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Alcohol and other drug treatment services in Australia 2013–14

DRUG TREATMENT SERIES NO. 25

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Number 25

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2013–14

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Contents

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Abbreviations

AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	*Australian Standard Classification of Drugs of Concern*
ASGC	*Australian Standard Geographical Classification*
ASGS	*Australian Statistical Geography Standard*
ERP	estimated resident population
MDMA	3,4-methylenedioxy-N-methylamphetamine (or ecstasy)
NDSHS	National Drug Strategy Household Survey
NGOTGP	Non-Government Organisation Treatment Grants Program
OSR	Online Services Report
SA2	Statistical Area level 2
SLK	statistical linkage key

Notes

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

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

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

Summary

Alcohol and other drug (AOD) treatment services across Australia provide a broad range of treatment services and support to people using drugs and to their families and friends. This report presents the information for 2013–14 about publicly funded AOD treatment service agencies, the people they treat and the treatment provided.

Around 119,000 clients received over 180,000 treatment episodes from 795 publicly funded AOD treatment agencies across Australia

An estimated 118,741 clients received treatment in 2013–14. This equates to a rate of 509 clients per 100,000 people, or about 1 in 200 people in the general population. About 2 in 3 clients were male (67%) and 1 in 2 were aged 20–39 (54%). Despite only comprising 2.7% of the population, 1 in 7 (14%) clients were Aboriginal and Torres Strait Islander.

Treatment agencies provided a total of 180,713 treatment episodes—an average of 1.5 episodes per client—and 4 in 5 (79%) episodes ended within 3 months. There has been a steady increase in the number of treatment episodes provided over the last 5 years (from 145,630 to 180,713), an increase of 24%. Between 2012–13 and 2013–14, the estimated number of clients who received treatment increased by 8%. Of those clients who received treatment in 2013–14, 22% also received treatment in 2012–13.

The age profile of people receiving treatment suggests there is an ageing cohort of clients

Over the 5 years to 2013–14, the proportion of treatment episodes for clients who were aged 20–29 fell from 29% to 27%, while the proportion for those aged 40 and over rose from 30% to 33%.

Alcohol continues to be the most common drug leading clients to seek treatment but treatment for use of amphetamines is increasing

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs of concern for clients since 2003–04. Nationally, alcohol was the most common principal drug of concern in 2013–14, accounting for 40% of episodes. For clients aged 30 and over, alcohol was the most common principal drug of concern, while for clients aged 10–29, cannabis was the most common.

Since 2009–10, the proportion of episodes where alcohol was the most common principal drug of concern has decreased (from 48% to 40%), while the proportion of episodes for amphetamines have increased (from 7% to 17%). The number of episodes for clients injecting and smoking/inhaling amphetamines has also increased, with more than 6 times as many clients smoking/inhaling in 2013–14 as in 2009–10.

Most clients have more than 1 drug of concern

In more than half (54%) of treatment episodes, the client also reported additional drugs of concern. Just under a third (29%) had 1 additional drug of concern and 13% had 2 drugs. Nicotine and cannabis were the most common additional drugs of concern.

Counselling continues to be the most common type of treatment

Since 2003–04, the proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management and assessment only being the most common types of treatment. Counselling continues to be the most common main treatment type provided for clients (2 in 5 episodes since 2003–04).

1 Introduction

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

1.1 Drug use in Australia

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

- use of illegal drugs—a drug that is prohibited from manufacture, sale or possession in Australia, for example, cannabis, cocaine, heroin and ecstasy
- misuse, non-medical or extra-medical use of pharmaceuticals—drugs that are available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse, for example, opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids
- use of other psychoactive substances—legal or illegal, potentially used in a harmful way, for example, kava, or inhalants such as petrol, paint or glue (but not including tobacco or alcohol) (MCDS 2011).

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

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

1.2 National Drug Strategy

Australia has had a coordinated approach to alcohol and other drugs since 1985. The National Drug Strategy 2010–2015, is the latest cooperative strategy between the Australian Government, state and territory governments and the non-government sector. It has an

overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (MCDS 2011):

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

Harm reduction actions in the strategy include enhancing treatment 'across settings to provide help at all stages of drug use, particularly for disadvantaged populations', preventing drug overdoses through the use of 'substitution therapies, withdrawal treatment and other pharmacotherapies' and continuing drug diversion programs (MCDS 2011).

1.3 Agencies, clients and treatment

In Australia, publicly funded treatment services for AOD use are available in all states and territories. Most of these services are funded by state and territory governments while some are funded by the Australian Government.

This report presents information on clients and treatment episodes delivered by publicly funded treatment agencies for AOD use from the AODTS NMDS. It does not include information on agencies that provide:

- services primarily concerned with health promotion or accommodation
- private treatment agencies that do not receive public funding
- needle and syringe programs.

Other available data sources that support a more complete picture of AOD treatment in Australia include: the National Opioid Pharmacotherapy Statistics Annual Data collection <http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/>, the National Hospital Morbidity Database, Online Services Report Database, Specialist Homelessness Services collection and the National Prisoner Health Data collection. Relevant data from these collections will be available online in a subsequent release later in 2015.

Services are provided to people who are seeking assistance for their own drug use and those seeking assistance for someone else's drug use. Two types of clients are included in this report: distinct and imputed. Distinct clients refer to those closed treatment episodes for which a valid statistical linkage key (SLK) has been supplied. Imputed client numbers have been estimated based on closed treatment episodes with and without a valid SLK (refer to Appendix B for further details on the imputation methodology).

Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed. The following types of treatment are examined in this report: assessment only, counselling, information and education only, pharmacotherapy, rehabilitation, support and case management only and withdrawal management (see the Glossary for definitions).

1.4 The AODTS NMDS

As a part of government efforts to report regularly on the status, quality and performance of the healthcare system, the 2012 National Healthcare Agreement (COAG 2012) mandates the collection of data for several National Minimum Data Sets, one of which is the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). This information is used to inform policy and help improve service delivery.

The AODTS NMDS contains information on treatment episodes provided by publicly funded AOD treatment services, including government and non-government organisations. The main counting unit is closed treatment episodes, which is defined as a period of contact between a client and a treatment provider (or team of providers) that is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months, or treatment is ceased. Further details on the scope of the AODTS NMDS can be found online <http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/aodts-nmds/>.

Data are collected by treatment agencies who forward these data to state and territory government health departments. These departments extract required data according to definitions and technical specifications agreed to by the departments and the Australian Institute of Health and Welfare (AIHW). Agencies funded by the Australian Government through the Non-Government Organisation Treatment Grants Program (NGOTGP) generally forward data directly to the AIHW. Data are submitted to the AIHW on an annual basis for national collation and reporting.

The AODTS NMDS does not contain a unique identifier for clients and information about clients is collected at the episode level. For the 2012–13 collection, a statistical linkage key (SLK) was introduced. While the SLK is not a unique identifier, it enables the number of clients receiving treatment to be counted, while continuing to ensure their privacy. As SLK data are not available for all clients, an imputation strategy has been developed to estimate the number of clients and facilitate reporting at the client level. Further information about the imputation methodology applied to these data can be found in Appendix B.

Coverage and data quality

It is difficult to fully quantify the scope of AOD services in Australia. Until the 2012–13 reference year, the AODTS NMDS has been based on counts of treatment episodes and counts of individual clients were not available. In addition, there are a variety of settings in which people receive treatment for alcohol or other drug-related issues that are not in scope for this collection.

Agencies are excluded from the AODTS NMDS if they:

- do not receive any public funding
- primarily provide accommodation or overnight stays as their main function (for example, half-way houses and sobering-up shelters)
- are based in prisons or other correctional institutions
- provide services primarily concerned with health promotion (for example, needle and syringe programs)
- are located in acute care or psychiatric hospitals and provide treatment only to admitted patients

- have the sole function of prescribing or providing dosing services for opioid pharmacotherapy (these agencies are excluded because of the multi-faceted nature of service delivery in this sector, however these data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection <http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/>).

Australian Government-funded primary health care services and substance-use services specifically aimed at Indigenous Australians are in scope for the AODTS NMDS, but most of these agencies do not contribute to the collection as they currently provide data to the Online Services Report (OSR) collection. To minimise reporting burden, agencies reporting to the OSR do not usually also report to the AODTS NMDS (see online <http://www.aihw.gov.au/publication-detail/?id=60129550843> for the latest OSR report).

In 2013–14, over 97% of in-scope agencies submitted data to the AODTS NMDS in all jurisdictions. Overall, there was an increase of 9.4 percentage points since 2012–13 in the number of in-scope agencies that reported to the collection.

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

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

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

Further details on scope, coverage and data quality is available from the Data Quality Statement <http://meteor.aihw.gov.au/content/index.phtml/itemId/606485> for the AODTS NMDS and online <http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/aodts-nmds/>.

1.5 Report structure

Chapter 1 (this chapter) provides background information about AOD treatment services in Australia, the AODTS NMDS, and the context in which these data are reported.

Chapter 2 provides an overview of findings from the 2013–14 AODTS NMDS.

Chapter 3 presents data on AOD treatment agencies.

Chapter 4 provides information on the drugs of concern people receive treatment for.

Chapter 5 examines the type of treatment provided, including the characteristics of clients and episodes, and the type and outcome of treatment.

Two appendixes are included in this report:

- Appendix A—Information about the data and methods
- Appendix B—Imputation methodology for AODTS clients.

The following online information accompanies this report:

- scope, coverage and data quality <http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/aodts-nmds/>
- data quality statement <http://meteor.aihw.gov.au/content/index.phtml/itemId/606485>
- state and territory summaries http://www.aihw.gov.au/publication-detail/?id=60129551120
- supplementary tables (those with a prefix of 'S' in the report) http://www.aihw.gov.au/publication-detail/?id=60129551120.

2 At a glance

This chapter provides an overview of results from the AODTS NMDS for 2013–14.

2.1 Key facts

In 2013–14:

- A total of 795 publicly funded agencies provided data about services for clients seeking treatment services and support.
- An estimated 118,741 clients received treatment.
- Most clients (86%) received treatment at 1 agency.
- About 2 in 3 clients were male (67%) and half were aged 20–39 (54%).
- Treatment agencies provided a total of 180,713 closed treatment episodes.
- The main drugs that led clients to seek treatment were alcohol, cannabis, amphetamines and heroin (which was consistent for Indigenous and non-Indigenous clients), and for the majority of these, clients received treatment in a non-residential facility.
- Counselling was the most common treatment type (43%).
- 4 in 5 (79%) closed treatment episodes ended within 3 months.

Over the 5-year period to 2013–14:

- The number of publicly funded agencies providing data about services for clients seeking treatment services and support increased by 19%.
- The number of closed treatment episodes increased from 145,630 to 180,713 (a 24% increase).
- Alcohol continued to be the most common drug leading clients to seek treatment.
- Treatment for the use of amphetamines increased (from 7% to 17%).
- There were no substantial changes to the treatment types received by clients.

2.2 Agencies

In 2013–14, a total of 795 publicly funded AOD treatment agencies provided data about services for clients seeking treatment services and support, an increase of 19% over the 5-year period from 2009–10. Over half (56%) of treatment agencies were non-government, and these agencies provided almost two-thirds (63%) of closed treatment episodes. Nationally, just over half (57%) of treatment agencies were located in *Major cities* and almost one-quarter (23%) in *Inner regional* areas. Relatively few agencies were in *Remote* or *Very remote* areas (7%) (tables SA.1–SA.3).

2.3 Clients

In 2013–14, 118,741 clients were estimated to have received treatment from publicly funded AOD treatment agencies across Australia. This equates to a rate of 509 clients per 100,000 people, or about 1 in 200 people in the general population. These clients received over 180,000 treatment episodes (Table 2.1) (see Appendix B for details of the imputation strategy used to estimate client numbers). Between 2012–13 and 2013–14, the number of estimated clients rose from 110,427 to 118,741, an 8% increase.

Clients can receive treatment for their own or someone else's drug use (see the Glossary for further details). In 2013–14, around 113,000 clients received treatment for their own drug use, and about 7,000 received support in relation to someone else's drug use (Table 2.1). A small proportion (1.1%) of clients received treatment for both their own drug use and someone else's drug use in 2013–14.

Table 2.1: Estimated clients[(a)], episodes and rates, by client type and state and territory, 2013–14

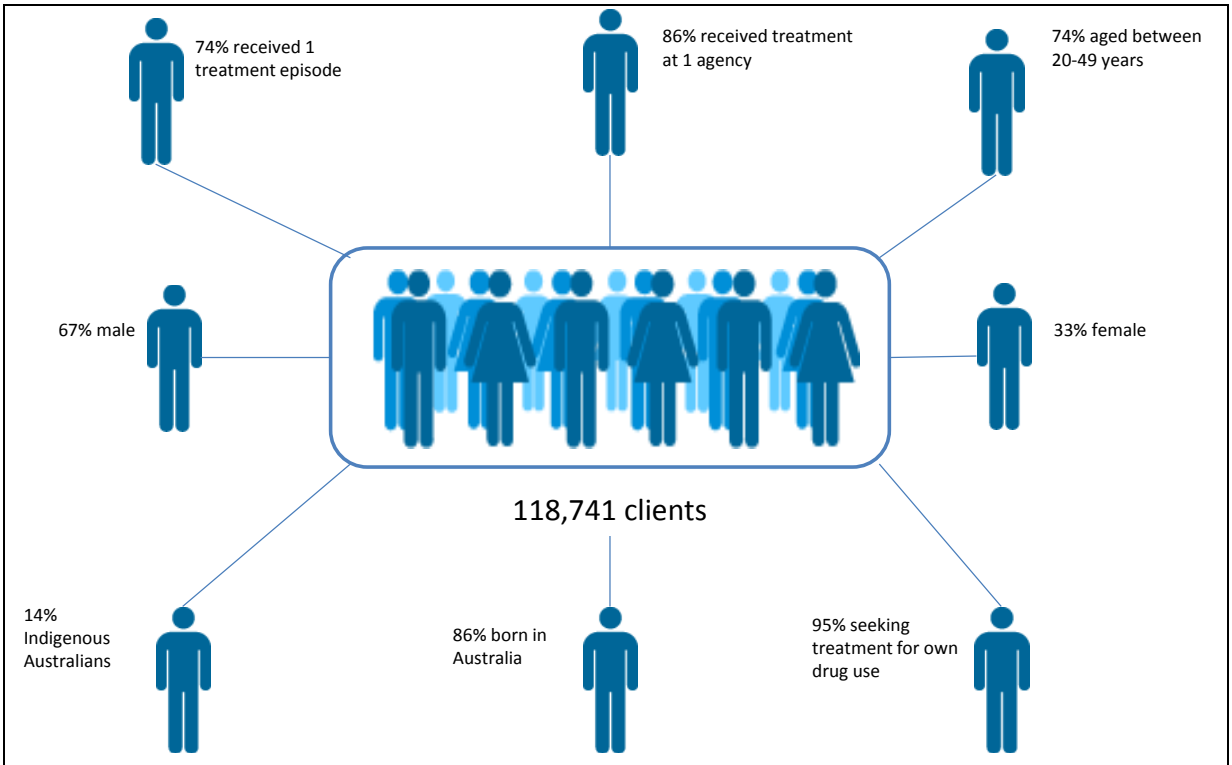
	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Own drug use				
Number of episodes	40,824	52,261	35,127	19,456	12,979	2,649	4,545	3,917	171,758
Number of clients	25,545	27,427	28,394	14,430	9,282	2,271	3,231	2,599	112,573
Episodes per client	1.6	1.9	1.2	1.3	1.4	1.2	1.4	1.5	1.5
Rate of episodes[(b)] (per 100,000 population)	547	902	749	763	774	515	1,183	1,615	737
Rate of clients[(b)] (per 100,000 population)	342	474	605	566	553	442	841	1,071	483
					Other's drug use				
Number of episodes	1,582	4,131	966	1,411	106	192	107	460	8,955
Number of clients	954	3,208	909	1,363	89	191	106	410	7,174
Episodes per client	1.7	1.3	1.1	1.0	1.2	1.0	1.0	1.1	1.2
Rate of episodes[(b)] (per 100,000 population)	21	71	21	55	6	37	28	190	38
Rate of clients[(b)] (per 100,000 population)	13	55	19	53	5	37	28	169	31
					All clients				
Number of episodes	42,406	56,392	36,093	20,867	13,085	2,841	4,652	4,377	180,713
Number of clients	26,402	29,877	29,207	15,760	9,365	2,444	3,332	2,963	118,741
Episodes per client	1.6	1.9	1.2	1.3	1.4	1.2	1.4	1.5	1.5
Rate of episodes[(b)] (per 100,000 population)	568	974	769	818	780	553	1,211	1,804	775
Rate of clients[(b)] (per 100,000 population)	354	516	623	618	558	476	867	1,222	509

(a) Client numbers presented are the imputed total (estimated from data with and without a valid SLK). Refer to Appendix B for further details.

(b) Crude rate is based on the preliminary Australian estimated resident population as at 31 December 2013.

Sources: Tables SC.21 and SC.27.

Of all clients receiving treatment, 2 in 3 (67%) were male and around 1 in 7 (14%) were Aboriginal and Torres Strait Islander (from here on referred to as 'Indigenous Australians'). These proportions were similar for clients receiving treatment for their own drug use, however clients receiving support for someone else's drug use were more likely to be female (64%) and less likely to be Indigenous (8%) (tables SC.1 and SC.3).



Note: Client numbers presented are imputed (estimated from data with and without a valid SLK). Proportions presented are not imputed (based on data with a valid SLK).

Sources: Tables SC.1–SC.3, SC.21–SC.23 and SE.7.

