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**Australian Institute of
Health and Welfare**

Alcohol and other drug treatment services in Australia 2012–13

DRUG TREATMENT SERIES NO. 24



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**Australian Institute of
Health and Welfare**

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

DRUG TREATMENT SERIES

24

Alcohol and other drug treatment services in Australia

2012–13

Australian Institute of Health and Welfare
Canberra

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

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- Department of Health, Western Australia
- Department of Health, South Australia
- Department of Health and Human Services, Tasmania
- Health Directorate, Australian Capital Territory
- Department of Health, Northern Territory.

Abbreviations

ADS	Alcohol and Drug Services
AIHW	Australian Institute of Health and Welfare
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	<i>Australian Standard Classification of Drugs of Concern</i>
ASGC	<i>Australian Standard Geographical Classification</i>
ASGS	<i>Australian Statistical Geography Standard</i>
DAO	Drug and Alcohol Office
DASSA	Drug and Alcohol Services South Australia
DoH	Australian Government Department of Health
ERP	estimated resident population
LSD	lysergic acid diethylamide
MDMA	3,4-methylenedioxy-N-methylamphetamine (or ecstasy)
NADA	Network of Alcohol and other Drug Agencies
NAHA	National Affordable Housing Agreement
NDSHS	National Drug Strategy Household Survey
NGO	non-government organisation
NGOTGP	Non-Government Organisation Treatment Grants Program
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NPAH	National Partnership Agreement on Homelessness
NPHDC	National Prisoner Health Data Collection
OSR	Online Services Report
SA2	Statistical Area level 2
SHS	Specialist Homelessness Services
SHSC	Specialist Homelessness Services Collection
SLA	Statistical Local Area
SLK	statistical linkage key
SMSDGF	Substance Misuse Service Delivery Grants Fund

Symbols

- nil or rounded to zero
- .. not applicable

Notes

Components of tables may not sum to totals due to rounding.

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia* due to data revisions.

Supplementary tables referred to in this report (tables with the prefix 'S') are available for download from <<https://www.aihw.gov.au/publications/>>.

Summary

Alcohol and other drug treatment services across Australia provide a broad range of treatment services and support to people using drugs and to their families and friends. This report presents the latest annual snapshot of information about publicly funded alcohol and other drug treatment service agencies, the people they treat and the treatment received. For the first time in 2012–13, the AIHW has been able to estimate the number of clients receiving treatment.

Around 108,000 clients received almost 162,400 treatment episodes from 714 publicly funded alcohol and other drug treatment agencies across Australia

There has been a steady increase in both the number of agencies and treatment episodes provided over the last decade. More specifically, in 2012–13, alcohol and other drug treatment agencies provided a total of 162,362 closed treatment episodes, an increase of 6% from 2011–12. These services were provided by 714 agencies, an increase of 8% from 2011–12.

The age profile of people using services suggests that there is an ageing cohort of people in alcohol and other drug treatment

Over the 5 years to 2012–13, the proportion of people treated who were aged 20–29 fell from 31% to 27% while the proportion for those aged 40 and over rose from 29% to 32%. The proportions for those aged 10–19 and 30–39 remained steady.

Alcohol continues to be the most common principal drug of concern and treatment for amphetamines is increasing

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs of concern since 2003–04. Since 2009–10, the proportion of episodes where alcohol was the most common principal drug has decreased (from 48% to 41%), while the proportion for amphetamines has increased (from 7% to 14%).

The majority of clients have more than 1 drug of concern

In 3 out of 5 (63%) closed episodes, the client reported additional drugs of concern. Of these, 31% reported 1 additional drug and 17% reported 2. Nicotine was the most common additional drug along with cannabis (both 23%), although nicotine was the principal drug for only 2% of episodes.

Counselling continues to be the most common type of treatment with diversion influencing increases in assessment

Over the 10 years from 2003–04 to 2012–13, the proportion of episodes for each main treatment type has remained quite stable, with counselling (46%), assessment only (17%) and withdrawal management (16%) being the most common types of treatment over that period. In 2012–13, assessment only overtook withdrawal management as the second most common main treatment type for the first time since these data have been collected.

Aboriginal and Torres Strait Islander people continue to be over represented in alcohol and other drug treatment services

Despite comprising just 3% of the Australian population, 14% of episodes were provided to Indigenous Australians by publicly funded alcohol and other drug treatment services. In addition, 73,991 alcohol and other drug treatment episodes were delivered by specialist Indigenous services.

1 About the collection

In Australia, publicly funded treatment services for alcohol and other drug 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. Treatment services are provided to people for their own drug use and to those seeking assistance for someone else's drug use.

This report presents information on clients and treatment episodes provided by publicly funded treatment services for alcohol and other drug use from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) and related sources such as hospitals, homelessness and Indigenous data. For more information on the data used in this report, see Section 1.4 and Appendix A.

1.1 Drug use in Australia

Drug use can be either licit or illicit. 'Licit drug use' refers to the use of legal drugs in a legal manner, and includes tobacco smoking and alcohol consumption. 'Illicit drug use' refers to a number of broad concepts including:

- the use of illegal drugs – a drug that is prohibited from manufacture, sale or possession in Australia, for example, cannabis, cocaine, heroin and 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, for example 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, for example, kava, or inhalants such as petrol, paint or glue (but not including tobacco or alcohol) (MCDS 2011).

Licit and illicit use of drugs is a significant issue in Australia and cost an estimated \$56 billion in 2004–05, of which \$8 billion was for illicit drug use (Collins & Lapsley 2008). The 2013 National Drug Strategy Household Survey (NDSHS) found that alcohol and tobacco were the most common drugs used in Australia, with 78% of Australians aged 14 and over drinking alcohol in the previous 12 months and 13% smoking tobacco daily (AIHW 2014b). Nearly 1 in 5 (18%) people drank at levels that put them at increased risk of harm over their lifetime (more than 2 standard drinks a day on average), while 26% of people drank at least once a month at levels that put them at risk of accident or injury (more than 4 standard drinks in a session).

Although less prevalent than the use of licit drugs, illicit drug use is still relatively common. In 2013, about 2 in 5 people (42%) aged 14 and over reported using illicit drugs in their lifetimes, while 1 in 7 (15%) reported using illicit drugs within the previous 12 months (AIHW 2014b). Cannabis was the most common illicit drug; 1 in 3 (35%) Australians aged 14 and over had used cannabis in their lifetime, while 1 in 10 (10%) had used it in the previous 12 months. Ecstasy and hallucinogens were the second and third most common drugs for use in their lifetime (11% and 9%, respectively), while pain killers (analgesics) for non-medical purposes and ecstasy were the second and third most common for use in the previous 12 months (3% and 2%, respectively).

1.2 National Drug Strategy

Australia has had a coordinated approach to alcohol and other drugs since 1985. The current strategy, the National Drug Strategy 2010–2015, is a cooperative venture between Australian, state and territory governments and the non-government sector. It has an overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (MCDS 2011):

- **demand reduction** to prevent and reduce the use of drugs, support people to recover from dependence and support efforts to promote social inclusion and resilient individuals, families and communities
- **supply reduction** to reduce the supply of illegal drugs and control and manage the supply of alcohol, tobacco and other legal drugs
- **harm reduction** to reduce harms to individuals, families and community safety.

Harm reduction actions in the Strategy include enhancing treatment ‘across settings to provide help at all stages of drug use, particularly for disadvantaged populations’, preventing drug overdoses through the use of ‘substitution therapies, withdrawal treatment and other pharmacotherapies’ and continuing drug diversion programs.

1.3 Types of agencies and treatment

Alcohol and other drug treatment services assist people to address their drug use through a range of treatments. Treatment objectives can include reduction or cessation of drug use as well as improvements to social and personal functioning. Services are also provided to people who are seeking assistance for someone else’s drug use.

This report focuses on publicly funded treatment agencies. It does not include information on agencies that provide services primarily concerned with health promotion or accommodation, private treatment agencies that do not receive public funding, or needle and syringe programs. Information on agencies whose sole function is to prescribe or provide dosing for opioid pharmacotherapy, services provided in prisons, and primary health care services and substance-use services funded by the Australian Government is in Section 8.

Many types of treatment are available in Australia. Most aim to reduce the harm of drug use, while some use a structured drug-free setting with abstinence oriented interventions to help prevent relapse and develop skills and attitudes that assist clients to make changes leading to drug-free lifestyles (AIHW 2011).

This report looks at the following types of treatment:

- **assessment only.** Most types of treatment include an assessment to identify the nature of the drug issue, the needs of the client and the type of treatment most appropriate for the client. This category is used when only an assessment is provided in a treatment episode, for example, by an agency whose main function is to assess and refer people to appropriate treatment agencies.
- **counselling, both individual and group.** This is the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013).

- **information and education only**, for individuals and groups.
- **pharmacotherapy, where the client receives another type of treatment in the same treatment episode.** Pharmacotherapy includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy.
- **rehabilitation.** This focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011).
- **support and case management only.** Support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007).
- **withdrawal management, both medicated and non-medicated.** This is the process of stopping or reducing drug use, often after a period of long or frequent use.

Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not provided to clients seeking treatment for someone else's drug use.

1.4 Scope of the AODTS NMDS

The main source of data for this report is the AODTS NMDS. This data set contains information on treatment episodes provided by publicly funded alcohol and other drug treatment services. Data are collected by treatment agencies that forward these data to state and territory government health departments. These departments then extract the required data according to definitions and technical specifications agreed to by the departments and the Australian Institute of Health and Welfare (AIHW). Agencies funded by the Australian Government through the Non-Government Organisation Treatment Grants Program (NGOTGP) generally forward data directly to the AIHW.

The 2012 National Healthcare Agreement (COAG 2012) seeks to improve health outcomes for all Australians and the sustainability of the Australian health system. The Agreement mandates the collection of data for several National Minimum Data Sets; one of which is the AODTS NMDS as part of governments' efforts to report regularly on the status, quality and performance of the healthcare system. This information is used to inform policy and help improve service delivery.

Other sources of data included in this report to support a more complete picture of alcohol and other drug treatment in Australia include the National Hospital Morbidity Database, Online Services Report (OSR) Database, Specialist Homelessness Services collection, the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection and the National Prisoner Health Data collection.

For more information about these other sources of data, the data quality statements for the data sources and the methods used in this report, see the appendixes.

Data on agencies

The AODTS NMDS contains information on publicly funded alcohol and other drug treatment services. Agencies are excluded from the AODTS NMDS if they:

- do not receive any public funding
- provide accommodation as their main function (including half-way houses and sobering-up shelters)
- are located in prisons or detention centres
- are located in acute care or psychiatric hospitals and provide treatment only to admitted patients
- have the sole function of prescribing or providing dosing for opioid pharmacotherapy (these agencies are excluded because of the multi-faced nature of service delivery in this sector).

Australian Government-funded primary health care services and substance-use services are in scope for the AODTS NMDS but most of these agencies do not contribute to the collection as they currently provide data to the Online Services Report (OSR) collection. To minimise reporting burden, agencies reporting to the OSR do not usually also report to the AODTS NMDS; however, there is some overlap. See Appendix B for further information.

For each agency in the AODTS NMDS, data are collected on the geographical location of the agency.

Data on treatment episodes

The AODTS NMDS contains information on all treatment episodes provided by in-scope agencies where the episode was closed in the relevant financial year. A treatment episode is considered closed where any of the following occurs:

- The treatment is completed or has ceased.
- There has been no contact between the client and treatment provider for 3 months.
- There is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy 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
- are for a client aged under 10.

For each treatment episode in the AODTS NMDS, data are collected on:

- the client: sex, date of birth, Indigenous status, country of birth, preferred language, source of referral and injecting drug status
- whether the client is receiving treatment for their own drug use or someone else's drug use
- the drugs of concern (principal drug of concern and up to 5 additional drugs of concern)
- the method of use for the principal drug of concern

- types of treatment (main treatment type and up to 4 additional treatment types)
- the start and end dates of the episode and the reason the episode was closed.

Data on drugs of concern

'Principal drug of concern' refers to the main substance that the client stated led them to seek treatment from the alcohol and other drug treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses involving principal drug of concern because it is assumed that only substance users themselves can accurately report their own principal drug of concern.

'Additional drugs of concern' refers to any other drugs reported by the client, in addition to the principal drug of concern. Clients can nominate up to 5 additional drugs of concern.

'All drugs of concern' refers to all drugs reported by clients, including the principal drug of concern as well as any additional drugs of concern reported.

Data on clients

The AODTS NMDS does not contain a unique identifier for clients and information about clients is collected at the episode level. For the 2012–13 collection, a statistical linkage key (SLK) was introduced. While the SLK is not a unique identifier, it enables the number of clients receiving treatment to be counted while continuing to ensure the privacy of these individuals receiving treatment.

Because SLK data are not available for all clients, an imputation strategy has been developed to adjust the data to account for this. Further information about the imputation methodology applied to these data can be found in Appendix C.

Coverage and data quality

It is difficult to fully quantify the scope of alcohol and other drug services in Australia, in particular the number of clients, as, until recently, the national collection has been based on counts of treatment episodes. In addition, there are a variety of settings in which people receive treatment for alcohol or other drug-related issues that are not in scope for this collection, such as in hospital, from general practitioners or in pharmacies (where a large proportion of opioid pharmacotherapy treatment is provided).

Over 90% of in-scope agencies submitted data to the AODTS NMDS (Table 3.1) in all jurisdictions, except New South Wales (approximately 80%). Overall, there was an increase of 1 percentage point since 2011–12 in the number of in-scope agencies that reported to the collection. However, there was a decrease in the number of in-scope agencies reporting for New South Wales (6 percentage points) and Victoria (4 percentage points).

Several factors can contribute to changes in the number of agencies reporting between years. As well as changes in the actual numbers of agencies, some jurisdictions may change data collection approaches, for example, moving from collecting data at an administrative or management level to a service outlet level.

Data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between them. Also, the AODTS NMDS has been implemented in stages, so comparisons across years, particularly the earlier years of the collection, need to be made with caution.

The AODTS NMDS reports on both main and additional treatment types. However, Victoria, Western Australia and Tasmania do not differentiate between main and other treatment types. Caution should be used in comparing episodes from these states with those of other states and territories. Despite variations in reporting practices between jurisdictions, there is very little difference between the proportions for principal drug of concern and all drugs of concern when these 3 jurisdictions are excluded from analysis. For example, the top 4 drugs of concern retain their size and their order.

Further information on coverage and data quality is available in Chapter 4 and in the Data Quality Statement for the AODTS NMDS in Appendix A.

1.5 Report structure

This report contains the following chapters:

- **Chapter 1: About the collection** – (this chapter) introduces the report; provides a background to the alcohol and other drug sector in Australia; and outlines the data and methods used.
- **Chapter 2: Overview** – provides an overview of results from the AODTS NMDS for 2012–13.
- **Chapter 3: Treatment agencies** – presents data on alcohol and other drug treatment agencies and episodes closed in the financial year.
- **Chapter 4: Clients** – provides information on client characteristics.
- **Chapter 5: Treatment episodes for own drug use** – provides information on the characteristics of the episodes closed in the financial year for clients receiving treatment for their own drug use, including drugs of concern and treatment types.
- **Chapter 6: Treatment episodes for someone else's drug use** – provides information on the characteristics of the episodes closed in the financial year for clients receiving treatment for someone else's drug use, including treatment types.
- **Chapter 7: State and territory comparisons** – compares key information across each state and territory.
- **Chapter 8: Other data sources** – summarises information from other data sources.

Four appendixes accompany this report:

- Appendix A – Data quality statement for the AODTS NMDS
- Appendix B – Information about the data and methods
- Appendix C – Imputation methodology for AODTS clients.
- Appendix D – State and territory summaries (online)

Supplementary tables referred to in this report (tables with 'S' as a prefix) can be downloaded from <<http://www.aihw.gov.au/publications/>>. Past reports in this series are also available for downloading.

2 Overview

The Australian Government and state and territory governments fund a range of alcohol and other drug treatment services provided by non-government and government organisations. Services are delivered in residential and non-residential settings and include treatment such as detoxification and rehabilitation programs, information and education courses, counselling and pharmacotherapy.

The AODTS NMDS contains information on a subset of publicly funded alcohol and other drug treatment agencies. These agencies provide services to people for their own drug use and those seeking assistance for someone else's drug use. Alcohol and other drug treatment varies considerably depending on the demographic features of clients, the drug of concern, the nature of treatment provided, the type of agencies involved and the location at which treatment is provided. In contrast to later chapters, which focus on more detailed information, this chapter gives an overview of results from the AODTS NMDS for 2012–13.

2.1 Agencies

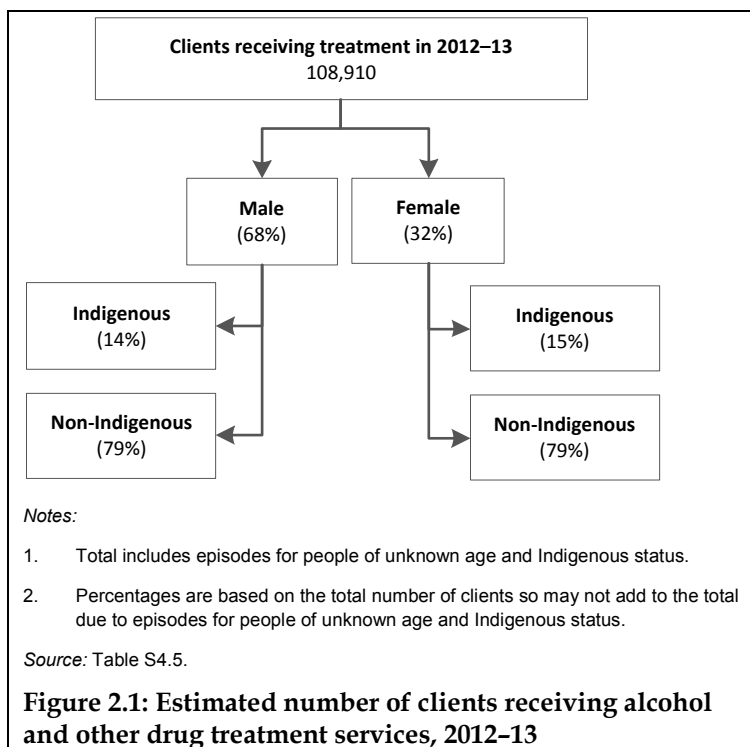
A total of 714 publicly funded alcohol and other drug treatment agencies reported to the AODTS NMDS in 2012–13. The number of reporting agencies increased from 622 in 2003–04. Over half (56%) of treatment agencies were non-government, and these agencies provided almost two-thirds (63%) of episodes closed in 2012–13. Nationally, 55% of treatment agencies were in *Major cities*, while 23% of agencies were in *Inner regional* areas (Figure 3.3). Relatively few agencies were in *Remote* or *Very remote* areas.

2.2 Clients

While the AODTS NMDS is based on information about treatment episodes, the inclusion of a statistical linkage key in the 2012–13 data collection enabled the number of clients to be estimated for the first time (for more detail see Chapter 4).

In 2012–13, there were 108,910 individual clients estimated to have received treatment (Figure 2.1). About 2 in 3 clients were male (68%) and about 1 in 7 clients were Aboriginal and Torres Strait Islander people (14%). These proportions were similar for clients receiving treatment for their own drug use, who comprised 96% of total clients (Figure 2.2 and tables S4.2 and S4.4). Clients seeking treatment for someone else's drug use were more likely to be female (64%) and less likely to report as being Indigenous (7%) when compared with the client group as a whole.

Clients aged 20–39 represented over half (55%) of all clients; this is strongly influenced by the large proportion of clients seeking treatment for their own drug use where 57% of clients were aged 20–39 (Figure 4.1). Clients seeking treatment for someone else's drug use tended to be older, with more clients aged 40–59 (42%) than 20–39 (30%). For less than 1% of clients, treatment was received for both their own drug use and for someone else's drug use within the 2012–13 collection period.



2.3 Episodes

Information on clients and treatment agencies is included in the AODTS NMDS when an episode of treatment provided to a client is closed. In 2012–13, alcohol and other drug treatment agencies provided a total of 162,362 closed treatment episodes (Figure 2.2), an increase of 6% from 2011–12.

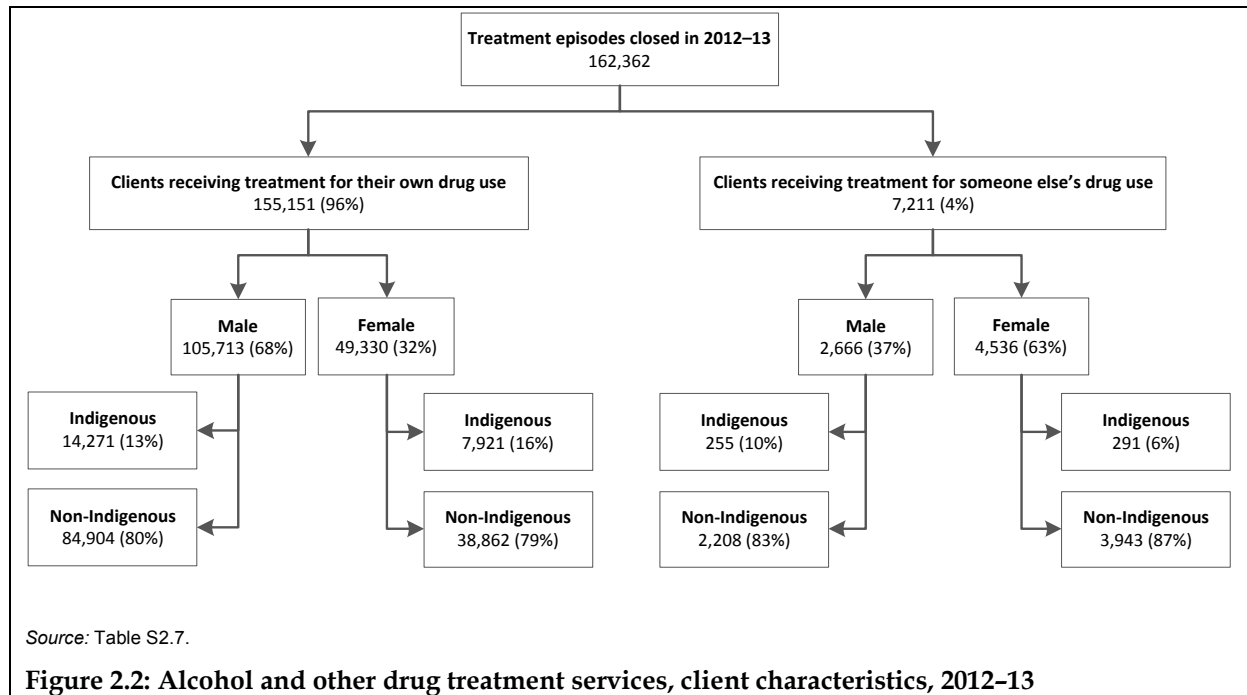


Figure 2.2: Alcohol and other drug treatment services, client characteristics, 2012–13

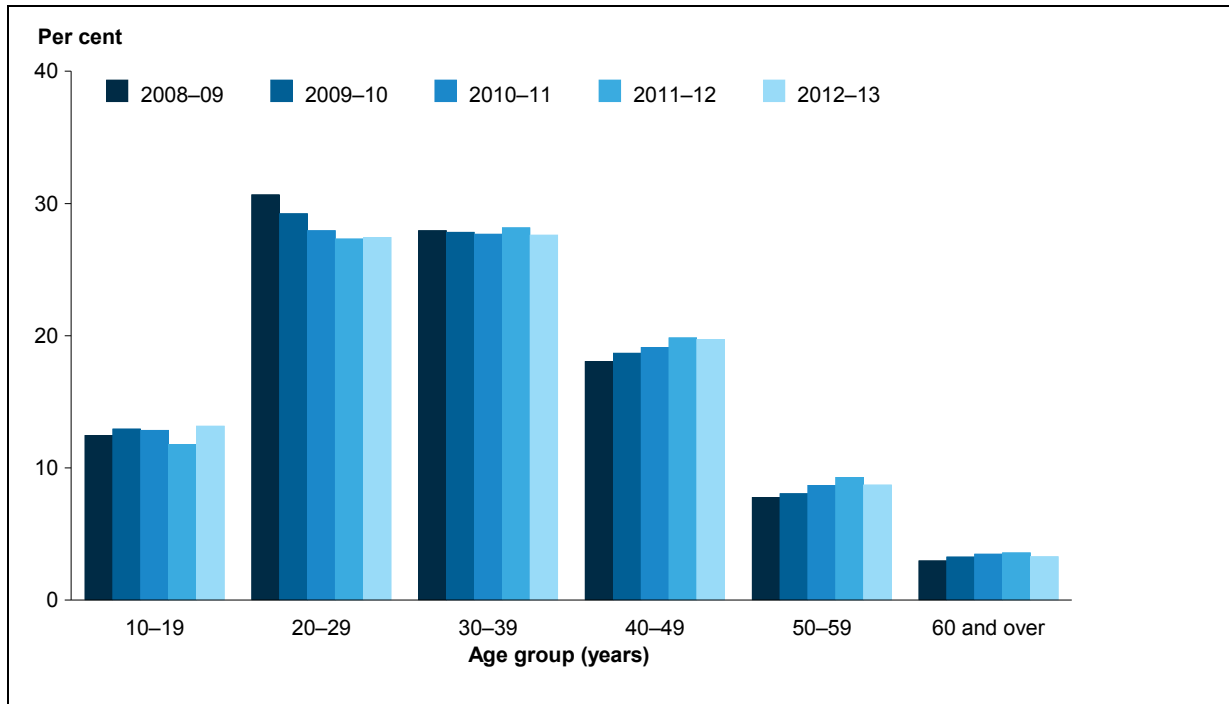
Demographic patterns relating to treatment episodes – including for age, sex and Indigenous status – are generally consistent with those found for individual clients.

A large majority of treatment episodes provided in 2012–13 (96%) were provided to clients receiving treatment for their own drug use. Of these, around 2 in 3 episodes (68%) were provided to male clients. The reverse was found among clients receiving treatment for someone else's drug use, where about 2 in 3 episodes (63%) were provided to female clients.

More than half (55%) of closed episodes were for clients aged 20–39. This is strongly influenced by episodes where clients received treatment for their own drug use, where 56% of episodes were for those aged 20–39. For episodes involving clients seeking treatment for someone else's drug use, clients tended to be older. Half (51%) of these episodes were provided to clients 40 and over compared with less than one-third (31%) of episodes for clients receiving treatment for their own drug use. (Table S6.9).

The age profile of people using services suggests that there is an ageing cohort of people in alcohol and other drug treatment. Over the 5 years to 2012–13, the percentage of people being treated who were aged 20–29 fell from 31% to 27% while the percentage for those aged 40 and over rose from 29% to 32%. The percentages for those aged 10–19 and 30–39 remained steady (Figure 2.3).

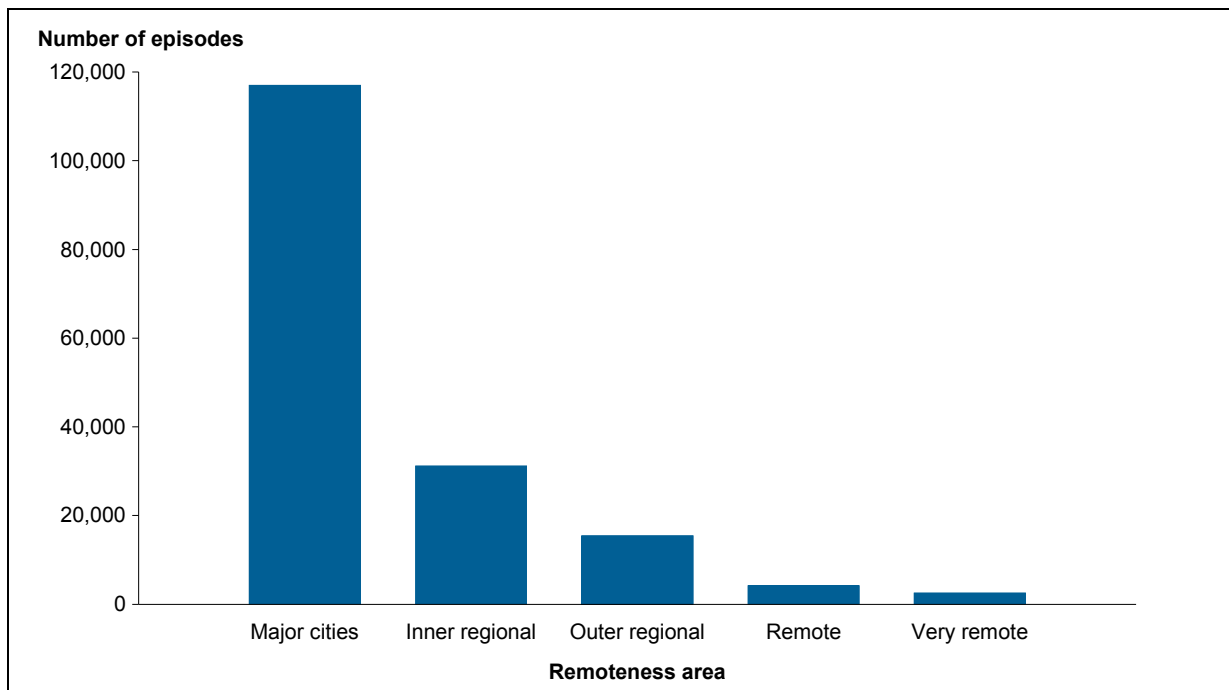
There was an overall increase over the 10 years from 2003–04 to 2012–13 for the number of episodes closed in the financial year, from 136,869 to 162,362 (Table S2.2). The number of episodes closed in 2012–13 increased from 2011–12 (up 6% from 153,668).



Source: Table S2.8.

Figure 2.3: Closed episodes provided by alcohol and other drug treatment services, by age group, 2008-09 to 2012-13

Nationally, 69% of episodes closed in 2012-13 were in *Major cities*, while 18% of episodes closed were in *Inner regional* areas (Figure 2.4). Relatively few episodes were in *Remote* or *Very remote* areas. This general pattern was found across most states and territories (Table S3.3).



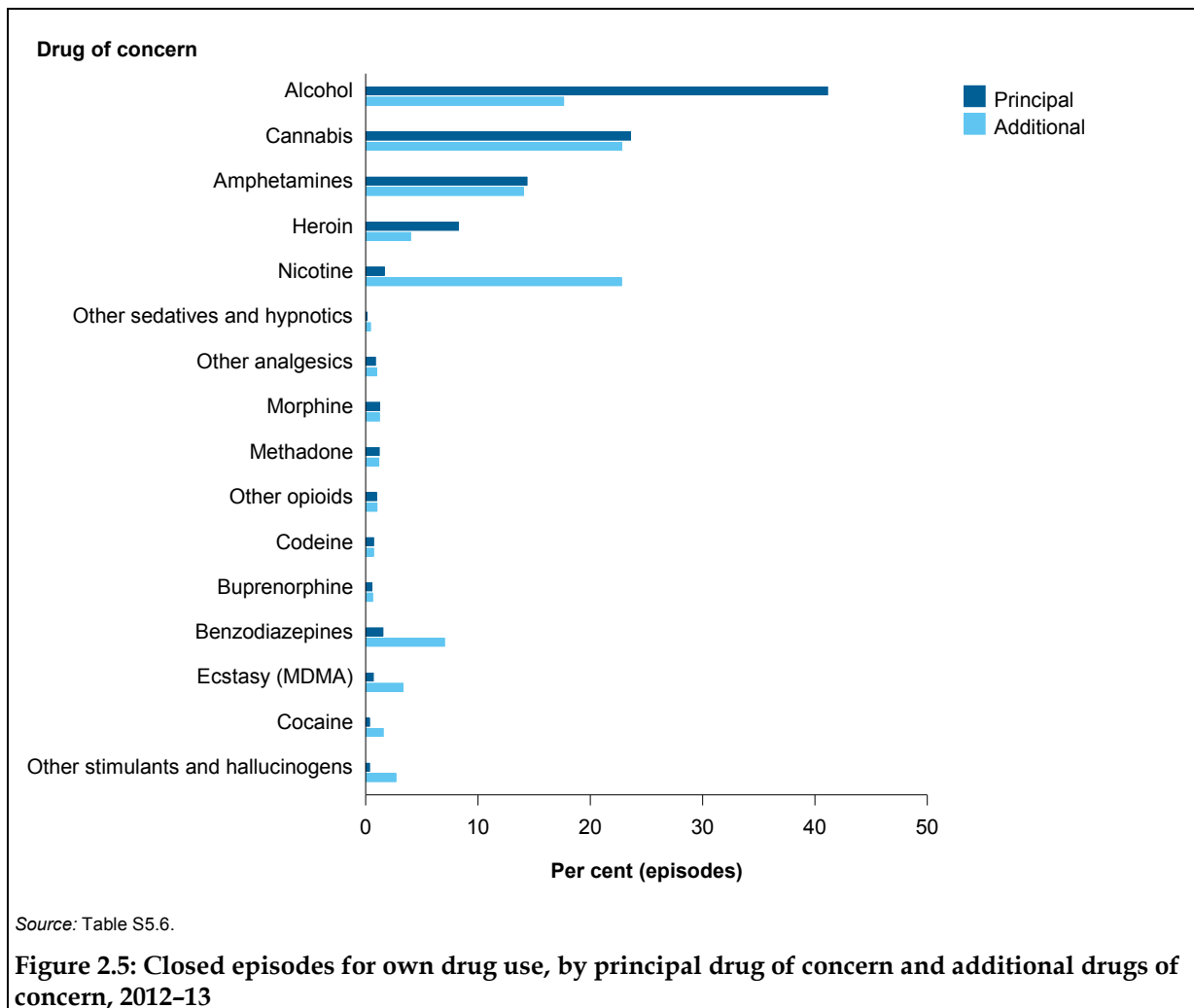
Source: Table S3.3.

Figure 2.4: Closed episodes by remoteness of agency, 2012-13

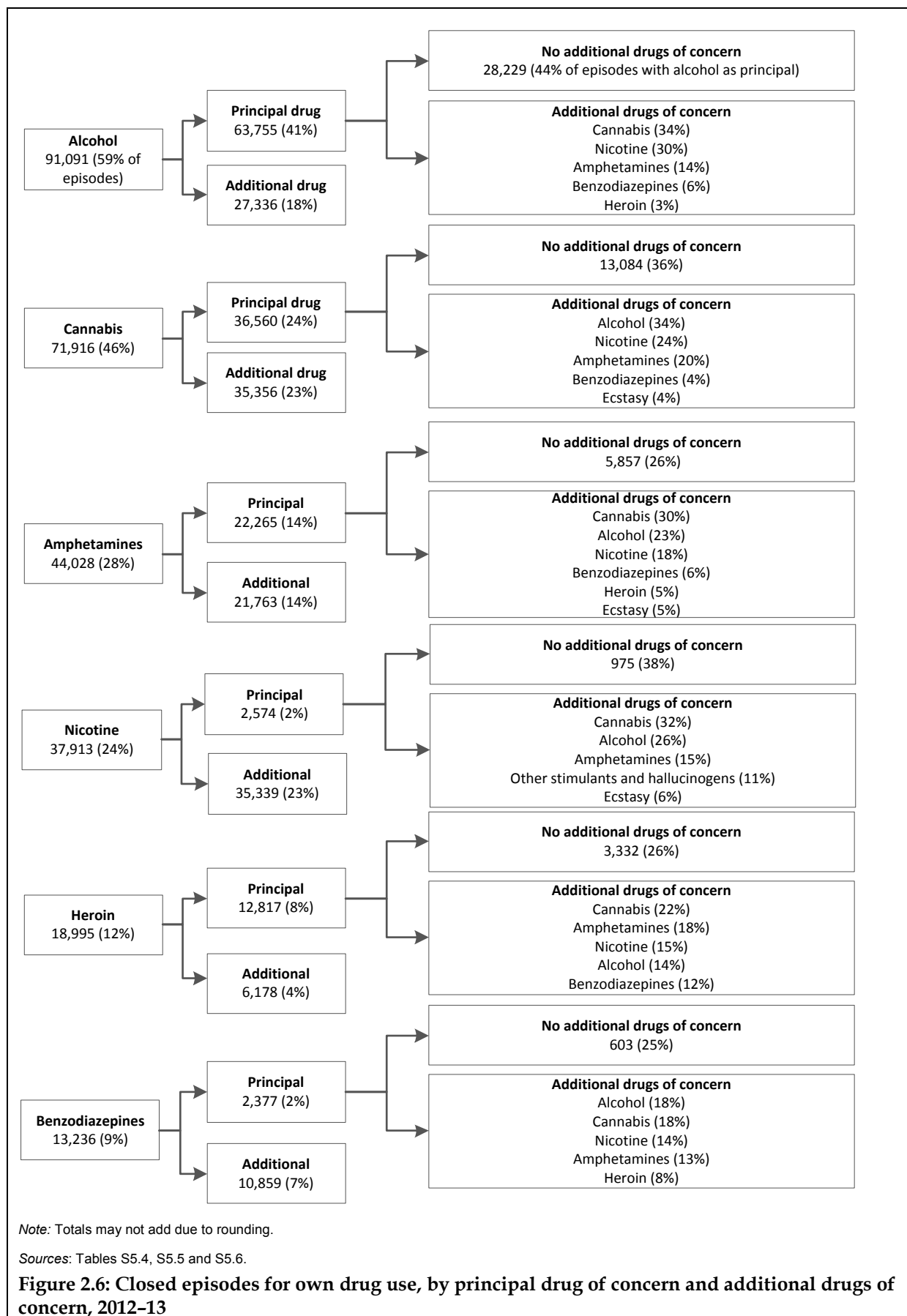
Drugs of concern

This section focuses on the drugs of concern reported by clients of alcohol and other drug treatment services. This includes the main drug that led them to seek treatment, called the 'principal drug of concern' and additional drugs reported to be of concern to the client.

The most common principal drugs of concern were alcohol (41%), cannabis (24%), amphetamines (14%) and heroin (8%) (Figure 2.5). In 3 of every 5 (63%) closed episodes, the client reported drugs of concern in addition to their principal drug of concern (Table S5.4). Almost one-third (31%) had 1 additional drug and 17% had 2, while 2% had 5 additional drugs. When both principal and additional drugs are considered, alcohol was the most common drug (59%), followed by cannabis (46%), amphetamines (28%), nicotine (24%) and heroin (12%) (Figure 2.5).



Nicotine was the principal drug of concern in just 2% of episodes, but it was the most common additional drug along with cannabis (both 23%) (Figure 2.6). The low proportion of episodes with nicotine as a principal drug is likely due to the ability of people with nicotine dependence to access support and treatment from other services including pharmacies and general practitioners.



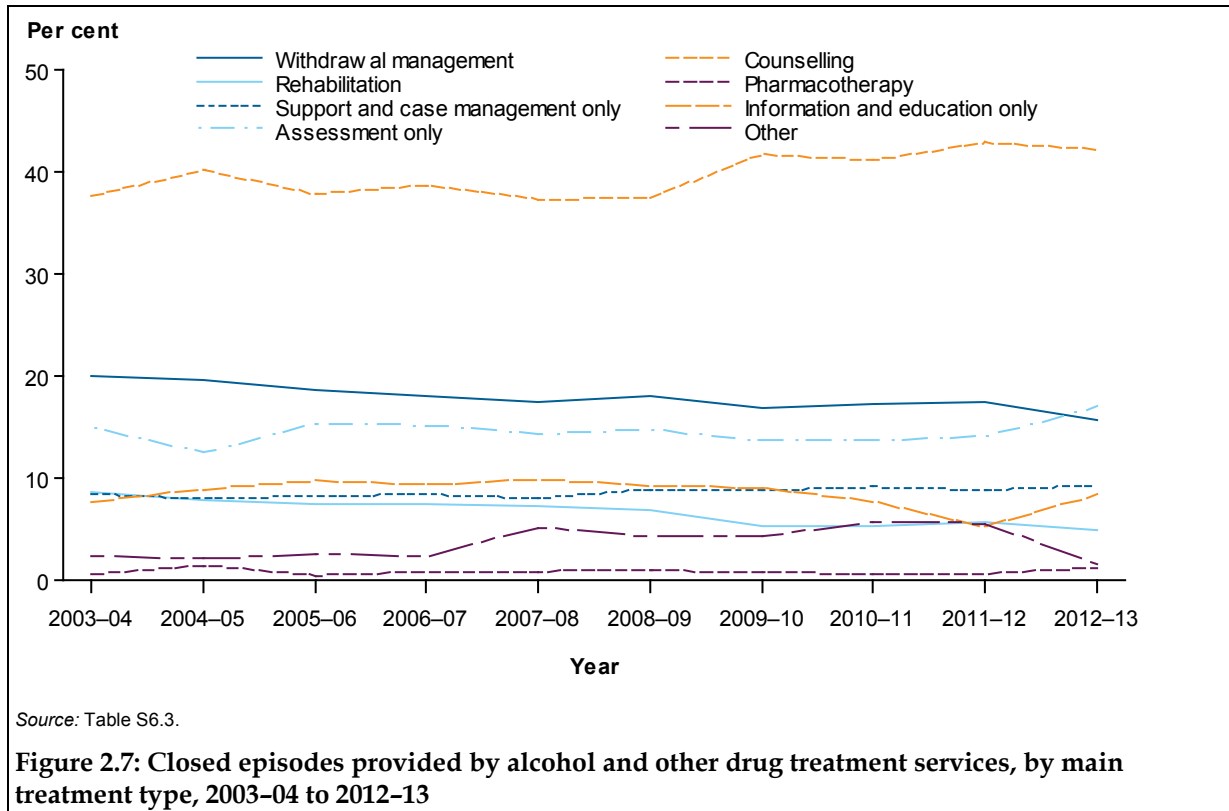
Treatment

This section focuses on the types of treatment provided to the client. 'Main treatment type' refers to the principal activity, as judged by the provider, necessary for the completion of the treatment plan for the principal drug of concern. Agencies are asked to provide the main treatment type for each episode. One main treatment type is reported for each episode and additional treatment types are recorded as appropriate. Up to 4 are recorded in the AODTS NMDS.

