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Alcohol and other drug treatment services in Australia 2003–04

Report on the National Minimum Data Set

August 2005

Australian Institute of Health and Welfare
Canberra

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Intergovernmental Committee on Drugs, Alcohol and Other Drug Treatment Services National Minimum Data Set (IGCD AODTS–NMDS) Working Group

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AODTS	Alcohol and Other Drug Treatment Services
AODTS-NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
ASGC	Australian Standard Geographical Classification
BEACH	Bettering the Evaluation and Care of Health survey
DoHA	(Australian Government) Department of Health and Ageing
IDRS	Illicit Drug Reporting System
IGCD	Intergovernmental Committee on Drugs
n.e.c.	not elsewhere classified
NHDD	National Health Data Dictionary
NMDS	National Minimum Data Set

Highlights

The 2003–04 AODTS–NMDS data

- The 2003–04 AODTS–NMDS included data from 622 government-funded alcohol and other drug treatment agencies from across Australia. Over half (52%) of all treatment agencies were identified as non-government. Most agencies were located in major cities (57%) and inner regional areas (26%).
- There were 136,869 closed treatment episodes, an increase from 130,930 episodes reported in 2002–03.

Of the 136,869 closed treatment episodes reported in 2003–04...

- 95% involved clients seeking treatment for their own alcohol or other drug use.
- 33% were for clients aged between 20 and 29 years, with over one-quarter of all treatment episodes (28%) provided for clients in the 30–39 years age group.
- Male clients accounted for close to two-thirds (65%).
- 10% (13,238 episodes) involved clients who identified as Aboriginal and Torres Strait Islander people, which is higher than the overall proportion of Aboriginal and Torres Strait Islander peoples in the Australian population (2.4%).¹
- 86% were for clients born in Australia and 95% were for clients who nominated English as their preferred language.
- Two-fifths (40%) involved clients who were self-referred, followed by referrals from alcohol and other drug treatment services (11%).

What were the treatment types accessed by clients?

- Counselling was the most common treatment type provided (38%), followed by withdrawal management (detoxification) (18%) and assessment only (15%).
- Main treatment for female clients was more likely to involve counselling (43%) than for male clients (35%), and less likely to involve assessment only (11% and 17% respectively).
- Counselling as the main treatment type increased with the age of the client, from 28% of closed treatment episodes for clients aged 10–19 years to 47% of episodes for clients aged 50–59 years.
- Closed treatment episodes for clients identifying as Aboriginal or Torres Strait Islander peoples were more likely to involve assessment only and information and education only (20% and 15% respectively), compared with other Australians (14% and 7% respectively), and less likely to involve withdrawal management (detoxification) (11%, compared with 20% for other Australians) or counselling as the main treatment (33% compared with 38%).

1. This figure needs to be interpreted with caution due to a high number of 'not stated' responses and the fact that the majority of dedicated Indigenous substance use services are not included in the AODTS–NMDS collection.

- Across all geographical areas – except for very remote areas – counselling was the most commonly reported main treatment (accounting for 36% of treatment episodes in major cities, 44% in inner regional, 38% in outer regional and 47% in remote areas). In very remote areas, rehabilitation was the most common treatment type (49% of treatment episodes).

Where did treatment take place and what were the reasons for ending treatment?

- Over two-thirds (68%) of treatment episodes occurred at a non-residential treatment facility, 20% in a residential treatment facility and 7% in an outreach setting such as a mobile van service.
- Treatment episodes conducted in residential treatment facilities were most likely to involve withdrawal management (detoxification) (53%) or rehabilitation (29%).
- Of treatment episodes that were conducted in non-residential treatment facilities, the majority had counselling as the main treatment (52%), followed by assessment only (17%).
- Treatment was more likely to cease because it was completed where the main treatment type was assessment only (64% of episodes with this treatment type) and less likely where the main treatment type was information or education only (36%).
- The majority (54%) of treatment episodes for information and education only ceased due to expiation, that is, where a client has atoned for the offence by completing a recognised education or information program.
- Counselling was the treatment type most likely to end because the client ceased to participate without notice (25% of all episodes for counselling ended for this reason), and rehabilitation and withdrawal management (detoxification) were the treatment types most likely to end with a client ceasing to participate against advice (15% and 11% of treatment episodes respectively ending for this reason).

Of the 129,331 closed treatment episodes where clients were seeking treatment for their own drug use...

- Alcohol (38%) was the most common principal drug of concern, followed by cannabis (22%), heroin (18%) and amphetamines (11%).
- Over half (53%) involved at least one other drug of concern in addition to the principal drug of concern, with an average of 1.6 other drugs of concern.
- Ingestion (45%), followed by injection (28%) and smoking (23%) were the most likely methods of using the principal drug of concern.
- Counselling accounted for the highest proportion of closed treatment episodes for all principal drugs of concern – except benzodiazepines, where the main treatment type was withdrawal management (detoxification).

In 2003–04, alcohol was...

- the most common principal drug of concern to clients overall (38%) and for those identified as Aboriginal and Torres Strait Islander peoples (46%)
- the drug most commonly involved for both sexes: 39% of males and 35% of females
- the drug most likely to be reported as the principal drug of concern for clients aged over 30 years (52%)
- the most prominent principal drug of concern to clients across all geographic areas, accounting for 36% of treatment episodes in major cities, 41% in inner regional, 40% in outer regional, 71% in remote and 67% in very remote areas
- the principal drug of concern most likely to be recorded (39%) where the client was self-referred
- most commonly treated through counselling (41%), withdrawal management (detoxification) (21%), assessment only (17%) and rehabilitation (10%) when it was the principal drug of concern.

Where alcohol was the principal drug of concern, treatment most commonly ceased because it was completed (59%) or the client ceased to participate without notice (17%).

In 2003–04, cannabis was...

- identified as the principal drug of concern for 22% of clients overall, and for 22% of those identified as Aboriginal and Torres Strait Islander peoples
- the second most common principal drug involved in treatment episodes for both sexes: 23% for males and 20% for females
- the most commonly reported principal drug of concern for closed treatment episodes of clients aged 10–19 (49%) and 20–29 years (27%); the most common method of use for clients aged 10–19 years was smoking, the same age group where cannabis was the most common principal drug
- the second most prominent principal drug of concern for clients across most geographic areas, accounting for 28% of treatment episodes in inner regional areas, 32% in outer regional, 13% in remote and 31% in very remote areas
- most commonly treated through counselling (33%), information and education only (24%), withdrawal management (detoxification) (14%) and assessment only (11%) when it was the principal drug of concern
- the principal drug of concern most likely to be nominated where the client was referred to treatment through a police or court diversion process (72%).

Where cannabis was the principal drug of concern, treatment most commonly ceased because the treatment was completed (47%) or clients ceased to participate owing to expiation (22%).

In 2003–04, heroin was...

- identified as the principal drug of concern for 18% of clients overall, and for 11% of those identified as Aboriginal and Torres Strait Islander peoples
- the second most commonly reported principal drug of concern for closed treatment episodes of clients aged 20–29 years (26%); the most common method of use for those aged 20–29 years was injecting, the same age group where heroin was the most common principal drug
- the second most prominent drug of concern for clients in major cities, accounting for 23% of treatment episodes in major cities
- the second principal drug of concern most likely to be recorded in treatment episodes where the client was self-referred (22%)
- most commonly treated through counselling (27%), followed by withdrawal management (detoxification) (25%), assessment only (17%) and support and case management only (12%) when it was the principal drug of concern.

Where heroin was the principal drug of concern, treatment most commonly ceased because the treatment was completed (51%) or clients ceased to participate without notice (15%).

In 2003–04, amphetamines were...

- identified as the principal drug of concern for 11% of clients overall, and for 9% of those identified as Aboriginal and Torres Strait Islander peoples
- most commonly treated through counselling (38%), followed by assessment only (19%), rehabilitation (16%) and withdrawal management (detoxification) (14%).

Where amphetamines were nominated as the principal drug of concern:

- a higher proportion of episodes involved those aged 20–29 years and 30–39 years (48% and 33% respectively) compared with episodes for all other principal drugs of concern (32% and 28% respectively)
- males were more likely clients than females (68% and 32% respectively)
- injecting accounted for 79% of closed treatment episodes, followed by ingesting (11%), sniffing (4%) and smoking (3%)
- clients were more likely to be current injectors than those nominating all other principal drugs of concern (63% and 22% of treatment episodes respectively)
- the most common source of referral was self-referring (42%), followed by referral from a correctional service (12%). Treatment most commonly ceased because the treatment was completed (46%) followed by those who ceased to participate without notice (22%).

Data quality

- The data transmission process for the 2003–04 AODTS–NMDS collection represented an improvement on that of previous years. Data were received at the AIHW earlier, and cleaned faster.

1 Introduction

This report presents national, state and territory data about alcohol and other drug treatment services and their clients, including information about the type of drug problems for which treatment is sought and the types of treatment provided. This is the fourth report in the series of annual publications on Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) (AIHW 2002a, 2003a, 2004a).

1.1 Background

The AODTS-NMDS was implemented to help monitor and evaluate key objectives of the National Drug Strategic Framework 1998–99 to 2003–04 and to help plan, manage and improve the quality of alcohol and other drug treatment services (see AIHW: Grant & Petrie (2001) for historical development of the AODTS-NMDS). The AODTS-NMDS will continue to support the National Drug Strategy 2004–09, particularly as trend data become available in the coming years.

Since 1985, Australia's drug strategies have been based on the principle of minimising harm caused by licit drugs, illicit drugs and other substances. The principle of harm minimisation incorporates strategies to reduce drug-related harm to individuals and communities as well as supply and demand reduction strategies. No single data collection can provide all of the information relating to national treatment objectives. This report therefore also presents information from a range of other data sources to provide context to the AODTS-NMDS data and present a more complete picture of the current state of alcohol and other drug treatment services in Australia today (see Chapter 7).

The data presented in this report, in conjunction with other information sources, can be used to inform issues of access to treatment services and more generally to inform debate, policy decisions and planning processes that occur within the alcohol and other drug treatment sector.

1.2 Collection method and data included

The AODTS-NMDS collection for 2003–04 consists of de-identified unit record data for treatment agencies and closed treatment episodes. Each agency record consists of three data items and each treatment episode record consists of 20 data items. The treatment episode data items collect demographic information on clients, along with information about their drug use behaviour and the types of treatment received. See Appendix 1 for a full list of data items included in the national collection for 2003–04. The methods of collecting data vary across the country. Appendix 2 outlines the policy and administrative features of the AODTS-NMDS collection within each jurisdiction. The most common feature across jurisdictions is the requirement for agencies to collect and provide treatment service data consistent with the AODTS-NMDS specifications.

Responsibility for the collection

The AODTS–NMDS is a nationally agreed set of common data items collected by all in-scope service providers, collated by relevant health authorities and compiled into a national data set by the Australian Institute of Health and Welfare (AIHW). The AIHW is the data custodian for the national data set and performs a coordinating role as national secretariat to the collection. The Intergovernmental Committee on Drugs AODTS–NMDS Working Group is responsible for the ongoing development and maintenance of the national collection. The Working Group has representatives from the Australian Government, each state and territory government, and organisations such as the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the National Drug and Alcohol Research Centre. The key responsibilities of each authority in regard to the AODTS–NMDS collection follow.

Government health authorities

It is the responsibility of the Australian Government and state and territory government health authorities to establish and coordinate the collection of data from their alcohol and other drug treatment service providers. To ensure that the AODTS–NMDS is effectively implemented and collected, these authorities are responsible for providing data according to agreed formats and timeframes, participating in data development related to the collection, and providing advice to the IGCD AODTS–NMDS Working Group about emerging issues which may affect the AODTS–NMDS.

Government health authorities also need to ensure that appropriate information security and privacy procedures are in place. In particular, data custodians are responsible for ensuring that their data holdings are protected from unauthorised access, alteration or loss.

The federal, state and territory government departments have custodianship of their own data collections under the National Health Information Agreement.

Alcohol and other drug treatment agencies

Publicly funded alcohol and other drug treatment agencies are responsible for collecting the agreed data elements and forwarding this information to the appropriate health authority as arranged. Agencies need to ensure that the required information is accurately recorded, and should inform their health authority if they have difficulty collecting the information. They must ensure that their clients are generally aware of the purpose for which the information is being collected, the fact that the collection of the information is authorised or required, and whether any personal information is passed on to another agency. Treatment agencies are also responsible for ensuring that their data collection and storage methods comply with existing privacy principles. In particular, they are responsible for maintaining the confidentiality of their clients' data and/or ensuring that their procedures comply with relevant state, territory and federal government legislation.

AIHW

Under a memorandum of understanding with the Australian Government Department of Health and Ageing, the AIHW is responsible for the management of the AODTS–NMDS. The AIHW maintains a coordinating role in the collection, including providing the secretariat for the responsible working group, undertaking data development work, and

highlighting national and jurisdictional implementation and collection issues. The AIHW is also the data custodian of the national collection and prepares annual reports (at national and state/territory levels) and online interactive data cubes, in consultation with the Working Group.

1.3 Scope of the AODTS–NMDS

Agencies and clients included

The agencies, clients and treatment activities that were included in the 2003–04 AODTS–NMDS collection are as follows:

- All publicly funded (at state, territory and/or Australian government level) government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services, including residential and non-residential agencies. Specialist alcohol and drug units based in acute care hospitals or psychiatric hospitals were included if they provided treatment to non-admitted patients (e.g. outpatient services).
- All clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during the relevant reporting period (1 July 2003 to 30 June 2004).

Agencies and clients excluded

There is a diverse range of alcohol and other drug treatment services in Australia and not all of these are currently included in the scope of the AODTS–NMDS. For example, agencies whose sole activity is to prescribe and/or dose opioid maintenance pharmacotherapies and Aboriginal and Torres Strait Islander substance use services are not within the scope of the AODTS–NMDS. Data sources relating to these services, along with a range of other supporting data sources, are detailed in Chapter 7.

Specifically, agencies and clients excluded from the AODTS–NMDS collection are:

- agencies whose sole activity was to prescribe and/or dose for opioid maintenance pharmacotherapy treatment
- clients who were on an opioid maintenance pharmacotherapy program and who were not receiving any other form of treatment that fell within the scope of the AODTS–NMDS
- agencies for which the main function was to provide accommodation or overnight stays such as ‘halfway houses’ and ‘sobering-up shelters’
- agencies for which the main function was to provide services concerned with health promotion (e.g. needle and syringe exchange programs)
- treatment services based in prisons or other correctional institutions
- clients receiving treatment from services based in prisons or other correctional institutions
- clients receiving support from the majority of Australian government-funded Indigenous substance use services or Aboriginal primary health care services that also provide treatment for alcohol and other drug problems

- alcohol and drug treatment units in acute care or psychiatric hospitals that provided treatment only to admitted patients
- admitted patients in acute care or psychiatric hospitals
- people who sought advice or information but who were not formally assessed and accepted for treatment
- private treatment agencies that did not receive public funding
- clients aged under 10 years, irrespective of whether they were provided with services, or received these services from agencies included in the collection.

Some people who are concerned about their alcohol or other drug use may approach a general practitioner or pharmacy for advice and/or treatment rather than attending a specialist alcohol and other drug treatment service. Thus the estimates in this report do not reflect the total number of people in Australia receiving treatment for alcohol and other drug use. (See Section 1.5 for more details on some of these exclusions.)

1.4 Counts in the collection

The main unit of measurement for the 2003–04 AODTS–NMDS collection is closed (or completed) treatment episodes (the 2000–01 AODTS–NMDS focused on client registrations and a small amount of data are presented in this report on client registrations for continuity). The ‘closed treatment episode’ concept is included in the national collection because it best reflects clinical practice within the alcohol and other drug treatment sector and it enhances the quality of information on service use. This measure allows information to be reported about the nature of treatment received by clients, including the length of the treatment episode. Technical notes, including a discussion of the use of client registration and closed treatment episode data, are included in Appendix 3.

A closed treatment episode may be for a single treatment, such as ‘education and information only’ that may not be part of a larger treatment plan, or for a specific treatment, such as withdrawal management (detoxification) or counselling that may be part of a long-term overall treatment plan.

The following counting rules have been used for the data included in this report.

Closed treatment episodes

A closed treatment episode refers to a period of contact between a client and a treatment agency, and:

- it must have a defined date of commencement and cessation
- during the period of contact there must have been no change in:
 - the principal drug of concern
 - the treatment delivery setting
 - the main treatment type
- a treatment episode may cease for a number of valid reasons such as the treatment being completed or the client ceasing to participate without notice. A treatment episode is deemed to have terminated in the event that there has been no (service) contact between the client and the treatment agency for a period of 3 months or more, unless the period of non-contact was planned between the client and the treatment agency.

If a client receives treatment in multiple settings, in some cases a separate treatment episode is reported for each setting. Therefore, it is possible that more than one treatment episode may be in progress for a client at any one time. It is possible for each of these episodes to have different dates of commencement and cessation.

1.5 Nature of the 2003–04 AODTS–NMDS collection

In 2003–04 the overall quality and comprehensiveness of the AODTS–NMDS data continued to improve. Data quality issues relating to the scope and completeness of the 2003–04 NMDS collection are detailed further in Chapter 8. When interpreting the 2003–04 data in this report it is important to consider a number of features of the collection.

Firstly, the national collection is a compilation of agency administrative data from state and territory health authorities. There is some diversity across Australian jurisdictions in the data collection systems and practices in place within the alcohol and other drug treatment sector.

Secondly, national implementation of the AODTS–NMDS collection has been done in stages. Care should be taken when comparing data across collection years for the following reasons:

- In the first year of the collection (2000–01) there was a mix of client registration and treatment episode data, and one jurisdiction (Queensland) was unable to supply data. For the 2001–02 collection period, Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data. All other jurisdictions supplied treatment episode data.
- The total number of agencies may have increased in 2003–04, compared with 2002–03, as a result of methodological changes (i.e. moving from collecting data at the administrative or management level to the service outlet level) and increased coverage of in-scope agencies.

Thirdly, readers should be aware of the following general features of the 2003–04 AODTS–NMDS data:

- Reported numbers for each state/territory include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). As in the 2002–03 AODTS–NMDS annual report, federal government data are not analysed separately under the title ‘other’.
- Reported numbers do not include the majority of Australian Government-funded Indigenous substance use services (3 out of 42 were included) or Aboriginal primary health care services (6 out of 140 were included) that also provide treatment for alcohol and other drug problems. These services are generally not under the jurisdiction of the state or territory health authority and are not included in the specific program under which the Australian Government currently reports NMDS data. In addition, the data collections relating to these services have a different collection basis to the AODTS–NMDS. As a result, most of these data are not currently included in the AODTS–NMDS collection. Therefore the number of Indigenous clients in this report underrepresents the total number of Indigenous Australians who received treatment for alcohol and other drug problems during 2003–04.

Finally, the reader should be aware of the following data completeness issues in 2003–04:

- As in 2002–03, data were provided from Queensland government AODTS agencies and/or police diversion clients but not for other non-government funded agencies.

- In the Australian Capital Territory, a data collection error resulted in the exclusion of one large service provider and, hence, the overall closed treatment episode number for 2003–04 for the Australian Capital Territory may be undercounted.

Reported numbers do not include agencies delivering pharmacotherapy services, where their sole activity is to prescribe and/or dose for opioid maintenance pharmacotherapy treatment. Approximately 39,000 clients were recorded as receiving these services throughout Australia in 2003–04, an unknown proportion of whom may also have accessed the services included in the AODTS–NMDS (see Section 7.4).

1.6 Outputs from the AODTS–NMDS collection

The AODTS–NMDS collections provide national data on government-funded alcohol and other drug treatment services in Australia. AODTS–NMDS data outputs are designed to provide useful information to government health authorities, researchers and the broader community, as well as to provide an important form of feedback to treatment agencies that took part in the collection.

Each year the AODTS–NMDS data are processed and published in a detailed and comprehensive national report – this being the report for 2003–04 data – which is made available to the public free of charge on the AIHW website <www.aihw.gov.au> or in hard copy for a small fee.

As well as this detailed annual report, a national AODTS–NMDS bulletin is produced, which is a 12-page newsletter summarising the main findings from the collection. Data briefings specific to individual states and territories are also produced.

Further to this, the AIHW has an interactive alcohol and other drug treatment data site, <www.aihw.gov.au/drugs/datacubes/index.html> containing subsets of national information on alcohol and other drug treatment services from the 2003–04 collection. This also allows anyone who has access to the Internet to view a subset of the AODTS–NMDS data via the web interface. The user can look up figures and present them in a way suitable to their needs.

Each year the agencies that contribute data via the AODTS–NMDS receive a state/territory briefing containing data specifically designed to be relevant to their jurisdiction. In addition, these agencies are surveyed each year with the aim of discovering special areas of interest to treatment agencies. This input feeds into the AODTS–NMDS reporting, and in particular the special theme chapter in this report – Chapter 6 on amphetamines.

1.7 Recent drug use

This section provides a brief overview of drug use patterns in the Australian population, as background to the data on treatment services in the remainder of the report. Data from the 2004 National Drug Strategy Household Survey (NDSHS) are the most recent population data on this topic, and are presented in Table 1.1 together with data from the 2001 NDSHS and 2003–04 AODTS–NMDS. More detailed information about the 2004 NDSHS and its findings can be found in the publications *2004 National Drug Strategy Household Survey: First Results* (AIHW 2005a) and *2004 National Drug Strategy Household Survey: Detailed Findings* (AIHW 2005e).

The 2004 NDSHS estimated that 84% of Australians aged 14 years and over recently consumed alcohol and just over one-fifth (21%) smoked tobacco (Table 1.1). Between 2001 and 2004, a significant increase was observed in the proportion of persons who recently consumed alcohol (from 82% in 2001 to 84% in 2004) and significant decrease in the proportion of persons who recently smoked tobacco (23% to 21% respectively). The proportion of the population recently using ecstasy increased significantly from 2.9% in 2001 to 3.4% in 2004.

In 2004, lower proportions of people aged 14 years and over reported using cannabis (11%) and amphetamines (3%) than in 2001. Less than 1% of people reported using heroin or methadone in the last 12 months (0.2% and 0.1% respectively).

Table 1.1: Summary of selected drugs recently^(a) used, and principal drugs for which treatment was sought, Australia (per cent)

Drug/behaviour	Recent use, population aged 14 years and over^(b) 2001	Recent use, population aged 14 years and over^(b) 2004	Closed treatment episodes for clients aged 10 years and over 2003–04
Tobacco	23.2	20.7 #	1.5
Alcohol	82.4	83.6 #	37.5
Illicits			
Marijuana/cannabis	12.9	11.3	22.0
Heroin	0.2	0.2	18.0
Methadone ^(c)	0.1	0.1	1.9
Meth/amphetamines (speed)	3.4	3.2	11.0
Cocaine	1.3	1.0 #	0.2
Ecstasy ^(d)	2.9	3.4 #	0.4
Any illicit drug ^(e)	16.9	15.3 # ^(f)	60.5
None of the above	14.7	13.7 #	n.a.

(a) Used in the last 12 months. For tobacco, 'recent use' means daily, weekly and less than weekly smokers.

(b) Proportion of population aged 14 years and over from 2001 and 2004 National Drug Strategy Household Surveys.

(c) Non-maintenance.

(d) Before 2004, this category included substances known as 'designer drugs'.

(e) 'Any illicit drug' for 2001 and 2004 NDSHS includes the illicit drugs listed plus pain-killers/analgesics, tranquilisers/sleeping pills, steroids, barbiturates, inhalants, other opiates/opioids when used for non-medical purposes, hallucinogens and injected drugs.

(f) In 2004, also includes GHB and ketamine.

2001 result significantly different from 2004 result (2-tailed $\alpha = 0.05$).

Source: AIHW 2005a.

In the 2003–04 AODTS–NMDS collection, alcohol (38%) was the most common principal drug of concern in treatment episodes for clients aged 10 years and over (Table 1.1). This reflects the pattern of consumption among the Australian population where alcohol was the most common drug used. Tobacco was nominated as the second most used drug in the population (21%), yet accounted for less than 2% of closed treatment episodes for clients seeking treatment for its use. These differences in treatment for tobacco (nicotine) are perhaps not surprising given that most 'treatment' for nicotine addiction is through pharmacies, general practitioners (e.g. advice and nicotine patches) or 'quit' lines.

Although very low proportions of the general population reported using heroin (0.2%), 18% of closed treatment episodes of alcohol and other drug treatment services had heroin nominated as the principal drug of concern. The differences in results from the two sources of data reflect the nature of the treatment services captured by the AODTS-NMDS. These services focus on the people who have a problem with their drug use, whereas the household survey data cover all people who consume alcohol or use tobacco or other drugs regardless of whether or not they think they have a problem. Further to this, agencies whose sole purpose is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS-NMDS, and so the collection may exclude many clients receiving treatment for heroin. See Section 7.4 for information about the estimated numbers of clients receiving treatment from pharmacotherapy programs in Australia.

2 Treatment agency profile

This chapter presents the main features of the alcohol and other drug treatment agencies that supplied data for the 2003–04 AODTS-NMDS collection. The number of treatment agencies does not necessarily equate to the number of service delivery outlets as some treatment agencies were reported only under the main administrative centre of the service.

2.1 Establishment sector

A total of 622 alcohol and other drug treatment agencies contributed data for the period 2003–04, with the largest proportion of agencies in New South Wales (42%), Victoria (23%) and Queensland (15%). This split was similar in 2002–03 where 39% of agencies were located in New South Wales, 25% in Victoria and 16% in Queensland.

Over half of all agencies identified as non-government providers (52% or 322 out of 622), with the largest proportion of non-government agencies being located in Victoria (143 or 100% of agencies), Western Australia (25 or 74% of agencies), Tasmania (9 or 75% of agencies), the Australian Capital Territory (8 or 100% of agencies) and the Northern Territory (15 or 79% of agencies). In contrast, agencies were more likely to be in the government sector in New South Wales (193 or 75% of agencies) and South Australia (42 or 79% of agencies). In Queensland, approximately half of all agencies were provided by the government sector (52%) but this relates to the current exclusion of non-government agencies, except for those providing police diversion programs and those provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program (funded by the Australian Government) (see Section 1.3).

Table 2.1: Treatment agencies by sector of service and jurisdiction, Australia, 2003–04

Service type	NSW	Vic	Qld ^(a)	WA	SA	Tas	ACT ^(b)	NT	Australia
	(number)								
Government	193	0	49	9	42	3	0	4	300
Non-government	66	143	45	25	11	9	8	15	322
Total	259	143	94	34	53	12	8	19	622
<i>Total 02–03</i>	<i>229</i>	<i>148</i>	<i>96</i>	<i>28</i>	<i>50</i>	<i>11</i>	<i>6</i>	<i>19</i>	<i>587</i>
	(per cent)								
Government	64.1	0.0	16.3	3.0	14.0	1.0	0.0	1.3	100.0
Non-government	20.5	44.4	14.0	7.8	3.4	2.8	2.5	4.7	100.0
Total	41.6	23.0	15.1	5.5	8.5	1.9	1.3	3.0	100.0
<i>Total 02–03</i>	<i>39.0</i>	<i>25.2</i>	<i>16.4</i>	<i>4.8</i>	<i>8.5</i>	<i>1.9</i>	<i>1.0</i>	<i>3.2</i>	<i>100.0</i>

(a) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(b) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data-collection error.

The number of treatment agencies reporting under the AODTS-NMDS increased from 587 agencies in 2002–03 to 622 agencies in 2003–04. However, much of this increase related to methodological changes and increased coverage of in-scope agencies (see Section 1.3 for further details). The overall response rate for in-scope treatment agencies was 96% (see Chapter 8 for further details).

2.2 Location of treatment agencies

In 2003–04, treatment agencies were mostly located in major cities (57%) and inner regional areas (26%) (Table 2.2), as in the previous reporting period (56% and 25% respectively) (AIHW 2004a). The number of agencies located in major cities, however, may be over-represented as some treatment agencies, particularly several of those in non-metropolitan areas, were reported under the main administrative centre of the service. The bulk of the Australian population lives in major cities (66%), 31% in regional areas and 3% in remote areas (AIHW 2004b).

A significant proportion of treatment agencies in the Northern Territory (53%) and, to a lesser extent, Queensland (13%) were located in remote or very remote areas.

Table 2.2: Treatment agencies by geographical location^(a) and jurisdiction, Australia, 2003–04

Location	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
(number)									
Major cities	161	88	33	23	38	0	8	0	351
Inner regional	78	45	23	4	6	7	0	0	163
Outer regional	20	10	26	5	8	5	0	9	83
Remote	0	0	7	2	1	0	0	8	18
Very remote	0	0	5	0	0	0	0	2	7
Not stated	0	0	0	0	0	0	0	0	0
Total	259	143	94	34	53	12	8	19	622
(per cent)									
Major cities	62.2	61.5	35.1	67.6	71.7	0.0	100.0	0.0	56.5
Inner regional	30.1	31.5	24.5	11.8	11.3	58.3	0.0	0.0	26.2
Outer regional	7.7	7.0	27.7	14.7	15.1	41.7	0.0	47.4	13.3
Remote	0.0	0.0	7.4	5.9	1.9	0.0	0.0	42.1	2.9
Very remote	0.0	0.0	5.3	0.0	0.0	0.0	0.0	10.5	1.1
Not stated	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The geographical location of treatment agencies in the 2003–04 AODTS-NMDS has been analysed using the Remoteness Areas of the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 6 for information on how these categories are derived).

(b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data-collection error.

3 Client profile

This chapter provides a profile of clients receiving alcohol and other drug treatment services in 2003–04, the main analysis focusing on ‘closed treatment episodes’ (Box 3.1).

3.1 Closed treatment episodes and client registrations

In 2003–04 there were 136,869 closed treatment episodes in alcohol and other drug services reported in the AODTS–NMDS collection. These episodes related to an estimated 115,163 client registrations (see Box 3.1). On average, each of these registrations accounted for 1.2 treatment episodes during the year.

The number of closed treatment episodes in the 2003–04 AODTS–NMDS collection was higher than in 2002–03 (136,869, compared with 130,930). However, it is likely that this increase relates mostly to the increasing comprehensiveness of the AODTS–NMDS collection in 2003–04, rather than indicating an overall increase in clients being treated.

Box 3.1: Key definitions and counts for closed treatment episodes and registrations, 2003–04

***Closed treatment episode** refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2003–04 there were **136,869** closed treatment episodes.*

***Client registrations** refers to the estimated number of clients who were registered or reregistered for alcohol and other drug treatment services. In 2003–04 there were an estimated **115,163** client registrations.*

It is important to note that neither number of closed treatment episodes or estimated number of client registrations equates to the total number of persons in Australia receiving treatment for alcohol and other drug use. Using the current collection methodology, it is not possible to reduce duplication in client registrations that can occur where, for example, a client attends a number of different agencies throughout the collection period or reregisters with the same agency and is assigned a new record number. See Appendix 3 for more information on treatment episodes and client registrations.

Caution should be exercised when comparing the client registration data in 2000–01 with those of 2001–02 to 2003–04 as the method for calculating ‘registrations’ has changed. In the 2000–01 collection, registrations were based on all new or returning clients who registered or reregistered for treatment during the reporting period. For the 2001–02 to 2003–04 collections, registrations were based on the number of episodes closed within the reporting period.

See Section 1.2 and Boxes 4.1 and 5.1 for other related definitions.

3.2 Client type and jurisdictions

Overall, 95% of all closed treatment episodes in 2003–04 involved clients seeking treatment for their own alcohol or other drug use (Table 3.1). This is very similar to 2002–03, where 94% of closed treatment episodes involved clients seeking treatment for their own drug use

(AIHW 2004a). This proportion of episodes was observed in most states and territories except Western Australia, the Northern Territory and Tasmania, where 88%, 87% and 68% respectively of closed treatment episodes were for the client's own drug use.

Accordingly, less than 10% of closed treatment episodes in most states and territories were related to another person's drug use. However, 32% of all closed treatment episodes in Tasmania, and 13% in both Western Australia and the Northern Territory were for clients receiving treatment for another person's alcohol or drug use.

Overall, the majority of the 136,869 closed treatment episodes were recorded in Victoria (35%), followed by New South Wales (31%), Queensland (14%) and Western Australia (10%).

Table 3.1: Closed treatment episodes by client type and jurisdiction, Australia, 2003–04^(a)

Client type	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia 03–04	Australia 2002–03
	(number)									
Own drug use	41,426	45,030	17,912	12,479	7,234	1,596	1,317	2,337	129,331	123,032
Other's drug use	1,103	2,608	554	1,777	379	761	—	355	7,538	7,898
Total	42,529	47,638	18,466	14,256	7,613	2,357	1,318	2,692	136,869	130,930
	(per cent)									
Own drug use	97.4	94.5	97.0	87.5	95.0	67.7	99.9	86.8	94.5	94.0
Other's drug use	2.6	5.5	3.0	12.5	5.0	32.3	0.1	13.2	5.5	6.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
<i>Per cent of all closed treatment episodes</i>	31.1	34.8	13.5	10.4	5.6	1.7	1.0	2.0	100.0	

(a) Small cell sizes have been suppressed to preserve confidentiality. These are marked with a '—'.

(b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

3.3 Age and sex

In 2003–04, the majority of closed treatment episodes were for clients aged between 20 and 29 years who were accessing treatment services (44,684 or 33%), with over one-quarter of all treatment episodes (28%) provided for clients in the 30–39 years age group (Table 3.2). Thirteen per cent of treatment episodes were for clients aged between 10 and 19 years and a small proportion of episodes were for clients aged over 60 years (2%). This age distribution is almost identical to that in 2002–03.

As was the case in 2002–03, male clients in 2003–04 accounted for close to two-thirds (65% or 89,348) of all closed treatment episodes. Of treatment episodes for male clients, just over a third (34% or 30,386 of 89,348) were for clients aged 20–29 years, with over a quarter (28% or 25,201) for clients in the 30–39 years age group. Over three-quarters (79% or 70,351) of all closed treatment episodes with a male client involved men between 20 and 49 years. The age distribution was similar for males and females.

Females were more likely than males to be seeking treatment for someone else's drug use. Around three-quarters (74% or 5,601 of 7,538) of treatment episodes for someone else's drug use were for female clients. Female clients aged 40 years and over were more likely than younger women to seek treatment for the substance use of another person. For example, 17% of treatment episodes for females aged 40–49 years, 33% for females aged 50–59 years and 36% for females aged 60 years and over were for treatment related to someone else's substance use, compared with 9% for females aged 10–19 years, 5% of treatment episodes for females aged 20–29 years, and 8% for females aged 30–39 years.

