almost half of the services saw people self-referring to services (41%), followed by referral by criminal justice settings (14%) and non-residential community health centre (6%).

**Table 2 Types of referrals from services across NGO AOD, 2021-2022**

Referral source	N, 18,420	%
Self	7465	40.5
Other criminal justice setting	2600	14.1
Non-residential community health centre	1028	5.6
Other	1008	5.5
Non-residential AOD treatment agency	983	5.3
Family member/ friend	970	5.3
Residential AOD treatment agency	871	4.7
Court diversion	691	3.8
General practitioner	661	3.6
Other hospital	399	2.2
Non-residential community mental health care	345	1.9
Family and child protection	317	1.7
Other non-health service agency	305	1.7
Not stated/inadequately described	141	0.8
Residential community mental health care unit	140	0.8
Medical officer	127	0.7
Education institution	121	0.7
Psychiatric hospital	110	0.6
Workplace (EAP)	60	0.3
Other residential community care unit	46	0.2
Police diversion	32	0.2

Figure 2 provides a summary of the primary service delivery settings. Community or outpatient (71.5%) and residential (21.7%) were the most commonly accessed treatment settings.

**Figure 2 Settings of accessed services across NGO AOD, 2021-2022**

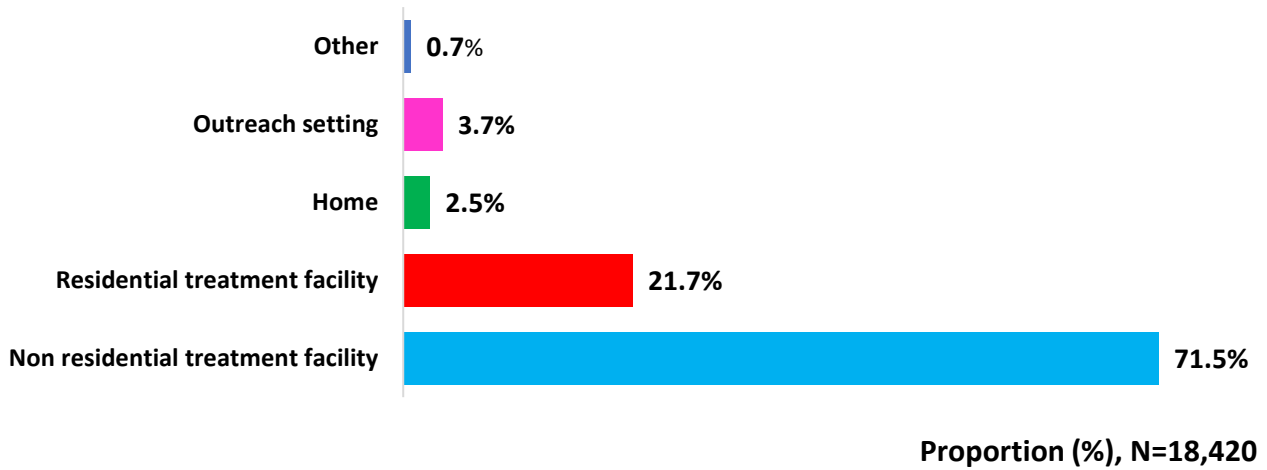
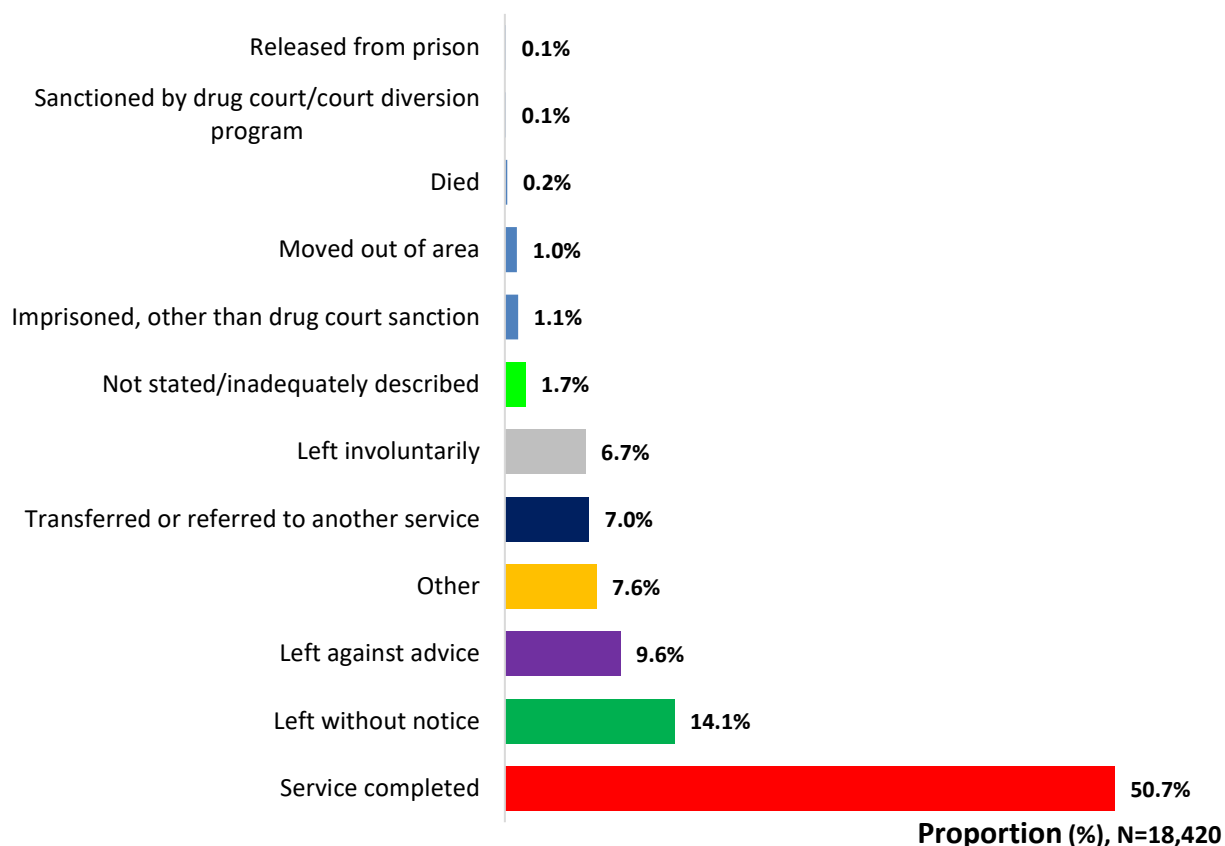


Figure 3 provides a summary of the reasons that people left treatment. These reasons are specified by the organisation at the completion of the persons episode of care. The most common reasons were the completion of treatment (50.7%), leaving against advice (14.1%) and leaving without notice (9.6%).

**Figure 3 Reasons for treatment cessation amongst people accessing NGO AOD services, NSW, 2021-2022**



### Section One: Substances of concern

All people were asked to nominate their primary substance of concern (see Figure 4 ). Most people reported that this was in the context of their own substance use (97.7%) compared to the minority whose nominated substance of concern was on behalf of family members or friends (2.3%). Alcohol was the most cited primary substance of concern (36.0%), followed by methamphetamine (including amphetamine) (28.6%), and cannabinoids (18.4%).

**Figure 4 Most common primary substance use of concern, NGO AOD, 2021-2022**

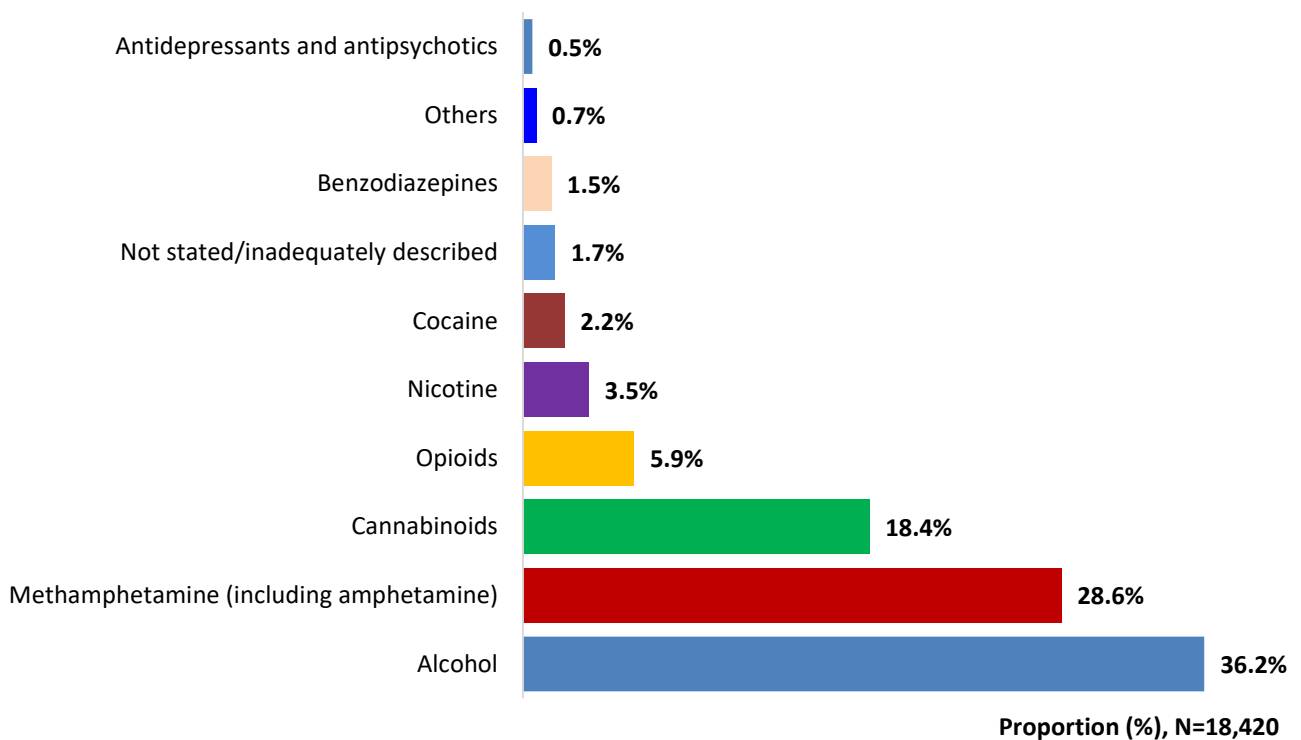
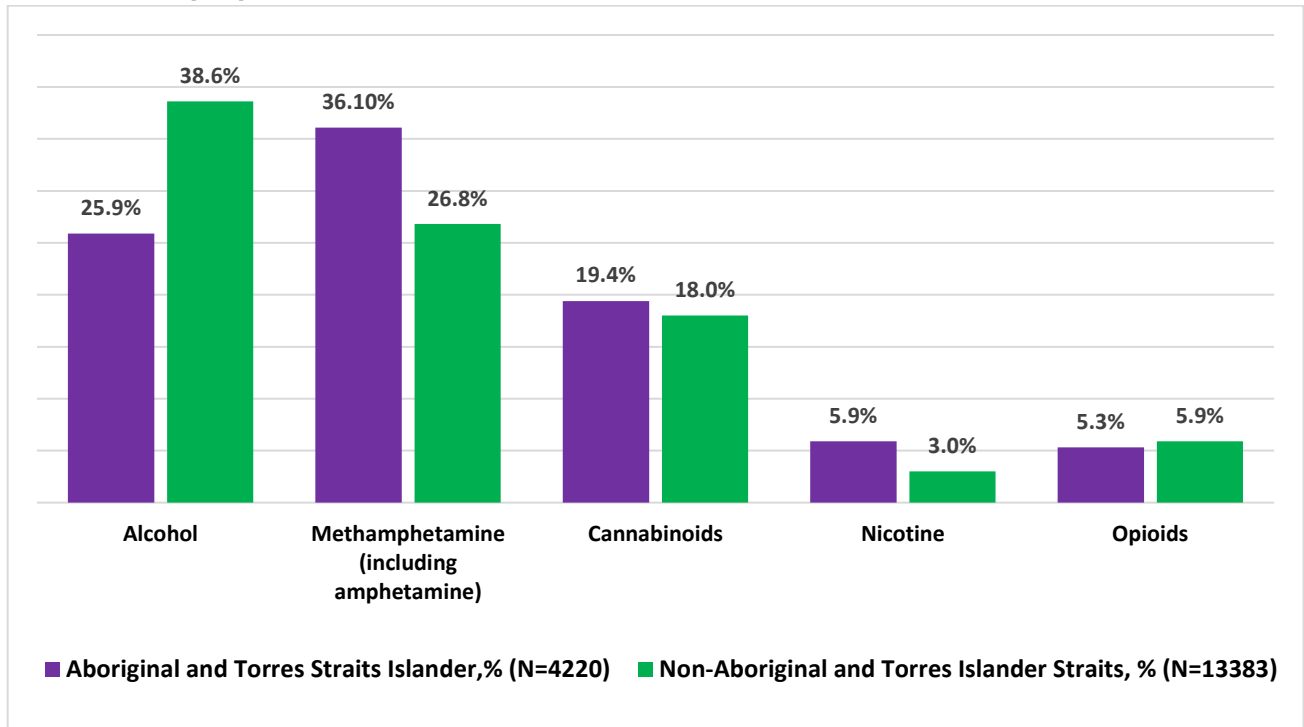


Figure 5 and Figure 6 present the distribution for primary substance of concern across Aboriginal and Torres Strait Islander status and sex, respectively. These figures included the most cited primary substances of concern, i.e. methamphetamine (including amphetamine), alcohol, cannabinoids, opioids and nicotine.

As seen in Figure 5, the primary substance of concern differed between people who identified as Aboriginal and Torres Strait Islander, and who did not identify as Aboriginal and Torres Strait Islander. Methamphetamine (including amphetamine) was the most cited substance of concern for Aboriginal and Torres Strait Islander people (36.1%), with alcohol being the most cited substance for the non-Aboriginal and Torres Strait Islander people (38.6%). Figure 6 shows that the primary substance of concern were consistent between males and females. Alcohol was the most cited substance of concern for both sexes (36.6% for males, and 35.1% for females).

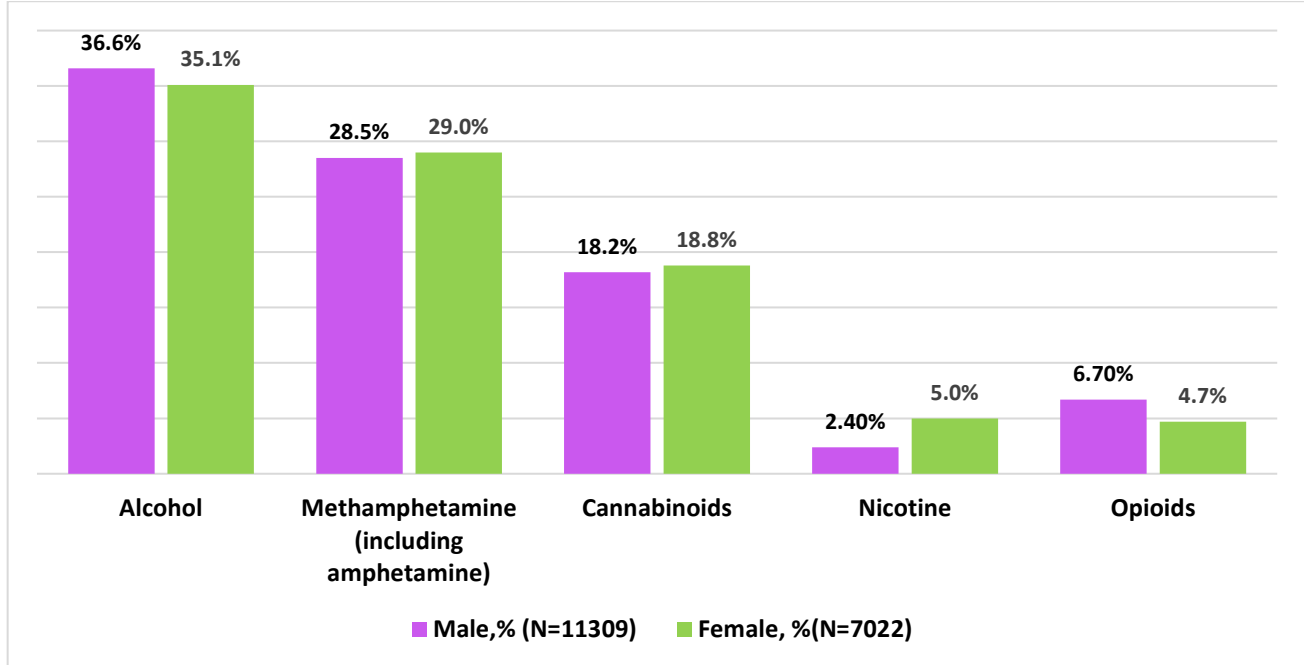


**Figure 5 Distribution of most common primary substance use of concern by Aboriginal and Torres Strait Islander people, NGO AOD, 2021-2022**