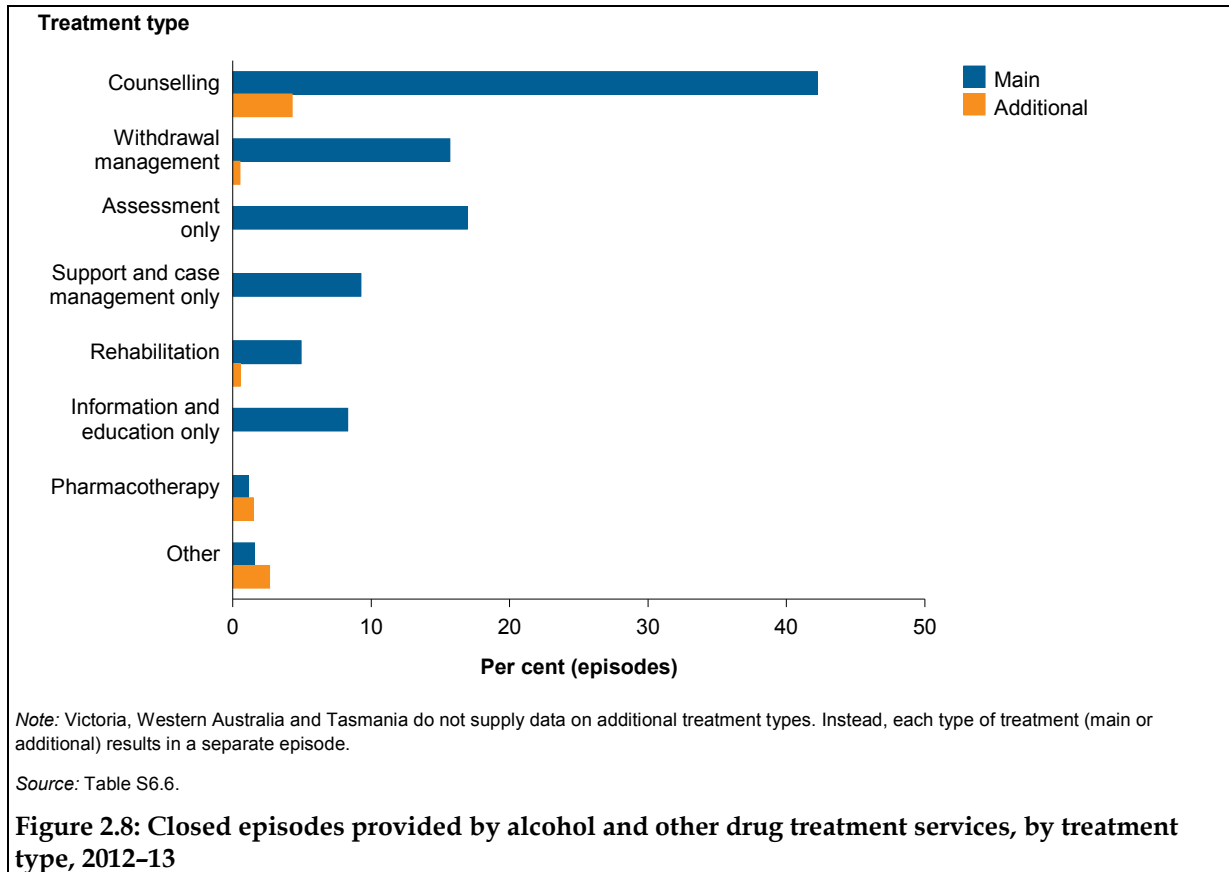
Some types of treatment are only available to clients receiving treatment for their own drug use (withdrawal management, rehabilitation and pharmacotherapy), while others are only main treatment types, not additional (assessment only, support and case management only and information and education only). 'Pharmacotherapy' refers to episodes where pharmacotherapy was the main treatment and at least 1 additional treatment was provided, or where it was an additional type of treatment (see Chapter 1 for details).

Unlike other states and territories, Victoria, Western Australia and Tasmania do not supply data on additional treatment types. Instead, each type of treatment (main or additional) results in a separate episode. Nationally, this results in an underestimate of the number of episodes with additional treatment types and an overestimate of episodes per client nationally, and in those jurisdictions.

Over the 10 years from 2003–04 to 2012–13, the proportion of episodes for each main treatment type has remained quite stable, with counselling, withdrawal management and assessment only being the most common types of treatment over that period (Figure 2.7). Counselling continues to be the most common main treatment type provided, comprising about 2 in every 5 episodes since 2003–04. In 2012–13, assessment only overtook withdrawal management as the second most common main treatment type for the first time since 2003–04. This has been influenced in part by the inclusion of the South Australian Police, Drug Diversion Assessment Program data in the collection, which has seen an increase in episodes with a main treatment type of assessment only.



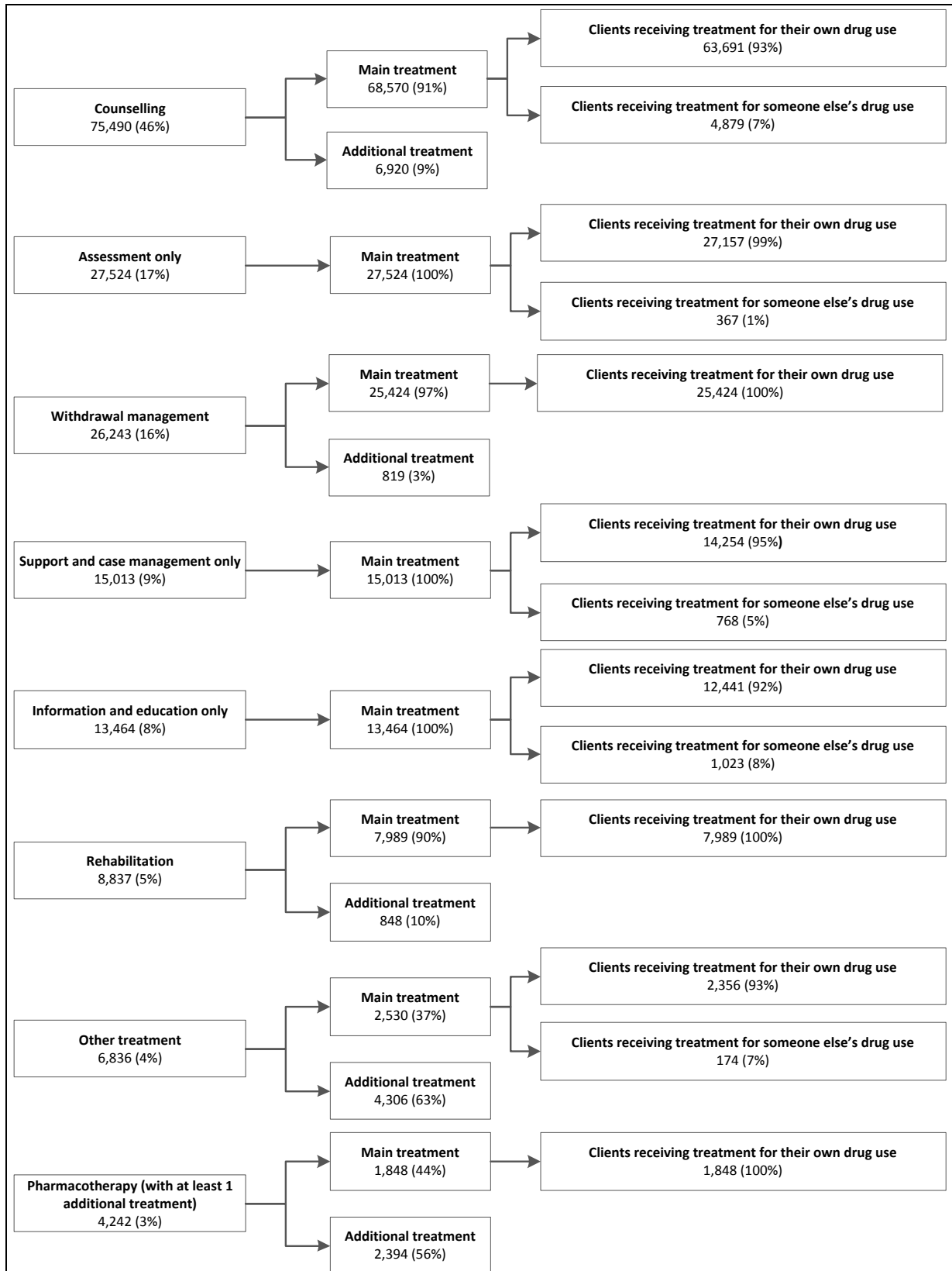
When both main and additional types of treatment are considered, counselling was the most common type of treatment (46% of episodes), followed by assessment only (17%), withdrawal management (which is only possible for clients receiving treatment for their own drug use) (16%) and support and case management only (9%) (Figure 2.8). These types of treatments were also the most common main treatment types: counselling (42%), assessment only (17%), withdrawal management (16%) and support and case management only (9%) (note that assessment, support and case management, and information and education are available only as main treatments).



Of the treatment types that were available both to clients receiving treatment for their own drug use and to those receiving treatment for someone else’s drug use, most episodes were for clients receiving treatment for their own drug use; this ranged from 92% for information and education only to 99% for assessment only (Figure 2.9).

Counselling was the most common main treatment type both for clients receiving treatment for their own drug use and for those receiving treatment for someone else’s. Clients receiving treatment for someone else’s drug use were more likely to receive counselling as a main treatment (68% of closed episodes compared with 41% for own use) (Table S6.1).

Other than counselling, clients receiving treatment for their own drug use were more likely to have assessment only as a main treatment (18% of closed episodes compared with 5% for clients receiving treatment for someone else’s use). Information and education only was more common for clients receiving treatment for someone else’s drug use (14% of closed episodes compared with 8% for clients receiving treatment for their own use) (Table S6.1).



Source: Table S6.1.

Figure 2.9: Summary treatment characteristics (main and additional) of closed episodes, 2012–13

Counselling

Counselling was a treatment type for 46% of the episodes closed in 2012–13; it was the main treatment type in 42% of episodes and an additional treatment type in 4% (Table S6.1). Most (93%) of the episodes with counselling as the main treatment type were provided to clients for their own drug use. Counselling was the most common main treatment type both for clients receiving treatment for their own drug use, and those receiving treatment for someone else's. Counselling was the main treatment for 4 in 10 (41%) episodes provided to clients receiving treatment for their own drug use; it was the main treatment for 7 in 10 (68%) episodes where clients were receiving treatment for someone else's drug use (Table S6.1).

Withdrawal management

Withdrawal management is only provided in episodes for clients receiving treatment for their own drug use. Withdrawal management was a treatment type for 16% of episodes closed in 2012–13. It was the main treatment type in 16% of episodes and an additional treatment type in 1% (Table S6.1).

Assessment only

Assessment only was the main type of treatment for 17% of episodes closed in 2012–13 (it is not available as an additional treatment type) (Figure 2.9). Nearly all (99%) of the closed episodes where assessment only was a main treatment type were provided to clients for their own drug use (Figure 2.9). Assessment only was the second most common main treatment type for clients receiving treatment for their own drug use, accounting for nearly one-fifth (18%) of closed episodes (Table S6.6). It was far less popular as a main treatment type for clients receiving treatment for someone else's drug use, accounting for only one-twentieth (5%) of those episodes.

Support and case management only

Support and case management only was the main treatment type for 9% of episodes closed in 2012–13 (it is not available as an additional treatment type) (Figure 2.9). Nearly all (95%) of these episodes were provided to clients for their own drug use (Figure 2.9). This may be because clinicians view this treatment type as most appropriate for clients seeking treatment for their own alcohol and drug issues. Support and case management only accounted for a similar proportion of closed episodes for both clients receiving treatment for their own or someone else's drug use (9% and 11%, respectively) (Table S6.1).

Rehabilitation

Rehabilitation is only provided in episodes for clients receiving treatment for their own drug use. Rehabilitation was the main type of treatment in 5% of episodes and an additional treatment type in 1% (Table S6.1).

Information and education only

Information and education only was the main treatment type for 8% of the episodes closed in 2012–13 (it is not available as an additional treatment type) (Figure 2.9). Nearly all (92%) of these episodes were provided to clients receiving treatment for their own drug use (Figure 2.9). Clients receiving treatment for someone else's drug use were more likely to have information and education only as a main treatment type (14% of closed episodes compared with 8% for client's own drug use) (Table S6.1).

Pharmacotherapy

Pharmacotherapy was the treatment type (main or additional) for 3% of the episodes closed in 2012–13 (it is only reported if there is at least 1 other treatment type provided) (Figure 2.9). Of these, it was the main treatment type in 44% of episodes and an additional treatment type in 56% (Figure 2.9). Pharmacotherapy is only available to clients receiving treatment for their own drug use.

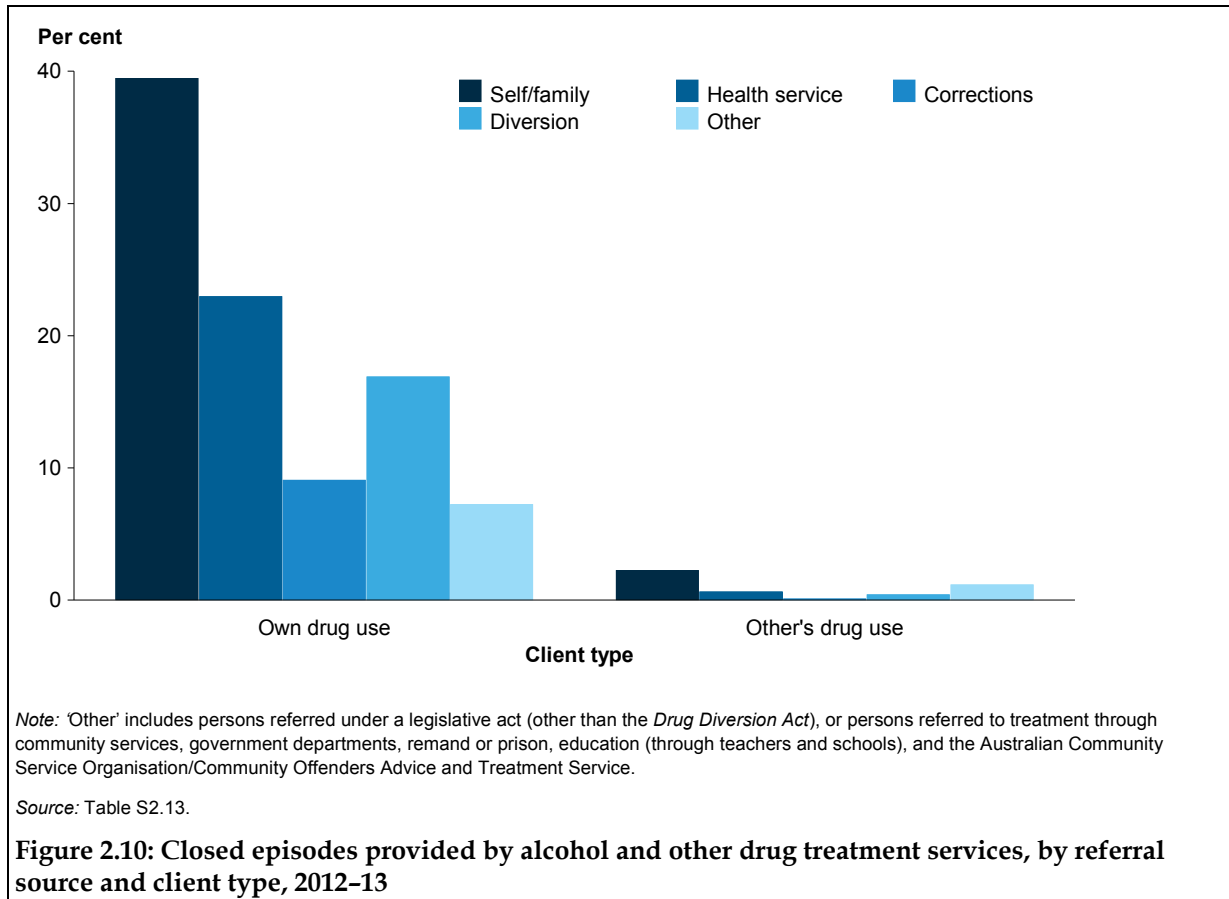
Other treatment

Other treatment refers to treatment types such as nicotine replacement therapy or outdoor therapy. Nationally in 2012–13, 'other' was the treatment type (main or additional) for 4% of episodes. Of these, it was the main treatment type in 37% of episodes and an additional treatment type in 63% (Figure 2.9). Nearly all (93%) were provided to clients receiving treatment for their own drug use.

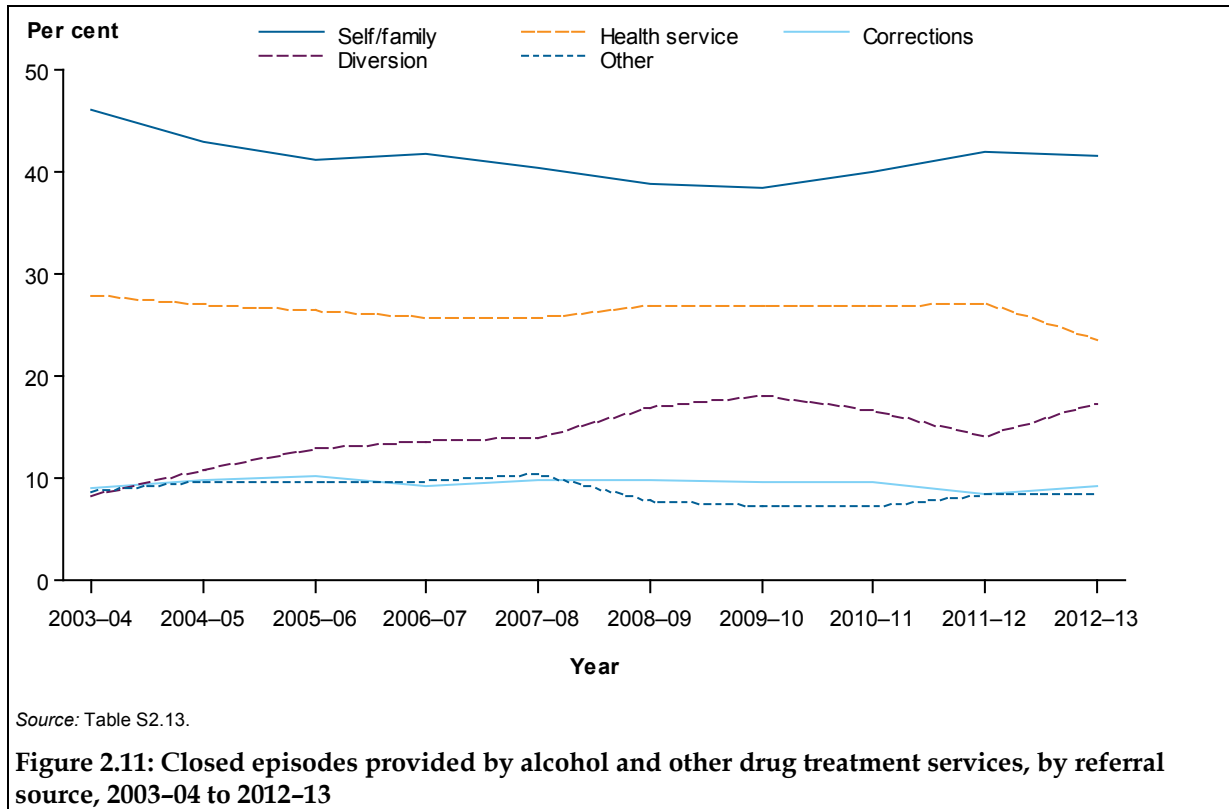
Referral source

'Referral source' is the avenue through which clients are referred to drug treatment services. Nationally, the most common source of referral in 2012–13 was self or family (42%), followed by referral from a health service (24%) (Table S2.13). Referrals from police or court diversion programs accounted for 17% of episodes (these programs divert people with minor drug offences from the criminal justice system) (Table S2.13). Clients referred by diversion programs tended to be younger; 24% of these episodes were for clients aged 10–19 and 36% were for clients aged 20–29, compared with 13% and 27%, respectively, for all episodes (Table S6.16). In 1 in 11 (9%) episodes, the client was referred by a correctional service.

Self or family was the most common source of referral both for clients receiving treatment for their own drug use and for those receiving treatment for someone else's drug use (40% and 50% respectively). Health services were also a common source of referral for clients receiving treatment for their own drug use and for those receiving treatment for someone else's use (27% and 14% respectively); however, people receiving treatment for their own drug use were more likely to be referred by police or court diversion than clients receiving treatment for someone else's drug use (15% compared to 9%) (Figure 2.10 and Table S2.13).



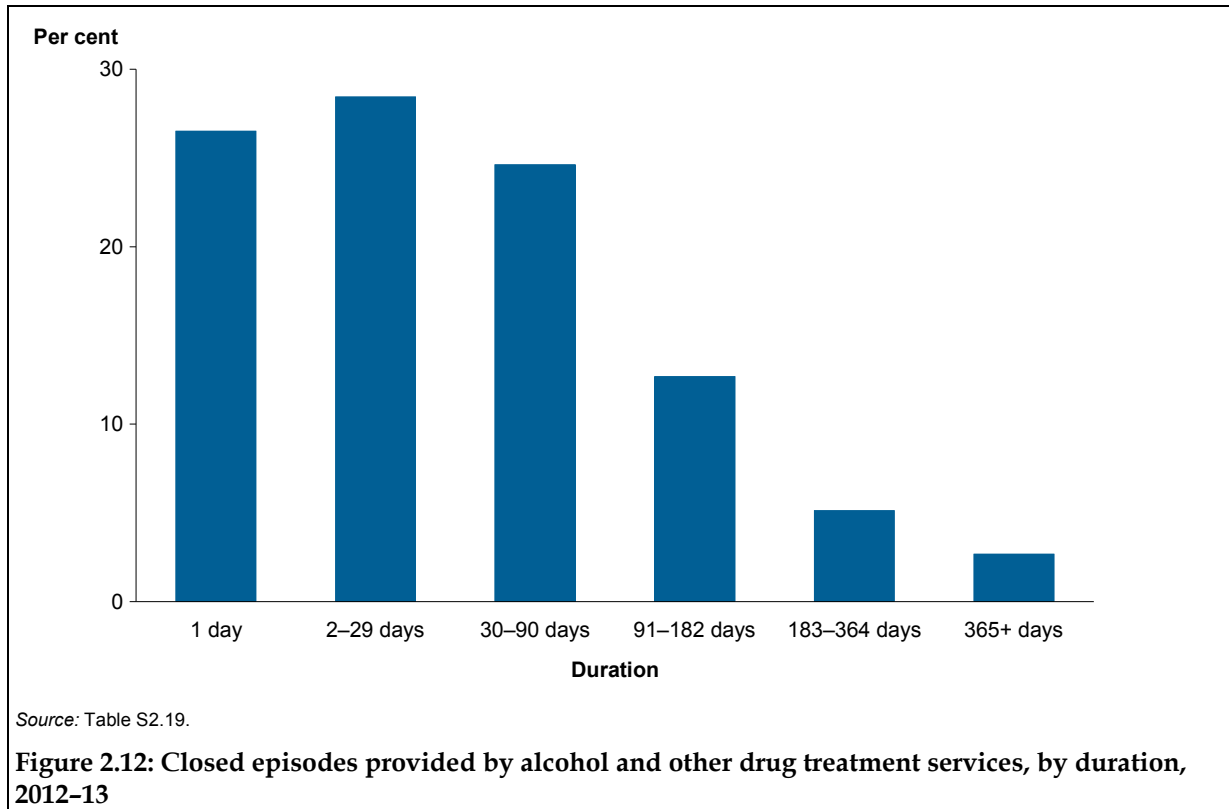
Over the 10 years from 2003-04, the proportion of episodes where the client was referred by a diversion program increased from 8% to 17% with a peak of 18% in 2009-10, while the proportion of episodes with a referral source of self or family decreased from 46% to 42% with a low of 38% in 2009-10 (Figure 2.11). There was also a decline in referrals from a health service, from 28% to 24% for the same period. There was little change in the other sources of referral.



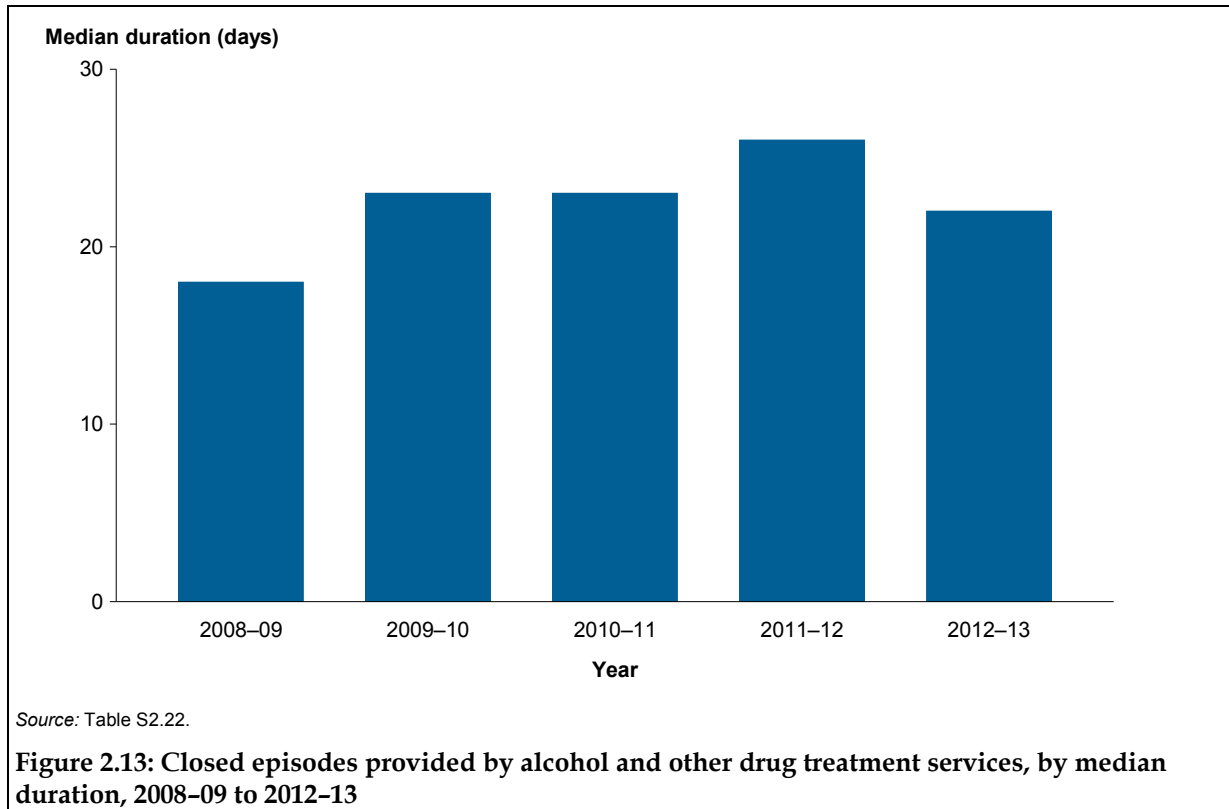
Length of treatment episodes

Four in 5 (80%) closed episodes ended within 3 months. Of these, more than one-quarter (27%) ended within 1 day, almost 3 in 10 (28%) between 2 days and 1 month, and one-quarter (25%) between 1 and 3 months (Figure 2.12). Only 8% of episodes lasted 6 months or longer.

Over time, the proportion of episodes that ended within 3 months remained at around 82-83% from 2003-04 to 2008-09, but decreased slightly in more recent years to 80% (with a low of 78% in 2011-12) (Table S2.20).



Nationally, the median duration of episodes closed in 2012-13 was just over 3 weeks (22 days) (Figure 2.13). The median duration of closed episodes gradually increased from 17 days in 2003-04 to 23 days in 2009-10 and 2010-11, peaking at 26 days in 2011-12 before falling to 22 days in 2012-13 (Figure 2.13). This trend is strongly influenced by data quality improvements (see Appendix A for further information).



Reason for cessation

The AODTS NMDS does not contain an indicator of treatment outcomes; however reasons for cessation can provide some insight into the client situation at the end of treatment. It is possible to group cessation reasons into broader categories for this purpose. These can be defined as 'expected' cessations, 'unexpected' cessations and 'administrative' cessations, where there was a change in the treatment.

In 2012-13, around 2 in 3 closed treatment episodes (63%) had an expected cessation. Unexpected cessations accounted for about 1 in 5 (20%) closed episodes and about 1 in 20 treatment episodes (6%) were administrative cessations (Table 2.16).

Over the 5 years from 2008-09, the proportion of episodes with an expected cessation has decreased slightly, from 66% to 63% with a high of 68% in 2009-10 and 2010-11. There was very little change to the proportion of episodes in the unexpected category, remaining around 20%, and no change for episodes ending due to an administrative cessation (6% over the same period) (Table S2.16).

Table 2.1: Reason for cessation grouped by indicative outcome type, 2012–13

Expected cessation (63%)	Unexpected cessation (20%)	Administrative cessation (6%)	Other (10%)
<p>Reasons reported:</p> <ul style="list-style-type: none"> • treatment completed • legally mandated treatment expiated^(a) • ceased to participate by mutual agreement 	<p>Reasons reported:</p> <ul style="list-style-type: none"> • ceased to participate against advice • ceased to participate without notice • ceased to participate involuntarily (non-compliance) 	<p>Reasons reported:</p> <ul style="list-style-type: none"> • change in treatment type • change in delivery setting • change in principal drug of concern • transferred to another service provider 	<p>Reasons reported:</p> <ul style="list-style-type: none"> • sanctioned into jail by court diversion service • imprisoned, other than drug court sanctioned • died • other • not stated

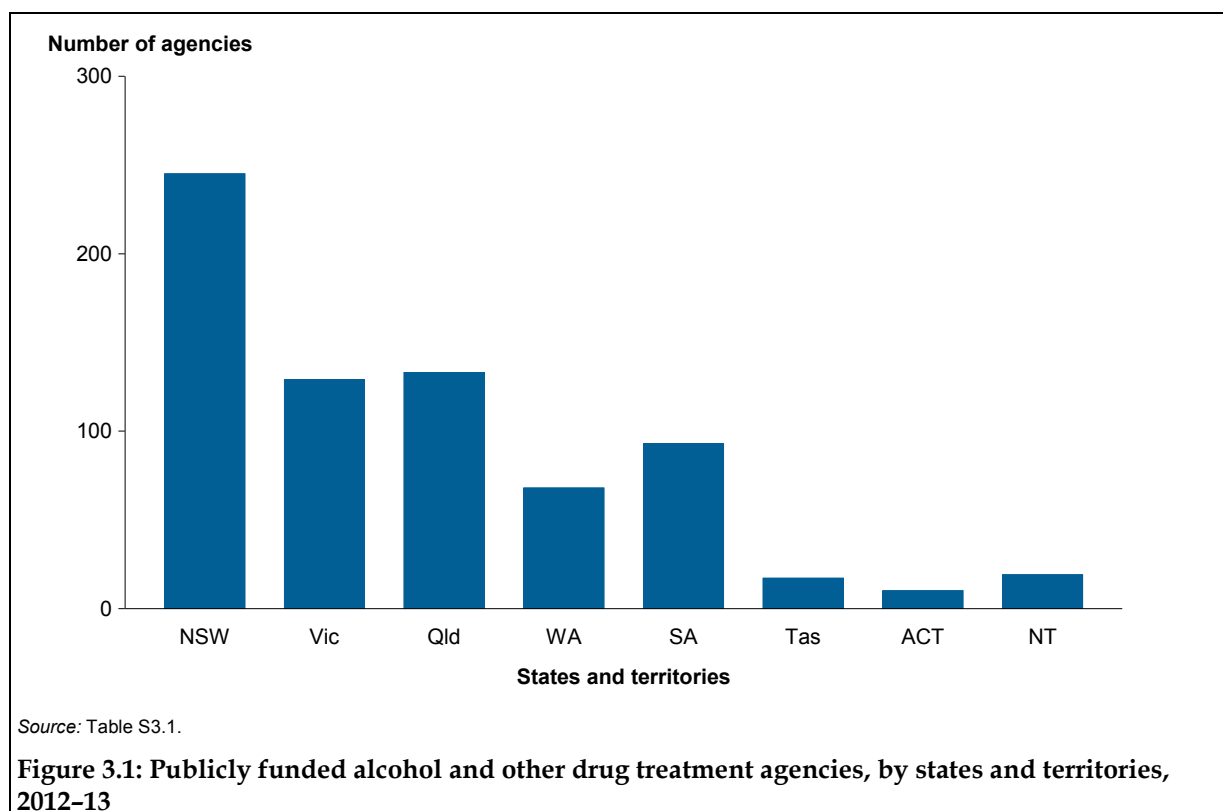
(a) This category is reported as 'ceased to participate at expiation'. This is an expected cessation in the sense that legally mandated treatment is completed. It is not possible to exclude episodes reported as 'ceased to participate at expiation' where clients finished enough treatment to expiate their offence but did not return for further treatment as expected.

3 Treatment agencies

This chapter provides information on the alcohol and other drug treatment agencies that provided data to the AODTS NMDS and the number of treatment episodes that were closed in the financial year 2012–13.

3.1 Number of agencies

There were 714 publicly funded alcohol and other drug treatment agencies in 2012–13 (Figure 3.1). The number of agencies ranged from 10 in the Australian Capital Territory up to 245 in New South Wales.



Over the 10 years from 2003–04 to 2012–13, the number of agencies supplying data to the AODTS NMDS increased in most states and territories, the largest increases being in Western Australia (from 34 to 68 agencies) and South Australia (from 53 to 93) (Table S3.1). The number was unchanged in the Northern Territory, and fell in both Victoria (from 143 to 129 agencies) and New South Wales (from 259 to 245 agencies).

In 2012–13 there was an 8% increase in the number agencies nationally. Queensland and South Australia had a substantial increase in the number of agencies (from 97 to 133, and 56 to 93 agencies, respectively), while the number of agencies decreased in New South Wales and Victoria.

The number of agencies reporting to the NMDS increased from 659 in 2011–12 to 714 in 2012–13. Jurisdictions were asked to provide information on the coverage of in-scope agencies. According to the information supplied, between 80–100% of in-scope agencies within jurisdictions submitted data to the collection (Table 3.1). Overall, there was an

increase of 1% in the number of in-scope agencies that reported to the collection. However, there was a decrease in the number of in-scope agencies reporting for New South Wales (6%), and Victoria (4%).

Table 3.1: In-scope agencies, AODTS NMDS 2011–12 and 2012–13

	2011–12			2012–13			Percentage points difference
	Agencies that submitted data	Agencies in-scope	% that submitted data	Agencies that submitted data	Agencies in-scope	% that submitted data	
NSW	261	306	85.3	242	304	79.6	-5.7
Vic	136	139	97.8	129	137	94.1	-3.7
Qld	83	84	99.0	*121	125	96.8	-2.2
WA	56	56	100.0	*64	64	100.0	0.0
SA	47	52	90.4	*85	88	96.5	6.1
Tas	16	16	100.0	16	16	100.0	0.0
ACT	9	11	81.8	*10	11	90.9	9.1
NT	19	19	100.0	19	19	100.0	0.0
DoH	32	39	82.1	28	28	100.0	17.9
Total	659	722	89.1	714	792	90.1	1.0

* Denotes increase in agency numbers for 2012-13.

Note: Some agencies that are in scope for DoH submitted data via their state health authorities (not directly to AIHW). These counts are included in the relevant state scope rather than the DoH scope (see Appendix 1).

Several factors can contribute to change in the number of agencies reporting between years. As well as changes in the actual numbers of agencies, some jurisdictions may change data collection approaches, for example, moving from collecting data at an administrative/management level to a service outlet level (see Appendix A for more details).

3.2 Service sector: government and non-government

While all agencies supplying data to the AODTS NMDS are publicly funded, some are government agencies and others are non-government. Government agencies are those that operate from the public accounts of the Australian Government or a state or territory government; are part of the general government sector; and are financed mainly from taxation. Non-government agencies receive some government funding but are not controlled by the government; are directed by a group of officers or an executive committee; and may be an income tax exempt charity. Nationally, over half (56%) of treatment agencies were non-government, and these agencies provided almost two-thirds (63%) of episodes closed in 2012–13 (Table 3.2).

Table 3.2: Publicly funded alcohol and other drug treatment agencies and closed episodes, by service sector, states and territories, 2012–13

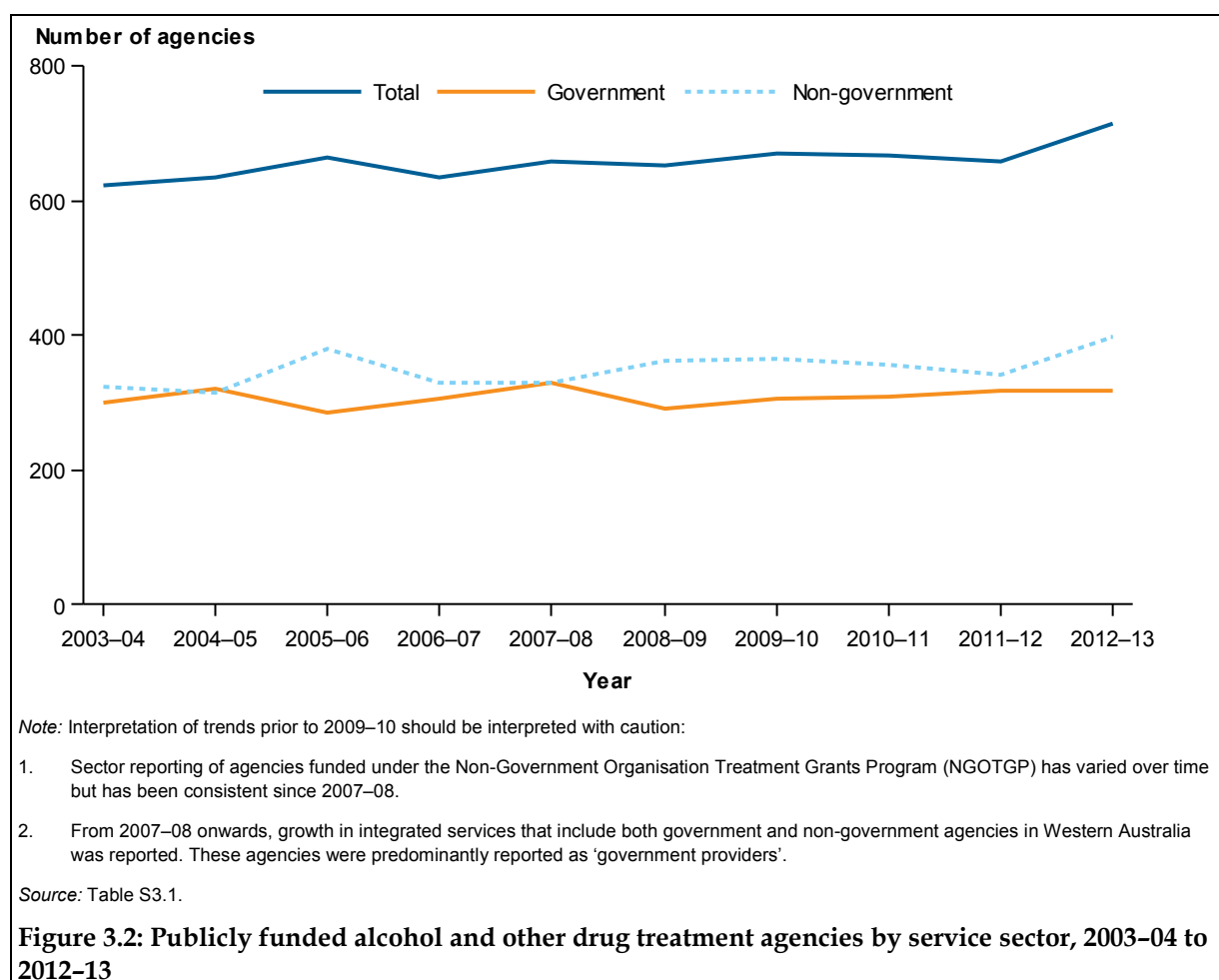
Service sector	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Treatment agencies									
Government	186	0	56	14	48	7	1	5	317
Non-government	59	129	77	54	45	10	9	14	397
Total	245	129	133	68	93	17	10	19	714
Closed episodes									
Government	26,197	0	18,923	2,475	6,566	1,570	2,383	1,177	59,291
Non-government	9,105	54,184	11,641	18,139	4,757	768	2,033	2,444	103,071
Total	35,302	54,184	30,564	20,614	11,323	2,338	4,416	3,621	162,362

Note: Western Australia has a number of integrated services that include both government and non-government providers. These agencies are predominantly reported as 'government providers'.

Source: AIHW analysis of the Alcohol and Other Drug Treatment Services NMDS 2012–13.

The majority of agencies in most states and territories were non-government, although this was not the case for New South Wales (24%) or South Australia (48%). In the remaining states and territories, the percentage that was non-government ranged from 58% in Queensland to 100% in Victoria (Table 3.1).

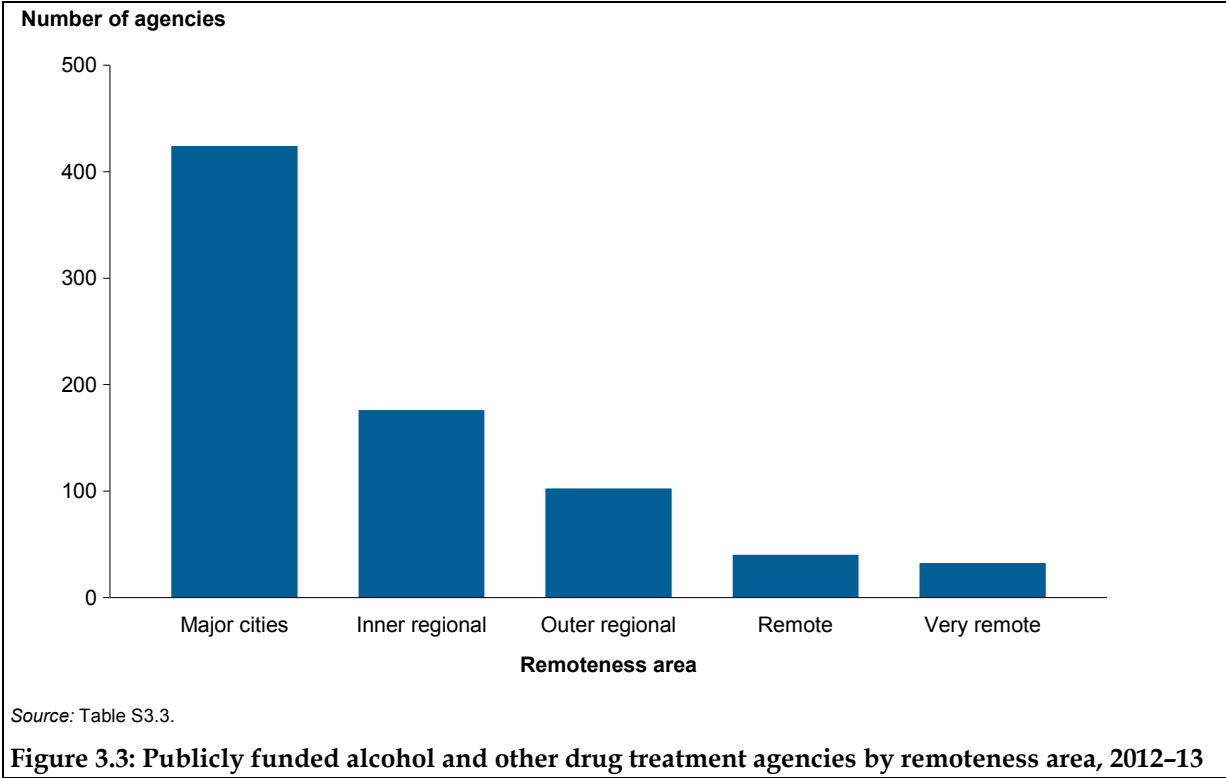
The proportion of non-government agencies has increased slightly since 2003–04 (Figure 3.2).