Figure 2.1: Estimated clients, key facts, 2013–14

Clients receiving treatment for their own drug use tended to be younger, on average, than clients receiving support for someone else's drug use. In 2013–14, clients aged 20–39 represented over half (56%) of clients receiving treatment for their own drug use, but only about one-third (29%) of clients receiving support for someone else's drug use. Clients aged 40 and over comprised nearly one-third (31%) of clients receiving treatment for their own drug use, compared with over half (57%) of clients receiving support for someone else's drug use (Table SC.2).

Over the 5 years to 2013–14, the proportion of treatment episodes for clients who were aged 20–29 fell from 29% to 27%, while the proportion for those aged 40 and over rose from 30% to 33%. The proportion of episodes for those aged 10–19 and 30–39 has remained stable over time. This suggests that there is an ageing cohort of people in AOD treatment (Table SE.5).

Despite only comprising 2.7% of the Australian population aged 10 and over, 14% of all clients were Indigenous Australians in 2013–14 (ABS 2014). This varied by client type—about 1 in 7 (14%) clients receiving treatment for their own drug use were Indigenous Australians, while 8% of clients receiving support for someone else's drug use were Indigenous Australians (Table SC.3).

The majority (86%) of treatment episodes were for clients who were born in Australia. This percentage is higher than that found in the general population (72%) (ABS 2015). Clients born in countries other than Australia represented only a small proportion of all clients, with the United Kingdom and New Zealand being the next most common countries of birth (2% and 3% respectively) (Table SE.7). Comparatively, in 2013–14, 5.2% of the Australian population were born in the United Kingdom and 2.6% in New Zealand (ABS 2015). English

was the most frequently reported preferred language (96% of treatment episodes for clients) (Table SE.8).

Australia has an ageing population and therefore an anticipated increase in absolute numbers of older Australians with AOD issues (Dowling et al. 2008). Further, Gossop (2008) estimates that, internationally, the number of older people needing treatment for AOD issues will double between 2000 and 2020. While the demographic profile of clients receiving treatment and support from publicly funded AOD services has changed little since 2003–04, in more recent years the age profile of people receiving treatment suggest there is an ageing cohort of AOD clients.

In 2013–14, clients seeking treatment for their own drug use received an average of 1.5 treatment episodes (Table 2.1). The main drugs that led clients to seek treatment were alcohol, cannabis, amphetamines and heroin. This was consistent for both Indigenous and non-Indigenous clients.

Further information on clients is provided in Chapters 4 and 5.

2.4 Drugs of concern and treatment provided

In 2013–14, AOD treatment services provided a total of 180,713 closed treatment episodes (see Box 2.1), an increase of 24% since 2009–10 (from 145,630 to 180,713 episodes). The majority (95%) of closed treatment episodes provided in 2013–14 were for clients receiving treatment for their own drug use (SE.1).

In 2013–14, the most common principal drugs of concern (the primary drug leading someone to seek treatment, see Box 2.1) were alcohol (40% of episodes), cannabis (24%), amphetamines (17%) and heroin (7%). Since 2009–10, the proportion of episodes where alcohol was the principal drug of concern has decreased (from 48% to 40%), while the proportion of episodes for amphetamines increased (from 7% to 17%) (Table SE.9).

In more than half (54%) of closed treatment episodes, the client also reported additional drugs of concern. Almost one-third (29%) had 1 additional drug of concern, 13% had 2 drugs, and 2% had 5. Nicotine and cannabis were the most common additional drugs of concern (Table SD.6).

Since 2003–04, the proportion of closed treatment episodes for each main treatment type (see Box 2.1) remained relatively stable. Counselling continues to be the most common main treatment type provided (comprising about 2 in 5 episodes since 2003–04), however, since 2012–13, assessment only has replaced withdrawal management as the next most common (Table ST.4).

In 2013–14, the majority of treatment episodes for clients receiving treatment for their own drug use were provided by non-residential treatment facilities, such as community health centres. Episodes provided for the 4 most common principal drugs of concern (alcohol, cannabis, amphetamines and heroin) were most likely to be provided by non-residential treatment facilities (67% of episodes), followed by residential treatment facilities (where clients reside in a facility that is not their home or usual place of residence) (16%) and outreach settings (10%) (Table SD.12).

Box 2.1: Key terminology

Closed treatment episode

A treatment episode is considered closed where any of the following occurs: treatment is completed or has ceased, there has been no contact between the client and treatment provider for 3 months, there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they: are not closed in the relevant financial year, are for clients who are receiving pharmacotherapy and not receiving any other form of treatment that falls within the scope of the collection, include only activities relating to needle and syringe exchange, or are for a client aged under 10.

Drugs of concern

Principal drug of concern is the main substance that the client stated led them to seek treatment from the AOD treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses of principal drug of concern. It is assumed that only substance users themselves can accurately report principal drug of concern, therefore these data are not collected from those who seek support for someone else's drug use.

Additional drugs of concern refer to any other drugs the client reports using in addition to the principal drug of concern. Clients can nominate up to 5 additional drugs of concern.

All drugs of concern refer to all drugs reported by clients, including the principal drug of concern and any additional drugs of concern.

Reasons for cessation

The reasons for a client ceasing to receive a treatment episode from an AOD treatment service include:

- *Expected cessation:* episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement.
- *Unexpected cessation:* episodes where the client ceased to participate against advice, without notice or due to non-compliance.
- *Administrative cessation:* episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

Treatment types

Treatment type refers to the type of activity used to treat the client's alcohol or other drug problem. Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not available for clients seeking support for someone else's drug use.

Main treatment type is the principal activity that is determined at assessment by the treatment provider necessary for the completion of the treatment plan for the client's alcohol or other drug problem for their principal drug of concern. One main treatment type is reported for each treatment episode. Assessment only, support and case management only, and information and education only can only be reported as main treatment types.

Other treatment types refer to other treatment types provided to the client, in addition to their main treatment type. Up to 4 additional treatment types can be reported. Note that Victoria and Western Australia do not supply data on additional treatment types. In these jurisdictions, each type of treatment (main or additional) results in a separate episode.

In 2013–14, 4 in 5 (79%) closed treatment episodes ended within 3 months, under one-quarter (24%) ended within 1 day, almost 3 in 10 (30%) between 2 days and 1 month, and one-quarter of episodes (25%) between 1 and 3 months. Only 7% of closed treatment episodes lasted 6 months or longer. Nationally, the median duration of closed treatment episodes in 2013–14 was just over 3 weeks (24 days) (tables SE.18–19).

3 Agencies

The Australian Government and state and territory governments fund both government and non-government organisations to provide a range of AOD treatment services (see Glossary). Services are delivered in residential and non-residential settings and include treatment such as detoxification, rehabilitation, counselling, and pharmacotherapy.

The AODTS NMDS contains information on a subset of publicly funded AOD treatment services (see section 1.4 for details of agencies that are excluded).

3.1 Key facts

In 2013–14:

- A total of 795 publicly funded agencies provided data about services for clients seeking treatment and support.
- Over half (56%) of agencies were non-government.
- Just over half (57%) of agencies were located in *Major cities.*

Over the 5-year period to 2013–14:

- The number of publicly funded agencies providing data about services for clients seeking treatment and support increased by 19%.

3.2 Number of agencies

In 2013–14, 795 publicly funded AOD treatment agencies reported to the AODTS NMDS, an increase of 9.4 percentage points since 2012–13 in the number of agencies nationally. This represents nearly all (99.5%) agencies covered by the AODTS NMDS. The number of agencies per state and territory ranged from 15 in the Australian Capital Territory to 292 in New South Wales (Table SA.1).

Over the 5-year period to 2013–14, there has been a 19% increase in the number of reporting agencies (from 670 to 795). This increase has largely been driven by increases in reporting agencies in New South Wales (from 258 to 292), Queensland (from 118 to 141), Western Australia (from 52 to 80) and South Australia (from 59 to 93) (Table SA.1).

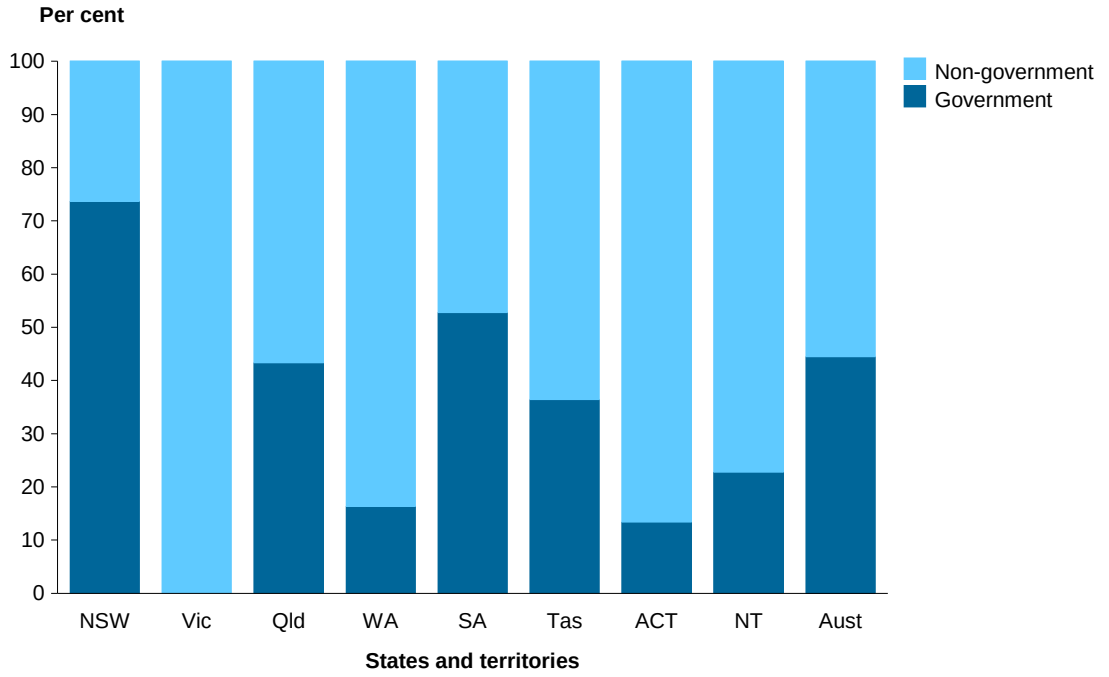
Several factors can contribute to changes in the number of agencies reporting between years, including changes in the actual numbers of agencies and changes in the mode of data collection. For example, agencies may move from collecting data at an administrative/management level to a service outlet level (see the Data quality statement <http://meteor.aihw.gov.au/content/index.phtml/itemId/606485> for further information).

3.3 Service sector

Nationally, over half (56%) of AOD treatment agencies were non-government, and these agencies provided almost two-thirds (63%) of closed treatment episodes (Figure 3.1). The proportion of non-government agencies has increased slightly since 2003–04 (from 52% to

56%), while the proportion of government agencies has decreased slightly (from 48% to 44%) (Table SA.2).

In New South Wales (74%) and South Australia (53%) the majority were government agencies. In the remaining states and territories most were non-government agencies, ranging from 57% in Queensland to 100% in Victoria (Figure 3.1).



Source: Table SA.2.

Figure 3.1: Publicly funded AOD treatment agencies by service sector, by state and territory, 2013–14

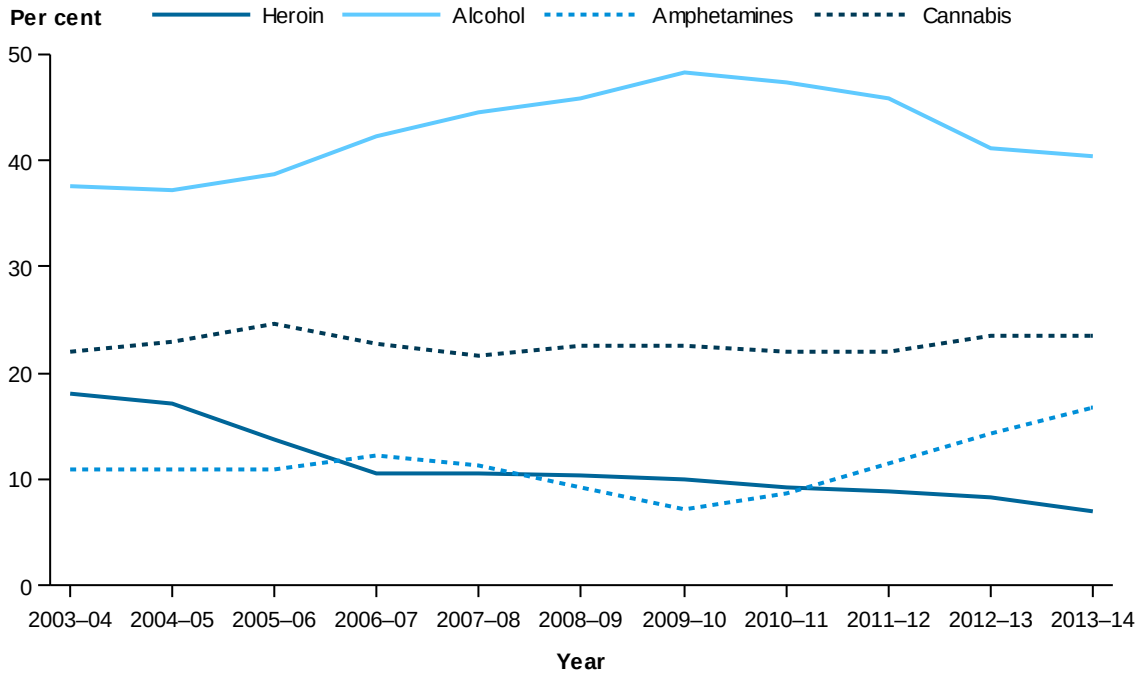
3.4 Remoteness

Nationally in 2013–14, over half (57%) of treatment agencies were located in *Major cities* and nearly one-quarter (23%) in *Inner regional* areas. Relatively few agencies were in *Remote* or *Very remote* areas (7%). This pattern was similar across most states and territories (Table SA.3).

4 Drugs of concern

People may seek AOD treatment services due to problematic use of one or more drugs. For most people, however, there is one drug that is of most concern for them, and therefore the focus of the treatment they receive. This is referred to as their principal drug of concern. Clients can also report other drugs of concern (referred to as additional drugs of concern). Information on clients and treatment agencies are included in the AODTS NMDS when a treatment episode provided to a client is closed (see Box 2.1 for more information).

While there are many different drugs people receive treatment for, the most common principal drugs of concern—alcohol, cannabis, heroin and amphetamines—have accounted for the large majority of services over time (Figure 4.1). Due to this consistent trend, the focus of this chapter will be on these four principal drugs of concern for clients in treatment. (Where a person receives treatment for someone else's drug use, the principal drug of concern for that person is not collected. Thus, no information is presented in this chapter on support received for someone else's drug use.)



Source: Table SD.2.

Figure 4.1: Closed episodes provided for own drug use, by selected principal drug of concern, 2003–04 to 2013–14

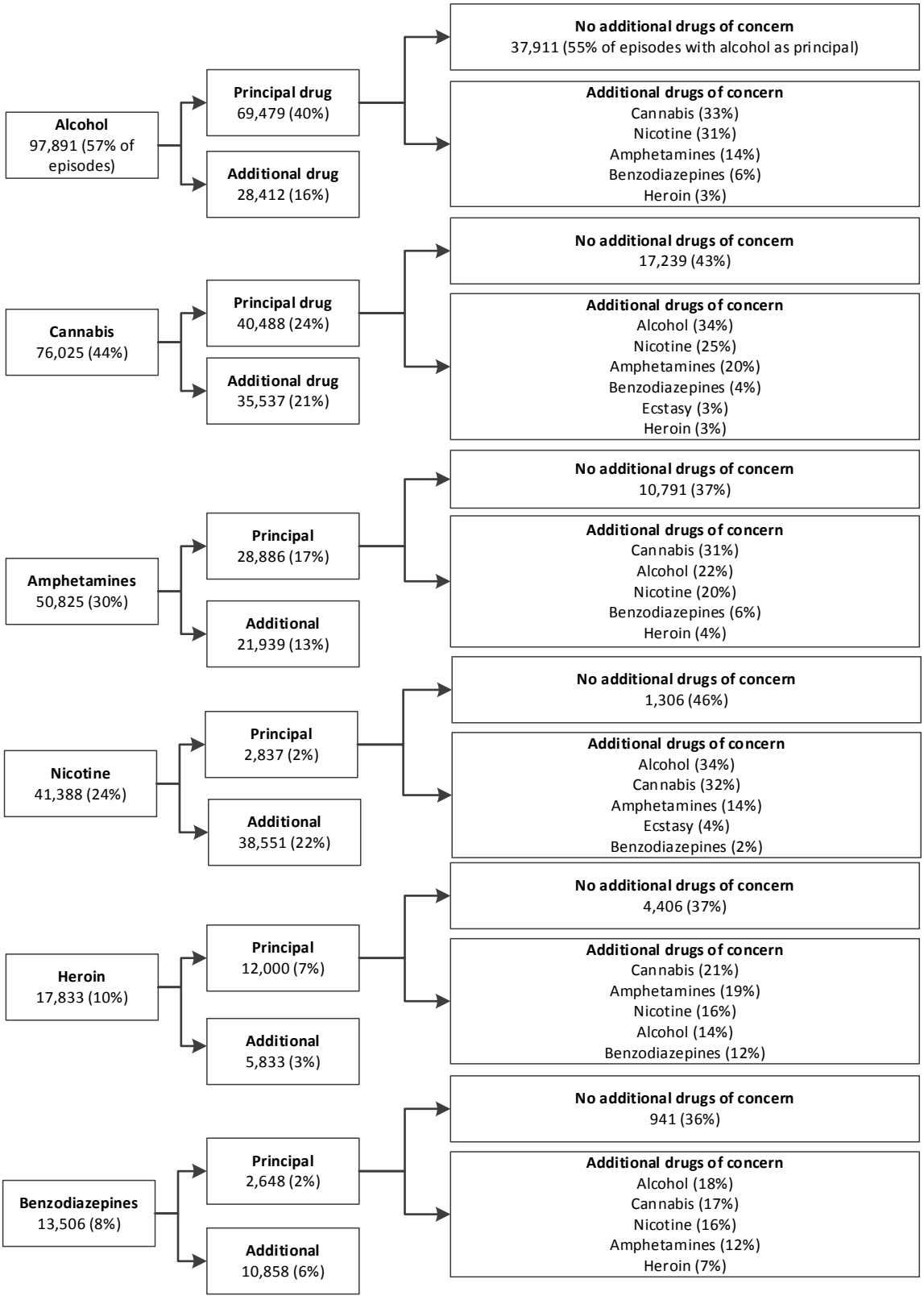
4.1 Key facts

In 2013–14:

- Nationally, alcohol was the most common principal drug of concern, accounting for 40% of episodes (Figure 4.2).
- Cannabis was the most common principal drug of concern for clients aged 10–29, while alcohol was the most common principal drug of concern for clients aged 30 and over.
- After alcohol, cannabis (24%), amphetamines (17%) and heroin (7%) were the next most common principal drugs of concern (Figure 4.2).
- Alcohol was the most common principal drug of concern in all remoteness areas—highest in *Very remote* areas (71%) and lowest in *Major cities* (38%).
- For the top four principal drugs of concern, most clients received treatment in a residential facility—alcohol (63% of episodes for alcohol), cannabis (71%), amphetamines (70%) and heroin (65%).
- Clients whose principal drug of concern was heroin or amphetamines generally spent longer in treatment; the median duration of episodes was 29 days compared to 23 days for all treatment episodes.