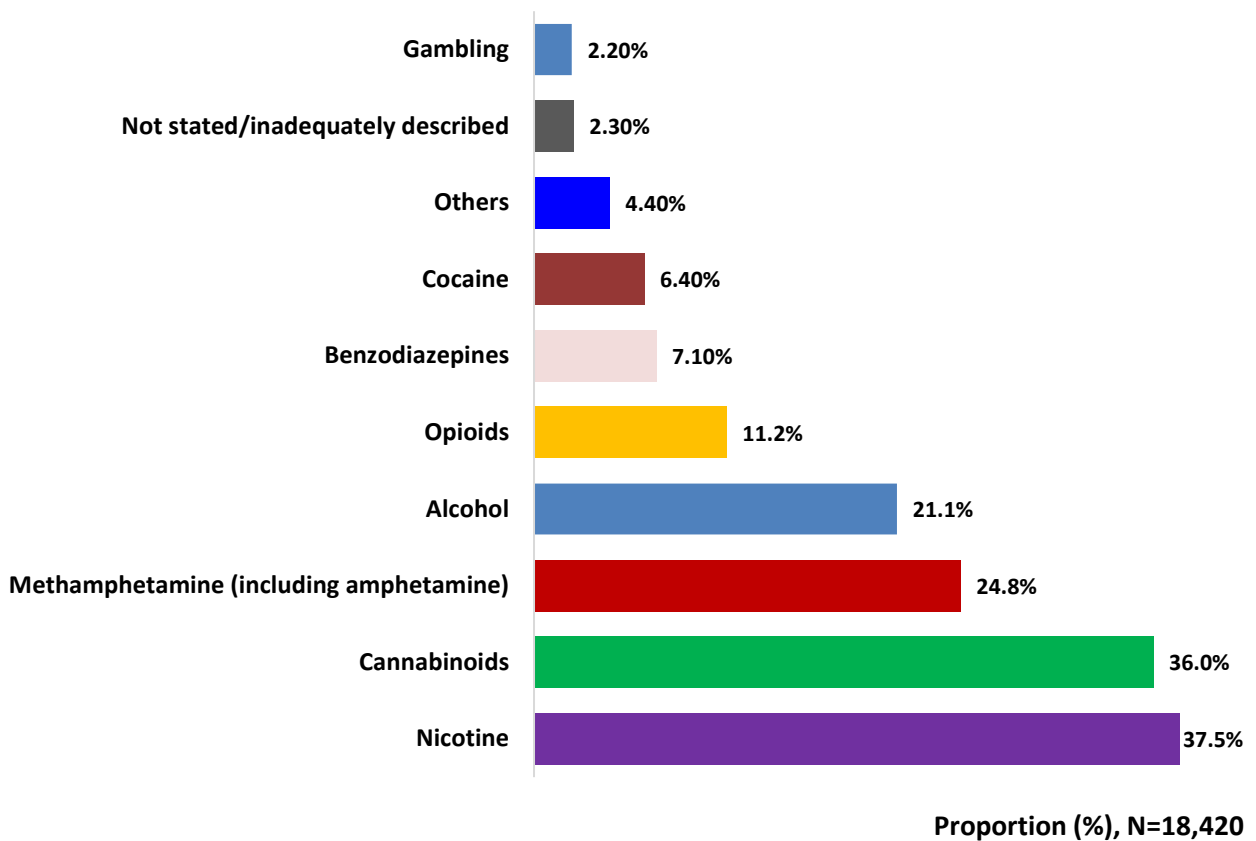
\*Missing values for information on their identification as Aboriginal and Torres Strait Islander people, 4.4% (N=817)

**Figure 6 Distribution of most common primary substance use of concern by sex, NGO AOD, 2021-2022**



People were also asked to nominate any other substances of concern (see Figure 7). More than a third of the people reported polydrug use (38.9%), with nicotine (37.5%) being the most highly nominated 'other drug of concern'. This was followed by cannabis (36.0%), Methamphetamine (including amphetamine) (24.8%) and alcohol (21.1%).

**Figure 7 Distribution of secondary substance of concern, NGO AOD, 2021-2022**



## **Section Two: Outcomes data using NADA COMS**

This section describes the total assessments completed for the measurement of outcomes (NADA COMS) for people whose episodes were closed within 2021-2022 period and compares the data available since 2012.

## **Section Two: Distribution of completed NADA COMS, by year**

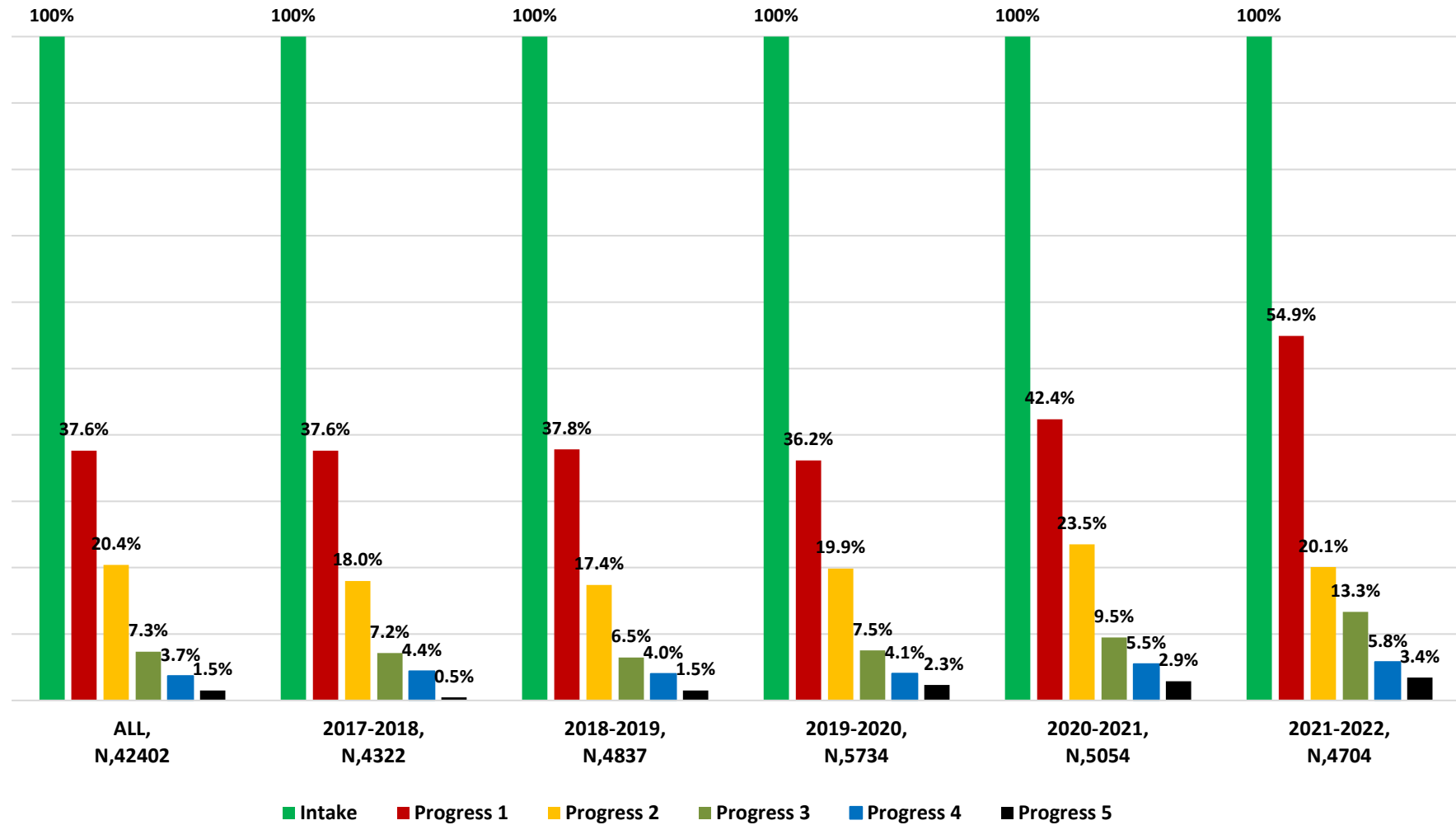
Figure 8 provides an overview of the total NADA COMS that have been completed since the NADAbase was set-up, i.e. 2012-22 and for the previous 5-year period, 2017-2018, 2018-2019, 2019-2020, 2020-2021 and 2021-2022. This finding is limited to those who had completed a baseline NADA COMS assessment (i.e. 100%). To re-iterate the definition of stages of the assessments carried out, each progress refers to the 30-day interval after the baseline assessment is carried out. Baseline assessment includes initial assessment that is carried out within 14 days of the commencement of an episode. Each subsequent progress is denoted by a 30-day interval, i.e. Progress 1 corresponded to a 30-day post-baseline, and Progress 5 included those assessments carried out within 150-day time period.

For 2021-2022, 54.9% had an assessment carried out at Progress 1 and the proportions were reduced to 20.1% for Progress 2 and increased slightly to 25.5% at Progress 3. This was an improvement compared to 2021-2020 and across 2012-2022, which saw 42.4% (Progress 1) and 37.6% (Progress 2).

## **Section Two: Distribution of completed NADA COMS assessments across different treatment settings, by stages of assessments**

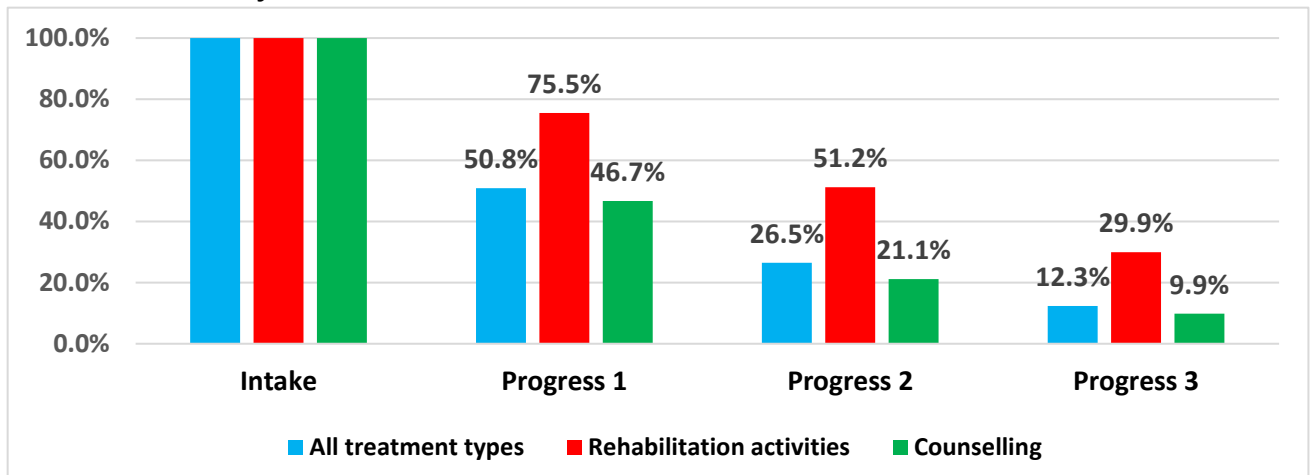
The following figures present the proportions of assessments completed for people who stayed in treatment for 30-days or more (**Figure 9**), 60-days or more (**Figure 10**), and 90-days or more (**Figure 11**). Each figure presents the total number of assessments completed by all people (blue bars), people who attended residential activities (red bar) or counselling (green bars).

**Figure 8 Distribution of completed NADA COMS across stages of treatment, by year**

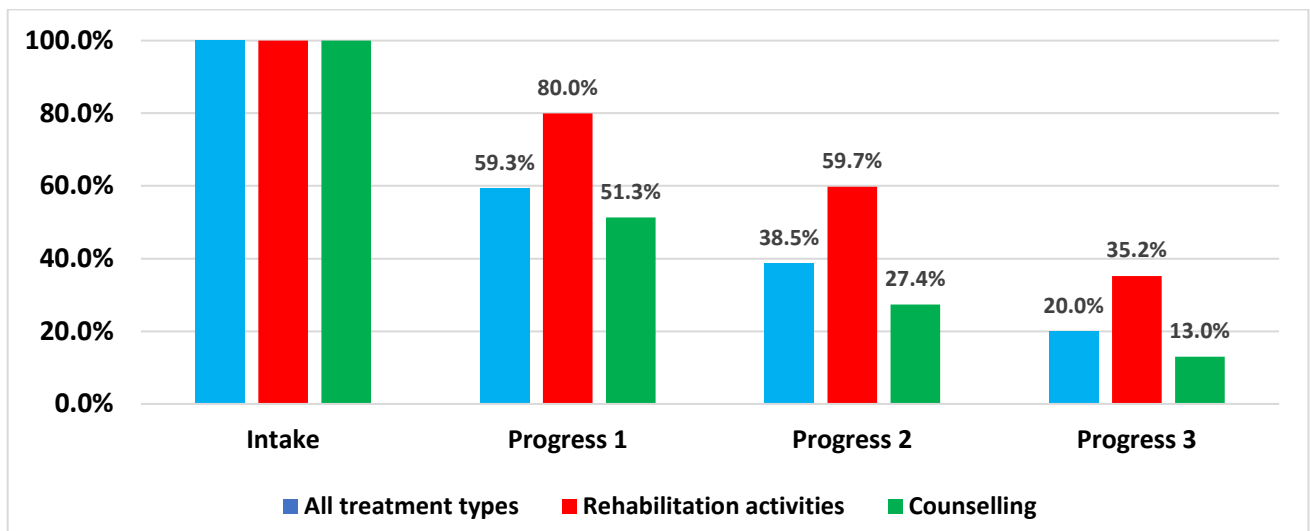


\*The proportion for baseline (intake) assessments across all time periods is 100%, as the analysis focused on people who completed an baseline assessment.

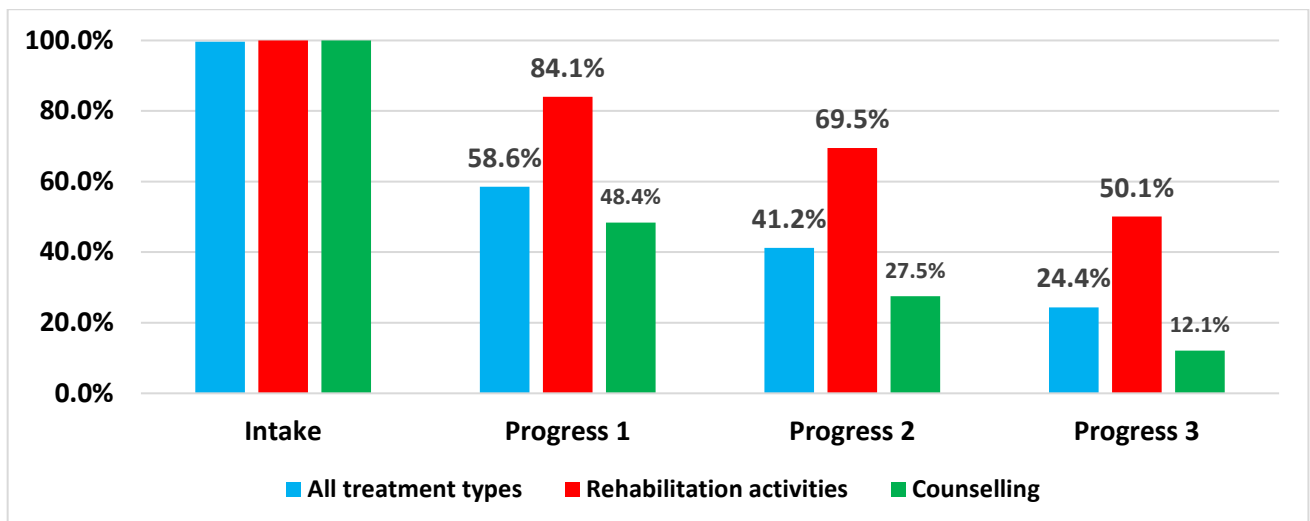
**Figure 9 Distribution of NADA COMS progress assessments completed for people who stayed in treatment for 30-days or more, NGO AOD services, 2021-2022**



**Figure 10 Distribution of NADA COMS progress assessments completed for people who stayed in treatment for 60-days or more NGO AOD services, 2021-2022**



**Figure 11 Distribution of NADA COMS progress assessments completed for people who stayed in treatment for 90-days or more, NGO AOD services, 2021-2022**



## Section Two: Demographics of people who completed a NADA COMS

There were 4704 unique commencement assessments completed (62% by people who identified as male and 38% for those who identified female as their sex). Their average age was 34.1 years (SD 12.0). About 22% of people were Aboriginal and/or Torres Strait Islander. Most people were born in Australia (89%) and reported that English was their preferred language (97%). Forty-three percent of all people were accessing temporary benefits as their primary source of income. Table 3 illustrates further descriptions of the demographics.

**Table 3. Baseline characteristics of people who completed a NADA COMS assessment in NGO AOD services, 2021-2022**

	N, 4,704	%
Age, years		
Younger than 18	619	13.2
18-29 years old	1667	35.4
30-39 years old	1107	23.5
40-49 years old	784	16.7
50-59 years old	419	8.9
Older than 60 years old	108	2.3
Aboriginal and Torres Strait Islander		
Neither Aboriginal nor Torres Strait Islander	3,587	76.3
Aboriginal but not Torres Strait Islander	962	20.5
Torres Strait Islander but not Aboriginal	91	1.9
Aboriginal and Torres Strait Islander	42	0.9
Not Stated	22	0.5
Sex		
Male	2,894	61.5
Female	1789	38.0
Not stated or inadequately described	21	0.4
Gender*		
Man or male	2,860	60.8
Woman or female	1,726	36.7
Trans man	9	0.2
Trans woman	14	0.3
Non-binary	<5	N/A
Prefer not to answer	<5	N/A
Sexuality***		
Not stated or inadequately described	2,314	49.2
Straight or heterosexual	2,146	45.6
Lesbian, gay, homosexual	133	2.8
Bisexual	83	1.8
Another term	26	0.6
Unknown	<5	N/A

	N, 4,704	%
Prefer not to answer	<5	N/A
<b>Language**</b>		
English	4,566	97.1
Arabic	19	0.4
Not Stated	18	0.4
Vietnamese	15	0.3
Persian, excluding Dari	11	0.2
Others	75	1.3
<b>Country of birth**</b>		
Australia	4,192	89.1
New Zealand	116	2.5
England	44	0.9
Vietnam	22	0.5
Lebanon	20	0.4
South Africa	19	0.4
United States of America	16	0.3
Iran	15	0.3
Others	260	4.5
<b>Income</b>		
Temporary benefit (including unemployment)	2023	43
Pension (including aged, disability)	842	17.9
Full-time employment	522	11.1
Dependent on others	381	8.1
Part-time employment	355	7.5
Not stated/not known/inadequately described	216	4.6
No income	190	4.0
Other	102	2.2
Student allowance	57	1.2
Retirement fund	16	0.3
<b>Accommodation</b>		
Rented house or flat (public or private)	2,474	52.6
Privately owned house or flat	1,191	25.3
No usual residence/homeless	240	5.1
Not known	200	4.3
Other	139	3.0
Alcohol/other drug treatment residence	118	2.5
Shelter/refuge	94	2.0
Hostel/supported accommodation services	87	1.8
Boarding house	73	1.6
Prison/detention centre	44	0.9
Caravan on a serviced site	37	0.8
Psychiatric hospital	7	0.1

\*County of birth or preferred language listed if there were 5 or more people.