3.3 Remoteness

Nationally, 55% of treatment agencies in 2012–13 were in *Major cities*, while 23% of agencies were in *Inner regional* areas (Figure 3.3). Relatively few agencies were in *Remote* or *Very remote* areas. This general pattern was found across most states and territories (note that not all remoteness areas occur in all states and territories) (Table S3.4).

There has been a change in methodology used for previous reports and therefore remoteness data are not comparable to earlier data on remoteness from this collection. See Appendix B for further information.



4 Clients

From the inception of this collection in the late 1990s, data have been collected only about treatment episodes provided by alcohol and other drug 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. *Developing client-based analyses for reporting on alcohol and other drug treatment services* (AIHW 2013a) documented methods for generating distinct client counts and explored possible client-based analyses.

That report determined that the number of clients should be estimated initially by using a simple deterministic method, due to anticipated levels of data quality and completeness. As data with unique client counts accumulate over time, more complex analyses on patterns of drug use and pathways through treatment will be possible.

4.1 Client counts and data quality

An SLK was reported for the vast majority (88%) of episodes in 2012–13. There are a number of records that had missing or invalid SLK data, which cannot be attributed to a client. This could lead to an underestimate of the total number of clients using the services, as some (but not all) of the records will belong to clients who are not observed via a valid SLK. Nationally, the proportion of episodes with a valid SLK was 88%, ranging from 67% in New South Wales to nearly 100% in Tasmania (Table 4.1). 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 a number of 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 a client with an episode missing and SLK has already been counted. See Appendix C for more information on the imputation strategy.

Using the imputation strategy to adjust for non-response and data quality issues, it is estimated there were nearly 108,000 clients who received treatment in 2012–13.

Table 4.1: Imputed numbers of distinct clients, by states and territories, 2012–13

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of episodes	35,302	54,184	30,564	20,614	11,323	2,338	4,416	3,621	162,362
Number of episodes with valid SLKs	23,482	53,340	25,214	19,539	11,007	2,327	4,331	3,377	142,617
Percentage of episodes with valid SLKs (%)	66.5	98.4	82.5	94.8	97.2	99.5	98.1	93.3	87.8
Number of episodes with invalid SLKs	11,820	844	5,350	1,075	316	11	85	244	19,745
Number of distinct clients (from valid SLKs)	17,271	29,040	21,105	15,789	8,332	2,004	3,164	2,429	98,902
Imputed number of distinct clients	23,084	29,319	24,772	16,502	8,522	2,012	3,212	2,562	108,910

Clients received an average of 1.5 treatment episodes nationally. Comparing states and territories, Queensland, Western Australia and Tasmania had the lowest average episodes per client (1.2) and Victoria the highest (1.8). The rate of clients who received alcohol and other drug treatment nationally was 475 clients per 100,000 people in the general population, but this varied greatly between states and territories. New South Wales had the lowest rate

of clients (314 per 100,000 population), while the Northern Territory had the highest (1,082 per 100,000 population), more than triple the rate of New South Wales (Table 4.2).

Table 4.2: Clients, episodes and rates, by states and territories, 2012–13

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of episodes	35,302	54,184	30,564	20,614	11,323	2,338	4,416	3,621	162,362
Number of clients	23,084	29,319	24,772	16,502	8,522	2,012	3,212	2,562	108,910
Episodes per client	1.5	1.8	1.2	1.2	1.3	1.2	1.4	1.4	1.5
Rate of episodes ^(a) (per 100,000 population)	480	954	663	834	681	456	1,163	1,529	709
Rate of clients ^(a) (per 100,000 population)	314	516	537	667	513	393	846	1,082	475

(a) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2012.

4.2 Client characteristics

This section looks at characteristics of clients and compares clients seeking treatment for their own drug use with those seeking treatment for another person, in 2012–13. All client percentages reported (such as for age, sex and Indigenous status) are based on episodes with valid SLK responses. This varied slightly for some jurisdictions, however. See Appendix Table C1 for details.

There were about 104,000 clients receiving treatment for their own drug use and 5,300 receiving treatment for someone else's drug use (Table S4.2). For 1% of clients, treatment was received for their own drug use and for someone else's drug use within the collection period. This indicates that there was very little overlap between these 2 client groups.

Sex

Among those clients receiving treatment for their own drug use, about 2 in 3 (69%) were male (Table 4.3). This equates to about 72,400 males who received treatment for their own drug use in 2012–13. The opposite was found among those receiving treatment for someone else's drug use, with about 2 in 3 (64%, 3,300 clients) being female. The relatively small number of clients receiving treatment for someone else's drug use meant that, overall, clients were more likely to be male (68%), with a total of 73,800 male clients estimated to be receiving treatment for their own or someone else's drug use in 2012–13 (Table S4.2).

Table 4.3: Clients, by sex and client type (%), 2012–13

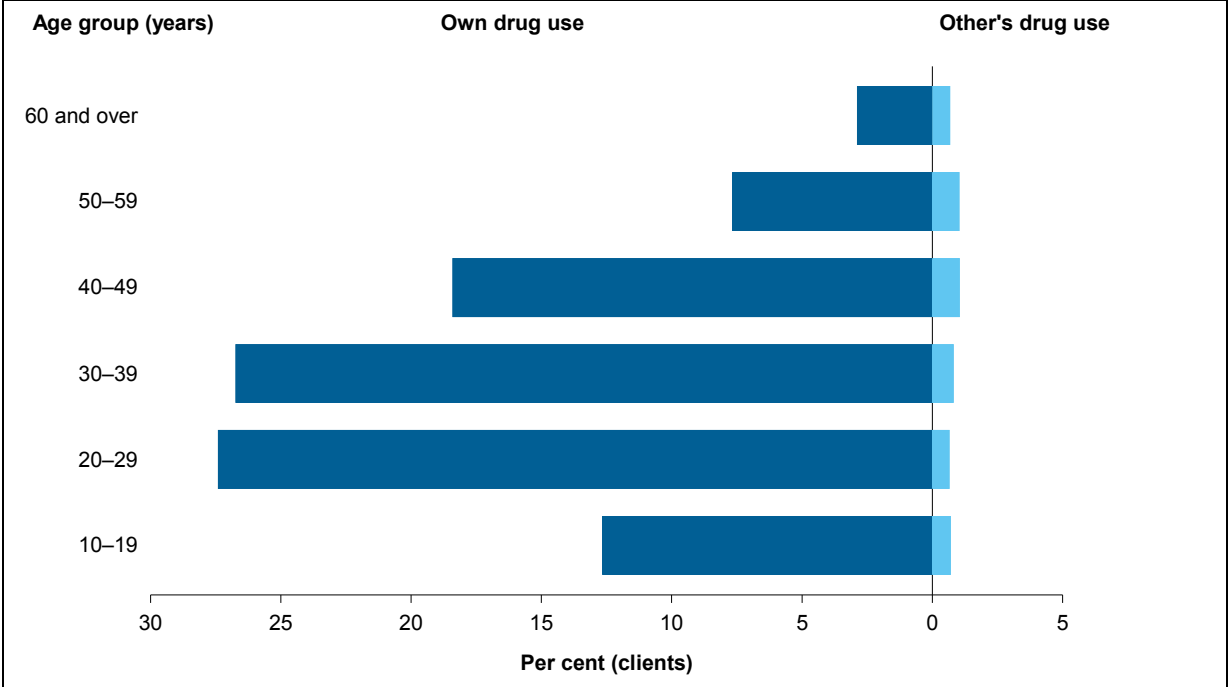
	Own drug use (%)	Other's drug use (%)	All clients (%)
Sex			
Male	69.4	36.3	67.8
Female	30.6	63.7	32.1
Total	100.0	100.0	100.0

Note: Totals include people of unknown sex.

Age

Clients seeking treatment for their own drug use tended to be younger, on average, than clients seeking treatment for someone else's drug use (Figure 4.1). Clients aged 20–39

represented over half (57%, 58,900 clients) of all clients seeking treatment for their own drug use, but only about one-third (30%, 1,600 clients) of all clients seeking treatment for someone else’s drug use (Table S4.3). Clients aged 40 and over, however, comprised nearly one-third (30%) of all clients receiving treatment for their own drug use, but comprised over half (56%) of all clients receiving treatment for someone else’s drug use. This equates to an estimated 31,500 clients aged 40 and over receiving treatment for their own drug use, and 3,000 receiving treatment for someone else’s drug use (Table S4.3).



Source: Table S4.3.

Figure 4.1: Clients, by age group and client type (%), 2012-13

Indigenous status

The proportion of clients reporting as Indigenous varied between client types. About 1 in 7 (14%) clients receiving treatment for their own drug use were Indigenous, whereas 7% of the clients receiving treatment for someone else’s drug use were Indigenous (Table 4.4). This equates to an estimated 15,000 clients reporting as Indigenous who received treatment for their own drug use, and 400 who received treatment for someone else’s use (Table S4.4).

However as previously mentioned, Indigenous people are under-represented in the AODTS NMDS as most information on drug services specifically provided to Indigenous Australians (funded by the Australian Government) is included in other collections (see Section 8.2 and Appendix B).

Table 4.4: Clients, by Indigenous status and client type (%), 2012–13

	Own drug use (%)	Other's drug use (%)	All clients (%)
Indigenous status			
Indigenous	14.4	7.2	14.1
Non-Indigenous	78.7	86.5	79.1
Not stated	6.8	6.3	6.8
Total	100.0	100.0	100.0

Country of birth and preferred language

The majority (86%) of AODTS NMDS clients were born in Australia (Table S4.6). This percentage is higher than that found in the general population (70%) (ABS 2012a).

Clients born in other countries were only a small proportion of all clients, with the United Kingdom and New Zealand (both 3%) being the next most common countries of birth (Table S4.6) after Australia. In comparison, in 2011, 5% of people in Australia were born in the United Kingdom and 2% in New Zealand (ABS 2012b).

English was the most frequently reported preferred language (96% of all clients) (Table S4.7). Less than 1% of episodes involved clients who reported an Australian Indigenous language as their preferred language.

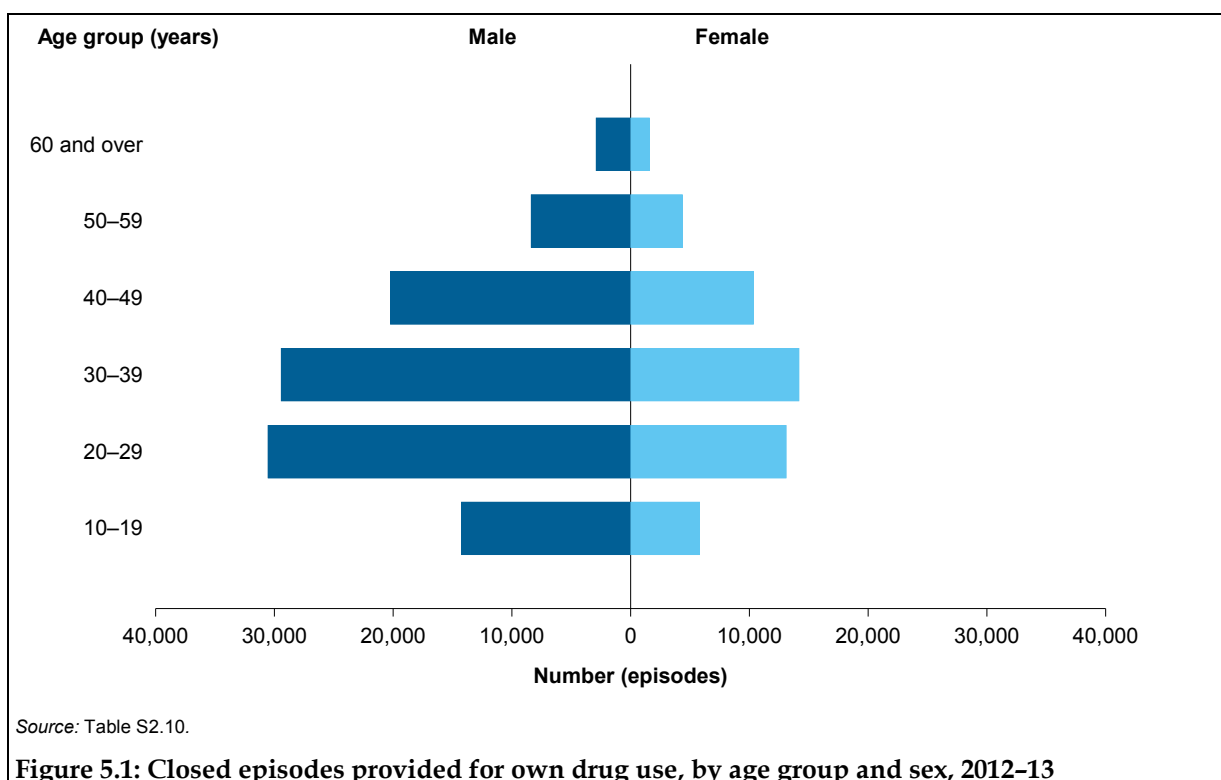
5 Treatment episodes for own drug use

This chapter explores the treatment provided to clients receiving treatment for their own drug use and reports on closed treatment episodes.

5.1 Demographics

Nearly all (96%) of the episodes closed in 2012–13 were for people receiving treatment for their own drug use (Figure 2.12). Of these, more than two-thirds (68%) were for male clients, and this has remained relatively unchanged since 2003–04 (Table S2.4). Over half (56%) of episodes were provided to clients aged 20–39 (28% for both 20–29 and 30–39 year olds). One in 5 (20%) were for clients aged 40–49 and 1 in 8 (13%) were aged 10–19. Proportions were similar for males and females (Figure 5.1). There was little change in the proportion of episodes provided to clients of different age groups from 2003–04 to 2012–13 (Table S2.9).

One in 7 (14%) closed episodes for people receiving treatment for their own drug use were for Indigenous clients. For both Indigenous and non-Indigenous client episodes, males were more likely to receive treatment for their own drug use (64% and 69% of closed episodes, respectively) (Table S2.7). However, many Indigenous clients receive treatment from Australian Government-funded agencies and data for these agencies are largely not included in this report. Data on the number of episodes of care provided by these Australian Government-funded agencies are available from the AIHW Online Services Report (OSR) Database. Data for 2012–13 is in Chapter 8 and Appendix B.



Most (87%) of the episodes for the client’s own drug use were provided to clients whose country of birth was Australia (Table S2.11). A further 3% were born in the United Kingdom

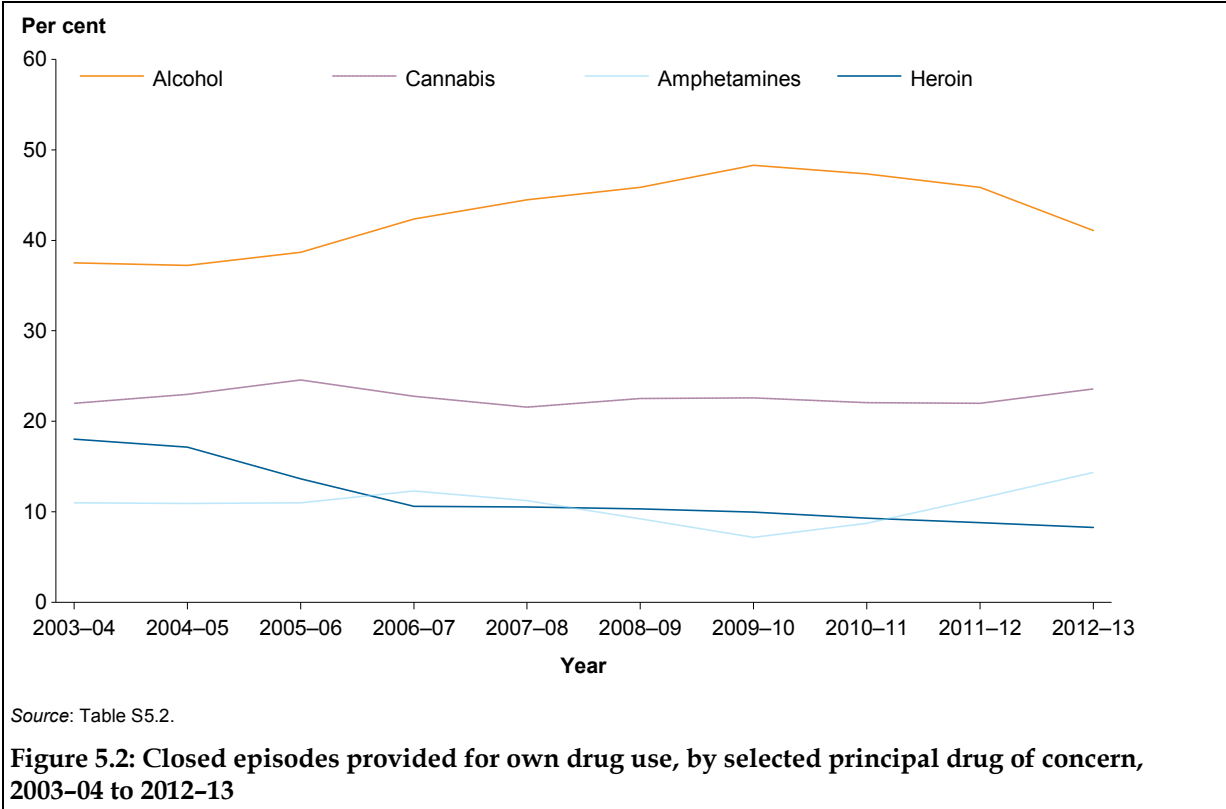
and 2% were born in New Zealand. In almost all (97%) episodes, the client had a preferred language of English (Table S2.12).

5.2 Drugs of concern

Overview

This section focuses on the drugs of concern for episodes reported by clients of alcohol and other drug treatment services. This includes the main drug that led them to seek treatment, called the 'principal drug of concern' and additional drugs reported to be of concern.

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs of concern since 2003–04 (Figure 5.2). Since 2009–10, the proportion of episodes where alcohol was the most common principal drug has decreased (from 48% to 41%), while the proportion of amphetamines has increased (from 7% to 14%).

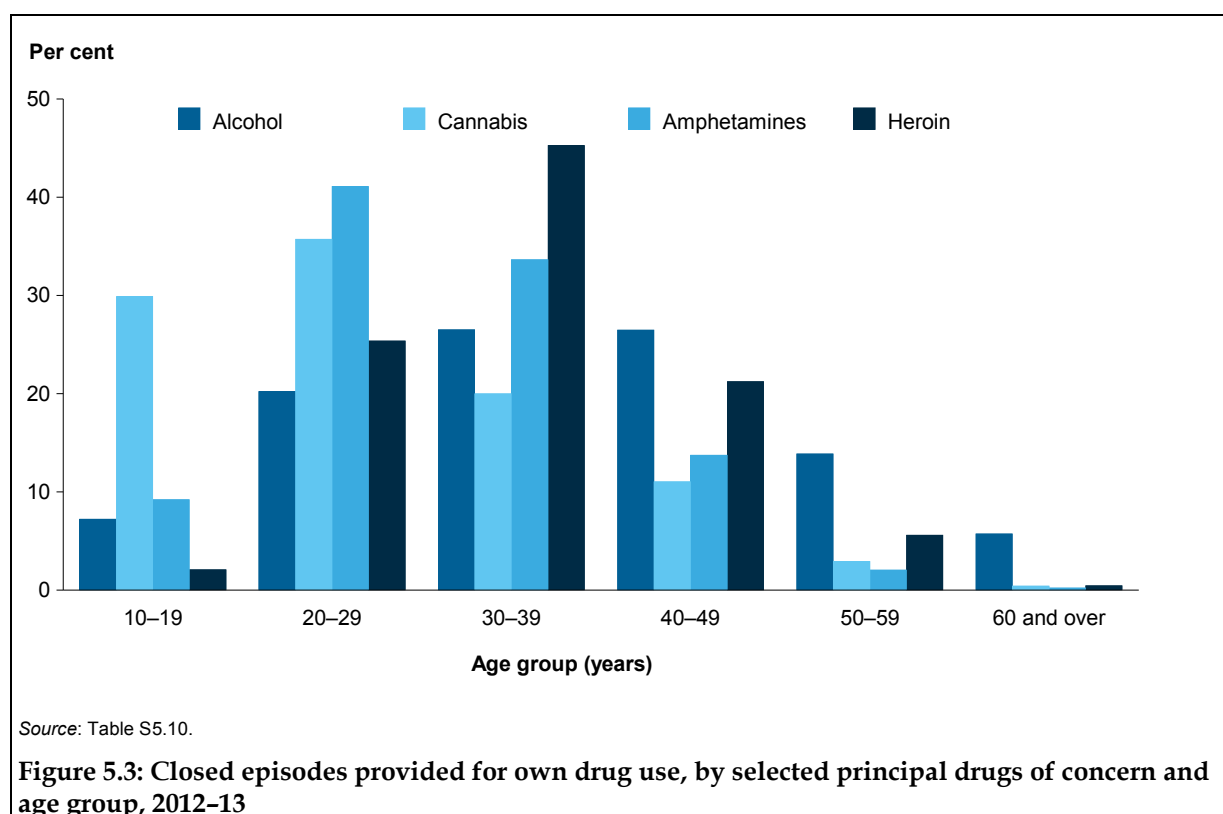


Drugs of concern varied considerably with age. People in older age groups were more likely to have sought treatment for alcohol than those in younger age groups. For people aged 10–19, alcohol was the principal drug of concern in 23% of treatment episodes, while for those aged 60 and over it was the principal drug in 82% of episodes (Table S5.10).

For people aged 60 and over, cannabis was the principal drug of concern in only 3% of episodes, while for people aged 10–19 it was the principal drug in 55% of episodes.

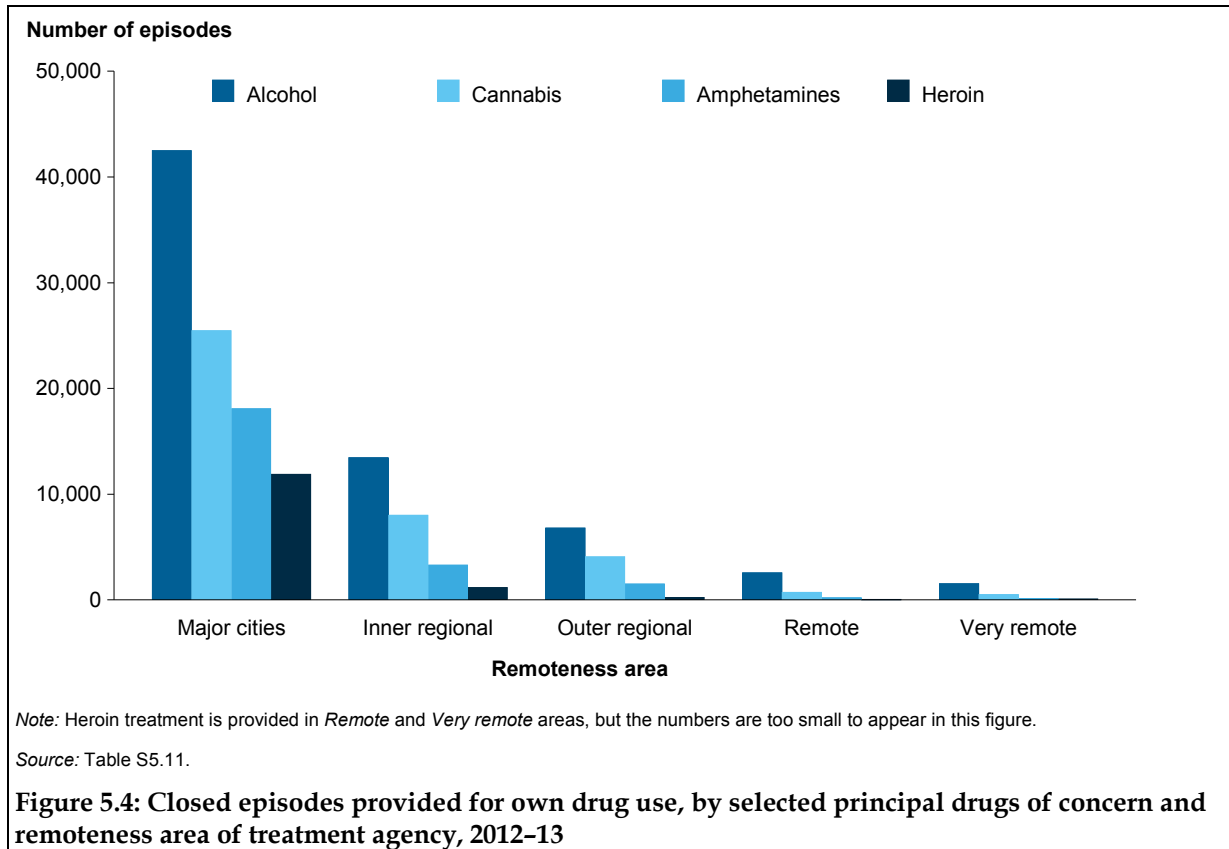
The largest percentage of episodes provided to clients receiving treatment for alcohol as their principal drug of concern was for clients aged 30–39 years and 40–49 years (both 26%). For cannabis and amphetamines, the largest proportion of episodes was for clients aged 20–29

year (36% and 41%, respectively), while for heroin, the largest proportion was for those aged 30–39 years (45%) (Figure 5.3)

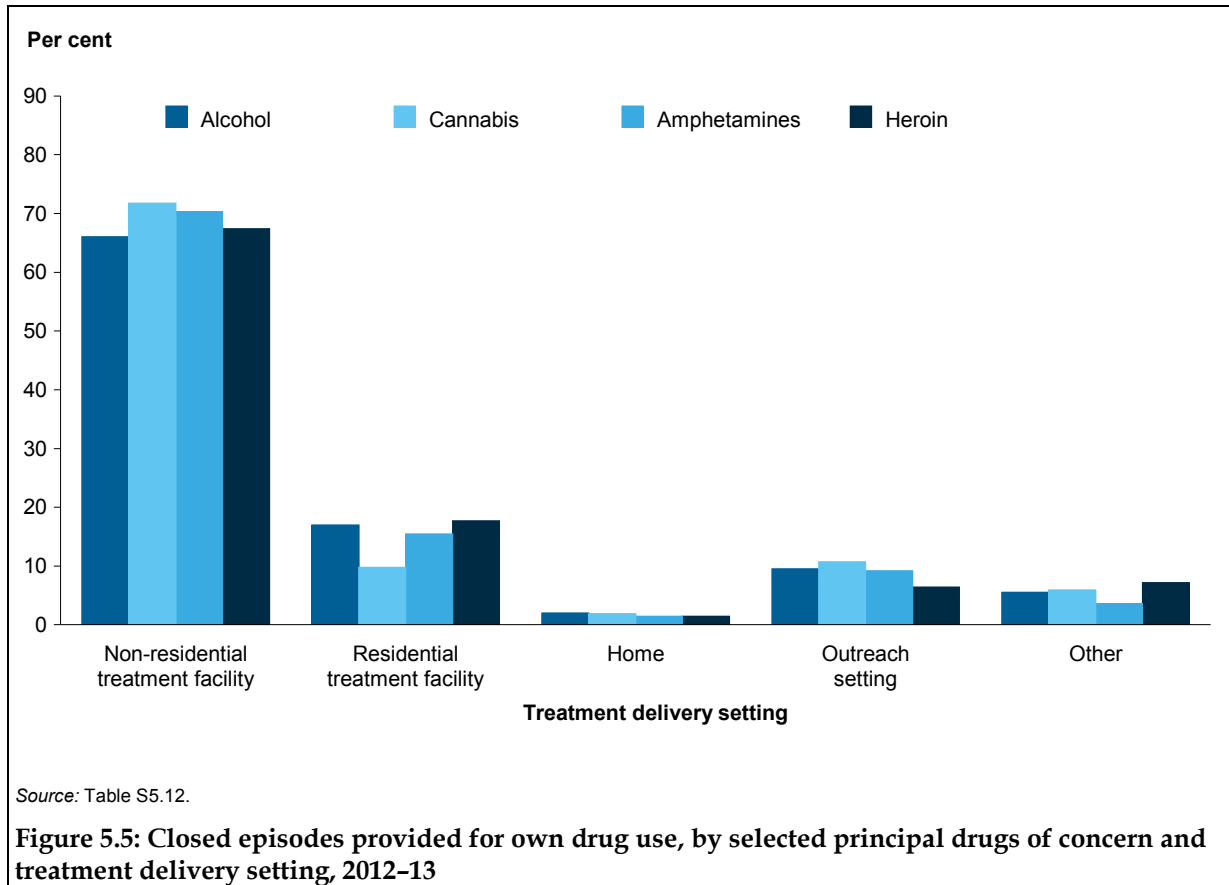


When looking at specific age groups, there may be other drugs that are more commonly treated. For example, for clients aged 10–19 and 60 and over, nicotine was in the top 4 most common principal drugs of concern (3% and 4% of episodes, respectively). For very young people (those aged 10–15) the pattern was different again. About 3% (5,293) of episodes provided for the client’s own drug use were provided to this age group, 30% of whom were Indigenous. Among 10–15 year olds, the top 4 most common principal drugs of concern were cannabis (52%), alcohol (29%), volatile solvents (8%) and nicotine (4%).

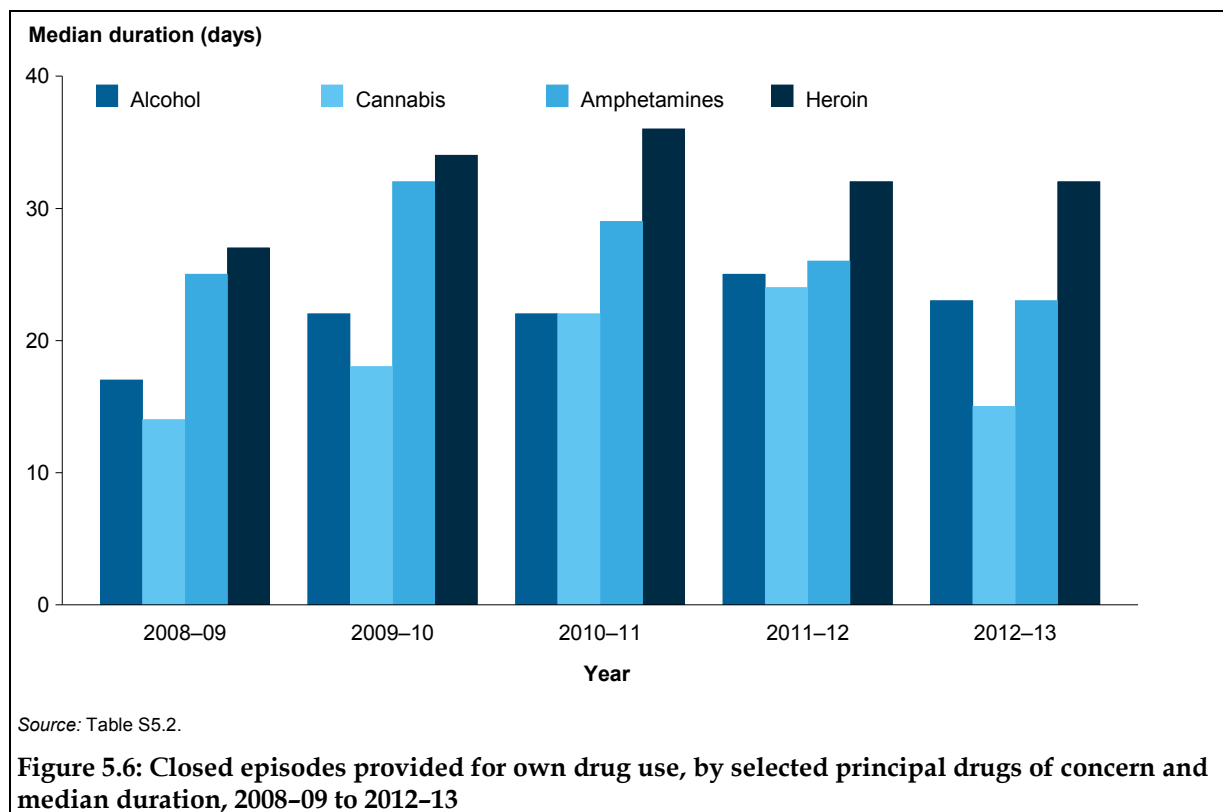
Alcohol was the most common principal drug in all remoteness areas, ranging from 65% of episodes in *Remote* areas to 38% of episodes in *Major cities* (Figure 5.4).



Based on principal drug of concern, the majority of clients receiving treatment for alcohol (66%), heroin (67%), amphetamines (70%) or cannabis (72%) received treatment in a non-residential treatment facility (Figure 5.5). Residential treatment facilities were the second most common treatment setting for clients with alcohol (17%), heroin (18%) or amphetamines (15%) as their principal drugs, while outreach settings were the second most common for clients receiving treatment for cannabis (11%) as their principal drug.



Over the 5 years to 2012-13, clients receiving treatment for heroin or amphetamines as their principal drug of concern have tended to receive longer treatment episodes compared to those receiving treatment for alcohol or cannabis (Figure 5.6). In 2012-13, the median duration of episodes was 32 days for clients receiving treatment for heroin as their principal drug of concern. The median episode duration was 23 days where alcohol or amphetamines were the principal drugs of concern, and 15 days for cannabis.



Alcohol

Alcohol is a central nervous system depressant that inhibits brain functions, dampens the motor and sensory centres and makes judgment, coordination and balance more difficult (NDARC 2010).

According to the 2009 *Australian guidelines to reduce health risks from drinking alcohol* (NHMRC 2009), people who drink more than 2 standard drinks on any day have an increased lifetime risk of harm from alcohol-related disease or injury, while those who drink more than 4 standard drinks on a single occasion are at risk of harm from that occasion (AIHW 2014b).

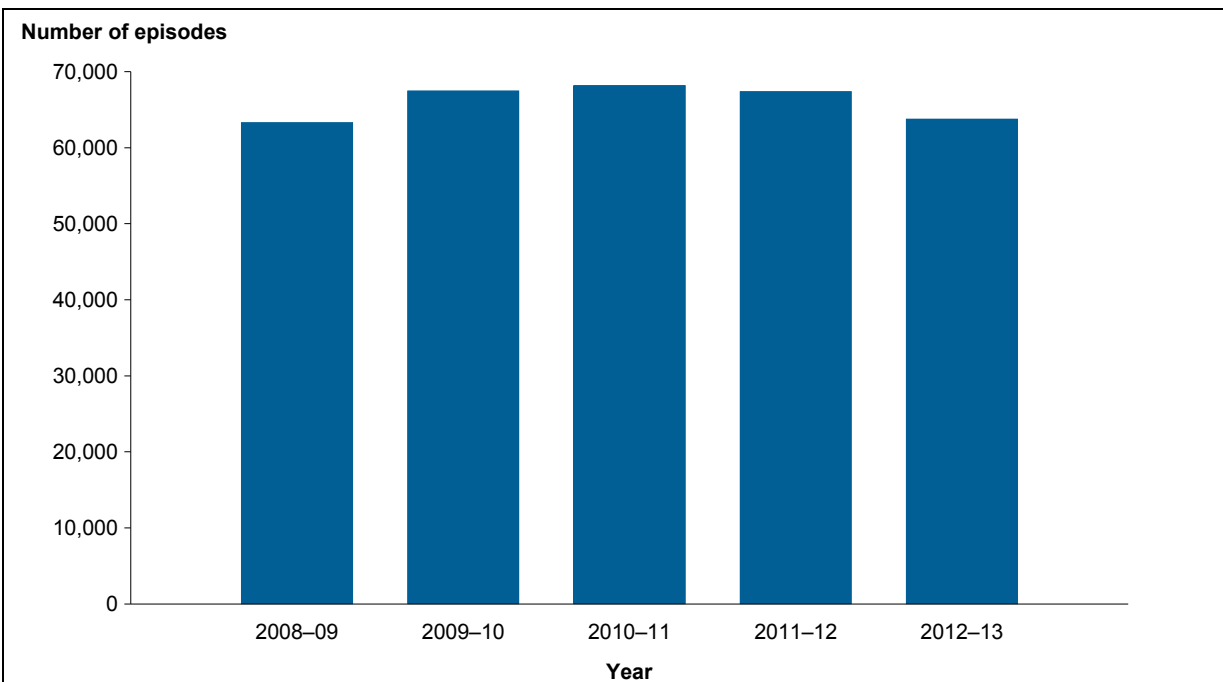
Results from the 2013 NDSHS (AIHW 2014b) showed:

- About 78% of Australians aged 14 years and over drank alcohol in the previous 12 months.
- A significant proportion of the Australian population drank at risky levels—1 in 5 (17%) aged 14 years and over drank at a level that put them at risk of alcohol-related harm over their lifetime, while 1 in 4 (26%) drank at levels that put them at risk of harm from a single drinking occasion at least once in the previous 12 months.
- Males are more likely than females to drink at levels that place them at risk of harm over their lifetime and on a single occasion.

Alcohol was a drug of concern (principal or additional) in 59% of episodes closed in 2012-13 and was the principal drug in 41% of episodes (Figure 2.6).

In more than half (54%) of episodes with alcohol as the principal drug of concern, the client reported additional drugs of concern (Figure 2.6). This was most commonly cannabis (34%) or nicotine (30%).

Over the 5 years from 2008–09, the proportion of closed episodes where alcohol was the principal drug of concern decreased from 46% to 41%, with a high of 48% in 2009–10 (Figure 5.7 and Table S5.2).



Source: Table S5.2.

Figure 5.7: Closed episodes provided for own drug use where alcohol was the principal drug of concern, 2008–09 to 2012–13

Demographics

When alcohol was the principal drug of concern, more than two-thirds of the episodes were for males (67%) and one-fifth were for Indigenous clients (21%) (Table S5.21).

More than one-quarter (26%) of episodes with alcohol as a drug of concern were provided to clients aged 30–39, followed by those aged 20–29 (25%) and 40–49 (22%) (Table S5.19). Only 4% of these episodes were provided to clients aged 60 or over. However, alcohol was more likely to be the principal drug of concern in episodes provided to older clients. For nearly all (96%) the episodes for clients aged 60 or over, alcohol was the principal drug. In contrast, less than half (44%) of the episodes where alcohol was a drug of concern for clients aged 10–19 had alcohol as the principal drug.

In almost two-thirds (64%) of episodes, the client reported they had never injected a drug (injecting status was not reported for 18% of episodes) (Table S5.9).

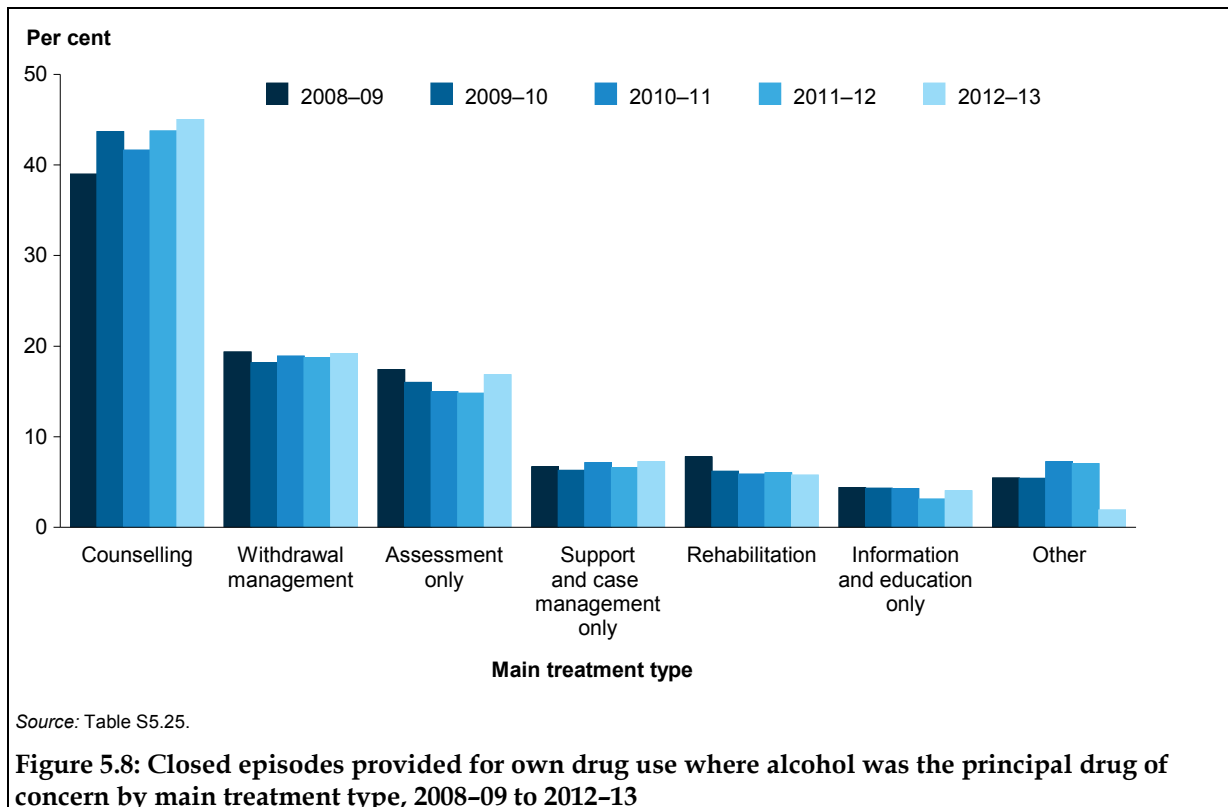
Treatment

The most common source of referral for clients where alcohol was the principal drug of concern was self or family (45%) followed by a health service (28%) (Table S5.13).