Over the 5-year period to 2013–14:

- The top four principal drugs of concern have remained consistent. However, between 2003–04 and 2013–14 amphetamines and heroin have replaced each other as the third and fourth most common principal drugs of concern several times.
- The trend in the top four principal drugs of concern has been consistent for both Indigenous and non-Indigenous clients.
- The number of episodes for clients injecting and smoking/inhaling amphetamines has increased, with more than 6 times as many clients smoking and inhaling in 2013–14 than in 2009–10.



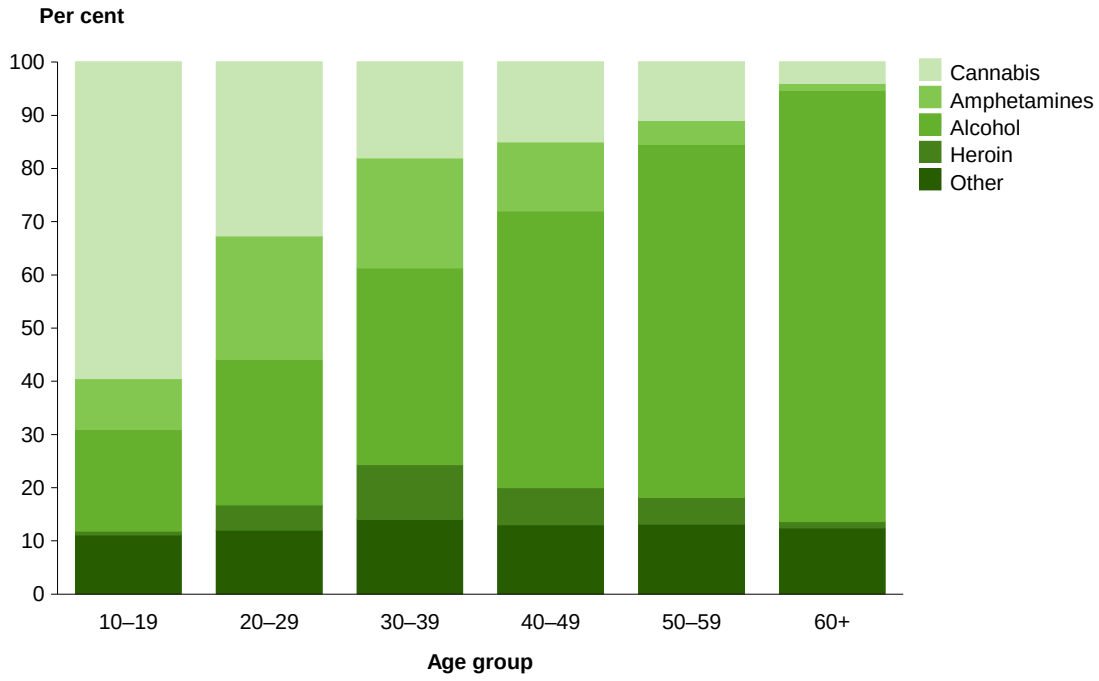
Note: Totals may not add due to rounding.

Sources: Tables SD.6, SD.7 and SD.9.

Figure 4.2: Closed episodes for own drug use, by principal drug of concern and additional drugs of concern, 2013–14

Nationally, alcohol was the most common principal drug of concern, accounting for more than a third (39%) of clients, followed by cannabis (26% of clients) and amphetamines (16%) (Table SC.4).

The proportion of clients receiving treatment where alcohol was the principal drug of concern increased substantially with age. Alcohol was the principal drug of concern for one in five (19%) of clients aged 10–19, but was more common in the older age groups—66% of those aged 50–59 and 81% of clients aged 60 and over (Figure 4.3). For clients receiving treatment for cannabis the opposite was true, with the proportion of clients decreasing with age. Clients aged 10–29 were most likely to be receiving treatment for cannabis use, with cannabis the principal drug of concern for more than half (60%) of clients aged 10–19, compared with 11% of those aged 50–59 and only 4% of clients aged 60 and over.



Note: Based on client records with a valid SLK.

Source: Table SC.5.

Figure 4.3: Principal drugs of concern for clients by age group, 2013–14

Clients receiving treatment where amphetamines and heroin were the principal drugs of concern were most likely to be aged 20–49. Amphetamines were most likely to be the principal drug of concern for clients aged 20–39 (ranging from 20 to 23% of clients), whereas only 9% of those aged 10–19 and 5% of clients aged 50–59 were receiving treatment. Heroin was most common among clients aged 30–49 (ranging from 7 to 10%), compared with only 1% of clients aged 10–19 and 5% of clients aged 50–59.

4.2 Alcohol

Alcohol is a central nervous system depressant that inhibits brain functions, dampens the motor and sensory centres and makes judgment, coordination and balance more difficult (NDARC 2010). According to the *2009 Australian guidelines to reduce health risks from drinking alcohol* (NHMRC 2009), people who drink more than 2 standard drinks per day on average have an increased lifetime risk of harm from alcohol-related disease or injury, while those

who drink more than 4 standard drinks on a single occasion are at risk of harm on that occasion (AIHW 2014).

Results from the 2013 NDSHS (AIHW 2014) showed:

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

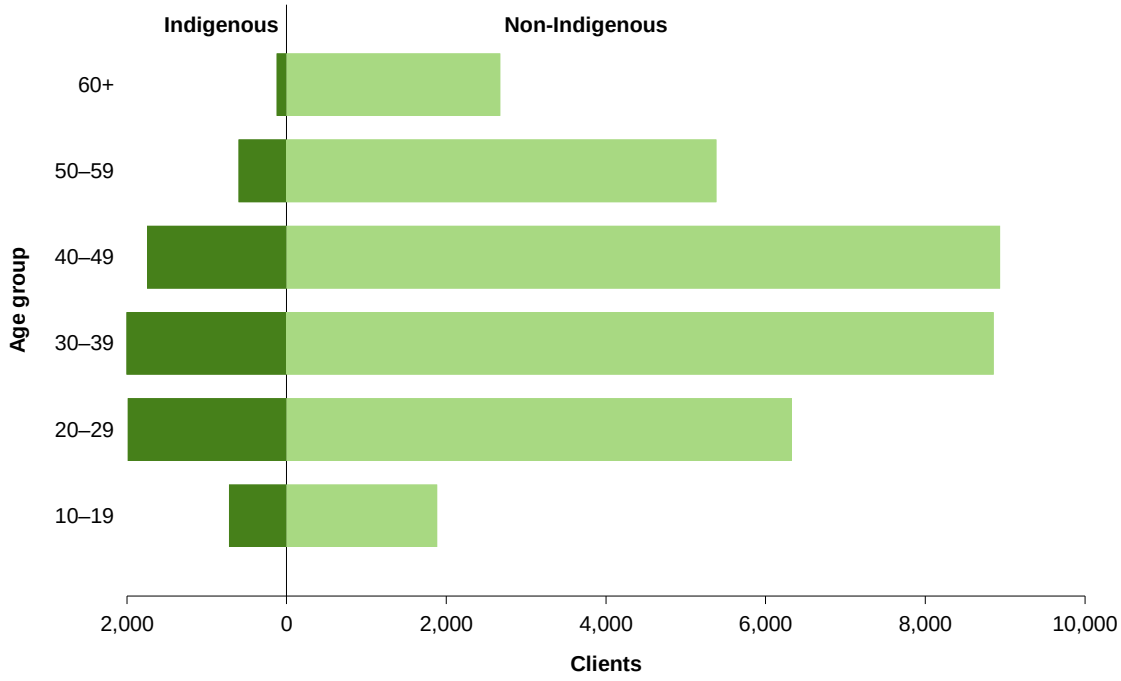
In 2013–14, alcohol was a drug of concern (principal or additional) in 57% of closed episodes, and the most common principal drug of concern in 40% (39% of clients) (Figure 4.2 and Table SC.4). This was consistent for both Indigenous and non-Indigenous clients, however the proportion of episodes where alcohol was the most common principal drug of concern was higher for Indigenous Australians—46% compared with 38% for non-Indigenous clients (Table SC.6). In 45% of episodes where alcohol was the principal drug of concern, the client reported additional drugs of concern. These were most commonly cannabis (33%) or nicotine (31%) (Figure 4.2).

For those clients who received episodes of treatment during both 2012–13 and 2013–14, alcohol was the main drug that led them to seek treatment in 39% of episodes (Table SC.29).

Over the 5 years to 2013–14, the proportion of closed episodes where alcohol was the principal drug of concern decreased from 48% to 40% (Table SD.2).

Client demographics

In 2013–14, where alcohol was the principal drug of concern, more than two-thirds of clients were male (68%) and just under one-sixth were Indigenous Australians (17%) (tables SC.4–6). Clients with alcohol as their principal drug of concern were most likely to be aged 30–39 or 40–49 (both 26% of clients), followed by 20–29 (20%) and 50–59 (14%). Indigenous clients who had a principal drug of concern of alcohol tended to be younger, with over half (56%) aged 20–39 (Figure 4.4).



Note: Based on client records with a valid SLK.

Source: AIHW analysis of the AODTS NMDS.

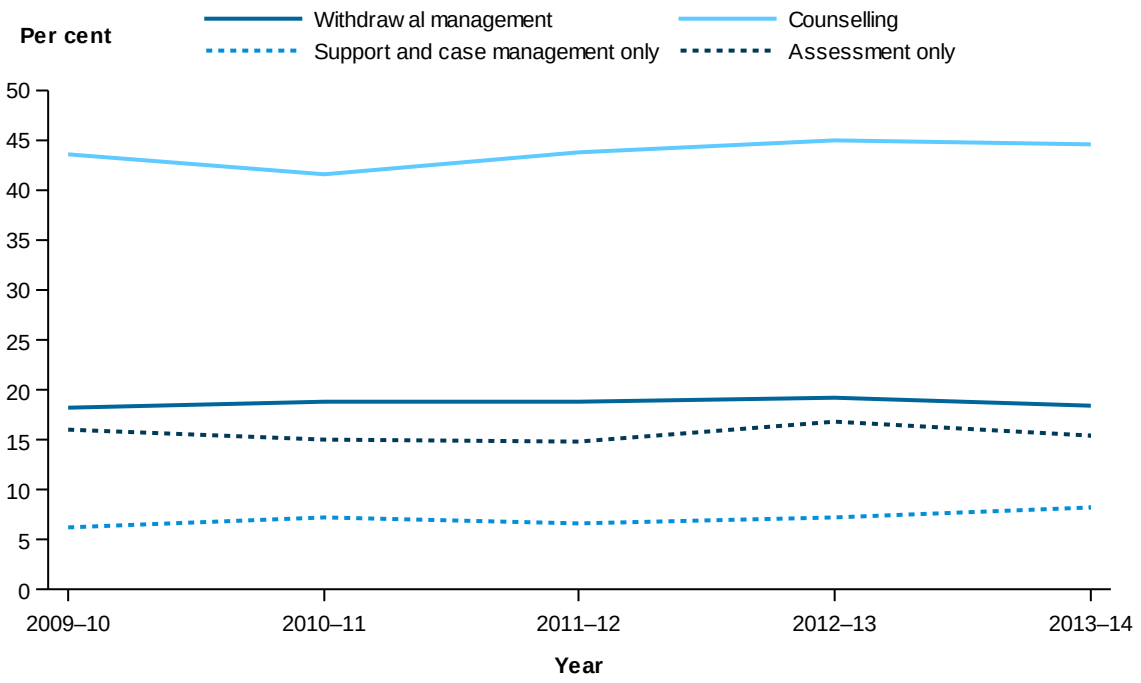
Figure 4.4: Number of clients with alcohol as a principal drug of concern, by age and Indigenous status, 2013–14

Treatment

In 2013–14, where alcohol was the principal drug of concern, the most common source of referral for treatment episodes was self/family (47%), followed by a health service (31%) (Table SD.21).

The most common main treatment type was counselling (45%), followed by withdrawal management (18%) and assessment only (15%)—this was consistent across all age groups (Table SD.25).

Over the 5 years from 2009–10, counselling, withdrawal management and assessment only have remained the most common main treatment types for episodes where alcohol was the principal drug of concern (Figure 4.5).



Source: Table SD.26.

Figure 4.5: Closed episodes with alcohol as the principal drug of concern by the top 4 treatment types received, 2009–10 to 2013–14

Alcohol-related treatment episodes were most likely to take place in a non-residential treatment facility (63%), with one-fifth (19%) occurring in a residential treatment facility. Most (91%) episodes where counselling was the main treatment type took place in a non-residential treatment facility, while episodes with a main treatment type of withdrawal management were most likely to take place in a residential treatment facility (62%) (Table SD.28).

About two-thirds (64%) of closed episodes where alcohol was the principal drug of concern ended with an expected cessation, while 21% ended due to an unexpected cessation (that is, the client ceased to participate against advice, without notice or due to non-compliance). Expected cessations were most common where the referral source was diversion (81%) (Table SD.29).

4.3 Cannabis

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

In 2013–14, cannabis was a drug of concern (principal or additional) in 44% of episodes, and was the second most common principal drug of concern (24% of closed treatment episodes

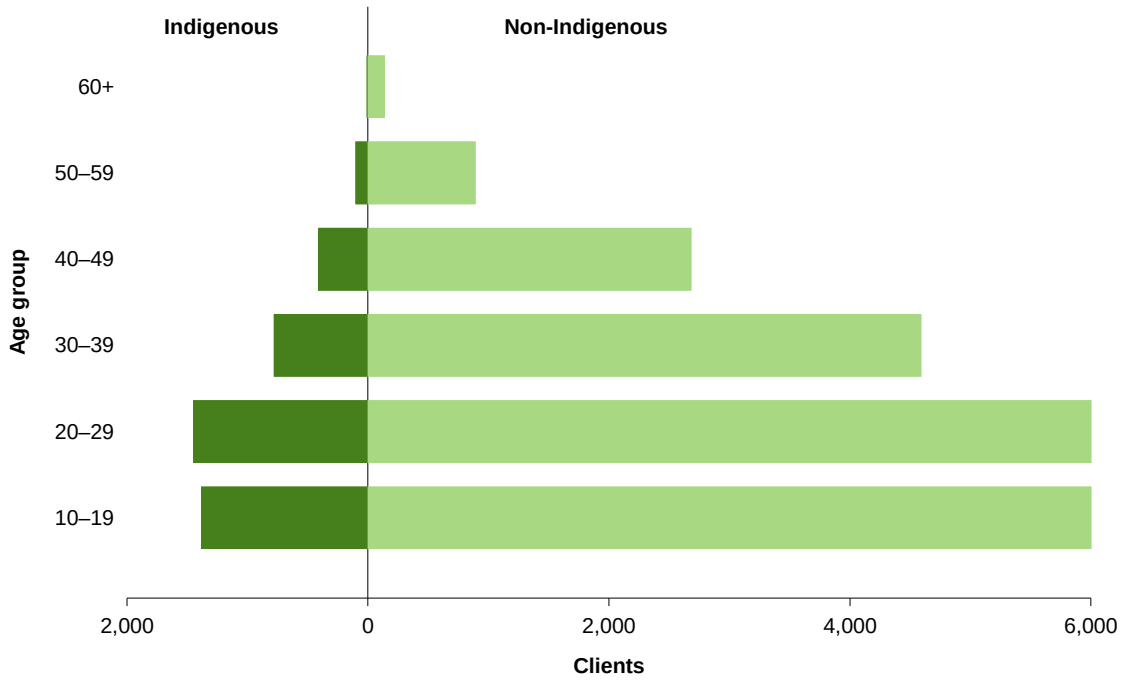
and 26% of Indigenous clients and 27% of non-Indigenous clients) (Figure 4.2 and Table SC.6). In more than half (57%) of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern. This was most commonly alcohol (34%), nicotine (25%) or amphetamines (20%) (Figure 4.2).

For those clients who received episodes of treatment during both 2012–13 and 2013–14, cannabis was the main drug that led them to seek treatment in 26% of episodes (Table SC.29).

The proportion of episodes where cannabis was the principal drug of concern has remained relatively stable over the 5 years to 2013–14 (Table SD.2). The small increase seen between 2011–12 and 2012–13 was in part due to the inclusion of new data in 2012–13 from the Drug Diversion Assessment Program in South Australia.