Table 3.2: Closed treatment episodes by sex and age group, Australia, 2003–04

	Age group (years)						Total ^(a)
	10–19	20–29	30–39	40–49	50–59	60+	
(number)							
Males							
Own drug use	10,815	30,135	24,913	14,357	5,017	1,677	87,419
Other's drug use	331	251	288	407	401	183	1,929
<i>Total males</i>	<i>11,146</i>	<i>30,386</i>	<i>25,201</i>	<i>14,764</i>	<i>5,418</i>	<i>1,860</i>	<i>89,348</i>
Females							
Own drug use	5,361	13,595	11,922	7,287	2,473	814	41,829
Other's drug use	538	674	1,025	1,502	1,207	462	5,601
<i>Total females</i>	<i>5,899</i>	<i>14,269</i>	<i>12,947</i>	<i>8,789</i>	<i>3,680</i>	<i>1,276</i>	<i>47,430</i>
Persons ^(b)							
Own drug use	16,190	43,757	36,853	21,654	7,497	2,493	129,331
Other's drug use	869	927	1,313	1,910	1,610	647	7,538
Total persons	17,059	44,684	38,166	23,564	9,107	3,140	136,869
(per cent)							
Males							
Own drug use	12.4	34.5	28.5	16.4	5.7	1.9	100.0
Other's drug use	17.2	13.0	14.9	21.1	20.8	9.5	100.0
<i>Total males</i>	<i>12.5</i>	<i>34.0</i>	<i>28.2</i>	<i>16.5</i>	<i>6.1</i>	<i>2.1</i>	<i>100.0</i>
Females							
Own drug use	12.8	32.5	28.5	17.4	5.9	1.9	100.0
Other's drug use	9.6	12.0	18.3	26.8	21.5	8.2	100.0
<i>Total females</i>	<i>12.4</i>	<i>30.1</i>	<i>27.3</i>	<i>18.5</i>	<i>7.8</i>	<i>2.7</i>	<i>100.0</i>
Persons ^(b)							
Own drug use	12.5	33.8	28.5	16.7	5.8	1.9	100.0
Other's drug use	11.5	12.3	17.4	25.3	21.4	8.6	100.0
Total persons	12.5	32.6	27.9	17.2	6.7	2.3	100.0

(a) Includes 'not stated' for age.

(b) Includes 'not stated' for sex.

3.4 Indigenous status

Of the 136,869 closed treatment episodes in 2003–04, 13,238 (or 10%) involved clients identified as being Aboriginal and/or Torres Strait Islander peoples (Table 3.3). This is a higher proportion than the overall proportion of Aboriginal and Torres Strait Islander peoples in the Australian population (2.4%; ABS 2004). For a number of reasons the data on Aboriginal and Torres Strait Islander clients in the AODTS treatment population should be interpreted with caution. The overall proportion of episodes relating to clients identified as being Aboriginal and Torres Strait Islander peoples is only slightly higher than the proportion of episodes where Indigenous status was ‘not stated’. Further, the majority of dedicated substance use services for Aboriginal and Torres Strait Islander peoples are not included in the AODTS–NMDS collection (see Section 7.5 for data on these services).

Compared with 2002–03, in 2003–04 a similar percentage of treatment episodes were for clients who identified as being from an Aboriginal and/or Torres Strait Islander background (10%, compared with 9%). The proportion of closed treatment episodes where ‘not stated’ was reported for Indigenous status remained at 6% across reporting periods (AIHW 2004a).

Table 3.3: Closed treatment episodes by age group, Indigenous^(a) status and sex, Australia, 2003–04

Age group (years)	Indigenous ^(b)		Non-Indigenous ^(b)		Not stated ^(b)		Total		
	Males	Females	Males	Females	Males	Females	Males	Females	Persons ^(c)
(number)									
10–19	1,793	832	8,748	4,776	605	291	11,146	5,899	17,059
20–29	2,698	1,420	25,876	11,923	1,812	926	30,386	14,269	44,684
30–39	2,517	1,443	21,188	10,676	1,496	828	25,201	12,947	38,166
40–49	1,207	652	12,714	7,570	843	567	14,764	8,789	23,564
50–59	293	152	4,801	3,292	324	236	5,418	3,680	9,107
60+	49	40	1,670	1,151	141	85	1,860	1,276	3,140
Not stated	64	68	448	442	61	60	573	570	1,149
Total	8,621	4,607	75,445	39,830	5,282	2,993	89,348	47,430	136,869
(per cent)									
10–19	20.8	18.1	11.6	12.0	11.5	9.7	12.5	12.4	12.5
20–29	31.3	30.8	34.3	29.9	34.3	30.9	34.0	30.1	32.6
30–39	29.2	31.3	28.1	26.8	28.3	27.7	28.2	27.3	27.9
40–49	14.0	14.2	16.9	19.0	16.0	18.9	16.5	18.5	17.2
50–59	3.4	3.3	6.4	8.3	6.1	7.9	6.1	7.8	6.7
60+	0.6	0.9	2.2	2.9	2.7	2.8	2.1	2.7	2.3
Not stated	0.7	1.5	0.6	1.1	1.2	2.0	0.6	1.2	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Per cent of treatment population	6.3	3.4	55.1	29.1	3.9	2.2	65.3	34.7	100.0

(a) In tables, the term ‘Indigenous’ refers to people who identified as being Aboriginal or Torres Strait Islander peoples; ‘Non-Indigenous’ refers to people who said they were not Aboriginal or Torres Strait Islander peoples.

(b) There were 10 closed treatment episodes for Indigenous people where sex was not stated, 63 episodes for non-Indigenous people where sex was not stated and 18 episodes where Indigenous status and sex were not stated.

(c) Includes ‘not stated’ for sex.

Indigenous clients tended to have a younger age profile than other Australian clients. Aboriginal and Torres Strait Islander males aged 10–19 years accounted for 21% of all Indigenous male treatment episodes, whereas other Australian males 10–19 years accounted for only 12% of all other Australian males. This pattern was similar for female clients aged 10–19 years, but not so marked (18% for Indigenous females, compared with 12% for other Australian females). In contrast, treatment episodes involving clients older than 40 years were less common for Aboriginal and Torres Strait Islander clients than for other clients. This finding may relate to differences in the underlying age structures of the two populations, with Aboriginal and Torres Strait Islander peoples having a younger age profile than other Australians.

3.5 Country of birth and preferred language

The majority of closed treatment episodes in 2003–04 and in 2002–03 involved clients born in Australia (86% of closed treatment episodes in each year) (Table 3.4). Clients born in other countries were represented in only a very small proportion of closed treatment episodes, with England (3%) and New Zealand (2%) being the next most common countries of birth.

English was the most frequently reported preferred language – 95% of treatment episodes involved clients who indicated English as their preferred language (Table A4.4). Of closed treatment episodes, 1% involved clients with an Australian Indigenous language as their preferred language. Other preferred languages were relatively uncommon, each accounting for less than 1% of treatment episodes.

Table 3.4: Closed treatment episodes by country of birth^(a), Australia

Country of birth	2003–04		2002–03	
	No.	%	No.	%
Australia	117,036	85.5	111,722	85.3
England	3,388	2.5	3,460	2.6
New Zealand	2,710	2.0	2,493	1.9
Viet Nam	1,353	1.0	1,227	0.9
Scotland	750	0.5	736	0.6
Ireland	495	0.4	438	0.3
Germany	355	0.3	378	0.3
South Africa	319	0.2	306	0.2
Italy	316	0.2	366	0.3
United States of America	299	0.2	353	0.3
All other countries	6,378	4.7	6,205	4.7
Not elsewhere classified	409	0.3	377	0.3
Inadequately described	871	0.6	530	0.4
Not stated	2,190	1.6	2,339	1.8
Total	136,869	100.0	130,930	100.0

(a) The countries listed here are the 10 most frequently recorded countries; all other countries are combined in the row labelled 'All other countries'.

4 Drugs of concern

This chapter examines the profile and characteristics of clients in relation to the principal drug of concern nominated by them when using treatment services in 2003–04. The analysis is based on ‘closed treatment episodes’.

The principal drug of concern refers to the main substance that clients state led them to seek treatment from the alcohol and other drug treatment agency. This section reports only on those 129,331 episodes where clients were seeking treatment for their own substance use. It is reasoned that only substance users themselves can accurately report on the principal drug of concern to them.

Box 4.1: Key definitions and counts for closed treatment episodes and drugs, 2003–04

***Closed treatment episodes** refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2003–04 there were **136,869** closed treatment episodes.*

***Principal drug of concern** refers to the main substance that clients state 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. It is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2003–04, **129,331** closed treatment episodes were reported for principal drug of concern.*

***Other drugs of concern** refers to any other drugs apart from principal drug of concern which clients perceive as being a health concern. Clients can nominate up to five other drugs of concern. In 2003–04, there were **110,887** other drugs of concern (apart from principal drug of concern) reported.*

***All drugs of concern** refers to all drugs reported by clients including principal drug of concern and all other drugs of concern. In 2003–04, there were a total of **240,218** drugs of concern reported, either as a principal or other drug of concern.*

See Section 1.2 and Boxes 3.1 and 5.1 for other definitions.

4.1 Jurisdictions and principal drug of concern

Nationally in 2003–04, alcohol (38%) and cannabis (22%) were the most common principal drugs of concern in treatment episodes, followed by heroin (18%) and amphetamines (11%).² Overall, less than 1% of closed treatment episodes were for the principal drugs ecstasy and cocaine (0.4% and 0.2% respectively) (Table 4.1). The distribution of principal drug of concern across treatment episodes was almost identical in 2002–03 (AIHW 2004a).

2. The AODTS-NMDS collection excludes agencies whose sole purpose is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies. Therefore, the collection excludes many clients receiving treatment for heroin.

Alcohol was the most common principal drug of concern reported in most jurisdictions. Alcohol as the principal drug accounted for 77% of all treatment episodes in the Northern Territory, 47% in South Australia and 41% in New South Wales. Queensland reported the lowest proportion of treatment episodes where alcohol was the principal drug (26%) and the highest proportion of treatment episodes where cannabis was the principal drug (40%). The pattern of principal drugs in Queensland relates largely to the scope of collection in 2003–04 (namely the inclusion of police diversion and government-provided services but not non-government-funded services; see Section 1.3 for further details). In Tasmania and the Australian Capital Territory, the most common principal drug was cannabis, accounting for 37% and 30% respectively of closed treatment episodes.

After alcohol, the three most commonly nominated drugs of concern nationally – cannabis, heroin and amphetamines – varied in their ‘position’ from state to state. Heroin was second in Victoria (23% of treatment episodes) and New South Wales (21%), followed by cannabis in Victoria (22%) and New South Wales (16%) (Table 4.1). In Western Australia and South Australia, amphetamines were second (26% and 17% respectively), followed by cannabis in Western Australia (22%) and heroin in South Australia (15%).

Nationally, only a small proportion of closed treatment episodes were for clients who identified nicotine as their principal drug of concern (1.5% or 2,001 treatment episodes). It is important to note, however, that this does not equate to the total number of clients receiving treatment for nicotine use but, rather, to the number of clients who attended a government-funded alcohol and other drug treatment service and nominated nicotine as their principal drug of concern. The relatively low rate of treatment for nicotine identified in this data collection is not surprising, because in most states and territories the majority of people with a nicotine addiction obtain treatment through pharmacies, general practitioners (e.g. advice and nicotine patches) or ‘quit’ lines. Tasmania recorded the highest proportion of episodes where nicotine was reported as the principal drug of concern (13%), and South Australia and Western Australia the lowest proportion (0.4% each).

In two jurisdictions, there were principal drugs of concern that were notably higher than the corresponding national figures:

- In the Northern Territory, alcohol was the principal drug of concern in 77% of closed treatment episodes, the highest of all jurisdictions, and just over double the national figure of 38%.
- In Western Australia, amphetamines were the principal drug of concern in 26% of closed treatment episodes, the highest of all jurisdictions, and just over double the national figure of 11%. More specific information on amphetamines can be found in Chapter 6.

Table 4.1: Closed treatment episodes by principal drug of concern and jurisdiction, Australia, 2003–04^(a) (per cent)

Principal drug	NSW	Vic	Qld ^{(b)(c)}	WA	SA	Tas	ACT ^(d)	NT	Australia	Total (no.)	<i>Australia a 2002–03</i>
Alcohol	41.2	37.1	26.3	32.6	46.6	28.9	22.4	77.2	37.5	48,500	38.0
Amphetamines	10.9	6.5	10.3	25.6	17.3	8.5	17.5	4.5	11.0	14,208	10.7
Benzodiazepines	2.5	2.4	1.0	1.5	2.1	1.0	3.3	0.4	2.1	2,711	2.1
Cannabis	16.1	22.3	39.5	22.0	10.2	37.0	29.5	7.9	22.0	28,427	22.0
Cocaine	0.4	0.1	0.1	0.2	0.1	0.1	0.8	0.1	0.2	272	0.3
Ecstasy	0.3	0.4	0.5	0.4	0.4	0.7	0.8	0.2	0.4	508	0.3
Heroin	21.4	23.3	7.6	9.9	14.7	0.8	20.2	0.9	18.0	23,326	18.4
Methadone	2.5	1.2	2.4	1.6	1.6	3.0	2.7	0.7	1.9	2,404	1.8
Nicotine	1.3	0.8	4.4	0.4	0.4	12.5	0.5	1.3	1.5	2,001	1.4
All other drugs ^(e)	2.0	5.8	7.8	5.5	6.5	7.1	2.4	6.8	4.9	6,342	4.4
Not stated	1.4	0.0	0.0	0.4	0.0	0.5	0.0	0.0	0.5	632	0.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..	100.0
Total (number)	41,426	45,030	17,912	12,479	7,234	1,596	1,317	2,337	..	129,331	123,032

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and reason for cessation as 'ceased at expiation'. It is possible that the principal drug is not actually cannabis and it is expected that future modifications to data collection processes will enable this possibility to be reflected.

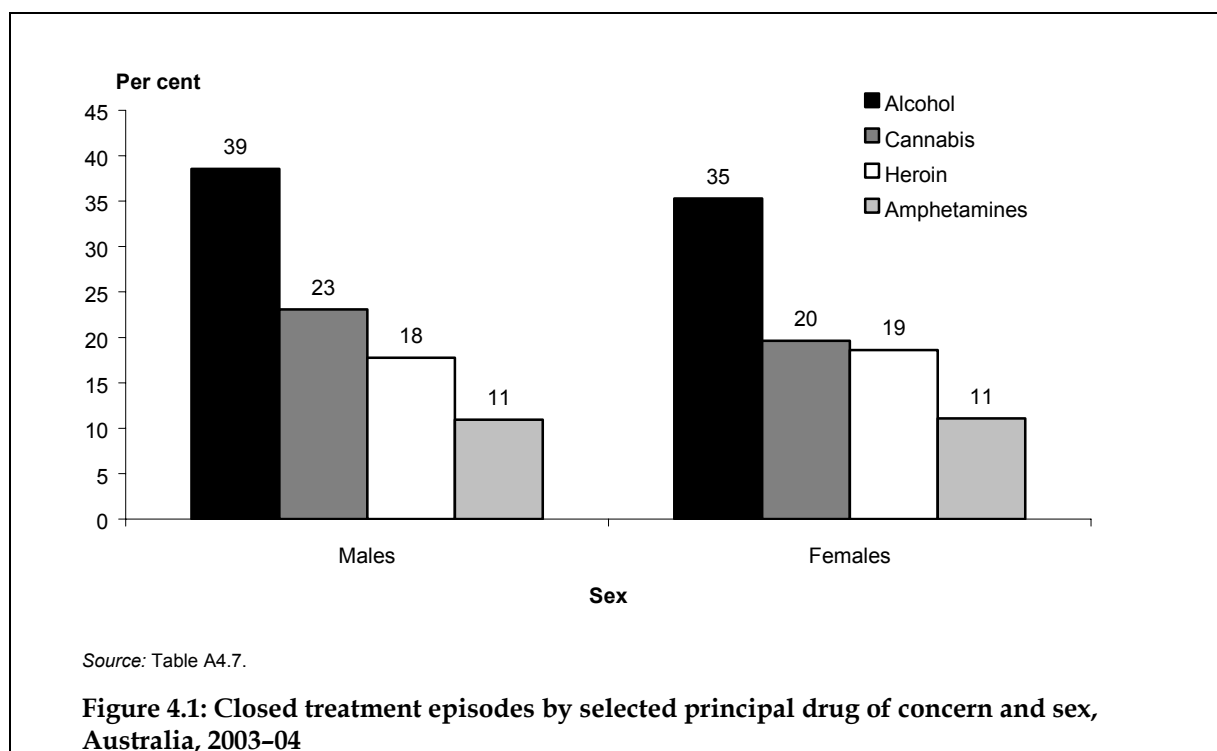
(c) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(d) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

(e) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7 and Table A4.5.

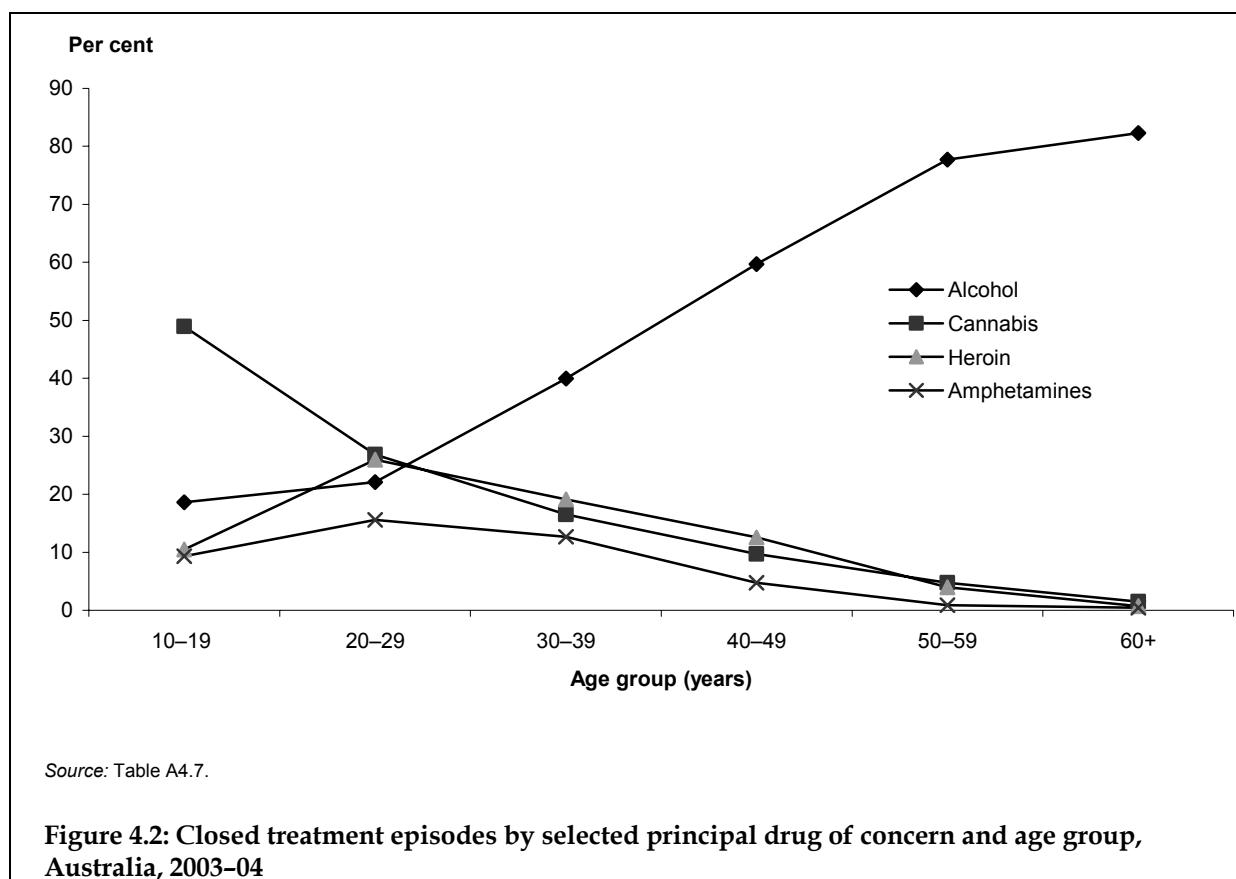
4.2 Sex, age and principal drug of concern

In 2003–04, the principal drug of concern in treatment episodes was similar between sexes (Figure 4.1). For all closed treatment episodes, alcohol was the most commonly recorded principal drug of concern for both sexes (39% for males and 35% for females), followed by cannabis (23% for males and 20% for females) and heroin (18% for males and 19% for females). The proportion of treatment episodes where amphetamines were recorded as the principal drug was 11% for both sexes.



The principal drug of concern in a treatment episode was strongly related to the client's age. For closed treatment episodes involving 20-29-year-olds, there was a fairly even distribution of drugs of concern, with younger clients much more likely to report cannabis as the drug of concern, and older clients more likely to report alcohol (Figure 4.2). Specifically:

- For treatment episodes of clients in the 10-19 age group, the most commonly reported principal drug was cannabis (49%) (Figure 4.2). This proportion varied by sex – 54% for males in this age group and 39% for females (Table A4.7). Although 11% of all treatment episodes among the 10-19 age group had heroin as the principal drug, females were more likely than males to be seeking treatment for this drug (16% compared with 8%).
- Overall, for treatment episodes of clients in the 20-29 age group, cannabis was the drug most commonly recorded (27%), followed closely by heroin (26%) and then alcohol (22%). This general pattern was reflected for males in this age group (28%, 25% and 24% respectively). However, for treatment episodes involving female clients, the most commonly reported principal drug was heroin (29%), followed by cannabis (24%) and alcohol (18%).
- Overall, alcohol was the drug most likely to be reported as the principal drug of concern (38% of closed treatment episodes), but this proportion was even higher for clients aged over 30 (52% or 35,522 of 68,497) and peaked for males and females aged 60 and over (85% and 76%, respectively).



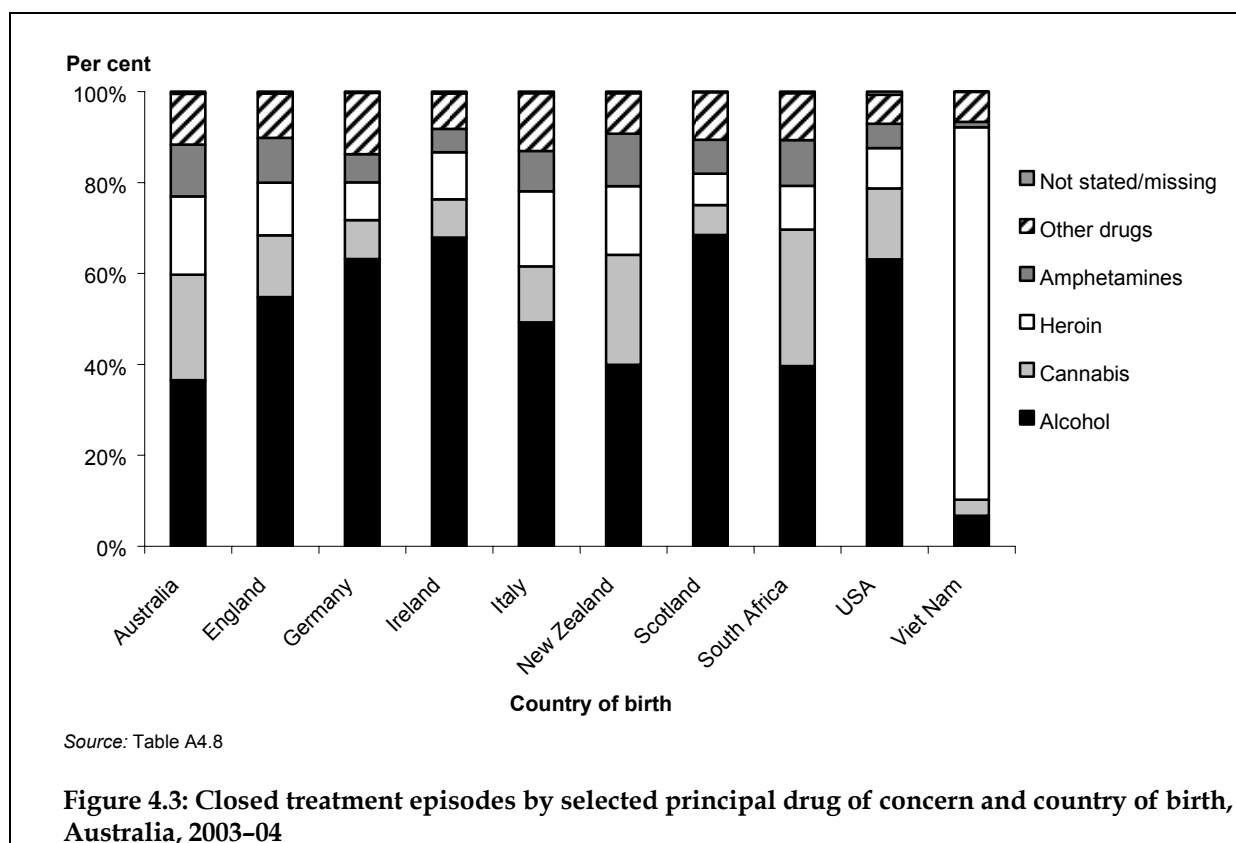
4.3 Country of birth and principal drug of concern

The distribution of the principal drug of concern varied somewhat with the client's country of birth (Figure 4.3). For closed treatment episodes where clients reported being born in Australia, 37% reported alcohol as their principal drug of concern, followed by cannabis (23%) and heroin (17%). This pattern was reflected for clients born in a number of other countries, including New Zealand (40% alcohol, 24% cannabis and 15% heroin), South Africa (40%, 30% and 10% respectively), and England (55%, 14% and 12% respectively).

The countries of birth reporting the highest proportion of closed treatment episodes for alcohol as the principal drug were Scotland, Ireland and Germany (68%, 68% and 63% respectively); alternatively, closed treatment episodes for clients born in Viet Nam reported the lowest proportion of episodes where alcohol was the principal drug (7%). Viet Nam is also the country of birth with the highest proportion of episodes where the principal drug of concern is heroin (82%).

The highest proportions of treatment episodes where amphetamines were reported as the principal drug of concern were for clients born in New Zealand and Australia (12% and 11% respectively), followed by South Africa and England (10% each).

It is important to note that the age distributions of migrants from these countries are not the same. For example, migrants from the United Kingdom and European countries are likely to be older than those from many Asian countries (ABS 2003). Given the strong relationship between age and principal drug of concern, it is not surprising that alcohol is the most likely drug of concern for most European migrants seeking treatment.



4.4 Indigenous status and principal drug of concern

Overall, closed treatment episodes involving Aboriginal and Torres Strait Islander clients were most likely to involve alcohol (46%), cannabis (22%), heroin (11%) and amphetamines (9%) – that is, the same four principal drugs of concern as the population overall – but with alcohol more likely to be nominated (46%, compared with 37%) and heroin less so (11%, compared with 18%) (Table 4.2). As previously noted, data relating to Indigenous status should be interpreted with caution for a number of reasons, including the relatively high proportion of treatment episodes where Indigenous status was ‘not stated’ (6%) (see Section 1.5 for further details). Further, for some principal drugs of concern, the number of treatment episodes where Indigenous status was ‘not stated’ was higher than the number of episodes where the client identified as being an Aboriginal or Torres Strait Islander person. For example, in 23 episodes where ecstasy was the principal drug of concern reported, the client identified as being an Indigenous person, compared with 35 episodes where Indigenous status was ‘not stated’.

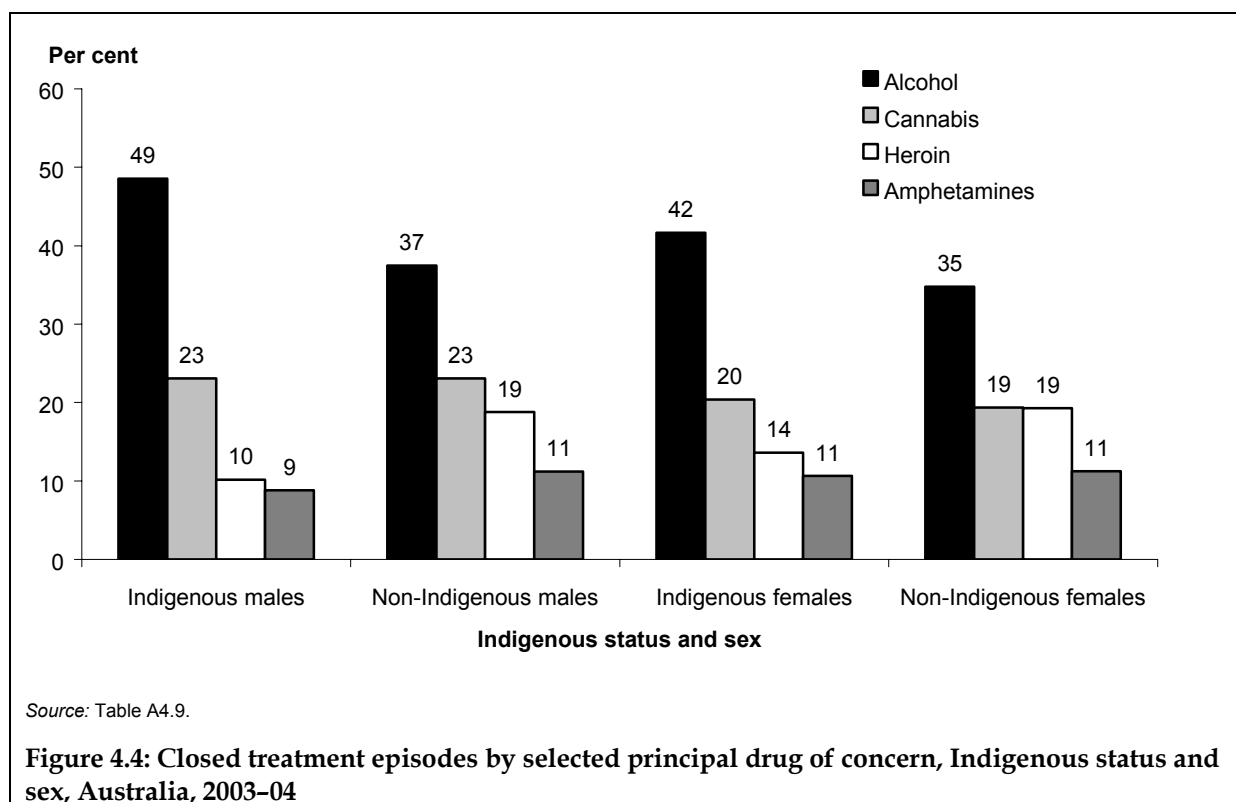
Table 4.2: Closed treatment episodes by principal drug of concern and Indigenous status, Australia, 2003–04^(a)

Principal drug of concern	Indigenous		Non-Indigenous		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Alcohol	5,888	46.2	39,815	36.6	2,797	36.0	48,500	37.5
Amphetamines	1,200	9.4	12,210	11.2	798	10.3	14,208	11.0
Benzodiazepines	154	1.2	2,417	2.2	140	1.8	2,711	2.1
Cannabis	2,825	22.2	23,813	21.9	1,789	23.1	28,427	22.0
Cocaine	14	0.1	240	0.2	18	0.2	272	0.2
Ecstasy	23	0.2	450	0.4	35	0.5	508	0.4
Heroin	1,439	11.3	20,624	18.9	1,263	16.3	23,326	18.0
Methadone	170	1.3	2,070	1.9	164	2.1	2,404	1.9
Nicotine	183	1.4	1,647	1.5	171	2.2	2,001	1.5
All other drugs ^(b)	751	5.9	5,091	4.7	500	6.4	6,342	4.9
Not stated	88	0.7	459	0.4	85	1.1	632	0.5
Total	12,735	100.0	108,836	100.0	7,760	100.0	129,331	100.0
Per cent of Indigenous status	9.8	..	84.2	..	6.0	..	100.0	..

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

The pattern of principal drug of concern among treatment episodes for Aboriginal and Torres Strait Islander clients also varied according to clients' sex (Figure 4.4). Nearly half of all treatment episodes for male clients identifying as Aboriginal or Torres Strait Islander involved alcohol as the principal drug of concern (49%), compared with 37% for other male clients; 42% of closed treatment episodes for female Aboriginal and Torres Strait Islander clients involved alcohol as the principal drug of concern, compared with 35% for other female clients. As part of this pattern of sex differences, treatment episodes for female Indigenous clients were somewhat more likely than those for male Indigenous clients to involve heroin as the principal drug of concern (14% of all treatment episodes compared with 10%). This difference was not found in other clients – 19% of treatment episodes involved heroin as the principal drug of concern for both males and females.



4.5 Geographical location and principal drug of concern

In 2003-04, 70% of all closed treatment episodes related to clients receiving services in major cities, 20% in inner regional and 9% in outer regional areas, with few closed treatment episodes in remote (1%) and very remote areas (0.1%) (see Appendix 6 for information on how these categories are derived). These proportions were nearly identical to those in 2002-03 (72%, 19%, 8%, 1% and 0.1% respectively) (AIHW 2004a). In 2003-04, across all areas, alcohol was the most commonly reported drug of concern (36% major cities, 41% inner regional, 40% outer regional, 71% remote areas and 67% very remote areas – Table 4.3). In most areas, the second most prominent drug of concern reported was cannabis (28% inner regional, 32% outer regional, 13% remote and 31% very remote). In major cities, alcohol, although still the most common principal drug of concern, was nominated in 36% of treatment episodes, followed by heroin 23%, cannabis 19% and amphetamines 12% – a much more even spread than in other regions.

Caution should be used when interpreting geographical data – especially for remote and very remote areas – because of the small population in some areas. In addition, the number of agencies located in major cities may be overrepresented because some treatment agencies, particularly in non-metropolitan areas, were reported only under the main administrative centre of the services. Geographical location may also have an effect on the type of treatment services available, especially in more remote areas, with the focus of the services available possibly targeted to a particular substance.

Table 4.3: Closed treatment episodes^(a) by principal drug of concern and geographical location, Australia, 2003–04 (per cent)

Principal drug of concern	Major cities	Inner regional	Outer regional	Remote	Very remote	Total ^(b)	Total (number) ^(b)
Alcohol	35.6	41.1	40.0	71.2	67.1	37.5	48,500
Amphetamines	11.9	9.7	7.2	6.8	1.2	11.0	14,208
Benzodiazepines	2.4	1.7	1.1	0.8	0.0	2.1	2,711
Cannabis	19.2	27.5	32.0	13.3	30.6	22.0	28,427
Cocaine	0.3	0.1	0.1	0.1	0.0	0.2	272
Ecstasy	0.4	0.2	0.4	0.1	0.0	0.4	508
Heroin	22.8	9.4	2.8	1.1	0.0	18.0	23,326
Methadone	1.8	2.2	2.0	0.6	0.0	1.9	2,404
Nicotine	1.1	2.1	3.6	1.8	0.0	1.5	2,001
All other drugs ^(c)	4.1	5.3	10.6	4.2	1.2	4.9	6,342
Not stated	0.4	0.8	0.3	0.0	0.0	0.5	632
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	..
Total (number)	90,275	26,034	11,519	1,418	85	..	129,331
Per cent of location	69.8	20.1	8.9	1.1	0.1	100.0	..

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for location.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

4.6 Source of referral and principal drug of concern

In 2003–04, two-fifths of all closed treatment episodes for clients seeking treatment for their own drug use involved clients who were self-referred (40%), followed by referrals from alcohol and other drug treatment services (12%) and correctional services (10%) (Table 4.4). The proportion of closed treatment episodes being self-referred increased slightly from 37% in 2002–03 to 40% in 2003–04. For other sources of referral, the proportion of closed treatment episodes has remained relatively stable.

Of treatment episodes where the client was self-referred, the principal drug of concern was most likely to be recorded as alcohol (39%) or heroin (22%). Much smaller proportions of self-referring clients nominated cocaine (0.2%) or ecstasy (0.3%) as their principal drug of concern. Referrals from alcohol and other drug treatment services were most likely to involve clients who nominated alcohol (39%), heroin (22%) or cannabis (17%) as their principal drug.

Of closed treatment episodes where the client was referred through the court diversion, 25% involved clients who nominated cannabis as their principal drug of concern. A higher proportion of episodes where the client was referred through police diversion involved cannabis (72%). These two diversion types are the only sources of referral where alcohol was not the most commonly noted principal drug of concern.