The most common main treatment type was counselling (45%), followed by withdrawal management (19%) and assessment only (17%) (Table S5.24). Counselling was the most common main treatment type for all age groups (from 42% of episodes for those aged 10–19 and 60 and over; to 48% for those aged 20–29), followed by withdrawal management for those aged 30–39 and over, while support and case management and assessment only were

the second most common types of main treatment for those aged 10–19 and 20–29, respectively (Table S5.24). Counselling was also the most common main treatment type where alcohol was an additional drug of concern (42%), followed by assessment only (17%) (Table S5.28).

Over the 5 years from 2008–09, counselling, withdrawal management and assessment only have remained the most common main treatment types for episodes where alcohol was the principal drug of concern. The proportion of episodes where counselling was the main treatment type has increased (from 39% to 45%), while there was little change from 2008–09 to the proportion of episodes for withdrawal management and assessment only (remaining at 19% and 17% respectively) (Figure 5.8).



Treatment episodes where alcohol was the principal drug of concern were most likely to take place in a non-residential treatment facility (66%) or a residential treatment facility (17%) (Table S5.30). Most (91%) alcohol-related episodes where counselling was the main treatment type took place in a non-residential treatment facility, while episodes with a main treatment type of withdrawal management were most likely to take place in a residential treatment facility (59%).

About 3 in 5 (63%) closed episodes where alcohol was the principal drug of concern ended with an expected cessation, while 21% ended due to an unexpected cessation (see the Glossary for explanation of terms) (Table S5.16). Expected cessations were most common where the referral source was diversion (74%), and where the main treatment type was information or education only (88%) (Table S5.31).

More than half (54%) of the episodes with alcohol as the principal drug lasted less than 1 month (22% ended within 1 day) (Table S5.33). The median duration of episodes with alcohol as the principal drug of concern was just over 3 weeks (23 days). Episodes with counselling as the main treatment type were more than 7 times as long as episodes with

withdrawal management as the main treatment type (median duration of 57 days compared with 8) (Table S5.34).

Cannabis

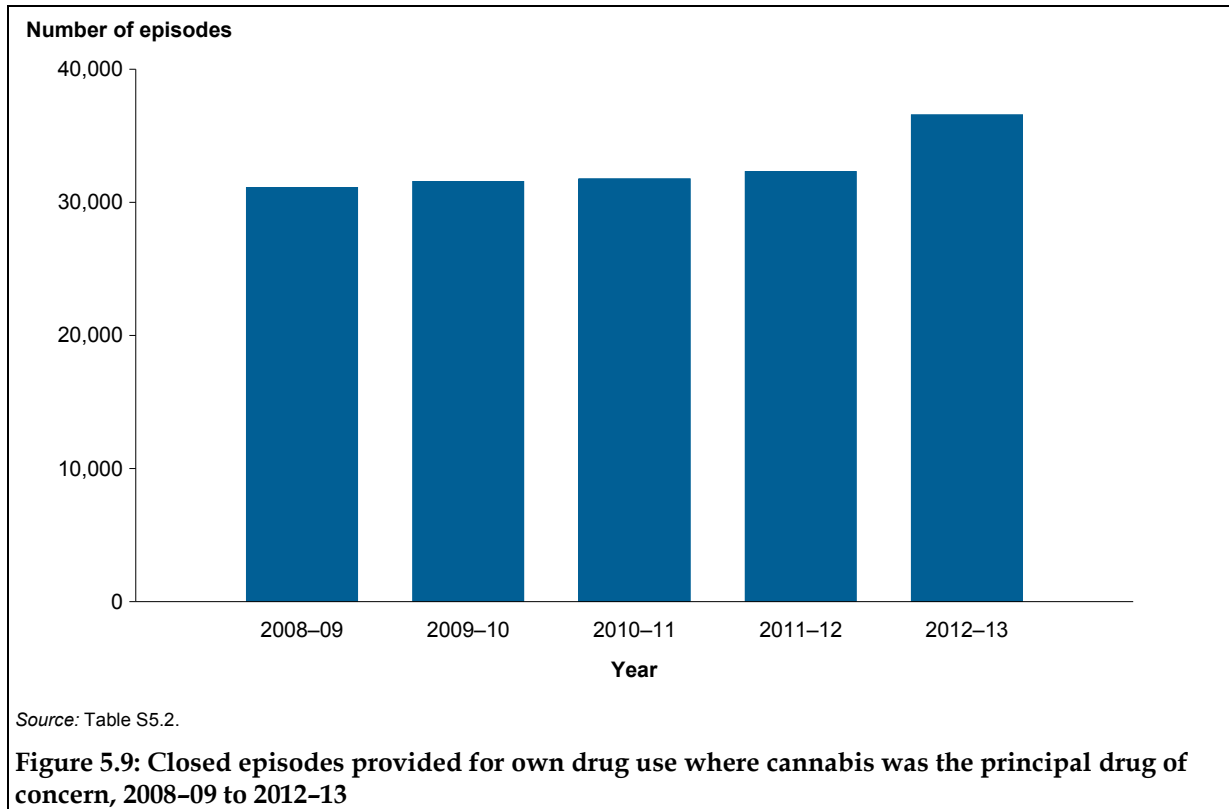
Cannabis ('marijuana' or 'gunja') is derived from the cannabis plant (usually *Cannabis sativa*) and is used in whole plant (usually the flowering heads), resin or oil forms. Cannabis has a range of stimulant, depressant and hallucinogenic effects. The risks associated with long-term or regular use of cannabis include damage to lungs and lung functioning, effects on memory and learning, psychosis and other mental health conditions, and addiction with cannabis withdrawal now also listed as a discrete syndrome (NCPIC 2011). According to the 2013 NDSHS (AIHW 2014b), 1 in 3 Australians aged 14 and over have used cannabis at some point in their lifetime, while 1 in 10 have used it in the previous 12 months.

Cannabis was the second most common drug of concern (principal or other) in episodes closed in 2012–13 (46%), and was the principal drug for almost one-quarter of treatment episodes (24%) (Figure 2.6).

In almost two-thirds (64%) of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern (Figure 2.6). The most common of these were alcohol (34%) and nicotine (24%).

Smoking was the most common usual method of use in most episodes (88%) where cannabis was the principal drug (Table S5.8).

Over the 5 years from 2008–09, the proportion of closed episodes where cannabis was the principal drug of concern has remained relatively stable, fluctuating from 22–24% (Figure 5.9 and Table S5.2). However, there was an increase of 13% in the number of episodes from 2011–12 to 2012–13 which may be due to a number of factors. For example, in South Australia, the inclusion of the Drug Diversion Assessment Program data for the first time in the collection has led to an increase in episodes with a principal drug of concern of cannabis.



Demographics

Where cannabis was the principal drug of concern, 72% of episodes were for male clients and 21% were for Indigenous clients.

Almost two-thirds (60%) of episodes with cannabis as a drug of concern were provided to clients aged 20-39, while more than one-fifth (21%) were for those aged 10-19 (Table S5.38). Cannabis was more likely to be the principal drug (rather than an additional drug) among younger age groups. Four-fifths (86%) of episodes with cannabis as the principal drug of concern were for clients aged under 40.

In almost two-thirds (65%) of episodes, clients reported that they had never injected a drug (injecting status was not reported for 14% of episodes) (Table S5.9).

Treatment

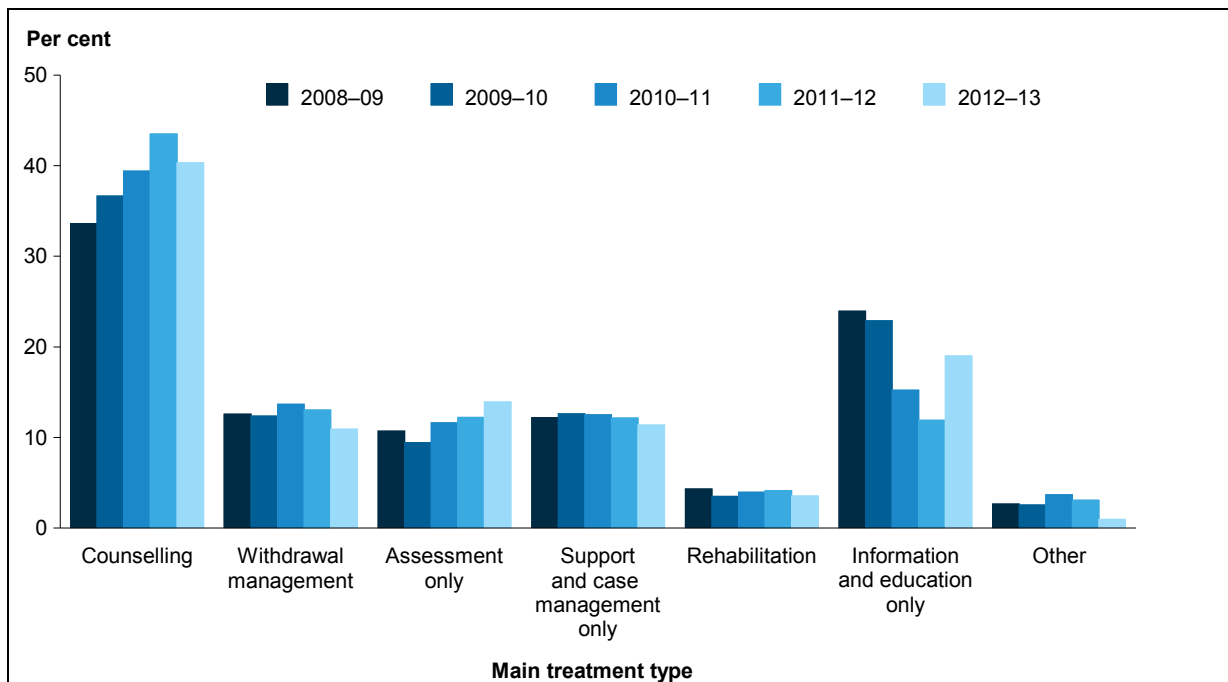
The most common source of referral for clients where cannabis was a principal drug of concern was diversion (32%), followed by self or family (31%) and a health service (20%) (Table S5.13).

The most common main treatment type was counselling (40%), followed by information and education only (19%). Assessment only (14%) and withdrawal management and support and case management only (both 11%) were also common main treatment types (Table S5.43).

Counselling was also the most common main treatment type where cannabis was an additional drug of concern (40%), followed by assessment only (20%) and withdrawal management (18%) (Table S5.47).

Over the 5 years from 2008-09, in episodes where cannabis was the principal drug, the proportion of episodes with counselling as a main treatment type increased from 34% to

40%, with a high of 43% in 2011–12. The opposite is true for information and education, which declined over the same period from 24% to 19%, with a low of 12% in 2011–12 (Figure 5.10).



Source: Table S5.44.

Figure 5.10: Closed episodes provided for own drug use where cannabis was the principal drug of concern, by main treatment type, 2008–09 to 2012–13

Seven in 10 (69%) closed episodes where cannabis was the principal drug of concern ended with an expected cessation, while 18% ended due an unexpected cessation (Table S5.16). Expected cessations were most common for episodes where the referral source was diversion (89%) and least common for referrals from corrections (42%). For main treatment types, expected cessations were most common for information and education only (97%) and least common for rehabilitation (39%) (Table S5.50). This is to be expected as information and education only treatment can be completed in as little as 2 hours whereas rehabilitation treatment tends to take 3–6 months to complete.

Treatment episodes where cannabis was the principal drug of concern were most likely to take place in a non-residential treatment facility (72%) (Table S5.49). Most (92%) episodes where counselling was the main treatment type took place in a non-residential treatment facility.

More than half (59%) of the episodes with cannabis as the principal drug lasted less than 1 month (36% ended within 1 day) (Table S5.52). The median duration of episodes with cannabis as the principal drug of concern was just over 2 weeks (15 days). Episodes with support and case management only as the main treatment type had a median duration of more than 7 weeks (52 days), compared with 1 week (9 days) for withdrawal management and 1 day for information and education only and assessment only (Table S5.53).

Amphetamines

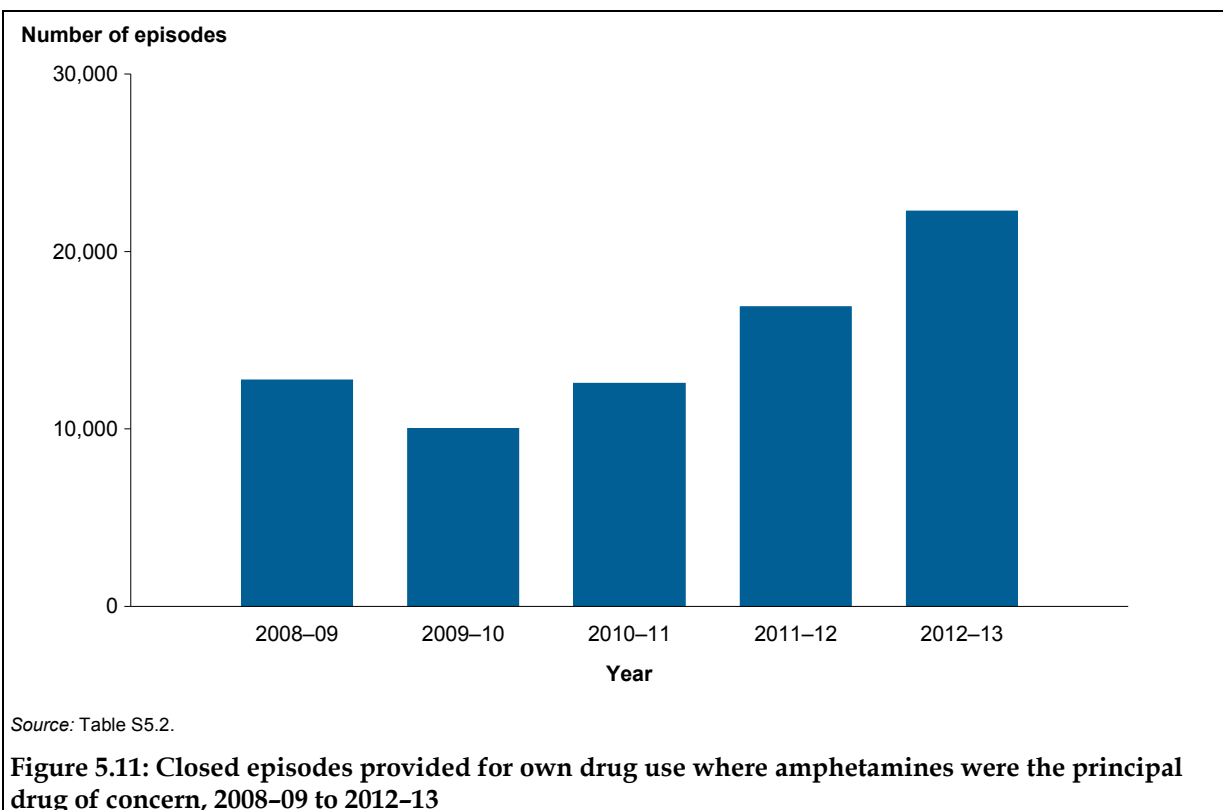
Amphetamines stimulate the central nervous system and can result in euphoria, increased energy, decreased appetite and increased blood pressure (ADCA 2013). Long-term effects include high blood pressure, extreme mood swings, paranoia, depression and anxiety, and seizures. Evidence is inconclusive regarding the efficacy of pharmacotherapies in managing amphetamine withdrawal or relapse; however, trials with dexamphetamine show promise as a replacement therapy (NCETA 2004). According to the 2013 NDSHS (AIHW 2014b), 1 in 14 Australians aged 14 and over have used amphetamines at some point in their lifetime, while 1 in 50 have used them in the previous 12 months.

Amphetamines were a drug of concern (principal or additional) in 28% of closed episodes in 2012–13 and were the principal drug in 1 in 7 episodes (14%) (Figure 2.6).

In 74% of episodes with amphetamines as the principal drug, the client reported additional drugs of concern (Figure 2.6). The most common of these were cannabis (30%) and alcohol (23%).

Injecting was the most common usual method of use in most episodes (45%) where amphetamines were the principal drug, followed by smoking (35%) (Table S5.8).

Over the 5 years from 2008–09, the proportion of episodes where amphetamines were the principal drug of concern has increased (from 9% to 14%), with a low of 7% in 2009–10 (Figure 5.11 and Table S5.2). According to the 2013 NDSHS (AIHW 2014b) the proportion of the population using methamphetamine has remained stable; however, there has been a significant increase in the use of crystal methamphetamine or ‘ice’ among methamphetamine users.



Demographics

Where amphetamines were the principal drug of concern, 70% of episodes were for male clients and 20% were for Indigenous clients.

Three-quarters (75%) of episodes with amphetamines as a drug of concern were for clients aged 20–39, followed by those aged 40–49 (14%) and 10–19 (9%) (Table S5.57).

In 37% of episodes, clients reported that they had last injected drugs in the previous 3 months, while in a further 36%, clients reported they had never injected drugs (injecting status was not reported for 11% of episodes) (Table S5.9).

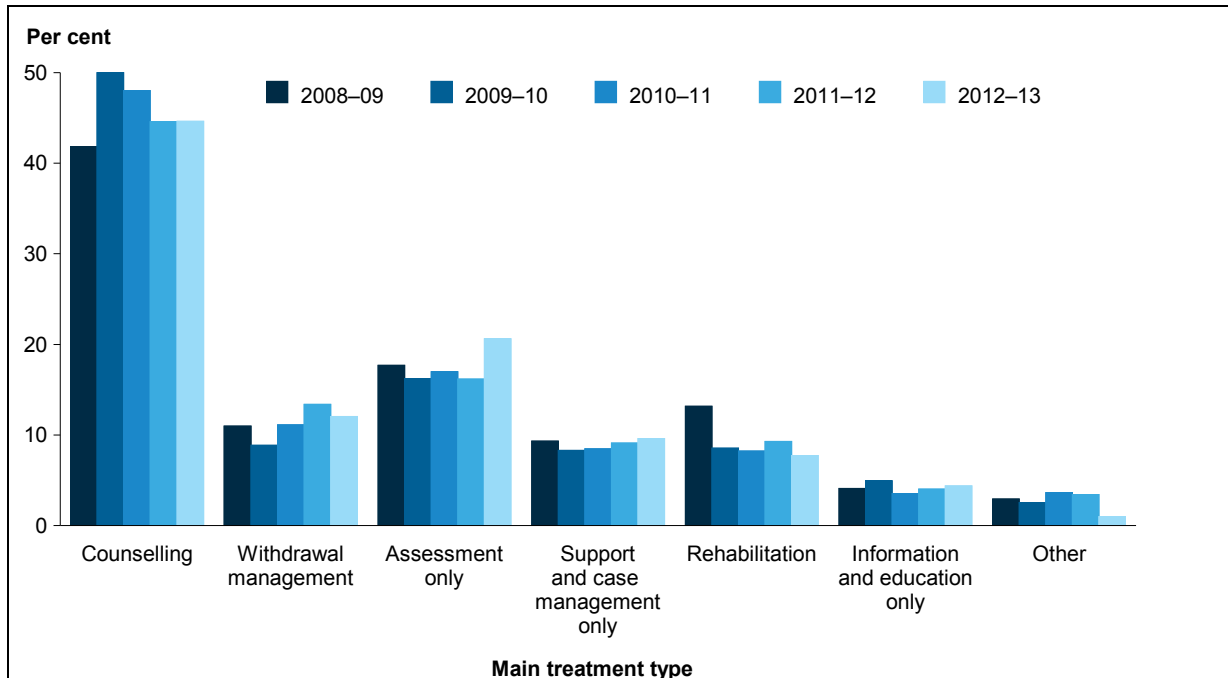
Treatment

The most common source of referral for clients where amphetamines were the principal drug of concern was self or family (43%), followed by diversion (22%) (Table S5.3).

The most common main treatment was counselling (45%), followed by assessment only (21%) and withdrawal management (12%) (Table 5.61)

Counselling was also the most common main treatment type where amphetamines were an additional drug of concern (38%), followed by withdrawal management (19%) and assessment only (18%) (Table S5.66).

Over the 5 years from 2008–09, where amphetamines were the principal drug, the proportion of episodes with counselling as a main treatment type increased from 42% to 45%; however, the proportion declined from a high of 51% in 2009–10. The proportion of episodes with rehabilitation as a main treatment type declined over the same period, from 13% to 8% (Figure 5.12).



Source: Table S5.63.

Figure 5.12: Closed episodes provided for own drug use where amphetamines were the principal drug of concern, by main treatment type, 2008–09 to 2012–13

Three-fifths (61%) of closed episodes where amphetamines were the principal drug of concern ended with an expected cessation, while 25% ended with an unexpected cessation. Expected cessations were most common for episodes where diversion was the referral source (78%) and least common for referrals from corrections (47%). As seen for cannabis, expected cessations were most common for information and education only (86%) and least common for rehabilitation (29%) (Table S5.69).

Treatment episodes where amphetamines were the principal drug of concern were most likely to take place in a non-residential treatment facility (70%) or a residential treatment facility (15%). Most (91%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table S5.68).

More than half (55%) of the episodes with amphetamines as the principal drug lasted less than 1 month (25% ended within 1 day) (Table S5.71). The median duration of episodes with amphetamines as the principal drug of concern was more than 3 weeks (23 days). Episodes with counselling as the main treatment type had a median duration of 7.3 weeks (51 days), compared with 1 week (8 days) for withdrawal management and 1 day for assessment only and information and education only (Table S5.72).

Heroin

Heroin is an opioid, which are strong pain killers with addictive properties. It can result in feelings of euphoria and wellbeing, and pain relief, while long-term effects can include lowered sex drive and infertility (for women), along with risk of overdose, coma and death (ADCA 2013).

Heroin users seeking treatment can enter a withdrawal program or attend an opioid maintenance substitution program (NCETA 2004).

Results from the 2013 NDSHS (AIHW 2014b) showed:

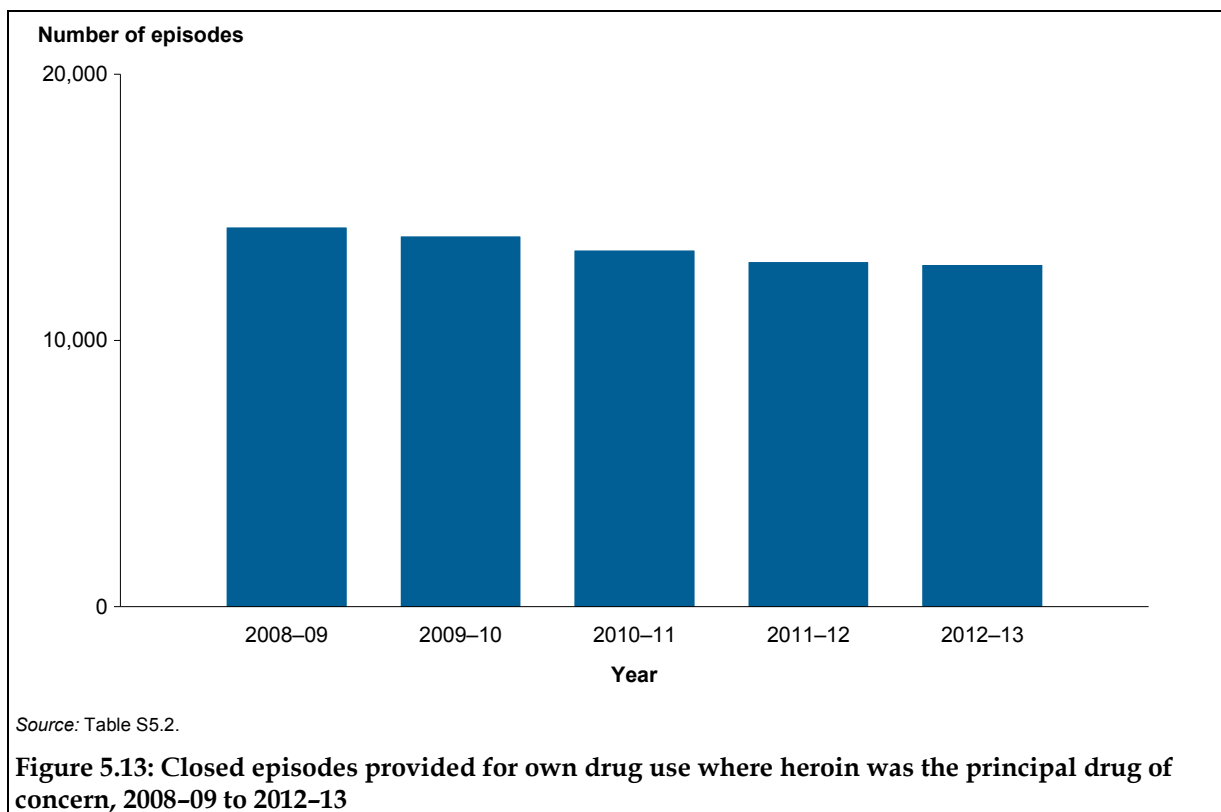
- In 2013, 1.2% of people in Australia aged 14 years or over had used heroin in their lifetime and 0.1% had used it in the previous 12 months.
- There was a significant decline in the proportion of people using heroin between 2010 and 2013.

Heroin was a drug of concern (principal or additional) in 12% of episodes closed in 2012–13 (Figure 2.6). It was the principal drug in 1 in 12 episodes (8%), a decrease from 18% in 2003–04 (Table S5.7).

Almost three-quarters (74%) of the episodes with heroin as the principal drug of concern had an additional drug of concern (Figure 2.6). The most common additional drugs of concern were cannabis (22%) and amphetamines (18%).

Injecting was the most common usual method of use for clients whose principal drug of concern was heroin (86% of episodes) (Table S5.8).

Over the 5 years from 2008–09, the proportion of episodes where heroin was the principal drug of concern has decreased steadily from 10% to 8% (Figure 5.13 and Table S5.2).



Demographics

Where heroin was the principal drug of concern, 67% of episodes were for male clients and 14% were for Indigenous clients (Table S5.97).

Nearly half (45%) of episodes with heroin as a drug of concern were provided to clients aged 30-39, followed by those aged 20-29 (25%) and 40-49 (21%) (Table S5.95). Heroin was more likely to be the principal drug rather than an additional drug for all age groups except 10-19.

In 3 in 5 (57%) episodes, the client reported they had injected drugs in the previous 3 months, while in 15%, they reported they last injected 3-12 months ago (injecting status was not reported for 9% of episodes) (Table S5.9).

Treatment

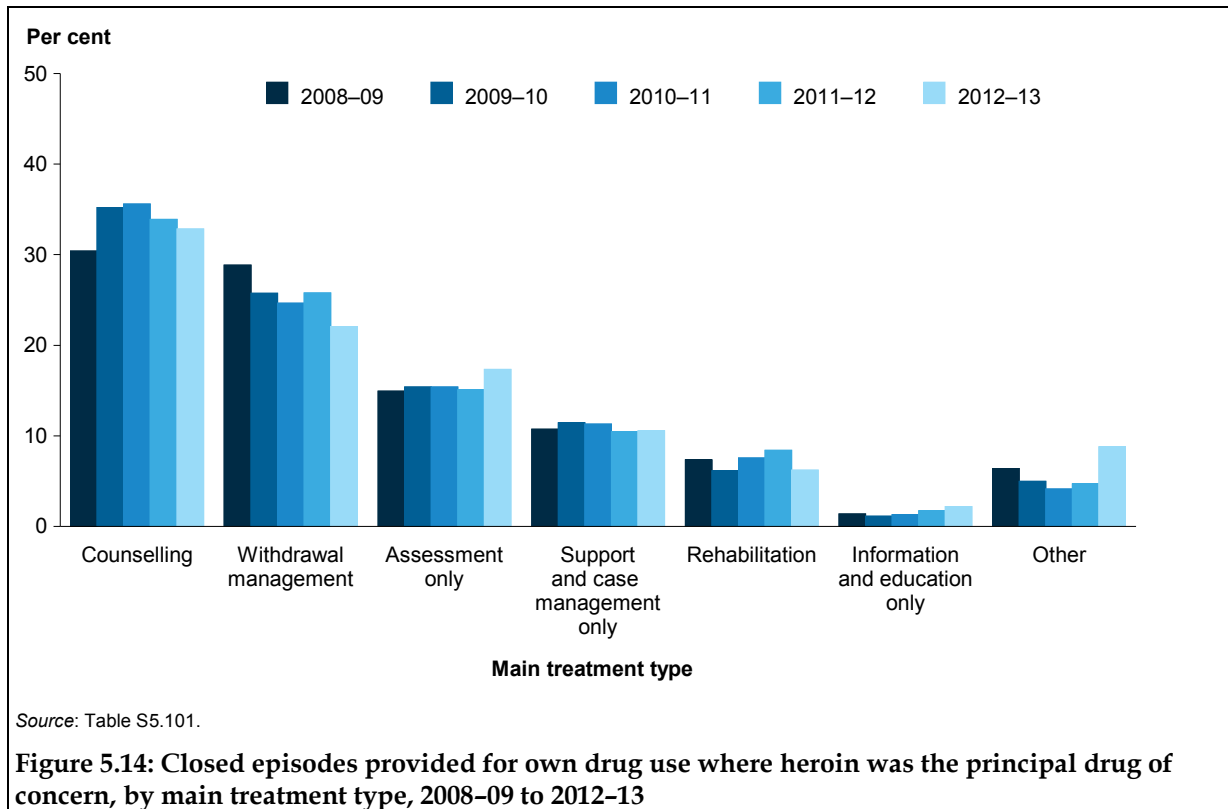
The most common source of referral for clients where heroin was the principal drug of concern was self or family (49%), followed by a health service (19%) and diversion programs (15%) (Table S5.3).

The most common types of main treatment were counselling (33%), withdrawal management (22%) and assessment only (17%) (Table S5.100).

Counselling was the most common type of main treatment for clients aged 20-29 (31%), 30-39 (34%), 40-49 (34%), 50-59 (32%) and 60 and over (38%), while support and case management only was most common for clients aged 10-19 (28%) (Table S5.82).

Similar to episodes with heroin as the principal drug, counselling (39%), assessment only (21%) and withdrawal management (19%) were the most common types of main treatment in episodes with heroin as an additional drug (Table S5.104).

Over the 5 years from 2008–09, in episodes where heroin was the principal drug, the proportion of episodes with counselling as the main treatment type increased from 30% to 33%, with a high of 36% in 2010–11, while the opposite is true for withdrawal management, which declined from 29% to 22%. Assessment only remained relatively stable, over the 4 years from 2008–09 to 2011–12, increasing only in the last year (by 2% from 15% to 17%) (Figure 5.14).



More than half (53%) of closed episodes with heroin as the principal drug of concern ended with an expected cessation, while 20% ended due to an unexpected cessation (Table S5.16). Once again, expected cessations were most common for episodes where the main treatment was information and education only (87%) as this treatment type is usually completed within a day.

Treatment episodes with heroin as the principal drug of concern were most likely to take place in a non-residential treatment facility (67%) or a residential treatment facility (18%) (Table S5.106). Most (95%) episodes where counselling was the main treatment type took place in a non-residential treatment facility.

Almost half (49%) of the episodes with heroin as the principal drug lasted less than 1 month (21% ended within 1 day) (Table S5.109). The median duration of episodes with heroin as the principal drug of concern was almost 5 weeks (32 days) (Table S5.110). Episodes with support and case management only as the main treatment type had a median duration of more than 11 weeks (79 days), compared with just over 1 week (9 days) for withdrawal management and 1 day for both information and education only and assessment only.

Selected other drugs

Treatment services are provided for a number of other drugs, which make up a smaller proportion of the overall services due to them being less common or where treatment services are less likely to be sought. Information on the following drugs is presented in this section due to the size of the population using the drug and/or harms associated with use of that drug.

Nicotine

Nicotine is the stimulant drug in tobacco smoke. It is highly addictive and causes dependency (ADCA 2013). Almost 8% of Australia's burden of disease was attributable to tobacco smoking in 2003 (Vos et al. 2007). The health effects of smoking include premature death and tobacco-related illnesses such as cancer, chronic obstructive pulmonary disease and heart disease. According to the 2013 NDSHS (AIHW 2014b) almost 1 in 6 Australians were current smokers and 1 in 8 were daily smokers.

Most of the population generally access various forms of treatment for nicotine addiction through their local GP, pharmacy, helplines or web services. Smoking cessation treatment and support services include brief intervention by trained health professionals, individual or group counselling, telephone counselling, and pharmacotherapies including nicotine replacement therapies and non-nicotine products.

Nicotine was a principal drug of concern in just 2% of episodes (Figure 2.6). However, it was an additional drug of concern in a further 23% of episodes. The proportion of episodes with nicotine as the principal drug has remained from 1–2% since 2003–04 (Table S5.2). Possible reasons for the low proportion of episodes in which nicotine was the principal drug include the wide availability of support and treatment for nicotine use in the community, and that people tend to view alcohol and other drug treatment services as most appropriate for drug use that is beyond the expertise of general practitioners.

Demographics

Where nicotine was a principal drug of concern, 60% of episodes were for male clients and 31% were for Indigenous clients (Table S5.78).

More than half (54%) of episodes with nicotine as a drug of concern were provided to clients aged 20–39. Only 3% of these episodes were provided to clients aged 60 or over (Table S5.76). Nicotine was more likely to be an additional drug rather than the principal drug (93%) for all age groups (Table S5.76).

Treatment

The most common source of referral for clients where nicotine was the principal drug of concern was a police or court diversion program (41%), followed by self or family (26%) (Table 5.13).

The most common types of main treatment were counselling (33%), information and education only (27%) and assessment only (19%) (Table S5.81). Counselling was also the most common type of main treatment where nicotine was an additional drug of concern (36%) (Table S5.85).

More than three-quarters (78%) of episodes with nicotine as the principal drug of concern ended with an expected cessation, while one-fifth (13%) ended due to an unexpected

cessation (Table S5.16). As previously reported, expected cessations were most common where the main treatment type was information and education only (97%) (Table S5.88).

Treatment episodes where nicotine was the principal drug of concern were most likely to take place in a non-residential treatment facility (60%) or an outreach service (16%) (Table S5.87).

Almost two-thirds (65%) of the episodes with nicotine as the principal drug lasted less than 1 month (48% ended within 1 day) (Table S5.90). The median duration of episodes with nicotine as the principal drug of concern was 4 days (Table S5.91). Episodes with counselling as the main treatment type had a median duration of 9 weeks (64 days), compared with 3.7 weeks (26 days) for withdrawal management and 1 day for assessment only and information and education only.

Ecstasy

Ecstasy is the popular street name for a range of drugs containing the substance 3, 4-methylenedioxymethamphetamine (MDMA) – a stimulant with hallucinogenic properties. Ecstasy is usually sold in tablet or pill form, but is sometimes found in capsule or powder form. The short-term effects of ecstasy include euphoria and a feeling of wellbeing and closeness to others and increased energy. Other serious harms include psychosis, heart attack and stroke. Little is known about the long-term effects of ecstasy use, but there is some research linking regular and heavy use of ecstasy to memory problems and depression (ADCA 2013). According to the 2013 NDSHS (AIHW 2014b), 2% of people aged 14 or over used ecstasy in the previous 12 months in 2013.

Ecstasy was a drug of concern (principal or additional) in 4% of closed episodes in 2012–13 and was the principal drug in less than 1% (Figure 2.6). Counselling was the most common type of main treatment in episodes with ecstasy as the principal drug (40%), followed by information and education only (29%) and assessment only (22%) (Table S5.138). Counselling was also the most common main treatment type where ecstasy was an additional drug of concern (40%), followed by assessment only (17%), and information and education only (15%) (Table S5.142).

Benzodiazepines

Benzodiazepines are depressant drugs – they slow down the activity of the central nervous system and the speed of messages going between the brain and the body. Also known as ‘minor tranquillisers’, benzodiazepines are most commonly prescribed by doctors to relieve stress and anxiety and to help people sleep. Some people use benzodiazepines illegally to become intoxicated or to ‘come down’ from the effects of stimulants such as amphetamines or cocaine (ADF 2013).

According to the 2013 NDSHS (AIHW 2014b), 4.5% of the Australian population had used tranquillisers/sleeping pills (including benzodiazepines) for non-medical purposes at some stage in their lifetime.

Benzodiazepines were a drug of concern (principal or other) in 9% of episodes closed in 2012–13 and they were the principal drug in 2% of episodes (Figure 2.6). There was no change in the proportion of episodes with benzodiazepines as the principal drug in the 10 years from 2003–04.

In 75% of the episodes with benzodiazepines as the principal drug, the client reported additional drugs of concern (Figure 2.6). The most common additional drugs were alcohol and cannabis (both 18%).

Ingestion was the most common usual method of use (86%) in episodes with benzodiazepines as the principal drug (Table S5.8).

Demographics

Where benzodiazepines were the principal drug, 51% of episodes were for male clients and 11% were for Indigenous clients (Table S5.116).

More than one-third (36%) of episodes with benzodiazepines as a drug of concern were provided to clients aged 30–39, followed by those aged 20–29 (28%) and 40–49 (20%). Only 5% of these episodes were provided to clients aged 60 or over (Table S5.114).

Benzodiazepines were more likely to be an additional drug rather than the principal drug (82%) for all age groups.

In more than one-third (34%) of closed episodes, the client reported they had never injected a drug, while in 1 out of every 5 episodes (20%), the client reported they had injected drugs in the previous 3 months (injecting status was not reported for 21% of episodes) (Table S5.9).

Treatment

The most common source of referral for clients where benzodiazepines were the principal drug of concern was self or family (46%), followed by a health service (34%) (Table S5.13).

The most common types of main treatment were counselling (38%), withdrawal management (26%) and assessment only (18%) (Table S5.119). Counselling was most common for clients aged 30–39 (35%) and least common for clients aged 10–19 (5%) (Table S5.119). Withdrawal management was most common for clients aged 30–39 (36%) and least common for clients aged 10–19 (2%).

Counselling was also the most common type of main treatment type where benzodiazepines were an additional drug of concern (34%) (Table S5.123).

Three in 5 (61%) episodes with benzodiazepines as the principal drug of concern ended with an expected cessation, while 1 in 5 (20%) ended due to an unexpected cessation (Table S5.16). Expected cessations were more common for episodes where the main treatment type was information and education only (84%) or withdrawal management (66%) (Table S5.126).

Treatment episodes where benzodiazepines were the principal drug of concern were most likely to take place in a non-residential treatment facility (69% of closed episodes) or a residential treatment facility (16%) (Table S5.125). Most (92%) episodes where counselling was the main treatment type took place in a non-residential treatment facility.

More than half (54%) of the episodes with benzodiazepines as the principal drug lasted less than 1 month (21% ended within 1 day) (Table S5.128). The median duration of episodes with benzodiazepines as the principal drug of concern was 3 weeks (23 days) (Table S5.129).

Episodes with rehabilitation as the main treatment type had a median duration of almost 10 weeks (68 days), a similar length of time as rehabilitation for heroin and cocaine. In comparison, benzodiazepine withdrawal management episodes had a median duration of less than 2 weeks (10 days) and assessment only and information and education only episodes had a median of 1 day (Table S5.129).

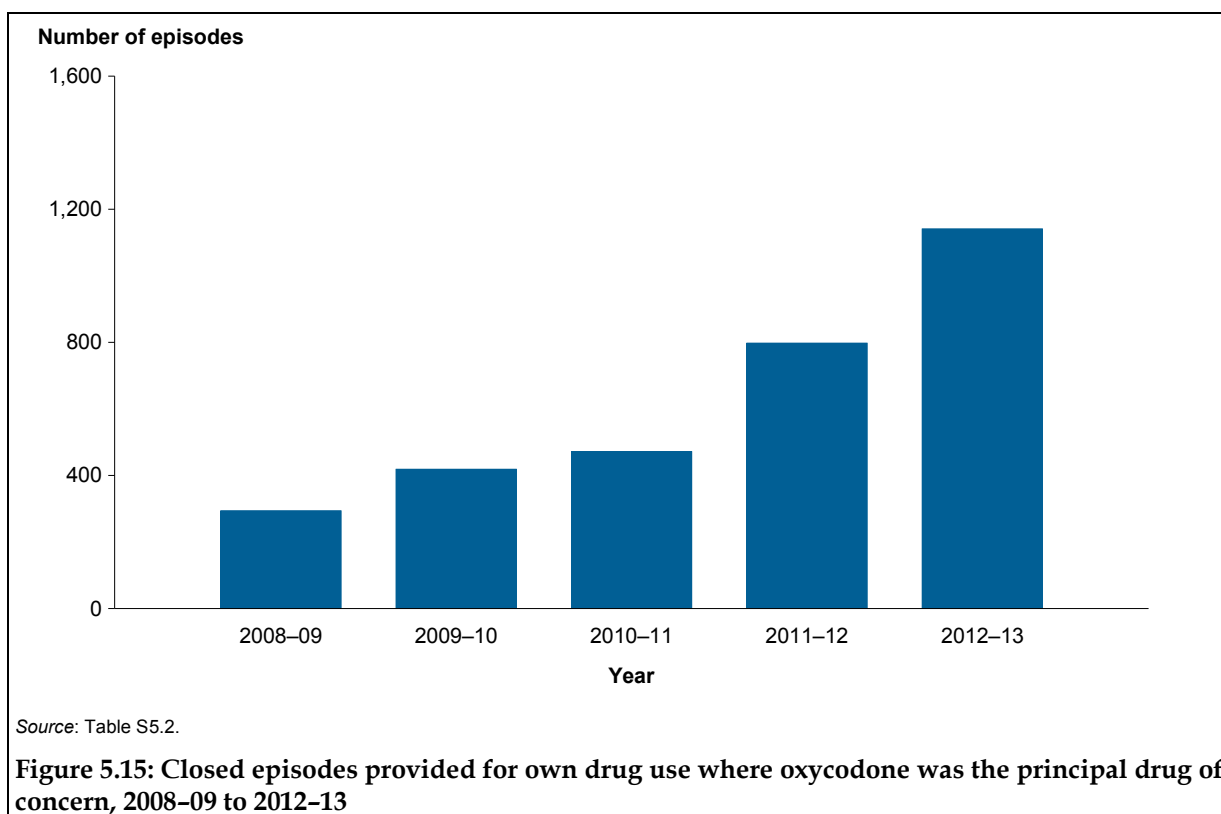
Licit opioids

Licit opioids can be obtained by prescription, for example, morphine, buprenorphine, methadone, oxycodone, fentanyl and pethidine; or over-the-counter, for example, codeine. They do not include illicit opioids, such as heroin. As a group, licit opioids are the principal drug of concern in 5% of episodes (Table S5.1).