Client demographics

In 2013–14, where cannabis was the principal drug of concern, nearly three-quarters of clients were males (73%), and around 1 in 7 were Indigenous Australians (14%). Cannabis was most likely to be the principal drug among younger age groups—two-thirds (66%) of clients aged 10–29 had a principal drug of concern of cannabis (tables SC.4–6). This pattern was similar for both Indigenous and non-Indigenous clients (Figure 4.6).



Note: Based on client records with a valid SLK.

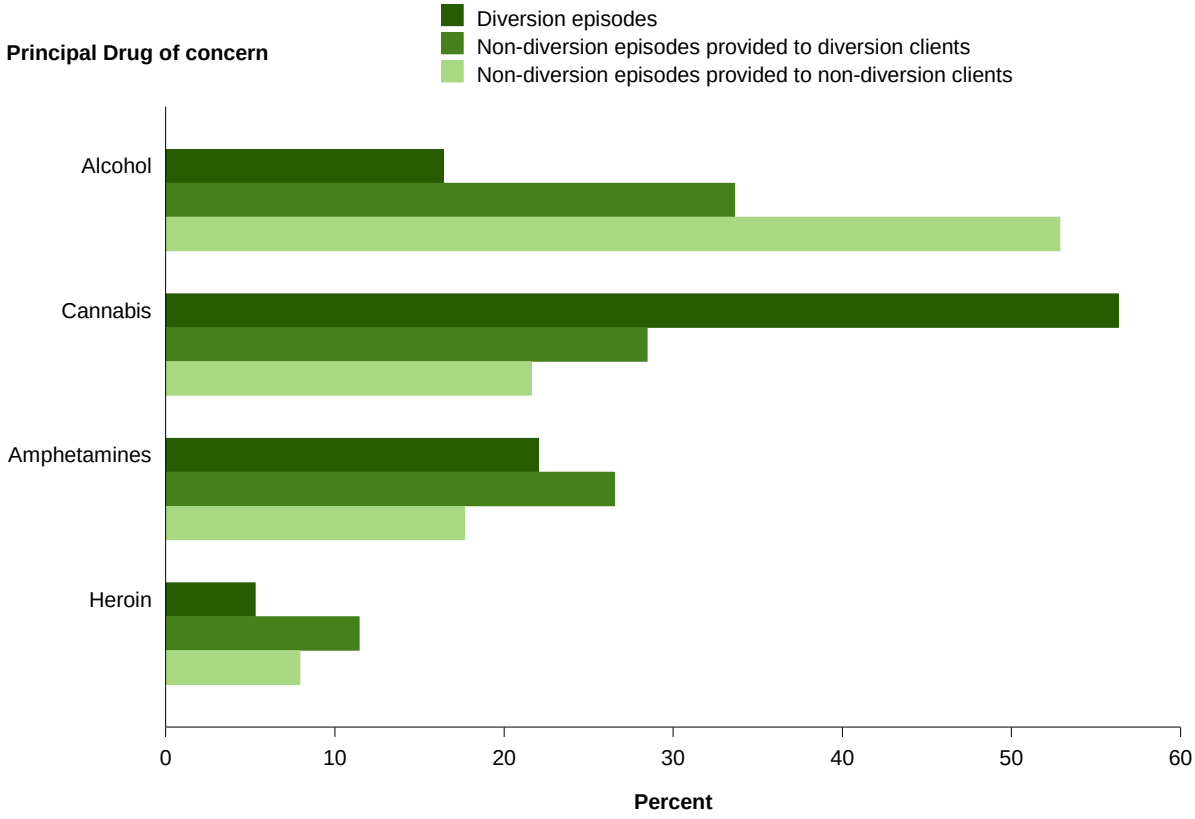
Source: AIHW analysis of the AODTS NMDS.

Figure 4.6: Number of clients with cannabis as a principal drug of concern, by age and Indigenous status, 2013–14

Treatment

The most common source of referral for treatment episodes where cannabis was the principal drug of concern was diversion (that is, referred from the criminal justice system into AOD treatment for drug or drug-related offences) (33%) (Table SD.37). Of the top four principal drugs of concern, cannabis was the only drug where diversion was the most common source of referral (Figure 4.7). Ecstasy and nicotine were the only other drugs with

'diversion' as the most common source of referral (70% and 42% respectively). Ecstasy was reported as the principal drug in just 1% of episodes and nicotine in just 2% of episodes.



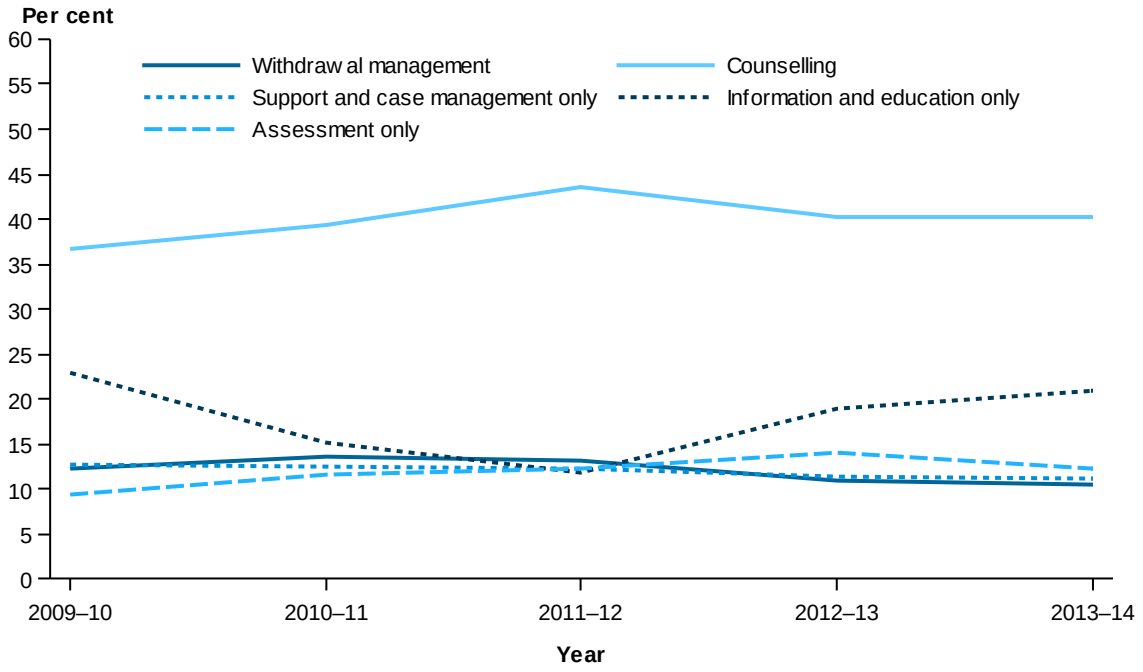
Source: Table SE.10.

Figure 4.7: Closed episodes provided to clients by selected principal drug of concern and diversion client type, 2013–14

Counselling was the most common main treatment type (40%) where cannabis was the principal drug of concern, followed by information and education only (21%) (Table SD.41). Treatment episodes where cannabis was the principal drug of concern were most likely to take place in a non-residential treatment facility (71%). Most (91%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table SD.44).

Over the 5 years from 2009–10, in episodes where cannabis was the principal drug, the proportion of episodes with a main treatment type of counselling increased from 37% to 40%, with a high of 43% in 2011–12 (Figure 4.8).

More than half (58%) of the episodes with cannabis as the principal drug lasted less than 1 month (34% ended within 1 day) (Table SE.22). The median duration of episodes with cannabis as the principal drug of concern was just over 2 weeks (16 days) (Table SD.47). Episodes with support and case management only as the main treatment type had a median duration of more than 8 weeks (57 days), compared with 1 week (8 days) for withdrawal management and 1 day for information and education only and assessment only (Table SD.47).



Source: Table SD.42.

Figure 4.8: Closed episodes with cannabis as the principal drug of concern by the top 5 treatment types received, 2009–10 to 2013–14

Seven in 10 (70%) closed episodes where cannabis was the principal drug of concern ended with an expected cessation, and, expected cessations were most common for episodes where the client was diverted from the criminal justice system (43%). Around 1 in 5 (19%) episodes ended due to an unexpected cessation (Table SD.45).

4.4 Amphetamines

Amphetamines stimulate the central nervous system and can result in euphoria, increased energy, decreased appetite, paranoia and increased blood pressure (ADCA 2013). Long-term effects include: high blood pressure, extreme mood swings, depression, anxiety, psychosis and seizures. There is no approved pharmacotherapy for the management of amphetamine withdrawal or replacement therapy (Lee et al. 2007). According to the 2013 NDSHS (AIHW 2014), 1 in 14 Australians aged 14 and over have used meth/amphetamines for non-medical purposes at some point in their lifetime, while 1 in 50 have used them in the previous 12 months.

In 2013–14, amphetamines were a drug of concern (principal or additional) in 30% of closed treatment episodes, and were the third most common principal drug of concern (17% of all episodes and 16% of clients) (Figure 4.2 and Table SC.4). This was consistent for both Indigenous and non-Indigenous clients, however, the proportion of episodes where amphetamines were the most common principal drug of concern was higher for non-Indigenous clients—16% compared with 13% for Indigenous Australians (Table SC.6). In just under two-thirds (63%) of episodes with a principal drug of concern of amphetamines, the client reported additional drugs of concern. These were most commonly cannabis (31%), alcohol (22%) and nicotine (20%) (Figure 4.2).

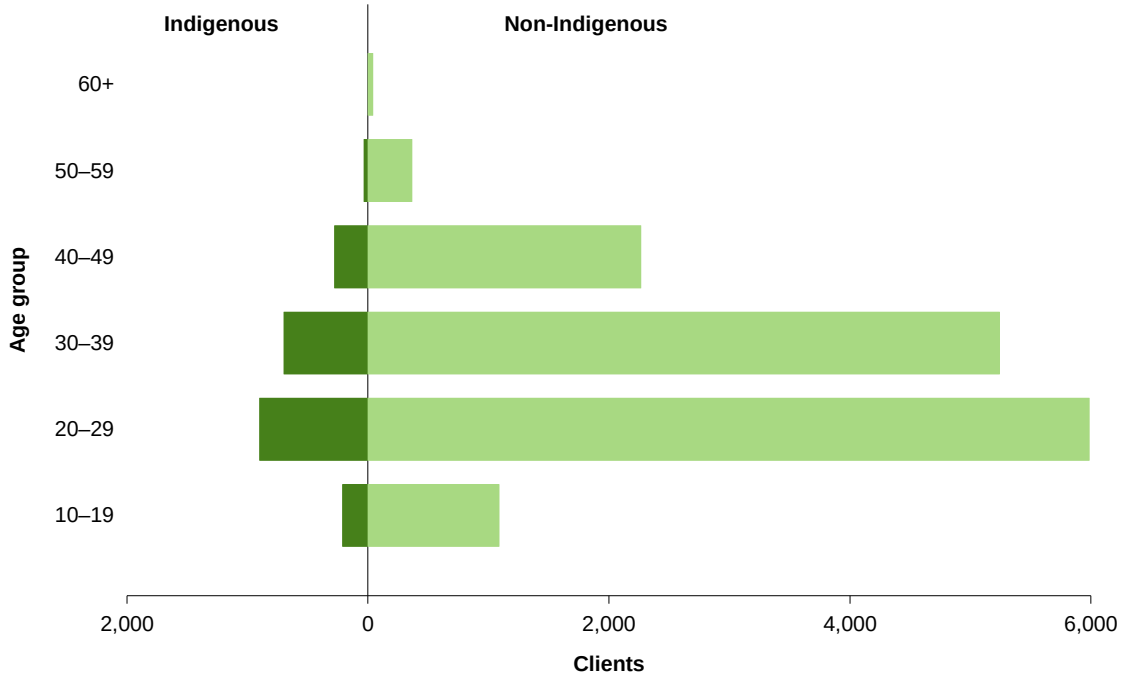
For those clients who received episodes of treatment during both 2012–13 and 2013–14, amphetamines were the main drug that led them to seek treatment in 16% of episodes (Table SC.29).

In 2013–14, injecting was the most common usual method of use (44% of episodes), followed by smoking/inhaling (41%) (Table SD.55).

Over the 5 years to 2013–14, the proportion of episodes where amphetamines were the principal drug of concern has increased (from 7% to 17%) (Table SD.2). According to the 2013 NDSHS (AIHW 2014), the proportion of the adult population using methamphetamine in the previous 12 months has remained fairly stable (declining only slightly from 2.4% to 2.1% between 2007–2013). However, among recent methamphetamine users there has been a change in the main form used—a significant increase in the use of crystal methamphetamine or 'ice' (from 27% to 50% over the same time period).

Client demographics

In 2013–14, more than two-thirds of clients receiving treatment for a principal drug of amphetamines were male (70%), and just under one-sixth of clients were Indigenous Australians (11%). Clients with a principal drug of concern of amphetamines were most likely to be aged 20–39 (74%), followed by those aged 40–49 (15%) and 10–19 (8%) (tables SC.4–6). The age profile was similar for Indigenous and non-Indigenous clients (Figure 4.9).



Note: Based on client records with a valid SL.

Source: AIHW analysis of the AODTS NMDS.

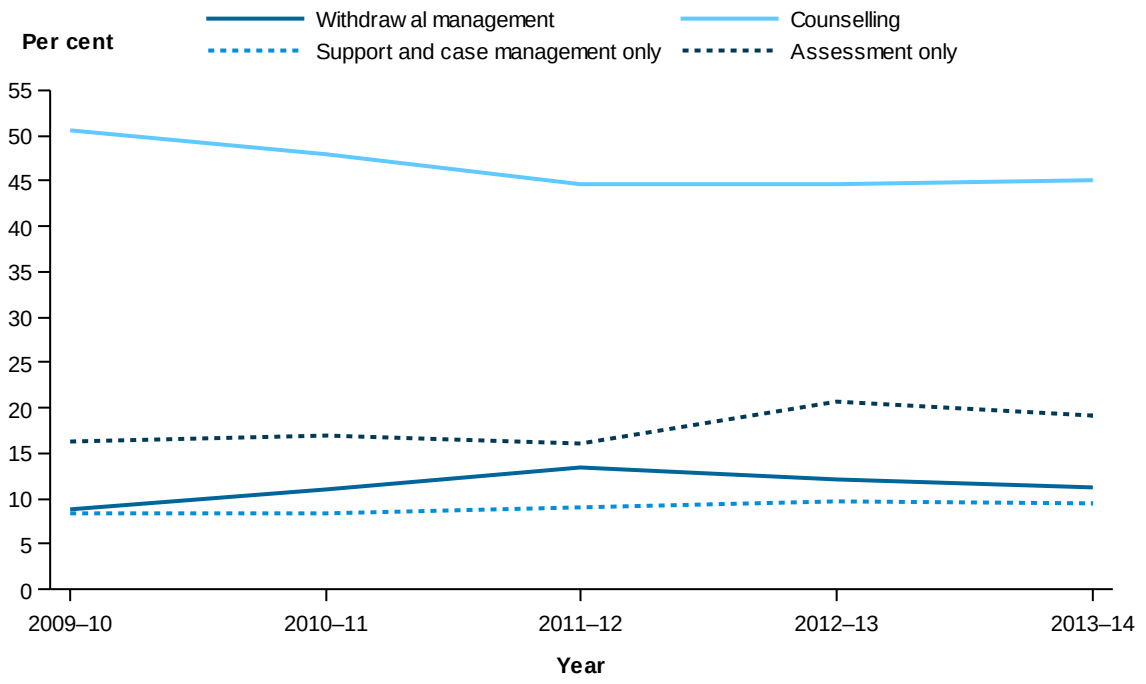
Figure 4.9: Number of clients with amphetamines as a principal drug of concern, by age and Indigenous status, 2013–14

Treatment

The most common source of referral for treatment episodes where amphetamines were the principal drug of concern was self/family (43%), followed by diversion and health services (both 21%) (Table SD.53).

In 2013–14, the most common main treatment type for episodes where amphetamines was the principal drug of concern was counselling (45%), followed by assessment only (19%) and withdrawal management (11%) (Table SD.57). Treatment was most likely to take place in a non-residential treatment facility (70%) (Table SD.60).

Over the 5 years from 2009–10, where amphetamines were the principal drug, the proportion of episodes where counselling was the main treatment type declined (from 51% to 45%) (Figure 4.10).