Of treatment episodes where the client was referred from a hospital, including psychiatric hospitals, the principal drug of concern was most likely to be recorded as alcohol (55%), cannabis (13%) or amphetamines (10%). Referrals from general practitioners or medical specialists were more likely to involve closed treatment episodes where the principal drug of concern was alcohol (47%), cannabis or heroin (12% each).

Table 4.4: Closed treatment episodes^(a) by principal drug of concern and source of referral, Australia, 2003–04

Principal drug of concern	Self	Family member/friend	GP/medical specialist	Hospital	Community mental health service	AODTS	Other community health/care services	Correctional service	Police diversion	Court diversion	Other	Not stated	Total
(number)													
Alcohol	20,029	2,239	3,925	2,639	1,151	5,827	2,112	4,733	1,163	396	4,049	237	48,500
Amphetamines	5,919	1,113	589	494	265	1,509	716	1,715	486	478	855	69	14,208
Benzodiazepines	1,186	94	313	151	85	466	79	100	57	24	143	13	2,711
Cannabis	8,610	1,629	1,003	603	724	2,519	1,284	2,831	6,388	553	2,216	67	28,427
Cocaine	128	28	16	4	3	22	8	39	14	2	8	0	272
Ecstasy	180	57	21	12	10	32	24	50	51	25	46	0	508
Heroin	11,219	941	990	371	135	3,300	679	2,373	452	495	2,291	80	23,326
Methadone	1,049	62	278	124	27	492	57	69	70	24	140	12	2,404
Nicotine	586	81	518	154	43	42	287	30	43	41	173	3	2,001
All other drugs ^(b)	2,667	280	727	226	104	721	437	246	58	183	631	62	6,342
Total^(c)	51,894	6,537	8,438	4,797	2,561	14,989	5,700	12,237	8,841	2,221	10,569	547	129,331
(per cent)													
Alcohol	38.6	34.3	46.5	55.0	44.9	38.9	37.1	38.7	13.2	17.8	38.3	43.3	37.5
Amphetamines	11.4	17.0	7.0	10.3	10.3	10.1	12.6	14.0	5.5	21.5	8.1	12.6	11.0
Benzodiazepines	2.3	1.4	3.7	3.1	3.3	3.1	1.4	0.8	0.6	1.1	1.4	2.4	2.1
Cannabis	16.6	24.9	11.9	12.6	28.3	16.8	22.5	23.1	72.3	24.9	21.0	12.2	22.0
Cocaine	0.2	0.4	0.2	0.1	0.1	0.1	0.1	0.3	0.2	0.1	0.1	0.0	0.2
Ecstasy	0.3	0.9	0.2	0.3	0.4	0.2	0.4	0.4	0.6	1.1	0.4	0.0	0.4
Heroin	21.6	14.4	11.7	7.7	5.3	22.0	11.9	19.4	5.1	22.3	21.7	14.6	18.0
Methadone	2.0	0.9	3.3	2.6	1.1	3.3	1.0	0.6	0.8	1.1	1.3	2.2	1.9
Nicotine	1.1	1.2	6.1	3.2	1.7	0.3	5.0	0.2	0.5	1.8	1.6	0.5	1.5
All other drugs ^(b)	5.1	4.3	8.6	4.7	4.1	4.8	7.7	2.0	0.7	8.2	6.0	11.3	4.9
Total^(c)	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
% of referrals	40.1	5.1	6.5	3.7	2.0	11.6	4.4	9.5	6.8	1.7	8.2	0.4	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC.

(c) Includes 'not stated' for principal drug of concern.

4.7 Other drugs of concern

In 2003–04, of the 129,331 closed treatment episodes where clients were seeking treatment for their own drug use, 68,465 episodes (53%) involved at least one other drug of concern – that is, episodes involved a principal drug of concern and at least one other drug of concern (Table 4.5). This proportion varied with the principal drug of concern – in closed treatment episodes where the principal drug of concern was ecstasy, amphetamines, or benzodiazepines, more than 65% of episodes included at least one other drug of concern. Treatment episodes where nicotine and alcohol were reported as the principal drug were least likely to report additional drugs of concern (32% and 43% respectively).

Between 2002–03 and 2003–04, cocaine and nicotine experienced the largest changes in proportion of episodes with other drugs of concern. The percentage of episodes where cocaine was the principal drug of concern (that had other drugs of concern) decreased from 71% to 64%, while nicotine increased from 20% to 32% (AIHW 2004a). These data indicate the drugs of concern to clients and should not be used as a proxy indicator for poly-drug use.

Table 4.5: Number of closed treatment episodes^(a) by principal drug of concern, with or without other drug of concern, Australia, 2003–04

Principal drug of concern	With other drugs	With no other drugs	Total closed treatment episodes	Proportion of episodes with 'other drugs' of concern (%)
Alcohol	20,776	27,724	48,500	42.8
Amphetamines	9,583	4,625	14,208	67.4
Benzodiazepines	1,770	941	2,711	65.3
Cannabis	15,300	13,127	28,427	53.8
Cocaine	175	97	272	64.3
Ecstasy	353	155	508	69.5
Heroin	14,568	8,758	23,326	62.5
Methadone	1,470	934	2,404	61.1
Nicotine	643	1,358	2,001	32.1
All other drugs ^(b)	3,713	2,629	6,342	58.5
Not stated	114	518	632	18.0
Total^(b)	68,465	60,866	129,331	52.9

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

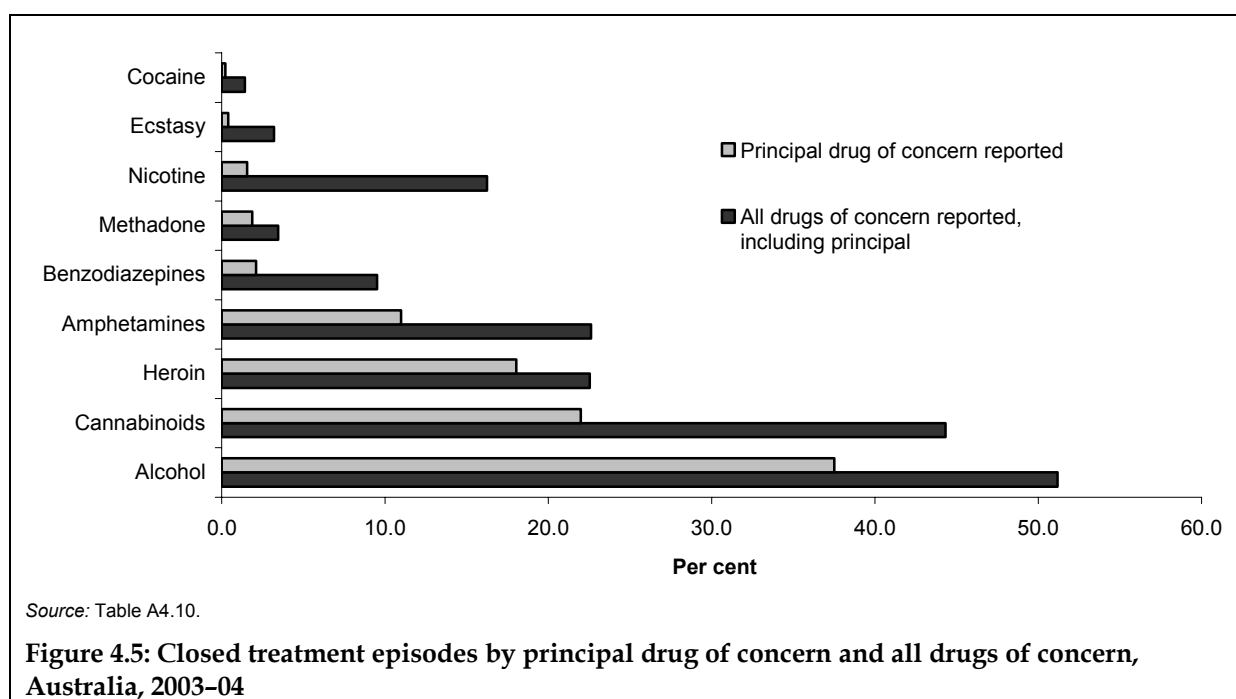
(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

From the 68,465 closed treatment episodes that did involve at least one other drug of concern, 110,887 other drugs of concern were reported (clients are able to report up to five other drugs of concern). This equates to 1.6 other drugs of concern for clients of these treatment episodes.

When considering all drugs of concern, alcohol and cannabis remain the two most commonly reported drugs of concern (Figure 4.5). Alcohol was reported as the principal drug of concern in 38% of treatment episodes and when all drugs are considered, 51% of treatment episodes included alcohol as one of the drugs of concern. A similar pattern can be seen for cannabis (identified in 22% of treatment episodes as the principal drug of concern and in 44% of treatment episodes as one of the drugs of concern) (Table A4.10).

Benzodiazepines were reported as a principal drug of concern in 2% of treatment episodes, yet when all drugs are considered, 10% of treatment episodes included benzodiazepines as one of the drugs of concern. Treatment episodes involving amphetamines also followed this pattern – 11% of treatment episodes involved amphetamines as the principal drug of concern, whereas 23% included them as a drug of concern. Eighteen per cent of closed treatment episodes involved heroin as the principal drug of concern, rising to 23% when all drugs of concern are considered.

Despite being reported as a principal drug of concern in only 2% of treatment episodes, nicotine was the fifth most common overall, reported in 16% of closed treatment episodes as one of the clients' drugs of concern (see Section 4.1 for further information on nicotine treatment).



4.8 Injecting drug use and method of use

For the purposes of the AODTS–NMDS collection, ‘injecting drug use’ includes drug administration methods such as intravenous, intramuscular and subcutaneous forms of injection.

Over two-fifths (43%) of closed treatment episodes in 2003–04 involved clients who reported never having injected drugs (Table 4.6). Just over one-quarter (26%) of treatment episodes involved clients who identified themselves as current injectors (i.e. injected within the previous 3 months) and a further 18% involved clients who reported they had injected drugs in the past (8% between 3 months and 12 months ago and 10% 12 or more months ago). Caution should be used, however, when interpreting data for ‘injecting drug use’ due to the high ‘not stated’ response for this item (13% of treatment episodes).

A relatively high proportion of closed treatment episodes for clients in the 20–29 and 30–39 age groups reported being ‘current injectors’ (36% and 30% respectively), with a significant proportion of clients in these age groups also reporting having injected drugs some time in the past (approximately 22% of treatment episodes for each age group).

In only a small proportion of treatment episodes were clients aged 50 years and over reported as being 'current injectors' (5% of episodes in the 50–59 age group and 2% for those aged 60 years and over). A very high proportion of treatment episodes for clients in these age groups were reported as never having injected drugs (72% and 84% respectively).

Table 4.6: Closed treatment episodes^(a) by injecting drug use and age group, Australia, 2003–04

Injecting drug use	10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total
(number)								
Current injector	2,721	15,809	11,042	3,746	361	43	277	33,999
Injected 3–12 months ago	1,042	5,016	3,430	1,134	132	11	87	10,852
Injected 12+ months ago	547	4,241	4,617	2,685	475	22	55	12,642
Never injected	9,393	13,946	12,929	10,845	5,405	2,091	307	54,916
Not stated	2,487	4,745	4,835	3,244	1,124	326	161	16,922
Total persons	16,190	43,757	36,853	21,654	7,497	2,493	887	129,331
(per cent)								
Current injector	16.8	36.1	30.0	17.3	4.8	1.7	31.2	26.3
Injected 3–12 months ago	6.4	11.5	9.3	5.2	1.8	0.4	9.8	8.4
Injected 12+ months ago	3.4	9.7	12.5	12.4	6.3	0.9	6.2	9.8
Never injected	58.0	31.9	35.1	50.1	72.1	83.9	34.6	42.5
Not stated	15.4	10.8	13.1	15.0	15.0	13.1	18.2	13.1
Total persons	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

As part of the AODTS–NMDS, clients are asked to nominate the usual method of administering their principal drug of concern, that is, their 'method of use'. In 2003–04, the most likely methods of use were ingestion (45% of all treatment episodes for clients seeking treatment for their own drug use), followed by injection (28%) and smoking (23%). Sniffing and inhaling were the methods of use for around 1% and 2% of treatment episodes, respectively (Table 4.7).

Most principal drugs of concern involved one main method of use (Table 4.7). Ingestion was the most common method of use when the principal drugs of concern were alcohol (99%), benzodiazepines (92%), ecstasy (86%) or methadone (85%), and least common for heroin (1%). Injecting was most common for heroin (92%), amphetamines (79%), and cocaine (42%), and smoking was most common for nicotine (96%) and cannabis (90%).

Cocaine and 'other drugs' did not appear to have one foremost method of use among clients of agencies. Cocaine was injected (42%), sniffed (37%) and smoked (11%). 'Other drugs' were ingested (40%), injected (35%) or inhaled (15%).

Table 4.7: Closed treatment episodes^(a) by principal drug and method of use, Australia, 2003–04 (per cent)

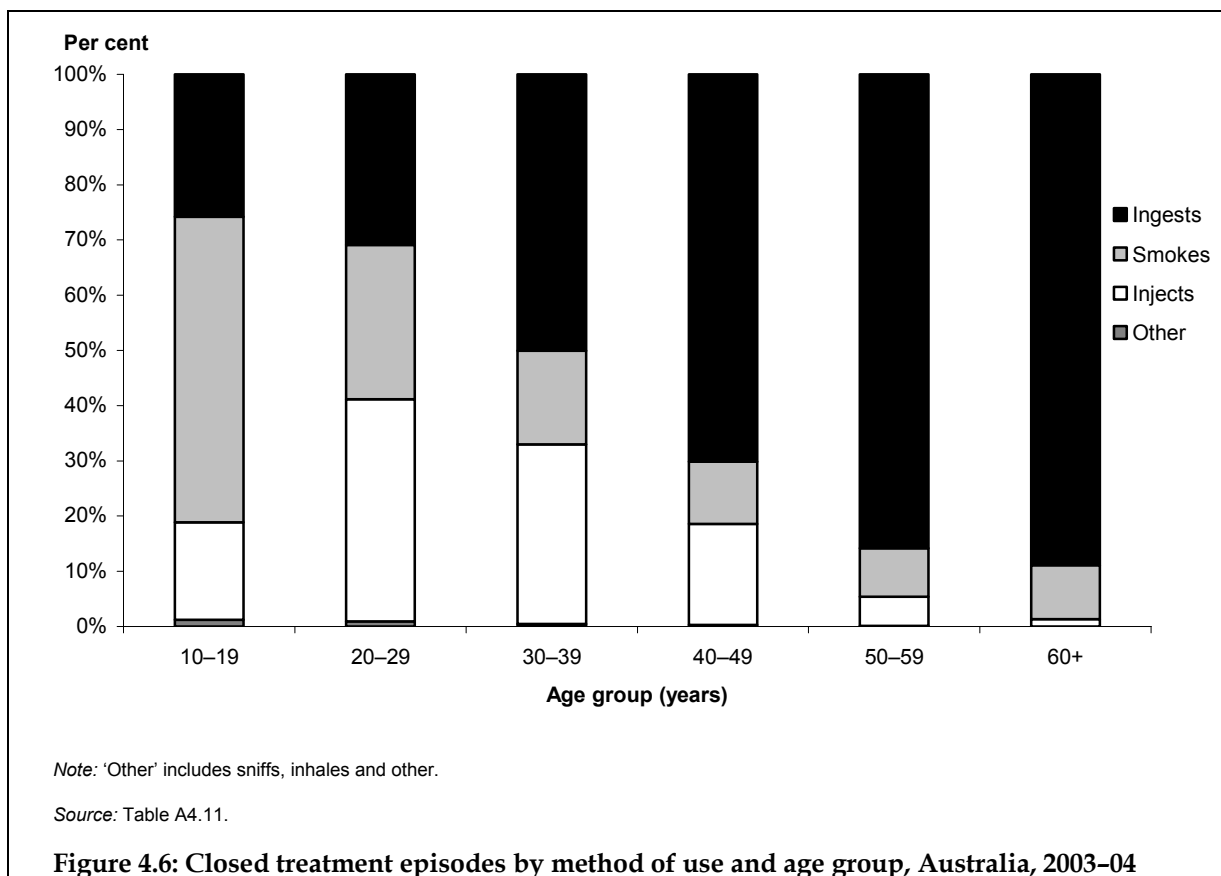
Principal drug of concern	Ingests	Smokes	Injects	Sniffs	Inhales	Other	Not stated	Total
Alcohol	99.1	0.2	0.1	0.0	0.1	0.0	0.6	100.0
Amphetamines	11.0	3.0	79.1	4.4	0.5	0.2	1.9	100.0
Benzodiazepines	92.2	0.2	6.3	0.0	0.0	0.1	1.1	100.0
Cannabis	3.0	90.4	0.4	0.0	3.9	0.2	2.1	100.0
Cocaine	4.0	11.0	42.3	37.1	1.5	0.0	4.0	100.0
Ecstasy	86.2	1.4	9.1	1.6	0.4	0.0	1.4	100.0
Heroin	1.3	4.8	91.7	0.2	0.7	0.1	1.2	100.0
Methadone	84.5	0.2	13.3	0.0	0.0	0.3	1.7	100.0
Nicotine	1.6	96.4	0.4	0.0	1.0	0.1	0.3	100.0
Other drugs ^(b)	39.5	1.8	35.3	0.3	15.1	1.8	6.3	100.0
Not stated/ missing	10.9	1.4	5.5	0.2	0.3	8.2	73.4	100.0
Total	45.1	22.7	27.6	0.6	1.8	0.2	1.8	100.0
Total (numbers)	58,365	29,396	35,742	815	2,354	295	2,364	129,331

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

The most common method of use varied with the client's age (Figure 4.6). The distribution of the different methods of use among age groups was related to the most common principal drug of concern for the age groups.

- For clients aged 10–19 years, smoking was the most common method of use, related to cannabis being the most common principal drug of concern for this age group.
- For clients aged 20–29 years, injecting was the most common method of use, related to heroin being the most common principal drug of concern for this age group.
- For clients aged 30–39 years and over, ingestion was the most common method of use, related to alcohol being the most common principal drug of concern for these age groups.
- Ingestion as a method of use increases in prevalence with age, whereas smoking and injection decrease. This corresponds to alcohol being a more likely principal drug of concern in older years and cannabis, heroin and amphetamines decreasing in likelihood from 20–29 years onwards.



4.9 Reason for cessation and principal drug of concern

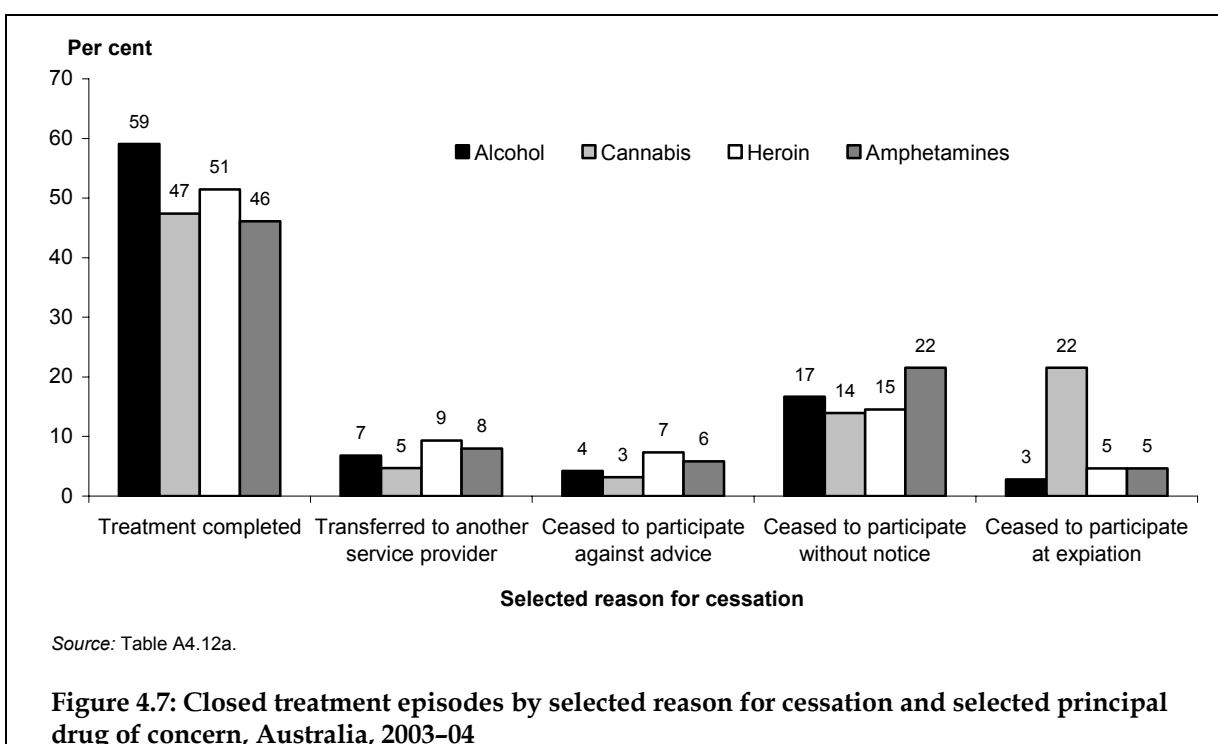
According to the AODTS-NMDS definition, there are a number of reasons a treatment episode can cease. The treatment may be completed, which in the context of this collection means that all of the immediate goals of the treatment plan have been fulfilled. Other reasons include a change in main treatment type for the client; a change in treatment delivery setting; the client ceasing to participate without notice, or by mutual agreement with the service provider; or the client being imprisoned or dying.

The majority of closed treatment episodes in 2003-04 involved clients ending treatment because the treatment was completed (53%; Table A4.12a). The next most common reason for treatment episodes to end was that the client ceased to participate without notice (16%). The client ceasing to participate at expiation – that is, where the client has atoned the offence by completing a recognised education or information program – accounted for 8%, closely followed by the client transferred to another service provider (7%). Only 5% of episodes ended because the client ceased to participate against advice. Nationally, a very small proportion of treatment episodes ceased because the client was imprisoned (0.5%), or because the client had died (0.1%).

This pattern of distribution was similar to that in 2002-03 where 51% involved clients ending treatment because the treatment was completed, 16% where clients ceased to participate without notice, 7% transferred to another service provider, 6% ceased at expiation and 5% ended treatment against the advice of the service provider (AIHW 2004a).

The reason for cessation varied across treatment episodes according to the principal drug of concern. For example, treatment episodes where alcohol was the principal drug of concern were more likely to end because treatment was completed (59%) than treatment episodes where heroin (51%), cannabis (47%) or amphetamines (46%) was the principal drug (Figure 4.7). Just over one-fifth of all treatment episodes with cannabis as the principal drug ceased at expiation (22%). A relatively high proportion of treatment episodes with amphetamines as the principal drug (22%) ended because the client ceased to participate without notice, compared with heroin, alcohol and cannabis, (15%, 17% and 14% respectively).

Examining these figures from another angle we see that, of all treatment episodes ending due to expiation—that is, where the client had expiated their offence by completing a recognised education or information program—63% involved cannabis as the principal drug of concern³ (Table A4.12b). Accordingly, only a small proportion of treatment episodes where alcohol, heroin or amphetamines was the principal drug ended due to expiation (14% of episodes for alcohol, 11% for heroin and 7% for amphetamines).



3. In Queensland, clients undergoing police diversion automatically have their principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and the reason for cessation as 'ceased to participate due to expiation'. It is possible that their principal drug of concern is not actually cannabis. It is expected that future modifications to data collection processes will enable this possibility to be reflected.

5 Treatment programs

'Main treatment type' is the main activity determined at assessment by the treatment agency to treat the client's principal alcohol and/or other drug problem. This chapter focuses on these treatment types and programs, and examines their relationship to a selection of variables of interest, in particular the principal drug of concern. Data presented in this chapter relate to all closed treatment episodes, that is, for clients seeking treatment for their own or someone else's alcohol or other drug use, except for Section 5.2 which relates to episodes for clients seeking treatment for their own drug use.

Box 5.1: Key definitions and counts for treatment programs, 2003–04

Closed treatment episode refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2003–04 there were **136,869** closed treatment episodes.

Main treatment type refers to the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. In 2003–04, main treatment type was reported for **136,869** treatment episodes..

Caution should be used when comparing the number of closed treatment episodes for main treatment type in 2003–04 and 2002–03 with those of 2001–02: in 2001–02 records from South Australia were excluded from tables using main treatment type as South Australia did not provide this data item. Details of each treatment type included in the AODTS–NMDS are included in Appendix 5.

Main treatment type and principal drug of concern. In 2003–04, data on the combination of these two data items were reported for **129,331** closed treatment episodes. This count excludes closed treatment episodes for clients seeking treatment for the drug use of others.

Other treatment type refers to all other forms of treatment provided to the client in addition to the main treatment type (up to three other treatment types can be recorded for each client). In 2003–04, there were **16,230** closed treatment episodes which provided a total of **19,889** other treatment types. In 2003–04, closed treatment episodes from Victoria and the Northern Territory were excluded from any analysis involving 'other treatment types' as Victoria and the Northern Territory did not provide data for 'other treatment types'.

All treatment types refers to all treatment types reported by a client including main treatment and other treatment. In 2003–04, there were a total of **156,758** treatment types reported, either as a main or other treatment type.

See Section 1.2 and Boxes 3.1 and 4.1 for other definitions.

5.1 Jurisdictions and treatment programs

Nationally in 2003–04, counselling (38%), withdrawal management (detoxification) (18%) and assessment only (15%) were the most common main treatment types provided within alcohol and other drug treatment services (Table 5.1). In 2003–04 a slightly higher proportion of closed treatment episodes were for assessment only (15% in 2003–04, compared with 13% in 2002–03) and a slightly lower proportion for counselling (38% in 2003–04, compared with 42% in 2002–03).

In 2003–04, counselling was the most common main treatment type reported in all jurisdictions except Queensland and South Australia. In Tasmania, counselling as the main treatment accounted for 63% of all treatment episodes, in Western Australia, 50%, and in Victoria and the Australian Capital Territory, 47% each. South Australia reported the lowest proportion of treatment episodes where counselling was the main treatment (23%) and the highest proportion of treatment episodes where rehabilitation was the main treatment type (21%).

In Queensland, the most common main treatment types were information and education only (37%), followed by counselling (28%). This pattern of main treatment in Queensland relates largely to the scope of the collection in 2003–04 (namely the inclusion of police diversion and government-provided services but not non-government-funded services; see Section 1.3 for further details).

Nationally, close to 3,000 closed treatment episodes were provided where the main treatment type was pharmacotherapy. This is a small proportion of pharmacotherapy treatment, as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are excluded from the AODTS–NMDS (see also Section 7.4).

Table 5.1: Closed treatment episodes by main treatment type and jurisdiction, Australia, 2003–04 (per cent)

Main treatment type	NSW	Vic	Qld ^{(a)(b)}	WA	SA	Tas	ACT ^(c)	NT	Australia	Total (no.)	Australia 2002–03
Withdrawal management (detoxification)	23.3	22.2	7.9	6.6	19.8	2.5	36.1	8.4	18.4	25,123	18.9
Counselling	28.9	47.1	27.7	50.2	22.7	62.8	47.2	24.6	37.6	51,514	41.5
Rehabilitation	10.0	3.8	5.7	16.4	20.8	4.5	13.1	14.9	8.6	11,717	7.5
Support and case management only	8.3	13.0	6.4	1.1	3.8	1.7	3.1	0.9	8.4	11,494	6.9
Information and education only	2.0	0.7	37.2	9.7	1.3	11.1	0.4	23.9	7.6	10,465	8.0
Assessment only	22.3	10.2	11.5	9.8	22.8	5.9	0.0	24.3	14.9	20,414	12.7
Other ^(d)	5.1	3.0	3.6	6.1	8.8	11.5	0.1	3.0	4.5	6,142	4.4
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..	100.0
Total (number)	42,529	47,638	18,466	14,256	7,613	2,357	1,318	2,692	..	136,869	130,930
<i>Per cent of closed treatment episodes</i>	31.1	34.8	13.5	10.4	5.6	1.7	1.0	2.0	100.0	..	

(a) In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and the reason for cessation as 'ceased to participate at expiation'. It is possible that the principal drug is not actually cannabis and it is expected that future modifications to data collection processes will enable this possibility to be reflected.

(b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

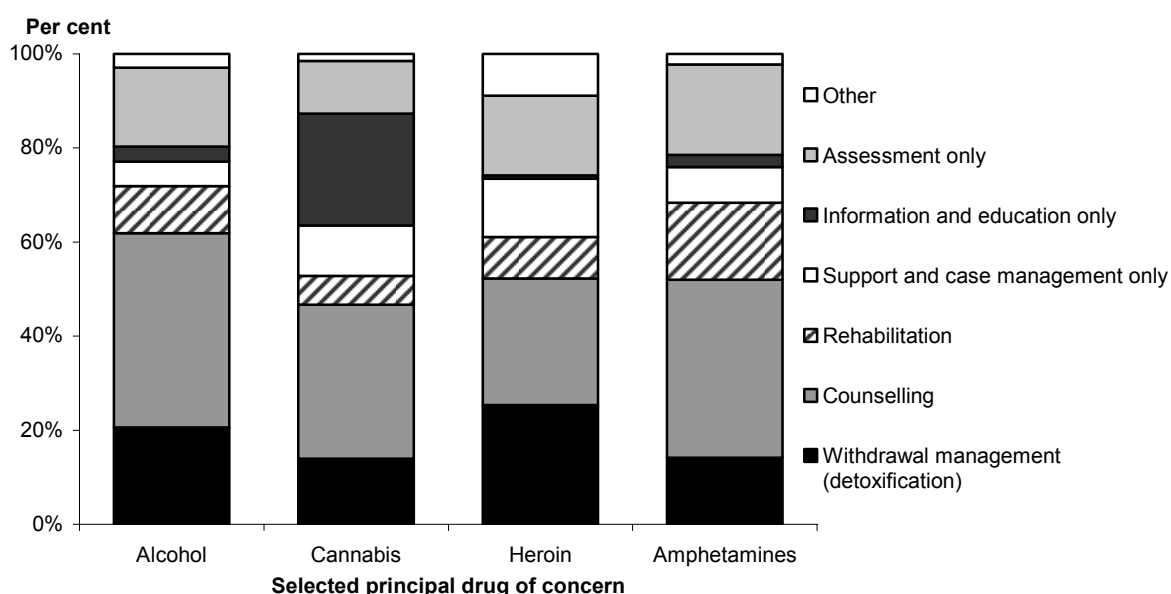
(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

(d) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.2 Main treatment for selected principal drugs

The main treatment type varied with the principal drug of concern the client sought treatment for. Overall, counselling accounted for the highest proportion of closed treatment episodes for all principal drugs of concern except benzodiazepines (Table A4.15 and Figure 5.1). Where alcohol was the principal drug, the next most common treatment type was withdrawal management (detoxification) (21% of treatment episodes), followed by assessment only (17%) and rehabilitation (10%). For treatment episodes where cannabis was reported as the principal drug, counselling (33%) was the most common treatment, followed by information and education only (24%), withdrawal management (detoxification) (14%) and assessment only (11%).

The most common treatment types reported for treatment episodes where heroin was the principal drug of concern were counselling (27%), withdrawal management (detoxification) (25%), assessment only (17%) and support and case management only (12%). For treatment episodes where amphetamines were reported as the principal drug, the most common treatments were counselling (38%), followed by assessment only (19%), rehabilitation (16%) and withdrawal management (detoxification) (14%).



Note: 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS-NMDS (see also Section 7.4).

Source: Table A4.15.

Figure 5.1: Closed treatment episodes by selected main treatment type and selected principal drug of concern, Australia, 2003–04

Duration of treatment episode—principal drug of concern

Duration of a closed treatment episode is determined by calculating the number of days between the date the client commenced a treatment episode and the date the client ended the treatment episode. The following analysis investigates duration using the 'median number of days' per treatment episode.

The duration of a treatment episode may depend on the type of treatment received and the principal drug of concern for which treatment is provided. Overall, the median number of days for a treatment episode in 2003–04 was 16, similar to the figure for 2002–03 (17) (Table 5.2). The highest median number of treatment days within a treatment episode occurred where the principal drug of concern was heroin (21), followed by treatment episodes where amphetamines was the principal drug (19), then alcohol (17) and cannabis (12).

The category 'other' treatment had the highest median number of treatment days per treatment episode (47). This is largely due to the inclusion of treatment episodes where pharmacotherapy was identified as the main treatment type.

Counselling had the second highest median number of treatment days per treatment episode (45). This varied slightly with the principal drug. For treatment episodes where the client was receiving counselling as the main treatment, the median number of days per treatment episode was highest when heroin was the principal drug of concern (57), compared with 44 when alcohol was the principal drug, 43 for amphetamines and 41 for cannabis.

The median length of time spent on support and case management was longest where the principal drug of concern was amphetamines (55 days) and shortest where alcohol was the principal drug (29 days). For rehabilitation treatment, the overall median number of treatment days per treatment episode was 30, ranging from 28 when amphetamines and cannabis were the principal drug to 35 for heroin.

Table 5.2: Duration of closed treatment episodes^(a) by main treatment type and selected principal drugs of concern, Australia, 2003–04

Main treatment type	Alcohol	Heroin	Cannabis	Amphetamines	Total ^(b)	Total 2002–03
(median number of days)						
Withdrawal management (detoxification)	7	7	9	7	8	7
Counselling	44	57	41	43	45	44
Rehabilitation	32	35	28	28	30	32
Support and case management only	29	45	52	55	43	43
Information and education only	1	1	1	1	1	1
Assessment only	1	8	7	1	2	1
Other ^(c)	21	92	29	6	47	55
Total (median number of days)	17	21	12	19	16	17
Total (number of treatment episodes)	48,500	23,326	28,427	14,208	129,331	123,032

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for principal drug of concern and balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

(c) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.3 Client type, source of referral and treatment programs

Overall in 2003–04, the most common sources of referral to services were self-referrals (40% of treatment episodes), followed by referrals from alcohol and other drug treatment services (11%) (Table 5.3). Compared with 2002–03, closed treatment episodes in 2003–04 were slightly more likely to have resulted from self-referral (41% compared with 37% respectively) (AIHW 2004a). Section 4.6 contains further information on source of referral, specifically in relation to principal drug of concern.

As noted in Section 3.2, a very high proportion of closed treatment episodes were for clients seeking treatment for their own drug use (95%), and therefore the pattern of referral for this client group is expected to mirror the overall referral patterns. However, the referral pattern for clients seeking treatment for others' drug use was different from those seeking treatment for their own drug use. Where treatment is sought for someone else's drug use, a higher proportion of closed treatment episodes were self-referred (46%) followed by referrals from family members or friends (17%), compared with episodes relating to clients seeking treatment for their own drug use (40% and 5% respectively).