Oxycodone is a pharmaceutical opioid (whether prescribed for the person or obtained illicitly) used to help control pain and is an alternative to morphine. There has been a large growth in oxycodone prescriptions in Australia in the last decade, with an increase of around 152% during the 6 years spanning 2002–03 to 2007–08. (Roxburgh et al. 2011).

After morphine (27%) and methadone (25%), oxycodone (16%) comprises the next highest proportion of treatment episodes where licit opioids are the principal drug of concern (Table S5.2). This proportion has grown from 5% in 2008–09.

While the proportion of episodes with licit opioids as a principal drug of concern has remained relatively stable over the 5 years from 2008–09, there has been a considerable increase in the number of episodes of people receiving treatment for their own drug use where oxycodone was a principal drug of concern (from 305 episodes to 1,140) (Figure 5.15 and Table S5.2). This has coincided with a decrease in the proportion of episodes with morphine or methadone as a principal drug of concern.



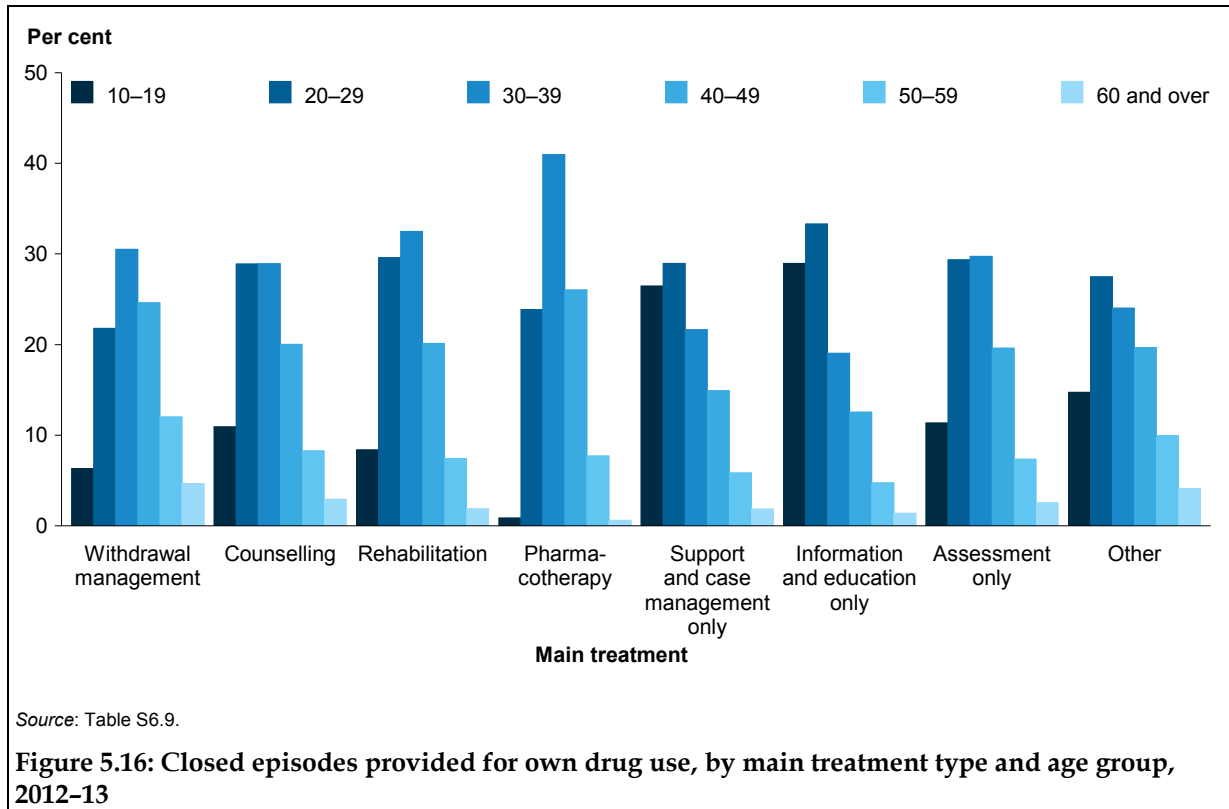
5.3 Treatment provided

Overview

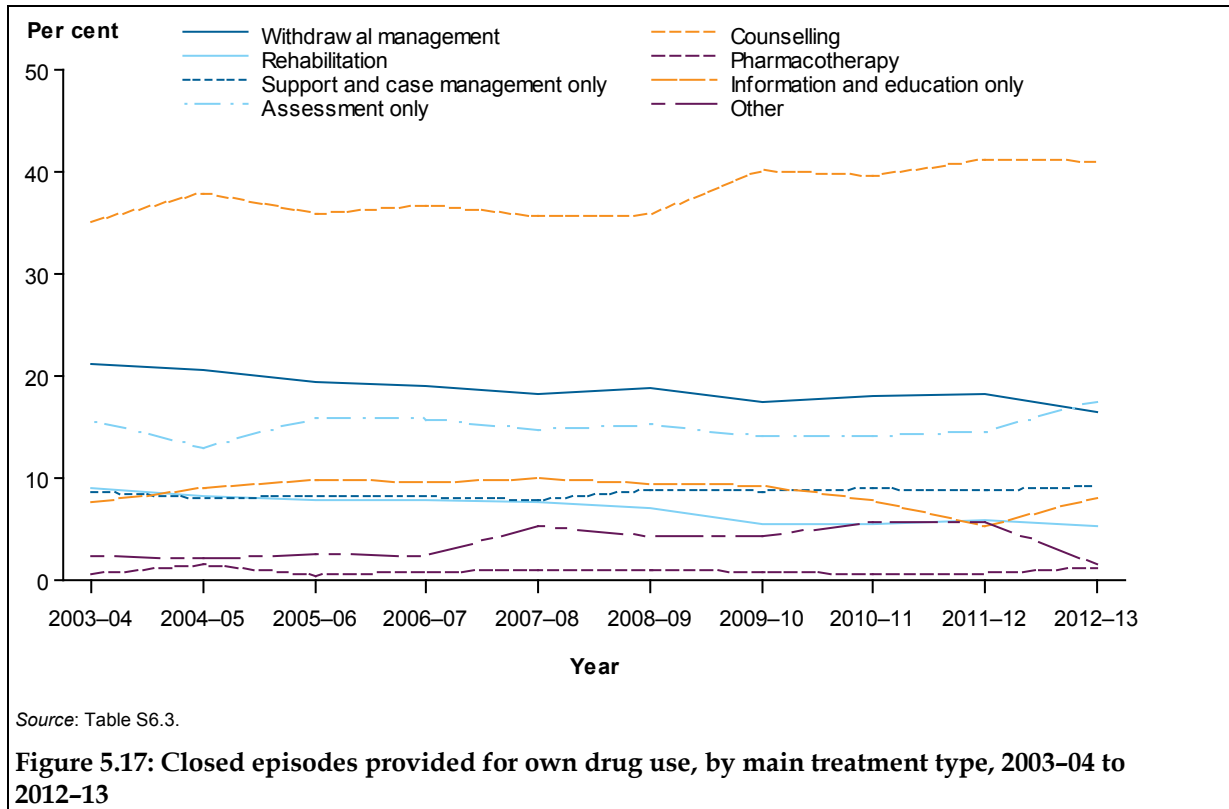
Among clients receiving treatment for their own drug use, counselling was the most common main treatment type provided in 2012–13 (41%). This was followed by assessment only (18%) and withdrawal management (16%) (Table S6.1). There was little difference in the proportion of main treatment types provided to males and females, although assessment only was more common in episodes provided to males (19%) than to females (14%) (Table S6.7). There was little difference in the proportion of main treatments provided by Indigenous status. The largest difference existed for withdrawal management, which was more likely to be provided to Indigenous clients (18%) than to non-Indigenous clients (10%) (Table S6.8).

More than half (56%) of episodes provided for own drug use were to clients aged 20–39, with clients aged 20–29 or 30–39 accounting for the largest proportion of episodes across all treatment types (Table S6.9).

Episodes with support and case management or information and education as a main treatment type were more likely to be provided to younger clients, with 55% and 62% of episodes provided to 10–29 year olds, respectively. Episodes provided to clients aged 10–19 were most likely to have a main treatment type of support and case management only or information and education only, with 26% and 29% of episodes respectively, compared with 13% for 10–19 year olds across all treatment types. About 2 in 5 (41%) episodes where pharmacotherapy was a main treatment type were provided to clients aged 30–39. While only a small proportion of total episodes (11%), episodes provided to clients aged 50 and over were most likely to have a main treatment type of counselling followed by withdrawal management (Figure 5.16).



Over the 10 years from 2003-04 to 2012-13, the proportion of episodes for each main treatment type has remained quite stable, with counselling, withdrawal management and assessment only being the most common types of treatment over that period (Figure 5.17). Counselling continues to be the most common main treatment type provided, comprising about 2 in every 5 episodes since 2003-04. In 2012-13, assessment only overtook withdrawal management as the second most common main treatment type for the first time since 2003-04. This may be influenced by changes to administrative practices in some states and territories.



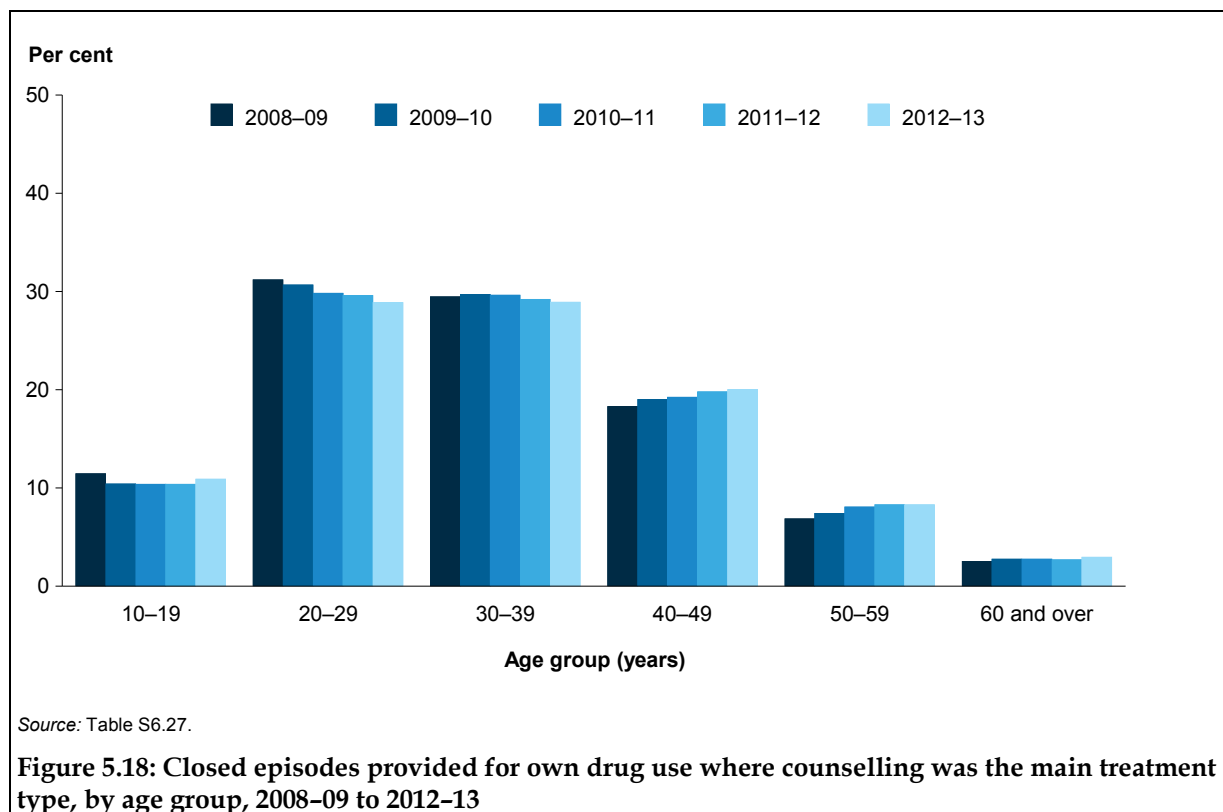
Counselling

Two in 5 (41%) of the episodes provided to clients for their own drug use had counselling as the main treatment type (Table S6.2).

More than two-thirds (67%) of the closed episodes provided to clients for their own drug use with a main treatment type of counselling were provided to male clients. One in 5 (20%) episodes were for Indigenous clients (Table S6.28). Female clients were as likely to be Indigenous as male clients (16% compared with 15%).

Most (58%) of these episodes were for those in the 20-29 and 30-39 age groups (both 29%) (Figure 5.18). A further 20% were for clients aged 40-49, 11% were for clients aged 10-19 and 3% were for clients aged 60 and over.

Male clients tended to be younger; two-fifths (42%) of the episodes provided to males were for clients aged 10-29, compared with 36% for females (Table S6.26). There has been little variation in the age proportions over the 5 years from 2008-09 (Figure 5.18).



More than one-third (35%) of the episodes for the client's own use with a main treatment type of counselling lasted 1-3 months, while a further one-fifth (21%) lasted 2-29 days (Table S6.24). Compared with 2008-09, closed episodes in 2012-13 tended to be longer. Over the 5 years from 2008-09, the proportion of episodes ending within 1 month decreased slightly (from 44% to 36%), while the proportion of episodes lasting more than 1 month increased (from 56% to 64%) (Table S6.25).

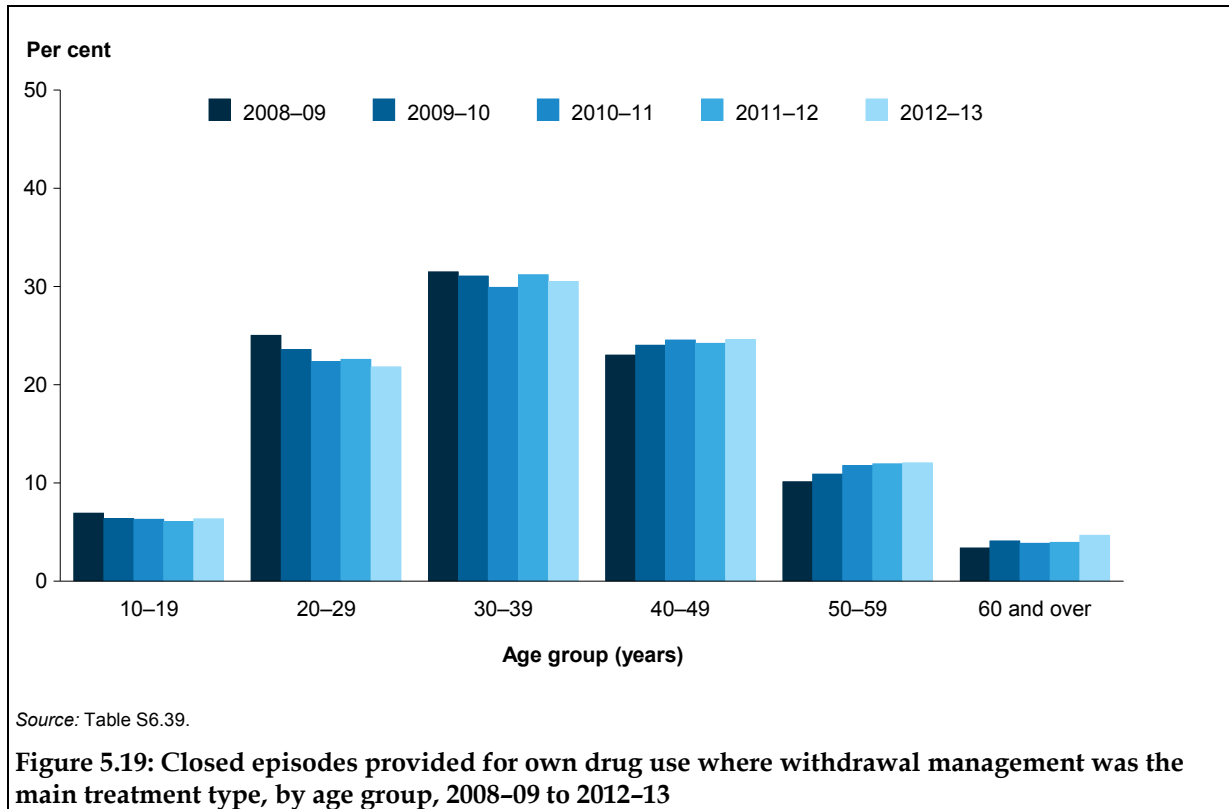
Withdrawal management

Withdrawal management is only provided in episodes for clients receiving treatment for their own drug use. Withdrawal management was a treatment type for 16% of episodes closed in 2012-13 (Table S6.1).

Two-thirds (66%) of the closed episodes provided to clients for their own drug use with a main treatment type of withdrawal management were provided to male clients. One in 10 (13%) episodes, were for Indigenous clients (Table S6.40). Female clients were equally as likely to be Indigenous as male clients (9% compared with 8%).

Most (56%) of these episodes were for those in the 30-39 (31%) and 40-49 (25%) age groups (Figure 5.19). A further 22% were for clients aged 20-29; just 5% were for clients aged 60 and over.

Over the 5 years from 2008-09, there has been an increase in the proportion of episodes provided to older clients where withdrawal management was the main treatment type. More than one-third (36%) of episodes were for clients aged 40 and over in 2008-09 compared with 42% in 2012-13 (Figure 5.19).



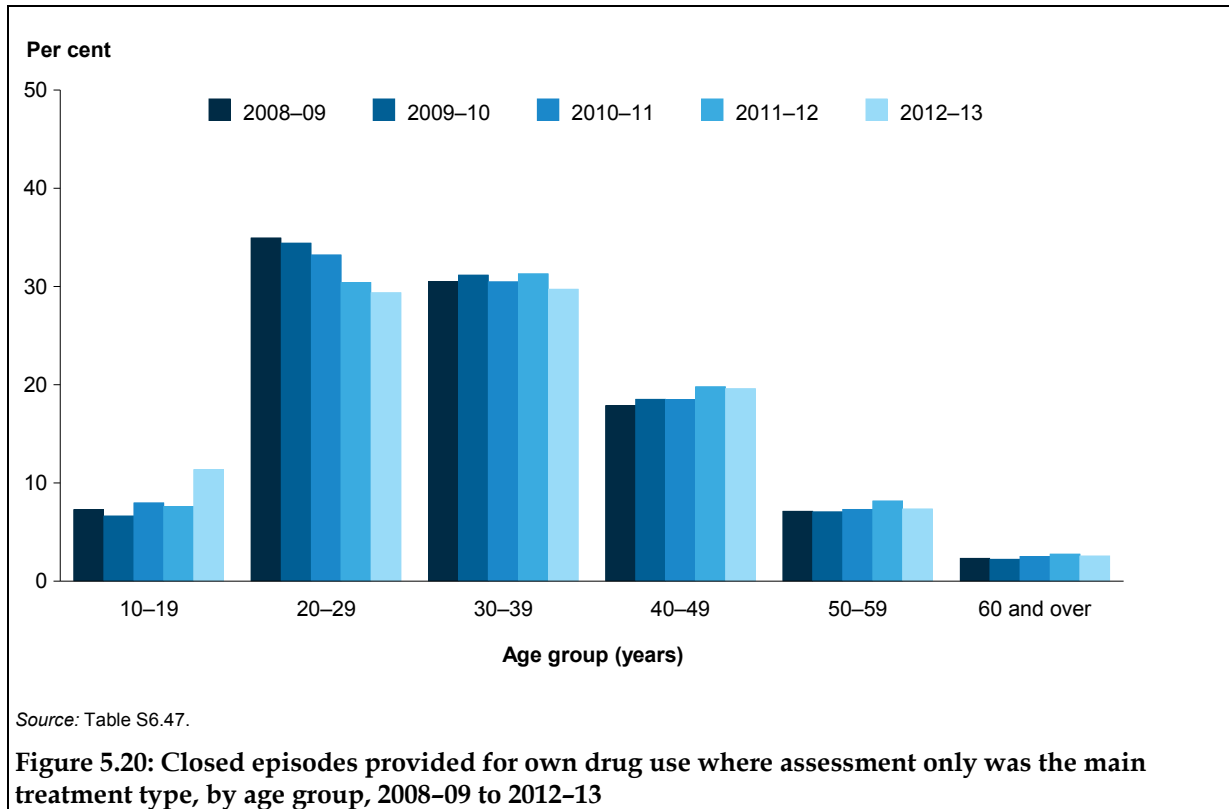
Nearly 8 in 10 (77%) episodes with a main treatment type of withdrawal management lasted less than 30 days while a further one-seventh (15%) lasted 1-3 months (Table S6.36). Short treatment durations may reflect a lack of engagement by clients in ambulatory withdrawal programs (outpatient detoxification). They may also be the result of a change to a more appropriate treatment type (for example, providing opioid pharmacotherapy for opioid dependence). Over the 5 years from 2008-09, there has been little change in the distribution of closed episodes among the duration groups (Table S6.37).

Assessment only

Assessment only was a treatment type for 17% of episodes closed in 2012-13 (Table S6.1).

Almost three-quarters (74%) of the closed episodes for the client's own drug use with a main treatment type of assessment only were provided to male clients, and 27% were for Indigenous clients (Table S6.48). Female clients were more likely to be Indigenous than male clients (19% compared with 14%).

Three-fifths (59%) of these episodes were for those in the 20-29 (29%) and 30-39 (30%) age groups (Figure 5.20). A further 20% of episodes were for clients aged 40-49; just 3% were for clients aged 60 and over. Some of the assessment only episodes for young people are conducted as part of early intervention and diversion from the youth justice system. Over the 5 years from 2008-09, the proportion of episodes for clients aged 10-19 increased from 7% to 11%, while the proportion for those aged 20-29 decreased from 35% to 29% (Figure 5.20).



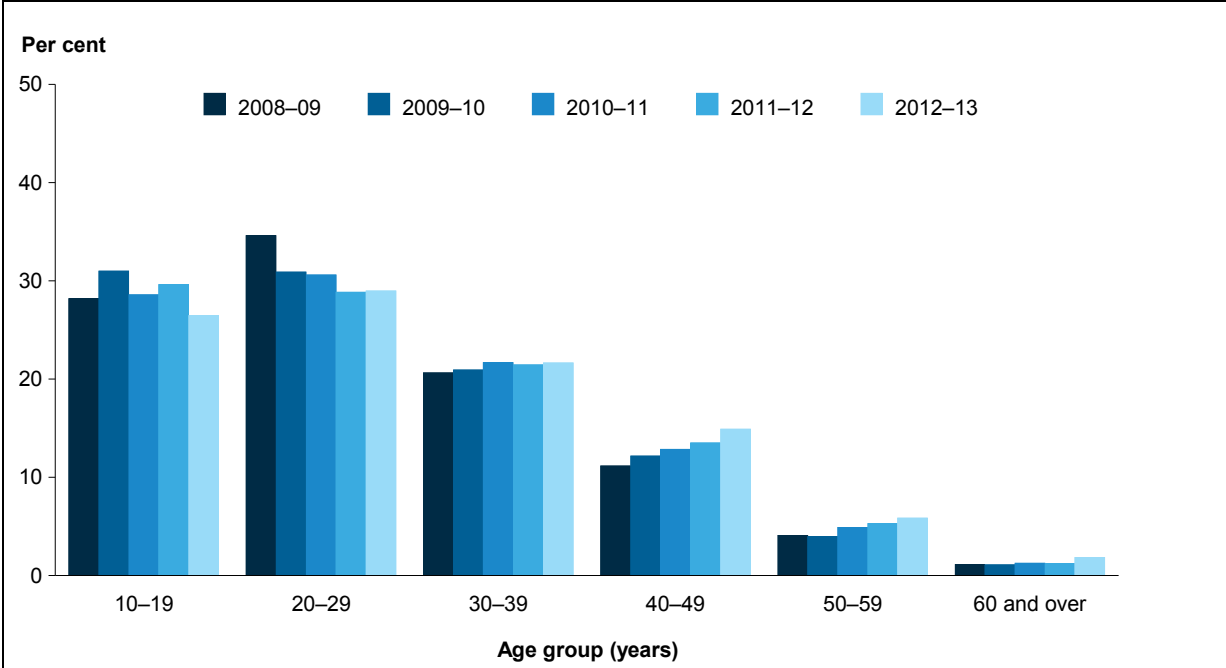
Seven in 10 (69%) episodes for the client's own drug use with a main treatment type of assessment only lasted just 1 day, while a further 19% lasted from 2-29 days (Table S6.49). The proportion of episodes that lasted 1 day ranged from 10% in Tasmania to 100% in Victoria. Over the 5 years from 2008-09, the proportion of closed episodes ending within 1 day increased substantially (from 49% to 69%), while the proportion of episodes lasting 2-29 days decreased (from 31% to 19%). The proportion of episodes in all other duration groups (from 1-3 months to more than 12 months) also decreased for the same time period (Table S6.50). These trends are influenced by differences in jurisdictional service delivery practices and data quality improvement over time.

The large increase to the proportion of closed episodes ending within 1 day has been influenced by changes to data collection practices across some states and territories. The increase in the proportion of episodes ending within 1 day is particularly evident in Victoria, (an increase from less than 1% in 2010-11 to 100% in 2012-13) (Table S7.44). Following implementation of a new operational system for brokerage services in Victoria in October 2011, brokerage assessments for treatment are closed when the client is referred to the nominated agency funded to deliver, rather than at the completion of treatment by that agency. This new system resulted in a decline in episode duration and reflects the increase in those ending within 1 day, as most assessments are completed in a day.

Support and case management only

Almost two-thirds (64%) of the closed episodes provided to clients for their own drug use with a main treatment type of support and case management only were provided to male clients, and 22% were for Indigenous clients (Table S6.56). Female clients were more likely to be Indigenous than male clients (20% compared with 14%).

More than half (55%) of these episodes were for those in the 10–19 (26%) and 20–29 (29%) age groups (Figure 5.21). A further 22% were for clients aged 30–39; just 2% were for clients aged 60 and over. Over the 5 years from 2008–09, the proportion of episodes for clients aged 40–49 increased from 11% to 15%, while the proportion for those aged 20–29 decreased from 35% to 29% (Figure 5.21).



Source: Table S6.55.

Figure 5.21: Closed episodes provided for own drug use where support and case management only was the main treatment type, by age group, 2008–09 to 2012–13

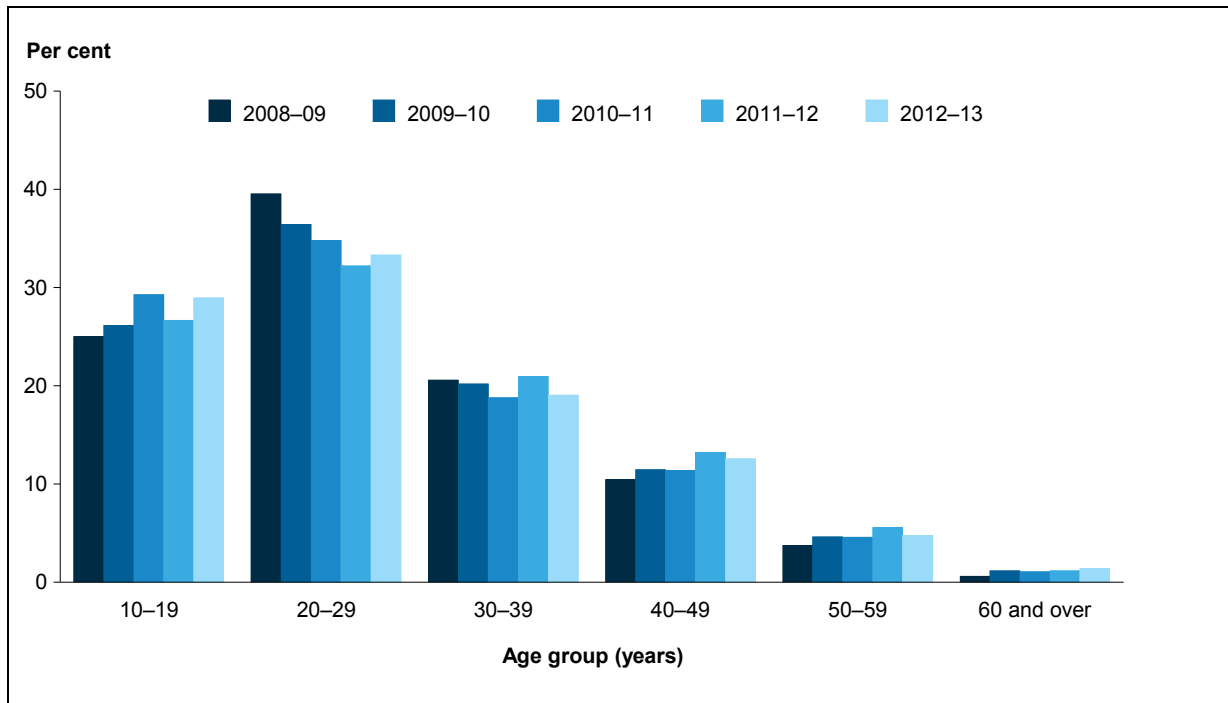
More than one-third (35%) of the episodes for the client's own drug use with a main treatment type of support and case management lasted 1–3 months, while 27% lasted 2–29 days and 2 in 5 (19%) lasted 3–6 months (Table S6.57). Over the 5 years from 2008–09, the proportion of closed episodes ending within 2 days to 3 months decreased (from 69% to 62%), while both the proportion of episodes ending within 1 day and those ending within 6 months or more, increased (from 6% to 9% and from 6% to 10%, respectively) (Table 6.58).

Information and education only

As mentioned previously, information and education only is not available as an additional treatment type.

Almost three-quarters (73%) of the closed episodes provided to clients for their own drug use with a main treatment type of information and education only were provided to male clients, and 19% were for Indigenous clients (Table S6.64). Female clients were more likely to be Indigenous than male clients (20% compared with 11%).

More than three-fifths (62%) of these episodes were for those in the 20–29 (33%) and 10–19 (29%) age groups (Figure 5.22). A further 19% were for clients aged 30–39; 1% were for clients aged 60 and over. Female clients tended to be older; almost one-quarter (23%) of the episodes provided to females were for those aged 40 and over, compared with 16% for males. (Table S6.54). Over the 5 years from 2008–09, the proportion of episodes for clients aged 10–19 increased from 25% to 29%, while the proportion for those aged 20–29 decreased from 40% to 33% (Figure 5.22).



Source: Table S6.63.

Figure 5.22: Closed episodes provided for own drug use where information and education only was the main treatment type, by age group, 2008–09 to 2012–13

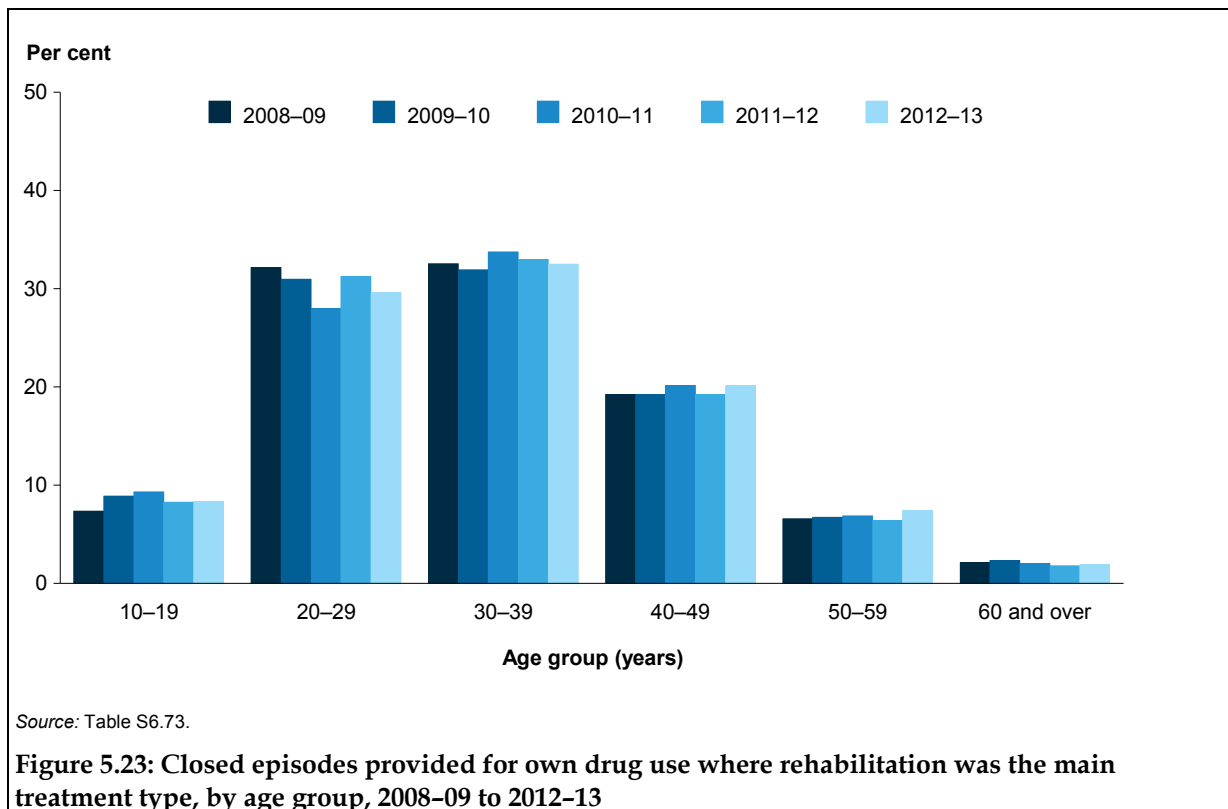
As expected for this type of treatment, most (82%) of the information and education only episodes for the client's own drug use lasted just 1 day (Table S6.57). Over the 5 years from 2008–09, the proportion of closed episodes ending within 1 day decreased from 89% to 82% with a trough of 65% in 2011–12, while the proportion of episodes ending within 2–29 days increased from 6% to 9% with a peak of 17% in 2011–12 (Table S6.58).

Rehabilitation

As mentioned previously, rehabilitation is only available to clients receiving treatment for their own drug use. Rehabilitation was a treatment type for 5% of episodes closed in 2012–13 (Table S6.1).

Almost two-thirds (65%) of the closed episodes with a main treatment type of rehabilitation were provided to male clients, and 22% were for Indigenous clients (Table S6.74).

Three in 5 (62%) of these episodes were for those in the 20–29 (30%) and 30–39 (32%) age groups (Table S6.73). A further 20% were for clients aged 40–49; just 2% were for clients aged 60 and over. There has been little variation in the age proportions over the 5 years from 2008–09 (Figure 5.23).



More than one-third (35%) of the episodes with a main treatment type of rehabilitation lasted from 1–3 months, while a further 31% lasted 2–29 days (Table S6.70). Compared with 2008–09, closed episodes in 2012–13 were more likely to be slightly longer. Over the 5 years from 2008–09, the proportion of episodes ending within 29 days decreased (from 42% to 35%), while the proportion of episodes ending within 1–12 months increased (from 55% to 62%) (Table S6.71).

Pharmacotherapy

Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment and an additional treatment was provided, are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded from the AODTS NMDS. Pharmacotherapy is only available to clients receiving treatment for their own drug use. As most pharmacotherapy services are outside the scope of the AODTS NMDS, this information is a significant

underestimate. More comprehensive information on pharmacotherapy treatment provided in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics Annual Data (NOSPAD) collection. See Chapter 8 for more information.

For those services that were within scope of the AODTS NMDS, nationally in 2012–13, 3% of episodes were provided with a treatment type of pharmacotherapy (main or additional) (Table S6.1). In more than half (56%) of these episodes, pharmacotherapy was an additional treatment; this is a result of the AOTDS NMDS scope, which excludes episodes in which pharmacotherapy is the main treatment type, and no additional treatment is provided.

Of the closed episodes where pharmacotherapy was the main treatment type, almost one-quarter (24%) lasted up to 1 month, while a further 18% lasted 1–3 months (Table S6.80).

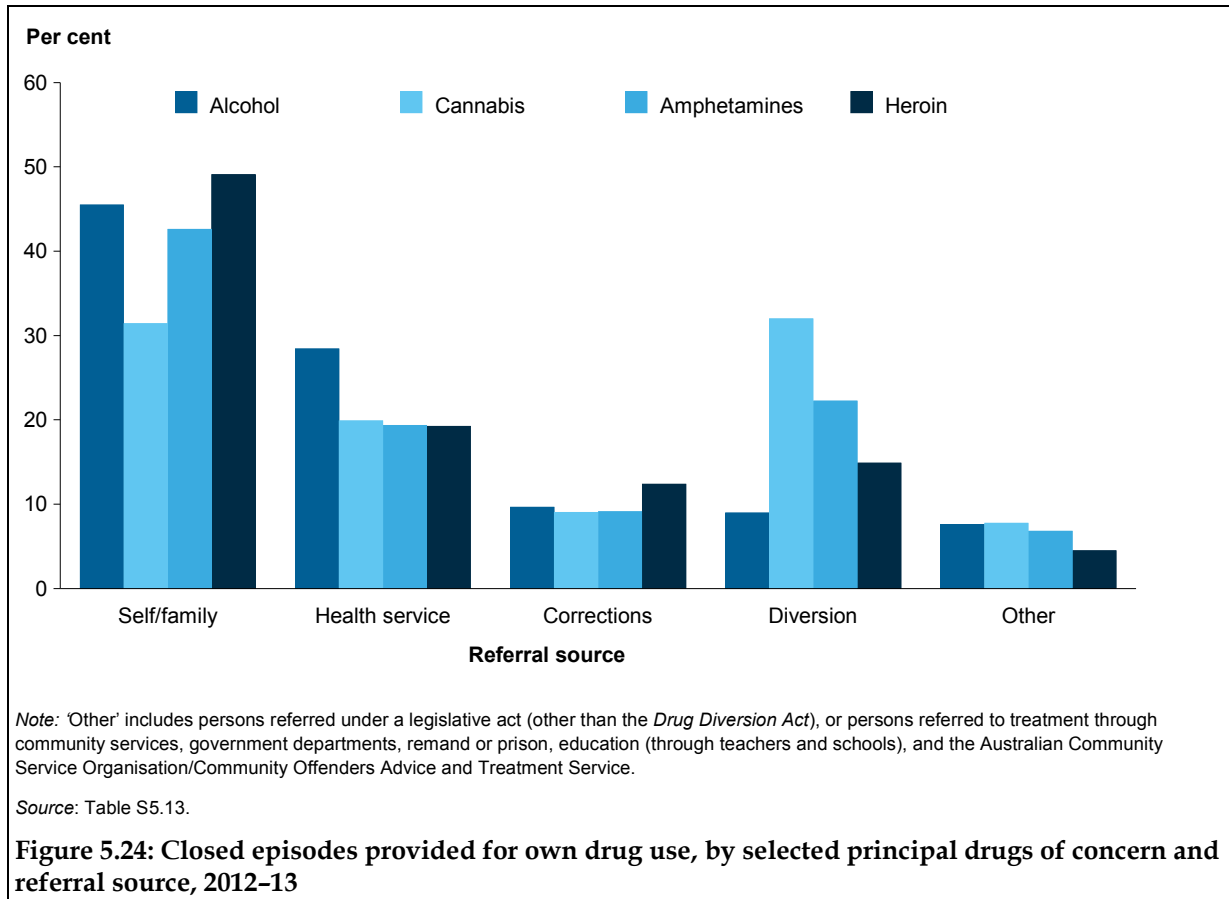
Two-thirds (67%) of the closed episodes with a main treatment type of pharmacotherapy were provided to male clients, and 17% to Indigenous clients (Table S6.84). Almost two-thirds (65%) of these episodes were for those in the 20–29 (24%) and 30–39 (41%) age groups. A further 26% were for clients aged 40–49; just 1% were for clients aged 60 and over.

Of the closed episodes provided to clients with a main treatment type of pharmacotherapy, more than half (54%) had heroin as a principal drug of concern, while almost 1 in 8 (12%) had a principal drug of methadone. Morphine (10% of episodes) was also a common principal drug of concern (Table S6.85).

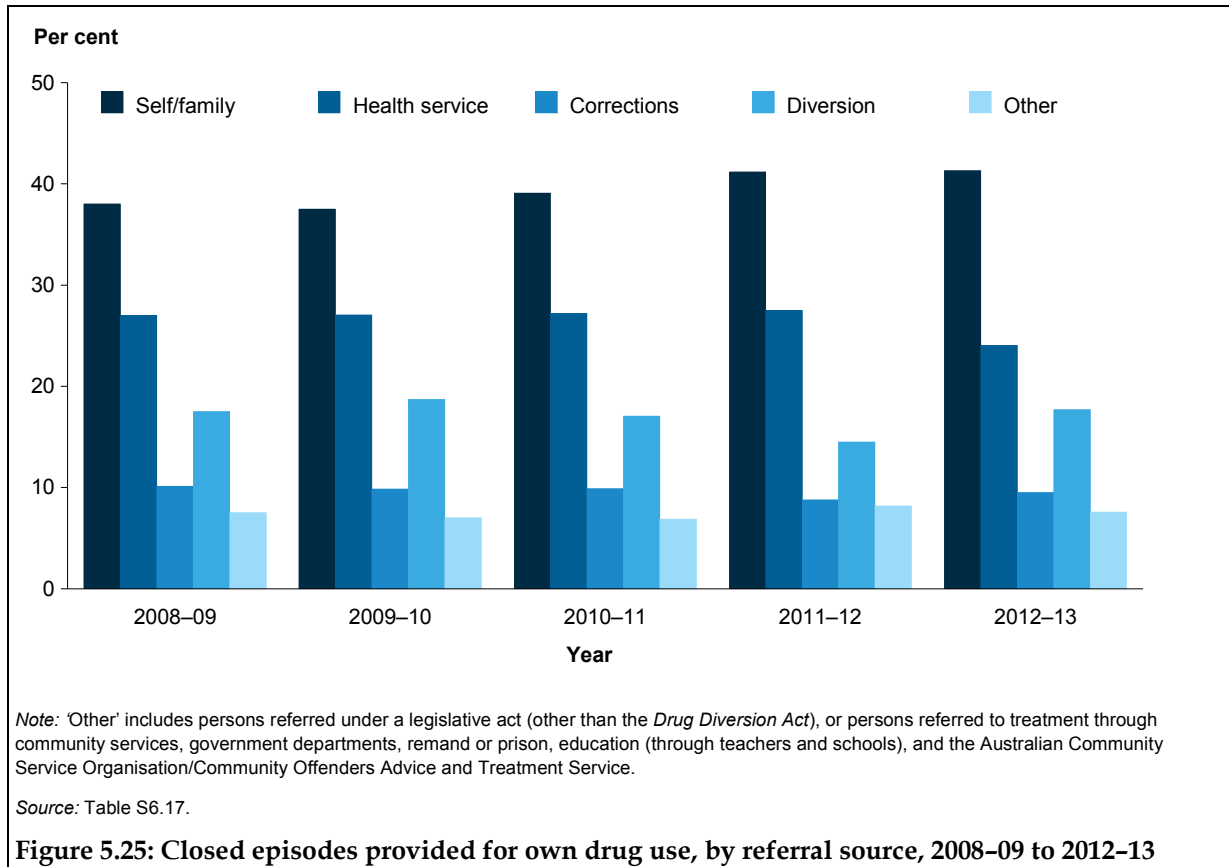
5.4 Referral source

Nationally, the most common source of referral for clients receiving treatment for their own drug use in 2012–13 was self or family (41%). Referral from a health service was also common (24%). Referrals from police or court diversion programs accounted for 18% of episodes (these programs divert people with minor drug offences from the criminal justice system) (Table S6.16). Clients referred by diversion programs tended to be younger; 24% of these episodes were for clients aged 10–19 and 36% were for clients aged 20–29, compared with 13% and 28%, respectively, for all episodes. In 1 in 11 (9%) episodes, the client was referred by a correctional service (Table S6.16).