\*\* People with <5 were reported as such to reduce disclosure risk of de-identifying information. This refers to the recommended guideline by ABS to report aggregate data<sup>4</sup>

## Section Two: Treatment setting of people who completed a NADA COMS

Of the people who entered treatment during the period, 38% were attending rehabilitation activities (see Figure 12). This was followed by people accessing counselling (35%) and people attending for support and case management (19%).

**Figure 12 Distribution of primary services accessed by people who had completed a NADA COMS across NGO AOD, 2021-2022**

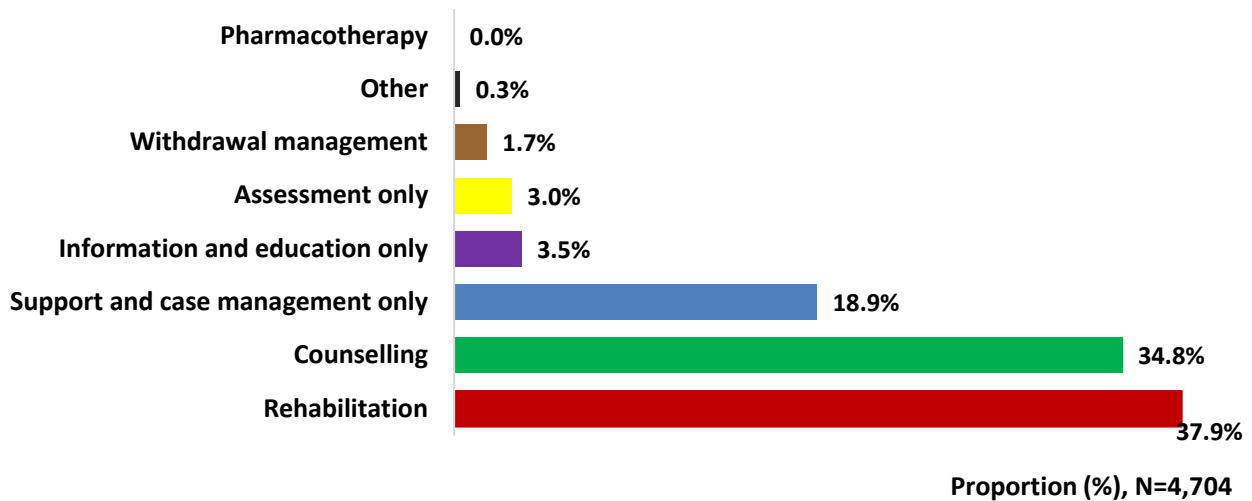


Figure 13 provides a summary of the primary service delivery settings. Community or outpatient (62.3%) and residential (31.0%) were the most common accessed treatment settings.

**Figure 13 Distribution of treatment settings of accessed service by people with NADA COMS, NGO AOD, 2021-2022**

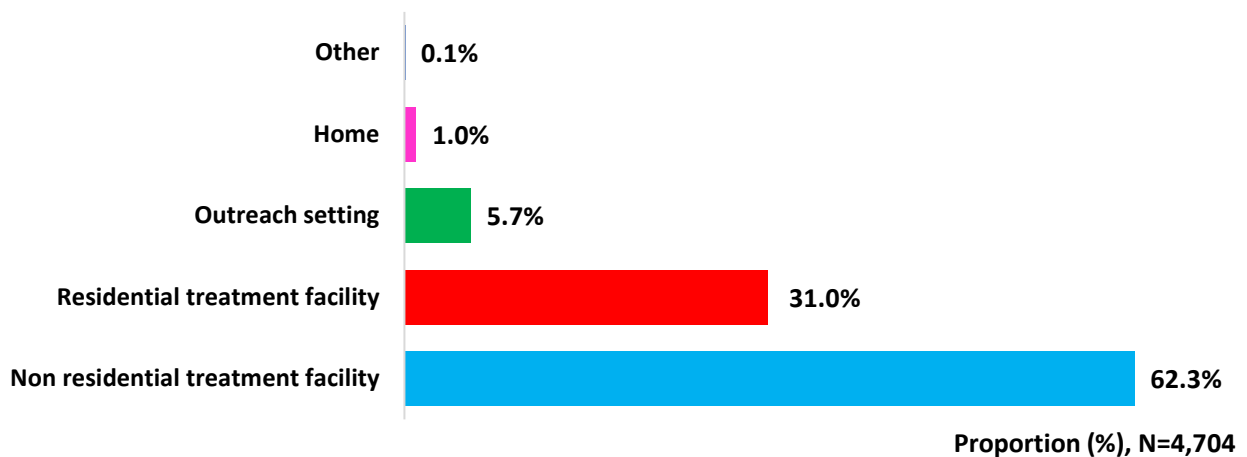
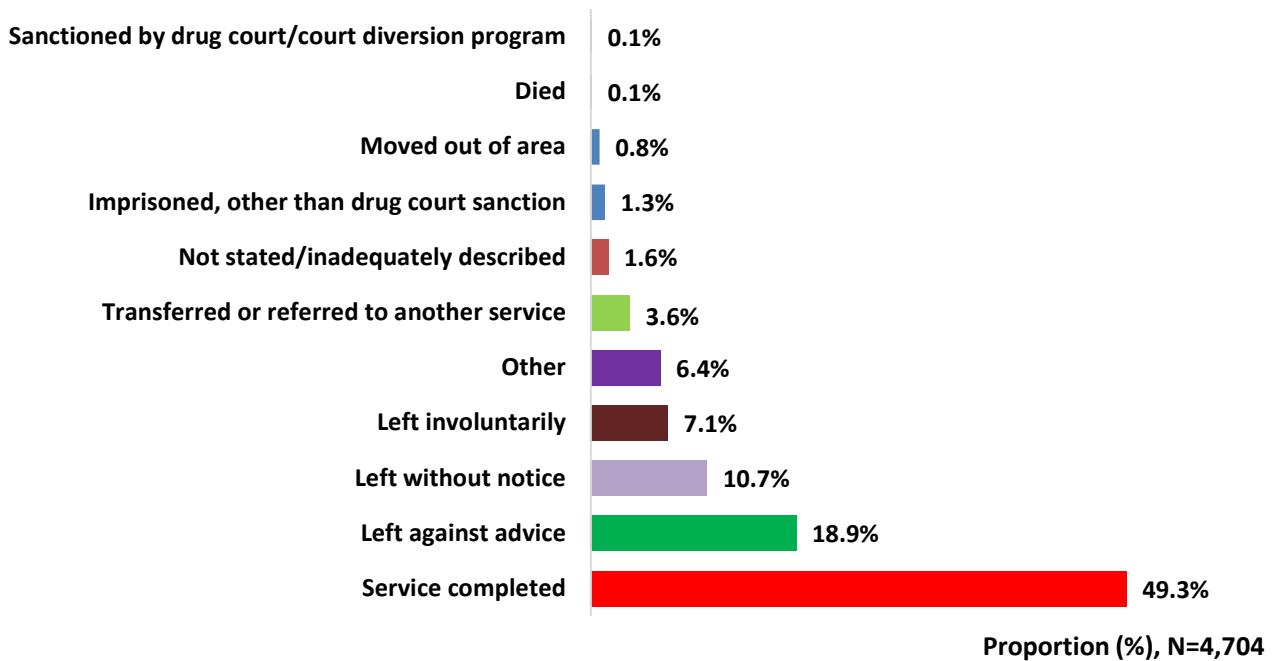




Figure 14 provides a summary of the reasons that people left treatment. These reasons are specified by the organisation at the completion of the persons episode of care. The most common reasons were the completion of treatment (49.3%), leaving against advice (18.9%), and leaving without notice (10.7%).

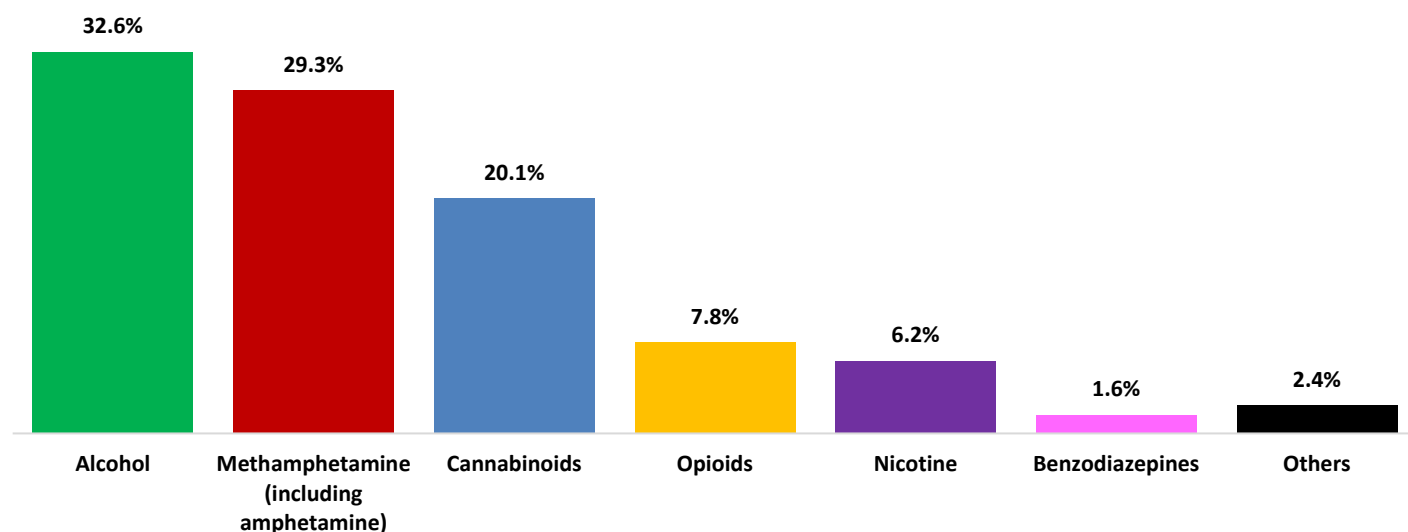
**Figure 14 Distribution of reasons for treatment cessation amongst people accessing NGO AOD services, 2021-2022**



## Section Two: Substances of concern for people who completed a NADA COMS assessment

All people were asked to nominate their primary substance of concern (see Figure 15). Alcohol was the most cited primary substance of concern (36.0%), followed by methamphetamine (including amphetamine) (28.6%) and cannabinoids (18.4%).

**Figure 15 Distribution of most common primary substance use of concern amongst people who completed a NADA COMS, NGO AOD, 2021-2022**



## Section Two: BBV Exposure risk assessments

People were asked to indicate when they last “injected” any drug. As seen in Table 4, 58% of people had ‘never injected’ any substances. Of those people who had “injected” drugs in the last 3-months (n =629), 121 (19%) had shared needles and 144 (23%) had shared injection equipment during this period. Fourteen people (3.0%) who reported injecting during the previous 3-months also reported that they overdosed in the previous 3-months.

**Table 4 Injecting practices amongst people accessing NGO AOD services, 2021-2022**

	N, 4,704	%
<b>History of injecting</b>		
Never injected	2722	57.9
Last injected within the previous 3-months	629	13.4
Not asked	611	13
Last injected more than 3-months ago, but less than twelve months ago	348	7.4
Last injected 12-months ago or more	324	6.9
Not stated / inadequately described	70	1.5
<b>Needle sharing practices*</b>		
Never	2692	57.8
Not asked	417	8.9
Once	42	0.9
More than 10 times	29	0.6
3 to 5 times	20	0.4
Twice	20	0.4

	N, 4,704	%
6 to 10 times	10	0.2
Missing*	1474	31.3
<b>Use of shared equipment*</b>		
No	794	16.9
Yes	144	3.1
Missing*	3766	80.1

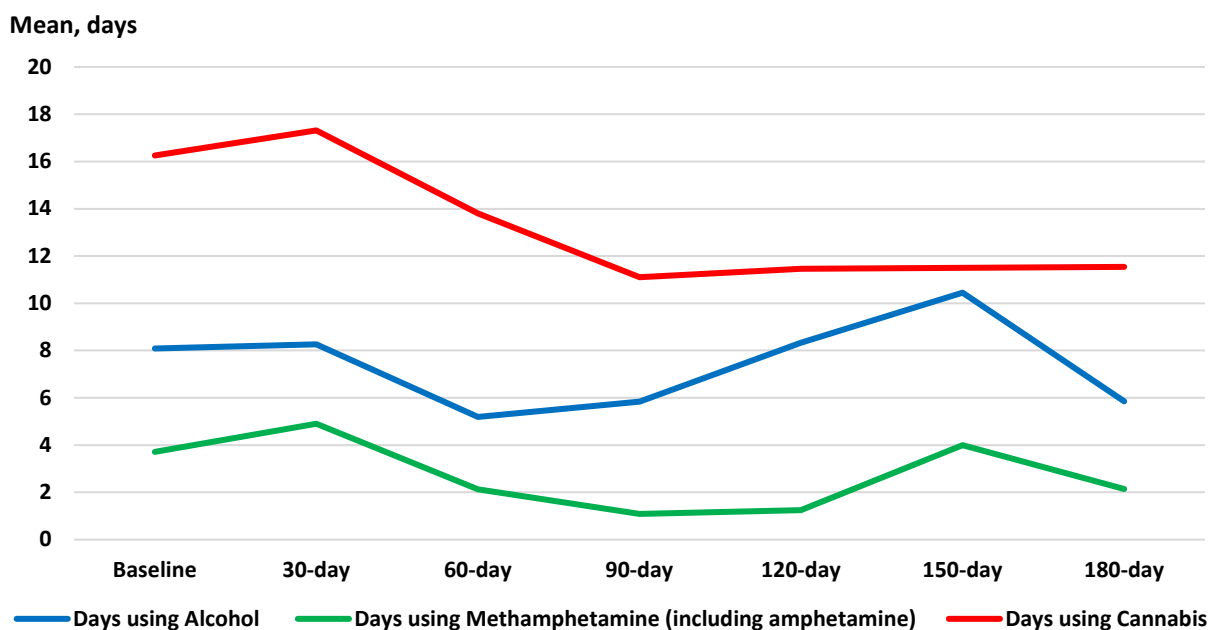
\*Information that were missing for more than 10% were reported for needle sharing practices and use of shared equipment. These variables had missing information due this survey item was mandated to be assessed across all services.

## Section Two: Drug and Alcohol Use (Days of using substances)

Figure 16 shows the average (mean values) of days using substances, stratified by primary substances of concern amongst clients who completed a COMS in a community setting across a 30-day time point since the initial assessment. The findings are limited to the three most common primary substances of concern.

On average at baseline, the number of days of using each month was highest for cannabis (see Figure 16). Overall, there is an improvement in the average number of days using cannabis as people stayed in the treatment longer after the initial assessment, i.e., from 30-day to 180-day time point. This pattern is not observed for those who reported using alcohol or methamphetamine (including amphetamine).

**Figure 16 Average days of using substances of concern in a community setting NGO AOD, 2021-2022**



\*restricted to people who nominated alcohol or methamphetamine (including amphetamine) or cannabis as their primary substance of concern

## **Section Two: Trends of NADA outcome measures across different groups**

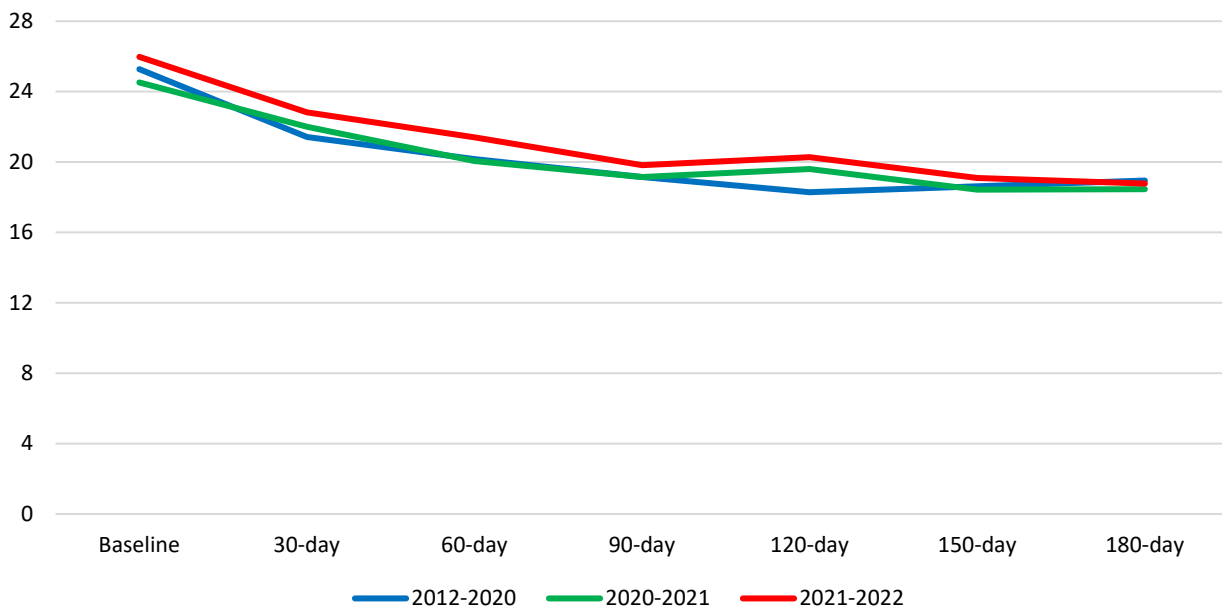
This section presents changes in NADA COMS average scores across a person's treatment episode. It includes sub-analyses that examine changes based on (1) sex, (2) Aboriginal and Torres Straits Islander, and (3) service setting (i.e., counselling, rehabilitation and support & case management). Each figure provides a comparison between people who accessed treatment during the current period (i.e., from 1 July 2021 to 30 June 2022), the previous period (1 July 2020-30 June 2021), and the past periods (2012-2020).