Table 5.3: Closed treatment episodes by client type and source of referral, Australia, 2003–04

Source of referral	Own drug use		Others' drug use		Total	
	No.	%	No.	%	No.	%
Self	51,894	40.1	3,465	46.0	55,359	40.4
Family member/friend	6,537	5.1	1,285	17.0	7,822	5.7
GP/medical specialist	8,438	6.5	398	5.3	8,836	6.5
Psychiatric and/or other hospitals	4,797	3.7	174	2.3	4,971	3.6
Community mental health services ^(a)	2,561	2.0	87	1.2	2,648	1.9
Alcohol & other drug treatment services ^(a)	14,989	11.6	554	7.3	15,543	11.4
Other community/health care services ^(b)	5,700	4.4	490	6.5	6,190	4.5
Community-based corrections	12,237	9.5	109	1.4	12,346	9.0
Police diversions	8,841	6.8	208	2.8	9,049	6.6
Court diversions	2,221	1.7	18	0.2	2,239	1.6
Other	10,569	8.2	649	8.6	11,218	8.2
Not stated	547	0.4	101	1.3	648	0.5
Total	129,331	100.0	7,538	100.0	136,869	100.0

(a) Includes residential and non-residential services.

(b) Comprises other residential community care unit; non-residential medical and/or allied health care agency; other non-residential community health care agency/outpatient clinic; and other community service agency.

When closed treatment episodes for clients seeking treatment for their own drug use are considered, the most common main treatments received were counselling (35%), withdrawal management (detoxification) (19%) and assessment only (16%) (Table 5.4). These proportions are very similar to those for the treatment population overall (Section 5.1)

Of the treatment types used by people seeking treatment for others' drug use, the highest proportion of closed treatment episodes were for counselling (80%), then information and education only (9%). As might be expected, some treatment types, such as withdrawal management (detoxification) and rehabilitation, are only very rarely used by clients receiving treatment for someone else's drug use.

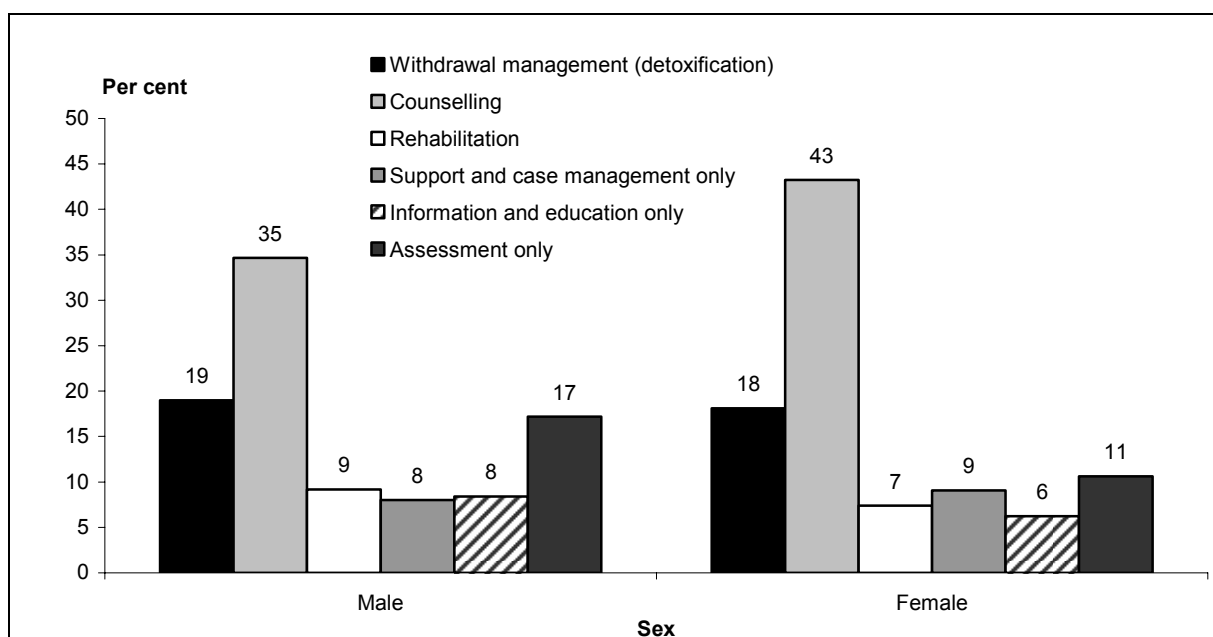
Table 5.4: Closed treatment episodes by client type and main treatment type, Australia, 2003–04

Main treatment type	Own drug use		Others' drug use		Total	
	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	25,123	19.4	—	—	25,123	18.4
Counselling	45,454	35.1	6,060	80.4	51,514	37.6
Rehabilitation	11,688	9.0	29	0.4	11,717	8.6
Support and case management only	11,157	8.6	337	4.5	11,494	8.4
Information and education only	9,788	7.6	677	9.0	10,465	7.6
Assessment only	20,195	15.6	219	2.9	20,414	14.9
Other ^(a)	5,926	4.6	216	2.9	6,142	4.5
Total	129,331	100.0	7538	100.0	136,869	100.0

(a) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.4 Sex, age and treatment program

In 2003–04, the main treatment type varied with the sex and age group of the client (Figures 5.2 and 5.3). Of closed treatment episodes where the clients were female, a higher proportion involved counselling as the main treatment (43%) than for males (35%). Male clients were more likely to receive assessment only as their main treatment (17% of treatment episodes for males, compared with 11% for females), and slightly more likely to receive rehabilitation (9% compared with 7%), and information and education only (8% compared with 6%). The proportion of treatment episodes for male and female clients receiving support and case management only were 8% and 9%, respectively.



Source: Table A4.16.

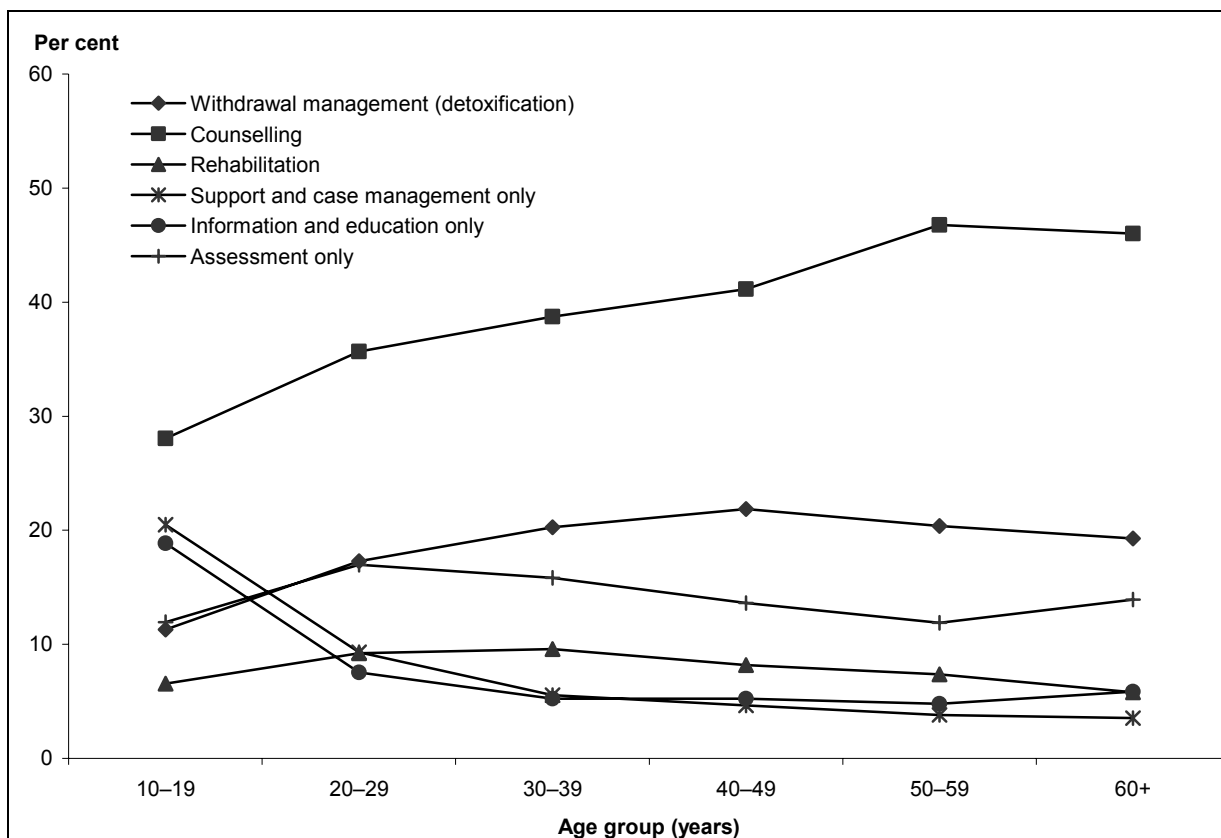
Figure 5.2: Closed treatment episodes by selected main treatment type and sex, Australia, 2003-04

Overall, counselling accounted for 38% of closed treatment episodes nationally; however, this proportion varied when age group was considered (Figure 5.3). In 2003-04, the proportion of treatment episodes where counselling was the main treatment increased with the age of the client, from 28% of closed treatment episodes for clients aged 10-19 years to 47% of episodes for clients aged 50-59 years.

Withdrawal management (detoxification) was most common treatment type in episodes where the clients were aged 40-49 years (22%), followed by those aged in the 50-59 age group (20%). Withdrawal management was least common among the younger age groups – 11% of treatment episodes for clients in the 10-19 age group and 17% for those in the 20-29 age group.

Compared with counselling and withdrawal management (detoxification), there was a more even spread of closed treatment episodes across age groups for rehabilitation services. Rehabilitation ranged between 6% and 10% of treatment episodes for all age groups, higher in the 20-29 and 30-39 age groups (9% and 10% respectively) and lower in clients aged 60 and over (6%).

As shown in Section 5.2, different principal drugs of concern show different distributions of main treatment types, and, as Figure 5.3 shows, different age groups show different distributions of main treatment types. The distribution of main treatment types over age could be related to the most common principal drug of concern for each age group. For example, cannabis was the principal drug of concern with the highest rate of information and education only as a treatment type, and, in the 10-19 age group, cannabis was the most common principal drug of concern. Cannabis was more common in the 10-19 age group compared with the 20-29 age group. Figure 5.3 shows that information and education only also showed a large drop between these age groups.



Source: Table A4.16.

Figure 5.3: Closed treatment episodes by main treatment type and age group, Australia, 2003-04

5.5 Indigenous status and treatment program

There are a number of differences when comparing treatment types for Aboriginal and Torres Strait Islander clients and other Australians. Closed treatment episodes involving Aboriginal and Torres Strait Islander clients were less likely to have withdrawal management (detoxification) (11% of treatment episodes for Indigenous clients, compared with 20% of episodes for other Australians) or counselling as the main treatment (33% compared with 38%) (Table 5.5). On the other hand, treatment episodes involving Aboriginal and Torres Strait Islander clients were more likely to have information and education only and assessment only as the main treatments (15% and 20% respectively), compared with episodes for other Australian clients (7% and 14% respectively).

Compared with 2002-03, there has been a decrease in the proportion of closed treatment episodes for Indigenous clients receiving counselling (38% in 2002-03 to 33% in 2003-04), and an increase in the proportion receiving assessment only (from 15% to 20%) (AIHW 2004a). A similar change can be observed for treatment episodes of other Australians across the collection period – counselling decreased from 42% to 38%.

Table 5.5: Closed treatment episodes by main treatment type and Indigenous status, Australia, 2003–04

Main treatment type	Indigenous		Non-Indigenous		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	1,503	11.4	22,480	19.5	1,140	13.7	25,123	18.4
Counselling	4,371	33.0	43,925	38.1	3,218	38.8	51,514	37.6
Rehabilitation	1,295	9.8	9,962	8.6	460	5.5	11,717	8.6
Support and case management only	1,188	9.0	9,621	8.3	685	8.3	11,494	8.4
Information and education only	1,933	14.6	7,757	6.7	775	9.3	10,465	7.6
Assessment only	2,581	19.5	16,279	14.1	1,554	18.7	20,414	14.9
Other ^(a)	367	2.8	5,314	4.6	461	5.6	6,142	4.5
Total	13,238	100.0	115,338	100.0	8,293	100.0	136,869	100.0
Per cent of closed treatment episodes	9.7	..	84.3	..	6.1	..	100.0	..

(a) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.6 Geographical location and treatment program

In 2003–04, across all areas – except for very remote areas – counselling was the most commonly reported main treatment type, accounting for 36% of treatment episodes in major cities, 44% in inner regional, 38% in outer regional and 47% in remote areas (Table 5.6). In very remote areas, rehabilitation was the most common treatment type (49% of treatment episodes). The spread of other treatment types varied by geographical location of the treatment agency. In major cities, withdrawal management (detoxification) was the second most common treatment (22%), followed by assessment (15%). In outer regional and very remote areas, information and education only was the second most prominent treatment type (29% and 23% respectively), followed by assessment only in outer regional areas (11%), and withdrawal management (detoxification) in very remote areas (9%). As noted in Section 4.5, caution should be used when interpreting geographical data.

Compared with 2002–03, the largest shift in distribution of main treatment by geographical location is observed in episodes based in very remote areas. In 2002–03, 22% of treatment episodes in very remote areas involved clients receiving withdrawal management (detoxification); this dropped to 9% in 2003–04 (AIHW 2004a). Other observed changes in distribution involve episodes in inner regional areas, where the proportion of episodes with counselling as main treatment dropped from 50% in 2002–03 to 44% in 2003–04; and assessment only, where the proportion of episodes increased from 8% in 2002–03 to 15% in 2003–04.

Table 5.6: Closed treatment episodes by main treatment type and geographical location,^(a) Australia, 2003–04 (per cent)

Main treatment type	Major cities	Inner regional	Outer regional	Remote	Very remote	Total ^(b)	Total (number) ^(b)
Withdrawal management (detoxification)	21.7	12.2	7.5	9.4	9.2	18.4	25,123
Counselling	35.6	44.0	38.3	46.8	5.7	37.6	51,514
Rehabilitation	9.5	6.9	4.1	12.0	49.4	8.6	11,717
Support and case management only	8.1	10.6	6.7	0.9	4.6	8.4	11,494
Information and education only	4.6	8.4	28.6	13.9	23.0	7.6	10,465
Assessment only	15.4	15.2	10.5	16.4	8.0	14.9	20,414
Other	5.1	2.8	4.2	0.6	0.0	4.5	6,142
Total	94,981	27,767	12,389	1,645	87	..	136,869
Per cent of closed treatment episodes	69.4	20.3	9.1	1.2	0.1	100.0	..

(a) The geographical location of treatment agencies in the 2003–04 AODTS–NMDS has been analysed using the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 6).

(b) Includes 'not stated' for geographical location.

(c) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.7 Additional treatments

As well as identifying the main treatment type, all other forms of treatment provided to the client for alcohol and other drugs are also recorded as part of the AODTS–NMDS. This section looks at the main treatment type of clients together with a short list of other treatment types. This analysis provides an indication of multiple treatment usage in alcohol and other drug treatment services. For this analysis, Victoria and the Northern Territory were excluded as they did not provide data for 'other treatment type'.

In 2003–04, of the 86,539 closed treatment episodes where clients were seeking treatment, 16,230 episodes (19%) reported at least one other treatment type – that is, a main treatment type and at least one other treatment type (Table 5.7). This proportion varied with the main treatment type – where withdrawal management (detoxification) was the main treatment type, 45% of clients reported at least one other treatment; where another treatment type was recorded, 44% of clients reported at least one other treatment type; and where rehabilitation was the main treatment, 36% of clients reported more than one treatment type. Where counselling was the main treatment, only 15% of clients reported at least one other treatment type.

The total proportion of episodes with other treatment types remained stable between 2002–03 and 2003–04. However, the proportion of episodes with another treatment type also used differed for withdrawal management (detoxification), falling from 45% to 35% between the reporting periods, and rehabilitation, increasing from 36% to 45%.

The nature of some treatments – such as support and case management only, information and education only and assessment only – means that they cannot be reported as a secondary treatment type, so these treatments were only recorded as main treatments.

Table 5.7: Number of closed treatment episodes by main treatment type, with or without other treatment type, Australia^(a), 2003–04

Main treatment type	With other treatment type	With no other treatment type	Total episodes	Proportion of episodes with other treatment type (%)	Proportion of episodes with other treatment type 2002–03 (%)
Withdrawal management (detoxification)	6,468	7,876	14,344	45.1	35.1
Counselling	4,251	24,162	28,413	15.0	16.6
Rehabilitation	3,466	6,051	9,517	36.4	45.1
Support and case management only	—	5,255	5,255	—	—
Information and education only	—	9,464	9,464	—	—
Assessment only	—	14,901	14,901	—	—
Other ^(b)	2045	2,600	4,645	44.0	46.1
Total	16,230	70,309	86,539	18.8	18.8

(a) Excludes 47,638 closed treatment episodes from Victoria and 2,692 closed treatment episodes from Northern Territory as these jurisdictions did not provide data for 'other treatment type'.

(b) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4)

From the 16,230 closed treatment episodes that did report at least one other treatment type, 19,889 other treatment types were reported (clients are able to report up to four other treatment types) (Table A4.14). This equates to an average of 1.2 other treatments for clients of these treatment episodes.

5.8 Reason for cessation and treatment program

As described in Section 4.9, in the AODTS–NMDS there are a number of reasons a treatment episode can end. When all closed treatment episodes are considered, the most common reason for ending a treatment episode was because the treatment was completed (53%), followed by treatment ending where the client ceased to participate without notice to the treatment agency (16%)⁴ (Table 5.8).

The reason for cessation of a treatment episode differs by main treatment type. Treatment was relatively more likely to be completed where the main treatment type was assessment only (64% of episodes with this treatment type) and withdrawal management (detoxification (61%)), and less likely where the main treatment type was information and education only (36%) (Table 5.8). The low proportion of completed episodes of information and education only related to the fact that the majority of these treatment episodes ended at expiation (54%). This finding may be expected, since expiation, as defined in the AODTS–NMDS, refers to when a client has atoned for the offence by completing a recognised education or information program. This relates closely to the use of expiation for

4. This number is different from that reported in Chapter 4, as data reported in this chapter include all client types, not just those receiving treatment for their own drug use or their own and someone else's drug use (as is the case in Chapter 4).

cannabis use—69% of all treatment episodes where information and education was the main treatment type involved cannabis as the principal drug of concern⁵ (Table A4.15).

A relatively high proportion of treatment episodes for counselling were recorded as ending because the client ceased to participate without notice (25% of all episodes for counselling). Rehabilitation and withdrawal management (detoxification) were the treatment types with the highest proportion of episodes ending with a client ceasing to participate against advice (15% and 11% of treatment episodes respectively).

Table 5.8: Closed treatment episodes by main treatment type and selected reason for cessation, Australia, 2003–04 (per cent)

Main treatment type	Treatment completed	Transferred to another service provider	Ceased to participate without notice	Ceased to participate against advice	Ceased to participate at expiation	Other ^(a)	Total ^(b)	Total (no.)
Withdrawal management (detoxification)	61.2	5.7	10.0	11.1	1.9	9.8	100.0	25,123
Counselling	52.0	4.3	25.4	2.2	3.1	12.5	100.0	51,514
Rehabilitation	40.1	7.0	14.7	14.5	2.2	20.7	100.0	11,717
Support and case management only	60.2	8.2	14.2	1.7	2.3	12.6	100.0	11,494
Information and education only	35.9	1.8	2.9	0.7	53.6	3.6	100.0	10,465
Assessment only	63.5	14.8	7.7	0.9	7.3	5.5	100.0	20,414
Other ^(c)	41.1	15.5	21.5	2.1	3.8	14.7	100.0	6,142
Total (per cent)	53.3	7.0	16.2	4.5	7.3	11.1	100.0	..
Total (number)	73,001	9,581	22,145	6,214	9,940	15,151	..	136,869

(a) Includes change in main treatment type; change in delivery setting; change in the principal drug of concern; all other ceased to participate categories; drug court and/or sanctioned by court diversion service; imprisoned other than drug court sanctioned; and died.

(b) Includes 'not stated' for reason for cessation.

(c) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5. In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and reason for cessation as 'ceased to participate at expiation'. It is possible that the principal drug of concern is not actually cannabis and it is expected that future modifications to data collection processes will enable this to be reflected.

5.9 Treatment delivery setting and treatment program

Treatment delivery setting refers to the setting in which the main treatment is provided – settings include non-residential or residential facilities, homes, outreach settings or other settings. Just over two-thirds (68%) of treatment episodes occurred at a non-residential facility⁶ (Table 5.9). One-fifth (20%) of treatment episodes occurred in residential facilities and 7% in an outreach setting such as a mobile van service.

Closed treatment episodes conducted in residential facilities or home settings were most likely to involve withdrawal management (detoxification) as the main treatment type (53% and 74% respectively). The next most likely treatment in a residential treatment facility was rehabilitation (29%), and for home settings, the next most likely treatment types were counselling (12%) and assessment only (9%).

Of treatment episodes that were conducted in a non-residential treatment facility, the majority of episodes had counselling as the main treatment (52%), followed by assessment only (17%), withdrawal management (detoxification) (8%) and information and education only (8%). A high proportion of treatment episodes that were conducted in an outreach setting reported support and case management only as their main treatment (53%), followed by information and education only (16%) and counselling (13%).

Table 5.9: Closed treatment episodes by main treatment type and treatment delivery setting, Australia, 2003–04 (per cent)

Main treatment type	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Withdrawal management (detoxification)	8.3	53.4	74.0	2.6	0.9	18.4
Counselling	51.8	2.2	11.7	12.5	32.4	37.6
Rehabilitation	3.4	28.8	0.6	2.1	14.1	8.6
Support and case management only	6.4	0.7	1.9	53.4	4.5	8.4
Information and education only	8.0	1.7	1.6	15.8	28.8	7.6
Assessment only	17.1	9.9	9.2	11.1	13.1	14.9
Other ^(a)	5.1	3.4	1.0	2.6	6.1	4.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	92,933	27,281	3,435	9,585	3,635	136,869
Per cent of closed treatment episodes	67.9	19.9	2.5	7.0	2.7	100.0

(a) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

6. Some of these non-residential facilities may also have a component of residential care available.

Duration of treatment episode—treatment delivery setting

Overall, when all closed treatment episodes are considered, the median number of treatment days⁷ for a treatment episode was 17⁷ (Table 5.10). The highest median number of days within a treatment episode occurred where the treatment delivery was either in a non-residential treatment facility or in an outreach setting (24 and 23 respectively). Treatment episodes where the treatment delivery setting was a client's home had a median length of treatment of 18 days, whereas clients receiving treatment in residential treatment facilities had a median length of 7 treatment days.

Overall, the median length of time spent on support and case management was 43 days. This varied by treatment delivery setting—45 days for those receiving treatment in an outreach setting, 44 days for non-residential treatment facilities, 22 days for residential treatment facilities and 11 days for home.

The median duration of treatment episodes involving withdrawal management (detoxification) was 8 days. The highest median length for this treatment type was for clients receiving services at home or in a non-residential treatment facility (19 and 17 days respectively). The shortest median duration for this treatment type was for clients receiving treatment through an outreach setting (4 days).

Table 5.10: Duration^(a) of closed treatment episodes by main treatment type and treatment delivery setting, Australia, 2003–04

Main treatment type	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
(median number of days)						
Withdrawal management (detoxification)	17	6	19	4	11	8
Counselling	44	7	61	33	63	44
Rehabilitation	26	30	31	15	39	30
Support and case management only	44	22	11	45	17	43
Information and education only	1	1	1	1	1	1
Assessment only	4	1	1	1	1	2
Other ^(b)	41	111	13	6	1	45
Total	24	7	18	23	11	17
Total (number of treatment episodes)	92,933	27,281	3,435	9,585	3,635	136,869

(a) As stated in Section 5.2, duration of a closed treatment episode is determined in the AODTS–NMDS by calculating the number of days between the date the client commenced a treatment episode and the date the client ended a treatment episode. This analysis investigates duration using the 'median number of days' per treatment episode for treatment delivery setting.

(b) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

7. The median number of treatment days for a treatment episodes in this section is different from that presented in Table 5.2, as the median number of treatment days for a treatment episode in Table 5.2 was calculated excluding clients seeking treatment for the drug use of others.

Treatment delivery setting and principal drug of concern

In 2003–04, for treatment episodes where the treatment delivery setting was either a non-residential treatment facility, a residential treatment facility, the client's home, or an outreach setting, the principal drug of concern of the client was most likely to be alcohol (38%, 39%, 39% and 31% respectively) (Table 5.11). This was also the case in 2002–03 (38%, 43%, 38% and 24% respectively) (AIHW 2004a). The next most common principal drug for clients in non-residential facilities, at home and in outreach settings was cannabis (24%, 23% and 26% respectively), followed by heroin for all three treatment delivery settings (16%, 15% and 15% respectively). This pattern was reversed for residential treatment facilities, where the second most common principal drug of concern was heroin (25%), and the third was cannabis (14%).

For treatment episodes where the delivery setting was an 'other' delivery setting, the most common principal drug was cannabis (34%), followed by alcohol (21%), amphetamines (19%) and heroin (18%).

These patterns largely reflect the fact that alcohol, cannabis, heroin and amphetamines are the four most common principal drugs of concern in the AODTS–NMDS for 2003–04.

Table 5.11: Closed treatment episodes by principal drug of concern and treatment delivery setting, Australia, 2003–04^(a) (per cent)

Principal drug of concern	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Alcohol	38.3	39.3	38.8	30.8	20.5	37.5
Amphetamines	10.7	12.7	8.5	6.4	18.9	11.0
Benzodiazepines	2.0	2.6	3.8	0.9	2.0	2.1
Cannabis	23.5	14.0	23.1	26.1	33.5	22.0
Cocaine	0.2	0.2	0.1	0.1	0.4	0.2
Ecstasy	0.4	0.2	0.2	0.7	0.4	0.4
Heroin	16.4	24.7	15.3	14.5	18.2	18.0
Methadone	1.8	1.8	1.6	2.3	2.0	1.9
Nicotine	1.3	0.2	0.7	8.8	1.3	1.5
Other drugs ^(b)	4.7	4.1	7.7	9.3	2.2	4.9
Not stated	0.6	0.1	0.2	0.2	0.5	0.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	86,350	27,170	3,358	8,920	3,533	129,331
Per cent of closed treatment episodes	66.8	21.0	2.6	6.9	2.7	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes not stated for principal drug of concern, and balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

6 Special theme: Amphetamines

Previous chapters of this report have profiled clients seeking treatment from government-funded alcohol and other drug treatment services in 2003–04, the types of drugs for which they sought treatment and the types of treatment they receive. This special theme chapter focuses on closed treatment episodes where amphetamines were the principal drug of concern for a client. This theme was selected on the basis of feedback received from the agencies via the 2004 Survey of Treatment Agencies. The analysis presented in Sections 6.2 and 6.3 examines those treatment episodes that involve clients who sought treatment for their own drug use.

Box 6.1: Key definitions and counts for closed treatment episodes and treatment programs, 2003–04

***Principal drug of concern** refers to the main substance that clients state 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. It is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2003–04 there were:*

- ***14,208** closed treatment episodes for clients who nominated amphetamines as their principal drug of concern*
- ***114,491** closed treatment episodes for clients who nominated a principal drug of concern other than amphetamines*
- ***632** closed treatment episodes for clients who did not nominate a principal drug of concern.*

***Other drugs of concern** refer to any other drugs apart from the principal drug of concern that clients perceive as being a health concern. Up to five other drugs of concern can be recorded for each client.*

- ***16,754** other drugs of concern were recorded where amphetamines were nominated as the principal drug of concern*
- ***94,133** other drugs of concern were recorded where principal drugs of concern, other than amphetamines, were nominated.*

See Section 1.2 and Boxes 3.1, 4.1 and 5.1 for other definitions.

6.1 Introduction

What are amphetamines?

‘Amphetamines’ refers to a group of psychostimulant drugs which includes methamphetamine. Amphetamines can be legally prescribed to help treat disorders such as epilepsy and narcolepsy, as well as attention deficit disorder. Illicitly, amphetamines are used, generally, to increase endurance, reduce tiredness, improve performance and to help stay awake for long periods of time. Amphetamines have long been associated with

clubbing, dance parties and 'raves', and long-distance truck driving, where the use of the stimulant allows people to keep active for longer periods of time.

Common names for amphetamines and methamphetamines include 'speed', 'ice', 'crystal', 'whiz' and 'uppers'. Amphetamines are commonly swallowed, injected or smoked, but, this depends on the form of amphetamines being taken. There are five distinct forms of amphetamines:

- powder (e.g. 'speed')
- liquid (e.g. 'ox blood', 'liquid red')
- base (e.g. 'paste', 'pure', 'meth')
- crystal (e.g. 'ice', 'crystal meth', 'shabu', 'glass')
- pharmaceutical or prescribed tablets (duromine, dexamphetamine, Ritalin).

As with most drugs, the effects of amphetamines depend on the strength of the dose and the characteristics of the individual using the drug – such as, height, weight, health. The most common and immediate effects experienced after taking amphetamines include:

- speeding up of bodily functions such as accelerated heart rate and breathing, and rise in blood pressure
- more energy and alertness, including a boost in confidence, becoming talkative, increased endurance and becoming excited
- reduction or loss of appetite
- other physical effects such as dilated pupils, dry mouth, sweating, jaw clenching and teeth grinding.

Long-term or regular use of amphetamines may lead to significant health problems including anxiety and tension, high blood pressure, amphetamine psychosis – which includes hallucinations, paranoia, and other symptoms similar to schizophrenia – reduced immunity, and risk of damage to brain cells (Better Health Channel 2004).

Amphetamine use in Australia

According to the 2004 National Drug Strategy Household Survey (AIHW 2005a), of Australians aged 14 years and over:

- 9.1% had used amphetamines⁸ at some stage in their lifetime, and 3.2% had used them in the previous 12 months (Table 6.1)
- the age group most likely to have ever used amphetamines was the 20–29-year age group (21.1%)
- males were more likely than females to have used amphetamines in the last 12 months (4.0% and 2.5% respectively); however, females aged between 14 and 19 years were slightly more likely to be recent users than males in the same age group (4.9% and 4.0% respectively)
- of those who had ever used amphetamines, the average age of initiation was 20.8.

8. The 2004 National Drug Strategy Household Survey refers to this group of drugs as meth/amphetamines. Similarly, within this report, the term 'amphetamines' includes those drugs that are classified as methamphetamines, such as ice, crystal and speed.

Table 6.1: Use of meth/amphetamines: proportion of the population aged 14 years and over, by age group and sex, Australia, 2004 (per cent)

Age group	Ever used ^(a)			Recent use ^(b)		
	Males	Females	Persons	Males	Females	Persons
14–19	6.6	6.5	6.6	4.0	4.9	4.4
20–29	24.3	17.9	21.1	12.4	9.0	10.7
30–39	19.8	12.3	16.0	5.7	2.5	4.1
40+	4.6	2.6	3.6	0.7	0.2	0.4
Aged 14+	11.0	7.3	9.1	4.0	2.5	3.2

(a) Used at least once in lifetime.

(b) Used in the last 12 months.

Source: AIHW 2005a.

Availability of amphetamines

The National Drug Strategy Household Survey also examines the availability of drugs – survey respondents were asked whether they have been offered or had the opportunity to use selected drugs in the preceding 12 months. Under one-tenth of the population (6.8%) were offered or had the opportunity to use amphetamines in 2004. This proportion was similar to 2001 where 7.6% of the population reported the availability of this drug (AIHW 2005a). From the 2004 survey, males were more likely than females to have been offered or had the opportunity to use amphetamines (8.3%, compared with 5.4%), as was the case in 2001 (9.3% and 5.8%).

Data from the Illicit Drug Reporting System (IDRS) are compiled through interviews with injecting drug users and key informants (including professionals) who have regular contact with illicit drug users through their work. Although these data are *not* representative of the population as a whole, they serve as an early warning system for emerging trends in local and national illicit drug markets. Data from the national 2004 IDRS show that:

- the majority of interviewees across Australia reported it was ‘easy’ or ‘very easy’ to obtain amphetamines in all forms (81% for powder, 82% base and 73% for crystal)
- injecting drug users were more likely to obtain (or score) powder most commonly from friends (34%), dealer’s home (20%) or mobile dealers (17%); for base, friends were again the most common place to score (31%), then dealer’s home (24%) or mobile dealers (26%). The proportions reporting common places to score crystal were slightly different – friends (35%), dealer’s home (20%), mobile dealers (16 %) or street dealers (15%)
- the median price of amphetamines (based on the participant’s last purchase) varied according to the form of amphetamine purchased and by jurisdiction. For example, in 2004 the median price *per gram* of powder ranged from \$50 in South Australia to \$290 in Tasmania; for a *point* of base from \$25 in South Australia to \$50 in all other jurisdictions (except Victoria); and for a *point* of crystal prices ranged from \$30 in South Australia to \$50 in all other jurisdictions
- the purity of ‘crystal’ was reported as high, ‘base’ purity was medium and the purity of ‘powder’ was mixed with similar patterns of injecting drug users reporting purity as low, medium and high (NDARC 2005).

Data from the Australian Customs Service – as reported in the IDRS report – show an increase in the number of detections of amphetamine-type stimulants at the Australian border (NDARC 2005), with the number of seizures increasing from 51 in 2000–01 to 215 in 2002–03, but decreasing to 140 seizures in 2003–04. Similarly, the weight of the seizures has also increased substantially over the last few years, from 85 kg in 2000–01 to 239 kg in 2002–03. The total weight of seizures was highest in 2001–02 (428 kg).

6.2 Client profile

Sex and age group

Amphetamines were more likely to be reported as the principal drug of concern for younger age groups. Of those closed treatment episodes where amphetamines were the principal drug of concern, a higher proportion of episodes involved people in the 20–29 and 30–39-year age groups (48% and 33% respectively) compared with episodes for all other principal drugs of concern (32% of episodes for 20–29-year-olds and 28% for 30–39-years-olds) (Table 6.2). Clients aged over 40 are more likely to seek treatment for alcohol (Figure 4.2).

Overall, males were more likely than females to receive treatment for their own drug use – 68% of treatment episodes related to male clients and 32% to female clients (Table 6.2). This pattern was very similar for episodes where amphetamines were nominated as the principal drug of concern (67% males and 33% females).

When considering those episodes where amphetamines were nominated as the principal drug, some sex and age differences are observed. For example:

- a higher proportion of female clients aged 10–19 were seeking treatment for amphetamines compared with male clients in the same age group (14% compared with 9%)
- a slightly higher proportion of male clients aged 30–39 were seeking treatment for amphetamines compared with females clients in the same age group (34% and 31%).

Table 6.2: Closed treatment episodes^(a) by principal drug of concern by age group and sex, Australia, 2003–04 (per cent)

Age group	Amphetamines			All other principal drugs of concern			Total ^(b)		
	Males	Females	Persons ^(c)	Males	Females	Persons ^(c)	Males	Females	Persons ^(c)
10–19	9.1	13.6	10.6	12.8	12.7	12.8	12.4	12.8	12.5
20–29	48.1	47.6	48.0	32.8	30.6	32.1	34.5	32.5	33.8
30–39	33.8	30.9	32.9	27.8	28.2	27.9	28.5	28.5	28.5
40–49	7.6	6.4	7.2	17.5	18.8	17.9	16.4	17.4	16.7
50–59	0.5	0.4	0.5	6.4	6.6	6.5	5.7	5.9	5.8
60+	0.1	0.1	0.1	2.2	2.2	2.2	1.9	1.9	1.9
Not stated	0.7	1.0	0.8	0.6	0.9	0.7	0.6	0.9	0.7
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (no.)	9,563	4,637	14,208	77,475	36,942	114,491	87,419	41,829	129,331

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for principal drug of concern.

(c) Includes 'not stated' for sex.