Source of referral varied according to clients' principal drugs of concern. Self or family referral was the most common source of referral for clients receiving treatment for heroin (49%), alcohol (45%) or amphetamines (43%) as their principal drug of concern (Figure 5.24). For clients receiving treatment for cannabis as their principal drug, diversion (32%) was the most common referral source, followed closely by self/family (31%). Clients receiving treatment for alcohol as their principal drug were less likely to be referred through diversion (9%) and more likely to be referred from a health service (28%), when compared to clients receiving treatment for heroin, amphetamines or cannabis.



Over the 5 years from 2008-09, the proportion of episodes where the client was referred by self or family increased from 38% to 41%, while the proportion referred by a health service decreased from 27% to 24% (Figure 5.25). There was little change in the other sources of referral over the same period.

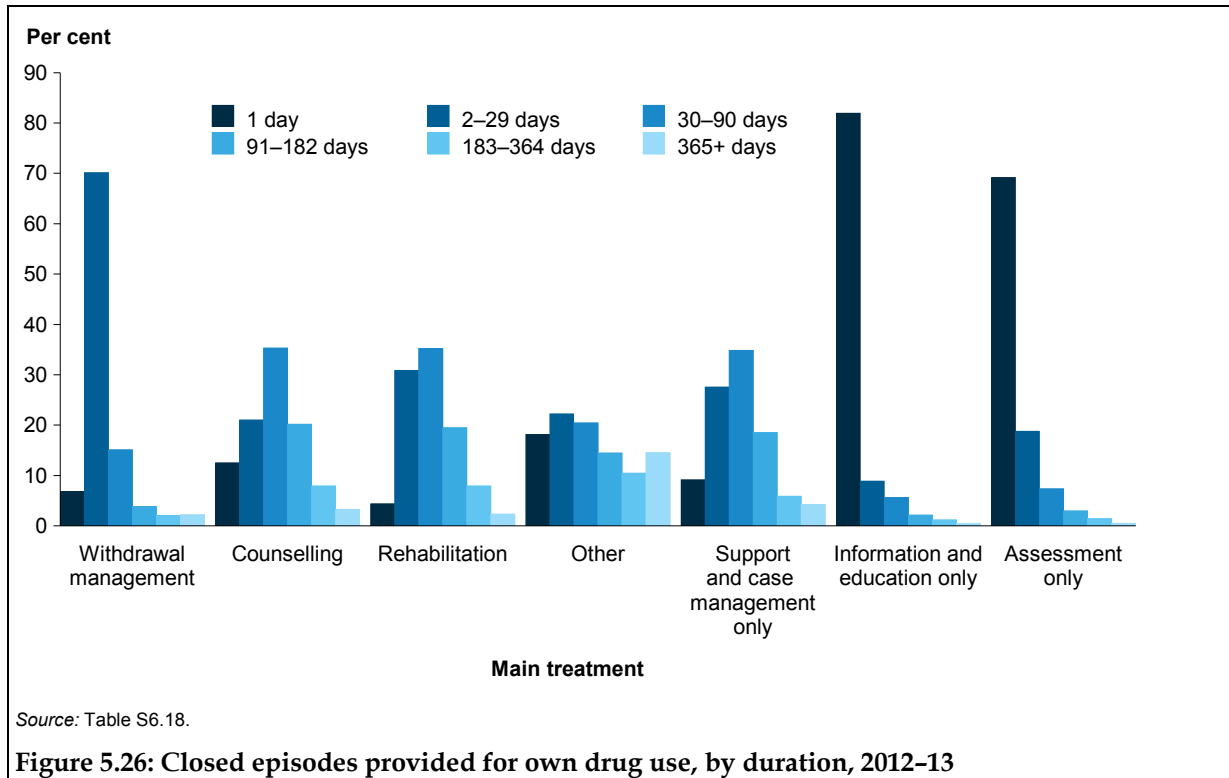


5.5 Length of treatment episodes

Four-fifths (79%) of closed episodes for the client's own drug use ended within 3 months, more than half (55%) ended within 1 month and over one-quarter (26%) ended within 1 day (Table S6.18). Just 8% of episodes lasted 6 months or more.

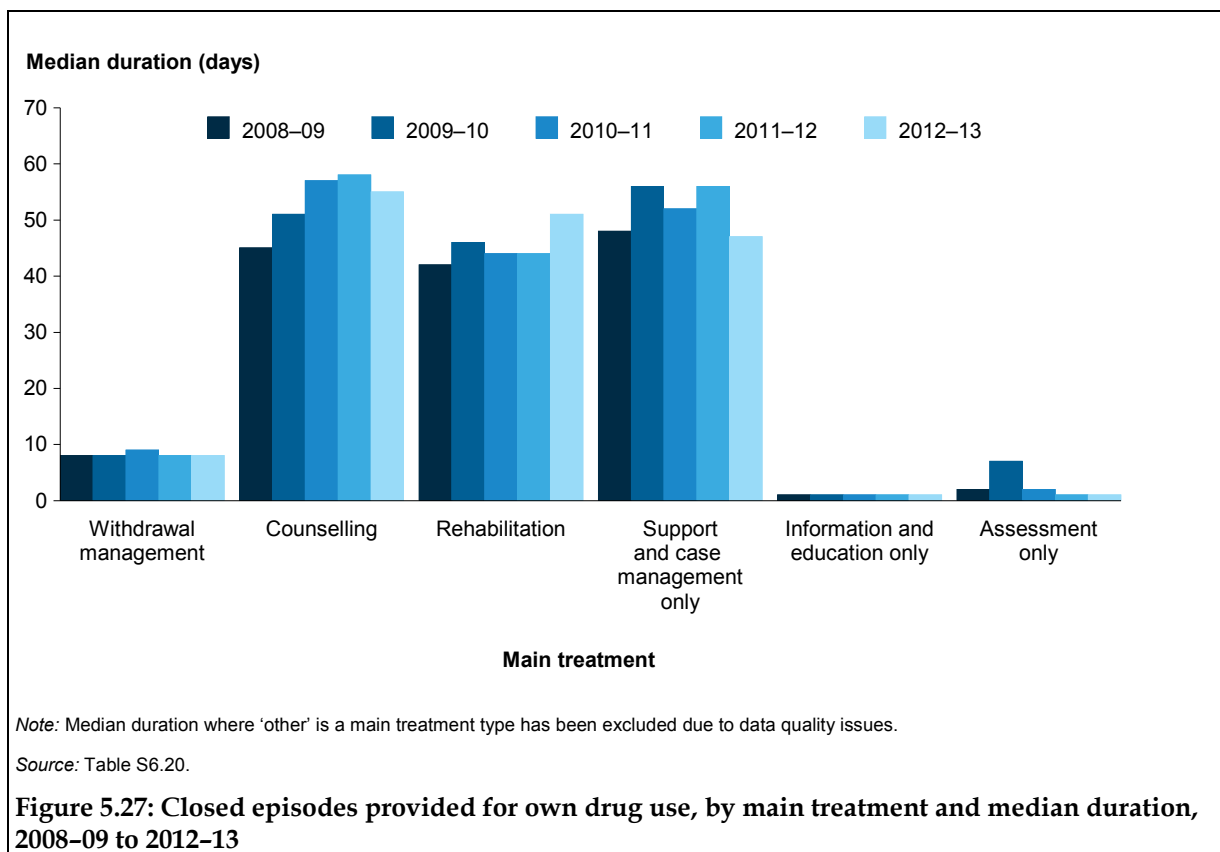
Over the 10 years from 2003-04, the proportion of episodes that ended within 3 months decreased slightly from 83% to 79% (Table S6.19).

As expected, episodes with a main treatment type of information and education only or assessment only were most likely to end within 1 day. Episodes with counselling, rehabilitation and support and case management had similar duration patterns, most commonly lasted 1-3 months (35% of episodes each) (Figure 5.26). The majority (70%) of withdrawal management episodes lasted 2-29 days.



Nationally, the median duration of closed episodes for the client’s own drug use was just over 3 weeks (22 days) (Table S6.20). The median duration of closed episodes for the client’s own drug use increased over the 5 years from 2008-09 from 18 days to 22 days in 2012-13, peaking at 25 days in 2011-12.

This increase over time is largely due to increased median duration for episodes with a main treatment type of counselling, rehabilitation or other. The median duration of episodes where counselling was a main treatment type increased by 10 days (from 45 to 55), while the median duration for rehabilitation increased by 9 days (from 42 to 51) over the same period.



5.6 Reason for cessation

In 2012-13, around 3 in 5 (63%) completions recorded a reason for cessation in the 'expected' category. Unexpected cessations accounted for more than one-fifth (21%) and administrative cessations around 6% (Table 5.1). The proportion of episodes with expected cessations remained at around one-third over the 4 years from 2008-09, (with proportions between 65% and 68%), declining to 63% in 2012-13. There was little change to the proportion of episodes in the 'unexpected' category for clients receiving treatment for their own drug use, with the proportion remaining between 20% and 22% over the same period (Table S2.16).

Table 5.1: Reason for cessation grouped by indicative outcome type, 2012-13

Reason for cessation	%
Expected cessation	62.9
Unexpected cessation	20.8
Administrative cessation	6.3
Other	10.0
Total	100.0

When all reasons were considered, 'treatment completed' was the most common reason for cessation for clients receiving treatment for their own drug use (53%), followed by 'ceased to participate without notice' (15%), 'other' (8%) and 'ceased to participate at expiation' (7%) (Table 5.2). 'Transferred to another service provider' and 'ceased to participate against advice' were also reasons for cessation (both 4%).

Table 5.2: Reason for cessation of treatment episodes, 2012–13

Reason for cessation	%
Treatment completed	52.9
Ceased to participate without notice	14.9
Ceased to participate at expiration	7.2
Transferred to another service provider	4.3
Ceased to participate against advice	3.9
Ceased to participate by mutual agreement	2.8
Ceased to participate involuntary (non-compliance)	1.9
Imprisoned, other than drug court sanctioned	1.2
Change in delivery setting	1.0
Change in main treatment type	0.9
Drug court and/or sanctioned by court diversion service	0.2
Died	0.2
Change in principal drug of concern	0.1
Other	8.4
Total	100.0

In 2012–13, clients whose principal drug of concern was ecstasy were the most likely to have an expected cessation, with almost 9 in 10 (88%) falling into this category. The lowest rate of expected cessations was for episodes with morphine as the primary drug of concern (43%). Amphetamines had the highest rate of unexpected cessations (25%), while the lowest rate was observed where ecstasy was the principal drug of concern (6%) (Table 5.3).

Table 5.3: Reason for cessation grouped by indicative outcome type, by principal drug of concern (%), 2012–13

Principal drug of concern	Expected cessation (%)	Unexpected cessation (%)	Administrative cessation (%)	Other (%)	Total (%)
Analgesics					
Codeine	55.4	21.7	15.4	7.5	100.0
Morphine	43.1	24.5	17.6	14.7	100.0
Buprenorphine	52.5	17.7	19.8	9.9	100.0
Heroin	53.2	20.6	10.3	15.9	100.0
Methadone	57.1	15.7	17.2	10.1	100.0
<i>Total analgesics</i>	<i>52.6</i>	<i>20.8</i>	<i>13.0</i>	<i>13.6</i>	<i>100.0</i>
Sedatives and hypnotics					
Alcohol	63.0	21.4	6.1	9.6	100.0
Benzodiazepines	60.6	20.3	9.5	9.6	100.0
<i>Total sedatives and hypnotics</i>	<i>62.9</i>	<i>21.4</i>	<i>6.2</i>	<i>9.5</i>	<i>100.0</i>
Stimulants and hallucinogens					
Amphetamines	61.2	25.4	5.3	8.1	100.0
Ecstasy	88.4	5.8	2.0	3.8	100.0
Cocaine	72.1	15.8	4.1	8.0	100.0
Nicotine	77.7	12.9	3.2	6.3	100.0
<i>Total stimulants and hallucinogens</i>	<i>64.2</i>	<i>23.1</i>	<i>5.0</i>	<i>7.7</i>	<i>100.0</i>
Cannabis	69.3	18.7	3.9	8.1	100.0

For episodes with alcohol or cannabis as the principal drug of concern, expected cessations remained the most common over the 5 years from 2008–09, although the proportion of these episodes declined slightly (from 66% – with a high of 69% in 2010–11 – to 63% and from 73% to 69% respectively).

Over the same period, there was very little change to the reason for cessation for episodes with amphetamines as the principal drug of concern (Table S5.17).

The proportion of episodes with an expected cessation or an unexpected cessation where heroin was the principal drug of concern both declined (from 57% to 53% and 25% to 21%, respectively). ‘Other’ reasons increased from 9% in 2008–09 to 16% in 2012–13.

6 Treatment episodes for someone else's drug use

This chapter explores the treatment provided to clients receiving treatment for someone else's drug use. Those people who sought treatment in relation to someone else's drug use may include people looking for ideas to help someone with their drug use and people seeking assistance because of the personal impact on them of someone else's drug use. Not all treatments related to someone else's drug use are reported through the NMDS as it is likely that many people approach other services for assistance, such as relationship counsellors. What is reported though, is this assistance when it is sought from an alcohol and other drug treatment service.

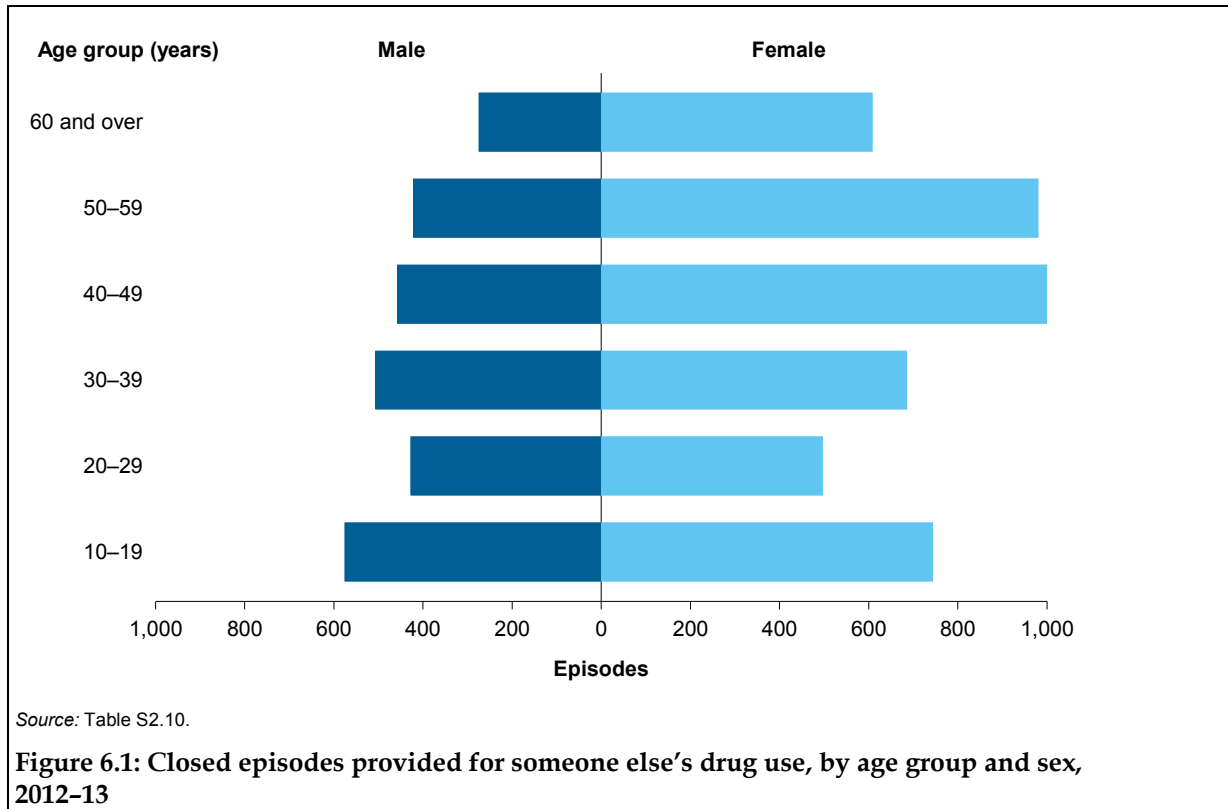
Data relating to drug of concern are not reported for those who sought treatment for someone else's drug use. In addition, rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not provided to clients seeking treatment for someone else's drug use.

6.1 Demographics

Just 4% (7,211) of episodes closed in 2012–13 were for people receiving treatment for someone else's drug use (Table S2.1). Of these 7,211 episodes, 63% were for female clients, which is the same proportion as for 2011–12 but a decline from 74% in 2003–04 (Table S2.4). These clients tended to be older than those receiving treatment for their own drug use; one-fifth (20%) of episodes were for clients aged 40–49 while a further 19% were for clients aged 50–59 (Table S2.9). There was little change in the distribution of episodes among the different age groups in the 10 years from 2003–04 (Table S2.9).

Among clients seeking treatment for someone else's drug use, the AODTS NMDS does not capture information about the relationship between the client and the associated drug user. However, given the age and sex profile of this client group it is possible that a large proportion are parents (most likely mothers) or relatives and the one-fifth of clients that are aged 10–19 may be children of drug users.

Male clients tended to be slightly younger than female clients (Figure 6.1). More than half (57%) of episodes provided to female clients were for people aged 40 or over, compared with 43% for those provided to male clients (Figure 6.1). Clients who received treatment for someone else's drug use were more likely to be female. Non-Indigenous clients (64%) were more likely to be female than Indigenous clients (53%) (Table S2.7).



More than four-fifths (81%) of the episodes for someone else's drug use were provided to clients whose country of birth was Australia (Table S2.11). A further 4% of episodes were provided to clients born in the United Kingdom and 2% were born in New Zealand. In nearly all (95%) episodes, the client had a preferred language of English (Table S2.12).

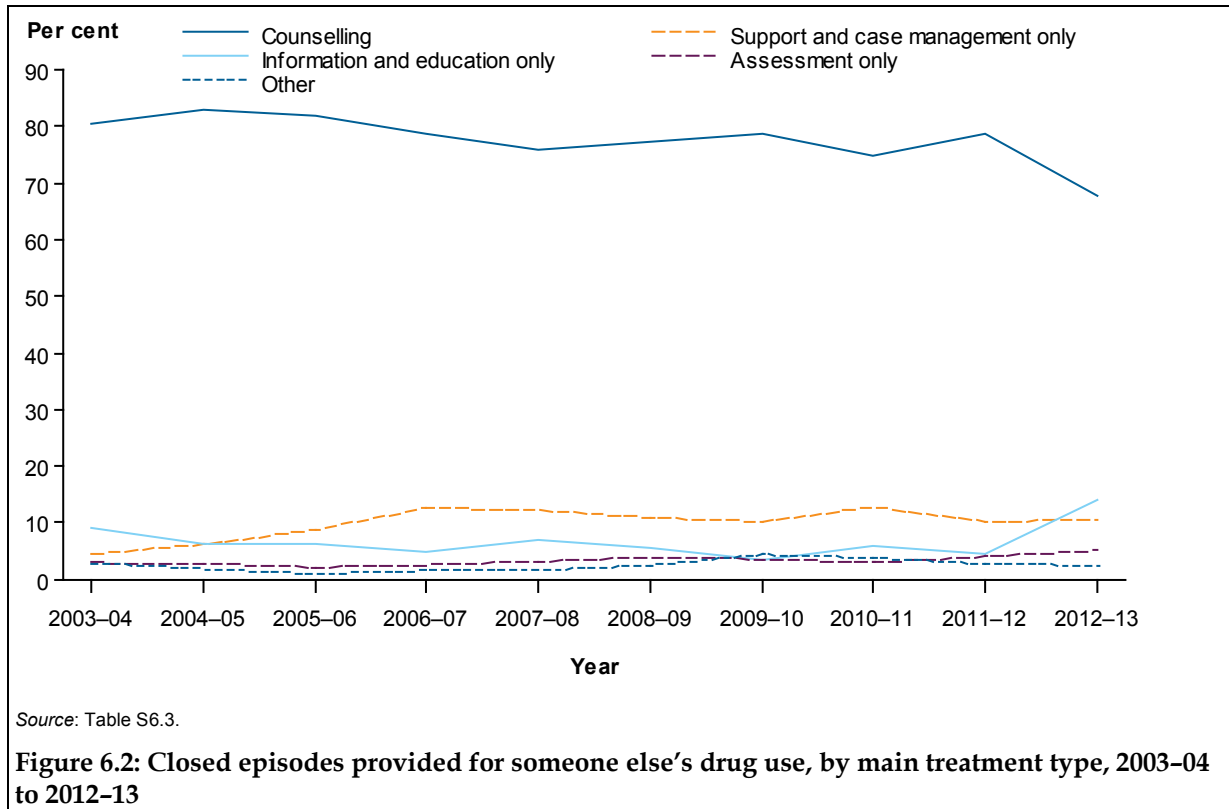
6.2 Treatment provided

Overview

Counselling (68%) was most common type of treatment provided, followed by information and education only (14%), support and case management only (11%) and assessment only (5%). Rehabilitation, withdrawal management and pharmacotherapy are not provided to clients receiving treatment for someone else's drug use (Table S6.1).

Episodes with support and case management only, information and education only and other were most likely to be provided to clients aged 10-19 (51%, 26% and 64%, respectively). Counselling and assessment only were most common among clients aged 40-59 (44% and 49% of episodes for these treatment types, respectively).

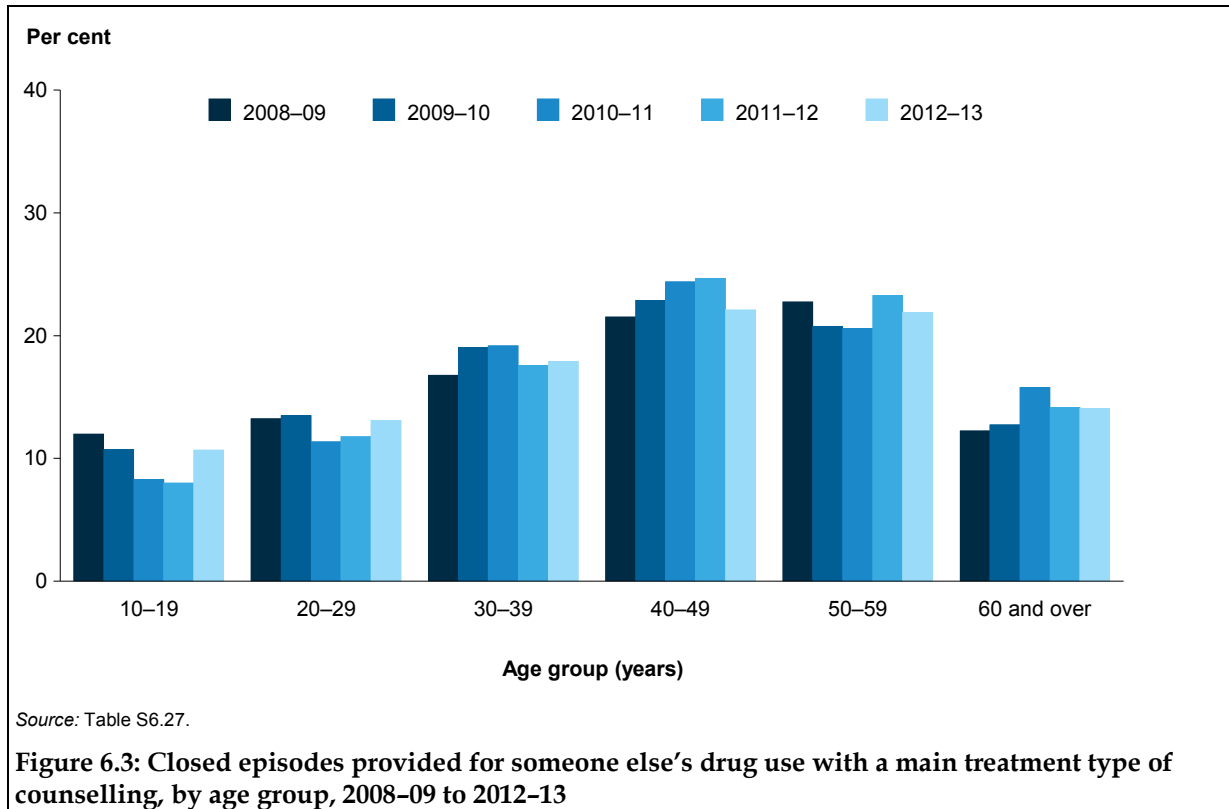
Over the 10 years from 2003-04 to 2012-13, there was little fluctuation in the proportion of episodes for each main treatment type (Figure 6.2). While counselling continues to be the most common main treatment type provided it has decreased from 80% of episodes in 2003-04 to 68% in 2012-13.



Counselling

Compared with episodes for the client's own drug use, episodes for someone else's drug use with a main treatment type of counselling were more likely to be provided to female clients (66%). Male clients were more likely to be Indigenous than female clients (9% compared with 5%) (Table S6.28).

These episodes tended to be provided to older clients. More than half (58%) were for clients aged 40 and over; 22% of episodes were provided each to clients in the 40-49 and 50-59 age groups, while a further 14% of episodes were for clients aged 60 or over (Figure 6.3). Female clients were more likely to be older than males: 48% of episodes provided to females were for clients aged 40-59, compared with 37% of episodes for male clients (Table S6.26). There has been little variation in the age proportions over the last 5 years from 2008-09 (Figure 6.3).



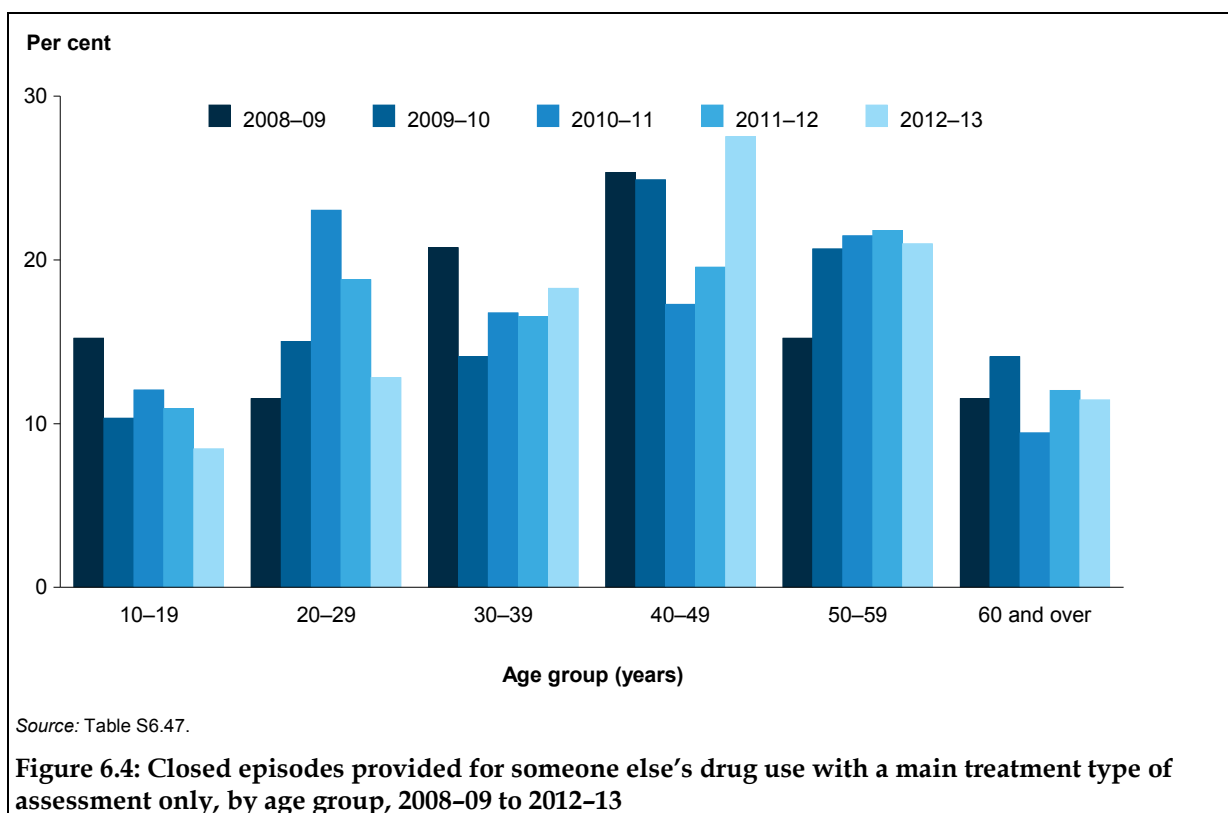
More than one-third (36%) of the closed episodes provided to clients for someone else's drug use with a main treatment type of counselling lasted 1-3 months, while a further quarter (24%) lasted 2-29 days (Table S6.24). Over the 5 years from 2008-09, the proportion of closed episodes lasting 1-3 months increased (from 30% to 36%), while the proportion lasting 12 months or more decreased (from 7% to 3%) (Table S6.25). There was little change in the proportions of episodes across all other durations for the same period.

Assessment only

In this context, assessment only refers to assessing the needs of the client who is seeking treatment to help them cope with someone else's drug use. Episodes for someone else's drug use with a main treatment type of assessment only were more likely to be provided to female clients (58%) (Table S6.48).

The episodes for someone else's drug use tended to be provided to older clients. Almost half (49%) were for clients in the 40–49 (28%) or 50–59 (21%) age groups (Figure 6.4).

Female clients were more likely to be older than males: 54% of episodes provided to females were for clients aged 40–59, compared with 42% of episodes for male clients (Table S6.46). Over the 5 years from 2008–09, there was an increase in the proportion of episodes provided to older clients. More than half (52%) of episodes were provided to clients aged 40 and over in 2008–09 compared with 60% in 2012–13 (Table 6.4).

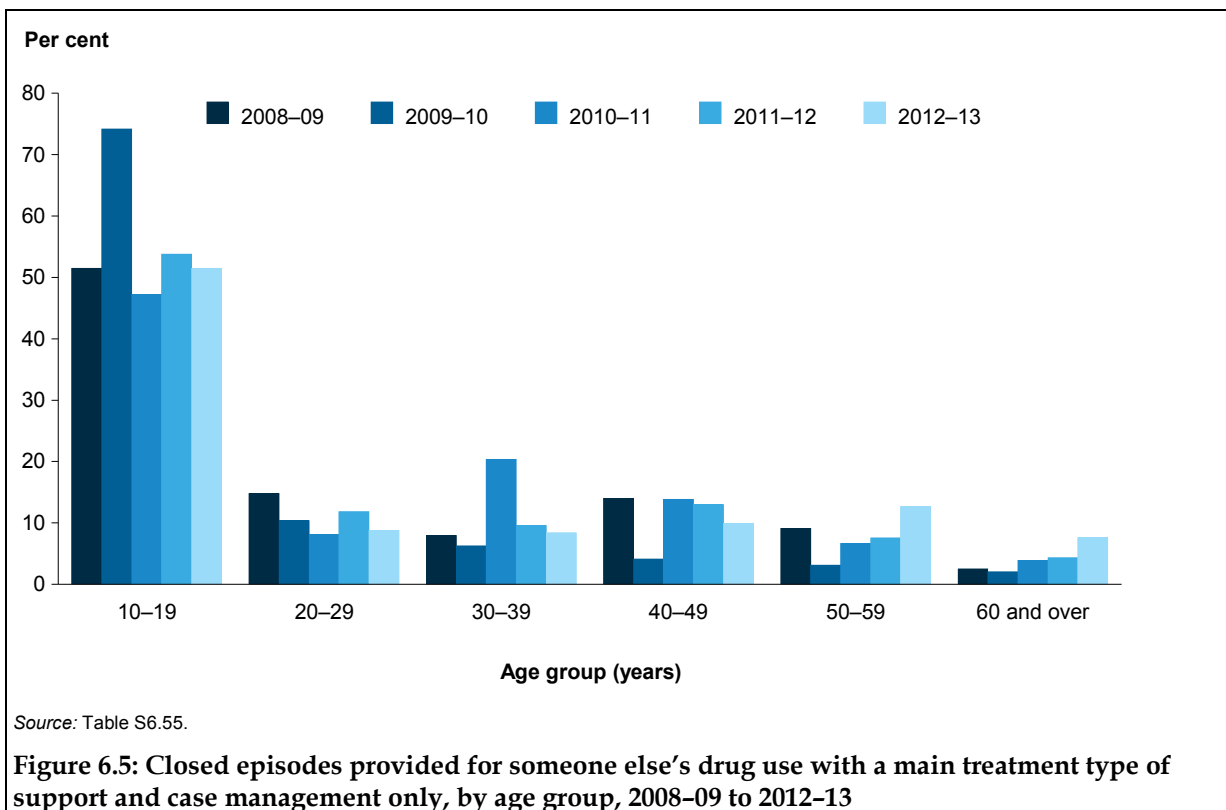


Four-fifths (83%) of the episodes for someone else's drug use with a main treatment type of assessment only lasted only 1 day, while a further 7% lasted 2–29 days (Table S6.49). Over the 5 years from 2008–09, the proportion of episodes ending within 1 day increased (from 80% to 83%), while the proportion of those ending within 2–29 days decreased (from 9% to 7%). There was little change to the episodes lasting other durations over the same period (Table S6.50).

Support and case management only

Episodes for someone else's drug use with a main treatment type of support and case management only were more likely to be provided to female clients (56%) (Table S6.56). They also tended to be provided to younger clients, with more than half (51%) the episodes for clients aged 10–19 (Figure 6.5).

Female clients were more likely to be older than males: 41% of episodes provided to females were for clients aged 30 and over, compared with 34% of episodes for male clients (Table S6.54). Over the 5 years from 2008–09, the proportion of episodes provided to clients aged 50 and over increased (from 11% to 21%), while episodes provided to clients aged 20–29 decreased (from 15% to 9%). The proportion of episodes provided to clients aged 10–19 increased substantially in 2009–10 (from 51% to 74%); however, it has since declined, returning to 51% and resulting in no overall change since 2008–09 (Figure 6.5).

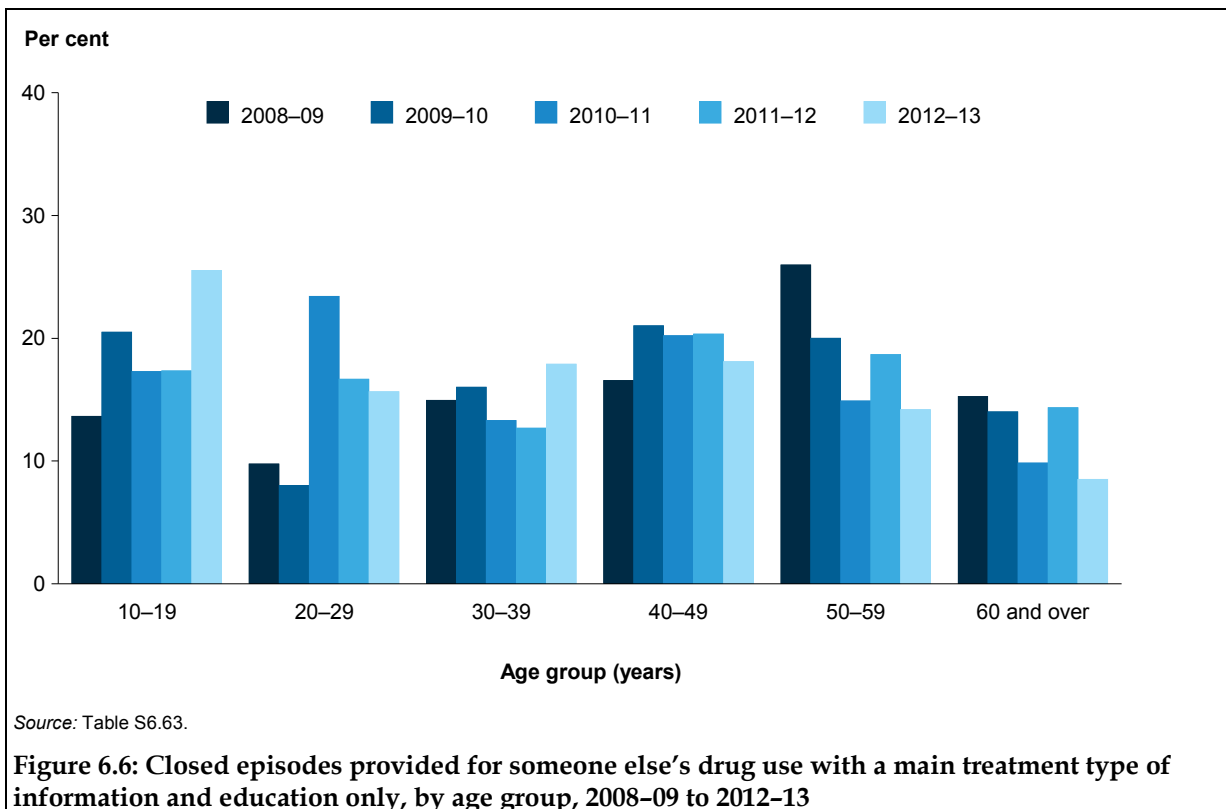


Almost half (49%) of closed episodes provided to clients for someone else's drug use with a main treatment type of support and case management lasted 1–3 months, while over one-quarter (26%) lasted 2–29 days (Table S6.57). The proportion of closed episodes lasting 1–3 months and 2–29 days have changed substantially over the 5 years from 2008–09. Both episode durations accounted for a similar proportion of closed episodes in 2008–09 (36% for 2–29 days and 33% for 1–3 months). However, since then, the proportion of episodes lasting 2–29 days has declined (to 26%), while the opposite is true for episodes lasting 1–3 months (to 49%), making 1–3 months the most common duration since 2011–12 (Table S6.58).

Information and education only

Episodes for someone else's drug use with a main treatment type of information and education only were more likely to be provided to female clients (58%) (Table S6.64).

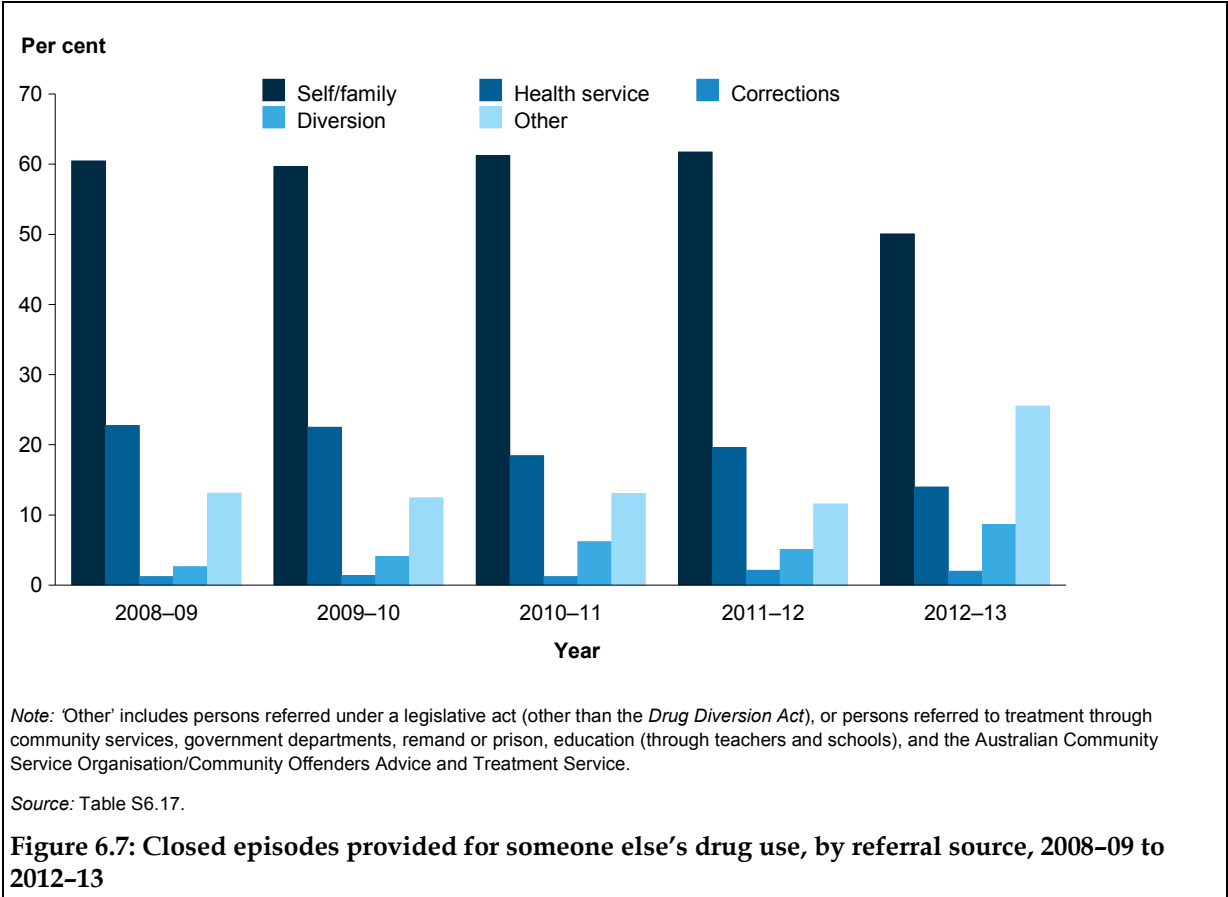
These episodes tended to be provided to younger clients. More than two-fifths (42%) were for clients in the 10–19 (26%) or 20–29 (16%) age groups (Figure 6.6). Female clients were more likely to be in the youngest and the oldest age groups compared to males who were more likely to be of middle age: 29% of episodes provided to females were for clients aged 10–19, compared with 21% of episodes for male clients, while 57% of episodes were for males aged 20–49 compared with 48% for females. (Table S6.62). Over the 5 years from 2008–09, the proportion of episodes for clients aged 10–19 increased from 14% to 26%, while the proportion for those aged 50–59 decreased from 26% to 14% (Figure 6.6).