As the same people 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, symptoms of 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 reduced (i.e., scores decreased). Quality of life (measured by the EUROHIS WHO 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.

## **Section Two: Average trends of NADA COMS measures**

As seen in Figure 17, overall, there is a general reduction of mean K10 scores (average levels of distress) across treatment episodes. Compared to 2020-2021 and 2012-2020 periods, the 2021-2022 period reported the highest average scores for levels of distress and this pattern is consistent across baseline, 30-, 60-, 90-, 120-, 150- and 180- timepoints. Both 2020-2021 and 2021-2022 periods observed a similar downward trend of reduction in the mean K10 scores from baseline to 90 days after the initial assessment.

**Figure 17 Distribution of mean K10 scores across different time-points, NGO AOD, 2012-2022**



Similarly, there is a general reduction of average levels of dependence for their nominated primary of substance across treatment episodes (see Figure 18). There is an observed slight rise of the average SDS scores at the 90-day time point of the treatment episode before the overall observed decline in the levels after 90-day time point.

**Figure 18 Distribution of mean SDS scores across different time-points, NGO AOD,2012-2022**

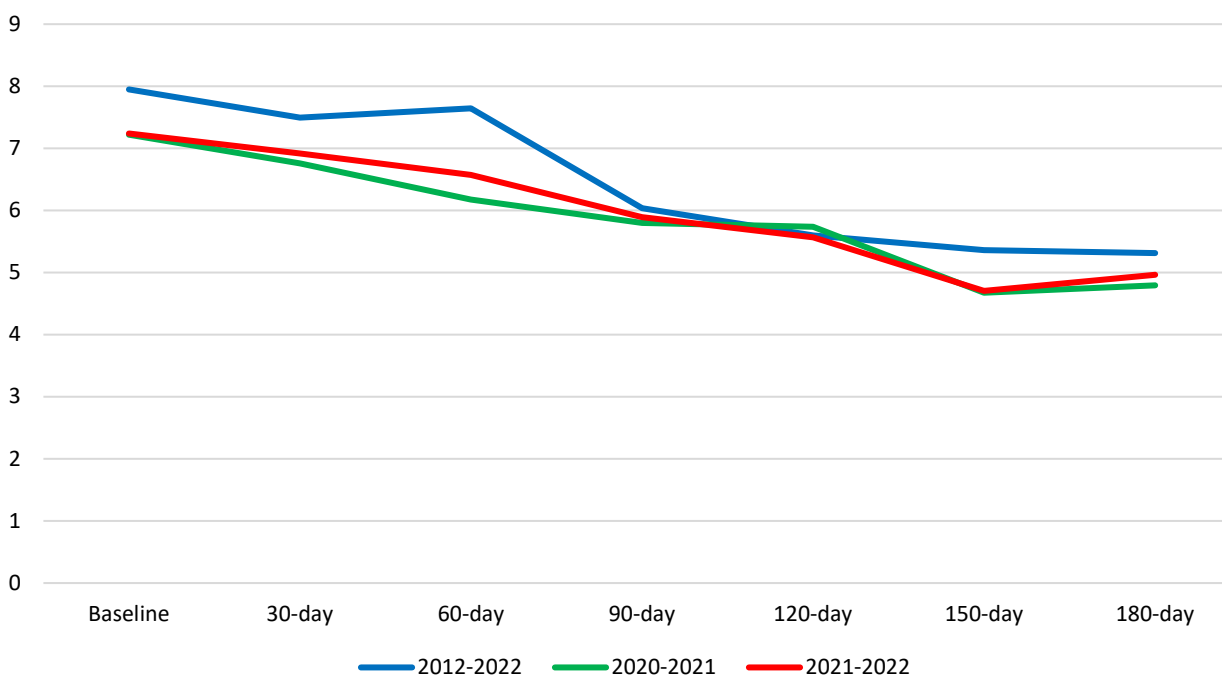
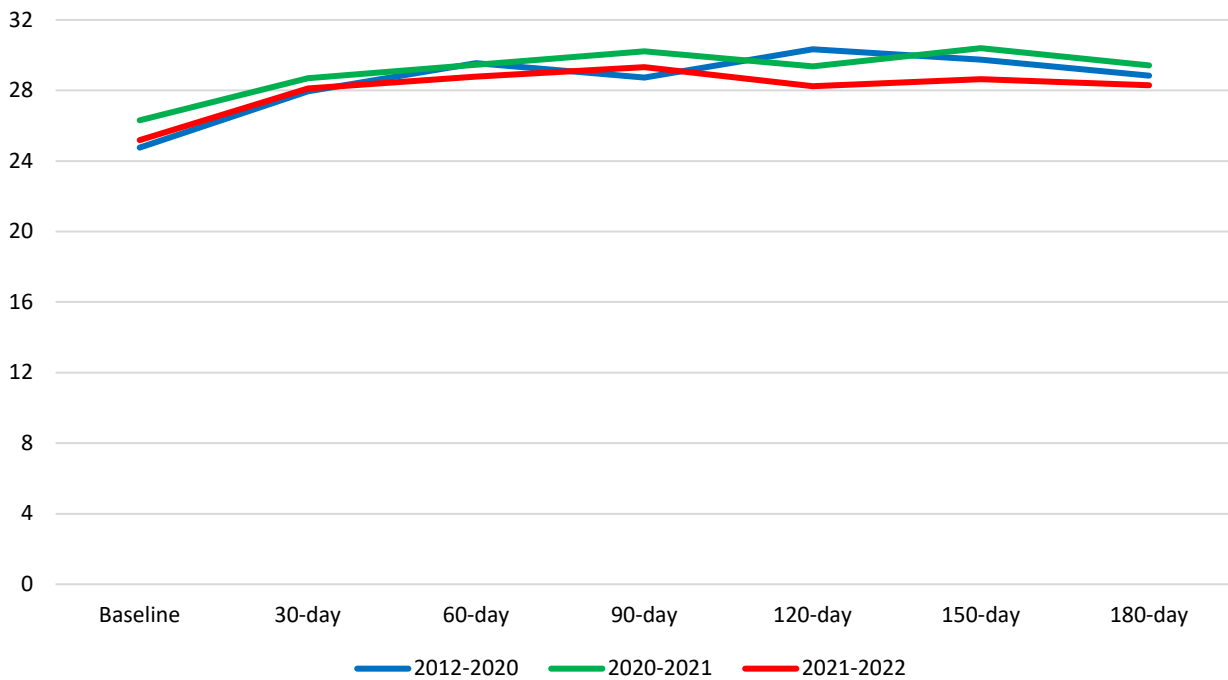


Figure 19 also shows an improvement in the average QoL scores across treatment episodes from baseline to 180-day time point. This pattern is observed throughout each time period.

**Figure 19 Distribution of mean Quality of life (QOL) scores across different time-points, NGO AOD,2012-2022**



**Section Two: Average trends of NADA COMS measures across people who identified as female and male as their sex**

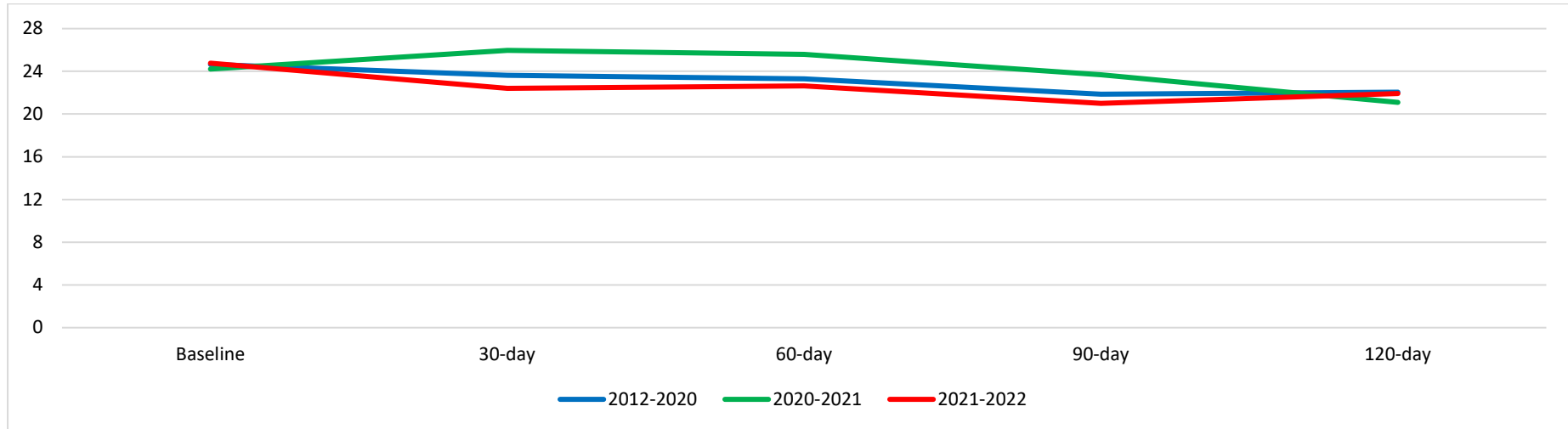
The findings are limited to people who identified as female and male due to the available data across different time points. Both Figure 20 and Figure 21 show the differences between females and males, with females consistently having a higher average level of distress (mean K10 scores) at baseline and the subsequent time points. The trend showed improvement over the time for females across the three time periods. In contrast, males reported an inconsistent level of distress (mean K10 scores), having the lowest average level at 90 days after the initial assessment.

Both Figure 22 and Figure 23 show the differences between people who identified as females and males as their sex, with females having a higher average level of dependence (mean SDS scores) at baseline and the subsequent time points. The trend showed improvement over the time for males

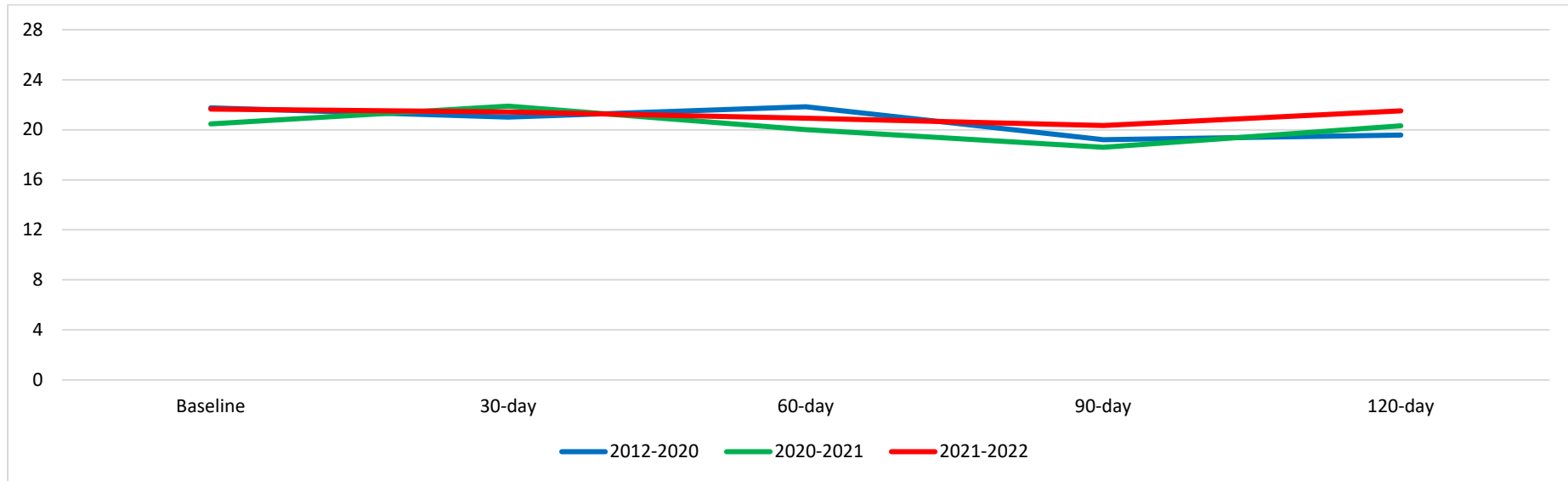
across the three time periods. In contrast, females reported an inconsistent level of dependence (mean SDS scores) across all timepoints after the initial assessment.

Both Figure 24 and Figure 25 show the differences between people who identified as females and males as their sex, with males consistently having a higher average level of QoL (mean QoL scores) at baseline and the subsequent time points. The trend was relatively stable over the time for males across the three time periods, with a sharp reduction at the 120-day time point for 2021-2022 period. Similarly, females also reported a lower average QoL scores after 90-day and 120-day timepoint after initial assessment across the three time periods.

**Figure 20 Distribution of mean K10 scores across different time-points among people who identified as females as their sex, NGO AOD, 2012-2022**

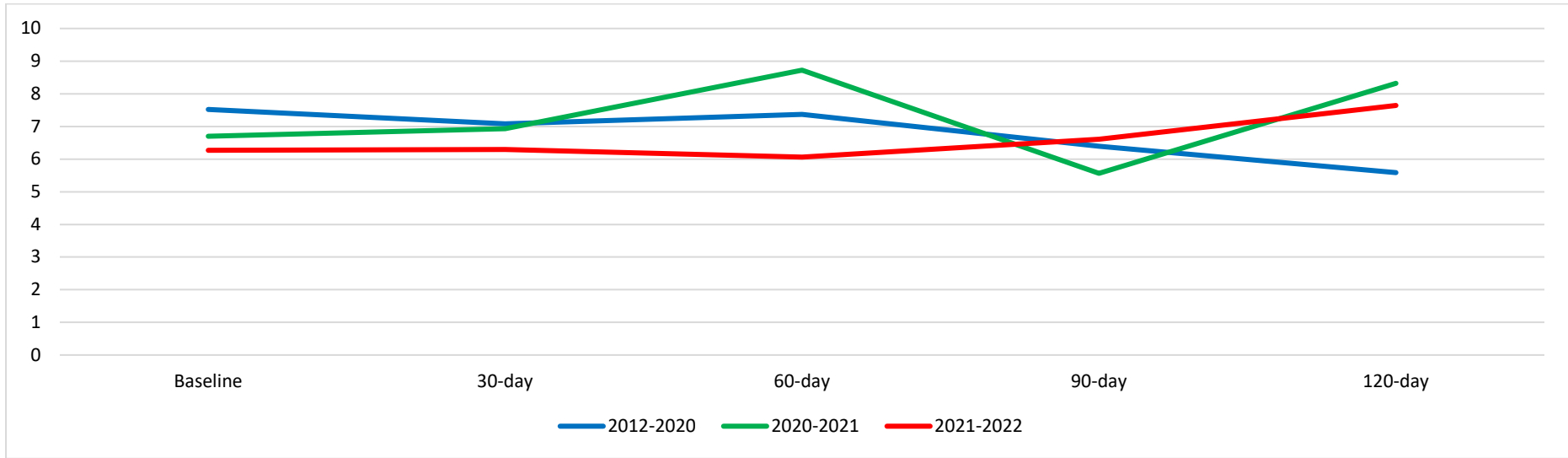


**Figure 21 Distribution of mean K10 scores across different time-points among people who identified as males as their sex, NGO AOD, 2012-2022**