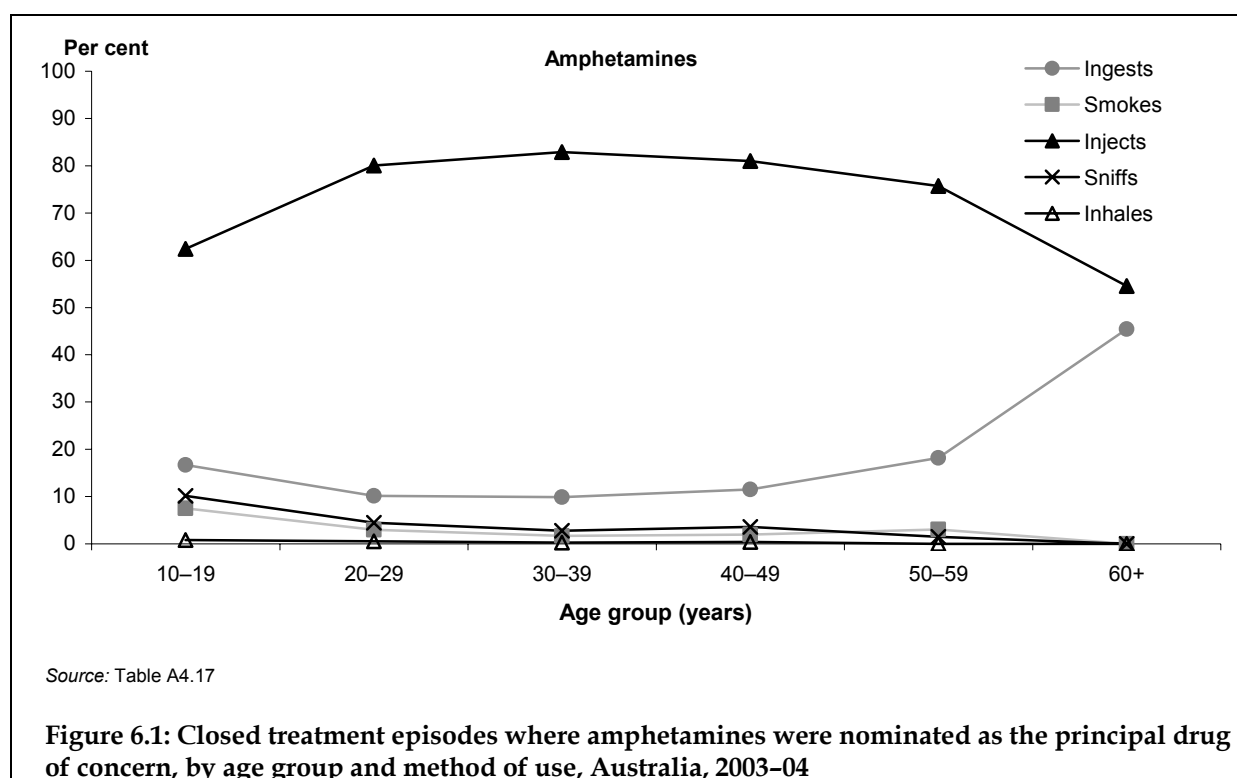
Method of use

As part of the AODTS-NMDS, clients are asked to nominate the usual method of administering their principal drug of concern, that is, their 'method of use'. Overall, for all closed treatment episodes in 2003–04 the most likely methods of use were ingestion (45%), followed by injection (28%) and smoking (23%) (Table 4.7). Inhaling accounted for 2% of treatment episodes overall, and sniffing was nominated for fewer than 1% of episodes (0.6%).

Where amphetamines were nominated as the principal drug of concern, injecting accounted for 79% of closed treatment episodes within this group, followed by ingesting (11%), sniffing (4%) and smoking (3%), compared with all other drugs of concern, where injecting accounted for 22%, ingesting 49%, sniffing 0.2% and smoking (25%) (Tables A4.17 and A4.18).

Across all age groups, injecting was the most common method of use for closed treatment episodes where amphetamines were the drug of concern (Figure 6.1). This was most marked for the 30–39 age group, with 83% of episodes in this age group nominating injecting as their preferred method of use. Similar proportions were recorded for the 40–49 and 20–29 age groups (81% and 80% respectively).

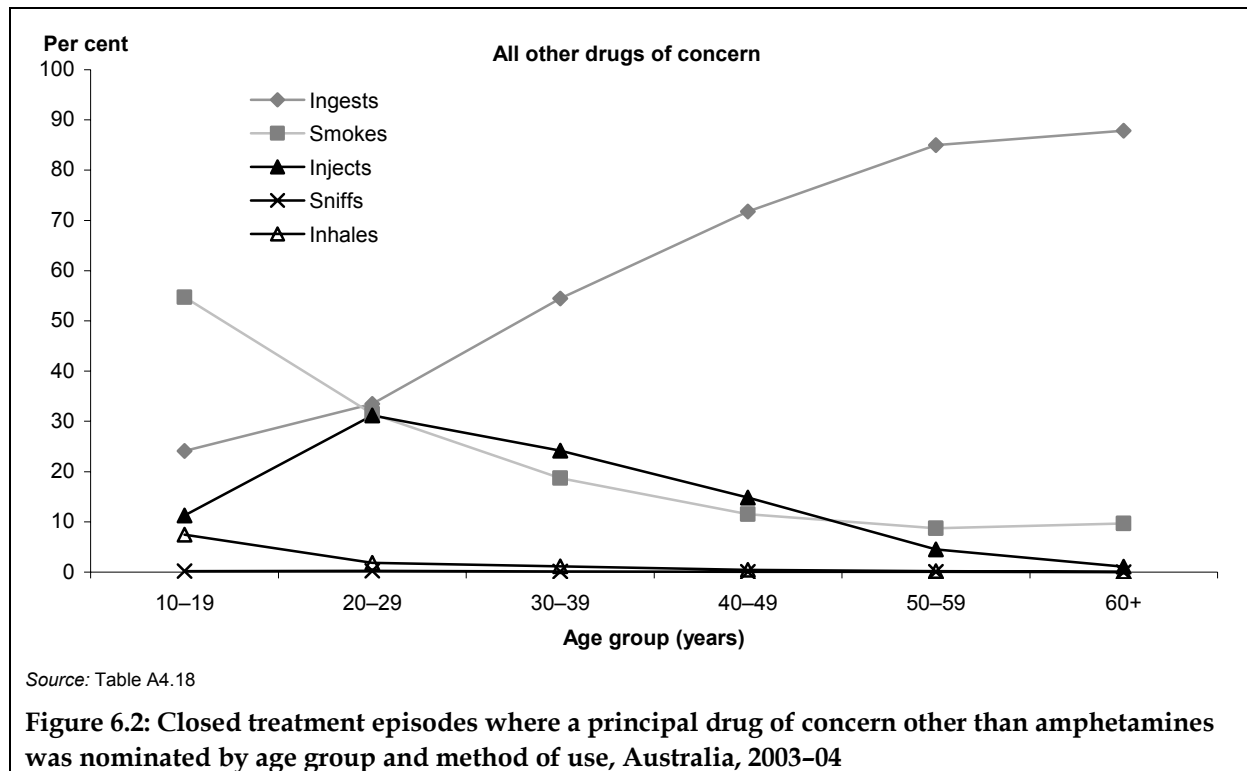
Figure 6.1 also shows higher rates of ingestion in the 50–59 and 60 years and over age groups compared with other age groups (18% and 46% respectively).



For closed treatment episodes where a principal drug of concern other than amphetamines was nominated, the pattern for method of use varies significantly compared with the amphetamines group (Figure 6.2). Overall, in this group, ingesting was the most common method of use, accounting for 50% of closed treatment episodes, followed by smoking (25%) and injecting (21%).

Relationships between age group and method of use illustrated in Figure 6.2 relate to principal drug of concern. For example:

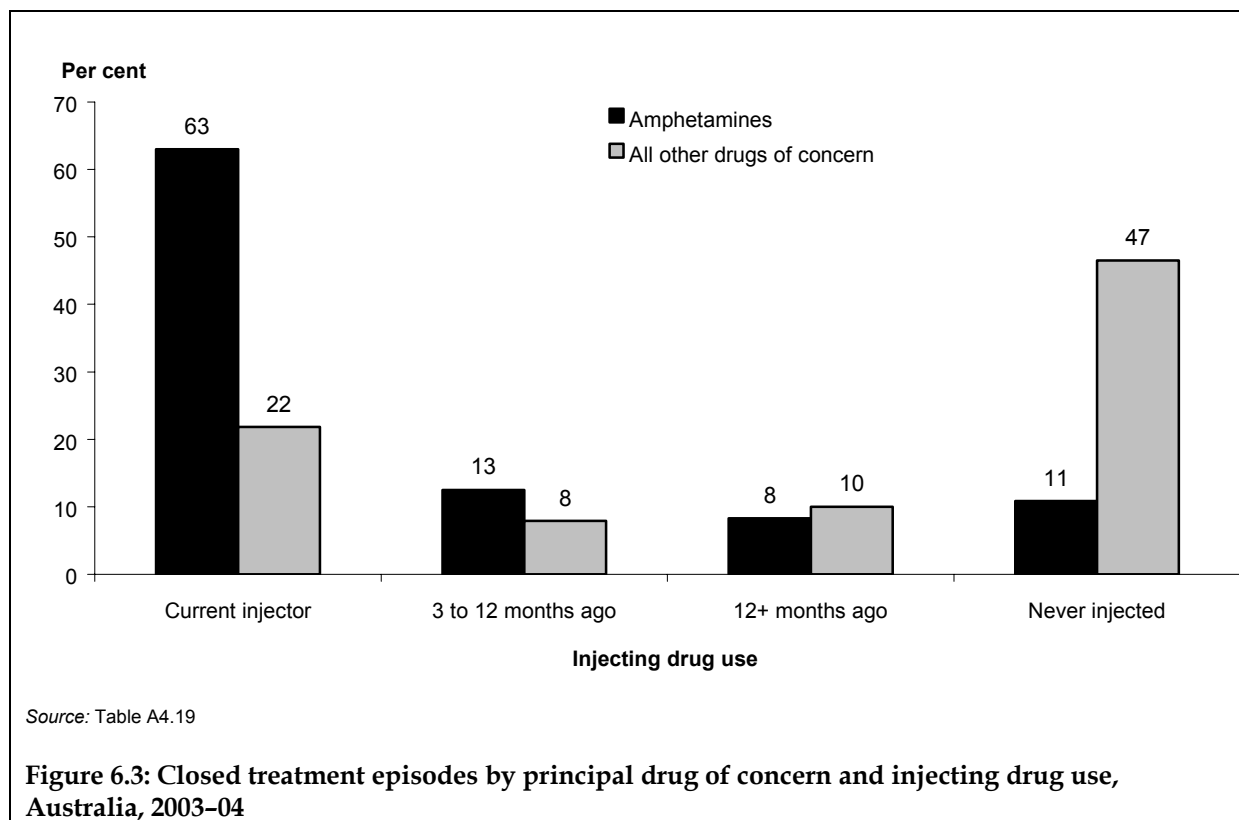
- among episodes where clients are aged between 10 and 19 years, the preferred method of use was smoking (55%); the most common principal drug of concern for this age group is cannabis (49%)
- for episodes where clients are aged 60 years and over, ingesting was the most common method of use (88%); the most common drug of concern for this age group is alcohol (82%).



Injecting drug use

Overall, 26% of clients in 2003-04 reported that they were current injectors, a further 18% had injected in the past (8% between 3 and 12 months ago and 10% 12 or more months ago) and 43% had never injected (Table A4.19). Clients nominating amphetamines as the principal drug of concern were more likely than those nominating all other principal drugs of concern to be current injectors (63% and 22% respectively) and less likely to have never injected (11% and 47% respectively) (Figure 6.3). The proportion of clients ever having injected in the past was similar for each group: 21% of episodes where amphetamines were the principal drug of concern compared with 18% of episodes where a principal drug other than amphetamines was selected.

Note that caution should be used when interpreting data for 'injecting drug use' due to the high 'not stated' response for this item (13% of overall closed treatment episodes).



Other drugs of concern

As stated in Section 4.7, of closed treatment episodes where amphetamines were nominated as the principal drug of concern, 9,583 episodes (or 67%) had at least one other drug of concern reported (Tables 4.5 and 6.3). From these episodes, 16,754 other drugs of concern were recorded (clients are able to report up to five other drugs of concern), equating to 1.7 other drugs of concern per treatment episode.

For closed treatment episodes where a drug other than amphetamines was nominated as the principal drug of concern, 58,882 episodes (or 51%) had at least one other drug of concern reported. From these episodes, 94,133 other drugs of concern were recorded, equating to 1.6 other drugs of concern per treatment episode.

Of the 16,754 other drugs of concern recorded for clients who nominated amphetamines as their principal drug of concern, 37% of these were cannabis, 21% alcohol, 10% nicotine and 9% heroin (Table 6.3). Of the other drugs of concern recorded for clients who nominated a principal drug of concern other than amphetamines, 24% of other drugs were cannabis, 18% nicotine, 16% amphetamines, 15% alcohol and 9% benzodiazepines.

Table 6.3: Other drugs of concern where the principal drug of concern is amphetamines and where the principal drug of concern is not amphetamines, Australia, 2003–04^(a)

Other drugs of concern	Amphetamines		All other principal drugs of concern		All principal drugs of concern	
	No.	%	No.	%	No.	%
Alcohol	3,506	20.9	14,188	15.1	17,694	16.0
Amphetamines	61	0.4	14,989	15.9	15,050	13.6
Benzodiazepines	1,065	6.4	8,517	9.0	9,582	8.6
Cannabis	6,206	37.0	22,696	24.1	28,902	26.1
Cocaine	403	2.4	1,161	1.2	1,564	1.4
Ecstasy	1,033	6.2	2,606	2.8	3,639	3.3
Heroin	1,490	8.9	4,319	4.6	5,809	5.2
Methadone	175	1.0	1,899	2.0	2,074	1.9
Nicotine	1,666	9.9	17,354	18.4	19,020	17.2
Other drugs ^(b)	1,149	6.9	6,404	6.8	7,553	6.8
Total	16,754	100.0	94,133	100.0	110,887	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

Source of referral

People seeking treatment for amphetamines as the principal drug of concern were more likely than those nominating other drugs of concern to be referred to treatment by a family member or friend (8%, compared with 5%) or from a correctional service (12%, compared with 9%), and less likely to be referred to treatment by a general practitioner or medical specialist (4%, compared with 7%) or through police diversion (3%, compared with 7%). For both groups, self-referring to treatment was the most common source of referral (42% of episodes where amphetamines were the principal drug and 40% of episodes for all other principal drugs of concern) (Table 6.4).

Table 6.4: Closed treatment episodes by principal drug of concern and source of referral, Australia, 2003–04 ^(a)

Source of referral	Amphetamines		All other principal drugs of concern		Total ^(b)	
	No.	%	No.	%	No.	%
Self	5,919	41.7	45,654	39.9	51,894	40.1
Family member/friend	1,113	7.8	5,411	4.7	6,537	5.1
General practitioner/medical specialist	589	4.1	7,791	6.8	8,438	6.5
Hospital	494	3.5	4,284	3.7	4,797	3.7
Community health care centre	265	1.9	2,282	2.0	2,561	2.0
Alcohol and other drug treatment service	1,509	10.6	13,421	11.7	14,989	11.6
Other community/health care service	716	5.0	4,967	4.3	5,700	4.4
Correctional service	1,715	12.1	10,471	9.1	12,237	9.5
Police diversion	486	3.4	8,296	7.2	8,841	6.8
Court diversion	478	3.4	1,743	1.5	2,221	1.7
Other	855	6.0	9,697	8.5	10,569	8.2
Not stated	69	0.5	474	0.4	547	0.4
Total	14,208	100.0	114,491	100.0	129,331	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Total includes 'not stated' for principal drug of concern.

6.3 Treatment programs

Main treatment type

Clients who nominated amphetamines as their principal drug of concern were more likely to receive rehabilitation (16%) and assessment only (19%), compared with clients who nominated a principal drug other than amphetamines (8% and 15% respectively) (Table 6.5). Conversely, clients with a principal drug other than amphetamines were more likely than those who nominated amphetamines as their principal drug to receive withdrawal management (detoxification) and information and education only (20% and 8%, compared with 14% and 3% respectively). A similar proportion of episodes were for clients receiving counselling as their main treatment (38% of episodes where amphetamines were the drug of concern, compared with 35% of episodes for all other principal drugs of concern).

Table 6.5: Closed treatment episodes by principal drug of concern and main treatment type, Australia, 2003–04^(a)

Main treatment type	Amphetamines		All other principal drugs of concern		Total ^(b)	
	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	2,003	14.1	23,102	20.2	25,123	19.4
Counselling	5,380	37.9	39,947	34.9	45,454	35.1
Rehabilitation	2,327	16.4	9,349	8.2	11,688	9.0
Support and case management	1,081	7.6	10,046	8.8	11,157	8.6
Information and education only	366	2.6	9,379	8.2	9,788	7.6
Assessment only	2,734	19.2	17,236	15.1	20,195	15.6
Other ^(c)	317	2.2	5,432	4.7	5,926	4.6
Total	14,208	100.0	114,491	100.0	129,331	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for principal drug of concern.

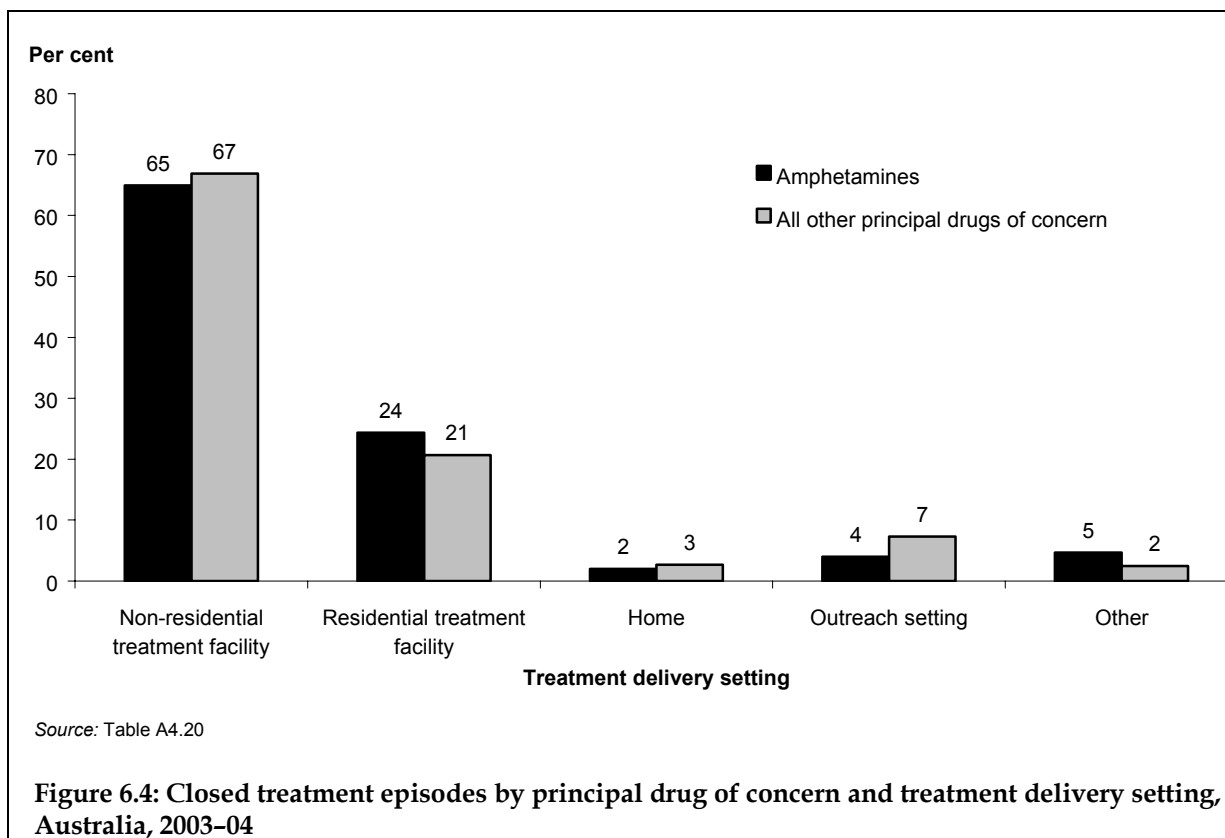
(c) 'Other' includes 2,953 closed treatment episodes (64 episodes for amphetamines group, 2,885 episodes for all other drugs of concern group and 4 episodes not stated) where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

Treatment delivery setting

Overall in 2003–04, just over two-thirds of all closed treatment episodes were conducted in non-residential treatment facilities (67%), around one-fifth in residential treatment facilities (21%) and 7% in outreach settings⁹ (Table A4.20).

Nearly one-quarter of treatment episodes where clients nominated amphetamines as their principal drug of concern were conducted in a residential treatment facility (24%), compared with just over one-fifth of the episodes where clients nominated a principal drug other than amphetamines (21%) (Figure 6.4). Closed treatment episodes where a principal drug of concern other than amphetamines was recorded were more likely to receive treatment in a non-residential treatment facility (67%) or in an outreach setting (7%), compared with clients who nominated amphetamines as their principal drug of concern (65% and 4% respectively). A similar proportion of closed treatment episodes in both groups had treatment delivered at home: 2% of episodes where amphetamines were the principal drug and 3% of episodes where all other principal drugs were reported.

9. These proportions are different from those reported in Chapter 5, as data in this chapter exclude clients who are seeking treatment for the drug use of others.



Reason for cessation of treatment episode

In 2003-04, among closed treatment episodes where clients were seeking treatment for their own drug use, where amphetamines were the principal drug of concern, 46% of episodes ceased because the treatment was completed, compared with 54%¹⁰ for other principal drugs of concern (Table 6.6). The next most common reason for ceasing treatment for both groups was where the client ceased to participate without notice to the treatment agency (22% and 15% respectively).

A higher proportion of closed treatment episodes where the principal drug of concern was a drug other than amphetamines ended treatment at expiation—that is, where the client had atoned for the offence by completing a recognised education or information program—compared with episodes where the principal drug was amphetamines (8% compared with 5%). For both groups, a very small proportion of treatment episodes ceased because the client died (Table 6.6).

10. These proportions are different from those reported in Chapter 5, as data in this chapter exclude clients who are seeking treatment for the drug use of others.

Table 6.6: Closed treatment episodes by principal drug of concern and selected reason for cessation, Australia, 2003–04^(a)

Reason for cessation	Amphetamines		All other principal drugs of concern		Total ^(b)	
	No.	%	No.	%	No.	%
Treatment completed	6,551	46.1	61,807	54.0	68,671	53.1
Change in main treatment type	209	1.5	2,579	2.3	2,788	2.2
Change in delivery setting	260	1.8	885	0.8	1,145	0.9
Change in principal drug of concern	15	0.1	195	0.2	210	0.2
Transferred to another service provider	1,132	8.0	8,068	7.0	9,342	7.2
Ceased to participate against advice	833	5.9	5,252	4.6	6,100	4.7
Ceased to participate without notice	3,063	21.6	17,642	15.4	20,787	16.1
Ceased to participate involuntary (non-compliance)	544	3.8	2,289	2.0	2,849	2.2
Ceased to participate at expiation	663	4.7	8,987	7.8	9,712	7.5
Ceased to participate by mutual agreement	434	3.1	3,052	2.7	3,488	2.7
Drug court and/or sanctioned by court diversion service	91	0.6	146	0.1	237	0.2
Imprisoned, other than drug court sanctioned	80	0.6	545	0.5	625	0.5
Died	7	0.0	131	0.1	138	0.1
Other	218	1.5	2,278	2.0	2,496	1.9
Not stated	108	0.8	635	0.6	743	0.6
Total	14,208	100.0	114,491	100.0	129,331	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for principal drug of concern.

7 Other data collections

This chapter briefly describes a range of relevant Australian data collections that provide context for the information presented in the remainder of this report.

7.1 Background

Harmful drug use has many social, health and economic impacts on Australian society. It was estimated that, in 1998, 17,671 deaths and 185,558 hospital separations were related to drug use (AIHW: Ridolfo & Stevenson 2001). The economic costs associated with harmful drug use, including prevention, treatment, loss of productivity in the workplace, property crime, theft, accidents and law-enforcement activities, were estimated in 1996 to amount to over \$18 billion annually (Collins & Lapsley 1996).

Internationally, there is great interest in improving the coordination of drug information systems. An effective and integrated drug information system should be able to 'address questions about emerging drug trends, general population prevalence, treatment seeking, demographics of drug users, at-risk groups, the drugs-crime nexus, drug-related harms (mortality and morbidity) and the effectiveness of education, health and law enforcement strategies' (Shand et al. 2003). In Australia, data are already collected in all of these areas. For example, the AODTS-NMDS provides data about a large proportion of the treatment-seeking population (those attending government-funded treatment services), the National Drug Strategy Household Survey provides information about national prevalence of drug use and perceptions of drugs, and school-based surveys provide information about at-risk groups. These and a range of other Australian data sources relating to drugs are described below.

7.2 Monitoring alcohol and other drug problems

This section identifies, and briefly describes data collections that relate to alcohol and other drug treatment services and drug use in Australia.

Key data collections relating to alcohol and other drug treatment services

- Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) (annual, from 2000-01).
- Aboriginal and Torres Strait Islander substance use specific services data from the Australian Government Department of Health and Ageing. See for example, *Drug and Alcohol Service Report (DASR): 2000-2001 Key Results* (DoHA 2003a) (annual, from 1999-2000, except for 2001-02).
- Indigenous primary health care services (includes substance use services) data from a joint initiative of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the National Aboriginal Community Controlled Health Organisations (NACCHO). See, for example, *A National Profile of Australian Government Funded Aboriginal and Torres*

Strait Islander Primary Health Care Services, Service Activity Reporting: 2000–2001 Key Results (DoHA 2003b).

- National Opioid Pharmacotherapy Statistics Annual Data Collection provides data on the number of pharmacotherapy clients and the type and location of their prescribers (see Section 7.4).
- National Hospital Morbidity database (held by AIHW) on the estimated numbers of hospital episodes and bed-days caused by alcohol, cigarettes and illicit drug use in Australia (see Section 7.3) (annual, from 1993).
- National Mortality database (held by AIHW) for deaths related to alcohol, tobacco and illicit drug use (see Section 7.3) (annual).

Key population surveys relating to drug use and treatment

- National Drug Strategy Household Survey (see Section 7.3) (approximately triennial, from 1985).
- Australian Secondary School Alcohol and Drugs Survey (ASSADS) (1996, 1999 and 2002) samples school students aged 12–17 years across Australia and uses a self-completion questionnaire to identify drug and alcohol knowledge, attitudes, awareness and behaviours among secondary school students. The data are collected under the umbrella of the National Cancer Council (approximately triennial, from 1996).

Other data collections and surveys relating to drug use and treatment

The following collections include information of relevance to drug and alcohol use and treatment activities:

- Clients of Treatment Services Agencies (COTSA): a one-day snapshot census of all clients using drug and alcohol treatment services across Australia, conducted in 1990, 1992, 1995 and 2001 (e.g. Shand & Mattick 2002). This census has effectively been superseded by the AODTS-NMDS (irregular, from 1990).
- The Council of Australian Governments Illicit Drug Diversion Initiative (COAG IDDI) provides drug users with the opportunity to be diverted from the criminal justice system to receive education, treatment and support to tackle their drug problem (DoHA 2004). All government and non-government agencies funded under this initiative are asked to collect data under the COAG IDDI NMDS, and available data are held centrally by the Australian Government Department of Health and Ageing (ongoing).
- Drug Use Monitoring in Australia (DUMA): an ongoing quarterly collection that measures recent drug use among persons detained by police and includes information on demographic characteristics and financial, criminal, drug use, drug market and treatment activities. Treatment information includes current and previous treatment history, types of treatment used, substance being treated for and reasons for entering treatment (AIC 2005) (quarterly).
- Drug Use Careers of Offenders (DUCO): a survey of a random sample from prisons in all states and territories which examines the relationship between drug-using careers and criminal careers. Key objectives are to examine the relationship between illicit drug use and violent and property crime in the adult and juvenile incarcerated population; links

between criminal careers and family background and mental health; and the nature of alcohol and other drug treatment both in and outside prison. The interviewer-administered questionnaire includes questions on sociodemographic characteristics, past criminal history, past drug history, illicit drug market activity, offender decision-making processes, estimated costs associated with drug use, and use of alcohol and other drug treatment, including perceptions of effectiveness of treatment currently received (AIC 2004) (irregular).

- Illicit Drug Reporting System (IDRS): a survey that monitors emerging trends in the use and supply of illicit drugs in Australia. The system collects data annually about the price, purity, availability and patterns of use of heroin, methamphetamine, cocaine and cannabis. The IDRS has three components: interviews with injecting drug users; interviews with key informants (professionals who have regular contact with illicit drug users through their work); and analysis of other sources of indicator data related to illicit drugs. The survey is designed to be sensitive to trends over time rather than to describe issues in detail, and is not based on a representative sample of intravenous drug users (NDARC 2005). The IDRS also involves a Party Drug Initiative, conducted nationally for the first time in 2003. This collection involves surveys with regular ecstasy users, interviews with people who have had contact with users, and analysis of existing indicator data sources to monitor emerging issues in party drugs markets (see, for example, Breen et al. 2004) (annual).
- Bettering the Evaluation and Care of Health (BEACH) survey data: a continuous survey of general practice activity covering about 100,000 general practitioner-patient encounters each year. Information is available on the number of encounters that provide advice, education, counselling or rehabilitation for alcohol, tobacco and illicit drug use and alcohol and tobacco risk factors (see, for example, AIHW: Britt et al. 2004) (annual).
- National Survey of Mental Health and Wellbeing of Adults (ABS 1998): provided information on estimates of the population prevalence of the more common forms of illicit drug use and on alcohol use and misuse and comorbid disorders.
- National Coroners Information System (NCIS): a national Internet-based data storage and retrieval system for coronial cases in Australia. The NCIS draws on coroners' files including police investigation reports, autopsy reports, supporting forensic medical reports and coroners' findings, and the core data set includes case demographics, cause of death details, and incident information such as the activity the person was engaged in at the time of death (MUNCCI 2004) (ongoing).
- National Community Mental Health Care Database (held by AIHW): contains information on non-admitted-patient service contacts provided by public community mental health establishments. Data include basic demographic details of patients such as date of birth and sex, clinically relevant information such as principal diagnosis and mental health legal status, and the date of service contact (e.g. AIHW 2005c) (annual).
- Australian Needle and Syringe Programme Survey: collected and collated by the National Centre in HIV Epidemiology and Clinical Research annually since 1995, this collection surveys intravenous drug users to monitor the prevalence of HIV, HBV and HCV infection among injecting drug users and examines injecting and sexual behaviours associated with these infections (NCHECR 2003).

- Medicare data: these data provide information on the type of service provided and the benefit paid by Medicare for the service. The Health Insurance Commission collects these data and provides them to the Australian Government Department of Health and Ageing.
- Pharmaceuticals Benefits Scheme (PBS) data: these data provide information on the type and cost of medication prescribed, the speciality of the prescribing practitioner and the location of the supplying pharmacy. The Health Insurance Commission collects these data and provides them to the Australian Government Department of Health and Ageing.

Detailed information on a range of data sources relating to substance use and mental health disorders is available from the AIHW publication *National Comorbidity Initiative: A Review of Data Collections Relating to People with Coexisting Substance Use and Mental Health Disorders* (2005d). Also, information on a range of national data sources relating to alcohol is available from the AIHW publication *A Guide to Australian Alcohol Data* (AIHW 2004c)

<www.aihw.gov.au> and information on a range of national sources of data relating to illicit drug use is available from the ABS publication *Illicit Drug Use, Sources of Australian Data* (2001).

The following sections outline more detailed information from the National Drug Strategy Household Survey, National Hospital Morbidity database, National Mortality database, and pharmacotherapy client statistics.

7.3 Use, mortality and morbidity data

This section provides an overview of trends in alcohol and other drug use, as well as trends in mortality and morbidity that can be attributed to the use of alcohol and other drugs.

National Drug Strategy Household Survey

The National Drug Strategy Household Survey provides information on patterns and trends in the use of alcohol and other drugs in the Australian population. Surveys have been conducted every 2 to 3 years from 1985 onwards, with the most recent survey in 2004. The 1998, 2001 and 2004 surveys have been managed by the AIHW on behalf of the Australian Government Department of Health and Ageing.

In 2004, almost 30,000 participants aged 12 years and over were surveyed from a stratified random sample of households across Australia. As the sample was based on households, it excluded homeless and institutionalised persons. Participants in the 2004 survey were asked about their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours (AIHW 2005a and AIHW 2005e).

The 2004 survey estimated that 84% of Australians aged 14 years and over recently consumed alcohol and just over one-fifth (21%) smoked tobacco (Table 7.1). Illicit drugs were used by less than one in five Australians (15%) in the last 12 months. Marijuana/cannabis (11%) was the most commonly used illicit drug in 2004, with 11% of the population aged 14 years and over using the drug in the last 12 months. A much smaller proportion of Australians aged 14 years and over had used other illicit drugs such as ecstasy (3%), cocaine (1%), hallucinogens (1%) or heroin (0.2%).

Between 1993 and 2004, the proportion of the population who had recently consumed alcohol increased from 73% to 84%, and this proportion increased significantly between 2001 (82%) and 2004 (84%) (Table 7.1). Between 1998 and 2004, there was a decline in the proportion of persons who had recently smoked tobacco (25% down to 21%).

With few exceptions, the proportion of the population using illicit drugs generally declined between 1993 and 2004. For example, the proportion of the population aged 14 years and over recently using marijuana/cannabis declined between 1993 and 2004 (13% to 11%). Overall, the use of any illicit drugs in the last 12 months prior to the NDSHS being conducted dropped from 17% in 2001 to 15% in 2004.

Table 7.1: Summary of drugs recently^(a) used by the population aged 14 years and over, Australia, 1993–2004 (per cent)

Drug	1993	1995	1998	2001	2004
Tobacco	n.a.	n.a.	24.9	23.2	20.7 #
Alcohol	73.0	78.3	80.7	82.4	83.6 #
Illicits					
Marijuana/cannabis	12.7	13.1	17.9	12.9	11.3 #
Painkillers/analgesics ^(b)	1.7	3.5	5.2	3.1	3.1
Tranquillisers/sleeping pills ^(b)	0.9	0.6	3.0	1.1	1.0
Steroids ^(b)	0.3	0.2	0.2	0.2	– #
Barbiturates ^(b)	0.4	0.2	0.3	0.2	0.2
Inhalants	0.6	0.6	0.9	0.4	0.4
Heroin	0.2	0.4	0.8	0.2	0.2
Methadone ^(c)	n.a.	n.a.	0.2	0.1	0.1
Other opiates ^(b)	n.a.	n.a.	n.a.	0.3	0.2
Meth/amphetamines (speed) ^(b)	2.0	2.1	3.7	3.4	3.2
Cocaine	0.5	1.0	1.4	1.3	1.0 #
Hallucinogens	1.3	1.8	3.0	1.1	0.7 #
Ecstasy ^(d)	1.2	0.9	2.4	2.9	3.4 #
Injected drugs	0.5	0.6	0.8	0.6	0.4
Any illicit	14.0	17.0	22.0	16.9	15.3 # ^(e)
None of the above	21.0	17.8	14.2	14.7	13.7 #

(a) Used in the last 12 months. For tobacco 'recent use' means daily, weekly and less than weekly smokers.