Similar to those provided for the client's own drug use and as expected for this type of treatment, most (77%) of the episodes provided for someone else's drug use where information and education was the main treatment type lasted 1 day, while a further 13% lasted 1–3 months (Table S6.65). Over the 5 years from 2008–09, the proportion of episodes lasting 1 day increased (from 51% to 77%, peaking at 85% in 2010–11) while the opposite is true for episodes lasting 2–29 days (declining from 28% to 8%) (Table S6.66).

6.3 Referral source

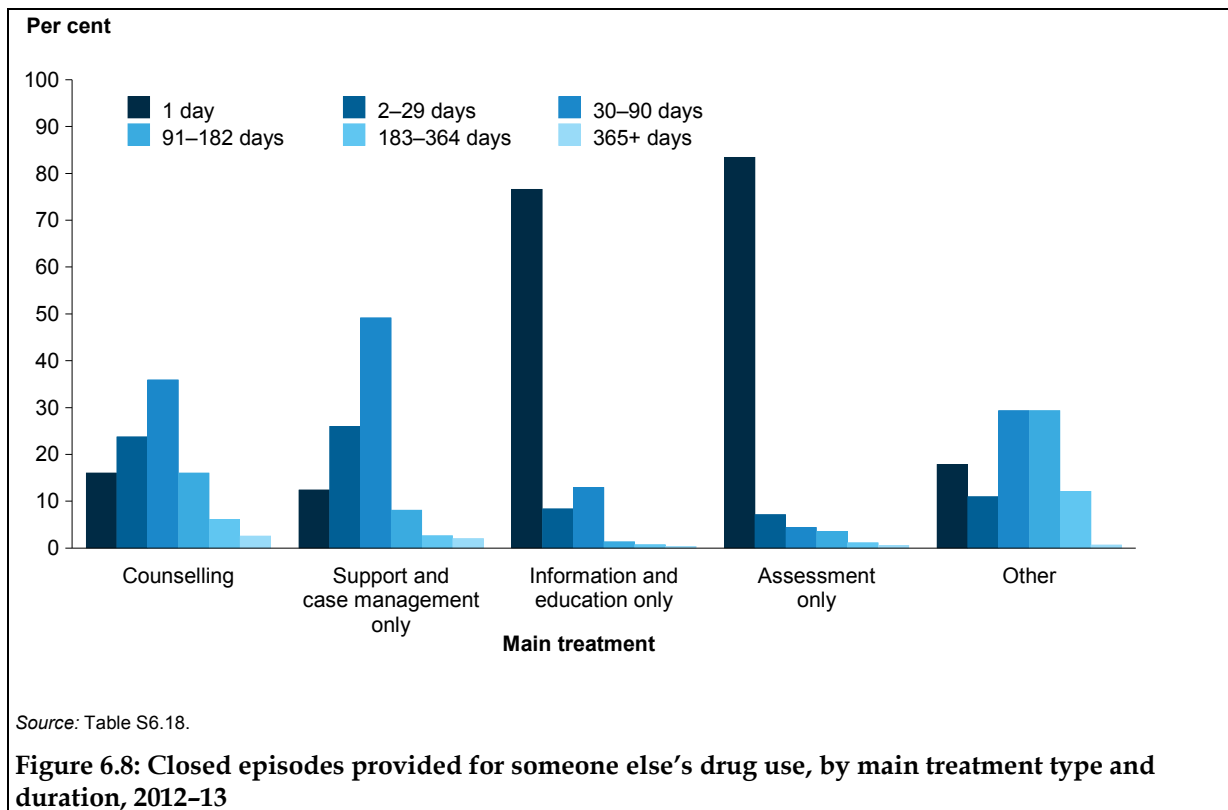
Half (50%) of episodes provided to clients for someone else’s drug use had a referral source of self or family, while 1 in 7 (14%) were referred by a health service (Figure 6.7). While self or family has remained the most common source of referral in the 5 years from 2008–09, the proportion of closed episodes in which self or family was the referral source has declined (from 60% to 50%) (Figure 6.7). Over the same period, the proportion of health service referrals also declined (from 23% to 14%), while there has been an increase in the referral source of ‘other’ (from 13% to 25%) (Figure 6.7).



6.4 Length of treatment episodes

Four-fifths (81%) of episodes provided to clients for someone else's drug use ended within 3 months – almost one-third (32%) lasted 1–3 months (Figure 6.8).

As for treatment provided to clients for their own use, episodes with a main treatment type of information and education only or assessment only were most likely to end within 1 day. Episodes with counselling and support and case management had similar duration patterns, most commonly lasting 1–3 months (36% and 49% of episodes, respectively) (Figure 6.8).



Nationally, the median duration of closed episodes for someone else's drug use was 4.4 weeks (31 days) (Table S6.20). This is strongly influenced by counselling which is the main treatment type for 68% of episodes. Over the 5 years from 2008-09, the median duration of closed episodes decreased from 36 days with a high of 42 days in 2011-12.

The median duration for episodes with a main treatment type of support and case management only or other increased (from 22 to 36 days and 47 to 75 days, respectively) (Figure 6.9). There has been no change to the median duration for episodes with the remaining main treatment types over the same period.

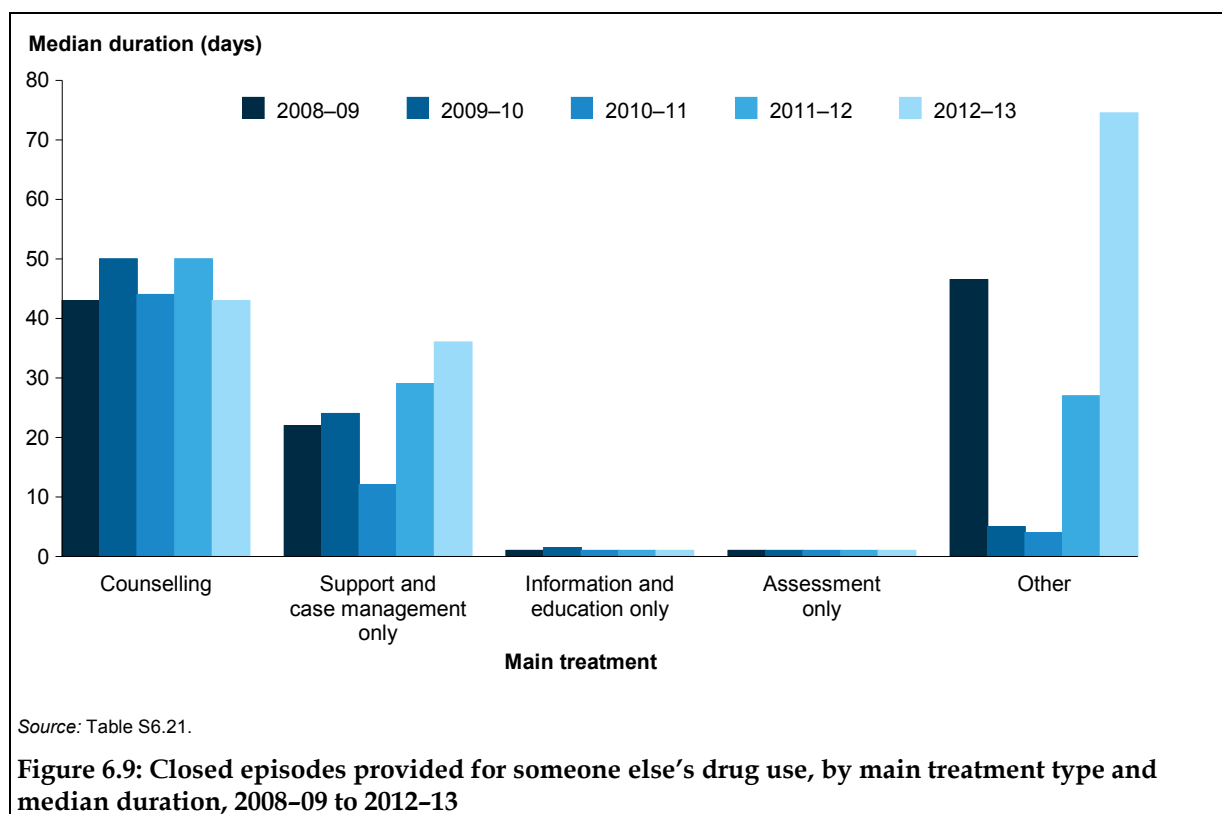


Figure 6.9: Closed episodes provided for someone else's drug use, by main treatment type and median duration, 2008-09 to 2012-13

6.5 Reason for cessation

In 2012-13, three-quarters (75%) of completions recorded an expected cessation. Unexpected cessations accounted for 1 in 9 (11%) completions and 'changes to treatment' (3%) (Table 6.1). Over the 5 years from 2008-09, there was an increase in the proportion of episodes with expected cessations for clients receiving treatment for someone else's drug use (from 69% to 75%), while the opposite is true for episodes with unexpected cessations (decreasing from 17% to 11%) (Table S2.16).

Table 6.1: Reason for cessation grouped by indicative outcome type, 2012-13

Reason for cessation	%
Expected cessation	74.9
Unexpected cessation	11.0
Administrative cessation	3.1
Other	10.9
Total	100.0

7 State and territory comparisons

Alcohol and other drug treatment can vary by state and territory for a range of reasons, including differences in the client profile, such as demographics and drug use patterns, and in service delivery, such as treatment priorities, policy and legislation. This chapter highlights similarities and differences in alcohol and other drug treatment between state and territory jurisdictions. It also focuses on episodes rather than clients. Information on individual states and territories is available in Appendix D (online).

Demographic characteristics

Among the states and territories, the proportion of episodes provided to males ranged from 63% in Western Australia, Tasmania and the Australian Capital Territory to 71% in South Australia (Table S2.3). The proportion of episodes provided to Indigenous clients varied greatly across the states and territories, ranging from 7% in Victoria to 62% in the Northern Territory (Table S2.5). Most episodes were provided to clients aged 20–39, as is the case nationally. The proportion of episodes provided to clients aged 20–29 ranged from 25% in New South Wales and the Australian Capital Territory to 30% in Queensland, while the proportion provided to clients aged 30–39 ranged from 25% in Queensland and the Northern Territory to 30% in New South Wales (Table S2.8).

Principal drug of concern

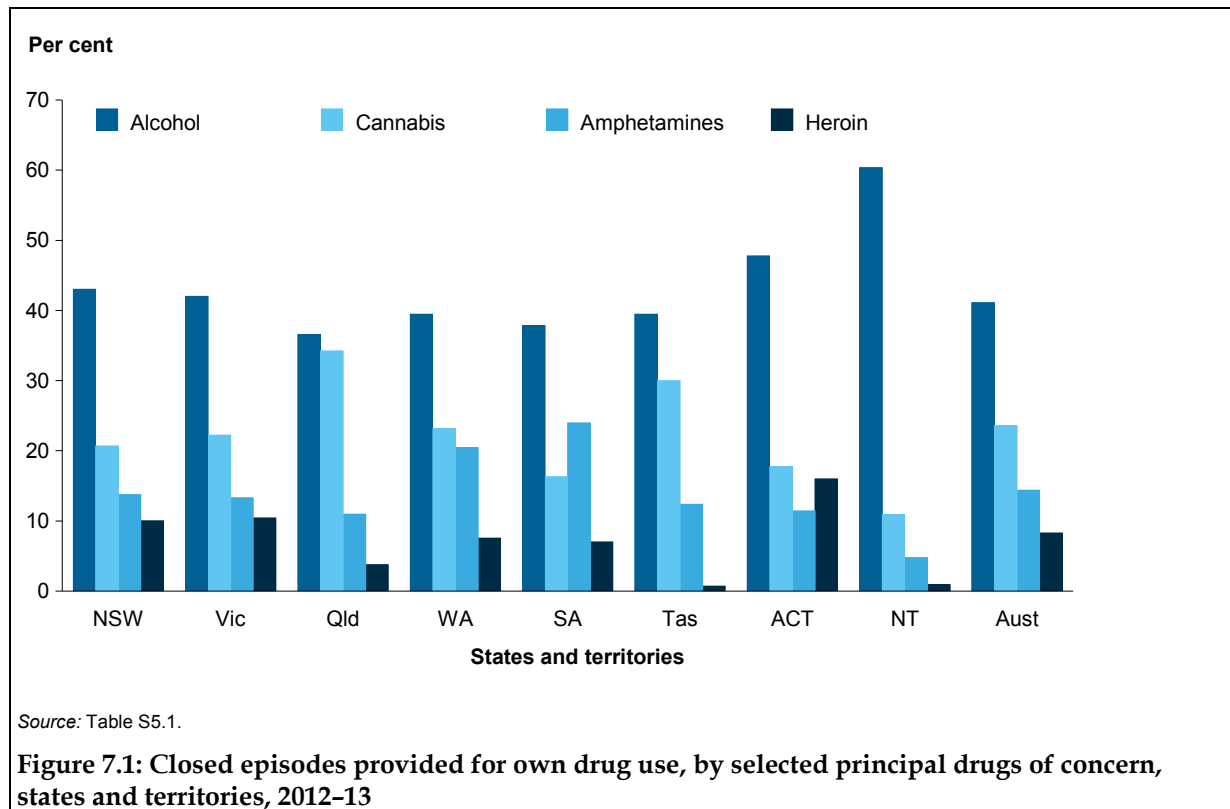
Alcohol was the most common principal drug of concern in all states and territories, ranging from 37% of episodes in Queensland to 60% in the Northern Territory (Figure 7.1). The Northern Territory was half as much again above the national average (41%) for episodes where alcohol was the principal drug of concern (Table S5.1).

After alcohol, cannabis was the next most common principal drug in all states and territories except South Australia, where amphetamines were more common and the Northern Territory where volatile solvents were more common. In Queensland, the proportion of episodes with cannabis as the principal drug of concern was well above the national average (34% compared with 24% nationally), while the opposite was true for the Northern Territory (11%). The Australian Capital Territory reported a lower proportion of episodes where cannabis was the principal drug of concern and the proportion of episodes where heroin was the principal drug was double the national average (16% compared with 8% nationally) (Table S5.1).

Amphetamines were the third most common principal drug of concern nationally, accounting for 1 in 7 (14%) episodes. However, in South Australia, the proportion of episodes with amphetamines as the principal drug was substantially higher than the national average, accounting for almost 1 in 4 (24%) episodes (Table S5.1).

Nationally, both volatile solvents and morphine account for only 1% each of total episodes when they are the principal drug of concern. The Northern Territory was substantially above the national average for volatile solvent treatment, with 14% of closed episodes having volatile solvents as the principal drug of concern. The proportion of episodes where morphine was the principal drug of concern was substantially higher than the national

average in both Tasmania and the Northern Territory (5% and 4% of episodes, respectively) (Table S5.1).

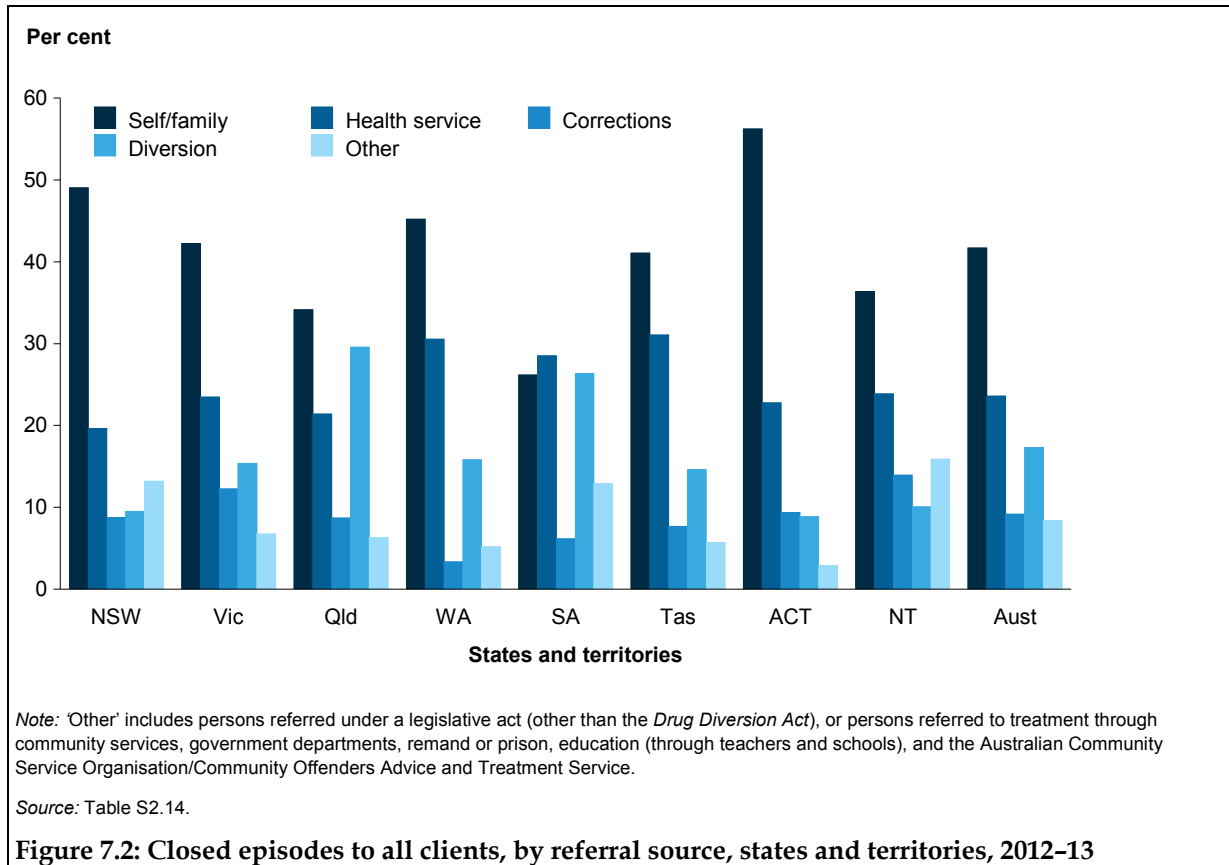


Main treatment type

Counselling was the most common main treatment type in 5 out of 8 states and territories in 2012–13, comprising between 33% and 61% of closed episodes in those states (Table S6.2). Assessment only was the most common main treatment type in South Australia and the Northern Territory (43% and 44% respectively), while in the Australian Capital Territory, information and education only was the most common (22%). The profile of main treatment types varied greatly between states and territories. Withdrawal management, for example, was the main treatment type in 1% of closed episodes in Tasmania, but comprised 21% in Victoria. Similar fluctuations occurred for most main treatment types.

Referral source

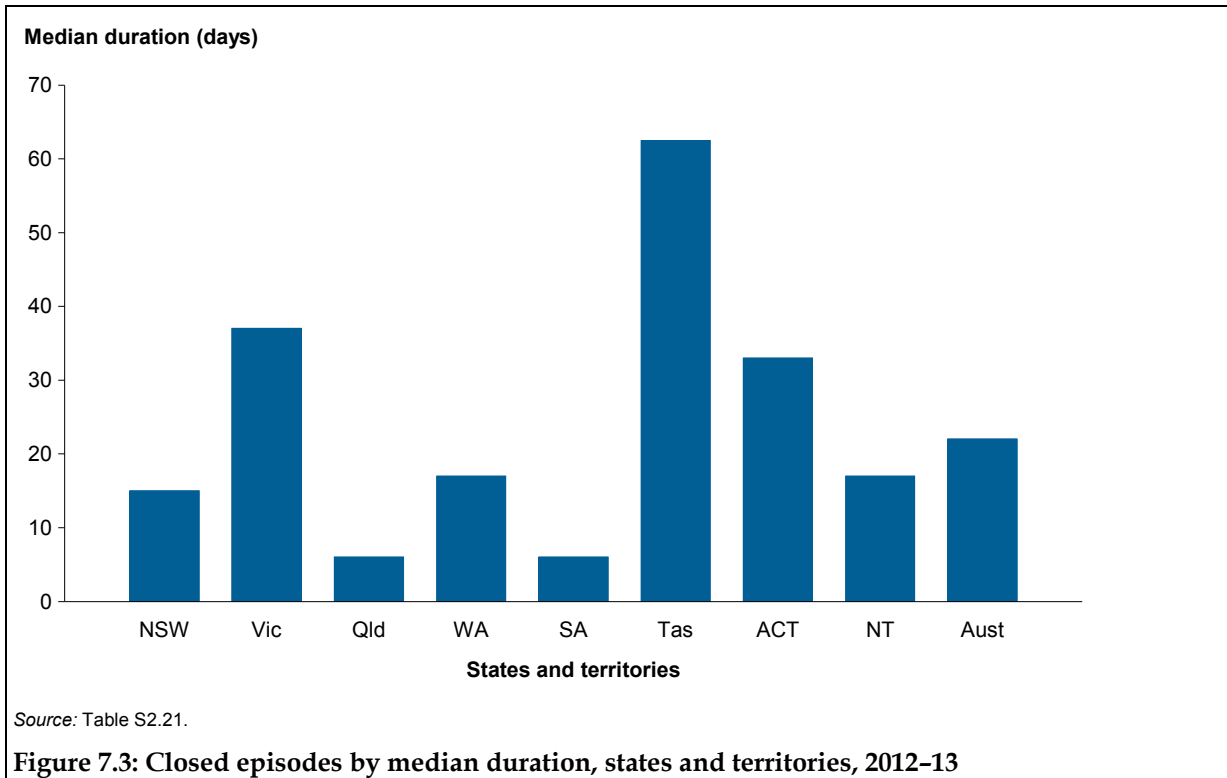
Except for South Australia, self or family was the most common referral source in all states and territories, spanning 34% in Queensland to 56% in the Australian Capital Territory (Figure 7.2). Referral from a health service was also common (24% nationally), and this was the most common referral source in South Australia (28%). Referrals from police or court diversion programs accounted for 17% of episodes (these programs divert people with minor drug offences from the criminal justice system). Among the states and territories, this ranged from 9% in the Australian Capital Territory to 30% in Queensland. Referrals from the corrections system were lowest in Western Australia (3%) and highest in the Northern Territory (14%).



Length of treatment episodes

Among the states and territories, the proportion of closed episodes that ended within 1 month ranged from 31% in Tasmania to 71% in South Australia (Table S2.19).

Nationally, the median duration of episodes closed in 2012-13 was about 3 weeks (22 days) (Figure 7.3). Among the states and territories, the median duration ranged from just under 1 week (6 days) in Queensland and South Australia to more than 2 months (63 days) in Tasmania.



8 Other data sources

8.1 Hospitals

Information on hospitalisations is available from the National Hospital Morbidity Database (NHMD). This database includes almost all public hospitals that provided data for the NHMD in 2012–13. The exception was a mothercraft hospital in the Australian Capital Territory. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities in the Australian Capital Territory, the single private free-standing day hospital in the Northern Territory and a private free-standing day hospital in Victoria.

A hospital separation refers to a completed episode of admitted hospital care ending with discharge, death, transfer or a portion of a hospital stay beginning or ending in a change to another type of care (for example, from acute care to rehabilitation). The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments.

Drug-related separations refer to hospital care with selected diagnoses of substance-use disorder or harm (accidental, intended or self-inflicted) due to selected substances (see Appendix B for details). Hospital separations where the diagnosis of drug-related harm or disorder is additional to the principal diagnosis such as problems related to certain chronic conditions caused by the use of drugs like tobacco and alcohol have been excluded. Hospital separations for drug-related injuries and drug-related allergic responses have also been excluded.

Drugs described in this section include legal, accessible drugs such as alcohol and tobacco, drugs that are available by prescription or over the counter, such as analgesics and antidepressants, and drugs that are generally not obtained through legal means, such as heroin and ecstasy. Therefore, a proportion of the separations reported here may result from harm arising from the therapeutic use of drugs, and the inclusion of therapeutic use in these data may mean the burden on the hospital system appears larger than expected.

About 113,000 hospital separations with a drug-related principal diagnosis were reported in 2012–13 (Table 8.1), which represents 1% of all hospital separations, a similar proportion to previous years.

In 2012–13, sedatives and hypnotics continued to account for the highest proportion of hospital separations with a drug-related principal diagnosis (64% of all such separations), with alcohol making up 88% of separations for sedatives and hypnotics. On its own, alcohol accounted for 56% of all drug-related hospital separations (Table 6.1). Of all separations with a drug-related principal diagnosis, 13% were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for half of this group (7% of all drug-related separations). Stimulants and hallucinogens, including cannabis and cocaine, accounted for 11% of all separations where the principal diagnosis was drug-related.

Separations can be either same-day (where the patient is admitted and separated on the same day) or overnight (where the patient is admitted to hospital and separates on a different date). In 2012–13, overnight separations continued to be more common for drug-related treatment than same-day separations, accounting for 60% of all drug-related separations.

Table 8.1: Hospital separations by drug-related principal diagnosis and duration, 2012–13

Drug-related principal diagnosis	Same-day separations		Overnight separations		Total separations	
	Number	%	Number	%	Number	%
Analgesics						
Opioids (includes heroin, opium and methadone)	2,599	5.8	4,992	7.3	7,591	6.7
Non-opioid analgesics (includes paracetamol)	1,915	4.3	5,610	8.2	7,525	6.7
<i>Total analgesics</i>	<i>4,514</i>	<i>10.0</i>	<i>10,602</i>	<i>15.6</i>	<i>15,116</i>	<i>13.4</i>
Sedatives and hypnotics						
Alcohol	29,105	64.8	34,206	50.2	63,311	56.0
Other sedatives and hypnotics	2,801	6.2	6,160	9.0	8,961	7.9
<i>Total sedatives and hypnotics</i>	<i>31,906</i>	<i>71.0</i>	<i>40,366</i>	<i>59.3</i>	<i>72,272</i>	<i>63.9</i>
Stimulants and hallucinogens						
Cannabinoids (includes cannabis)	1,227	2.7	3,181	4.7	4,408	3.9
Hallucinogens (includes LSD and ecstasy)	100	0.2	115	0.2	215	0.2
Cocaine	261	0.6	183	0.3	444	0.4
Tobacco and nicotine	19	—	41	0.1	60	0.1
Other stimulants (includes amphetamines, volatile solvents)	2,249	5.0	4,616	6.8	6,865	6.1
<i>Total stimulants and hallucinogens</i>	<i>3,856</i>	<i>8.6</i>	<i>8,136</i>	<i>11.9</i>	<i>11,992</i>	<i>10.6</i>
<i>Antidepressants and antipsychotics</i>	<i>1,993</i>	<i>4.4</i>	<i>5,931</i>	<i>8.7</i>	<i>7,924</i>	<i>7.0</i>
<i>Volatile solvents</i>	<i>374</i>	<i>0.8</i>	<i>431</i>	<i>0.6</i>	<i>805</i>	<i>0.7</i>
Other and unspecified drugs of concern						
Multiple drug use	2,247	5.0	2,354	3.5	4,601	4.1
Unspecified drug use and other drugs not elsewhere classified	49	0.1	250	0.4	299	0.3
<i>Total other drugs of concern</i>	<i>2,296</i>	<i>5.1</i>	<i>2,604</i>	<i>3.9</i>	<i>4,900</i>	<i>4.4</i>
<i>Fetal and perinatal related conditions</i>	<i>0</i>	<i>..</i>	<i>27</i>	<i>—</i>	<i>27</i>	<i>—</i>
Total	44,939	100.0	68,097	100.0	113,036	100.0

Note: Separations with a care type of 'Newborn' (without qualified days), and records for 'Hospital boarders' and 'Posthumous organ procurement' have been excluded.

Source: AIHW analysis of the National Hospital Morbidity Database 2012–13.

The total number of drug-related hospital separations has increased from 80,913 in 2003–04 to 113,036 in 2012–13 (Table 8.2). At the same time, total hospital separations have increased, with drug-related hospital separations consistently making up about 1% of all hospital separations across this period.

Alcohol has consistently been the drug-related principal diagnosis with the highest number of hospital separations from 2003–04 to 2012–13, with the number of separations increasing from 40,774 to 63,311 in that time.

Table 8.2: Hospital separations by drug-related principal diagnosis, 2003–04 to 2012–13

Drug of concern	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12	2012–13
Analgesics										
Opioids	6,058	5,849	5,595	6,618	6,992	7,168	7,515	7,517	7,677	7,591
Non-opioid analgesics	6,005	6,525	6,504	5,604	5,679	6,704	6,691	6,557	7,031	7,525
Sedatives and hypnotics										
Alcohol	40,774	42,976	46,683	52,021	54,923	57,532	61,125	61,467	63,230	63,311
Other sedatives and hypnotics	9,571	9,702	9,750	10,062	10,424	10,619	10,404	10,089	9,960	8,961
Stimulants and hallucinogens										
Cannabinoids	2,672	2,881	3,497	3,263	3,047	3,270	3,364	3,745	4,157	4,408
Hallucinogens	190	416	412	362	449	187	169	151	150	215
Cocaine	188	305	234	220	234	230	290	179	286	444
Tobacco and nicotine	49	37	47	59	36	51	50	51	59	60
Other stimulants	4,550	4,005	4,350	4,621	3,844	3,447	3,182	3,997	5,758	6,865
Antidepressants and antipsychotics										
	6,575	6,756	6,615	6,701	6,753	7,661	7,540	7,650	7,907	7,924
Volatile solvents										
	925	1,023	872	816	734	825	780	763	842	805
Other drugs of concern										
Multiple drug use	3,037	2,823	3,078	3,384	3,307	3,039	3,234	4,189	4,384	4,601
Unspecified drug use and other drugs of concern	267	228	206	187	167	241	242	290	297	299
Fetal and perinatal conditions										
	52	46	45	41	43	50	30	34	25	27
Total	80,913	83,572	87,888	93,959	96,632	101,024	104,616	106,679	111,763	113,036
Rate of separation ^(a) (per 100,000 population)	408	417	433	456	460	470	478	481	496	493

(a) Crude rate is based on the Australian estimated resident population as at 31 December of the reference year.

Note: Separations with a care type of 'Newborn' (without qualified days), and records for 'Hospital boarders' and 'Posthumous organ procurement' have been excluded.

Source: AIHW analysis of the National Hospital Morbidity Database 2012–13.

8.2 Online Services Reporting

The number of treatment episodes reported through the AODTS NMDS for Aboriginal and Torres Strait Islander people does not represent all alcohol and other drug treatments provided to Indigenous people in Australia. Information on drug services specifically aimed at Indigenous Australians (funded by the Australian Government) is included in the Online Services Report (OSR) data collection, managed by the AIHW. Key information is provided below and additional information on the definitions used in the OSR, including the definition of 'episodes of care', is in Appendix B.

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2012–13, around 2,600 episodes of care were provided to clients in Australian Government-funded Indigenous residential treatment/rehabilitation services (Table 8.3). Of these episodes of care, 74% were for male clients. It is important to note that these data are not directly comparable with AODTS NMDS data, since definitions of treatment episodes differ between the 2 collections.

In 2012–13, around 24,000 episodes of care were provided to clients accessing Australian Government-funded Indigenous sobering-up or residential respite services. Sobering-up clients are in residential care overnight and do not receive formal rehabilitation, whereas residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. Nearly half (48%) of these episodes were for male clients.

'Other care' refers to a diverse range of non-residential programs, including preventive care, after-care, follow-up and mobile assistance/night patrol. In 2012–13, there were approximately 278,000 episodes of 'other care'. The high number of 'other care' episodes, compared with residential or sobering-up episodes, is due to their short-term nature, with some clients receiving multiple episodes of care over the course of the year (see Appendix B). Over half (55%) of the episodes of 'other care' were for females clients

There were 5 organisations with a large client base that began reporting in 2012–13 that dramatically increased the number of episodes of care, especially for non-residential, follow-up and aftercare services. If episodes of care for these services were excluded, the total episodes of care would be around 113,300, much closer to the numbers reported in previous years (68,000 in 2008–09, 76,000 in 2009–10, 94,000 in 2010–11 and 74,000 in 2011–12). The increase may also be partly due to improvements in data recording and management at health organisations.

Table 8.3: Estimated number of episodes of care provided by Australian Government-funded Indigenous substance use-specific services, by sex and treatment type, 2012–13

Treatment type	Male		Female		Total	
	Number	%	Number	%	Number	%
Residential treatment/rehabilitation	1,952	73.9	642	24.3	48	100.0
Sobering-up/residential respite	11,580	48.0	9,195	38.1	3,349	100.0
Other care ^(a)	113,429	40.8	152,459	54.8	12,279	100.0
Total	126,961	41.6	162,296	53.2	15,676	100.0

(a) Sex was reported as 'unknown' in 95 episodes of care and these have been excluded for analysis purposes.

Source: *Aboriginal and Torres Strait Islander health services report 2011–12* (AIHW 2014a)

8.3 Specialist Homelessness Services

The Specialist Homelessness Services Collection (SHSC) began on 1 July 2011. The SHSC describes all clients who receive services from specialist homelessness agencies and the assistance they receive, including clients with an alcohol and other drug issue.

For this report, a client is identified as having a current alcohol and other drug issue in this collection if they provided any of the following information:

- Their formal referral source to the specialist homelessness agency was a 'drug and alcohol service'.
- They reported 'problematic drug or substance use' or 'problematic alcohol use' as a reason for seeking assistance.
- At some stage during their support period, a need was identified, provided or referred for 'drug/alcohol counselling'.
- They reported they had been in a rehabilitation facility in the last 12 months.

In addition to supporting clients who are homeless, a key aim of specialist homelessness services is to prevent homelessness from occurring among those who find themselves at risk of becoming homeless. Services provided by Specialist Homelessness Services (SHS) agencies include accommodation and associated support services. For further details regarding the scope and coverage of the SHSC, see Appendix B.

The SHSC includes data on the use of specialist homelessness services by clients with an alcohol and other drug issue. This section presents information provided by SHS agencies on clients with a current alcohol and other drug issue for 2012–13.

Drug and alcohol-related support

There were nearly 194,000 (SHS clients aged 10 years or over reported in 2012–13 (AIHW 2013b). Of these, 12,964 (7%) were clients with a current alcohol and other drug issue.

Nationally, there were 1.3 clients per 100,000 population with a current alcohol and other drug issue who accessed accommodation services from SHS agencies in 2012–13. Across jurisdictions, rates ranged from 3.4 per 100,000 population for the Northern Territory to 0.6 for Western Australia.

For other types of support services provided (excluding accommodation services), the national rate was 30.9 per 100,000 population for general assistance and support, and 23.0 per 100,000 for specialised services.

Specialist Homelessness Services clients

For clients with a current alcohol and other drug issue, those aged 30–39 had the highest rate of SHS agency use (119 per 100,000 population) followed by 40–49 year olds (92) for 2012–13. Rates of SHS agency use were higher for males than females (71 and 43 per 100,000 population, respectively).

The rate of SHS clients with a current alcohol and other drug issue for Indigenous Australians was 11 times that for non-Indigenous Australians (4,599 and 409 per 100,000 population, respectively).

There were over 1,500 clients with a current alcohol and other drug issue aged 10–19.

A specialist homelessness agency/outreach worker was the most frequently recorded source of referral to SHS agencies (12%) for clients with a current alcohol and other drug issue during 2012–13. The next most frequently recorded sources were referrals from other agencies (government or non-government) (11%) and referrals from drug and alcohol services (9%).

More than half of SHS clients (53%) with a current alcohol and other drug issue reported an episode of homelessness in the 12 months before presenting, compared to 28% of those clients without a current alcohol and other drug issue (AIHW 2013b).

Service use

Main reason for seeking SHS agency assistance

Around 1 in 7 SHS clients (14%) with an alcohol and other drug issue had time out from family/other situation as the main reason for seeking assistance, followed by unemployment (13%) and relationship/family breakdown (12%). In terms of alcohol and other drug issues being the main presenting reason, only 5% of SHS clients with a current alcohol and other drug issue had this reason recorded as their main reason for seeking assistance.

When all presenting reasons for seeking assistance are considered, unemployment (65%) and financial difficulties (52%) are the most frequently reported reasons.

Services and assistance

About 111,000 services were provided to SHS clients with a current alcohol and other drug issue in 2012–13. Of these, nearly 8 out of 10 (78%) related to general support and assistance, such as providing advice and information (support services not related directly to housing/accommodation services). Only 2% of services were provided for drug/alcohol counselling.

Length of support provided

More than two-thirds of clients with a current alcohol and other drug issue received over 180 days of support (67%) in 2012–13. About 1 in 16 clients received 5 days or less (6%).

8.4 National Opioid Pharmacotherapy Statistics Annual Data

Although the AODTS NMDS captures some information on pharmacotherapy treatment, more comprehensive information on pharmacotherapy treatment provided in relation to opioid use is available from the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection.

Treatment of opioid dependence using pharmacotherapy is administered according to the laws of the relevant state or territory, and within a framework that may include not only medical treatment but also social and psychological treatment.

The Australian Government contributes funds for the provision of pharmacotherapy drugs via pharmaceutical benefits arrangements. These drugs are prescribed by medical professionals and provided to clients through clinics and pharmacies approved by state and territory governments. Three pharmacotherapy drugs are currently available for the

treatment of opioid dependence in Australia: methadone, buprenorphine and buprenorphine-naloxone (naloxone is added to deter injection).

Clients

The most recent report on the NOPSAD collection (AIHW 2014c) showed that over 47,000 people were on a course of pharmacotherapy treatment for their opioid dependence on a snapshot day in June 2013. The number of people receiving opioid pharmacotherapy treatment almost doubled between 1998 (from around 25,000 people) and 2013, but growth in client numbers slowed in recent years (to less than 1% a year from 2010 to 2013).

Around two-thirds (69%) of clients in 2013 were aged 30–49, and this proportion has been fairly consistent since 2006. However, from 2006 to 2013 the proportion of clients aged less than 30 more than halved (from 28% to 11%), and the proportion of clients aged 50 and over more than doubled (from 8% to 19%). These trends suggest an ageing cohort of people in opioid pharmacotherapy treatment.

Around two-thirds (65%) of clients receiving pharmacotherapy on a snapshot day in June 2013 were male. This proportion was similar for each of the 3 pharmacotherapy types (methadone, buprenorphine and buprenorphine-naloxone) and has remained stable since 2006.

About 1 in 10 clients (9%) who received pharmacotherapy identified as Aboriginal or Torres Strait Islander. This excludes Victoria and Western Australia which do not report Indigenous status). Indigenous people were around 3 times as likely to have received pharmacotherapy treatment as the non-Indigenous population. Indigenous clients were more likely to be treated with methadone (73%) than non-Indigenous pharmacotherapy clients (66%).

Clients receive pharmacotherapy treatment for a range of opioid drugs. These include illicit opioids (such as heroin) and pharmaceutical opioids, which are obtained illicitly or are available by prescription (such as morphine and oxycodone) or over-the-counter (such as codeine–paracetamol combinations). At the national level, opioid pharmacotherapy clients were about twice as likely to report heroin as an opioid drug of dependence than they were for opioid pharmaceuticals; however this varied by jurisdiction.

Around two-thirds (67%) of clients were treated with methadone in 2013, and the remaining one-third (33%) were treated with a form of buprenorphine. Treatment with methadone ranged from 31% of clients in the Northern Territory to 79% of clients in the Australian Capital Territory.

Prescribers

Methadone and buprenorphine are controlled drugs, and health professionals need authorisation to prescribe them to clients. Nationally, there were 2,025 authorised prescribers of opioid pharmacotherapy drugs in 2013, an increase of 15% from 2012. The majority of these prescribers were authorised to prescribe more than 1 type of drug (71%) and worked in the private sector (82%).

Dosing points

Most clients need to attend a dosing point regularly to take their opioid pharmacotherapy drug under supervision. Nationally, there were 2,355 dosing points in Australia in 2013. The

majority were located in pharmacies (88%), followed by hospitals, public clinics and correctional settings such as prisons.

8.5 Prisoner health

Prisoners typically have far greater health needs than the general population, with high levels of drug use, mental health disorders, chronic disease, communicable disease and disability (AIHW 2013c; Hockings et al. 2002; Indig et al. 2010). State and territory governments are responsible for providing health services to prisoners. In most states and territories, health departments deliver these services, although in some, these services are provided by the department responsible for corrective services or by private organisations (AIHW 2013c). The AIHW's National Prisoner Health Data Collection (NPHDC) contains data on prisoner health in Australia. The following information is based on the most recent collection, as reported in *The health of Australia's prisoners 2012* (AIHW 2013c).

Alcohol and other drug use

Almost 4 in 5 (78%) prison entrants during the survey period were daily smokers (AIHW 2013c). This is much higher than the general population aged 18 and over, with less than 1 in 8 people age 18 years and over (13%) being daily smokers in 2013 (AIHW 2014b). However, prisoners are younger than the average age of the general population, which will influence their drug use prevalence. Similar differences apply to weekly or irregular smokers, comprising 6% of prison entrants (AIHW 2013c) but only 3% of the general population aged 18 and over.

Nearly half (46%) of prison entrants consumed alcohol in the previous 12 months at levels placing them at a high risk of alcohol-related harm, while a further 29% were at a low risk of alcohol-related harm (AIHW 2013c). By comparison, among the general population in 2013, 19% of people aged 18 years and over consumed alcohol at levels placing them at high risk of harm across their lifetime, while 61% were at low risk (AIHW 2014b).

Consuming alcohol at high risk levels was more likely for those in the younger prisoner age groups (50% for entrants aged 18–24 compared with 39% for those aged 45 and over), although there was little difference in the low risk proportion of prison entrants (AIHW 2013c).

Seven in 10 (70%) prison entrants reported using illicit drugs in the 12 months before their imprisonment (AIHW 2013c). This was higher than the general population aged 18 and over, with less than 2 in 10 (15%) having used illicit drugs in the previous 12 months (AIHW 2014b). In both contexts, however, illicit drug use was less common among those aged in their mid-40s and over.