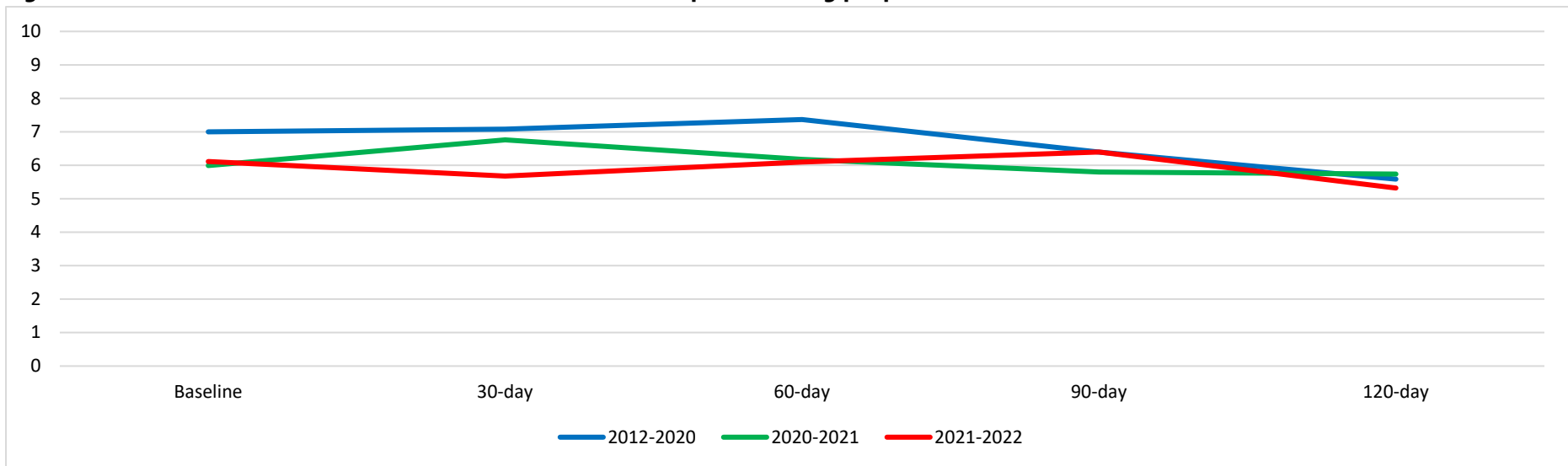




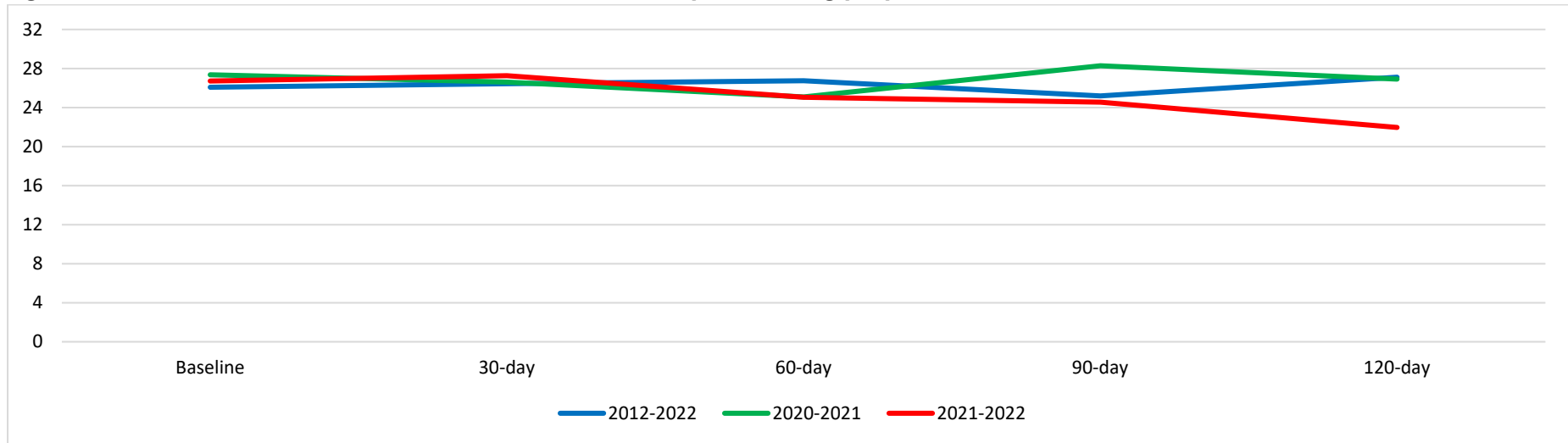
**Figure 22 Distribution of mean SDS scores across different time-points among people who identified as females as their sex, NGO AOD, 2012-2022**



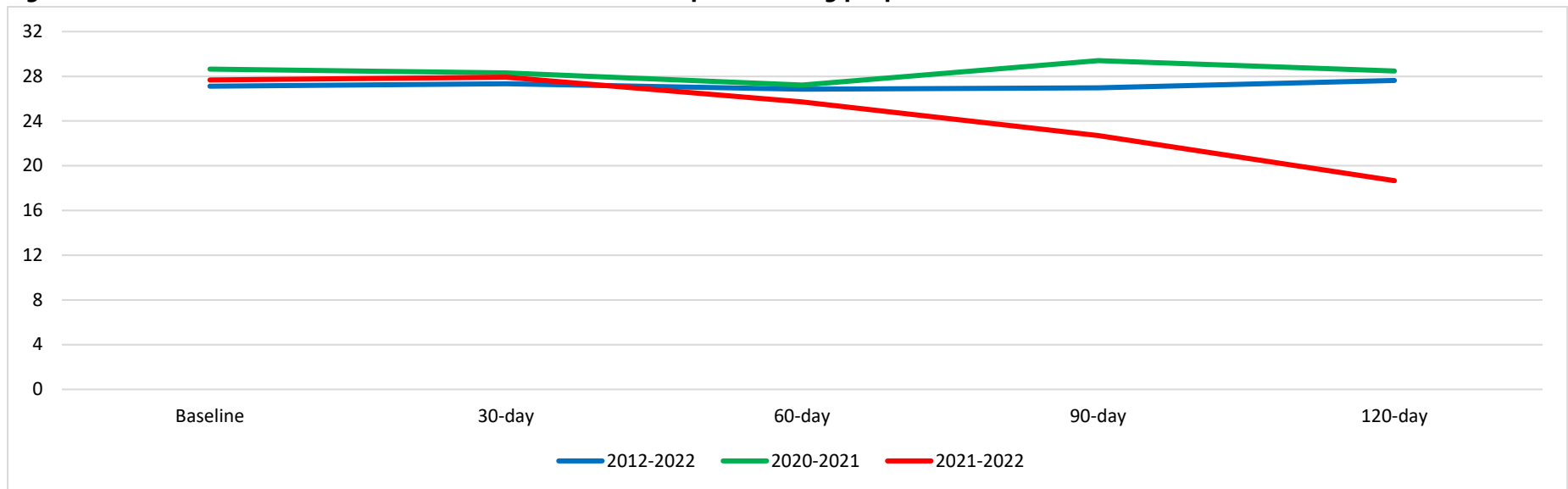
**Figure 23 Distribution of mean SDS scores across different time-points among people who identified as males as their sex, NGO AOD, 2012-2022**



**Figure 24 Distribution of mean QoL scores across different time-points among people who identified as females, NGO AOD, 2012-2022**



**Figure 25 Distribution of mean QoL scores across different time-points among people who identified as males, NGO AOD, 2012-2022**



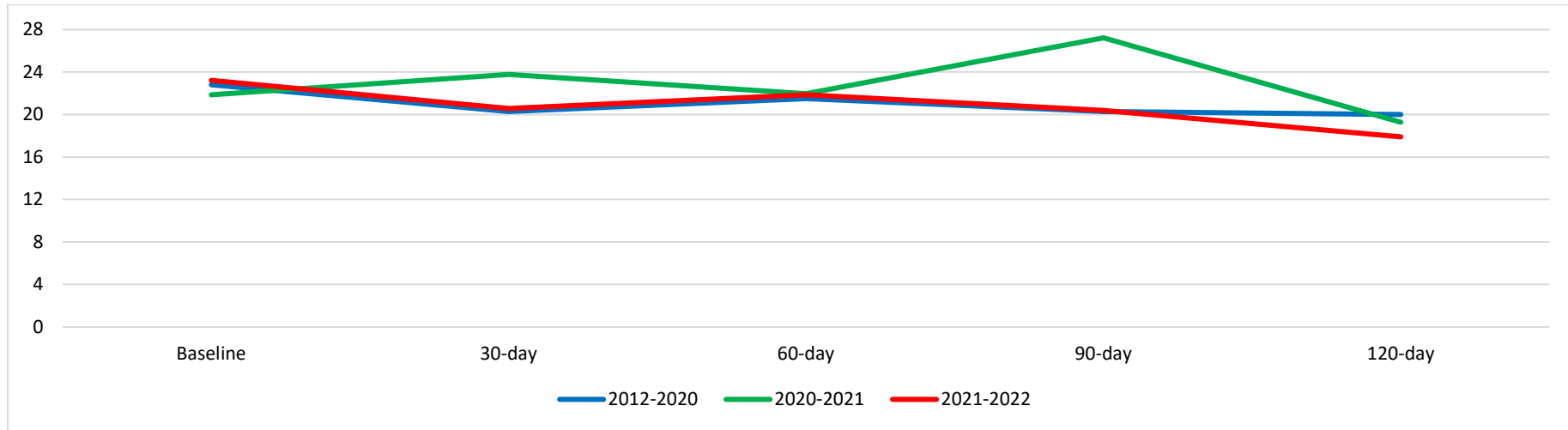
## **Section Two: Average trends of NADA COMS measures across people who identify as Aboriginal and Torres Straits Islander and who did not identify as Aboriginal and Torres Straits Islander**

Both Figure 26 and Figure 27 show the differences between people who identified as Aboriginal and Torres Strait Islander and people who did not identify as Aboriginal and Torres Strait Islander. The Aboriginal and Torres Strait Islander people consistently having a higher level of distress (mean K10 scores) at baseline and the subsequent time points, having inconsistent levels of distress (mean K10 scores) across all the three time-points. In contrast, the trend showed improvement over the time for non- Aboriginal and Torres Strait Islander people across the three time periods.

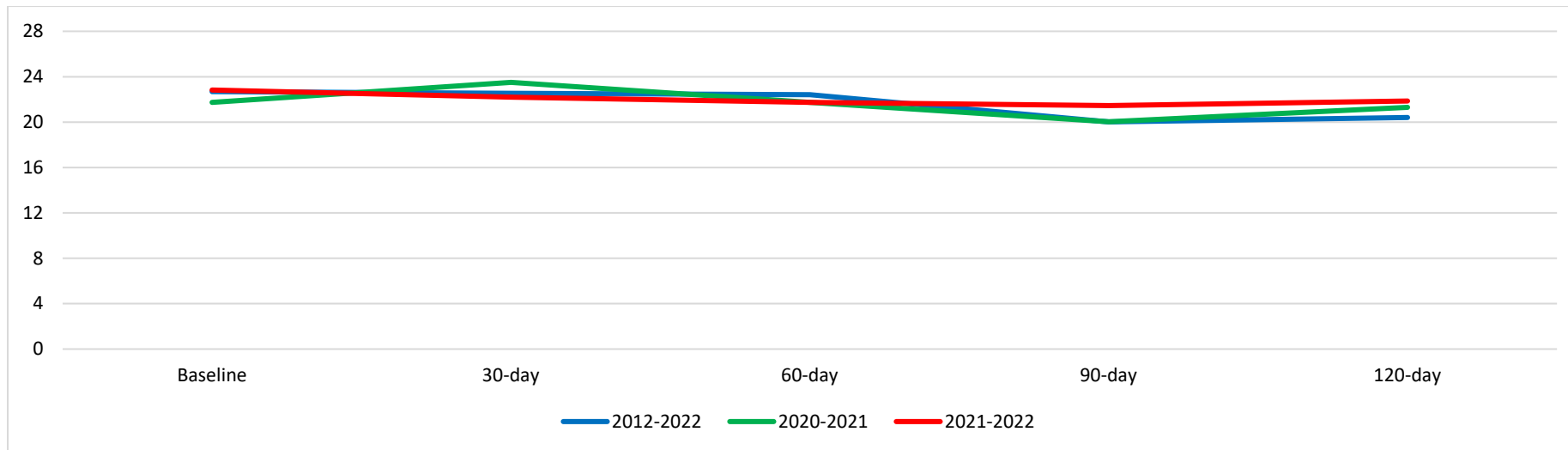
Both Figure 28 and Figure 29 show the differences between people who identified as Aboriginal and Torres Strait Islander and who did not identify as Aboriginal and Torres Strait Islander, with both groups showed improvement in their levels of dependence (mean SDS scores) for the nominated substance of concern over the time across the three time periods.

Both Figure 30 and Figure 31 show the differences between people who identified as Aboriginal and Torres Strait Islander and who did not identify as Aboriginal and Torres Strait Islander, with both groups showed improvement over the time for their average level of quality of life (mean QoL scores) across the three time periods. However, for 2021-2022, the overall trend showed deterioration over the time for their average level of quality of life (mean QoL scores) after the 30-day timepoint as both groups of people stayed in treatment for longer than 30 days.

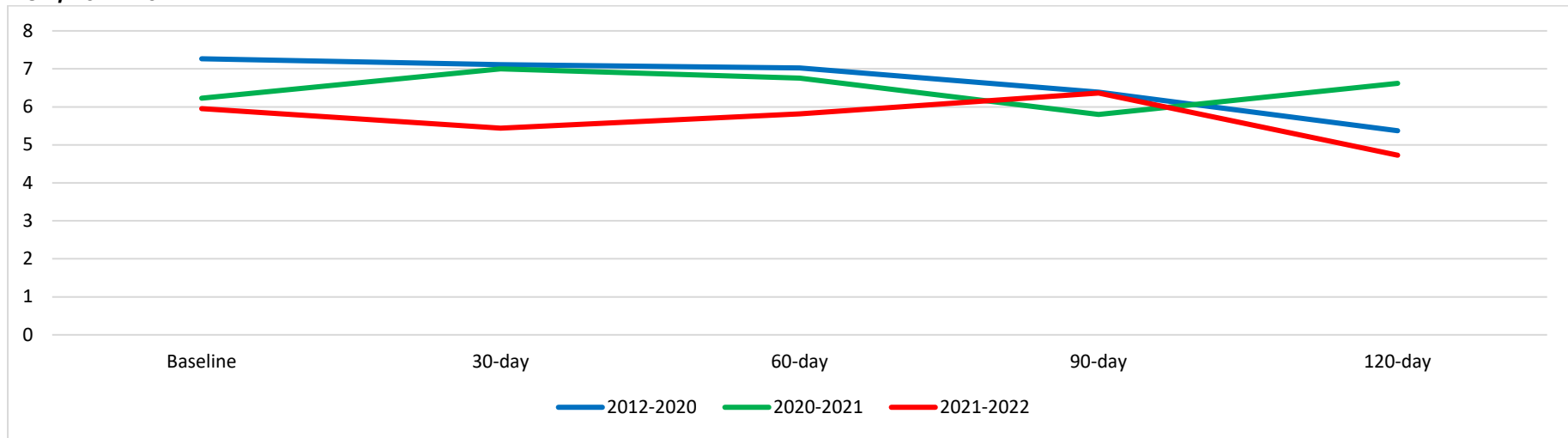
**Figure 26 Distribution of mean K10 scores across different time-points among people who identified as Aboriginal and Torres Strait Islander, NGO AOD, 2012-2022**



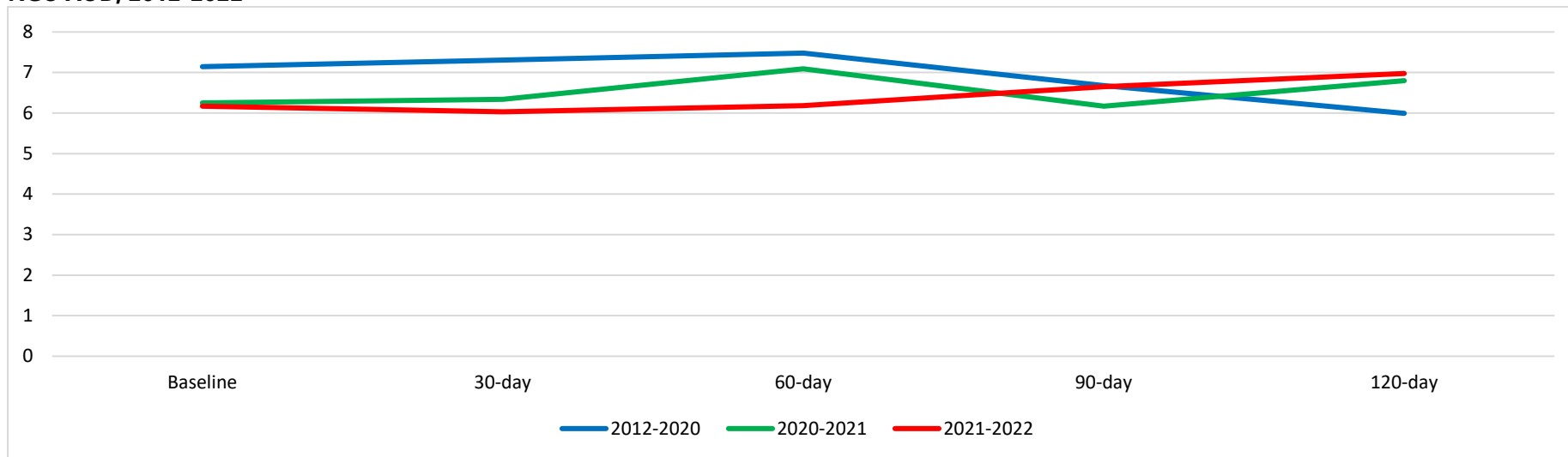
**Figure 27 Distribution of mean K10 scores across different time-points among people who did not identify as Aboriginal and Torres Strait Islander, NGO AOD, 2012-2022**