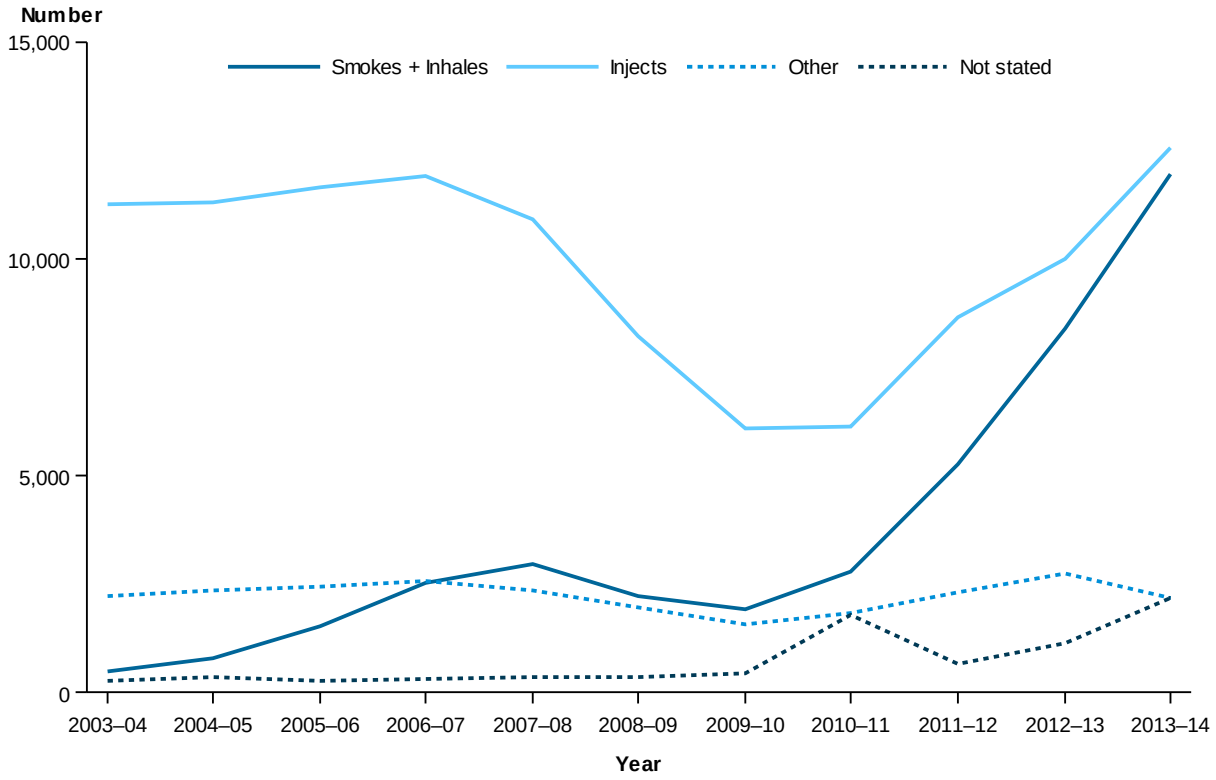
Source: Table SD.58.

Figure 4.10: Closed episodes with amphetamines as the principal drug of concern by the top 4 treatment types received, 2009–10 to 2013–14

Just over half (51%) of episodes where amphetamines were the principal drug of concern lasted less than 1 month (17% ended within 1 day and were mostly for the main treatment type of information and education only) (Table SE.22). The median duration of episodes was just over 4 weeks (29 days). Episode duration varied depending on the main treatment type—episodes with a main treatment type of counselling had a median duration of 8 weeks (56 days), while episodes with withdrawal management ended within 1 week (7 days) and information and education only lasted a median duration of 1 day (Table SD.63).

Three-fifths (62%) of closed episodes where amphetamines were the principal drug of concern ended with an expected cessation, with expected cessations most common for episodes where diversion was the referral source (78%). One-quarter (25%) of episodes ended with an unexpected cessation (Table SD.61).

Over the 5 years to 2013–14, the number of episodes for clients injecting and smoking/inhaling amphetamines increased. In 2013–14, clients were 6 times as likely to smoke/inhale amphetamines as they were in 2009–10 (Figure 4.11).



Note: 'Other' includes 'Ingests', 'Sniffs' and 'Other'.

Source: Table SD.55.

Figure 4.11: Closed episodes provided for own drug use with a principal drug of concern of amphetamines, by method of use, 2003–04 to 2013–14

4.5 Heroin

Heroin is one of the opioid drugs, which are strong pain killers with addictive properties. Short-term side effects of use include pain relief and feelings of euphoria and wellbeing, while long-term effects can include lowered sex drive and infertility (for women), along with risk of overdose, coma and death (ADCA 2013). Heroin users seeking treatment can undertake a withdrawal program (also called detoxification), an abstinence-based treatment (for example, residential rehabilitation in a therapeutic community), or attend an opioid maintenance substitution program (O'Brien 2004). Results from the 2013 NDSHS (AIHW 2014) showed:

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

In 2013–14, heroin was a drug of concern (principal or additional) in 10% of closed treatment episodes, and was the fourth most common principal drug of concern in 7% of episodes (6% of clients) (Figure 4.2 and Table SC.4). This was consistent for both Indigenous and non-Indigenous clients, however, the proportion of episodes where heroin was the most common principal drug of concern was higher for non-Indigenous clients—6% compared with 4% for Indigenous Australians (Table SC.6). In just under two-thirds (63%) of episodes with heroin

as the principal drug of concern, the client reported additional drugs of concern. These were most commonly cannabis (21%) and amphetamines (19%) (Figure 4.2).

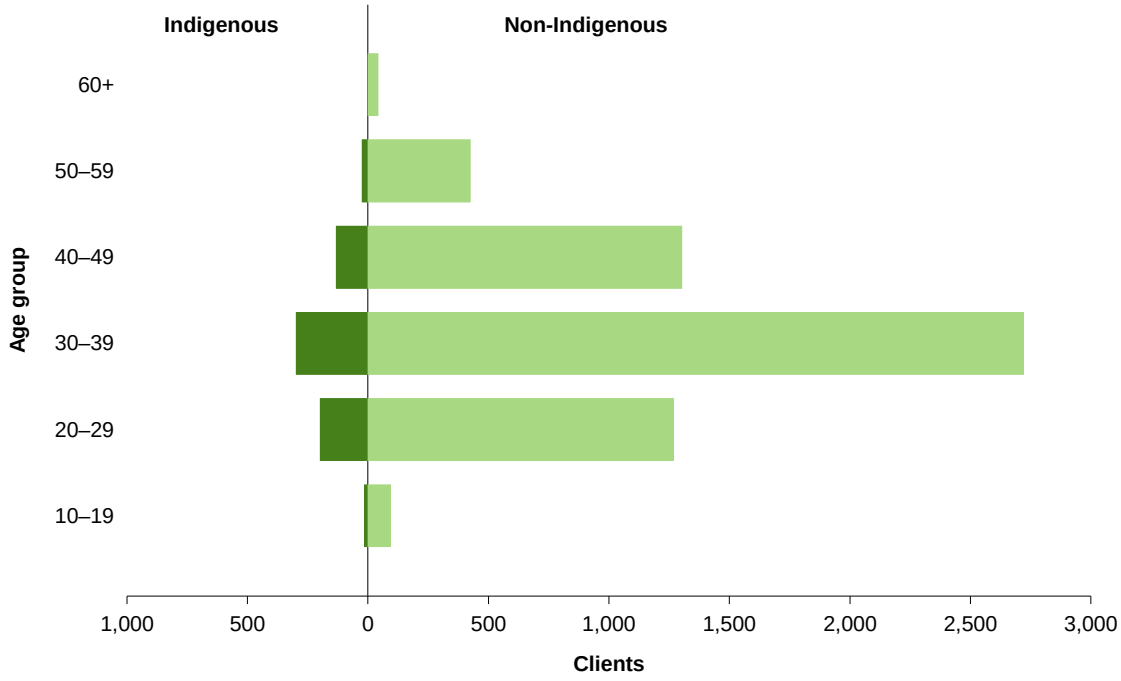
Injecting was the most common method of use in most episodes where the principal drug of concern was heroin (83% of episodes) (Table SD.87). In 3 in 5 (59%) episodes, the client reported they had injected drugs in the previous 3 months, while 16% reported they last injected 3–12 months ago (injecting status was not reported for 8% of episodes) (Table SD.88).

For those clients who received episodes of treatment during both 2012–13 and 2013–14, heroin was the principal drug of concern in 6.0% of episodes (Table SC.29).

Over the 5 years from 2009–10, the proportion of episodes where heroin was the principal drug of concern decreased steadily (from 10% to 7%) (Table SD.2).

Client demographics

Where heroin was the principal drug of concern, 69% of clients were male and 10% were Indigenous Australians. Clients with heroin as their principal drug of concern were most likely to be aged 30–39 (46%), followed by those aged 20–29 and 40–49 (both 22%) (tables SC.4–6). This pattern was similar for Indigenous and non-Indigenous clients (Figure 4.12).



Note: Based on client records with a valid SLK.

Source: AIHW analysis of the AODTS NMDS.

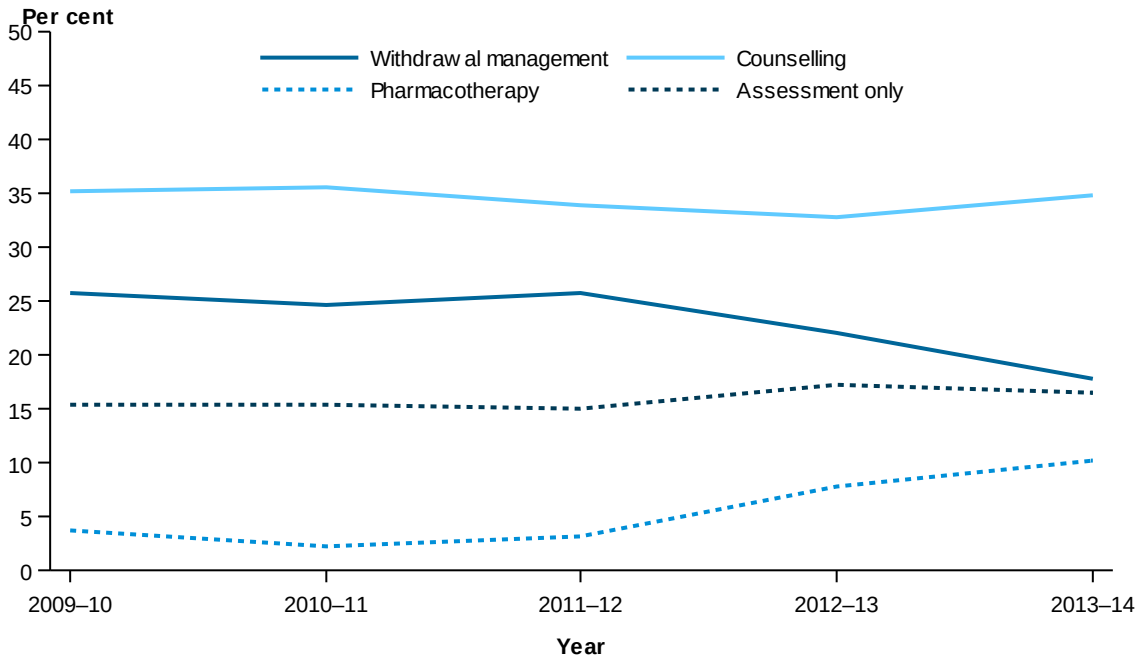
Figure 4.12: Number of clients with heroin as a principal drug of concern, by age and Indigenous status, 2013–14

Treatment

The most common source of referral for treatment episodes where heroin was the principal drug of concern was self/family (50%), followed by a health service (20%) and diversion programs (14%) (Table SD.85).

The most common main treatment types were counselling (35%), withdrawal management (18%) and assessment only (16%) (Table SD.89). Note this collection does not systematically cover replacement therapies. Treatment episodes with heroin as the principal drug of concern were most likely to take place in a non-residential treatment facility (65%) (Table SD.92).

Over the 5 years to 2013–14, the proportion of episodes with withdrawal management as the main treatment type for the principal drug of concern of heroin decreased (from 26% to 18%) (Figure 4.13).



Source: Table SD.90.

Figure 4.13: Closed episodes with heroin as the principal drug of concern by the top 4 treatment types received, 2009–10 to 2013–14

Half (50%) of episodes where heroin was the principal drug of concern lasted less than 1 month (20% ended within 1 day and were mostly for the main treatment types of information and education only and assessment only) (Table SE.22). The median duration of episodes with heroin as the principal drug of concern was just over 4 weeks (29 days). Episodes with counselling as the main treatment type had a median duration of 10 weeks (70 days) and support and case management only had a median duration of more than 9 weeks (66 days). While episodes with a main treatment type of withdrawal management had a median duration of around one week (6 days) and 1 day for both information and education only and assessment only (Table SD.95).

More than half (57%) of closed episodes with heroin as the principal drug of concern ended with an expected cessation, and expected cessations were most common where the main treatment type was information and education only (87%) as this treatment type is usually completed within a day (Table SD.93).

4.6 Selected other drugs

A number of other drugs make up a smaller proportion of overall treatment services. These drugs may be less prominent in treatment services as they are less common or users are less likely to seek treatment. Information on the following drugs is presented in this section due to the size of the population using the drug and/or harms associated with use of that drug.

Nicotine

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

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

Nicotine was a principal drug of concern in just 2% of episodes. However, it was an additional drug of concern in a further 22% of episodes (Figure 4.2). The proportion of episodes with nicotine as the principal drug has remained stable at 1–2% since 2003–04 (Table SD.2). Possible reasons for the low proportion of episodes in which nicotine was the principal drug include the wide availability of support and treatment for nicotine use in the community, and that people tend to view AOD treatment services as most appropriate for drug use that is beyond the expertise of general practitioners.

Client demographics

Where nicotine was a principal drug of concern, 63% of clients were male and 11% were Indigenous Australians. Clients with nicotine as a principal drug of concern were most likely to be aged 10–29 (49%). Only 6% of clients were aged 60 or over (tables SC.4–6). Nicotine was more likely to be an additional drug of concern rather than the principal drug for all age groups—of all episodes where nicotine was a drug of concern, it was an additional drug of concern in 93% of episodes (Table SD.66).

Treatment

The most common source of referral for treatment episodes where nicotine was the principal drug of concern was a police or court diversion program (42%), followed by self/family (25%) (Table SD.69).

Counselling (32%), information and education only (26%) and assessment only (19%) were the most common main treatment types (Table SD.73). Treatment episodes where nicotine was the principal drug of concern were most likely to take place in a non-residential treatment facility (66%) (Table SD.78).

Just over three-fifths (61%) of episodes with nicotine as the principal drug lasted less than 1 month (32% ended within 1 day and were mostly for the main treatment type of

information and education only) (Table SE.22). The median duration of episodes with nicotine as the principal drug of concern was 15 days (Table SD.79).

More than three-quarters (82%) of episodes with nicotine as the principal drug of concern ended with an expected cessation, while one in ten (10%) ended due to an unexpected cessation. Expected cessations were most common where the main treatment type was information and education only (31%) (Table SD.78).

Ecstasy

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

Ecstasy was a drug of concern (principal or additional) in 3% of closed episodes in 2013–14 and was the principal drug in less than 1% of episodes (tables SD.114 and SE.9). Counselling was the most common main treatment type for episodes where ecstasy was the principal drug (42%), followed by information and education only (32%) and assessment only (18%) (Table SD.121).

Benzodiazepines

Benzodiazepines are depressant drugs—they slow down the activity of the central nervous system and the speed of messages going between the brain and the body. Formerly known as 'minor tranquillisers', benzodiazepines are most commonly prescribed by doctors to relieve stress and anxiety and to aid sleep. They are a drug of dependence and are associated with fatal and non-fatal overdose among opioid users. Some people use benzodiazepines illegally to become intoxicated or to 'come down' from the effects of stimulants such as amphetamines or cocaine (ADF 2013).

According to the 2013 NDSHS (AIHW 2014), 4.5% of Australians aged 14 and over had used tranquillisers/sleeping pills (including benzodiazepines) for non-medical purposes at some stage in their lifetime.

In 2013–14, benzodiazepines were a drug of concern (principal or other) in 8% of closed episodes and the principal drug in 2% of episodes (Figure 4.2). There was no change in the proportion of episodes with benzodiazepines as the principal drug in the 10 years from 2003–04 (Table SD.2).

In 64% of the episodes with benzodiazepines as the principal drug, the client reported additional drugs of concern. These were most commonly alcohol (18%) and cannabis (17%) (Figure 4.2).

Ingestion was the most common usual method of use (88%) in episodes with benzodiazepines as the principal drug although they are commonly crushed and injected among injecting drug users (Table SD.103).

Client demographics

Where benzodiazepines were the principal drug of concern, half (51%) of clients were male and 8% were Indigenous Australians. More than one-third (36%) of clients with benzodiazepines as a principal drug of concern were aged 30–39, just under one-quarter (24%) were aged 40–49 and nearly one-fifth (19%) were aged 20–29. Only 7% of clients were aged 60 or over (tables SC.4–6).

Benzodiazepines were more likely to be an additional drug of concern rather than the principal drug for all age groups—of all episodes where benzodiazepines were a drug of concern, it was an additional drug of concern in 80% of episodes (Table SD.98).

In more than one-third (37%) of closed episodes, the client reported they had never injected a drug, while in 1 of 5 episodes (19%), the client reported they had injected drugs in the previous 3 months (injecting status was not reported for 20% of episodes) (Table SD.104).

Treatment

The most common source of referral for treatment episodes where benzodiazepines were the principal drug of concern was self/family (48%), followed by a health service (36%) (Table SD.101).

The most common main treatment type for episodes where benzodiazepines were the principal drug of concern was counselling (35%), followed by withdrawal management (25%) and assessment only (16%) (Table SD.105). Treatment episodes were most likely to take place in a non-residential treatment facility (64% of episodes) or a residential treatment facility (18%). Almost all (94%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table SD.108).

More than half (55%) of the episodes with benzodiazepines as the principal drug of concern lasted less than 1 month (21% ended within 1 day and were mostly for the main treatment type of information and education only) (Table SE.22). The median duration of episodes with benzodiazepines as the principal drug of concern was 3 weeks (22 days) (Table SD.111).

Episodes with counselling and support and case management only as the main treatment types had a median duration of just over 9 weeks (67 days each), followed by rehabilitation episodes which has a median duration of just over 7 weeks (50 days). In comparison, benzodiazepine withdrawal management episodes had a median duration of less than 2 weeks (10 days) and assessment only and information and education only episodes lasted a median of 1 day (Table SD.111).

Three in 5 (62%) episodes with benzodiazepines as the principal drug of concern ended with an expected cessation, while 1 in 5 (18%) ended due to an unexpected cessation. Expected cessations were more common for episodes where the main treatment type was information and education only (84%) or withdrawal management (66%) (Table SD.112).

Licit opioids

Licit opioids can be obtained by prescription—for example, morphine, buprenorphine, methadone, oxycodone, fentanyl and pethidine, or over-the-counter—for example, codeine. They do not include illicit opioids, such as heroin. There has been a substantial increase in the prescribing of pharmaceutical opioids in Australia in recent years—this increase may be a result of the ageing population in Australia or reflect a more widespread, clinical

acceptance of the use of pharmaceutical opioids for the treatment of pain (Nicholas et al. 2011).