(b) For non-medical purposes.

(c) Non-maintenance.

(d) This category included substances known as 'designer drugs' prior to 2004.

(e) In 2004, also includes GHB and ketamine.

n.a. not available

2001 result significantly different from 2004 result (2-tailed $\alpha = 0.05$).

Source: National Campaign Against Drug Abuse Household Survey 1993; National Drugs Strategy Household Survey 1995, 1998, 2001, 2004.

People aged 20–29 years were more likely to have used an illicit drug in the last 12 months – 32% of 20–29-year-olds compared with 21% of 14–19-year-olds, 20% 30–39-year-olds, and 8% of people aged 40 years and over (Table 7.2).

People in the younger age groups (14–19 years and 20–29 years) were more likely to have used marijuana/cannabis, inhalants, heroin and hallucinogens in the last 12 months compared with older people. Persons aged 20–29 years were more likely to have used each illicit substance in Table 7.2 when compared with persons aged 14–19 years. Cocaine is the only drug that was more likely to have been used by people in the 30–39 age group than people in the 14–19 age group. People in the 40 years and over age group were less likely than younger people to have used each illicit substance.

Table 7.2: Summary of illicit drugs used in the last 12 months by persons aged 14 years and over by age group, Australia 2004 (per cent)

Drug	Age group				All ages
	14–19 years	20–29 years	30–39 years	40+ years	
Marijuana/cannabis	17.9	26.0	15.9	3.9	11.3
Prescribed drugs ^(a)	4.0	5.1	3.9	3.3	3.8
Inhalants	1.0	1.1	0.4	0.1	0.4
Heroin, methadone and/or other opiates	0.6	0.7	0.5	0.1	0.3
Meth/amphetamines (speed)	4.4	10.7	4.1	0.4	3.2
Cocaine	1.0	3.0	1.8	0.2	1.0
Hallucinogens	1.5	2.3	0.7	0.1	0.7
Ecstasy	4.3	12.0	4.0	0.3	3.4
Any illicit drug ^(b)	21.3	31.5	20.2	7.4	15.3

(a) Includes prescription drugs such as pain-killers/analgesics, tranquillisers/sleeping pills, steroids and barbiturates, used for non-medical purposes.

(b) Includes all drugs listed above, plus injected drugs, inhalants, GHB and ketamine.

Source: 2004 National Drug Strategy Household Survey, AIHW analysis.

Alcohol and other drug treatment reported by the population

The NDSHS is able to provide a separate measure of participation in alcohol and other drug treatment programs to the AODTS-NMDS. Participants in the 2004 NDSHS were asked to indicate whether they had taken part in a treatment program. Table 7.3 presents the number and percentage of participants who reported that they had taken part in an alcohol or other drug treatment program in the 12 months before the survey. Approximately 3% of people aged 14 years and over had participated in a treatment program in the last 12 months. The most common treatments accessed were smoking programs (e.g. Quit) (2%), followed by prescription drugs (e.g. GP-supervised) and counselling (both 1%).

Unlike the data taken from the AODTS-NMDS, the results from the 2004 NDSHS are self-reported data. The results should be interpreted with caution, and used only as a rough indication of the proportion of the Australian population 14 years and over who had participated in a treatment program.

Table 7.3: Participation in alcohol or other drug treatment programs, persons aged 14 years and over, Australia, 2004

Type of program	Participants	
	(Number)	(Per cent)
Smoking (e.g. Quit)	275,600	1.7
Alcohol (e.g. AA)	48,200	0.3
Detoxification centre	11,600	< 0.1
Methadone maintenance	16,000	0.1
Prescription drugs (e.g. GP-supervised)	97,600	0.6
Counselling	96,500	0.6
Therapeutic community	8,300	< 0.1
Naltrexone	6,900	< 0.1
Other	29,600	0.2
Any treatment program	464,600	2.8

Source: AIHW analysis of 2004 National Drug Strategy Household Survey.

Mortality and morbidity attributable to tobacco, alcohol and illicit drug use

Mortality

The misuse of alcohol and the use of tobacco and illicit drugs are responsible, directly and indirectly, for a considerable number of accidents, injuries, illnesses and deaths. Various estimates of mortality attributable to alcohol, tobacco and illicit drugs have been calculated. For example,

- Ridolfo and Stevenson estimated that, in 1999 19,000 deaths in Australia were attributable to tobacco use and a further 1,000 deaths were attributable to the use of illicit drugs (AIHW: Ridolfo & Stevenson 2001)
- the National Drug Research Institute at Curtin University estimated that, in 2001, 3,000 deaths in Australia were attributable to alcohol consumption at risky and high-risk levels (Chikritzhs et al. 2003).

Updated estimates of mortality attributable to misuse of alcohol and the use of tobacco and illicit drugs are currently being undertaken and will be available in late 2005.

Morbidity

There were 72,803 hospital separations reported in 2003–04 with a substance use disorder as the principal diagnosis (Table 7.4). This represents 1.1% of all separations in Australia in that year (AIHW 2005b). This section refers only to these separations. Separations are reported separately by same day (where the patient was admitted and separated on the same day) and overnight (where the patient spends at least one night in hospital) as well as by drugs of concern.

Hospital separations by drugs of concern

As in previous years, sedatives and hypnotics accounted for the highest number of hospital separations (43,537 or 60% of all separations), with alcohol the main contributor in this category (34,091 or 47% of all separations) (Table 7.4). Fifteen per cent (or 11,082) of all separations reported were for analgesics, with opioids (heroin, opium and methadone) accounting for more than half of this group (6,058 or 8% of all separations). Antidepressants and antipsychotics accounted for 9% (or 6,572) of all separations.

Table 7.4: Same-day and overnight separations with a principal diagnosis related to substance use disorders, by drug of concern, Australia, 2003–04

Drug of concern identified in principal diagnosis ^(a)	Same-day separations	Overnight separations	Total separations ^(b)
Analgesics			
Opioids (includes heroin, opium & methadone)	1,588	4,470	6,058
Non-opioid analgesics (includes paracetamol)	1,527	3,497	5,024
<i>Total</i>	<i>3,115</i>	<i>7,967</i>	<i>11,082</i>
Sedatives & hypnotics			
Alcohol	16,369	17,722	34,091
Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes alcohol)	3159	6287	9,446
<i>Total</i>	<i>19,528</i>	<i>24,009</i>	<i>43,537</i>
Stimulants & hallucinogens			
Cannabinoids (includes cannabis)	544	2,128	2,672
Hallucinogens (includes LSD & ecstasy)	96	94	190
Cocaine	114	74	188
Tobacco & nicotine	34	32	66
Other stimulants (includes amphetamines, volatile nitrates & caffeine)	1,347	3,031	4,378
<i>Total</i>	<i>2,135</i>	<i>5,359</i>	<i>7,494</i>
Antidepressants & antipsychotics	1855	4717	6,572
Volatile solvents	381	461	842
Other & unspecified drugs of concern			
Multiple drug use	746	2,291	3,037
Unspecified drug use & other drugs not elsewhere classified	106	133	239
<i>Total</i>	<i>852</i>	<i>2,424</i>	<i>3,276</i>
Total (number)	27,866	44,937	72,803

(a) Drug of concern codes based on Australian Standard Classification of Drugs of Concern which are mapped to ICD-10-AM 2nd edition codes.

(b) Refers to total separations for substance use disorders.

Source: AIHW analysis of the National Hospital Morbidity Database 2003–04.

Same-day versus overnight separations

Overnight separations were more common than same-day separations, accounting for 62% of all separations (Table 7.4). Separations were relatively more likely to be overnight when the principal drug identified was cannabis (80% of such separations were overnight), for multiple drug use (75%), or for an opioid (74%). The highest proportion of same-day and overnight separations was for separations where the principal diagnosis was alcohol (59% of same-day separations and 39% of overnight separations).

7.4 National pharmacotherapy statistics

The first part of this section presents information on pharmacotherapy statistics collected by state and territory governments and provided to the AIHW. The second part provides some information on the small number of treatment episodes relating to opioid maintenance pharmacotherapies, collected as part of the AODTS-NMDS.

National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection 2004

Methadone maintenance was endorsed as an effective treatment for opioid dependence in 1985. The National Pharmacotherapy Policy for People Dependent on Opioids recognises that methadone is currently the most common pharmacotherapy used in Australia and is recognised nationally and internationally as an effective method for treating opioid dependence. Buprenorphine has also been used as a maintenance treatment for opioid dependence in Australia since 2000 (Commonwealth of Australia 2004). The broad goal of treatment for opioid dependence is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use (Commonwealth of Australia 2004).

Data on the clients participating in opioid pharmacotherapy programs are routinely collected by the state and territory health departments and, since the 2004 collection, provided annually to the Australian Institute of Health and Welfare (before 2004 data were provided directly to the Australian Government Department of Health and Ageing). Data items collected for the NOPSAD collection include:

- number of clients registered with public and private prescribers and correctional institutions in each state and territory
- number of clients collecting doses at pharmacies, public clinic, private clinics, correctional facilities and other outlets in each jurisdiction
- number of registered prescribers authorised to script for pharmacotherapy treatment.

Numbers of pharmacotherapy clients have been collected since 1986, with the most recent data being from 2004. The type of data collected has varied in terms of detail over this period of time.

Table 7.5: Number of pharmacotherapy clients by state and territory, Australia, 1998–2004^(a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1998 ^(b)	12,107	5,334	3,011	1,654	1,839	306	406	—	24,657
1999	12,500	6,700	3,341	2,449	1,985	370	559	2	27,906
2000	13,594	7,647	3,588	2,140	2,198	423	615	32	30,237
2001	15,069	7,743	3,745	2,307	2,522	464	641	25	32,516
2002	15,471	7,700	3,896	3,602	2,417	513	590	21	34,210
2003	16,165	8,685	4,289	4,079	2,486	498	686	98	36,986
2004	15,719	10,003	4,470	4,437	2,706	576	748	82	38,741

(a) The number of clients on the program at 30 June each year, except for Western Australia, when the number of clients treated throughout the year 2004 is reported.

(b) The figure for SA has been updated from 1,810 to 1,839, to include pharmacotherapy provided in prisons. The total figure for Australia in 1998 has therefore been amended from 24,628 to 24,657 and differs from previous reports.

Source: Unpublished data from the NOPSAD collection held at the Australian Institute of Health and Welfare, 2005.

Number of pharmacotherapy clients by prescriber type

Nationally, 38,741 clients were receiving pharmacotherapy treatment as at 30 June 2004 (Table 7.6). Of these, the majority of clients received treatment in New South Wales (41%), followed by Victoria (26%), Queensland and Western Australia (12% each), and South Australia (7%). The Australian Capital Territory and Tasmania accounted for 2% each, and the Northern Territory accounted for less than 1% of all the clients receiving pharmacotherapy treatment.

Of the overall 38,741 clients receiving pharmacotherapy treatment, 69% received the treatment from a private prescriber, 24% from a public prescriber and 6% from a correctional facility.

Victoria accounted for the highest proportion of clients prescribed for by private prescribers (97% or 9,700 of 10,003), followed by Tasmania (74%), New South Wales (72%), Western Australia (63%) and South Australia (56%). In contrast, clients scripted by public prescribers were most common in the Northern Territory (82%), Queensland (80%) and the Australian Capital Territory (79%). The category 'public/private prescribers' refers to New South Wales prescribers working in dual clinics, which are private clinics receiving some public funding, and where client data cannot be segregated into either section. Clients scripted by 'public/private prescribers' accounted for 1% of all clients in New South Wales.

Clients being prescribed for at correctional facilities were most common in Western Australia (10%), South Australia and New South Wales (9% each), and the Northern Territory (6%).

Table 7.6: Proportion of pharmacotherapy clients by prescriber, states and territories, Australia, 2004^(a) (per cent)

Prescriber	NSW	Vic	Qld	WA	SA	Tas	ACT	NT ^(b)	Australia
Public prescriber	18.1	—	79.9	26.8	35.0	24.5	78.9	81.7	24.1
Private prescriber	71.6	97.0	19.1	63.2	56.0	74.1	18.0	12.2	68.9
Public/private prescriber ^(c)	1.4	—	—	—	—	—	—	—	0.6
Correctional facilities	8.9	3.0	1.0	10.0	9.0	1.4	3.1	6.1	6.4
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	15,719	10,003	4,470	4,437	2,706	576	748	82	38,741

(a) Number of clients on program at 30 June, except for Western Australia, where the number of clients treated throughout the year is reported.

(b) Northern Territory data exclude the number of pharmacotherapy patients receiving treatment at the public clinic in Alice Springs.

(c) 'Public/private prescribers' refers to prescribers in dual clinics, which are private clinics receiving some public funding, where patients cannot be segregated into public or private.

Source: Unpublished data from the 2004 NOPSAD collection held at the Australian Institute of Health and Welfare, 2005.

Number of pharmacotherapy clients by dosing point

Nationally, 38,989 clients were being dosed as at 30 June 2004 – this total is different from that in Table 7.6 as clients in Queensland dosing at more than one dosing point are counted at each point, and therefore counted more than once (Table 7.7). The distribution of clients across jurisdictions by dosing point mirrored the distribution by prescriber type (Table 7.6). Overall, New South Wales accounted for most clients being dosed for pharmacotherapies (40%), followed by Victoria (26%), Queensland (12%), Western Australia (11%), and South Australia (7%). The Australian Capital Territory and Tasmania accounted for 2% each, and the Northern Territory accounted for less than 1%.

Of the 38,989 clients, the majority were dosed at pharmacies (69%, or 26,738), followed by public clinics (12%), private clinics (8%), correctional facilities (6%) and public/private prescribers (1%). Four per cent of all clients were dosed at a location other than a pharmacy, public or private clinic, correctional facility or public/private prescriber. In most jurisdictions, 'other' dosing point related to clients dosing in a hospital setting. In New South Wales, this category was also used for clients for whom the dosing point has not been registered. In the Northern Territory, clients dosing at public clinics or pharmacies cannot be distinguished and thus 'other' comprises clients receiving doses from either a public clinic or a pharmacy.

Table 7.7: Proportion of pharmacotherapy clients by dosing site, states and territories, Australia, 2004^(a) (per cent)

Dosing site	NSW ^(b)	Vic ^(c)	Qld ^(d)	WA	SA	Tas	ACT	NT ^(e)	Australia
Pharmacies	40.6	94.6	83.0	80.5	87.7	96.2	63.6	—	68.6
Public clinics	22.5	—	9.3	9.5	3.1	2.4	33.3	—	12.2
Private clinics	18.7	1.4	—	—	—	—	—	—	7.9
Correctional facilities	8.4	3.0	0.8	10.0	9.0	1.4	3.1	6.1	6.1
Public/private prescriber ^(f)	2.8	—	—	—	—	—	—	—	1.1
Other	7.0	1.0	6.9	—	0.2	—	—	93.9	4.1
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	15,719	10,003	4,718	4,437	2,706	576	748	82	38,989

- (a) Number of clients on the program at 30 June 2004, except for Western Australia, where the number of clients treated through the year is reported.
- (b) Due to a lag in the recording of program end date for some persons, numbers in NSW may be higher than the actual number of people in the program as at 30 June 2004. The total of 'Other' includes 771 people who are missing information about their current dosing. A dosing point may be listed as missing where the payment type has been identified (public or private), the dosing point type has not been identified (pharmacy or clinic) or the drug type has not been identified (for pharmacotherapy statistics). The remaining 332 people received treatment in a hospital setting.
- (c) In Victoria, specialist methadone services are considered 'private clinics', although they are agencies receiving state government funding. The total for 'Other' refers to 97 clients dosed in public hospitals while in treatment for unrelated conditions.
- (d) In Queensland, the total for 'Other' comprises 297 clients receiving doses at public hospital pharmacies, 24 clients receiving doses from doctors and 5 clients receiving doses from other dosing sites. For Queensland there are 248 more clients than in Table 7.6 because, a person who is dosed at more than one dosing point during the month is counted at each point, and therefore counted more than once.
- (e) In the Northern Territory, the number of people dosing at public clinics or pharmacies cannot be distinguished. 'Other' comprises 77 people receiving doses from either a public clinic or a pharmacy. Clients dosing at the public clinic in Alice Springs are excluded from the count.
- (f) 'Public/private prescriber' refers to prescribers in dual clinics in NSW, which are private clinics receiving some public funding, where clients cannot be segregated into public or private.

Source: Unpublished data from the 2004 NOPSAD collection held at the Australian Institute of Health and Welfare, 2005.

Number of pharmacotherapy prescribers

Every jurisdiction has a registration process through which a general practitioner is authorised to prescribe a pharmacotherapy drug. This registration process usually involves attending a training course on prescribing pharmacotherapies and/or passing an exam.

As methadone was the first drug used for opioid pharmacotherapy treatment, jurisdictions first authorised their prescribers to script for this drug only. With the introduction of buprenorphine as an opioid pharmacotherapy drug, the registration process in most jurisdictions changed to allow for the prescription of both drug types. Further to this, some prescribers – for various reasons – are authorised to prescribe buprenorphine only. Table 7.8 footnotes detail the jurisdiction authorisation differences.

The data presented in Table 7.8 relate to all registered prescribers, except for prescribers in New South Wales, Queensland and South Australia. Prescribers in these states relate to 'active' prescribers only – that is, prescribers who are scripting at least one client as at 30 June 2004.

Nationally, 1,259 practitioners were authorised to prescribe at 30 June 2004 (Table 7.8). Of these, 34% (or 428) were registered to prescribe methadone only, and 2% were registered to prescribe buprenorphine only. Those registered to prescribe both methadone and buprenorphine accounted for 64% of the total pharmacotherapy prescribers. Prescribers in South Australia and the Northern Territory follow a single accreditation process which allows them to prescribe both methadone and buprenorphine.

The majority of prescribers were located in Victoria (34% or 422), followed by New South Wales (31%), Western Australia (11%), Queensland (8%), Tasmania (7%) and South Australia

(5%). The Australian Capital Territory and the Northern Territory had the lowest percentages of prescribers (3% and 1% respectively).

Table 7.8: Number of prescribers registered^(a) to prescribe pharmacotherapy drugs by drug type and jurisdiction, Australia (as at 30 June 2004)

	NSW	Vic ^(b)	Qld	WA	SA ^(c)	Tas ^(d)	ACT	NT	Total	Total (%)
Methadone only	173	119	12	49	—	48	27	—	428	34.0
Buprenorphine only	17	—	1	2	—	—	—	—	20	1.6
Methadone and buprenorphine	203	303	89	86	65	39	13	13	811	64.4
Total (number)	393	422	102	137	65	87	40	13	1,259	100.0
Total (%)	31.2	33.5	8.1	10.9	5.2	6.9	3.2	1.0	100.0	—

(a) Data presented in this table relate to all registered prescribers, except in New South Wales, Queensland and South Australia, where active prescribers are counted—that is, prescribers who are scripting at least one client at 30 June 2004.

(b) In Victoria, prior to the development of the current training course, prescribers were trained and approved indefinitely to prescribe methadone only, and had to apply separately to become approved to prescribe buprenorphine. Since the implementation of the new training, all prescribers undertaking the training in Victoria are approved indefinitely to prescribe methadone and buprenorphine. In Victoria, no prescriber is authorised to prescribe only buprenorphine.

(c) In South Australia, prescribers are authorised to prescribe both methadone and buprenorphine. The number of prescribers for South Australia relates only to authorised private and prison active prescribers. This number excludes prescribers working in government drug treatment clinics who are accredited automatically only while employed in that facility.

(d) In Tasmania, training is provided separately for each pharmacotherapy drug.

Source: AIHW analysis of 2004 NOPSAD collection.

Data on opioid maintenance pharmacotherapies from the AODTS–NMDS

As outlined in Section 1.3, agencies whose sole activity is to prescribe and/or dose for opioid maintenance pharmacotherapy treatment (and their clients) are excluded from the AODTS–NMDS. In 2003–04 there were, however, 2,953 or 2.3% of closed treatment episodes where pharmacotherapy was the main treatment type provided (and where clients were seeking treatment for their own drug use). These treatment episodes were provided by AODT agencies that, among other treatment types included in the AODTS–NMDS, also prescribed and/or dosed for methadone or other opioid pharmacotherapies during the collection period. Throughout this report these treatment episodes have been included in the ‘other’ treatment type category.

Of the 2,953 AODTS–NMDS treatment episodes with pharmacotherapy as the main treatment type, most were provided in Victoria (878 treatment episodes) and Western Australia (703), followed by South Australia (600), Queensland (498), New South Wales (165), the Northern Territory (61), Tasmania (47) and the Australian Capital Territory (1).

7.5 Alcohol and other drug treatment services provided by services funded to assist Aboriginal and Torres Strait Islander peoples

Reported numbers in the 2003–04 annual report on the AODTS–NMDS do not include the majority of Australian government-funded Aboriginal and Torres Strait Islander substance use services or Aboriginal and Torres Strait Islander primary health care services. These services are generally not under the jurisdiction of the state or territory health authority and are not included in the specific program under which the Australian Government currently reports AODTS–NMDS data. Data are collected in relation to these services under two data collections:

- Drug and Alcohol Service Report (DASR), coordinated by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the Australian Government Department of Health and Ageing (DoHA). The DASR collects information from all Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services. In 2003–04, 41 services (98% of funded services) provided DASR data. Of these, 29 were classified as residential substance use services and 12 were classified as non-residential.
- Service Activity Reporting (SAR), a joint collection by the National Aboriginal Community Controlled Health Organisation (NACCHO) and OATSIH. The SAR collects information from Aboriginal and Torres Strait Islander primary health care services that receive Australian Government funding. In 2002–03, 134 services (98% of funded services) provided SAR data.

A selection of data from these collections is presented below to provide a broader picture of the types of treatment services being accessed by the Australian population for drug and alcohol problems. Note that the SAR, DASR and AODTS–NMDS have different collection purposes, scope and counting rules. For example, the SAR and DASR collect service-level estimates for client numbers and episodes of care whereas the AODTS–NMDS collects unit records for closed treatment episodes (and some data on client registrations). The definitions for ‘closed treatment episodes’ (AODTS–NMDS) and ‘episodes of care’ (SAR/DASR), and the definitions for ‘client registrations’ (AODTS–NMDS) and ‘estimated client numbers’ (SAR/DASR) are not consistent (see Box 7.1).

In 2003–04, 3 of 42 Australian Government-funded services reporting in the DASR also reported under the AODTS–NMDS and 6 out of 140 Aboriginal and Torres Strait Islander primary health care services, reporting in the SAR, also reported under the AODTS–NMDS. From these 9 agencies, approximately 2,000 closed treatment episodes were reported in the 2003–04 AODTS–NMDS, with 95% of these closed treatment episodes relating to clients who identified as being Aboriginals and/or Torres Strait Islanders.

Box 7.1: Comparison of treatment episode definitions in the SAR, DASR and AODTS-NMDS

The **DASR** 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 the DASR collection does not require agencies to commence a new 'episode of care' when the main treatment type ('treatment type') or primary drug of concern ('substance/drug') changed. It is therefore likely that the DASR concept of 'episode of care' produces smaller estimates of activity than the AODTS-NMDS concept of 'closed treatment episode'.

The **SAR** definition of 'episode of care' relates to each time a person sees someone from the health clinic for health care. If a person sees more than one staff member on the same day this is considered one episode and there can only ever be one episode of care on a single day. However, if a person sees staff members (the same or different staff members) on 2 days, this is considered two episodes. In contrast to the AODTS-NMDS definition of 'closed treatment episode', the SAR definition of 'episode of care' does not relate to a period of specific treatment (e.g. for a particular drug of concern). It is therefore likely that the SAR concept of 'episode of care' produces larger estimates of activity than the AODTS-NMDS concept of 'closed treatment episode'.

The DASR and SAR collections record information about clients of any age, whereas the AODTS-NMDS reports only about clients aged 10 years and over. The comparative information presented in this section should therefore be interpreted with caution.

Australian Government-funded Aboriginal and Torres Strait Islander substance use services (DASR)

In 2003–04, an estimated 24,900 clients were seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (Table 7.9). Of these clients, 85% identified as being Aboriginals and/or Torres Strait Islanders. The majority of clients accessed services in South Australia (41%), Queensland (30%) and the Northern Territory (13%).

Table 7.9: Estimated number of clients seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (DASR) by jurisdiction and Indigenous status, 2003–04

	Estimated number of clients					
	NSW & Vic	Qld	WA	SA	NT	Australia
Indigenous	1,300	5,500	2,300	9,200	3,000	21,200
Non-Indigenous	300	2,000	200	900	200	3,600
Total	1,600	7,500	2,500	10,100	3,200	24,900
Total (per cent)	6	30	10	41	13	100

Note: Totals may not add up as figures are rounded to the nearest hundred.

Source: Australian Government Department of Health and Ageing analysis of the 2003–04 Drug and Alcohol Service Reporting collection.

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2003–04, an estimated 4,000 episodes of care were provided to clients in residential treatment/rehabilitation services (Table 7.10). Of these, 68% of episodes of care were for male clients.

In 2003–04, there were 6,700 estimated episodes of care for clients accessing sobering-up or residential respite services. Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation. Residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. Close to two-thirds (65%) of episodes of care were for male clients.

‘Other care’ refers to services such as counselling and therapy, after-care follow-up and preventive care, all of which are not residential-based. In 2003–04, there were an estimated 42,500 episodes for other care services. The number of episodes of care for this service group is much higher than for residential-based services because of the way ‘episodes’ are counted for these services (see Box 7.1). Nearly two-fifths (39%) of episodes for other care were for female clients.

Table 7.10: Estimated number of ‘episodes of care’^(a) provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (DASR) by sex, and treatment type, 2003–04

	Estimated number of ‘episodes of care’					
	Male		Female		Total	
	No.	%	No.	%	No.	%
Residential treatment/rehabilitation ^(b)	2,700	68.2	1,300	31.8	4,000	100.0
Sobering-up/residential respite ^(c)	4,300	64.9	2,300	35.1	6,700	100.0
Other care ^(d)	26,000	61.1	16,500	38.9	42,500	100.0

(a) Estimated episodes of care refers to the number of episodes of the service. It does not always equate to the total number of clients in all programs as some clients may be in multiple programs.

(b) Includes people who were officially clients of the service, that is, people who received treatment/rehabilitation in a residential setting and had their own file/record.

(c) Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation. Respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation.

(d) Clients receiving ‘other care’ received non-residential care (e.g. counselling, assessment, treatment, education, support, home-visits and/or mobile assistance patrol/night patrol) or follow-up from residential services after discharge.

Note: Figures have been rounded to the nearest hundred.

Source: Australian Government Department of Health and Ageing analysis of the 2003–04 Drug and Alcohol Service Reporting.

During 2003–04, all (100%) Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services reported providing treatment or assistance for client alcohol use (Table 7.11). Other common substances/drugs for which services provided treatment or assistance included cannabis (93%), multiple drug use (78%), amphetamines (66%) and tobacco/nicotine (56%).

Table 7.11: Substances/drugs for which treatment/assistance was provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services, 2003–04

Substance/drug	Percentage of services that provided treatment/assistance for this substance/drug
Alcohol	100%
Cannabis (marijuana, gunja, yamdi)	93%
Multiple drug use (two or more drugs/substances)	78%
Amphetamines (speed, uppers)	66%
Tobacco/nicotine	56%
Heroin	54%
Benzodiazepines (sleeping pills, Valium, Rohypnol)	46%
Other solvents/inhalants (chroming, paint, glue, aerosol cans)	44%
Petrol	41%
Barbiturates (downers, Phenobarbital, Amytal)	32%
Methadone	29%
Ecstasy/MDMA	29%
Morphine	22%
Cocaine (coke, crack)	22%
LSD (acid, trips)	12%
Other	12%
Steroids/anabolic agents	7%
Kava	2%

Source: Australian Government Department of Health and Aging analysis of the 2003–04 Drug and Alcohol Service Reporting.

Australian Government-funded Aboriginal and Torres Strait Islander primary health care services (SAR)

Aboriginal and Torres Strait Islander primary health care services provide a wide variety of health care services including extended care roles (e.g. diagnosis and treatment of illness and disease, 24-hour emergency care, dental/hearing/optometry services), preventive health care (e.g. health screening for children and adults), health-related community support (e.g. school-based activities, transport to medical appointments) and support in relation to substance use issues. It is not possible to estimate the number of clients who attended Aboriginal and Torres Strait Islander primary health care services and received alcohol or other drug treatment. Similarly, it is not possible to estimate the number of reported episodes of care that related solely or partially to alcohol or other drug treatment.

Aboriginal and Torres Strait Islander primary health care services tackle a range of substance use issues. In many cases, substance use issues are covered on an individual client basis as they arise during client care. Table 7.12 shows the proportion of services that covered substance use issues on an individual basis as they arise by substance/drug type. Most services covered issues relating to alcohol (96%), tobacco/nicotine (85%) or cannabis (81%) on an individual basis as they arose. Around about half of all primary health care services had clients raise issues for substances such as petrol and multiple drug use (53% each), solvents and inhalants (51%) and benzodiazepines (50%).

Table 7.12: Substances/drugs for which Australian Government-funded Aboriginal and Torres Strait Islander primary health care services cover substance use issues on an individual basis as they arise, 2002–03

Substance/drug	Percentage of services that cover substance use issues on an individual basis as they arise
Alcohol	96%
Tobacco/nicotine	85%
Cannabis (marijuana, gunja, yamdi)	81%
Petrol	53%
Multiple drug use (two or more drugs/substances)	53%
Other solvents/inhalants (chroming, paint, glue, aerosol cans)	51%
Benzodiazepines (sleeping pills, Valium, Rohypnol)	50%
Heroin	43%
Methadone	39%
Amphetamines (speed, uppers)	37%
Barbiturates (downers, Phenobarbital, Amytal)	30%
Morphine	28%
Ecstasy/MDMA	23%
Cocaine (coke, crack)	22%
LSD (acid, trips)	12%
Kava	10%
Steroids/anabolic agents	10%
Other	7%

Source: Australian Government Department of Health and Ageing analysis of 2002–03 Service Activity Reporting.

8 Data quality of the AODTS–NMDS in 2003–04

8.1 Introduction

Several activities are undertaken in each year of the AODTS–NMDS collection to maximise the quality of the data collected, including:

- communication between the AIHW and jurisdictions before the supply of data, including written guidelines and file specifications
- agreeing on guidelines on the validation process to improve data collating and editing (see AIHW 2003b)
- jurisdictions improving their own data quality and checking mechanisms, and providing training to their service providers and written guidelines for collecting the National Minimum Data Set
- the validation processes that occur in each jurisdiction before forwarding the data to the AIHW, and in the AIHW on receipt of the data.

Comprehensiveness of the data

In 2003–04, data were provided from 545 (96%) of the 565 agencies that were in scope for this collection. This calculation excludes Queensland agencies as the number of missing non-government-funded agencies has not been recorded.

More detailed information on the undercount of Indigenous substance use services and Aboriginal health care services, as well as other data caveats, are available in Section 1.3.

Presentation of Australian Government data

Data reported for each state and territory in 2003–04 include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). As in 2002–03, Australian Government data are therefore not analysed separately under the title ‘other’; rather, they have been analysed as part of the jurisdiction in which the agency was located.

8.2 Data quality

Overall, the quality of AODTS-NMDS data has improved across collection periods (Table 8.1). Nationally, the proportion of responses that were 'not stated', 'missing' or 'unknown' has varied across data items.

Proportions of those responses that were 'not stated', 'missing' or 'unknown' in 2003–04 and 2002–03 are given for each state and territory and nationally, in Table 8.1, as a proportion of total responses for each data item.

For the client data items:

- 'Indigenous status' was 'not stated' for 6% of responses – with the highest rates in the Tasmanian data (18% missing), South Australia (9%) and Victoria (8%).
- Overall, 2% of responses were 'not stated' for 'preferred language' – this proportion was higher in the Northern Territory (5%) and South Australia (4%).

For drug data items:

- 'Injecting drug use' was 'not stated' for 13% of responses – higher in the Northern Territory (41%), Tasmania (29%), Queensland and Victoria (16% each) and South Australia (15%).

For treatment data items, 'reason for cessation' was 'not stated' for 0.6% of responses – higher in the Northern Territory (9%), Tasmania (2%) and Queensland (2%).

Compared with 2002–03, the national proportion of responses that were 'not stated', 'missing' or 'unknown' has dropped slightly for most variables. The largest shifts from 2002–03 to 2003–04 were seen in 'injecting drug use', 'reason for cessation' and 'date of birth/age' (14.4% to 13.1%, 1.8% to 0.6% and 1.7% to 0.8% respectively).

The Australian Capital Territory saw large drops in 'not stated' responses in 'method of use' and 'reason for cessation' (12% to 0.3% and 16% to 1% respectively); however, this may be related to the exclusion of data from one large service provider. Tasmania, Western Australia, South Australia and New South Wales had their largest shifts in 'injecting drug use' (38% to 29%, 9% to 2%, 18% to 15%, and 13% to 10% respectively), but, these figures increased in Queensland and the Northern Territory (12% to 16% and 20% to 41% respectively).

8.3 Data transmission

The data transmission process for the 2003–04 AODTS-NMDS collection represented an improvement on that of previous years. Most jurisdictions were able to transmit their data to the AIHW much earlier than in previous years and the AIHW also streamlined its data receipt and validation processes with the introduction of new software. These factors have contributed to the more timely release of this annual report and associated data products for the 2003–04 collection.

Table 8.1: Not stated/missing/unknown responses for data items by jurisdiction, Australia, 2003–04 and 2002–03^(a) (per cent)

Data item	NSW	Vic	Qld	WA	SA	Tas	ACT ^(b)	NT	Australia
2003–04									
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	1.7	3.2	2.0	0.2	4.6	0.0	1.5	0.2	2.2
Date of birth/age	0.1	1.8	0.2	1.2	0.1	0.0	1.3	0.1	0.8
Indigenous status	4.5	8.1	6.3	1.4	8.7	17.8	3.7	1.7	6.1
Preferred language	0.8	3.7	2.1	0.3	4.2	0.0	0.8	4.9	2.2
Sex	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.1
Source of referral	0.0	0.4	0.4	1.3	1.2	0.0	0.9	4.5	0.5
Drug data items^(c)									
Principal drug of concern	1.4	0.0	0.0	0.4	0.0	0.5	0.0	0.0	0.5
Method of use	2.2	2.2	1.2	0.3	2.0	1.2	0.3	1.3	1.8
Injecting drug use	10.1	15.6	15.8	2.4	15.1	28.5	7.5	41.2	13.1
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation	0.0	0.3	1.5	0.5	0.4	1.7	1.2	9.0	0.6
Treatment delivery setting	—	—	—	—	—	—	—	—	—
2002–03									
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	1.7	3.7	0.1	0.4	3.2	—	5.7	0.5	2.2
Date of birth/age	0.1	2.7	6.6	0.2	0.5	—	1.0	0.0	1.7
Indigenous status	5.1	8.0	4.1	1.3	7.2	19.9	7.7	2.2	6.0
Preferred language	0.6	4.1	1.3	0.4	2.7	0.0	7.7	7.1	2.3
Sex	0.1	0.1	0.0	0.0	—	—	1.8	—	0.1
Source of referral	0.9	0.4	0.2	1.5	1.1	0.1	1.3	1.8	0.8
Drug data items^(c)									
Principal drug of concern	1.3	—	0.0	0.6	—	—	3.5	—	0.5
Method of use	2.0	2.1	1.6	0.6	3.2	1.4	11.8	1.8	2.2
Injecting drug use	13.2	15.4	11.9	8.8	17.5	37.9	21.8	19.7	14.4
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation	1.5	1.0	1.4	0.3	0.2	2.2	15.8	16.1	1.8
Treatment delivery setting	—	—	—	—	—	—	—	—	—

(a) Proportion of 'not stated' of all responses for data item.