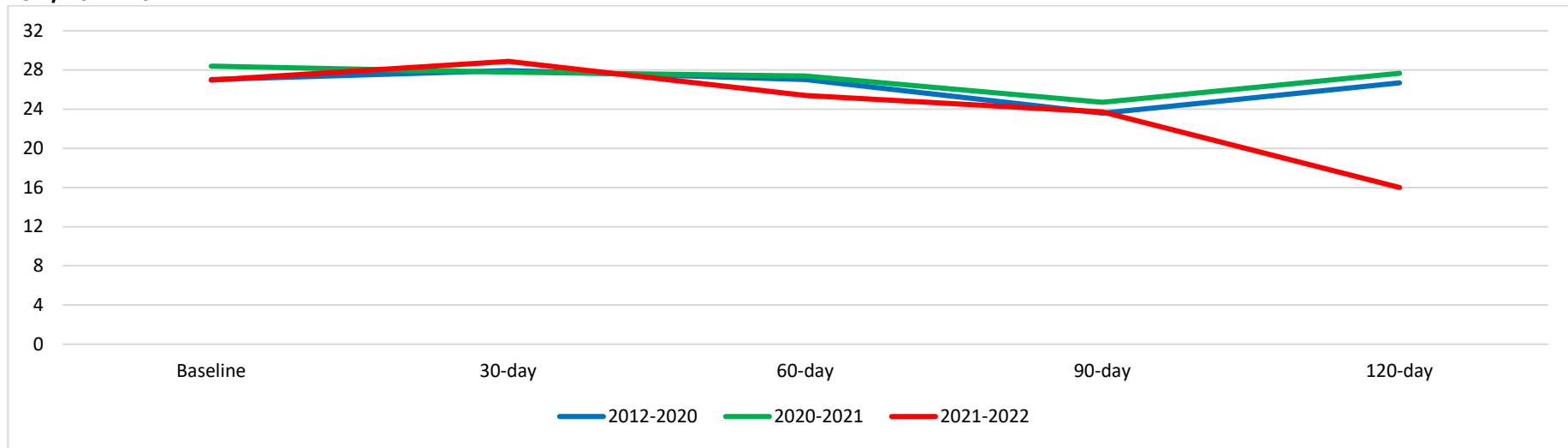
**Figure 28 Distribution of mean SDS scores across different time-points among people who identified as Aboriginal and Torres Strait Islander, NGO AOD, 2012-2022**



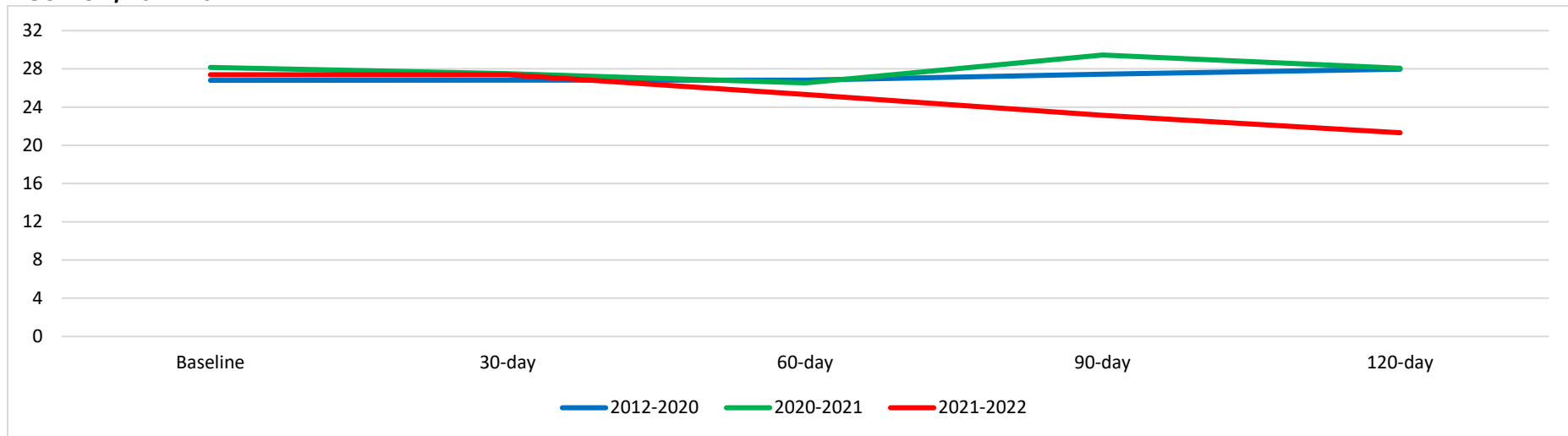
**Figure 29 Distribution of mean SDS scores across different time-points among people who did not identify as Aboriginal and Torres Strait Islander, NGO AOD, 2012-2022**



**Figure 30 Distribution of mean QoL scores across different time-points among people who identified as Aboriginal and Torres Strait Islander, NGO AOD, 2012-2022**



**Figure 31 Distribution of mean QoL scores across different time-points among people who did not identify as Aboriginal and Torres Strait Islander, NGO AOD, 2012-2022**



## **Section Two: NADA COMS measures across people who accessed different services**

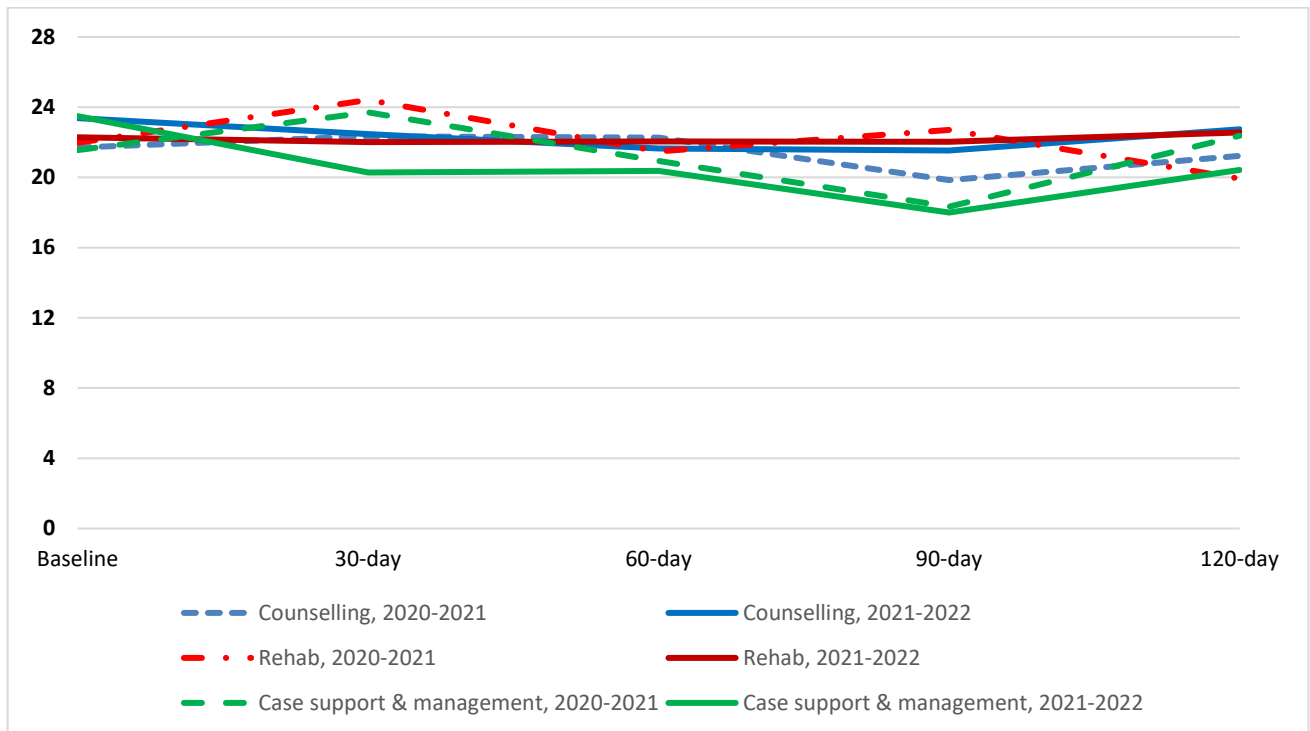
The following figures are limited to comparisons between 2021-2022 period and 2020-2021 period with the available data. This allows for a better interpretation of most common treatment settings that the people accessed, i.e., counselling, rehabilitation and support & case management across 0-day, 60-day, 90-day, 120-day, 150-day and 180-day timepoints.

As seen in Figure 32, in the 2021-2022 period, people who accessed case support and management services consistently reported the lowest average levels of distress (mean K10 scores) as compared to those who accessed counselling and rehabilitation services across all time-points. Compared to 2020-2021 period, the 2021-2022 period saw an improvement in the average scores for levels of distress (mean K10 scores) for people who accessed counselling and rehabilitation services across all time-points. This is in contrast with case support and management who saw a decline in the average scores for levels of distress (mean K10 scores) across all time-points after baseline assessment.

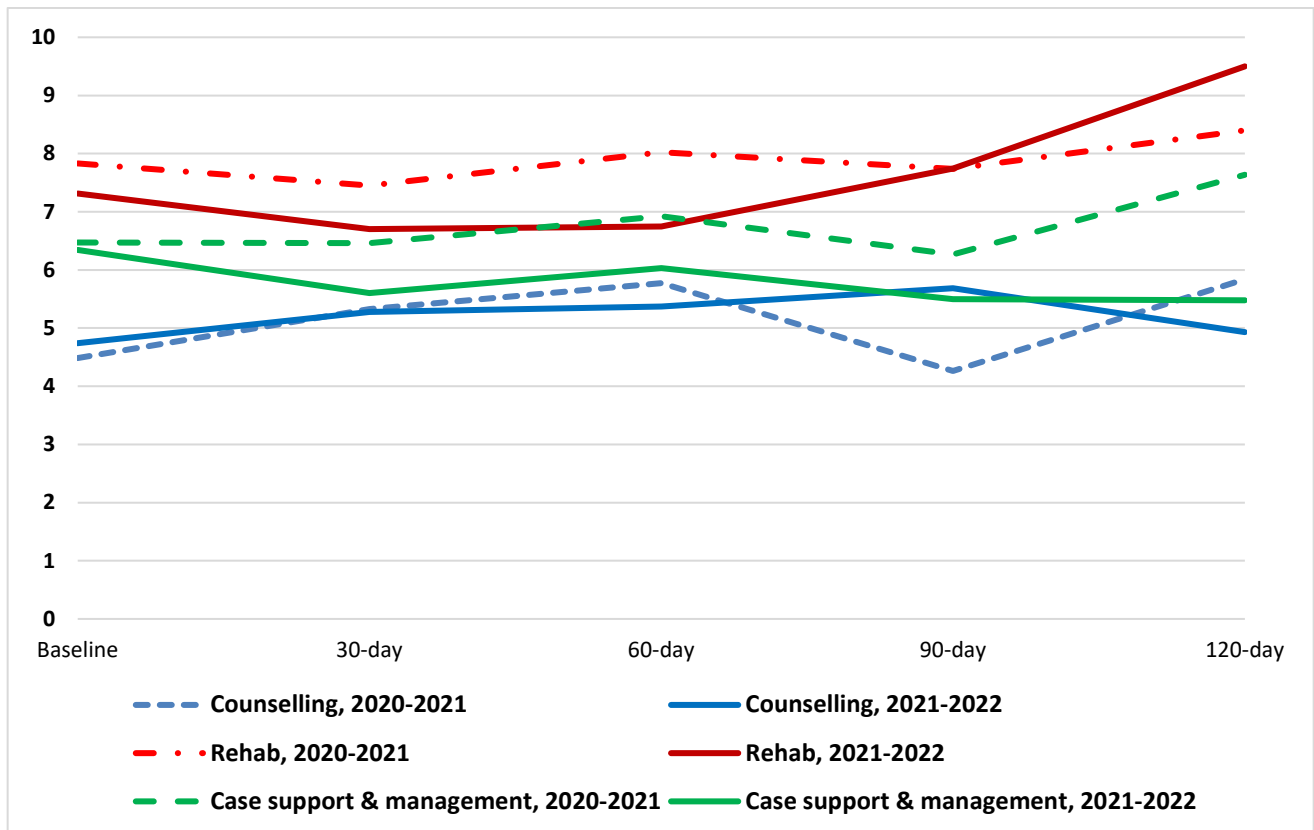
For the 2021-2022 period, people who accessed rehabilitation services consistently reported the highest average levels of dependence (mean SDS scores) as compared to those who accessed counselling and case support and management services across all time-points (see Figure 33).

As seen in Figure 34, in the 2021-2022 period, people who accessed case support and management services consistently reported the lowest average levels of quality of life (mean QoL scores) as compared to those who accessed counselling and rehabilitation services across all time-points.

**Figure 32 Distribution of mean K10 scores across different time-points in different services settings, NGO AOD, 2020-2022**

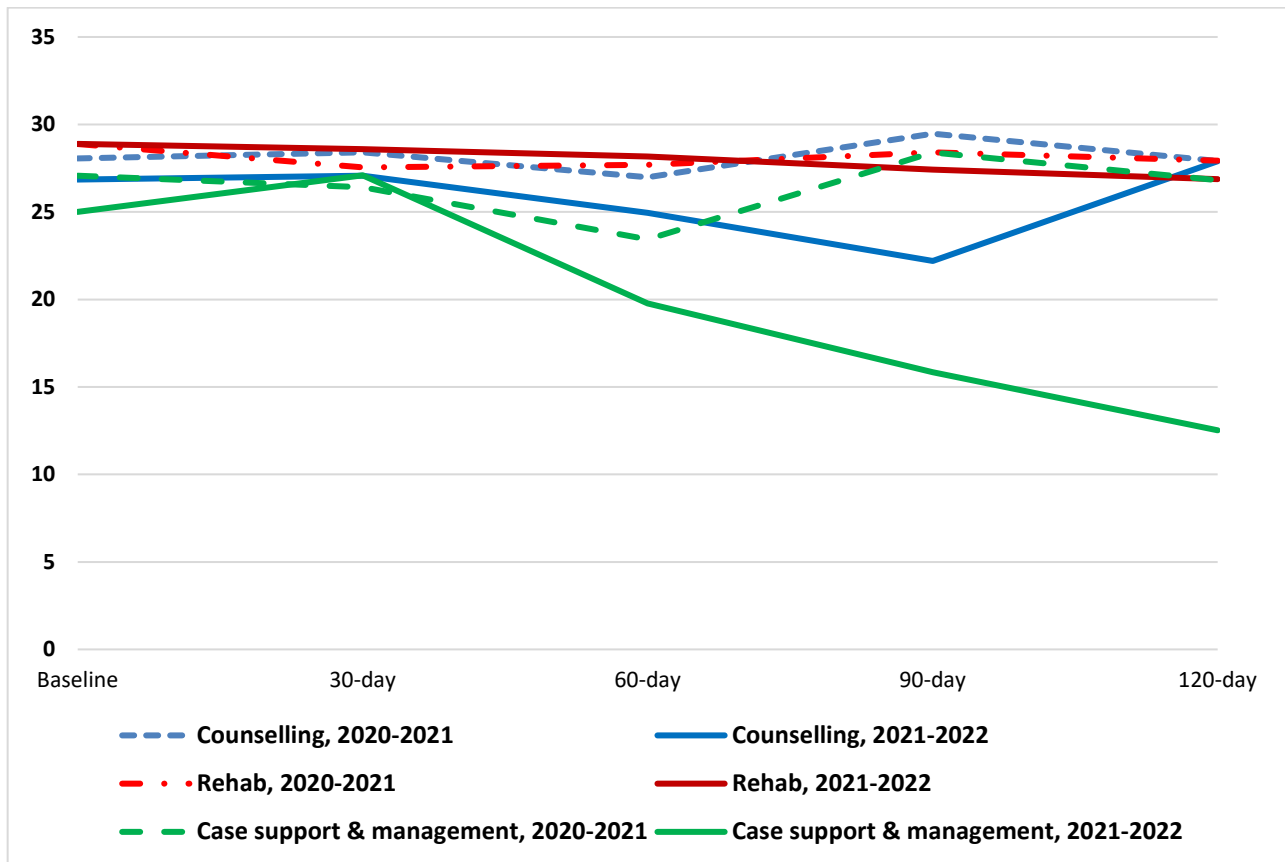


**Figure 33 Distribution of mean SDS scores across different time-points in different services settings, NGO AOD, 2020-2022**





**Figure 34 Distribution of mean QoL scores across different time-points in different services settings, NGO AOD, 2020-22**



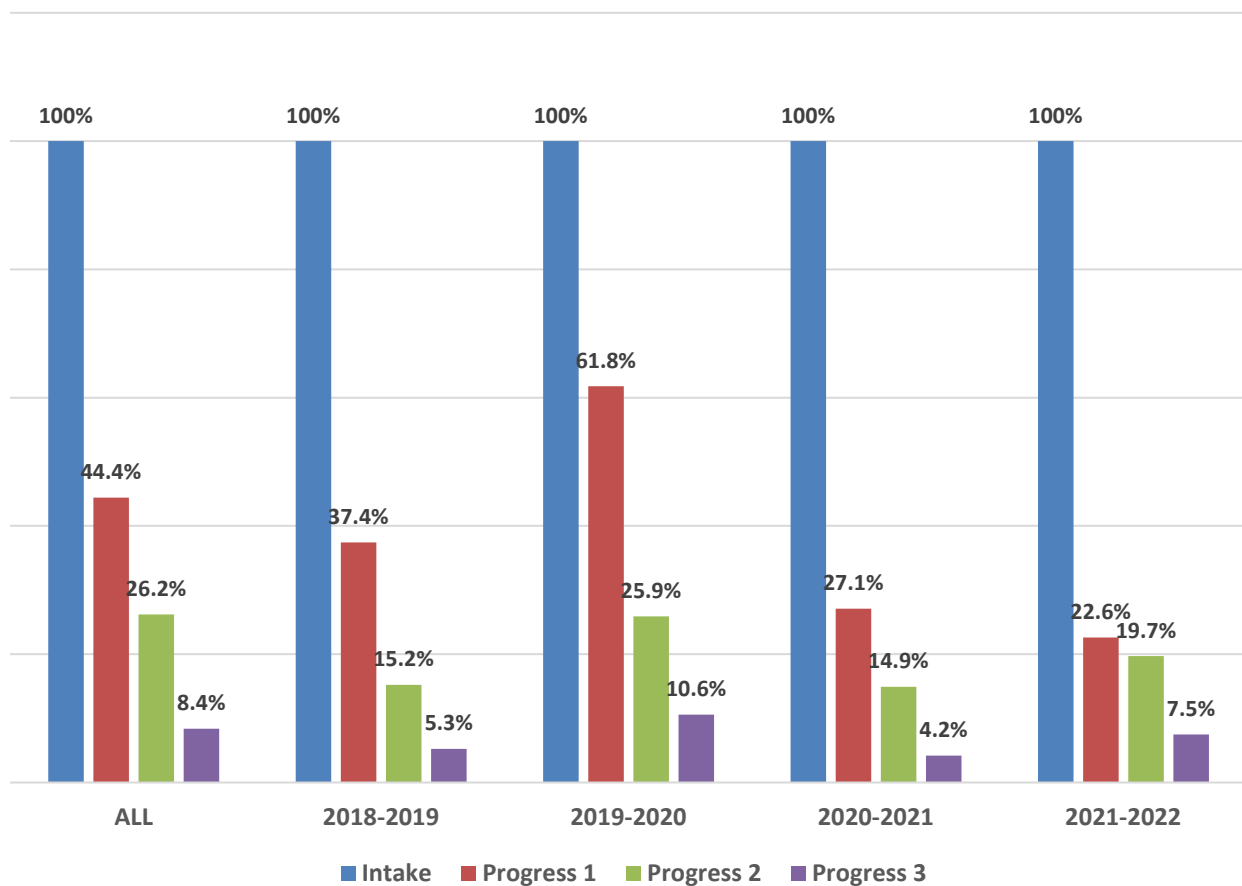
### Section Three: Outcomes data using ATOP measures

This section describes the total Australian Treatment Outcomes Profile (ATOP) assessments completed for the measurement of outcomes for people whose episodes were closed within 2021-2022 period.