In 2013–14, as a group, licit opioids (including codeine, morphine, buprenorphine methadone, oxycodone and other opioids) were the principal drug of concern in 4% of episodes (Table SD.1).

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

While the proportion of episodes with licit opioids as a principal drug of concern has remained relatively stable over the 5 years to 2013–14, there has been a considerable increase in the number of episodes for people receiving treatment for their own drug use where oxycodone was a principal drug of concern (from 418 episodes to 1,404). In 2013–14, oxycodone comprised the third highest proportion (18%) of treatment episodes where licit opioids were the principal drug of concern (after methadone, 23%, and morphine, 21%) (Table SD.3). This proportion has grown from 5% in 2009–10 and has coincided with a decrease in the proportion of episodes with morphine or methadone as a principal drug of concern. This may be a short-term trend, as attempts to limit supply of licit opioids is leading to an increase in illicit opioid use and injecting in the United States and more widely internationally.

5 Treatment provided

There are a number of treatment types available to assist people with problematic drug use in Australia. Most aim to reduce the harm of drug use, while others use a structured drug-free setting with abstinence-oriented interventions. This chapter provides information on the treatment types provided by publicly funded AOD treatment agencies in Australia. Information on clients and treatment agencies is included in the AODTS NMDS when a treatment episode provided to a client is closed (see Box 2.1). Treatment is available to assist people to address their own drug use, and to support the family and friends of people using drugs.

5.1 Key facts

In 2013–14:

- Counselling was the most common treatment type (43%).
- The most common source of referral for treatment episodes was self/family (43%).
- Around 4 in 5 (79%) closed treatment episodes ended within 3 months.
- The median duration of closed treatment episodes was about 3 weeks (23 days).
- Around 2 in 3 (64%) closed treatment episodes had an expected cessation.
- Most of the treatment episodes provided to clients for their own drug use were for male clients (67%), whereas most clients seeking support for someone else's drug use were female (64%).
- Clients seeking support for someone else's drug use tended to be older—half (51%) of the episodes were provided to clients aged over 40, compared with over two-thirds (68%) of clients seeking treatment for their own drug use who were aged 10–39.

Over the 5-year period to 2013–14:

- The proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management and assessment only being the most common types of treatment.
- The median duration of closed episodes for the client's own drug use increased from 22 days to 23 days, peaking at 25 days in 2011–12.
- The proportion of episodes with an expected cessation has decreased slightly, from 68% to 64%.

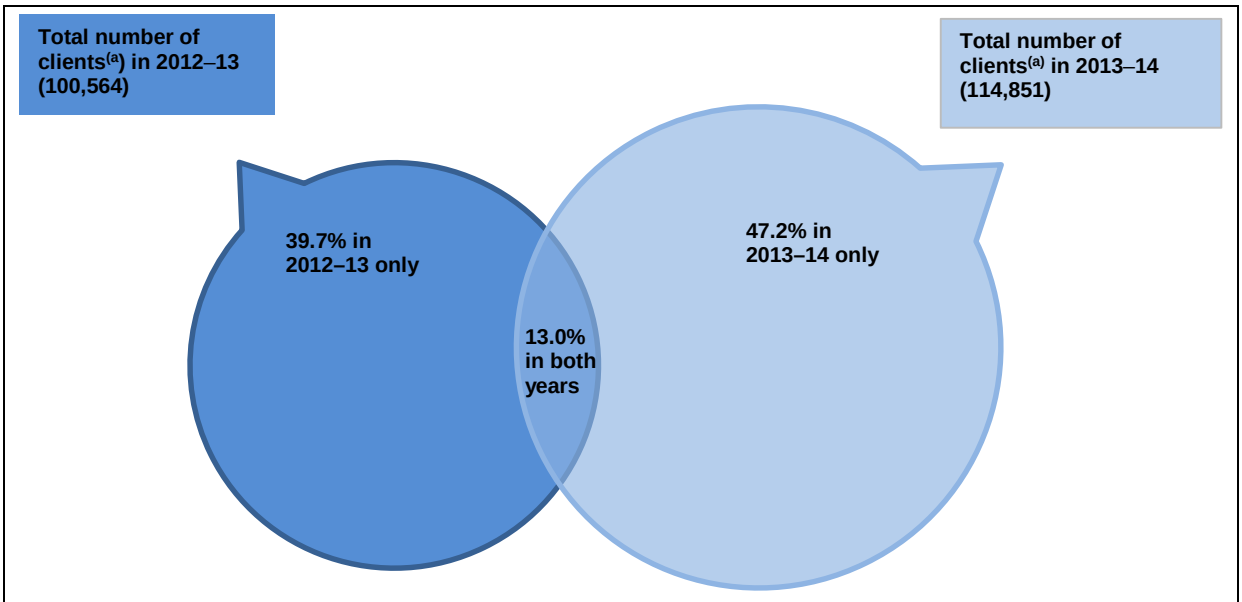
5.2 Characteristics of clients and episodes

In 2013–14, 114,851 clients (client records with a valid SLK) received 180,713 treatment episodes from AOD treatment agencies. Most (95%) of the clients were seeking treatment for their own drug use—a total of 108,972 clients (or 95% of episodes)—and most of these were male (69% of clients and 67% of episodes). Conversely, clients seeking support for someone else's drug use were more likely to be female (64%) (tables SC.1, SC.28 and SE.2).

Around 1 in 7 (14%) treatment episodes were provided to Indigenous Australians in 2013–14. This proportion was consistent for clients receiving treatment for their own drug use (14%), while for clients receiving support for someone else's drug use, 9% of treatment episodes were provided to Indigenous Australians (Table SE.4).

In 2013–14, more than half (54%) of clients seeking treatment were aged 20–39 (55% of episodes). Clients seeking support for someone else's drug use tended to be older—half (51%) of these treatment episodes were provided to clients aged 40 and over, compared with just under one-third (32%) of episodes for those receiving treatment for their own drug use (Table SC.2 and SE.5).

Nationally in 2013–14, just over two-thirds (69%) of closed treatment episodes were provided in *Major cities,* 19% in *Inner regional* areas and 10% in *Outer regional* areas. Relatively few treatment episodes were provided in *Remote* or *Very remote* areas (3%).



(a) Based on client records with a valid SLK.

Source: Table SC.28.

Figure 5.1: Clients receiving treatment in both years, 2012–13 and 2013–14

In 2013–14, most (86%) clients received treatment at 1 agency, 11% at 2, and 2% of clients received treatment at 3 or more agencies. Nationally, the number of clients presenting to publicly funded AOD services increased between 2012–13 and 2013–14. A total of 190,617 clients received treatment over these two years. Of these, 39.7% (75,766 clients) presented in 2012–13 only, 47.2% (90,053) presented in 2013–14 only, and 13.0% (24,798) received treatment in both years (Figure 5.1).

One-fifth (21.6%) of the total 114,851 clients receiving treatment in 2013–14, also received treatment in 2012–13.

5.3 Referral to treatment

Nationally in 2013–14, the most common source of referral for both clients receiving treatment for their own drug use and those receiving support for someone else's drug use was self/family (42% and 63% respectively). Referral from a health service was also common for both client groups (26% and 18% respectively). Referrals from police or court diversion programs accounted for 17% of episodes for clients receiving treatment for their own drug use (Table ST.13–14). Clients referred by diversion programs tended to be younger; 23% of these episodes were for clients aged 10–19 and 37% were for clients aged 20–29, compared with 13% and 27%, respectively, for all episodes (Table SE.13).

Over the 5 years from 2009–10, the proportion of episodes provided to clients for their own drug use where the client was referred by self/family increased from 37% to 42%. Over the same 5-year period, for clients receiving support for someone else's drug use, there was a decline in those episodes where health services were the source of referral (from 23% to 18%), and a rise in the proportion of referrals by self/family (from 60% to 63%) (Table SE.12).

Table 5.1: Closed episodes by principal drug of concern and source of referral, 2013–14 (per cent)

Principal drug of concern	Self/family	Health service	Corrections	Diversion	Other	Total
Analgesics						
Codeine	54	38	1	2	6	100
Morphine	53	31	7	4	5	100
Buprenorphine	47	36	10	2	5	100
Heroin	50	21	10	14	6	100
Methadone	46	38	5	4	6	100
Total analgesics	*51*	*26*	*8*	*9*	*6*	*100*
Sedatives and hypnotics						
Alcohol	47	31	7	7	8	100
Benzodiazepines	48	36	3	8	5	100
Total sedatives and hypnotics	*47*	*31*	*7*	*7*	*7*	*100*
Stimulants and hallucinogens						
Amphetamines	43	21	8	21	7	100
Ecstasy	16	5	6	71	3	100
Cocaine	45	13	8	27	7	100
Nicotine	25	21	3	42	10	100
Total stimulants and hallucinogens	*40*	*21*	*7*	*24*	*7*	*100*
Cannabis	31	21	8	33	7	100
Volatile solvents	22	34	4	19	21	100

Source: AIHW analysis of the AODTS NMDS.

In 2013–14, source of referral varied according to clients' principal drugs of concern. Self/family was the most common source of referral for clients receiving treatment for the principal drug of heroin (50% of episodes), alcohol (47% of episodes) and amphetamines (43% of episodes) (Table 5.1). Where cannabis was the principal drug of concern, diversion (33% of episodes) was the most common source of referral, followed by self/family (31% of

episodes) (see also Figure 4.7 in Chapter 4). Clients receiving treatment for alcohol as their principal drug of concern were less likely to be referred through diversion (7%) and more likely to be referred from a health service (31%), when compared with clients receiving treatment for heroin, amphetamines or cannabis. Around 7 in 10 (71%) treatment episodes for clients whose principal drug of concern was ecstasy were referred to treatment through police or court diversion programs (see Chapter 4 for further information).

Over the 5 years to 2013–14, the proportion of episodes where the client was referred by self /family increased from 38% to 43%. Episodes where alcohol was the principal drug of concern had the greatest increase in self/family as the source of referral, from 40% to 47% over the same period. The proportion of episodes where the client was referred by a health service decreased slightly from 27% in 2009–10 to 25% in 2013–14. However for the episodes where amphetamines were the principal drug of concern, the proportion of clients referred by a health service increased, from 19% to 21%, peaking in in 2010–11 at 22%. Over the same period, referrals from diversion programs decreased (from 18% to 16%) (Table SE.11).

5.4 Length of treatment

In 2013–14, around 4 in 5 (80%) closed episodes ended within 3 months (80% for clients receiving treatment for their own drug use and 80% for someone else's drug use, see sections 5.5 to 5.6 for further information). Over the 5 years to 2013–14, the proportion of episodes for the client's own drug use that ended within 3 months remained fairly stable (around 79%) (Table SE.18).

Nationally, the median duration of closed episodes for the client's own drug use was just over 3 weeks (23 days), and just under 5 weeks (33 days) for clients receiving support for someone else's drug use. The median duration of closed episodes for the client's own drug use increased slightly over the 5 years from 2009–10 from 22 days to 23 days in 2013–14, peaking at 25 days in 2011–12. This increase over time is largely due to increases in the median duration of episodes with a main treatment type of counselling, rehabilitation or 'other' (Table SE.19).

5.5 Treatment completion

Reasons for clients ceasing to receive a treatment episode from an AOD treatment service include expected cessations (for example, treatment was completed), unexpected cessations (for example, non-compliance) and administrative cessation (for example, client transferred to another service provider) (see the Glossary and Box 2.1 for further details). In 2013–14, around 3 in 5 (64%) completions for the client's own drug use recorded a reason for cessation in the 'expected' category. Unexpected cessations accounted for one-fifth (20%), other reasons around 9% and administrative cessations 6%. This pattern was broadly similar for completions for clients who received support for someone else's drug use (Table 5.2).

In 2013–14, treatment episodes with an expected cessation were highest where ecstasy was the principal drug of concern (87%), followed by nicotine (82%), and cocaine and cannabis (both 70%). The lowest proportion of expected cessations was for episodes with buprenorphine as the principal drug of concern (45%). As a group, analgesics tended to have the lowest proportion of closed episodes with an expected cessation (55%) (Table 5.3).

Table 5.2: Closed episodes by reason for cessation and client type, 2013–14 (per cent)

Reason for cessation	Own drug use	Other's drug use
Expected cessation	64.3	63.4
Unexpected cessation	20.4	12.9
Administrative cessation	6.0	4.0
Other	9.3	19.8
Total	**100.0**	**100.0**

Source: Table SE.14.

One-quarter (25%) of treatment episodes where amphetamines were the principal drug of concern had an unexpected cessation, followed by morphine (23%) and codeine (22%), while ecstasy had the lowest proportion (8%) of unexpected cessations (Table 5.3). As a group, stimulants and hallucinogens had the highest proportion of episodes with an unexpected cessation (23%).

Table 5.3: Closed episodes by principal drug of concern and reason for cessation, 2013–14 (per cent)

Principal drug of concern	Expected cessation	Unexpected cessation	Administrative cessation	Other	Total
Analgesics					
Codeine	58	22	15	5	100
Morphine	46	23	19	12	100
Buprenorphine	45	17	26	11	100
Heroin	57	20	8	15	100
Methadone	60	15	15	10	100
Total analgesics	*55*	*20*	*12*	*12*	*100*
Sedatives and hypnotics					
Alcohol	64	21	6	9	100
Benzodiazepines	62	18	10	10	100
Total sedatives and hypnotics	*64*	*21*	*6*	*9*	*100*
Stimulants and hallucinogens					
Amphetamines	62	25	5	8	100
Ecstasy	87	8	1	4	100
Cocaine	70	20	5	5	100
Nicotine	82	10	3	5	100
Total stimulants and hallucinogens	*65*	*23*	*5*	*7*	*100*
Cannabis	70	19	4	7	100
Volatile solvents	67	17	5	11	100

Source: AIHW analysis of the AODTS NMDS.

Over the 5 years to 2013–14, treatment episodes that ended in an expected cessation have decreased overall (by 4%) (Table SD.16). The decrease in expected cessation was greatest for episodes where heroin was the principal drug of concern (5%), followed by alcohol (4%) and amphetamines and cannabis (both 3%). Over the same time period, unexpected cessation increased by 1% for episodes with alcohol, amphetamines and cannabis as the principal drug

of concern, and decreased by 1% for episodes where heroin was the principal drug of concern (Table SD.16).

Over the 5 years to 2013–14, episodes where alcohol and cannabis were the principal drug of concern were consistently most likely to have expected cessations, although the proportion of these episodes declined slightly (from 68% to 64%, with a high of 69% in 2010–11, and 73% to 70% respectively) (Table SD.16).

Over the same period, there was a slight decrease in the proportion of episodes where amphetamines were the principal drug of concern ending in an expected cessation (from 65% to 62%), and slight increase in episodes ending in an unexpected cessation (from 24% to 25%) (Table SD.16).

The proportion of episodes with an expected cessation or an unexpected cessation where heroin was the principal drug of concern both declined (from 62% to 57%, with a low of 53% in 2012–13, and 21% to 20% respectively) (Table SD.16).

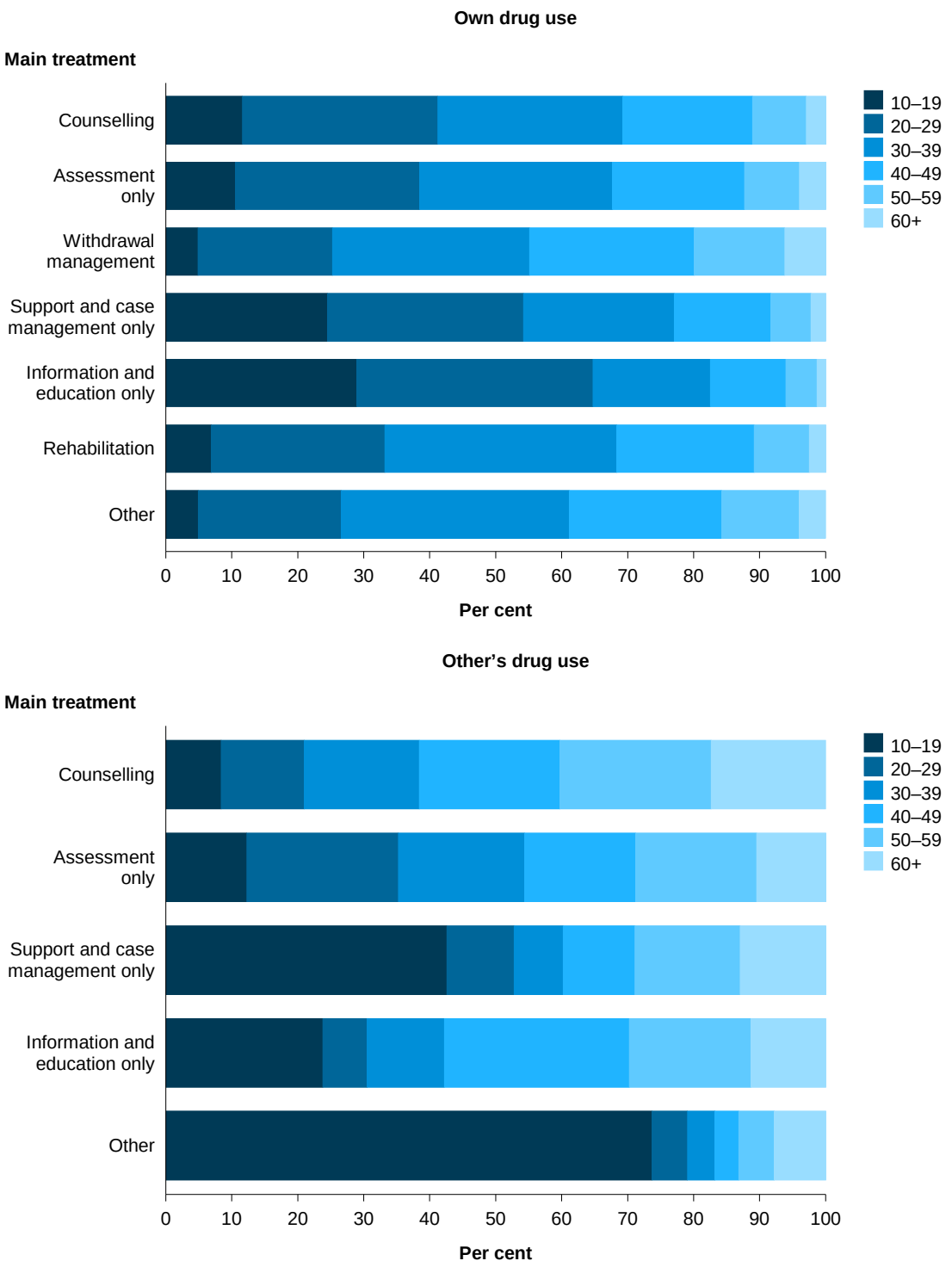
5.6 Treatment types

Counselling was the most common treatment type provided to all clients in 2013–14 (46%), followed by assessment only (16%), information and education only (11%) and withdrawal management (10%). This pattern was consistent for both client groups (that is, clients receiving treatment for their own drug use and clients receiving support for someone else's drug use) (Table SC.13).