Cannabis was used by half (50%) of prison entrants in the previous 12 months, and was the most commonly used illicit drug. Among the general population aged 14 and over, 1 in 10 people (10%) reported using cannabis in the previous 12 months in 2013 (AIHW 2014b). Use of amphetamines was also common among prison entrants, particularly in the younger age groups (39% for 18–24 and 43% for 25–34, compared with 16% for those aged 45 and over).

A large proportion of prison entrants reported having comorbid mental health and drug issues. Of those who had been told they had a mental health disorder, 50% had a high risk of alcohol-related harm, 86% were current smokers and 76% had used drugs in the 12 months

before their current imprisonment (Figure 6.36). Proportions were similar for those referred to mental health services after assessment.

Health services provided to prisoners

Of the 9,027 visits to prison clinics during the 2-week data collection period, 5% related to alcohol or other drug use (AIHW 2013c). Three-fifths (61%) of these visits resulted in treatment being provided and a further two-fifths (42%) resulted in advice and education (more than 1 service could be provided). For almost half (46%), only assessment was provided.

During the 1-day data collection period, 5% of prisoners received drugs for opioid dependence and 1% received drugs for nicotine dependence (AIHW 2013c). Those in the 25–34 and 35–44 age groups were most likely to receive drugs for opioid dependence (9% and 7%, respectively), while those in the 18–24 age group were most likely to receive drugs for nicotine dependence (3%).

Information on the differences between the data collection periods is available in *The health of Australia's prisoners 2012* (AIHW 2013c).

Appendix A: Data quality statement for the AODTS NMDS

Summary of key data quality issues

Data are reported by each state and territory regardless of funding type. Because all services are publicly funded, they receive at least some of their funding through a state, territory or Australian Government program. The actual funding program cannot be differentiated; however services are categorised according to their sector, with government funded and operated services reported as public services and those operated by non-government organisations reported as private services.

National data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between them. Also, the AODTS NMDS has been implemented in stages, so comparisons across years, particularly the earlier years of the collection, need to be made with caution. Data for 2001–02 and 2002–03 have not been included in the 2012–13 annual report due to these comparability issues.

The AODTS NMDS reports both main and additional treatment types. However, Victoria, Western Australia and Tasmania do not differentiate between main and other treatment types. Caution should be used in comparing episodes from these states with those of other states and territories.

As a unit of measurement, the ‘closed treatment episode’ used in the AODTS NMDS cannot 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. This is because it is possible for a single individual to access more than 1 service at a time, for different treatments and for different substance-use problems.

However, in 2012–13, the AODTS NMDS implemented an SLK for the first time. This linkage key enables the number of clients receiving treatment to be counted while continuing to ensure the privacy of these individuals, in addition to reporting on closed treatment episodes.

With the introduction of the SLK, a number of client-based analyses will be possible including:

- estimating the number and rate of clients receiving treatment and the remoteness and socioeconomic distribution of the client in the 2012–13 and 2013–14 annual reports
- more complex analyses on patterns of drug use and pathways through treatment, as data with unique client counts accumulate over time.

Description

The AODTS NMDS presents data about alcohol and other drug treatment services, their clients, drugs of concern and the types of treatment received. The AODTS NMDS counts treatment episodes completed during the collection period, which for this collection was 1 July 2012 to 30 June 2013. This includes all clients who had completed 1 or more treatment episodes at an alcohol and other drug treatment service that was in scope during 1 July 2012 to 30 June 2013.

The AODTS NMDS is a collection of data from publicly funded treatment services in all states and territories, including those directly funded by the Australian Government Department of Health (DoH). Publicly funded alcohol and other drug treatment agencies collect the agreed data items and forward this information to the appropriate health authority as arranged. Agencies ensure that the required information is accurately recorded.

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 at that level.

Institutional environment

Under a Memorandum of Understanding with the DoH, the AIHW is responsible for the management of the AODTS NMDS. The AIHW maintains a coordinating role in the collection, including providing secretariat duties to the AODTS NMDS Working Group, undertaking data development and highlighting national and jurisdictional implementation and collection issues. The AIHW is also the data custodian of the national collection and is responsible for collating data from jurisdictions into a national data set and analysing and reporting on the data.

The AIHW is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, from health and welfare expenditure, hospitals, disease and injury and mental health to ageing, homelessness, disability and child protection.

The AIHW also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The AIHW works closely with government and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national data sets based on data from each jurisdiction, to analyse these data sets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance with the *Privacy Act 1988* (Cwlth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website <www.aihw.gov.au>.

Timeliness

The state and territory health departments and the Australian Government DoH provide data to the AIHW using the AIHW's online data validation tool (Validata). This tool allows data suppliers to upload their data files and have them validated immediately. For the 2012–13 collection, data were due for submission through the Validata at the end of

November 2013 with final approval of all data due at the end of December 2013. The 2012–13 collection was finalised in mid-February 2014.

Accessibility

Publications containing AODTS NMDS data, including the annual *Alcohol and other drug treatment services in Australia* reports, are available on the AIHW website <www.aihw.gov.au>. These reports are available for download free of charge. To enhance data availability, a series of extensive supplementary tables accompanying the annual report is also available online.

Requests for unpublished data can be made by contacting the AIHW on (02) 6244 1000 or by email to info@aihw.gov.au. A cost-recovery charge may apply to requests that require substantial resources. Depending on the nature of the request, requests for access to unpublished data may require approval from the data custodians or the AIHW Ethics Committee.

Interpretability

Contextual information on the alcohol and other drug treatment sector is available in the annual *Alcohol and other drug treatment services in Australia* reports. Supporting information about the data includes footnotes to tables and figures and details about the data items and methods used in reporting, as well as glossary items.

Metadata for the AODTS NMDS is available from METeOR, the AIHW's online metadata repository. METeOR specifications for the collection can be accessed from <<http://meteor.aihw.gov.au/content/index.phtml/itemId/466861>>.

Relevance

The AODTS NMDS contains information on treatment episodes provided by publicly funded alcohol and other drug treatment services.

Data on agencies

The AODTS NMDS contains information on publicly funded alcohol and other drug treatment services. Agencies are excluded from the AODTS NMDS if they:

- do not receive any public funding
- provide accommodation as their main function (including half-way houses and sobering-up shelters)
- are located in prisons or detention centres
- are located in acute care or psychiatric hospitals and only provide treatment to admitted patients
- have the sole function of prescribing or providing dosing for opioid pharmacotherapy (these agencies are excluded because of the complexity of this sector).

Australian Government-funded primary health care services and substance-use services are in scope for the AODTS NMDS, but most of these agencies do not contribute to the collection as they currently provide data to other collections.

For each agency in the AODTS NMDS, data are collected on the geographical location of the agency.

Data on treatment episodes

The AODTS NMDS contains information on all treatment episodes provided by in-scope agencies where the episode was closed in the relevant financial year. A treatment episode is considered closed where:

- The treatment is completed or has ceased.
- There has been no contact between the client and treatment provider for 3 months.
- There is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy and not receiving any other form of treatment that falls within the scope of the collection
- only include activities relating to needle and syringe exchange
- are for a client aged under 10.

For each treatment episode in the AODTS NMDS, data are collected on:

- the client: sex, date of birth, Indigenous status, country of birth, preferred language, source of referral and injecting drug status
- whether the client is receiving treatment for their own drug use or someone else's drug use
- the drugs of concern (principal drug of concern and up to 5 additional drugs of concern)
- the method of use for the principal drug of concern
- types of treatment (main treatment type and up to 4 additional treatment types)
- the start and end dates of the episode and the reason the episode was closed.

Data on clients

The AODTS NMDS does not contain a unique identifier for clients and information about clients is collected at the episode level. For the 2012–13 collection, an SLK was introduced to enable the number of clients receiving treatment to be counted while continuing to ensure the privacy of these individuals receiving treatment.

The SLK is constructed from information about the client's date of birth, sex and an alphacode based on selected letters of their name.

Because SLK data are not available for all clients, an imputation strategy has been developed to adjust the data to account for this. Further information about the imputation methodology applied to these data can be found in Appendix C.

Accuracy

Data for the AODTS NMDS are extracted each year from the administrative systems of the health departments or are provided by the treatment agencies directly to the health departments. These data are then collated by the health departments according to the definitions and technical specifications agreed to by the departments and the AIHW.

Data for the AODTS NMDS are available from 2001–02; however, due to comparability issues, only data from 2003–04 onwards are used in this report.

Almost all jurisdictions submitted over 90% of in-scope treatment services provided data for the AODTS NMDS in 2012–13, except for New South Wales who provided 80% of in-scope agencies; the other jurisdictions ranged from 91% in the Australian Capital Territory to 100% in Western Australia, the Northern Territory and Tasmania. Each in-scope treatment service is required to provide information on each agency related to the service (including delivery outlets). However, some services only provide information on the main administrative centre. As a result, the number of treatment agencies may be under counted (information on the number of agencies for which data are not provided is not available).

Overall, the coverage of episode data in the AODTS NMDS for 2012–13 is good. For most data elements, less than 2% of records have missing data (including not stated or unknown responses) while around 6% of records have an unknown Indigenous status. Of the records relating to episodes provided to clients receiving treatment for their own drug use, reason for cessation is not available for 4%, method of drug use is not available for 6% and injecting drug use status is not available for 16%.

Not all jurisdictions code drug of concern using the full *Australian Standard Classification of Drugs of Concern 2011* (ABS 2011a) but rather use a short list of drug codes. As a result, some specific drugs may be under-reported. For example, oxycodone may be recorded as ‘opioid analgesics n.f.d.’ rather than the specific oxycodone code.

State and territory issues

New South Wales

New South Wales Health collects data from all Australian Government/state government-funded agencies as part of requirements stipulated in a signed service agreement at the commencement or renewal of each funding agreement. Data are provided monthly by agencies to their respective Local Health Districts (LHD). There are a number of data collection systems in use and development. The New South Wales Minimum Data Set is collected by those systems from which the collection of the AODTS NMDS is provided. New South Wales is developing a State Baseline Build related to alcohol and other drugs that will roll out to New South Wales through the CHIME and Cerner systems over the next few years. The majority of NGO data are collected via the Network of Alcohol and other Drug Agencies (NADA) online system. NADA is the peak organisation for the non-government drug and alcohol sector in New South Wales.

Victoria

The Victorian Drug Treatment Service Program provides a range of services to cover the needs of clients experiencing substance abuse issues. The Victorian Government purchases these drug treatment services from independent agencies (non-government organisations) on behalf of the community, and has developed the concept of an ‘episode of care’ as the fundamental unit for service funding. An episode of care is a particular course of treatment in which the client achieves at least 1 significant treatment goal under the care of an alcohol and other drug worker.

The episode of care is a measure of successful client outcomes. It aims to develop performance measurement beyond activities, throughputs and outputs, to measure what the client gets out of treatment. Agencies funded to provide drug treatment services in Victoria have service provision targets, which are defined in terms of number of episodes of care to be provided by service type and by target group (for example, youth or adult). As a requirement of their funding agreement with the Victorian Department of Health, agencies

are required to submit data quarterly, detailing their provision of drug treatment services and achievement of episodes of care. A subset of this data is contributed to the AODTS NMDS annually.

Victorian alcohol and other service providers use either SWITCH, FullADIS or their own internal information systems to report quarterly activity. However, since 2007–08, hospital and community health centres have used the HealthSMART client management systems to report on alcohol and other drug treatment activity.

Victoria does not differentiate between main and other treatment types. As such, Victoria is not directly comparable with other jurisdictions because every treatment type provided is reported as a separate episode. Caution should be used in comparing Victorian episodes with those of other states and territories.

Victoria only provides information about non-government agencies that receive public funding.

In Victoria, assessment only episodes include brokerage services wherein clients with drug conditions who have received sentences are assessed, a treatment plan developed, and the necessary treatment purchased from community-based alcohol and other drug treatment agencies. The very nature of these types of episodes results in durations that may exceed 90 days. Following the implementation of a new operational system for brokerage services, from October 2011 brokerage assessments for treatment are closed when the client is referred to the nominated agency funded to delivery, rather than at the completion of treatment by that agency. This will result in a significant reduction in the duration of these episodes. As the actual completion date was not available for episodes from October 2011 onwards, episodes for these brokerage assessments were given a nominal completion date that was equal to the commencement date as most assessments are completed within 1 day. Actual completion dates were reported from 2012–13.

Queensland

The Queensland Department of Health collects data from all Queensland Government alcohol and other drug treatment service providers and from all Queensland Illicit Drug Diversion Initiatives – Police and Court Diversion clients. The Australian Government currently collects data from the Australian Government-funded agencies operating in Queensland.

The Queensland Department of Health has a state-wide web-based clinical information management system supporting the collection of AODTS NMDS items for all Queensland Government alcohol and other drug treatment services.

Since 2007, the Queensland Department of Health has funded the Queensland Network of Alcohol and Drug Agencies Ltd (QNADA) to collate and deliver to the Queensland Department of Health aggregated AODTS NMDS data for the AOD non-government sector.

Care should be taken when interpreting principal drug of concern over time for Queensland, as Queensland did not provide data consistent with the AODTS NMDS specifications in 2001–02.

Treatment provided to people diverted to services by police and the courts is recorded as information and education only. Actual treatment involves a 2-hour treatment session that includes extensive alcohol and drug assessment to determine dependence, assessment of risk-taking behaviours, provision of advice and information on reducing/ceasing drug use and harm minimisation, motivational intervention, provision of resources and referral.

Western Australia

In Western Australia, clients are able to access treatment services from multiple sites within a single episode depending on client needs and appointment availability.

Data are provided by both government and non-government sectors. Non-government services are contracted by the Drug and Alcohol Office (DAO) to provide alcohol and drug services. They have contractual obligations to incorporate the data elements of the AODTS NMDS in their collections. They are also obliged to provide data in a regular and timely manner to DAO. These data are collated and checked by DAO before submission to the AIHW annually.

Due to the increase in integrated services that include government and non-government service providers, caution should be used in comparing services in Western Australia with those in other states and territories and across years. Services in Western Australia are not directly comparable with other states, or previous years, because of the growth of integrated services that include government and non-government service providers.

In Western Australia, a reform in the way non-residential treatment services are provided in the Perth metropolitan area has resulted in the co-location and integration of some government and non-government services. Time series data do not adequately illustrate these changes.

Western Australia reviews the geographical demographics of their clients regularly throughout the year and adjusts the locations of their service delivery outlets accordingly to meet the demands of the population. Therefore, variation between *Remote* and *Very remote* locations exists between years.

Clients are generally able to access the agencies from multiple sites within any 1 episode, depending on the client's need and the availability of appointments within the alcohol and other drug treatment service. Examples of where these situations occur are when clients:

- follow a specific worker from 1 service delivery outlet to another
- change workers during an episode and the workers are located at different service delivery outlets
- attend 1 service delivery outlet for the initial service contact (commencement of episode) due to availability of appointment times and move to a more convenient service delivery outlet during the episode
- move between service delivery outlets to fit service contacts within clients' other personal needs.

Western Australia does not differentiate between main and other treatment types. Caution should be used in comparing Western Australian episodes with those of other states and territories. As such, Western Australia is not directly comparable with other jurisdictions because every treatment type provided is reported as a separate episode. Note that a small number of episodes provided in Western Australia through the Non-Government Organisation Treatment Grants Program (NGOTGP) will have additional treatment types.

South Australia

Data are provided by government (Drug and Alcohol Services South Australia – DASSA) and non-government alcohol and other drug treatment services.

Non-government alcohol and other drug treatment services in South Australia are subject to service agreements with the South Australian Minister for Mental Health and Substance

Abuse. As part of these service agreements, non-government organisations are required to provide timely client data in accordance with the AODTS NMDS guidelines. Data are forwarded to DASSA for collation and checking. DASSA then forwards cleaned data to the AIHW annually. DASSA does not collect information directly from those services funded by the NGOTGP. These data are provided to DoH via AIHW.

This year, for the first time, the South Australian Police, Drug Diversion Assessment Program data has been included in the collection. This has seen an increase in episodes with a referral source of police diversion and a main treatment type of assessment only.

Tasmania

Data are provided by both government (Alcohol and Drug Services – ADS) and non-government organisations (NGOs).

NGOs funded by the Tasmanian Government provide AODTS NMDS and key performance indicator data under the provisions of a service agreement. AODTS NMDS data are submitted to ADS State Office either 6-monthly or yearly. Data quality reports are fed back to the NGOs and training/information on data capture practices are provided as required.

ADS uses the iPM patient administration system as its key business system. This state-wide system is in use across the 3 Tasmanian Health Organisations (THOs), which include inpatient, residential, outpatient and community service settings. It has been modified to capture the AODTS NMDS data items. A range of online self-service reporting is used to monitor performance activity and data quality.

Tasmania's illicit drug diversion treatment data are managed and extracted from the Drug Offence Reporting System (DORS). This system resides with Tasmania Police. A high proportion of treatment episodes in Tasmania with the principal drug of cannabis can be attributed largely to the inclusion of this data.

The Tasmania Early Intervention Project (TEIP) commenced in 2011. This project focuses on young people and involves a police caution that facilitates a referral for young people to an alcohol and other drug treatment service for brief or opportunistic intervention. AODTS NMDS data for this program are entered via the iPM patient administration system.

Training in culturally sensitive practice has been provided for service providers across the Tasmanian alcohol and other drug service sector. Despite this, Tasmanian data reporting for Indigenous status remains low.

NGOs funded by the Tasmanian Government provide AODTS NMDS and key performance indicator data under the provisions of a service agreement. AODTS NMDS data are submitted to Alcohol and Drug Service State Office on either a 6-monthly or yearly basis. Data quality reports are fed back to the NGOs and training/information on data capture practices are provided as required.

Australian Capital Territory

Australian Capital Territory alcohol and other drug treatment service providers supply the Health Directorate with their complete data collection for the AODTS NMDS by 31 August each financial year, as specified in their Service Funding Agreement. Since 1 July 2007 the treatment service providers have been encouraged to use a standardised reporting system developed by the Health Directorate to enhance uniformity and reliability of data.

Northern Territory

Alcohol and other drug treatment services in the Northern Territory are provided by government and non-government agencies. The bulk of services provided through non-government agencies are funded via service-level agreements with the Northern Territory Department of Health. All funded agencies are required to provide the AODTS NMDS data items to the department on a regular and timely basis as part of a larger data collection. Summary statistical reports are sent to all agencies every 6 months detailing client activity for the previous 12 months.

Australian Government Department of Health (DoH)

DoH funds a number of alcohol and other drug treatment services under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program (NGOTGP). These agencies are required to collect data (according to the AODTS NMDS specifications) to facilitate the monitoring of their activities and to provide quantitative information to the Australian Government on their activities. Data from these agencies are generally submitted to the relevant state/territory health authority, except for a number of agencies in New South Wales, Queensland, Western Australia and South Australia, which submit data annually to DoH. In 2012–13 for the first time, the data was submitted to DoH via the AIHW. In addition to NGOTGP agencies, a small number of agencies funded under the DoH Substance Misuse Service Delivery Grants Fund (SMSDGF) reported data to the AIHW.

Reported numbers for each state and territory in the AODTS NMDS annual report include services provided under the National Illicit Drug Strategy NGOTGP and SMSDGF.

To ensure consistency with previous years' data, where an organisation's sub-agencies had been given more than 1 establishment identifier, those identifiers were used and so sub-agencies were counted as separate agencies. When an organisation's sub-projects had been given 1 establishment identifier, only this establishment identifier was used, and so counted as 1 agency.

Coherence

The AODTS NMDS was initially developed from 1996–2001 and the first report containing data from the data set was published in 2002. The data specifications were significantly altered for the 2003–04 collection and data from 2000–01 to 2002–03 are not comparable with data from later years.

In 2011, the Australian Bureau of Statistics (ABS) updated the standard geography used in Australia for most data collections from the *Australian Standard Geographical Classification* (ASGC) to the *Australian Statistical Geography Standard* (ASGS). Also updated at this time were remoteness areas based on the 2011 ABS Census of Population and Housing (ABS 2011b). The new remoteness areas (RA) will be referred to as RA 2011, and the previous remoteness areas as RA 2006.

Data for previous years reported by remoteness are reported for RA 2006. Data for 2012–13 are reported for RA 2011. The AIHW considers the change from RA 2006 to RA 2011 to be a series break when applied to data supplied for this indicator; therefore remoteness data for 2011–12 and previous years are not comparable to remoteness data for 2012–13 and subsequent years.

Appendix B: Information about the data and methods

Age

Age is calculated as at the start of the episode.

Alcohol and other drug treatment provided by services funded to assist Indigenous Australians

The number of treatment episodes reported through the AODTS NMDS for Aboriginal and Torres Strait Islander people does not represent all alcohol and other drug treatments provided to Indigenous people in Australia for 2012–13. Data for the majority of Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services are available from the Online Services Report (OSR) data collection (AIHW 2014a). In the 2012–13 OSR, 63 substance use-specific services provided data.

This appendix presents a selection of data from the 2012–13 OSR. The OSR and AODTS NMDS have different collection purposes, scope and counting rules. For example, the OSR collects service-level estimates for client numbers and episodes of care, whereas the AODTS NMDS collects unit records for closed treatment episodes. The definitions of ‘closed treatment episodes’ (AODTS NMDS) and ‘episodes of care’ (OSR) are not consistent (Box B1).

In 2012–13, 27 out of the 63 Australian Government-funded substance use-specific services reporting in the OSR also reported to the AODTS NMDS.

Box B1: Comparison of treatment episode definitions in the OSR and AODTS NMDS

The OSR definition of ‘episode of care’ starts at admission and ends at discharge (from residential treatment/rehabilitation and sobering-up/respite). In the case of ‘other care’, the definition of ‘episode of care’ relates more to the number of visits or phone calls undertaken with clients. In contrast to the definition of ‘closed treatment episode’ used in the AODTS NMDS, the definition used in this collection does not require agencies to begin a new ‘episode of care’ when the main treatment type (‘treatment type’) or primary drug of concern (‘substance/drug’) changes. It is therefore likely that this concept of ‘episode of care’ produces smaller estimates of activity than the AODTS NMDS concept of ‘closed treatment episode’.

The OSR collection, managed by the AIHW, records information about clients of any age, whereas the AODTS NMDS reports only about clients aged 10 and over. Any comparisons drawn between the collections should therefore be made with caution.

Substance use-specific services

In 2012–13, an estimated 49,686 people were seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services (Table B1).

Table B1: Estimated number of clients seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services, by jurisdiction and Indigenous status, 2012–13

Indigenous status	NSW	Vic/Tas	Qld	WA	SA	NT	Total
Indigenous	4,547	2,650	4,791	5,030	3,279	20,501	40,798
Non-Indigenous	1,446	275	2,542	868	415	2,524	8,070
Total clients (number)	23	90	141	177	24	363	818
Total clients (%)	6,016	3,015	7,474	6,075	3,718	23,388	49,686

Note: The total estimated number of clients refers to individual clients, and does not include clients that attended groups only.

Source: Aboriginal and Torres Strait Islander health services report 2011–12 (AIHW 2014a)

Substance-use treatment and assistance

Aboriginal and Torres Strait Islander primary health-care services provide a variety of health care services, including extended care roles (for example, diagnosis and treatment of illness and disease, 24-hour emergency care, dental/hearing/optometry services), preventive health care (for example, health screening for children and adults), health-related community support (for example, school-based activities, transport to medical appointments) and support in relation to substance-use issues.

The number of clients who received alcohol or other drug treatment at Aboriginal and Torres Strait Islander primary health-care services is not collected in the OSR. Similarly, the number of reported episodes of care that related solely or partially to alcohol or other drug treatment is not collected. However, the drug types for which treatment was provided are known. In 2012–13, all or most services listed issues relating to alcohol (100%), cannabis (97%) and tobacco/nicotine (63%) among the top 5 most importance substance-use issues (Table B2). Due to changes in the questionnaire, comparisons between 2012–13 and previous reporting periods cannot be made.

Table B2: Five most common substances/drugs for which treatment/assistance provided by Australian Government-funded Aboriginal and Torres Strait Islander substance-use specific services, 2012–13

Substance use issue	Major cities	Inner regional	Outer regional	Remote	Very remote	Total
Alcohol	12	11	13	11	16	63
Cannabis/marijuana	11	11	13	10	16	61
Tobacco/nicotine	4	6	10	7	13	40
Multiple drug use	7	8	9	2	8	34
Amphetamines	9	6	6	1	5	27
Total number of services	12	11	13	11	16	63

Note: Percentage of services that cover substance use issues on an individual client basis.

Source: Aboriginal and Torres Strait Islander health services report 2012–13 (AIHW 2014a).

Data quality statements

Data quality statements for the National Hospital Morbidity Database, Online Services Report Data Collection, Specialist Homelessness Services Collection, National Opioid

Pharmacotherapy Statistics Annual Data and National Prisoner Health Data Collection are available from <www.aihw.gov.au>.

The data quality statement for the AODTS NMDS is available in Appendix A.

Duration

Duration is calculated in whole days.

Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's *Australian Standard Classification of Drugs of Concern 2011 (ASCDC)* (ABS 2011a). In this report, these drugs are grouped (Table B3).

Table B3: 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	Other	anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
	9000–9999		
Not stated	0000–0002	Not stated	

Hospital separations data

The hospital separation data included in this report was extracted from the AIHW National Hospital Morbidity Database using a selection of codes from the *International statistical classification of diseases and related health problems, 10th revision, Australian modification 8th edition* (ICD-10-AM) (NCCC 2012) (see Table B4).

Table B4: Relationship between the drug of concern and the ICD-10-AM codes

Drug of concern identified in principal diagnosis	ICD-10-AM codes
Analgesics	
Opioids (includes heroin, opium, morphine and methadone)	F11.0–11.9, T40.0–40.4
Non-opioid analgesics (includes paracetamol)	F55.2, T39.0, T39.1, T39.3, T39.4, T39.8, T39.9,
Sedatives & hypnotics	
Alcohol (ethanol)	E52, F10.0–10.9, G31.2, I42.6, K29.2, K70.0–70.9, K85.2, K86.0, T51.0–51.9, Z71.4
Other sedatives and hypnotics (includes barbiturates & benzodiazepines; excludes ethanol)	F13.0–13.9, T41.2, T42.3–42.8
Stimulants and hallucinogens	
Cannabinoids (includes cannabis)	F12.0–12.9, T40.7
Hallucinogens (includes LSD & ecstasy)	F16.0–16.9, T40.8, T40.9
Cocaine	F14.0–14.9, T40.5
Tobacco & nicotine	F17.0–17.9, T65.2, Z58.7, Z71.6
Other stimulants (includes amphetamines, pseudoephedrine, volatile nitrates and caffeine)	F15.0–15.9, T40.6, T43.6, T46.0, T46.3
Antidepressants and antipsychotics	
Antidepressants and antipsychotics	F55.0, T43.0–43.5
Volatile solvents	
Volatile solvents	F18.0–18.9, T52.0–52.9, T53.0–9, T59.0, T59.8
Other and unspecified drugs of concern	
Multiple drug use	F19.0–19.9
Unspecified drug use and other drugs not elsewhere classified (includes psychotropic drugs not elsewhere classified; diuretics; anabolic and androgenic steroids and opiate antagonists)	F55.1, F55.3–6, F55.8, F55.9, N14.1–3, T38.7, T43.8–9, T50.1–3, T50.7, Z71.5
Fetal and perinatal related conditions	
Fetal and perinatal related conditions (includes conditions caused by the mother's alcohol, tobacco or other drug addiction)	P04.2–4, Q86.0

Note: Data for 2012–13 were reported to the NHMD using the ICD-10-AM (NCCC 2012).

Population rates

In this publication, crude rates were calculated using the ABS estimated resident population (ERP) at the midpoint of the data range, that is, rates for 2012–13 data were calculated using the ERP at 31 December 2012.

Reason for cessation

The AODTS NMDS contains data on the episode end reason (reason for cessation). In this report, these end reasons are grouped (Table B5). Data for the individual end reasons are available in the online supplementary tables.

A different method was used for grouping end reasons in previous reports and therefore 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 B5: Grouping of cessation reasons by indicative outcome type

Outcome type	Reason for cessation
Expected cessation	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Unexpected cessation	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Administrative cessation	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

This report uses the ABS's *Australian Statistical Geography Standard (ASGS) Remoteness Structure 2011 (ABS 2011a)* to analyse the remoteness of alcohol and other drug treatment agencies. This structure allows areas that share common characteristics of remoteness to be classified into broad geographic regions of Australia. These areas are:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Remote*
- *Very remote.*

The Remoteness Structure divides each state and territory into several regions on the basis of their relative access to services.

Examples of places that are considered *Major cities* in the ASGS classification include Canberra and Newcastle. Hobart and Bendigo are *Inner regional* areas and Cairns and Darwin are *Outer regional* areas. Katherine and Mount Isa are *Remote* areas and Tennant Creek and Meekatharra are *Very remote*.

For this report, the remoteness of the agency was determined using the Statistical Area Level 2 (SA2) of the agency. Some SAs are split between multiple remoteness areas. Where this was the case, the data were weighted according to the proportion of the population of the SA in each remoteness area.

The ASGS has replaced the *Australian Standard Geographical Classification (ASGC) 2006 (ABS 2006)*. Remoteness areas for previous reports were calculated under the ASGC. Therefore remoteness data for 2011–12 and previous years are not comparable to remoteness data for 2012–13 and subsequent years.

Service sectors

From 2008–09, agencies funded by the Australian Government DoH under the NGOTGP were classified as 'non-government' agencies. Before this, many of these agencies were classified as 'government' agencies. Trends in service sectors of agencies should be interpreted with caution.

Specialist homelessness services data

All agencies that receive funding under the National Affordable Housing Agreement (NAHA) or the National Partnership Agreement on Homelessness (NPAH) to provide specialist homelessness services are in scope for the SHSC in general, but only those that received funding for at least 4 months during the 2012–13 financial year are in scope for the 2012–13 reporting period. Covered agencies are those in-scope agencies for which details have been provided to the AIHW by the relevant state/territory department.

Specialist homelessness agencies provided assistance to an estimated 244,176 clients in 412,614 support periods in 2012–13 (AIHW 2013b). It should be noted that these figures have been adjusted for non-responses.

Data collected include basic sociodemographic information and the services needed by, and provided to, each client. Information about each client's situation before and after receiving SHS agency services is also collected.

For further information on the SHS collection, refer to *Specialist Homelessness Services 2012–13* (AIHW 2013b).

There are a number of considerations related to the 2012–13 SHSC data:

- Data presented in this report exclude data for clients who were aged less than 10 at the beginning of their first support period in 2012–13.
- Data presented in this section are unweighted, meaning that there has been no adjustment for the undercounting of support periods that result from non-response. The data, therefore, are not comparable with other data published from the SHS Collection.
- Only those agencies that received NAHA or NPAH funding for at least 4 months during the 2012–13 financial year are in scope for the 2012–13 reporting period. Covered agencies are those in-scope agencies for which details have been provided to the AIHW by the relevant state/territory department.
- Of all agencies that were in scope of the collection for at least 1 month during 2012–13, 90% submitted information for all 12 collection months, and 95% submitted data for at least 1 month.
- The rate of invalid/'don't know'/missing responses was high for a number of 2012–13 SHSC data items.
- Matching of data from individual clients who presented at different agencies and/or at different times requires a valid SLK; with 94% of support periods having a valid SLK in 2012–13.

Trends

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia*, due to data revisions.

Appendix C: Imputation methodology for AODTS clients

Attributing number of clients to set of missing SLK records

The AODTS NMDS collects information at the service record level. Service records are associated with individual clients by way of an SLK. There are a number of records that have missing or invalid SLK data which cannot be attributed to a client. This leads to an underreporting of the total number of clients using the services as some (but not all) of the records will belong to clients who are not observed via a valid SLK.

This document describes a potential method of using the available data to, after making a number of assumptions about the behaviour of the whole population, impute the total number of clients.

Imputation groups

Imputation groups are formed to improve the performance of the imputation. The service records will be grouped according to properties that are thought to influence the behaviour of clients and the quality of SLK data, and then the imputation will be performed at this imputation group level.

Possible properties to group by include such things as location, provider size (measured by number of service records) and service type. The data are also grouped according to any sub-populations that are going to be reported upon, for example jurisdiction.

The final imputation groups will be formed by balancing the often-competing priorities of having homogenous groups and the need to have groups of sufficient size to ensure that the imputation is robust.

Assumptions and approximations

Assumption 1: randomness and independence

This imputation method assumes that which 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 sub-set 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 will be treated as if they have only 10 and the proportion of clients with 10 service records will be calculated accordingly.

Notation

We start by defining the notation used in this document.

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, $i = 1, 2, \dots, 10$.
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

$$P_{SLK1} = \sum_{i=1}^{10} P_{Ni}(1 - p_{SLK0}^i).$$

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 we require the values of the P_{Ni} . These are unknown given that we are unable to observe the whole population due to the records with invalid SLK values. This method imputes the unknown P_{Ni} using numerical methods and then uses these values to impute N_t .

The process starts with the distribution of number of records per client that has been 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

$$f(P_{N1,SLK1}, P_{N2,SLK1}, \dots, P_{N10,SLK1}, P'_{N1}, P'_{N2}, \dots, P'_{N10}) = \sum_{i=1}^{10} \frac{(P'_{Ni} - P_{Ni,SLK1})^2}{P_{Ni,SLK1}}$$

Using numerical methods the $P'_{N1}, P'_{N2}, \dots, P'_{N10}$ 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:

$$N'_t = \frac{N_{SLK1}}{\sum_{i=1}^{10} P'_{Ni} (1 - p_{SLK0}^i)}$$

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.

One known factor of particular interest to some jurisdictions that was not taken into account was the fact that a number of agencies failed to collect valid SLK data for any service records. The way to adjust the imputation to make allowance for this would be to alter the value of the proportion of service records with an invalid SLK that is used in the calculations. This alteration would add complexity to the imputation and require a number of additional assumptions about the behaviour of clients. Whether this complexity would improve the performance of the imputation relies on just how sound those assumptions are. Given that in some cases there is little data to guide the assumptions there is a fair chance that the performance of the imputation would be degraded and so this approach is not recommended.

There are many different penalty functions that could be used in this imputation. The function used was chosen because, compared to 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.

Table C1: Comparison of population characteristics for valid SLK episodes and all episodes, by states and territories, 2012–13

	NSW		Vic		Qld		WA		SA		Tas		ACT		NT	
	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %
Client type																
Own drug use	98.1	96.8	94.6	94.3	97.2	96.1	94.5	94.1	99.4	99.4	91.3	91.1	98.8	98.7	92.2	91.9
Other's drug use	1.9	3.2	5.4	5.7	2.8	3.9	5.5	5.9	0.6	0.6	8.7	8.9	1.2	1.3	7.8	8.1
Sex																
Male	66.2	67.3	65.7	65.6	68.8	69.4	63.8	63.4	71.0	70.5	63.5	63.3	63.4	63.2	71.0	70.5
Female	33.8	32.6	34.1	34.3	31.2	30.6	36.2	36.6	29.0	29.4	36.5	36.7	36.6	36.8	29.0	29.5
Not stated	0.0	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Indigenous status																
Indigenous	11.6	13.1	6.9	6.9	18.6	17.6	22.2	21.6	14.8	14.9	7.5	7.5	10.2	10.3	61.2	61.9
Non-Indigenous	86.4	84.4	86.7	86.7	75.1	76.8	77.8	78.2	58.7	59.0	82.7	82.6	82.9	82.2	37.8	36.8
Not stated	2.0	2.5	6.4	6.4	6.3	5.6	0.0	0.2	26.5	26.1	9.8	9.8	6.9	7.4	0.9	1.4
Age group (years)																
10–19	6.5	7.8	13.2	13.2	13.2	15.8	17.5	17.4	10.8	10.6	14.1	14.2	16.7	16.7	21.3	21.0
20–29	24.5	25.2	28.4	28.3	29.2	30.2	27.6	27.3	23.7	23.7	27.4	27.4	25.6	25.5	27.4	27.3
30–39	29.6	30.0	27.0	27.0	26.8	25.3	28.3	28.4	28.8	28.9	26.9	26.8	27.7	27.6	25.3	25.1
40–49	23.9	22.9	19.5	19.4	18.7	17.5	16.9	17.0	23.1	23.1	18.3	18.2	18.5	18.5	18.1	18.3
50–59	11.5	10.6	8.4	8.4	8.5	7.8	7.1	7.3	9.5	9.6	9.5	9.5	9.1	9.2	6.3	6.1
60 and over	3.9	3.5	3.4	3.5	3.5	3.1	2.5	2.6	4.1	4.1	3.8	3.8	2.3	2.3	1.7	1.9
Unknown	0.0	0.0	0.0	0.2	0.0	0.3	0.0	0.0	0.0	0.0	0.0	0.1	0.0	0.2	0.0	0.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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.

administrative cessation: 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 (see Appendix A for more information on reason for cessation).

alcohol: a central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgment, coordination and balance more difficult (NDARC 2010).

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): was used from 1984 to 2011 by the Australian Bureau of Statistics for the collection and dissemination of geographically classified statistics. The ASGC provided a common framework of statistical geography which enabled the production of statistics that were comparable and could be spatially integrated.

Australian Statistical Geography Standard (ASGS): is the Australian Bureau of Statistics' new geographical framework effective from July 2011. The ASGS replaces the Australian Standard Geographical Classification (ASGC).

Benzodiazepines: also known as 'minor tranquillisers', 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®), normies (Normison®).

closed 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 treatment is ceased (see reason for cessation).

cocaine: belongs to a group of drugs known as stimulants. Cocaine is extracted from 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.

expected cessation: includes episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement (see Appendix A for more information on reason for cessation).

ecstasy: 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, the love drug.

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

illicit drug use: the use of legal drugs in a legal manner, and includes tobacco smoking and alcohol consumption (MCDS 2011).

licit drug use: includes:

- the use of illegal drugs—a drug that is prohibited from manufacture, sale or possession in Australia, for example, cannabis, cocaine, heroin and 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, for example 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, for example, kava, or inhalants such as petrol, paint or glue (but not including tobacco or alcohol) (MCDS 2011).

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

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

nicotine: the stimulant drug in tobacco. It is highly addictive.

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 for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service; these are:

- **ceased to participate against advice:** where 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 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.
- **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 without notice**
- **change in the delivery setting**
- **change in the principal drug of concern**
- **change in the main treatment type**

- **death**
- **drug court or sanctioned by court diversion service:** where the client is returned to court or jail due to non-compliance with the program
- **imprisoned (other than sanctioned by a drug court or diversion service)**
- **treatment completed:** where the treatment was completed as planned
- **transferred to another service provider:** this includes situations 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.

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.

treatment type: the type of activity that is used to treat the client's alcohol or other drug problem; these are:

- **assessment only:** where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types.
- **counselling:** is the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013)
- **information and education only**
- **pharmacotherapy, where the client receives another type of treatment in the same treatment episode:** includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy.
- **rehabilitation:** focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011).
- **support and case management only:** support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007).
- **withdrawal management (detoxification):** includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

tobacco: see *nicotine*.

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.

unexpected cessation: includes episodes where the client ceased to participate against advice, without notice or due to non-compliance (see Appendix A for more information on reason for cessation).

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Related publications

This report, *Alcohol and other drug treatment services in Australia 2012–13*, is part of an annual series. This publication, as well as past and future reports in this series, can be downloaded free from the AIHW website, <www.aihw.gov.au/alcohol-and-other-drugs-publications/>. The website also includes information on ordering printed copies.

Data quality statements for the National Hospital Morbidity Database, Online Services Report Data Collection, Specialist Homelessness Services Collection, National Opioid Pharmacotherapy Statistics Annual Data and National Prisoner Health Data Collection are available from <www.aihw.gov.au>.

The following AIHW publications relating to alcohol and other drug use might also be of interest:

- AIHW (Australian Institute of Health and Welfare) 2011. *Drugs in Australia 2010: tobacco, alcohol and other drugs*. Drug statistics series no. 27. Cat. no. PHE 154. Canberra: AIHW.
- AIHW 2014b. National Drug Strategy Household Surveys (NDSHS). Viewed 17 July 2014, <<http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/>>.
- AIHW 2014c. National opioid pharmacotherapy 2013 report. Drug treatment series no. 23. Cat. no. HSE 147. Canberra: AIHW.

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- ABS 2011b. Australian Statistical Geography Standard (ASGS): Volume 5 – Remoteness Structure, July 2011. ABS Cat. no. 1270.0.55.005. Canberra: ABS.
- ABS 2012a. 2011 Census of Population and Housing: Basic Community Profile. ABS Cat. no. 2001.0. Canberra: ABS.
- ABS 2012b. Most Aussie migrants born in the UK. Media release by ABS. 15 August 2012. Canberra.
- ADCA (Alcohol and other Drugs Council of Australia) 2013. Tips and tricks for new players: a guide to becoming familiar with the alcohol and other drugs sector. Canberra: Alcohol and other Drugs Council of Australia.
- ADF (Australian Drug Foundation) 2013. ADF fact sheet: Benzodiazepine facts. Melbourne: Australian Drug Foundation.
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- AIHW 2013a. Developing client-based analyses for reporting on the alcohol and other drug treatment services. Drug treatment series 22. Cat. no. HSE 143. Canberra: AIHW.
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MCDS (Ministerial Council on Drug Strategy) 2011. National Drug Strategy 2010–2015. Canberra: Commonwealth of Australia.

NCCC (National Casemix and Classification Centre) 2012. International statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM), Australian Classification of Health Interventions (ACHI) and Australian Coding Standards (ACS), 8th edition. Wollongong: NCCC.

NCETA (The National Centre for Education and Training on Addiction) 2004. Alcohol and other drugs: a handbook for health professionals. Canberra: Australian Government Department of Health and Ageing.

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NDARC (National Drug and Alcohol Research Centre) 2010. Alcohol Fact Sheet: NDARC. NDARC UNSW.

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Roxburgh A, Bruno R, Larance B & Burns L 2011. Prescription of opioid analgesics and related harms in Australia. *Medical Journal of Australia* 195: 280–284.

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

Vos T, Barker B, Stanley L & Lopez A 2007. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: University of Queensland.

Over 700 agencies provided over 160,000 treatment episodes for alcohol and other drug issues to an estimated 108,000 clients in Australia in 2012–13. Most episodes were for clients receiving treatment for their own drug use, and these clients tended to be male and in their 20s and 30s. Alcohol was the most common principal drug of concern, accounting for almost half of these closed episodes, and counselling was the most common type of treatment.