### Section Three: Distributions of completed ATOP assessments, by year

Figure 35 provides an overview of the cumulative ATOP measures that have been completed since ATOP was introduced in NADABase (since 2017-2018 period); the 4-year lookback period, 2018-2019, 2019-2020, 2020-2021 and 2021-2022. The analyses were restricted to Progress 3 as limited data were available beyond Progress 3.

**Figure 35 Distributions of completed ATOP across stages of treatment, by year**



\*The proportion for baseline (intake) assessments across all time periods is 100%, as the analysis focused on people who completed baseline (intake) assessment.

There were 1015 people who accessed the 17 NGO AOD services. Table 5 describes the demographics of the 456 people who had completed at least one ATOP assessment during the 2012-2022 period. More than two-thirds identified as male as their sex (70%) and as heterosexual (78.3%). The average age was 39.8 years (SD 11.3 years). About 12% of people identified as being of Aboriginal and Torres Strait Islander. Majority of the people were Australia-born (81%) and reported that English was their preferred language (89%). More than half were accessing temporary benefits as their primary source of income (55%).

**Table 5. Baseline characteristics of people with ATOP assessment, NGO AOD, 2021-2022**

	N, 456	%
<b>Age, years</b>		
Younger than 18	0	0.0
18-29	89	19.5
30-39	111	24.3
40-49	125	27.4
50-59	69	15.1
Older than 60	18	3.9
*Missing	44	9.6
<b>Aboriginal and Torres Straits Islander</b>		
Neither Aboriginal nor Torres Strait Islander	387	76.3
Aboriginal but not Torres Strait Islander	962	20.5
Torres Strait Islander but not Aboriginal	91	1.9
Aboriginal and Torres Strait Islander	42	0.9
Not Stated	22	0.5
<b>Sex</b>		
Male	318	69.7
Female	137	30
Not stated or inadequately described	< 5	<1.0
Another term	< 5	<1.0
<b>Sexuality</b>		
Straight or heterosexual	357	78.3
Lesbian, gay, homosexual	82	18
Bisexual	<5	<1.0
Unknown	<5	<1.0
<b>Gender</b>		
Man or male	305	66.9
Woman or female	134	29.4
Trans woman	<5	<1.0
Trans man	0	0.0
Not stated or inadequately described	<5	<1.0
*Missing	12	2.6
<b>Language**</b>		

	N, 456	%
English	406	89.0
Arabic	14	3.1
Vietnamese	12	2.6
Others	24	5.3
Country of birth**		
Australia	370	81.1
Vietnam	14	3.1
Lebanon	10	2.2
New Zealand	8	1.8
Others	54	11.8
Income		
Temporary benefit (e.g., unemployment)	252	55.3
Pension (e.g., aged, disability)	94	20.6
Full-time employment	34	7.5
Not stated/not known/inadequately described	22	4.8
Part-time employment	21	4.6
Other	18	3.9
Living		
Alone	169	37.1
Parent(s)	80	17.5
Other	47	10.3
Friend(s)	33	7.2
Spouse or partner	32	7.0
Single parent with child(ren)	25	5.5
Not known or not stated or inadequately described	23	5.0
Other relative (s)	20	4.4
Spouse or partner and child(ren)	17	3.7
Friend(s) or parent(s) or relative(s) and children	10	2.2

As seen in Table 6 , of the people who completed an ATOP assessment, 22.8% reported that they were homeless and 12.1% faced the risk of eviction. More than three-quarters reported no-paid work (76.1%), and almost 90% reported that they did not engage in ongoing education.

About one-tenth of the people who completed at least one ATOP assessment reported that they had a history of being arrested (8.6%) and experienced violence in reference to self (8.1%) and others (7.5%).

**Table 6. Additional information from ATOP assessments for baseline characteristics of people, NGO AOD, 2021-2022**

	N, 456	%
Homeless		
No	329	72.1
Yes	104	22.8
Not stated	5	1.1
Risk of eviction		
No	377	82.7
Yes	55	12.1
Not stated	6	1.5
Primary caregiver		
No	6	1.3
Not answered	457	98.7
Total days of paid work		
None	347	76.1
1-7 days	19	4.1
8-14days	17	3.7
15-28days	40	8.7
Missing	33	7.2
Total days of education		
None	402	88.2
More than a day	10	2.1
Missing	44	9.6
Arrested		
Yes	39	8.6
No	392	86
Not stated/Do not wish to say	7	1.5
Missing	18	3.9
Violence towards you		
Yes	37	8.1
No	396	86.8
Not stated/Do not wish to say	<5	<1.0
Missing	<5	<1.0
Violence towards others		
Yes	34	7.5
No	399	87.5
Not stated/Do not wish to say	5	1.0
Missing	18	3.9

### Section Three: Distribution of completed ATOP assessments across different treatment settings

Figure 36 describes the most common treatment provided to people, who completed an baseline ATOP assessment, from July 2021 to June 2022. Support and case management (69%) as the most accessed treatment setting, followed by rehabilitation activities (18%) and counselling (10%).

**Figure 36 Distribution of completed ATOP assessments by treatment settings across NGO AOD, 2021-2022**

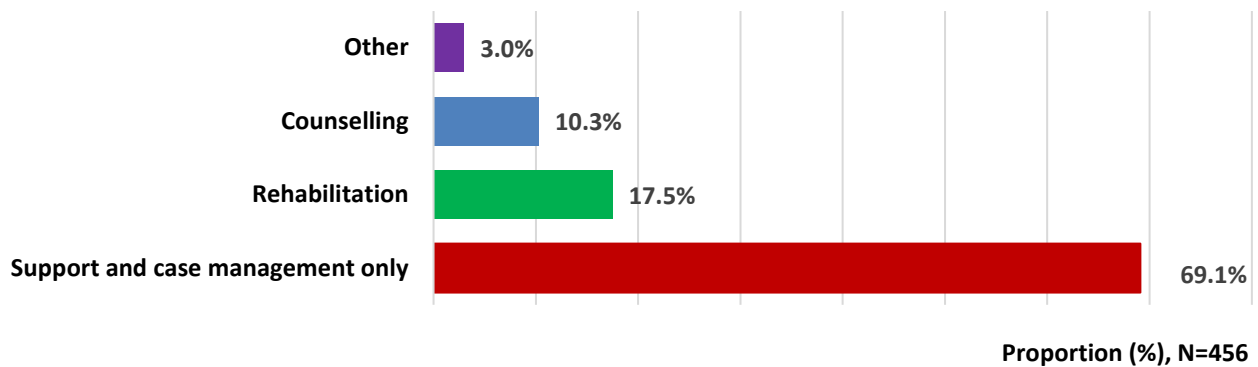


Figure 37 provides a summary of the primary service delivery settings, which comprised of community or outpatient (71.7%), outreach (25.9%) and home-based settings (2.4%).

**Figure 37 Settings of accessed service by people with ATOP assessments, NGO AOD, 2021-2022**

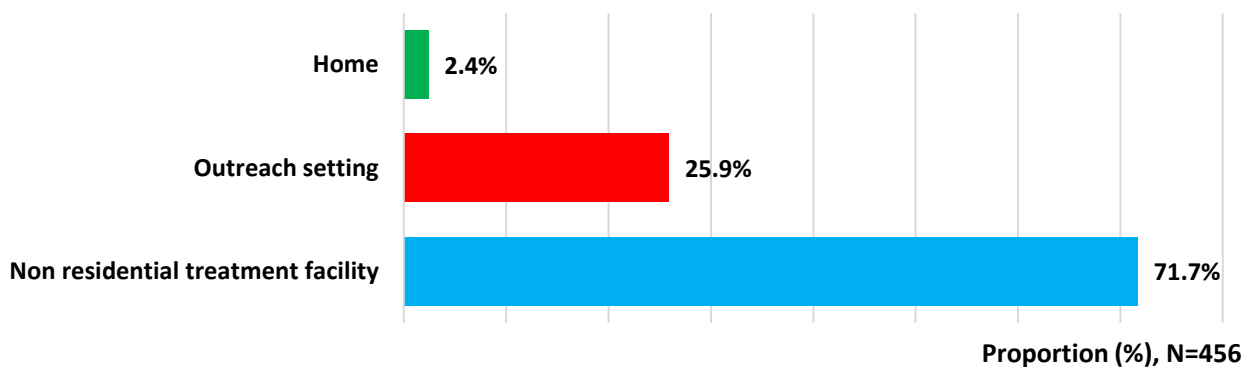
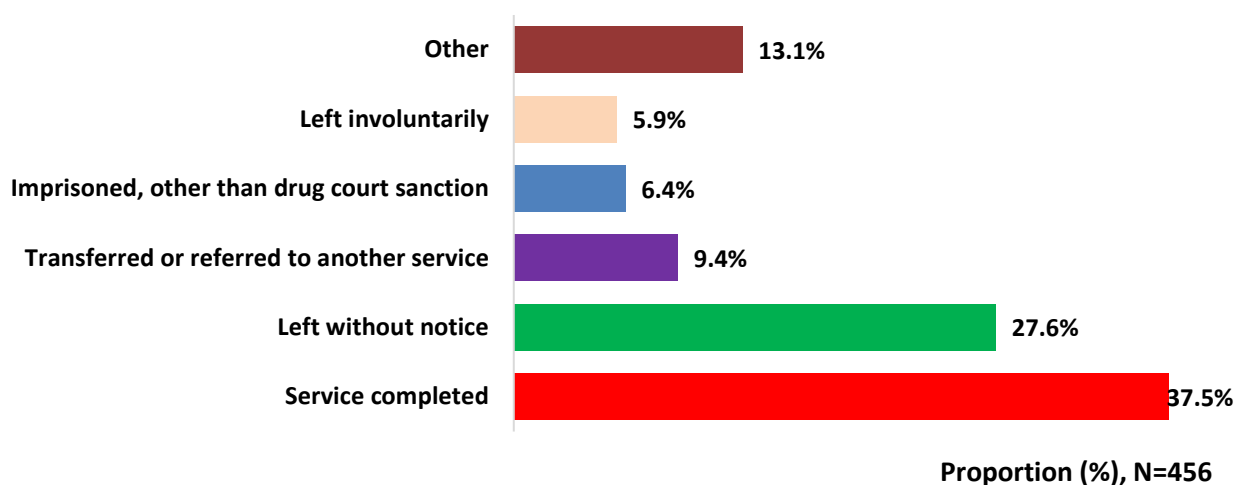


Figure 38 provides a summary of the reasons that people left treatment. The most common reasons were the completion of treatment (37.5%), leaving without notice (27.6%) and leaving against advice (9.4%).

**Figure 38 Reasons of cessation of treatment amongst people with ATOP assessments accessing NGO AOD services, 2021-2022**



As seen in Table 7, almost half of the services saw people self-referring to these services (40.5%), followed by referral by criminal justice settings (14.1%) and non-residential community health centre (5.6%).

**Table 7 Types of referrals received by services amongst people with ATOP assessments accessing NGO AOD services, 2012-2022**

	N, 456	%
<b>Referral source</b>		
Other criminal justice setting	142	31.1
Self	102	22.4
Non-residential alcohol and other drug treatment agency	68	14.9
Residential alcohol and other drug treatment agency	38	8.3
other non-health service agency	31	6.8
Non-residential community mental health care	16	3.5
Others	13	2.9
Other hospital	8	1.8
Family and child protection	8	1.8
Other residential community care unit	7	1.5
Court diversion	6	1.3
Family member/ friend	<5	<1.0
Not stated/inadequately described	<5	<1.0
Residential community mental health care unit	<5	<1.0
Non-residential community health centre	<5	<1.0
General practitioner	<5	<1.0
Psychiatric hospital	<5	<1.0

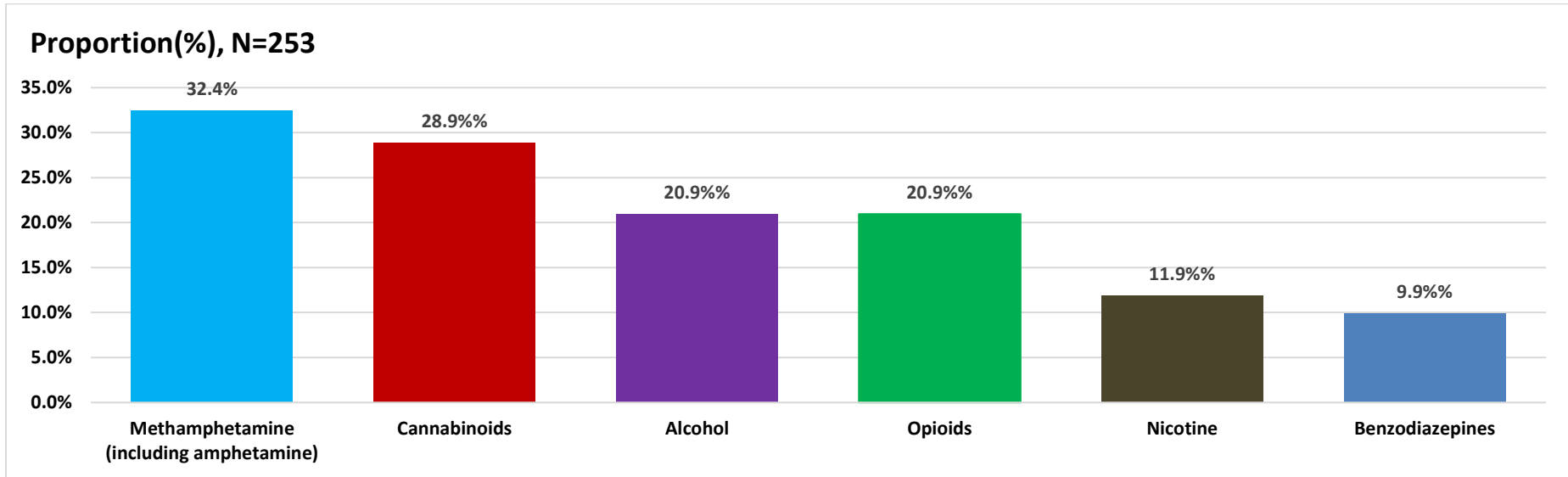
### **Section Three: Substance of concern for people who completed an ATOP assessment**

Most people reported that this was in the context of their own substance use (99.6%) compared to the minority whose nominated substance of concern was on behalf of family members or friends (0.4%). Of the 456 people who had completed an ATOP assessment, slightly more than one-third cited methamphetamine (including amphetamine) (36.2%) and alcohol (34.6%) as their primary substance of concern (see Figure 39).

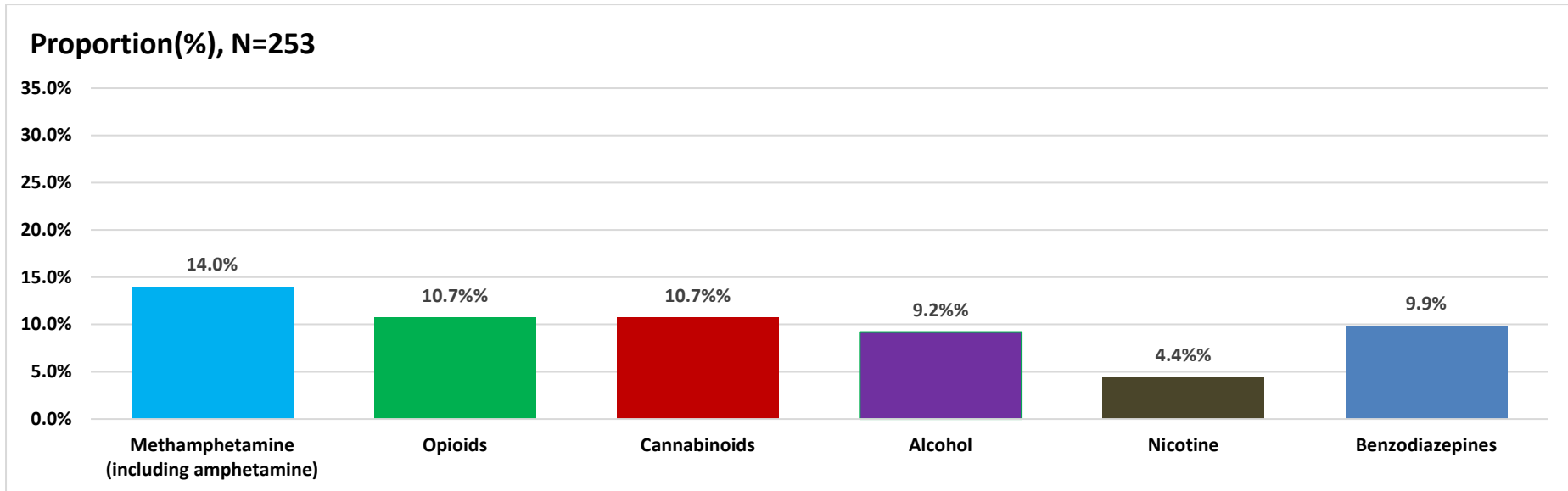
As seen in Figure 40, polysubstance was reported for slightly more than half by those who completed an ATOP assessment (55.5%). Among the 253 people who reported polydrug use, about one-third cited methamphetamine (including amphetamine) (36.2%) and cannabis (28.9%) as their secondary substance of concern.