In 2013–14, clients seeking treatment for their own drug use were more likely to be aged between 20–49 for all treatment types (ranging between 75–87%), with the exception of support and case management only and information and education only, where clients were more likely to be aged between 10–39 (77% and 83% respectively) (Figure 5.2). The age of clients was more varied for those seeking support for someone else's drug use. Clients receiving counselling and information and education only were most likely to be aged 40 or older (62% and 58% respectively), while clients receiving support and case management only were most likely to be 10–39 years (60%) (Figure 5.2).

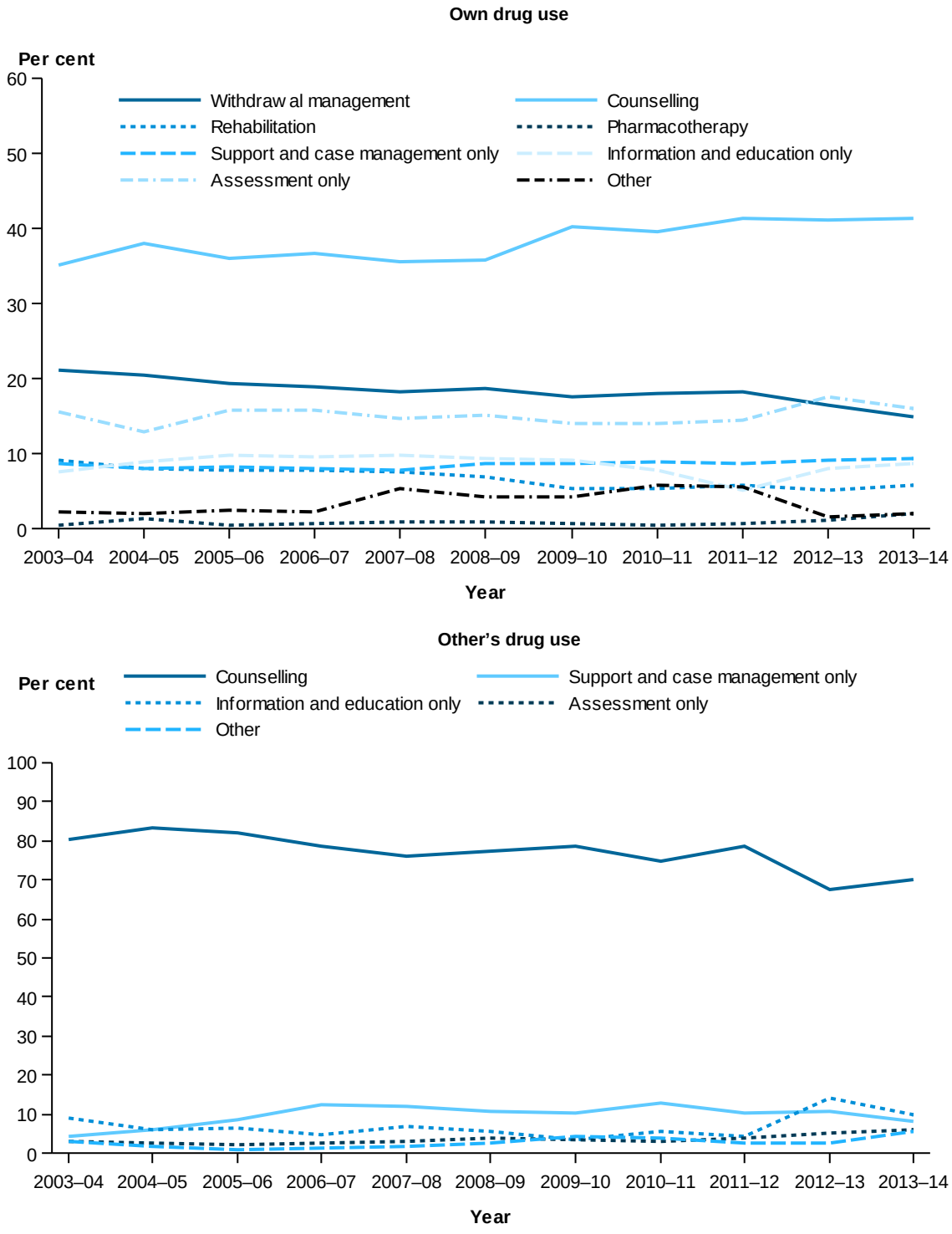
In 2013–14, the most common source of referral for clients was self/family (39%). This was consistent for all treatment types, with the exception of information and education only, where diversion was the most common source of referral (75%) (Table SC.16).

Nearly two-thirds (63%) of clients had an expected cessation (for example, their treatment was completed). This varied by treatment type—from 42% of clients receiving rehabilitation to 94% of those clients receiving information and education only (Table SC.18).



Source: Table SC.14.

Figure 5.2: Client's main treatment, by client type and age group, 2013–14



Source: Table ST.4.

Figure 5.3: Closed episodes provided by client type and main treatment type, 2003–04 to 2013–14

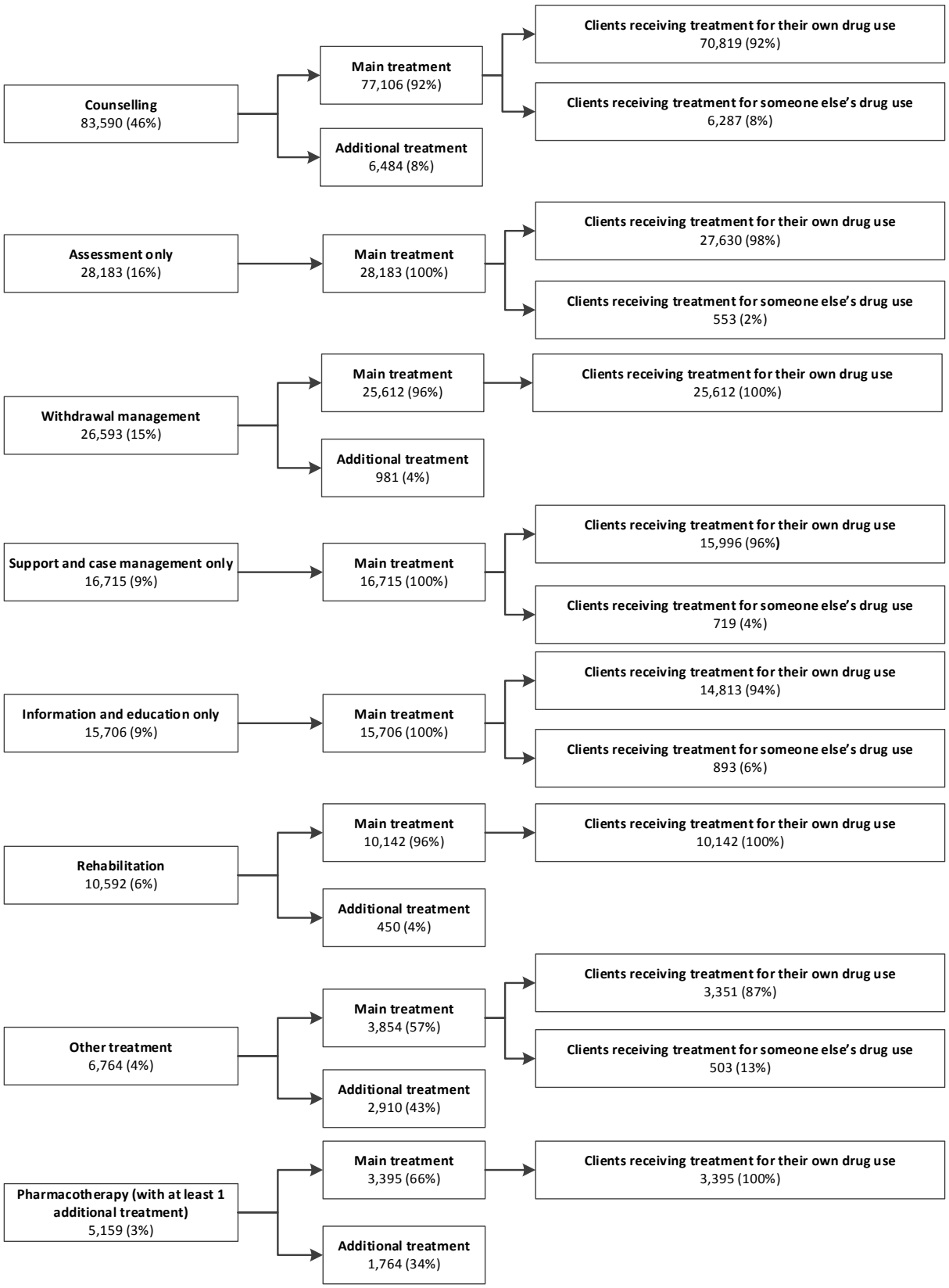
Overall since 2003–04, the proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management and assessment only being the most common types of treatment. Counselling continues to be the most common main treatment type provided (comprising about 2 in 5 episodes since 2003–04). In 2012–13, assessment only replaced withdrawal as the second most common main treatment type. While this pattern of

main treatment type is consistent for clients seeking treatment for their own drug, for those seeking support for someone else's drug use, counselling, information and education only and support and case management only have remained the most common main treatment types over the same period (Figure 5.3).

For clients seeking treatment for their own drug use, there has been an overall increase since 2003–04 in the proportion of episodes with counselling as the main treatment type (from 35% to 41%), and a decrease in those episodes with withdrawal management as the main treatment type (from 21% to 15%). For clients seeking support for someone else's drug use there has been an overall decrease over the same time period in the proportion of episodes with counselling as the main treatment type (from 80% to 70%), and a slight increase in those episodes with support and case management only as the main treatment type (from 5% to 8%) (Table ST.4).

Counselling was the most common treatment type in all regions. Withdrawal management (detoxification) was more common in *Major cities* than in other areas. The lowest number of treatment episodes for withdrawal management and rehabilitation were in *Very remote* areas (Table SA.9).

Of the main treatment types that were available to both clients receiving treatment for their own drug use and to those receiving support for someone else's drug use, most episodes were for clients receiving treatment for their own drug use—ranging from 92% for counselling to 98% for assessment only (Figure 5.4).



Sources: Tables ST.2 and ST.4.

Figure 5.4: Summary treatment characteristics (main and additional) of closed episodes, 2013–14

Counselling

Counselling is the most common treatment type for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013). In 2013–14, 2 in 5 (41%) episodes provided to clients for their own drug use, and almost 1 in 7 (70%) episodes provided to clients for someone else's drug use, had a main treatment type of counselling (Table ST.3). Younger males were more likely to receive counselling for their own drug use—66% of closed treatment episodes were for males, and 41% of these episodes were provided to those aged 10–29. Clients receiving counselling for someone else's drug use were more likely to be female (65% of episodes) and aged over 40 years (63% of episodes) (Table ST.19).

For those clients seeking treatment for their own drugs use, 1 in 7 (14%) closed treatment episodes with a main treatment type of counselling were for Indigenous clients. For episodes where clients received support due to someone else's drug use, 7% of clients identified as Indigenous Australians (Table ST.21).

For both client types, more than one-third of episodes with a main treatment type of counselling lasted 1–3 months (35% for own drug use and 36% for someone else's use), while nearly one-quarter (20% and 23% respectively) lasted 2–29 days (Table ST.26).

For clients receiving treatment for their own drug use, over the 5 years from 2009–10, the proportion of episodes ending within 1 month decreased slightly (from 36% to 32%), while the proportion of episodes lasting more than 1 month increased (from 63% to 67%) (Table ST.27). Over the same period, for clients receiving support for someone else's drug use, the proportion of closed episodes lasting 1–3 months increased slightly (from 36% to 37%), while the proportion lasting 12 months or more decreased (from 7% to 3%) (Table ST.27).

Assessment only

While all service providers would normally include an assessment component in all treatment types, these are treatment episodes for which only an assessment is provided to the client. In 2013–14, 16% of treatment episodes provided to clients for their own drug use, and 6% of episodes provided to clients for someone else's drug use, had a main treatment type of assessment only (Table ST.3).

Younger males were more likely to receive assessment only for their own drug use—68% of closed treatment episodes, with 58% of these episodes provided to those aged 20–39. Clients receiving assessment only for someone else's drug use were more likely to be female (53%) and aged 40 and over (52%) (Table ST.41).

Over the 5 years from 2009–10, for clients seeking treatment for their own drug use, the proportion of treatment episodes for clients aged 10–19 increased from 7% to 9%, while the proportion for those aged 20–29 decreased from 34% to 28%. For those clients seeking support for someone else's drug use, there was a decrease in the proportion of episodes provided to older clients. Nearly two-thirds (60%) of episodes were provided to clients aged 40 and over in 2009–10 compared with 44% in 2013–14 (Table ST.42).

Where the main treatment type was assessment only, 14% of closed treatment episodes for clients' own drug use were for Indigenous clients, and 12% of clients seeking support for some else's drug use identified as Indigenous Australians (Table ST.43).

The majority of treatment episodes for clients lasted just 1 day—54% of episodes for clients seeking treatment for their own drug use, and 81% of episodes those seeking support for someone else's drug use (Table ST.45).

Over the 5 years from 2009–10, the proportion of closed episodes ending within 1 day increased (from 45% to 54% for clients own use, and 77% to 81% for someone else's drug use), while the proportion of episodes lasting 2–29 days decreased (from 32% to 31%, and 10% to 7% respectively). The proportion of episodes in all other duration groups (from 1–3 months to more than 12 months) also decreased over the same time period, with the exception of those clients seeking treatment for their own drug use, where the proportion of episodes ending within 1 to less than 6 months increased from 3% to 7% (Table ST.46). It is important to note that these trends are influenced by differences in jurisdictional service delivery practices and data quality improvement over time.

Withdrawal management

Withdrawal management (detoxification) includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern. In 2013–14, 15% of closed treatment episodes provided to clients for their own drug use had a main treatment type of withdrawal management (Table ST.3). (Note that this type of treatment is not available for clients seeking support for someone else's drug use.) Two-thirds (64%) of these episodes were provided to male clients, and over 1 in 12 (8%) were for Indigenous clients (tables ST.30 and ST.32).

Most (54%) of the treatment episodes provided for withdrawal management were for those aged 30–39 (29%) and 40–49 (25%). Just over four-fifths (83%) lasted less than 30 days (tables ST.31 and ST.37).

Over the 5 years from 2009–10, there has been an increase in the proportion of episodes provided to older clients where withdrawal management was the main treatment type. In 2009–10, 39% of episodes were for clients aged 40 and over, compared with 43% in 2013–14 (Table ST.31).

Support and case management only

Support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007). In 2013–14, 9% of episodes provided to clients for their own drug use, and 8% of episodes provided to clients for someone else's drug use, had a main treatment type of support and case management only (Table ST.3).

Almost two-thirds (63%) of the closed treatment episodes provided to clients for their own drug use were for male clients, just over half (54%) were aged 10–29, and 19% were for Indigenous clients. Female clients were more likely to be Indigenous than male clients (24% compared with 16%) (tables ST.50–51).

For those clients seeking support for someone else's drug use, 61% of treatment episodes were for female clients, half (51%) were aged 10–19, and almost 1 in 12 (8%) were for Indigenous clients. Female clients were more likely to be Indigenous than male clients (4% compared with 10%) (tables ST.50–51).

Over the 5 years from 2009–10, there has been an increase in the proportion of episodes provided to older clients. For both client groups, those aged 10–19 decreased (from 31% to 25% of episodes for clients receiving treatment for their own drug use, and 74% to 51% for clients receiving support for someone else's drug use), and those aged 50 and over increased (from 5% to 9% for clients seeking treatment for their own drug use, and from 5% to 21% for clients receiving support for someone else's drug use) (Table ST.50).

Most (54%) of the treatment episodes provided to clients for their own drug use with a main treatment type of support and case management only were provided to those in the 10–19 (25%) and 20–29 (29%) age groups. Nearly two-thirds (61%) of episodes for the client's own drug use lasted between 2–29 days (26%) and 1–3 months (35%). Clients seeking support for someone else's drug use tended to be younger (51% were 10–19), and spend longer in treatment, with 41% of episodes lasting between 1–3 months (tables ST.50 and ST.54).

Over the 5 years from 2009–10, the duration of treatment episodes for clients seeking treatment for their own drug use remained relatively stable. Conversely, for clients seeking support for someone else's drug use, the proportion of closed episodes lasting 1–3 months and 2–29 days have changed substantially. The proportion of episodes lasting 1–3 months increased from 30% to 41% and those lasting 2–29 days decreased from 49% to 36% (Table ST.56.