(b) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

(c) Excludes treatment episodes for clients seeking treatment for the drug use of others.

Note: Includes 'inadequately described' for all data items except age group and Indigenous status.

Appendixes

Appendix 1: Data elements included in the AODTS–NMDS for 2003–04

The detailed data definitions for the data elements included in the AODTS–NMDS for 2003–04 are published in the *National Health Data Dictionary* (NHDD) version 12 (NHDC 2003). Table A1.1 lists all data elements collected for 2003–04.

Table A1.1: Data elements for the AODTS–NMDS, 2003–04

Data element	NHDD code
Establishment-level data elements	
Establishment identifier (comprising)	000050
– state identifier	000380
– establishment sector	000379
– region code	000378
– establishment number	000377
Establishment type	000327
Geographical location of establishment	000260
Client-level data elements	
Client type	000426
Country of birth	000035
Date of birth	000036
Date of cessation of treatment episode for alcohol and other drugs	000424
Date of commencement of treatment episode for alcohol and other drugs	000430
Establishment identifier	000050
Indigenous status	000001
Injecting drug use	000432
Main treatment type for alcohol and other drugs	000639
Method of use for principal drug of concern	000433
Other drugs of concern	000442
Other treatment type for alcohol and other drugs	000642
Person identifier	000127
Preferred language	000132
Principal drug of concern	000443
Reason for cessation of treatment episode for alcohol and other drugs	000423
Sex	000149
Source of referral to alcohol and other drug treatment services	000444
Treatment delivery setting for alcohol and other drugs	000646
Supporting data element concepts	
Cessation of treatment episode for alcohol and other drugs	000422
Commencement of treatment episode for alcohol and other drugs	000427
Treatment episode for alcohol and other drugs	000647

Appendix 2: Policy and administrative features in each jurisdiction

New South Wales

New South Wales Health collects data from all federal/state government-funded agencies as part of requirements stipulated within a signed Service Agreement at commencement/renewal of each funding agreement. Data is provided monthly by agencies to their respective Area Health Service (AHS) Drug and Alcohol Data Co-ordinator (DADC) on treatment episodes currently open and those closed in the preceding month. The AHS DADC is responsible for checking and cleaning the data and forwarding it to the Centre for Drug and Alcohol at New South Wales Health. Frequency and data-quality reports are provided by New South Wales Health to AHS/agencies and by AHS DADCs to agencies every 6 months detailing the previous 6 or 12 months services. New South Wales Health forwards cleaned data on treatment episodes closed during the reporting period to the AIHW annually.

New South Wales Health has developed a statewide data collection system in Microsoft Access, called MATISSE, which is provided free-of-charge to agencies to enable the registration of clients and the collection of the New South Wales and National MDS-AODTS. This data collection system will gradually be replaced in public sector agencies as the Community Health Information Management Enterprise (CHIME) is rolled out across 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' (EOC) as the fundamental unit for service funding. An EOC is defined as 'a completed course of treatment, undertaken by a client under the care of an alcohol and drug worker, which achieves significant agreed treatment goals'.

The EOC 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 EOCs to be provided by service type and by target group (e.g. youth or adult). As a requirement of their funding agreement with the Victorian Department of Human Services, agencies are required to submit data detailing their provision of drug treatment services and achievement of EOCs on a quarterly basis. A subset of this data is contributed to the AODTS NMDS annually.

Queensland

Queensland Health collects data from all Queensland Government AODT service providers and from all Queensland Illicit Drug Diversion Initiative – Police and Court Diversion clients. The Australian Government currently collects data from the Australian Government-funded agencies operating in Queensland.

Queensland Health has recently introduced a state wide web-based clinical information management system supporting the collection of AODTS-NMDS items for all Queensland Government AODT services. Queensland Health is also currently moving towards being the sole data custodian of all AODT services in Queensland.

Western Australia

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.

South Australia

Data is provided by government (Drug and Alcohol Services SA – 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 between themselves and the South Australian Minister of Health. As part of these service agreements, non-government organisations are required to provide timely client data in accordance with the AODTS-NMDS guidelines, and forward the data to DASSA for collation and checking. DASSA then forwards cleaned data to the AIHW annually.

Tasmania

All Tasmanian-funded alcohol and other drug treatment agencies sign a Service Agreement at commencement of funding each financial year. A key element of the agreement is they are required to input AODTS-NMDS data into the current collection application as well as report against specific performance indicators in their annual reports to the Department of Health and Human Services.

The department is in the process of conducting a Business, Gap Analysis and Business Case with a view to implementing a Clinical Information Management System (ADS IMPS Project). This project aims to provide a Clinical Information Management System with a client focus, whereas the current system was specifically designed to meet AODTS-NMDS requirements. It is expected that the new system will be in place in 2006-07.

Australian Capital Territory

ACT service providers supply ACT Health with data for the NMDS, as specified in their Service Agreement. These data are required to be submitted to ACT Health at the end of the financial year. At present, these service providers use a range of systems to collect their data.

The Australian Capital Territory is currently exploring the development of a standardised web-based reporting system to be implemented in non-government alcohol and drug service agencies. This is expected to enhance uniformity and reliability of the data and increase the user-friendliness of the system for service providers.

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 NT Department of Health and Community Services (DHCS). All funded agencies are required to provide the AODTS-NMDS data items to DHCS on a regular and timely basis. Summary statistical reports are sent to all agencies every 6 months detailing client activity for the previous 12 months.

DHCS is in the process of developing an intranet-based system where all non-government agencies will continue sending their data to the directorate but they will be entered via a web page into a data mart which will be managed by the DHCS Corporate Information Services section. Eventually, DHSC will make this system web-based so that agencies can directly enter all data themselves.

DHSC is also in the process of implementing an information system for government providers which will allow improvements in client case management and reporting. . This system is based on patient records and an extract is being developed to ensure that data required for the NMDS will be easily imported into the data mart.

Australian Government Department of Health and Ageing

The Australian Government Department of Health and Ageing funds a number of alcohol and other drug treatment services under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme. 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 submitted to the department annually.

Appendix 3: Technical notes

This appendix provides information on data presentation, population definitions and transformation of data from treatment episodes to estimates of number of clients in agencies. As noted previously, the state/territory data collection systems for the AODTS-NMDS are highly diverse. As a result:

- it is important to understand the agreed definitions, terms and collection rules – these are outlined in this appendix, with full specifications available in (see AIHW 2003b)
- there is a need to edit the data in a number of ways to enable their meaningful presentation in this report and to maximise comparability of the data between jurisdictions (see AIHW 2003b).

A3.1 Data presentation

The tables in this report include data only for government-funded in-scope alcohol and other drug treatment services from the Australian Government, states and territories for which data were available. Percentages may not add up to 100.0 due to rounding.

Population definitions

Populations used in the publication comprise treatment agencies, client registrations and closed treatment episodes:

- *Treatment agency population* refers to the number of alcohol and other drug treatment agencies that provided data for 2003–04.
- *Client registration population* refers to the number of clients registering or re-registering during 2003–04 (see also A3.2).
- *Closed treatment episode population* refers to the number of treatment episodes that closed during 2003–04. For all tables using this population that include principal drug of concern, other drug of concern, or injecting drug use status, the treatment episode population excludes clients seeking treatment for the drug use of others.

See also Boxes 3.1, 4.1, 5.1 and 6.1 for other key definitions and counts.

A3.2 Client registration data versus treatment episode data

Client registration data, 2000–01

In 2000–01, unit record data were collected for both establishment level and client level. For the establishment data, a single unit record was reported for each agency/organisation that provided client data. For client-level data, all new or returning clients who registered or re-registered for treatment during the reporting period were required to be included in the collection. Data were reported as a single unit record for each new client registration on commencement of treatment. A client is identified as commencing treatment when one or more of the following applies:

- (a) they are a new client; or
- (b) they have had no contact with the service for a period of 3 months, nor have they a plan in place for further contact; and/or
- (c) they are a current client whose principal drug of concern has changed.

For the 2000–01 collection, the AODTS–NMDS was to be a registration-based data collection that consisted of an establishment-level component and a client-level component. The establishment-level data items collected information about the type and location of the service provider. The client-level data items collected demographic and drug-related information about clients using the services in scope for the NMDS.

In practice, the 2000–01 collection also contained treatment episode data. New South Wales, Victoria and the Australian Capital Territory provided data based on the forthcoming treatment episode approach and a further three jurisdictions provided data that were a mixture of both collection types. This had a number of implications for the data analysis phase and for obtaining comparable counts across jurisdictions. For example, the data based on completed treatment episodes excluded clients with open episodes or records at 30 June 2001. This resulted in an undercounting of actual client numbers from these jurisdictions for the 2000–01 collection period as clients with open records were to be included under the client registration-based collection system. All data were converted back to client registration data and reported on that basis (see AIHW 2002a).

Treatment episode data, 2001–02 to 2003–04

For the 2001–02 collection, the majority of jurisdictions provided treatment episode data based on treatment episodes that closed during the period 1 July 2001 to 30 June 2002. South Australia supplied client registration data based on clients who opened treatment episodes during this period. For the 2002–03 and 2003–04 collections, all jurisdictions were able to provide treatment episode data.

For the purposes of calculating a closed treatment episode, a treatment episode is considered closed when one or more of the following applies:

- (a) a client's treatment plan has been completed
- (b) there has been no treatment contact between the client and the treatment agency for a period of 3 months, unless that period of non-contact was planned
- (c) the client's principal drug of concern has changed
- (d) the client's main treatment type has changed
- (e) the treatment delivery setting for the client's main treatment type has changed
- (f) the client's treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice or died).

Estimates of number of client registrations in 2001–02 to 2003–04

Although the majority of data presented in this report are based on closed treatment episodes, the report also includes estimates of the number of client registrations in agencies (Section 3.1 and Tables 1.1 and A4.1–A4.3). These estimates were obtained through a data transformation process (see below). More detailed information on factors affecting these estimates is available in Section 1.3.

Transformation of 2003–04 treatment episode data to estimates of number of client registrations was done as follows:

1. Select all records where the establishment identifier, person identifier, date of birth and sex are the same.
2. For each group of records where the above variables are the same, filter the records so that only the record with the earliest date of cessation remains.
3. Use the sum total of these filtered records as the equivalent of an estimate of number of client registrations.

Note that, in contrast to 2000–01 client registration data, the 2001–02 to 2003–04 estimates of client registrations, for all jurisdictions, were based on the date the client ceased treatment for an alcohol or other drug problem. In 2001–02, South Australian registration data were based on the date treatment commenced.

Appendix 4: Detailed tables

Client registrations

Table A4.1: Estimated number of client registrations^(a) by age group and sex, Australia, 2003–04

Age group (years)	Males		Females		Not stated		Persons	
	No.	%	No.	%	No.	%	No.	%
10–19	9,767	8.5	4,773	4.1	10	0.0	14,550	12.6
20–29	26,325	22.9	11,781	10.2	26	0.0	38,132	33.1
30–39	21,347	18.5	10,810	9.4	17	0.0	32,174	27.9
40–49	11,955	10.4	7,211	6.3	11	0.0	19,177	16.7
50–59	4,443	3.9	3,029	2.6	6	0.0	7,478	6.5
60+	1,598	1.4	1,089	0.9	4	0.0	2,691	2.3
Not stated	468	0.4	487	0.4	6	0.0	961	0.8
Total	75,903	65.9	39,180	34.0	80	0.1	115,163	100.0

(a) Client registrations refer to the estimated number of clients who registered or re-registered for alcohol and other drug treatment services.

Table A4.2: Estimated number of client registrations^(a) by client type and sex, Australia, 2003–04

Client type	Males		Females		Not stated		Persons	
	No.	%	No.	%	No.	%	No.	%
Own drug use	74,130	64.4	34,035	29.6	72	0.1	108,237	94.0
Others' drug use	1,773	1.5	5,145	4.5	8	0.0	6,926	6.0
Total	75,903	65.9	39,180	34.0	80	0.1	115,163	100.0

(a) Client registrations refer to the estimated number of clients who registered or re-registered for alcohol and other drug treatment services.

Table A4.3: Estimated number of client registrations^(a) by age group and Indigenous status, Australia, 2003–04

Age group (years)	Indigenous		Non-Indigenous		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
10–19	2,362	2.1	11,393	9.9	795	0.7	14,550	12.6
20–29	3,591	3.1	32,131	27.9	2,410	2.1	38,132	33.1
30–39	3,373	2.9	26,782	23.3	2,019	1.8	32,174	27.9
40–49	1,434	1.2	16,561	14.4	1,182	1.0	19,177	16.7
50–59	336	0.3	6,667	5.8	475	0.4	7,478	6.5
60+	81	0.1	2,428	2.1	182	0.2	2,691	2.3
Not stated	112	0.1	754	0.7	95	0.1	961	0.8
Total	11,289	9.8	96,716	84.0	7,158	6.2	115,163	100.0

(a) Client registrations refers to the estimated number of clients who registered or re-registered for alcohol and other drug treatment services.

Client tables

Table A4.4: Closed treatment episodes by client data items and jurisdiction, Australia, 2003–04^(a)

	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
Client type									
Own drug use	41,426	45,030	17,912	12,479	7,234	1,596	1,317	2,337	129,331
Others' drug use	1,103	2,608	554	1,777	379	761	—	355	7,538
Sex									
Male	28,730	29,777	12,674	9,098	5,123	1,376	834	1,736	89,348
Female	13,768	17,811	5,787	5,154	2,489	981	484	956	47,430
Not stated	31	50	5	4	1	0	0	0	91
Age group (years)									
10–19	2,976	6,998	3,258	2,428	608	325	279	187	17,059
20–29	14,096	16,026	6,107	4,532	2,125	676	516	606	44,684
30–39	13,058	12,504	4,697	3,605	2,386	564	339	1,013	38,166
40–49	8,118	7,671	2,791	2,205	1,579	412	136	652	23,564
50–59	3,090	2,774	1,118	1,022	627	256	26	194	9,107
60+	1,165	791	452	287	279	124	—	37	3,140
Not stated	26	874	43	177	9	0	17	3	1,149
Indigenous status									
Indigenous	4,141	2,827	1,797	1,926	578	147	113	1,709	13,238
Not Indigenous	36,490	40,950	15,504	12,136	6,374	1,790	1,156	938	115,338
Not stated	1,898	3,861	1,165	194	661	420	49	45	8,293
Country of birth									
Australia	36,621	40,200	16,136	11,727	6,307	2,258	1,235	2,552	117,036
England	1,078	544	386	917	381	16	34	32	3,388
Germany	101	99	54	66	25	8	—	—	355
Ireland	196	128	56	82	31	—	—	—	495
Italy	84	151	14	48	18	—	—	—	316
New Zealand	822	716	648	404	69	13	9	29	2,710
Scotland	157	291	91	139	53	7	—	9	750
South Africa	81	98	37	79	12	6	—	—	319
United States of America	118	60	59	41	16	—	—	—	299
Viet Nam	255	962	20	52	61	—	—	—	1,353
All other countries	2,262	2,475	570	672	289	45	14	51	6,378
Not elsewhere classified	24	367	17	—	—	—	—	—	409
Inadequately described	46	444	378	—	—	—	—	—	871
Not stated	684	1,103	0	29	349	0	20	5	2,190

(continued)

Table A4.4 (continued): Closed treatment episodes by client data items and jurisdiction, Australia, 2003–04

	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
Preferred language									
Arabic	68	37	—	—	—	—	—	—	112
Australian Indigenous languages	12	16	—	88	29	—	—	906	1,053
English	41,571	44,414	17,966	13,957	7,201	2,356	1,307	1,592	130,364
Greek	17	47	—	—	—	—	—	—	71
Italian	22	27	—	9	5	—	—	—	65
Polish	24	30	—	10	—	—	—	—	68
Serbian	19	12	—	5	8	—	—	—	48
Spanish	67	26	13	7	—	—	—	—	114
Turkish	20	44	—	—	—	—	—	—	68
Vietnamese	125	468	8	20	15	—	—	—	636
All other languages	245	749	73	112	26	—	—	62	1,267
Inadequately described	32	91	—	—	—	—	11	—	140
Not stated	307	1,677	387	43	321	0	0	128	2,863
English Proficiency (EP) Groups^(d)									
Australia	36,594	40,065	16,136	11,727	6,307	2,258	1,235	2,552	116,874
EP Group 1	2,579	2,043	1,339	1,741	579	58	49	81	8,469
EP Group 2	981	1,117	360	391	126	24	11	37	3,047
EP Group 3	1,172	1,297	206	306	169	16	—	12	3,180
EP Group 4	448	1,202	30	62	81	—	—	5	1,828
Inadequately described	46	444	378	—	—	—	—	—	871
Not elsewhere classified	24	367	17	—	—	—	—	—	409
Not stated/missing	684	1,103	0	29	349	0	20	5	2,190
Source of referral									
Self	22,310	17,164	5,288	4,664	2,839	1,198	609	1,287	55,359
Family member/ friend	2,567	2,071	781	1,517	544	115	98	129	7,822
GP/medical specialist	3,202	2,056	1,967	732	485	291	25	78	8,836
Psychiatric and/or other hospitals	1,855	749	846	427	617	189	214	74	4,971
Community mental health services ^(e)	878	820	449	209	105	6	140	41	2,648
AODTS	5,473	7,408	893	985	602	—	51	131	15,543
Other community/health care services ^(f)	812	2,275	1,232	910	489	119	147	206	6,190

(continued)

Table A4.4 (continued): Closed treatment episodes by client data items and jurisdiction, Australia, 2003–04

	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
Source of referral									
Community-based corrections	2,857	5,379	1,043	2,578	74	60	—	354	12,346
Police diversions	2,575	196	4,789	657	397	379	—	56	9,049
Court diversions	—	919	670	453	120	—	—	76	2,239
Other	—	8,430	435	941	1,252	—	20	140	11,218
Not stated	0	171	73	183	89	0	12	120	648
Total	42,529	47,638	18,466	14,256	7,613	2,357	1,318	2,692	136,869

- (a) Small cell sizes have been suppressed to preserve confidentiality. These are marked with a '—'.
- (b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.
- (c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.
- (d) See AIHW 2003a for further information about English Proficiency Groups.
- (e) Includes residential and non-residential services.
- (f) Comprises other residential community care unit; non-residential medical and/or allied health care agency; other non-residential community health care agency/outpatient clinic; and other community service agency.

Substance users tables

Table A4.5: Closed treatment episodes by drug-related data items and jurisdiction, Australia, 2003–04^{(a)(b)}

	NSW	Vic	Qld ^(c)	WA	SA	Tas	ACT ^(d)	NT	Australia
Injecting drug use									
Current injector	13,192	9,943	3,840	3,658	2,237	246	635	248	33,999
Injected 3–12 months ago	2,324	6,052	992	869	438	72	66	39	10,852
Injected 12+ months ago	3,670	4,625	1,905	1,497	679	103	81	82	12,642
Never injected	18,075	17,393	8,343	6,152	2,791	720	436	1,006	54,916
Not stated	4,165	7,017	2,832	303	1,089	455	99	962	16,922
Method of use									
Ingests	19,982	19,919	6,214	4,988	4,076	965	382	1,839	58,365
Smokes	7,912	9,174	7,634	2,897	761	417	391	210	29,396
Injects	12,228	12,682	3,482	4,216	2,206	187	514	227	35,742
Sniffs (powder)	299	308	31	143	30	—	—	—	815
Inhales (vapour)	45	1,827	304	115	7	6	20	30	2,354
Other	36	146	24	78	7	—	—	—	295
Not stated	924	974	223	42	147	19	4	31	2,364
Principal drug of concern									
Analgesics									
Heroin	8,855	10,509	1,367	1,233	1,064	12	266	20	23,326
Methadone	1,016	537	434	202	115	48	36	16	2,404
Balance of analgesics ^(e)	723	—	1,056	463	429	102	27	127	2,927
<i>Total analgesics</i>	<i>10,594</i>	<i>11,046</i>	<i>2,857</i>	<i>1,898</i>	<i>1,608</i>	<i>162</i>	<i>329</i>	<i>163</i>	<i>28,657</i>
Sedatives and hypnotics									
Alcohol	17,069	16,717	4,716	4,065	3,374	461	295	1,803	48,500
Benzodiazepines	1,034	1,081	185	191	151	16	43	10	2,711
Balance of sedatives and hypnotics ^(e)	29	—	5	13	—	—	—	—	50
<i>Total sedatives and hypnotics</i>	<i>18,132</i>	<i>17,798</i>	<i>4,906</i>	<i>4,269</i>	<i>3,527</i>	<i>477</i>	<i>338</i>	<i>1,814</i>	<i>51,261</i>

(continued)

Table A4.5 (continued): Closed treatment episodes by drug-related data items and jurisdiction, Australia, 2003–04^{(a)(b)}

	NSW	Vic	Qld ^(c)	WA	SA	Tas	ACT ^(d)	NT	Australia
Stimulants and hallucinogens									
Amphetamines	4,530	2,918	1,844	3,189	1,255	136	230	106	14,208
Cannabis	6,678	10,021	7,079	2,745	740	591	388	185	28,427
Ecstasy	127	198	83	45	30	11	10	—	508
Cocaine	160	60	10	21	7	—	11	—	272
Nicotine	537	355	795	47	31	199	6	31	2,001
Balance of stimulants and hallucinogens ^(e)	26	—	20	38	7	—	—	—	97
<i>Total stimulants and hallucinogens</i>	<i>12,058</i>	<i>13,552</i>	<i>9,831</i>	<i>6,085</i>	<i>2,070</i>	<i>941</i>	<i>645</i>	<i>331</i>	<i>45,513</i>
Balance of drugs of concern ^(e)	70	2,634	317	176	29	8	5	29	3,268
Not stated/missing	572	0	1	51	0	8	0	0	632
Total	41,426	45,030	17,912	12,479	7,234	1,596	1,317	2,337	129,331

(a) Small cell sizes have been suppressed to preserve confidentiality. These are marked with a '—'.

(b) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(c) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(d) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

(e) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

Table A4.6: Number of other drugs of concern by jurisdiction, Australia, 2003–04^(a)

Other drug of concern	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
Analgesics									
Heroin	1,547	2,879	574	442	208	8	131	20	5,809
Methadone	1,075	535	268	95	61	9	29	2	2,074
Balance of analgesics ^(d)	637	0	735	313	150	26	40	25	1,926
<i>Total analgesics</i>	<i>3,259</i>	<i>3,414</i>	<i>1,577</i>	<i>850</i>	<i>419</i>	<i>43</i>	<i>200</i>	<i>47</i>	<i>9,809</i>
Sedatives and hypnotics									
Alcohol	4,369	7,678	2,862	1,553	700	61	387	84	17,694
Benzodiazepines	2,588	4,472	934	794	583	27	144	40	9,582
Balance of sedatives and hypnotics ^(d)	38	0	41	55	13	2	3	10	162
<i>Total sedatives and hypnotics</i>	<i>6,995</i>	<i>12,150</i>	<i>3,837</i>	<i>2,402</i>	<i>1,296</i>	<i>90</i>	<i>534</i>	<i>134</i>	<i>27,438</i>
Stimulants and hallucinogens									
Amphetamines	4,275	6,684	1,606	1,295	715	77	345	53	15,050
Cannabinoids	8,699	12,066	3,126	2,513	1,458	134	553	353	28,902
Ecstasy	894	1,699	497	370	82	11	63	23	3,639
Cocaine	774	435	132	111	66	2	34	10	1,564
Nicotine	6,210	6,505	3,399	1,308	981	50	512	55	19,020
Balance of stimulants and hallucinogens ^(d)	412	0	127	387	37	15	13	3	994
<i>Total stimulants and hallucinogens</i>	<i>21,264</i>	<i>27,389</i>	<i>8,887</i>	<i>5,984</i>	<i>3,339</i>	<i>289</i>	<i>1,520</i>	<i>497</i>	<i>69,169</i>
Balance of drugs of concern ^(d)	201	3,587	222	326	34	6	76	19	4,471
Not stated/missing	0	0	648	121	199	1	0	0	969

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

(d) Includes balance of other drugs of concern coded according to ASCDC. See Appendix 7.

Table A4.7: Closed treatment episodes by principal drug of concern, sex and age group, Australia, 2003–04^(a)

Principal drug	Age group (years)						Not stated	Total
	10–19	20–29	30–39	40–49	50–59	60+		
Males	(per cent)							
Alcohol	19.5	23.8	40.7	60.5	80.1	85.2	33.3	38.6
Amphetamines	8.1	15.3	13.0	5.1	0.9	0.5	12.7	10.9
Benzodiazepines	0.3	1.3	1.9	1.8	1.2	1.8	1.4	1.4
Cannabis	53.9	28.1	16.4	9.9	4.9	1.5	19.8	23.1
Cocaine	0.1	0.3	0.3	0.2	0.1	0.0	0.0	0.2
Ecstasy	0.8	0.6	0.2	0.1	0.1	0.0	0.2	0.4
Heroin	7.9	24.7	19.7	13.7	4.0	0.5	24.6	17.8
Methadone	0.3	1.4	2.0	2.3	1.1	0.2	1.0	1.5
Nicotine	2.9	0.4	0.7	1.7	3.8	8.8	1.6	1.4
Other ^(b)	5.9	3.7	4.6	4.4	3.2	1.5	5.3	4.3
Not stated	0.3	0.4	0.5	0.5	0.5	0.2	0.2	0.4
<i>Total males (per cent)</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>
<i>Total males (number)</i>	<i>10,815</i>	<i>30,135</i>	<i>24,913</i>	<i>14,357</i>	<i>5,017</i>	<i>1,677</i>	<i>505</i>	<i>87,419</i>
Females								
Alcohol	16.8	18.4	38.3	58.1	72.7	76.3	33.7	35.3
Amphetamines	11.7	16.2	12.0	4.1	0.8	0.4	12.5	11.1
Benzodiazepines	1.0	2.6	3.8	5.4	6.1	7.7	2.1	3.5
Cannabis	39.0	24.0	16.8	9.4	4.5	1.5	14.9	19.6
Cocaine	0.2	0.2	0.2	0.1	0.1	0.0	0.0	0.2
Ecstasy	1.0	0.5	0.1	0.1	0.1	0.0	0.3	0.4
Heroin	15.5	28.6	17.9	10.4	3.8	1.2	19.9	18.6
Methadone	0.8	3.2	3.2	2.4	1.3	0.2	3.4	2.6
Nicotine	4.2	0.8	0.9	2.3	5.5	7.9	0.8	1.9
Other ^(b)	9.1	5.1	6.0	7.1	4.4	4.3	12.5	6.2
Not stated	0.6	0.5	0.6	0.6	0.8	0.5	0.0	0.6
<i>Total females (per cent)</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>	<i>100.0</i>
<i>Total females (number)</i>	<i>5,361</i>	<i>13,595</i>	<i>11,922</i>	<i>7,287</i>	<i>2,473</i>	<i>814</i>	<i>377</i>	<i>41,829</i>

(continued)

Table A4.7 (continued): Closed treatment episodes by principal drug of concern, sex and age group, Australia, 2003–04^(a)

Principal drug	Age group (years)						Not stated	Total
	10–19	20–29	30–39	40–49	50–59	60+		
Persons ^(c)								
Alcohol	18.6	22.1	39.9	59.7	77.7	82.3	33.5	37.5
Amphetamines	9.3	15.6	12.7	4.7	0.9	0.4	12.5	11.0
Benzodiazepines	0.5	1.7	2.5	3.0	2.8	3.7	1.7	2.1
Cannabis	49.0	26.8	16.6	9.7	4.8	1.5	17.8	22.0
Cocaine	0.1	0.3	0.2	0.1	0.1	0.0	0.0	0.2
Ecstasy	0.9	0.6	0.2	0.1	0.1	0.0	0.2	0.4
Heroin	10.5	25.9	19.1	12.6	3.9	0.7	22.5	18.0
Methadone	0.5	1.9	2.4	2.3	1.1	0.2	2.0	1.9
Nicotine	3.3	0.5	0.8	1.9	4.4	8.5	1.2	1.5
Other drugs ^(b)	7.0	4.1	5.1	5.3	3.6	2.4	8.3	4.9
Not stated	0.4	0.4	0.6	0.6	0.6	0.3	0.1	0.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	16,190	43,757	36,853	21,654	7,497	2,493	887	129,331

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

(c) Includes 'not stated' for sex.

Table A4.8: Closed treatment episodes by principal drug of concern and country of birth, Australia, 2003–04^(a)

	Alcohol	Cannabis	Heroin	Amphetamines	Other drugs ^(b)	Not stated	Total
	(number)						
Australia	40,531	25,669	19,076	12,654	12,401	532	110,863
England	1,676	414	353	301	300	12	3,056
Germany	206	28	27	20	44	1	326
Ireland	315	39	48	24	36	2	464
Italy	128	32	43	23	33	1	260
New Zealand	1,040	628	395	299	232	10	2,604
Scotland	477	46	48	52	73	1	697
South Africa	111	84	27	28	29	1	280
United States of America	178	44	25	15	18	2	282
Viet Nam	86	45	1,045	15	84	1	1,276
All other countries	2,372	808	1,658	433	599	23	5,893
Inadequately described	363	184	88	66	139	1	841
Not elsewhere classified	225	50	52	36	34	0	397
Not stated	792	356	441	242	216	45	2,092
Total	48,500	28,427	23,326	14,208	14,238	632	129,331
	(per cent)						
Australia	36.6	23.2	17.2	11.4	11.2	0.5	36.6
England	54.8	13.5	11.6	9.8	9.8	0.4	54.8
Germany	63.2	8.6	8.3	6.1	13.5	0.3	63.2
Ireland	67.9	8.4	10.3	5.2	7.8	0.4	67.9
Italy	49.2	12.3	16.5	8.8	12.7	0.4	49.2
New Zealand	39.9	24.1	15.2	11.5	8.9	0.4	39.9
Scotland	68.4	6.6	6.9	7.5	10.5	0.1	68.4
South Africa	39.6	30.0	9.6	10.0	10.4	0.4	39.6
United States of America	63.1	15.6	8.9	5.3	6.4	0.7	63.1
Viet Nam	6.7	3.5	81.9	1.2	6.6	0.1	6.7
All other countries	40.3	13.7	28.1	7.3	10.2	0.4	40.3
Inadequately described	43.2	21.9	10.5	7.8	16.5	0.1	43.2
Not elsewhere classified	56.7	12.6	13.1	9.1	8.6	0.0	56.7
Not stated	37.9	17.0	21.1	11.6	10.3	2.2	37.9
Total	37.5	22.0	18.0	11.0	11.0	0.5	37.5

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

Table A4.9: Closed treatment episodes by principal drug of concern, Indigenous status and sex, Australia, 2003–04^(a)

Principal drug of concern	Males		Females		Persons ^(b)		Total ^(c)
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	
(number)							
Alcohol	4,116	27,622	1,768	12,173	5,888	39,815	48,500
Amphetamines	746	8,265	451	3,940	1,200	12,210	14,208
Benzodiazepines	71	1,111	82	1,303	154	2,417	2,711
Cannabis	1,958	17,020	866	6,777	2,825	23,813	28,427
Cocaine	9	182	5	58	14	240	272
Ecstasy	17	322	6	128	23	450	508
Heroin	861	13,859	578	6,753	1,439	20,624	23,326
Methadone	85	1,156	85	914	170	2,070	2,404
Nicotine	111	968	72	679	183	1,647	2,001
Other drugs ^(d)	450	2,985	301	2,105	751	5,091	6,342
Not stated	56	269	32	189	88	459	632
Total	8,480	73,759	4,246	35,019	12,735	108,836	129,331
(per cent)							
Alcohol	48.5	37.4	41.6	34.8	46.2	36.6	37.5
Amphetamines	8.8	11.2	10.6	11.3	9.4	11.2	11.0
Benzodiazepines	0.8	1.5	1.9	3.7	1.2	2.2	2.1
Cannabis	23.1	23.1	20.4	19.4	22.2	21.9	22.0
Cocaine	0.1	0.2	0.1	0.2	0.1	0.2	0.2
Ecstasy	0.2	0.4	0.1	0.4	0.2	0.4	0.4
Heroin	10.2	18.8	13.6	19.3	11.3	18.9	18.0
Methadone	1.0	1.6	2.0	2.6	1.3	1.9	1.9
Nicotine	1.3	1.3	1.7	1.9	1.4	1.5	1.5
Other drugs ^(d)	5.3	4.0	7.1	6.0	5.9	4.7	4.9
Not stated	0.7	0.4	0.8	0.5	0.7	0.4	0.5
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for sex.

(c) Includes 'not stated' for Indigenous status.

(d) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

Table A4.10: Closed treatment episodes by principal drug of concern and all drugs of concern, Australia, 2003–04^(a)

	Principal drug of concern reported	Per cent of all closed treatment episodes	All drugs of concern reported, including principal	Per cent of all closed treatment episodes ^(b)
Alcohol	48,500	37.5	66,194	51.2
Amphetamines	14,208	11.0	29,258	22.6
Benzodiazepines	2,711	2.1	12,293	9.5
Cannabis	28,427	22.0	57,329	44.3
Cocaine	272	0.2	1,836	1.4
Ecstasy	508	0.4	4,147	3.2
Heroin	23,326	18.0	29,135	22.5
Methadone	2,404	1.9	4,478	3.5
Nicotine	2,001	1.5	21,021	16.3
Other drugs ^(c)	6,342	4.9	13,895	10.7
Not stated	632	0.5	1,601	1.2
Total	129,331	—	241,187	—

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) The total for 'all drugs of concern' adds to more than the total number of closed treatment episodes, and the total for 'per cent of all closed treatment episodes' adds to more than 100%, since closed treatment episodes may be counted in more than one drug of concern

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

Table A4.11: Closed treatment episodes by method of use and age, Australia, 2003–04^(a)

	Age group (years)						Not stated	Total
	10–19	20–29	30–39	40–49	50–59	60+		
	(number)							
Ingests	3,784	13,004	17,885	14,846	6,302	2,182	362	58,365
Smokes	8,113	11,788	6,066	2,385	646	240	158	29,396
Injects	2,588	16,933	11,622	3,874	387	32	306	35,742
Sniffs	180	393	175	56	7	—	—	815
Inhales	1,100	720	388	94	14	—	37	2,354
Other	69	97	68	40	16	—	—	295
Not stated	356	822	649	359	125	34	19	2,364
Total	16,190	43,757	36,853	21,654	7,497	2,493	887	129,331
	(per cent)							
Ingests	23.4	29.7	48.5	68.6	84.1	87.5	40.8	45.1
Smokes	50.1	26.9	16.5	11.0	8.6	9.6	17.8	22.7
Injects	16.0	38.7	31.5	17.9	5.2	1.3	34.5	27.6
Sniffs	1.1	0.9	0.5	0.3	0.1	0.0	0.5	0.6
Inhales	6.8	1.6	1.1	0.4	0.2	0.0	4.2	1.8
Other	0.4	0.2	0.2	0.2	0.2	0.2	0.1	0.2
Not stated	2.2	1.9	1.8	1.7	1.7	1.4	2.1	1.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

Table A4.12a: Closed treatment episodes^(a) by principal drug of concern and reason for cessation, Australia, 2003–04 (per cent)

Reason for cessation	Alcohol	Ampheta- mines	Benzodiaz- epines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Nicotine	Other drug ^(b)	Total ^(c)	Total (number)
Treatment completed	59.0	46.1	54.5	47.4	56.6	58.3	51.4	49.5	63.4	52.2	53.1	68,671
Change in main treatment type	1.7	1.5	4.5	1.8	0.4	1.6	3.1	2.6	0.9	4.7	2.2	2,788
Change in delivery setting	0.8	1.8	1.0	0.3	0.7	0.0	0.9	1.4	1.0	1.8	0.9	1,145
Change in principal drug of concern	0.2	0.1	0.3	0.1	0.4	0.4	0.3	0.2	0.1	0.2	0.2	210
Transferred to another service provider	6.8	8.0	10.0	4.7	8.1	3.7	9.3	14.5	3.7	8.1	7.2	9,342
Ceased to participate against advice	4.2	5.9	5.1	3.2	4.8	3.9	7.3	4.3	1.6	4.5	4.7	6,100
Ceased to participate without notice	16.7	21.6	13.1	13.9	17.6	19.5	14.5	13.5	17.7	16.1	16.1	20,787
Ceased to participate involuntary (non-compliance)	1.6	3.8	2.1	2.0	1.8	2.6	3.0	2.6	0.2	1.6	2.2	2,849
Ceased to participate at expiation	2.8	4.7	3.4	21.5	6.6	5.7	4.7	4.8	3.2	1.8	7.5	9,712
Ceased to participate by mutual agreement	3.1	3.1	3.2	2.7	2.6	2.6	1.7	2.0	2.6	3.0	2.7	3,488
Drug court and/or sanctioned by court diversion service	0.0	0.6	0.1	0.2	0.0	0.0	0.3	0.0	0.0	0.1	0.2	237
Imprisoned, other than drug court sanctioned	0.2	0.6	0.3	0.3	0.0	0.2	1.1	1.7	0.0	0.9	0.5	625
Died	0.1	0.0	0.2	0.0	0.0	0.2	0.1	0.1	0.1	0.2	0.1	138
Other	1.9	1.5	1.7	1.6	0.0	1.0	1.9	2.2	5.1	3.8	1.9	2,496
Not stated	0.7	0.8	0.6	0.3	0.4	0.4	0.4	0.5	0.1	1.0	0.6	743
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Total (number)	48,500	14,208	2,711	28,427	272	508	23,326	2,404	2,001	6,342	..	129,331

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

(c) Includes 'not stated' for principal drugs of concern.