**Figure 39 Distribution of most common primary substance use of concern among people with ATOP assessments, NGO AOD, 2021-2022**



**Figure 40 Distribution of most common secondary substance of concern amongst people with ATOP assessments, NGO AOD, 2021-2022**



### Section Three: Injecting and tobacco use for people who completed an ATOP assessment

Table 8 shows that almost one-third of the 456 people reported that they smoked tobacco daily. Very few (3.9%) reported that they shared injection equipment and almost one-tenth cited that they injected for at least a day within the past 28 days.

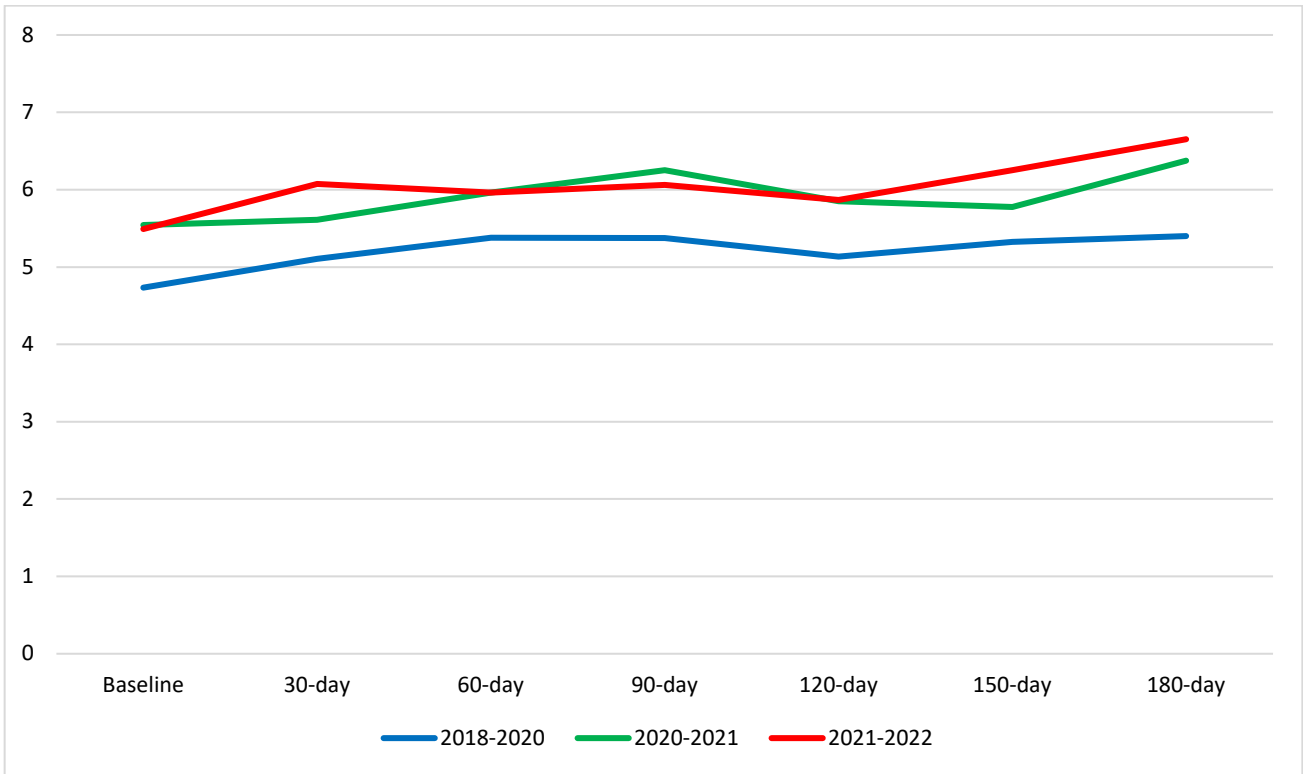
**Table 8 Tobacco use and injecting practices amongst people accessing NGO AOD services, 2021-2022**

	N, 456	%
Daily tobacco use		
Yes	147	32.2
No	271	59.4
Not stated	18	3.9
Missing	20	4.4
Injected with equipment used by someone else		
Yes	18	3.9
No	348	76.3
Not stated	12	3.7
Missing	73	16
Total days injected		
1- 14days	30	6.5
15-28days	12	2.5
None	380	83.3
Missing	34	7.5

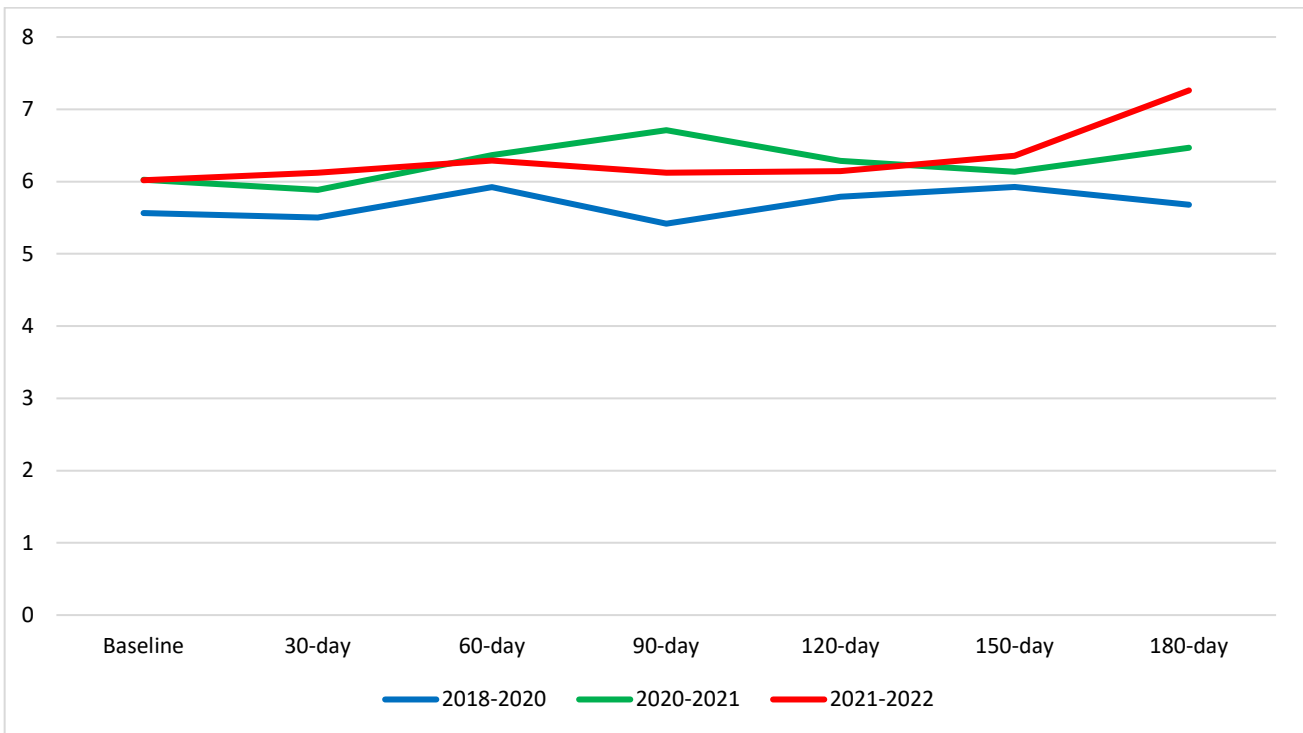
### Section Three: Average trends of ATOP measures

As seen in Figure 41, Figure 42 and Figure 43 overall, across all the comparisons, symptoms distress (measured by the ATOP Psychological Health scale) tended to demonstrate a consistent improvement over time (i.e., increase in the average scores). Physical health (measured by the ATOP Physical Health Scale) tended to improve over time (i.e., average scores increased). Quality of life (measured by the ATOP Quality of Life Scale) tended to show rapid improvements in the initial stages of treatment (i.e., increases in the average scores) and then tended to maintain those improvements over time in treatment.

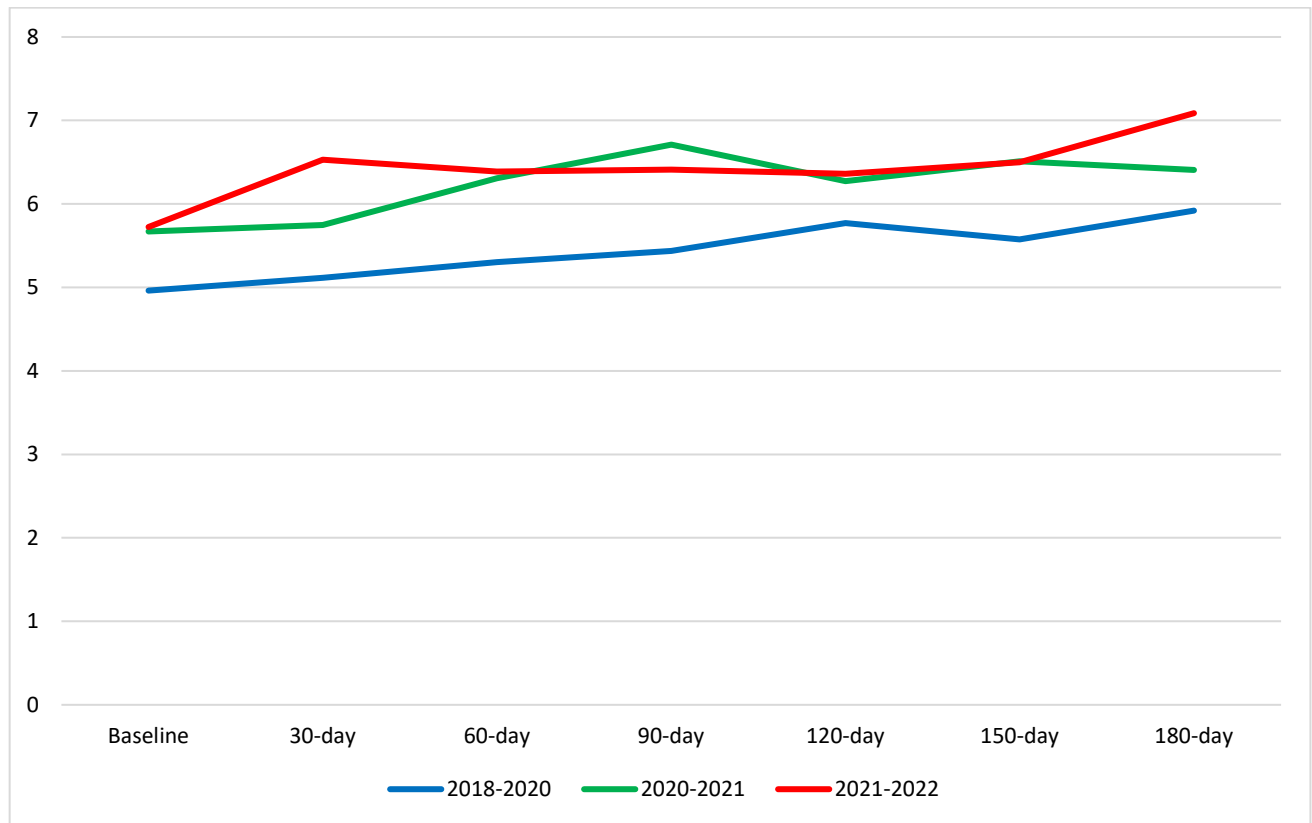
**Figure 41 Distribution of mean ATOP psychological health scores across different time-points, NGO AOD, 2018-2022**



**Figure 42 Distribution of mean ATOP physical health scores across different time-points, NGO AOD, 2018-2022**



**Figure 43 Distribution of mean ATOP Quality of Life (QoL) scores across different time-points, NGO AOD, 2018-2022**



## KEY FINDINGS AND IMPLICATIONS

This snapshot report provides the most current, state-wide picture of people who accessed specialist NGO AOD services, community and residential settings across NSW, focussing primarily on the period 1 July 2012 – 30 June 2022. The findings on the differences and similarities in the people who accessed different services, their most reported substance(s) of concern, as well as their outcomes after accessing the NGO AOD services highlight useful information to the AOD sector as a whole. In particular, the findings are likely to be beneficial to NADA, the policymakers, service providers and researchers focussing on NGO AOD treatment sector.

### **Description of people accessing specialist NGO AOD services across NSW from 1 July 2021 to 30 June 2022**

- 18,420 people accessed 219 services for at least one episode of care across NSW
- The demographics of most of the people who accessed the NGO AOD services were of 18–29-year-olds (31%), did not identify as Aboriginal and Torres Straits Islander (73%), identified as male as their sex (61%), preferred English as their language (98%), were Australian-born (90%), accessed temporary benefits (including unemployment) (47%) and lived in a rented accommodation (51%). They primarily seek counselling (33%) or rehabilitation services (21%), and self-referred to these services (41%).

### **The most common substance of concern varied by groups**

- There are two key findings regarding the most commonly reported primary substance of concern at the start of treatment engagement. First, alcohol (36.2%) remains the primary substance of concern for 2012-2022, consistent with the findings from 2020-2021 snapshot. This finding is in contrast with the 2017-2018 and 2018-2019 report where methamphetamine (including amphetamine) was consistently reported as the primary substance of concern. Further investigation is required as to whether this is related to the COVID-19 pandemic.
- Second, although alcohol is the most cited primary substance of concern by people of any sex, this differed for Aboriginal and/or Torres Strait Islander people (27.3%). Methamphetamine (including amphetamine) was the most nominated primary substance of

concern by Aboriginal and/or Torres Strait Islander people accessing NGO AOD services in 2021-2022.

- Polysubstance use was reported by slightly more than one third (38.9%) of the people accessing the NGO AOD services. The findings that nicotine was the most cited secondary substance of concern (37.5%) has two implications. First, although the use of nicotine appeared to have increased as compared to previous two years, this may be under-reported due to the manner in which the question was framed. Second, whether nicotine use is attributed to the use of vaping or smoking, this remains unknown as the current data collection limits the capturing of this information.

### **Outcomes measures are reported by a selection of NGO AOD services**

- Of the 18,420 people, 4,704 people had completed a baseline assessment and subsequently reported at least one assessment of their outcomes (NADA COMS). Of the 1,015 people who accessed the 17 services, 456 people had completed a baseline assessment and subsequently completed at least one assessment of their outcomes (ATOP).
- This is the first NADAbase snapshot to include outcomes measures using the ATOP. Most services that use ATOP were non-residential services.
- NADAbase provides a unique data source for collecting outcomes measures. As outcome assessments are not mandated for routine data collection and reporting, findings on outcome data in this snapshot may not reflect the outcomes of all people who accessed the NGO AOD services during this period.
- Amongst people who submitted baseline assessment data, the relative distribution of subsequent completion rates for NADA COMS varied across treatment settings is consistent with previous snapshot reports (2020-21 and 2019-20). This snapshot observed a higher proportion of completion rates for people who accessed rehabilitation services than those who accessed counselling services. Similarly, higher completion rates were observed with longer engagement with the services, i.e. 30-day to 60-day and to 90-day. The challenges lie within the AOD sector to ensure outcomes data are collected consistently throughout the duration of a person's engagement with treatment.
- Amongst people who completed an outcome assessment (NADA COMS), caution is required in interpreting their observed average trends as the information is pooled across groups of people who completed an assessment across different timepoints and does not reflect the

same individual who completed the assessment at each time-point. Overall, there is an observed reduction in the average levels of distress, decline in the average levels of dependence for the nominated substance of concern and increased in the average quality of life scores across the 30-day, 60-day, 90-day and 120-day time points. However, the relative distributions of outcome measures (NADA COMS) varied across groups of people. People who identified as females as their sex and Aboriginal and Torres Strait Islander were found to be having a higher average level of distress, higher average levels of dependence and lower average levels of quality of life at baseline and the subsequent time points. This calls for future research in understanding these priority population (females and Aboriginal and Torres Strait Islander people) experiences of engagement and care in accessing NGO AOD services and factors that may support better outcomes amongst females and Aboriginal and Torres Strait Islander people.

### **Optimising the benefits of outcome measurement**

- There remains a challenge in the potential to carry out benchmarking between services that use NADA COMS and those of ATOP. Regardless of which outcome measures are adopted, the key consideration lies in optimising the application of outcome measurement to inform individual client care, improve treatment access and quality, as well as services and systems planning within the AOD sector.
- Further work is needed to increase regular reporting of the outcomes which can then be used to inform better understanding of care in the diverse groups of people accessing NGO AOD services. To ensure regular reporting of outcome measures more feasible in the context of limited resources in the NGO AOD sector, one approach would be having standardised reporting requirements and specifications for performance measures for NGO AOD services<sup>5</sup>.

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