Table A4.12b: Closed treatment episodes^(a) by reason for cessation and principal drug of concern, Australia, 2003–04 (per cent)

Reason for cessation	Alcohol	Ampheta- mines	Benzodiaz- epines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Nicotine	Other drug ^(b)	Total ^(c)	Total (number)
Treatment completed	41.7	9.5	2.2	19.6	0.2	0.4	17.5	1.7	1.8	4.8	100.0	68,671
Change in main treatment type	29.9	7.5	4.4	18.1	0.0	0.3	26.1	2.3	0.6	10.7	100.0	2,788
Change in delivery setting	33.4	22.7	2.3	8.2	0.2	0.0	18.4	3.0	1.8	10.0	100.0	1,145
Change in principal drug of concern	35.2	7.1	3.8	11.4	0.5	1.0	30.5	2.9	1.0	6.7	100.0	210
Transferred to another service provider	35.3	12.1	2.9	14.4	0.2	0.2	23.3	3.7	0.8	5.5	100.0	9,342
Ceased to participate against advice	33.7	13.7	2.3	14.7	0.2	0.3	28.0	1.7	0.5	4.6	100.0	6,100
Ceased to participate without notice	38.9	14.7	1.7	19.1	0.2	0.5	16.3	1.6	1.7	4.9	100.0	20,787
Ceased to participate involuntary (non-compliance)	28.0	19.1	2.0	19.5	0.2	0.5	24.4	2.2	0.2	3.6	100.0	2,849
Ceased to participate at expiation	13.8	6.8	0.9	63.1	0.2	0.3	11.2	1.2	0.7	1.2	100.0	9,712
Ceased to participate by mutual agreement	43.0	12.4	2.5	21.8	0.2	0.4	11.3	1.3	1.5	5.4	100.0	3,488
Drug court and/or sanctioned by court diversion service	8.9	38.4	0.8	19.4	0.0	0.0	29.1	0.4	0.0	3.0	100.0	237
Imprisoned, other than drug court sanctioned	16.8	12.8	1.1	12.8	0.0	0.2	40.2	6.7	0.0	9.4	100.0	625
Died	47.8	5.1	3.6	8.7	0.0	0.7	21.7	2.2	1.4	8.7	100.0	138
Other	37.6	8.7	1.8	18.2	0.0	0.2	17.5	2.2	4.1	9.7	100.0	2,496
Not stated	48.2	14.5	2.0	12.7	0.1	0.3	11.7	1.5	0.4	8.6	100.0	743
Total (per cent)	37.5	11.0	2.1	22.0	0.2	0.4	18.0	1.9	1.5	4.9	100.0	129,331

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

(c) Includes 'not stated' for principal drugs of concern.

Treatment program tables

Table A4.13: Closed treatment episodes by treatment data items and jurisdiction, Australia, 2003–04^(a)

	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
Main treatment type									
Withdrawal management (detoxification)	9,892	10,553	1,465	946	1,505	60	476	226	25,123
Counselling	12,311	22,439	5,119	7,151	1,730	1,480	622	662	51,514
Rehabilitation	4,268	1,798	1,047	2,341	1,581	107	173	402	11,717
Support and case management only	3,538	6,216	1,186	162	287	41	41	23	11,494
Information and education only	850	357	6,864	1,383	101	261	5	644	10,465
Assessment only	9,502	4,858	2,127	1,398	1,736	138	—	655	20,414
Other ^(d)	2,168	1,417	658	875	673	270	—	80	6,142
Cessation reason									
Treatment completed	21,823	32,036	5,618	6,374	3,759	1,138	558	1,695	73,001
Change in main treatment type	—	2,350	351	60	106	20	55	50	2,992
Change in delivery setting	—	—	534	193	454	31	12	23	1,247
Change in principal drug of concern	—	183	11	11	5	—	—	—	212
Transferred to another service provider	6,022	1,273	933	718	408	125	49	53	9,581
Ceased to participate against advice	2,756	1,348	554	453	619	84	295	105	6,214
Ceased to participate without notice	7,138	5,003	3,372	4,132	1,548	626	72	254	22,145
Ceased to participate involuntary (non-compliance)	1,457	458	169	378	210	85	51	61	2,869
Ceased to participate at expiation	3,333	636	5,112	753	14	62	19	11	9,940
Ceased to participate by mutual agreement	—	1,923	639	809	274	118	144	94	4,001
Drug court and/or sanctioned by court diversion service	—	40	102	75	14	—	—	5	239
Imprisoned, other than drug court sanctioned	—	359	70	142	48	—	—	10	633
Died	—	72	26	18	18	7	—	—	147
Other	—	1,800	698	65	106	18	39	85	2,811
Not stated	0	157	277	75	30	41	16	241	837

(continued)

Table A4.13 (continued): Closed treatment episodes by treatment data items and jurisdiction, Australia, 2003–04

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Treatment delivery setting									
Non-residential treatment facility	27,974	32,928	13,507	10,095	5,893	1,521	42	973	92,933
Residential treatment facility	12,844	7,942	1,082	2,444	1,373	151	660	785	27,281
Home	630	1,997	197	481	29	15	—	86	3,435
Outreach setting	557	4,771	2,613	47	290	670	27	610	9,585
Other	524	—	1,067	1,189	28	—	589	238	3,635
Total	42,529	47,638	18,466	14,256	7,613	2,357	1,318	2,692	136,869

- (a) Small cell sizes have been suppressed to preserve confidentiality. These are marked with a '—'.
- (b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.
- (c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.
- (d) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

Table A4.14: Numbers of other treatment type by jurisdiction, Australia, 2003–04^(a)

Other treatment type	NSW	Qld ^(b)	WA	SA	Tas	ACT ^(c)	Australia
Withdrawal management (detoxification)	959	144	0	559	9	2	1,673
Counselling	6,309	1,200	34	1,032	193	64	8,832
Rehabilitation	852	405	0	170	10	3	1,440
Other ^(d)	5,183	804	96	1,490	357	14	7,944
All other treatments	13,303	2,553	130	3,251	569	83	19,889

- (a) Excludes 47,638 closed treatment episodes from Victoria and 2,692 closed treatment episodes from Northern Territory as these jurisdictions did not provide data for 'other treatment type'.
- (b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.
- (c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.
- (d) 'Other' includes 2,761 closed treatment episodes where other/additional treatment type was reported as pharmacotherapy.

Table A4.15: Closed treatment episodes^(a) by principal drug of concern and main treatment type, Australia, 2003–04

Main treatment type	Alcohol	Ampheta- mines	Benzo- diazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Nicotine	Other drug ^(b)	Not stated	Total ^(c)
(number)												
Withdrawal management (detoxification)	9,974	2,003	1,062	3,959	38	31	5,906	467	141	1,524	18	25,123
Counselling	20,039	5,380	873	9,304	113	242	6,285	548	782	1,761	127	45,454
Rehabilitation	4,855	2,327	121	1,733	32	42	2,053	126	144	243	12	11,688
Support and case management only	2,513	1,081	190	3,063	14	69	2,886	360	145	806	30	11,157
Information and education only	1,552	366	47	6,751	8	43	171	54	404	349	43	9,788
Assessment only	8,152	2,734	312	3,192	58	70	3,949	397	280	826	225	20,195
Other ^(c)	1415	317	106	425	9	11	2076	452	105	833	177	5926
Total	48,500	14,208	2,711	28,427	272	508	23,326	2,404	2,001	6,342	632	129,331
(per cent)												
Withdrawal management (detoxification)	20.6	14.1	39.2	13.9	14.0	6.1	25.3	19.4	7.0	24.0	2.8	19.4
Counselling	41.3	37.9	32.2	32.7	41.5	47.6	26.9	22.8	39.1	27.8	20.1	35.1
Rehabilitation	10.0	16.4	4.5	6.1	11.8	8.3	8.8	5.2	7.2	3.8	1.9	9.0
Support and case management only	5.2	7.6	7.0	10.8	5.1	13.6	12.4	15.0	7.2	12.7	4.7	8.6
Information and education only	3.2	2.6	1.7	23.7	2.9	8.5	0.7	2.2	20.2	5.5	6.8	7.6
Assessment only	16.8	19.2	11.5	11.2	21.3	13.8	16.9	16.5	14.0	13.0	35.6	15.6
Other ^(c)	2.9	2.2	3.9	1.5	3.3	2.2	8.9	18.8	5.2	13.1	28.0	4.6
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

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

(c) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4)

Table A4.16: Closed treatment episodes by main treatment type, sex and age group, Australia, 2003–04

Main treatment type	Age group (years)						Not stated	Total
	10–19	20–29	30–39	40–49	50–59	60+		
	(per cent)							
Males								
Withdrawal management (detoxification)	9.4	16.6	20.5	23.6	23.9	21.9	12.2	18.5
Counselling	27.8	34.0	35.9	36.3	39.2	39.5	51.0	34.7
Rehabilitation	7.0	9.5	10.2	9.3	8.3	6.8	3.5	9.2
Support and case management only	17.6	8.9	5.5	4.8	4.3	4.2	14.1	8.0
Information and education only	22.1	8.3	5.4	5.3	4.7	5.2	1.7	8.4
Assessment only	13.9	19.4	18.0	15.5	14.5	16.3	1.0	17.2
Other ^(a)	2.2	3.3	4.3	5.3	5.0	6.1	16.4	4.0
Total males (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total males (number)	11,146	30,386	25,201	14,764	5,418	1,860	573	89,348
Females								
Withdrawal management (detoxification)	14.9	18.7	19.8	18.9	15.1	15.4	9.6	18.1
Counselling	28.6	39.3	44.2	49.4	58.0	55.6	54.7	43.2
Rehabilitation	5.8	8.7	8.3	6.3	6.0	4.4	2.8	7.4
Support and case management only	25.8	10.1	5.6	4.4	3.0	2.6	16.0	9.1
Information and education only	12.8	5.9	4.8	5.2	4.9	6.8	2.6	6.2
Assessment only	8.2	11.9	11.7	10.4	8.0	10.3	1.4	10.6
Other ^(a)	3.8	5.4	5.7	5.3	5.0	4.9	12.8	5.3
Total females (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total females (number)	5,899	14,269	12,947	8,789	3,680	1,276	570	47,430
Persons ^(b)								
Withdrawal management (detoxification)	11.3	17.3	20.3	21.9	20.4	19.3	10.9	18.4
Counselling	28.1	35.7	38.7	41.1	46.8	46.0	52.9	37.6
Rehabilitation	6.6	9.2	9.6	8.2	7.4	5.8	3.1	8.6
Support and case management only	20.5	9.3	5.5	4.7	3.8	3.5	15.1	8.4
Information and education only	18.9	7.5	5.2	5.2	4.8	5.9	2.2	7.6
Assessment only	11.9	17.0	15.8	13.6	11.9	13.9	1.2	14.9
Other ^(a)	2.8	4.0	4.8	5.3	5.0	5.6	14.6	4.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	17,059	44,684	38,166	23,564	9,107	3,140	1,149	136,869

(a) 'Other' includes 2,953 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

(b) Includes 'not stated' for sex.

Special theme: amphetamines

Table A4.17: Closed treatment episodes^(a) where amphetamines were nominated as the principal drug of concern by age group and method of use, Australia, 2003–04

	Age group (years)						Total ^(b)
	10–19	20–29	30–39	40–49	50–59	60+	
	(number)						
Ingests	251	692	461	118	12	5	1,558
Smokes	113	205	80	20	2	0	420
Injects	939	5,454	3,875	832	50	6	11,241
Sniffs	153	305	130	37	1	0	630
Inhales	12	35	14	4	0	0	65
Other	3	15	8	0	0	0	26
Not stated	33	109	106	16	1	0	268
Total	1,504	6,815	4,674	1,027	66	11	14,208
	(per cent)						
Ingests	16.7	10.2	9.9	11.5	18.2	45.5	11.0
Smokes	7.5	3.0	1.7	1.9	3.0	0.0	3.0
Injects	62.4	80.0	82.9	81.0	75.8	54.5	79.1
Sniffs	10.2	4.5	2.8	3.6	1.5	0.0	4.4
Inhales	0.8	0.5	0.3	0.4	0.0	0.0	0.5
Other	0.2	0.2	0.2	0.0	0.0	0.0	0.2
Not stated	2.2	1.6	2.3	1.6	1.5	0.0	1.9
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for age.

Table A4.18: Closed treatment episodes^(a) where a principal drug of concern other than amphetamines was nominated by age group and method of use, Australia, 2003–04

	Age group (years)						Total ^(b)
	10–19	20–29	30–39	40–49	50–59	60+	
	(number)						
Ingests	3,528	12,298	17,405	14,712	6,277	2,175	56,738
Smokes	8,000	11,578	5,983	2,365	643	240	28,967
Injects	1,648	11,465	7,734	3,037	335	26	24,466
Sniffs	27	87	45	19	6	0	184
Inhales	1,088	685	373	89	14	1	2,287
Other	43	69	52	36	13	3	217
Not stated	292	572	378	248	97	30	1,632
Total	14,626	36,754	31,970	20,506	7,385	2,475	114,491
	(per cent)						
Ingests	24.1	33.5	54.4	71.7	85.0	87.9	49.6
Smokes	54.7	31.5	18.7	11.5	8.7	9.7	25.3
Injects	11.3	31.2	24.2	14.8	4.5	1.1	21.4
Sniffs	0.2	0.2	0.1	0.1	0.1	0.0	0.2
Inhales	7.4	1.9	1.2	0.4	0.2	0.0	2.0
Other	0.3	0.2	0.2	0.2	0.2	0.1	0.2
Not stated	2.0	1.6	1.2	1.2	1.3	1.2	1.4
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes 'not stated' for age.

Table A4.19: Closed treatment episodes^(a) by principal drug of concern and injecting drug use, Australia, 2003–04

	Amphetamines		All other drugs of concern		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Current injector	8,952	63.0	24,987	21.8	60	9.5	33,999	26.3
3–12 months ago	1,777	12.5	9,063	7.9	12	1.9	10,852	8.4
12+ months ago	1,177	8.3	11,431	10.0	34	5.4	12,642	9.8
Never injected	1,541	10.8	53,257	46.5	118	18.7	54,916	42.5
Not stated	761	5.4	15,753	13.8	408	64.6	16,922	13.1
Total	14,208	100.0	114,491	100.0	632	100.0	129,331	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

Table A4.20: Closed treatment episodes^(a) by principal drug of concern and treatment delivery setting, Australia, 2003–04

	Amphetamines		All other drugs of concern		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Non-residential treatment facility	9,230	65.0	76,568	66.9	552	87.3	86,350	66.8
Residential treatment facility	3,458	24.3	23,680	20.7	32	5.1	27,170	21.0
Home	285	2.0	3,066	2.7	7	1.1	3,358	2.6
Outreach setting	568	4.0	8,330	7.3	22	3.5	8,920	6.9
Other	667	4.7	2,847	2.5	19	3.0	3,533	2.7
Total	14,208	100.0	114,491	100.0	632	100.0	129,331	100.0

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

Appendix 5: AODTS–NMDS treatment types

Alcohol and other drug treatment activities can range from an early, brief intervention to long-term residential treatment. Brief intervention refers to the intervention at an early stage of a person's alcohol or drug use to prevent the development of serious drug problems later on. It involves less face-to-face counselling than other more traditional methods, has a strongly educational focus and places more emphasis on self-management (Australian Drug Foundation 2003). The brief intervention approach has been found successful in the treatment of alcohol misuse; simple advice from a general practitioner resulted in reductions in alcohol consumption for some patients (Teesson & Proudfoot 2003). In contrast, long-term residential treatment often involves a highly structured program of counselling and support services, designed to make changes in the drug user's lifestyle and facilitate long-term recovery (Australian Drug Foundation 2003).

The AODTS–NMDS covers a wide variety of treatment interventions and includes, among others, detoxification and rehabilitation programs, pharmacotherapy and counselling treatments, and information and education courses. These treatments are summarised below.

Assessment

All new or returning clients are assessed in some form to determine the most appropriate treatment. The method of assessment depends on the type of treatment offered, and the client's drug use, personal history and individual needs. A combination of interview and questionnaire may be used to obtain information on the client's lifestyle and drug taking habits, such as levels of use and dependence, previous drug history, motivation to change, and other health and lifestyle factors (Australian Drug Foundation 2003). Assessment itself is not a treatment; rather, its general aim is to match clients with an appropriate treatment intervention.

Withdrawal management (detoxification)

Withdrawal management, or detoxification, refers to the elimination of toxic levels of a drug from the body. Detoxification usually also involves counselling and is often a gradual process, taking a number of days or weeks, and may occur in a variety of settings including general hospitals, specialist drug and alcohol units, outpatient clinics and homes (Gowing et al. 2001). Although the detoxification process can be a treatment in itself, it can also be a precursor to a full treatment program.

Information gained on the type of drug used and the duration of use during the assessment period will guide the choice of detoxification program. For opiate detoxification these can range from several months on a stable dose of methadone before gradual reduction, through to detoxification using only non-opiates to alleviate withdrawal symptoms.

The following are the main types of opiate detoxification programs available (Ghodse 2002). These programs are not distinguished within the AODTS–NMDS collection but are grouped under the general heading 'withdrawal management (detoxification)'.

Non-opiate treatment includes neuroleptic drugs which reduce the symptoms of withdrawal, beta-adrenoreceptor blocking drugs which abolish the euphoric effect and reduce cravings, or other drugs such as clonidine which suppress the autonomic signs of withdrawal but are less successful at reducing subjective discomfort. These drugs are administered for periods of 5 days up to 3 weeks. They are suitable for clients who are not

opiate-dependent or who do not want to use opiates in their withdrawal program. Clients are usually treated on an outpatient basis.

Accelerated detoxification over 4 days uses an opiate antagonist such as naloxone or naltrexone to displace the existing opiates in the body. During this process, withdrawal symptoms are treated with non-opiate medication and hospital or in-patient treatment is required.

Detoxification using opiates generally involves the administration of an opiate such as methadone or buprenorphine to stabilise the client before a dose reduction regime is implemented. Dose reduction programs can take one month or more and treatment can be provided on an in-patient or outpatient basis (see also 'Pharmacotherapy treatment' below). Detoxification may also be required for alcohol or other non-opiate illicit drugs (Kasser et al. 2002).

For **alcohol detoxification**, sedative-hypnotics such as benzodiazepine are most commonly used to reduce withdrawal symptoms and prevent seizures and delirium. Clients are usually treated as in-patients, but outpatient detoxification is also possible.

Sedative-hypnotic withdrawal does not usually require detoxification, although clients may be stabilised on a substitute medication such as diazepam before being tapered off. Treatment may occur in an in-patient or outpatient setting or a combination of both.

Stimulant withdrawal such as from cocaine or amphetamine does not usually require detoxification but symptoms can be alleviated by the use of bromocriptine or amantadine, tricyclic antidepressants or short-acting benzodiazepines (Kasser et al. 2002). In cases of severely dependent clients or those who have consumed large quantities of stimulants, in-patient detoxification may be necessary (Ghodse 2002).

Where clients require detoxification from multiple drugs of a different pharmacological class, the program must provide treatment for each drug class (Kasser et al. 2002).

Relapse involving resumption of illicit drug use can occur both during the detoxification program or after it has been completed. As a result, for many individuals detoxification may need to be repeated (Ghodse 2002).

Pharmacotherapy treatment

Pharmacotherapy treatments are provided by pharmacies, public and private clinics, general practitioners, or hospitals. In the AODTS-NMDS collection, pharmacotherapy treatment includes treatments used as maintenance therapies or relapse prevention (e.g. naltrexone, buprenorphine, LAAM (levo alpha acetyl methadol) and specialist methadone treatment). However, agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS-NMDS, as are treatments provided by pharmacies, private clinics or general practitioners.

Pharmacotherapy treatments include reduction therapy, where the aim is to reduce the quantity of all drugs used, and maintenance therapy (also known as substitution treatment) which aims to stabilise the user by prescribing a less harmful drug rather than eliminate drug use in the short term (Drugscope 2000).

The drugs prescribed for reduction therapy usually consist of blocking and aversive agents that either stop the drug of dependence having an effect or produce an undesirable effect when combined with the drug of dependence (e.g. naltrexone) (Gowing et al. 2001).

Maintenance therapy is most commonly used for opiate addiction but can also be used for addiction to alcohol or other illicit drugs. There are two main drugs generally prescribed for opiate addiction, with methadone being the most common maintenance drug used in Australia. As a synthetic opioid antagonist it has reduced but similar effects to heroin and, although it is not a cure for heroin dependence, it can lead to improvements in clients' mental and physical health and the stability of their lifestyle. It is usually provided in syrup form and the effect lasts for around 24 hours; consequently, most clients must attend on a daily basis to receive their treatment.

Buprenorphine is the other main drug used for maintenance therapy for opiate addiction. It is a partial opioid antagonist, that is, it blocks the effects of heroin. Unlike methadone, one dose may last up to 3 days so clients are not required to attend daily to receive their treatment. It is provided in tablet form and is dissolved under the tongue (Australian Drug Foundation 2003). It is quite common for clients to switch between buprenorphine and methadone treatments.

LAAM is a similar substance to methadone but has a milder effect. It is available in Australia under clinical trial arrangements and is being actively investigated as an additional treatment for opioid maintenance programs. One benefit of using LAAM is that it needs to be administered only every 3 days and therefore offers greater flexibility to clients and staff (Gowing et al. 2001).

For clients who want to maintain abstinence from heroin or other opioids, the drug naltrexone may be prescribed. Its effectiveness depends heavily on clients' commitment to remain off heroin, the level of support they receive and the continuation of regular counselling. Tablets are taken orally from 1 to 3 days apart depending on dose. It is more expensive than methadone or buprenorphine. In addition, because naltrexone reduces tolerance to heroin, there is a greater risk of a heroin overdose if treatment is discontinued and heroin use resumes (Australian Drug Foundation 2003).

Naltrexone can also be used to support abstinence or harm-reduction measures for alcohol-dependent clients, although the drug acamprosate is normally considered the treatment drug of choice for a total abstinence approach (Graham et al. 2002).

Counselling

There are many different types of alcohol and other drug counselling available, including individual and group counselling in both outpatient and residential settings. The following discussion outlines the main types of counselling programs available. These programs are not distinguished within the AODTS-NMDS collection, but are grouped under the general heading 'counselling'.

At its most basic level, drug counselling provides advice and support to the client from a professional counsellor on an appointment basis. Areas discussed can include clients' drug-taking behaviour, their school, work and leisure activities, and relationships with family and friends.

Types of counselling include motivational interviewing, cognitive and behavioural techniques such as problem-solving skills, drink and drug refusal skills, relapse prevention, contingency management and aversive conditioning, and other skills-based training such as anger or sleep management, relaxation, assertiveness training and vocational rehabilitation (Ghodse 2002). The treatment can be provided at the individual or group level and by a range of specialists such as psychologists, social workers, community nurses, drug and

alcohol workers, medical practitioners, Alcoholics Anonymous or Narcotics Anonymous and others (New South Wales Health Department 2000).

The goal of counselling is to encourage and support emotional and behavioural change. Lifestyle adjustment is facilitated by the development of skills to cope with factors that trigger drug use or prevent full relapse to regular drug use (Gowing et al. 2001).

Rehabilitation

Rehabilitation programs begin with a thorough assessment and detoxification, if necessary. A specific treatment plan is then developed which may be provided as residential or outpatient treatment. This plan may include regular counselling, group and/or family therapy sessions, a pharmacotherapy program, an education program providing advice on ways to achieve and maintain recovery, exercise and relaxation sessions, plus support with employment and living arrangements (Ghodse 2002).

Residential rehabilitation programs may be short term (4–6 weeks) or long term (2–6 months). Short-term programs are suitable for people without a long-term history of substance dependence, who have not succeeded at outpatient treatment, do not have significant cognitive impairment or comorbidity and have better psychosocial supports. Long-term programs are preferred for people who have severe alcohol and drug use problems, or whose substance use problems were not overcome by outpatient or short-term residential treatment, or people with significant comorbid disorders (New South Wales Health Department 2000).

The goals of rehabilitation and treatment activities in general include reducing the use of illicit drugs, reducing the risk of infectious diseases, improving physical and psychological health, reducing criminal behaviour and improving social functioning (Gowing et al. 2001).

Information and education

Federal, state and territory governments provide a number of information and education programs, as well as 24-hour telephone information services, on alcohol and other drugs as part of their public health programs. National initiatives to provide information on drug-related harm to the wider community include the Australian Drug Information Network and the Community Partnership Initiative (MCDS 1998). Services provided by the states and territories include 24-hour telephone services and fact sheets on specific drugs and other drug-related reports available from the Internet. The telephone services provide information on drugs, access to drug and alcohol counselling, and referrals to appropriate services (Department of Human Services 2002).

Information and education programs are also provided specifically for clients of alcohol and other drug treatment services. These include education on the effects of cannabis or other drugs for clients who have been required to attend the service as a result of a police or court diversion order, information on what the client can expect during the withdrawal (detoxification) process, and information on harm minimisation strategies to increase the client's ability to maintain behaviour that reduces drug-related harm (Department of Human Services 2002).

Appendix 6: Australian Standard Geographical Classification

The Australian Standard Geographical Classification (ASGC) was released in 2001 by the ABS, and was based on an enhanced measure of remoteness (ARIA+) developed by the National Key Centre for Social Applications of Geographical Information (AIHW 2004b).

The Remoteness Areas of the ASGC replace the former national standard classification of Rural, Remote and Metropolitan Area (RRMA). The Remoteness Area classification summarises the remoteness of an area based on the road distance to different-sized urban centres, where the population size of an urban centre is considered to govern the range and type of services available.

There are five major Remoteness Areas into which the statistical local areas of the alcohol and other drugs treatment agencies are placed:

- major cities of Australia
- inner regional Australia
- outer regional Australia
- remote Australia
- very remote Australia.

For further information on how Remoteness Areas are calculated, see AIHW (2004b).

Appendix 7: Australian Standard Classification of Drugs of Concern (ASCDC)

The main classification structure is presented below. For detailed information, supplementary codes and the full version of the coding index, see *Australian Standard Classification of Drugs of Concern* (ABS 2000).

TYPE OF DRUG CLASSIFICATION: BROAD GROUPS, NARROW GROUPS AND DRUGS OF CONCERN

1 ANALGESICS

11 Organic Opiate Analgesics

- 1101 Codeine
- 1102 Morphine
- 1199 Organic Opiate Analgesics, n.e.c.

12 Semisynthetic Opioid Analgesics

- 1201 Buprenorphine
- 1202 Heroin
- 1203 Oxycodone
- 1299 Semisynthetic Opioid Analgesics, n.e.c.

13 Synthetic Opioid Analgesics

- 1301 Fentanyl
- 1302 Fentanyl analogues
- 1303 Levomethadyl acetate hydrochloride
- 1304 Meperidine analogues
- 1305 Methadone
- 1306 Pethidine
- 1399 Synthetic Opioid Analgesics, n.e.c.

14 Non Opioid Analgesics

- 1401 Acetylsalicylic acid
- 1402 Paracetamol
- 1499 Non Opioid Analgesics, n.e.c.

2 SEDATIVES AND HYPNOTICS

21 Alcohols

- 2101 Ethanol
- 2102 Methanol
- 2199 Alcohols, n.e.c.

22 Anaesthetics

- 2201 Gamma-hydroxybutyrate
- 2202 Ketamine
- 2203 Nitrous oxide
- 2204 Phencyclidine
- 2299 Anaesthetics, n.e.c.

23 Barbiturates

- 2301 Amylobarbitone
- 2302 Methylphenobarbitone
- 2303 Phenobarbitone
- 2399 Barbiturates, n.e.c.

24 Benzodiazepines

- 2401 Alprazolam
- 2402 Clonazepam
- 2403 Diazepam
- 2404 Flunitrazepam
- 2405 Lorazepam
- 2406 Nitrazepam
- 2407 Oxazepam
- 2408 Temazepam
- 2499 Benzodiazepines, n.e.c.

29 Other Sedatives and Hypnotics

- 2901 Chlormethiazole
- 2902 Kava lactones
- 2903 Zopiclone
- 2999 Other Sedatives and Hypnotics, n.e.c.

3 STIMULANTS AND HALLUCINOGENS

31 Amphetamines

- 3101 Amphetamine
- 3102 Dexamphetamine
- 3103 Methamphetamine
- 3199 Amphetamines, n.e.c.

32 Cannabinoids

- 3201 Cannabinoids

33 Ephedra Alkaloids

- 3301 Ephedrine
- 3302 Norephedrine
- 3303 Pseudoephedrine
- 3399 Ephedra Alkaloids, n.e.c.

34 Phenethylamines

- 3401 DOB
- 3402 DOM
- 3403 MDA
- 3404 MDEA
- 3405 MDMA
- 3406 Mescaline
- 3407 PMA
- 3408 TMA
- 3499 Phenethylamines, n.e.c.

35 Tryptamines

- 3501 Atropinic alkaloids
- 3502 Diethyltryptamine
- 3503 Dimethyltryptamine
- 3504 Lysergic acid diethylamide
- 3505 Psilocybin
- 3599 Tryptamines, n.e.c.

36 Volatile Nitrates

- 3601 Amyl nitrate
- 3602 Butyl nitrate
- 3699 Volatile Nitrates, n.e.c.

39 Other Stimulants and Hallucinogens

- 3901 Caffeine
- 3902 Cathinone
- 3903 Cocaine
- 3904 Methcathinone
- 3905 Methylphenidate
- 3906 Nicotine
- 3999 Other Stimulants and Hallucinogens, n.e.c.

4 ANABOLIC AGENTS AND SELECTED HORMONES

41 Anabolic Androgenic Steroids

- 4101 Boldenone
- 4102 Dehydroepiandrosterone
- 4103 Fluoxymesterone
- 4104 Mesterolone
- 4105 Methandriol
- 4106 Methenolone
- 4107 Nandrolone
- 4108 Oxandrolone
- 4111 Stanozolol
- 4112 Testosterone
- 4199 Anabolic Androgenic Steroids, n.e.c.

42 Beta₂ Agonists

- 4201 Eformoterol
- 4202 Fenoterol
- 4203 Salbutamol
- 4299 Beta₂ Agonists, n.e.c.

43 Peptide Hormones, Mimetics and Analogues

- 4301 Chorionic gonadotrophin
- 4302 Corticotrophin
- 4303 Erythropoietin
- 4304 Growth hormone
- 4305 Insulin
- 4399 Peptide Hormones, Mimetics and Analogues, n.e.c.

49 Other Anabolic Agents and Selected Hormones

- 4901 Sulfonylurea hypoglycaemic agents
- 4902 Tamoxifen
- 4903 Thyroxine
- 4999 Other Anabolic Agents and Selected Hormones, n.e.c.

5 ANTIDEPRESSANTS AND ANTIPSYCHOTICS

51 Monoamine Oxidase Inhibitors

- 5101 Moclobemide
- 5102 Phenelzine
- 5103 Tranylcypromine
- 5199 Monoamine Oxidase Inhibitors, n.e.c.

52 Phenothiazines

- 5201 Chlorpromazine
- 5202 Fluphenazine
- 5203 Pericyazine
- 5204 Thioridazine
- 5205 Trifluoperazin
- 5299 Phenothiazines, n.e.c.

53 Serotonin Reuptake Inhibitors

- 5301 Citalopram
- 5302 Fluoxetine
- 5303 Paroxetine
- 5304 Sertraline
- 5399 Serotonin Reuptake Inhibitors, n.e.c.

54 Thioxanthenes

- 5401 Flupenthixol
- 5402 Thiothixene
- 5499 Thioxanthenes, n.e.c.

55 Tricyclic Antidepressants

- 5501 Amitriptyline
- 5502 Clomipramine
- 5503 Dothiepin
- 5504 Doxepin
- 5505 Nortriptyline
- 5599 Tricyclic Antidepressants, n.e.c.

59 Other Antidepressants and Antipsychotics

5901 Butyrophenones

5902 Lithium

5903 Mianserin

5999 Other Antidepressants and Antipsychotics, n.e.c.

6 VOLATILE SOLVENTS

61 Aliphatic Hydrocarbons

6101 Butane

6102 Petroleum

6103 Propane

6199 Aliphatic Hydrocarbons, n.e.c.

62 Aromatic Hydrocarbons

6201 Toluene

6202 Xylene

6299 Aromatic Hydrocarbons, n.e.c.

63 Halogenated Hydrocarbons

6301 Bromochlorodifluoromethane

6302 Chloroform

6303 Tetrachloroethylene

6304 Trichloroethane

6305 Trichloroethylene

6399 Halogenated Hydrocarbons, n.e.c.

69 Other Volatile Solvents

6901 Acetone

6902 Ethyl acetate

6999 Other Volatile Solvents, n.e.c.

9 MISCELLANEOUS DRUGS OF CONCERN

91 Diuretics

9101 Antikaliuretics

9102 Loop diuretics

9103 Thiazides

9199 Diuretics, n.e.c.

92 Opioid Antagonists

9201 Naloxone

9202 Naltrexone

9299 Opioid Antagonists, n.e.c.

99 Other Drugs of Concern

9999 Other Drugs of Concern

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