Information and education only

In 2013–14, around 1 in 10 episodes provided to clients had a main treatment type of information and education only (9% of episodes for client's own drug use and 10% of episodes for someone else's) (Table ST.3).

Clients receiving information and education only for their own drug use were more likely to be male (73%) and younger (29% of episodes were for clients aged 10–19 and 35% for clients aged 20–29). Clients receiving information and education only for someone else's drug use were more likely to be female (79%) and younger (54% of episodes were provided to clients aged 10–19). The age of all clients seeking treatment remained relatively stable over the 5 years from 2009–10 (tables ST.57–58).

Similar rates of closed treatment episodes were provided to clients who identified as Indigenous Australians—13% of closed treatment episodes for those clients seeking treatment for their own drug use, and 11% of clients seeking support for some else's drug use (Table ST.59).

As expected for this type of treatment, the majority of episodes for clients lasted just 1 day—82% of episodes for clients seeking treatment for their own drug use, and 70% of episodes for those seeking support for someone else's drug use (Table ST.61).

Over the 5 years from 2009–10, the duration of treatment episodes for those clients seeking treatment for their own drug use remained relatively stable. Over the same period, for those seeking treatment for someone else's drug use, the proportion of episodes lasting 1 day increased (from 50% to 70%, peaking at 85% in 2010–11) while the opposite is true for episodes lasting 2–29 days (declining from 25% to 12%) (Table ST.62).

Rehabilitation

Rehabilitation focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug

use. Rehabilitation can be delivered in a number of ways including, residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011). In 2013–14, 6% of closed treatment episodes provided to clients for their own drug use had a main treatment type of rehabilitation. (Note that this type of treatment is not available for clients seeking support for someone else's drug use.) Almost two-thirds (65%) of these episodes were provided to male clients, and almost one-fifth (17%) were for Indigenous clients (tables ST.3, ST.65 and ST.67).

Three in 5 (63%) of the treatment episodes provided for rehabilitation were for those aged 20–29 (28%) and 30–39 (35%). More than one-third (34%) of the episodes lasted from 1–3 months, while a further 33% lasted 2–29 days (tables ST.66 and ST.73).

Over the 5 years from 2009–10, the duration of closed episodes for those clients seeking treatment for their own drug use remained relatively stable. There has been little variation in the age proportions over the 5 years from 2009–10 (tables ST.66 and ST.76).

Pharmacotherapy

Pharmacotherapy is the replacement of a person's drug of choice with a legally prescribed and dispensed substitute. Pharmacotherapy programs are available for a range of drugs, including alcohol and opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy. Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment and an additional treatment was provided, are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded. Pharmacotherapy is only available to clients receiving treatment for their own drug use. As most pharmacotherapy services are outside the scope of the AODTS NMDS, the information presented on pharmacotherapy episodes are a significant underrepresentation. More comprehensive information on opioid pharmacotherapy treatment provided in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics <http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/> Annual Data (NOSPAD) collection.

For those services that were within scope of the AODTS NMDS, nationally in 2013–14, 2% of treatment episodes were provided with a treatment type of pharmacotherapy (main or additional). In just over one-third (34%) of these episodes, pharmacotherapy was an additional treatment (tables ST.3 and ST.75).

Of the closed episodes where pharmacotherapy was the main treatment type, more than one-quarter (27%) lasted up to 1 month, while a further 20% lasted 1–3 months (Table ST.83).

Three-fifths (61%) of treatment episodes with a main treatment type of pharmacotherapy were provided to male clients, and 12% were for Indigenous clients. Two-thirds (66%) of these episodes were for those aged 30–39 (41%) and 40–49 (25%) and. A further 22% were for clients aged 20–29; just 2% were for clients aged 60 and over (tables ST.76–78).

Of the treatment episodes provided to clients with a main treatment type of pharmacotherapy, more than one-third (36%) had heroin as a principal drug of concern, while almost 1 in 8 (13%) had a principal drug of alcohol. Methadone (11% of episodes) was also a common principal drug of concern (Table ST.79).

Appendix A: Data and methods

Age

Age is calculated as at the start of the episode.

Duration

Duration is calculated in whole days and calculated only for closed episodes.

Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's *Australian Standard Classification of Drugs of Concern 2011* (ASCDC) (ABS 2011a). In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	ASCDC codes	Category	Includes
Analgesics	1000–1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other opioids	oxycodone, fentanyl, pethidine
		Other analgesics	paracetamol
Sedatives and hypnotics	2000–2999	Alcohol	ethanol, methanol and other alcohols
		Benzodiazepines	clonazepam, diazepam and temazepam
		Other sedatives and hypnotics	ketamine, nitrous oxide, barbiturates and kava
Stimulants and hallucinogens	3000–3999	Amphetamines	amphetamine, dexamphetamine and methamphetamine
		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Cannabinoids	7000–7199	Cannabis	
Other	4000–6999 9000–9999	Other	anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
Not stated	0000–0002	Not stated	

Population rates

In this publication, crude rates were calculated using the ABS estimated resident population (ERP) at the midpoint of the data range, that is, rates for 2013–14 data were calculated using the ERP at 31 December 2013.

Reason for cessation

The AODTS NMDS contains data on the episode end reason (reason for cessation). In this report, these end reasons are grouped (Table A2). Data for the individual end reasons are available in the online supplementary tables.

A different method was used for grouping end reasons in reports released prior to 2014 and therefore trend comparisons across reports should be made with caution. It is possible to compare data at the individual end reasons using the supplementary tables.

Table A2: Grouping of cessation reasons by indicative outcome type

Outcome type	Reason for cessation
Expected cessation	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Unexpected cessation	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Administrative cessation	Change in main treatment type
	Change in delivery setting
	Change in principal drug of concern
	Transferred to another service provider
Other	Drug court or sanctioned by court diversion service
	Imprisoned (other than drug court sanctioned)
	Died
	Other
	Not stated

Remoteness

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

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

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

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

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

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

Service sectors

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

Trends

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

Appendix B: Imputation methodology for AODTS clients

From the inception of the AODTS NMDS, data have been collected only about treatment episodes provided by AOD treatment services. Data about the clients those episodes relate to have not been available at a national level. A statistical linkage key (SLK) was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continue to ensure the privacy of these individuals receiving treatment. In 2012–13 and 2013–14, an SLK was reported for the majority of episodes (90% and 96% respectively) (tables B1 and B2).

An imputation strategy for the collection was developed to correct for the impact of invalid or missing SLKs on the total number of clients. This strategy takes into account a number of factors relating to the number of episodes per client and makes assumptions relating to spread across agencies. It also takes into consideration the likelihood that an episode with a missing SLK relates to a client that has already been counted through other episodes with a valid SLK. Further details on the imputation strategy are provided below.

Using the imputation strategy to adjust for non-response and data quality issues, it is estimated there were 118,741 clients who received treatment in 2013–14.

Table B1: Imputed numbers of clients, by states and territories, 2013–14

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Number of episodes	42,406	56,392	36,093	20,867	13,085	2,841	4,652	4,377	180,713
Number of episodes with valid SLKs	37,307	55,369	35,733	19,855	12,778	2,825	4,610	4,192	172,669
Percentage of episodes with valid SLKs (%)	88.0	98.2	99.0	95.2	97.7	99.4	99.1	95.8	95.5
Number of episodes with invalid SLKs	5,099	1,023	360	1,012	307	16	42	185	8,044
Number of distinct clients (from valid SLKs)	24,184	29,548	28,960	15,146	9,195	2,432	3,309	2,870	114,851
Imputed number of distinct clients	**26,402**	**29,877**	**29,207**	**15,760**	**9,365**	**2,444**	**3,332**	**2,963**	**118,741**

Attributing number of clients to set of missing SLK records

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

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

Imputation groups

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

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

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

Assumptions and approximations

Assumption 1: randomness and independence

This imputation method assumes that whichever service provider a client attends for each incidence of service is random and independent of any other incidents of service the client may have. It is further assumed that the validity or otherwise of the SLK recorded on each service record is random and independent of both the client and the service provider with which the record is associated.

Assumption 2: distribution of the number of service records per client

This method also assumes that the distribution of the number of records per client for all clients is similar to that observed using the sub-set of records with valid SLKs.

Approximation 1: no client has more than 10 service records

This imputation method uses the approximation that no client has more than 10 service records.

In order to implement this approximation, any clients observed to have more than 10 service records were treated as if they had only 10 and the proportion of clients with 10 service records calculated accordingly.

Notation

We start by defining the notation used in this document.

N_t:	the (unknown) total number of clients
N_t':	the imputed total number of clients
N_{SLK1}:	the number of clients observed using the records with a valid SLK
P_{SLK1}:	the proportion of clients with at least 1 service record with a valid SLK
P_{Ni}:	the (unknown) proportion of clients with i service records
P_{Ni}':	the imputed proportion of clients with i service records
$P_{Ni,SLK1}$:	the proportion of clients with i service records as observed using records with valid SLKs
n_t:	the total number of service records
$n_t \mid N_t, P_{Ni}$:	the number of service records given the total number of clients and the proportions of clients with i service records, $i = 1,2, \ldots 10$
n_{SLK1}:	the number of service records with a valid SLK
n_{SLK0}:	the number of service records with an invalid SLK
p_{SLK0}:	the proportion of service records with an invalid SLK

Methodology

Given Assumption 1 and Approximation 1, the proportion of clients who have at least 1 service record with a valid SLK is

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

Now

$$N_{SLK1} = P_{SLK1} \times N_t$$

so it follows that the total number of clients is

$$N_t = \frac{N_{SLK1}}{P_{SLK1}}$$

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

The process starts with the distribution of number of records per client that were observed using the records with valid SLKs $\left(P_{Ni,SLK1}\right)$. These values are then adjusted so that the following conditions are met.

Constraint 1

The sum of the imputed proportions is equal to 1. That is,

$$\sum_{i=1}^{10} P'_{Ni} = 1$$

Constraint 2

The imputed proportion of clients with 1 service record is less than or equal to the observed equivalent proportion among clients with records with valid SLKs. That is,

$$P'_{N1} \leq P_{N1,SLK1}$$

This constraint is used because some of the clients observed to have only 1 record will, in fact, have additional records with invalid SLKs. It is unlikely that the true proportion of clients with 1 service record is higher than that observed using records with valid SLKs.

Constraint 3

The total number of service records that the imputed total number of clients and the imputed distribution of records per client imply is equal to the observed number of service records. That is

$$n_t | N'_t, P'_{Ni} = N'_t \sum_{i=1}^{10} (i \times P'_{Ni}) = n_t.$$

This constraint is used to ensure that the imputed values are consistent with the observed number of records.

Penalty function

Under Assumption 2 we want to limit how much the imputed proportions differ from the proportions observed via the records with valid SLK data. To achieve this we use a penalty function that increases as the distance between the imputed and observed proportions increases. This function is defined to be

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

Using numerical methods the $P'_{N1}, P'_{N2}, \ldots P'_{N10}$ are chosen such that the penalty function is minimised, subject to the 3 constraints.

The final step is to use the imputed proportions to calculate the imputed total number of clients:

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

The resulting number is then rounded to the nearest integer.

Discussion

This imputation technique uses available information to impute the total number of clients. The methodology takes into account the proportion of records with invalid SLK data and the distribution of the number of service records per client as observed via the records with valid SLK data.

It is apparent that the assumptions made do not hold for every client or service record. It is reasonable to expect that a client's attendance at a service provider will be affected by location and any prior contact they had with a provider. It should also be noted that some service providers failed to collect SLK for any service record during the reference period.

Despite the known cases where Assumption 1 does not hold, it is reasonable to hope that, across the population as a whole, the assumption is a reasonable representation of the populations of clients and service records.

It is believed that the impact of Approximation 1 will be small because, given Assumption 1, the chance that a client with more than 10 service records is not observed via a record with a valid SLK is extremely small. The chance diminishes as the proportion of records with an invalid SLK decreases and across jurisdictions the highest proportion observed is about 0.3. It should also be noted that the largest proportion of clients with 10 or more service records observed in the data at the jurisdiction level was only 0.007.

There are many different penalty functions that could be used in this imputation. The function used was chosen because, compared to the other penalty functions investigated, it produced imputed proportions that were generally as close or closer to the observed proportions. It also most consistently resulted in a distribution that was similar in shape to the observed distribution of the number of records per client.

Table B2: Comparison of population characteristics for valid SLK episodes and all episodes, by states and territories, 2013–14

	NSW		Vic		Qld		WA		SA		Tas		ACT		NT	
	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %	Valid %	Total %
Client type																
Own drug use	97.1	96.3	92.9	92.7	97.9	97.3	93.6	93.2	99.3	99.2	93.2	93.2	97.9	97.7	91.9	89.5
Other's drug use	2.9	3.7	7.1	7.3	2.1	2.7	6.4	6.8	0.7	0.8	6.8	6.8	2.1	2.3	8.1	10.5
Sex																
Male	65.8	65.4	63.7	63.6	68.3	68.0	64.6	64.2	70.2	69.8	65.2	65.2	64.6	64.3	66.5	66.1
Female	34.2	34.6	36.2	36.3	31.7	32.0	35.4	35.8	29.8	30.2	34.8	34.8	35.4	35.7	33.4	33.9
Not stated	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
Indigenous status																
Indigenous	12.5	13.1	6.6	6.6	16.9	17.0	19.8	19.3	12.5	12.4	8.3	8.3	12.2	12.1	62.4	62.5
Non-Indigenous	85.2	84.5	86.4	86.5	78.1	77.9	80.2	80.5	68.3	68.6	86.7	86.6	81.8	81.4	36.8	36.7
Not stated	2.4	2.5	6.9	6.9	5.0	5.1	0.0	0.2	19.2	19.0	5.0	5.1	6.1	6.5	0.8	0.8
Age group (years)																
10–19	6.6	5.8	13.0	12.8	15.0	15.1	15.1	15.6	11.1	11.0	14.2	13.3	17.0	17.1	21.8	19.2
20–29	23.9	24.9	28.8	29.6	29.2	29.6	27.9	29.2	23.4	23.5	26.3	27.4	23.1	23.3	24.2	25.6
30–39	30.4	31.4	26.0	26.6	25.4	25.6	28.3	29.3	29.9	29.9	27.7	28.4	27.5	27.6	28.4	29.7
40–49	23.4	23.3	19.4	19.4	18.0	17.7	18.0	17.9	22.3	22.4	20.0	19.5	19.8	19.5	17.1	17.2
50–59	11.5	11.0	9.0	8.3	8.6	8.3	7.7	6.5	9.5	9.4	8.9	8.4	9.4	9.0	6.7	6.6
60 and over	4.2	3.6	3.8	3.1	3.8	3.6	3.0	1.6	3.8	3.8	2.9	2.6	3.3	3.0	1.8	1.6
Unknown	0.0	0.0	0.0	0.1	0.0	0.2	0.0	0.0	0.0	0.0	0.0	0.3	0.0	0.5	0.0	0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Glossary

additional drugs: clients receiving treatment for their own drug use nominate a principal drug of concern that has led them to seek treatment and additional drugs of concern, of which up to 5 are recorded in the AODTS NMDS. Clients receiving treatment for someone else's drug use do not nominate drugs of concern.

additional treatment type: clients receive 1 main treatment type in each episode and additional treatment types as appropriate, of which up to 4 are recorded in the AODTS NMDS.

administrative cessation: includes episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

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

amphetamines: stimulants that include methamphetamine, also known as methylamphetamine. Amphetamines speed up the messages going between the brain and the body. Common names are speed, fast, up, uppers, louee, goey and whiz. Crystal methamphetamine is also known as ice, shabu, crystal meth, base, whiz, goey or glass.

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

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

benzodiazepines: also known as 'minor tranquillisers', are most commonly prescribed by doctors to relieve stress and anxiety and to help people sleep. Common names include Benzos, tranx, sleepers, downers, pills, serras (Serepax®), moggies (Mogadon®), normies (Normison®).

client type: the status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person. Clients may seek treatment or assistance concerning their own alcohol and/or other drug use, or support and/or assistance in relation to the alcohol and/or other drug use of another person.

closed treatment episode: a period of contact between a client and a treatment provider or team of providers. An episode is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months or treatment is ceased (see reason for cessation).

cocaine: belongs to a group of drugs known as stimulants. Cocaine is extracted from leaves of the coca bush (*Erythroxylum coca*). Some of the common names for cocaine include C, coke, nose candy, snow, white lady, toot, Charlie, blow, white dust and stardust.

expected cessation: includes episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement.

ecstasy: the popular street name for a range of drugs containing the substance 3, 4-methylenedioxymethamphetamine (MDMA)—a stimulant with hallucinogenic properties. Common names for ecstasy include Adam, Eve, MDMA, X, E, the X, XTC, the love drug.

government agency: those that operate from the public accounts of the Australian Government or a state or territory government, are part of the general government sector, and are financed mainly from taxation.

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

illicit drug use: includes:

- the use of illegal drugs—a drug that is prohibited from manufacture, sale or possession in Australia, for example, cannabis, cocaine, heroin and ecstasy
- misuse, non-medical or extra-medical use of pharmaceuticals—drugs that are available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse, for example opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine, and steroids
- use of other psychoactive substances—legal or illegal, potentially used in a harmful way, for example, kava, or inhalants such as petrol, paint or glue (but not including tobacco or alcohol) (MCDS 2011).

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

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

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

nicotine: the highly addictive stimulant drug in tobacco.

non-government agency: receive some government funding but are not controlled by the government, are directed by a group of officers or an executive committee, and may be an income tax-exempt charity.

principal drug of concern: the main substance that the client stated led them to seek treatment from an alcohol and drug treatment agency.

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

- **ceased to participate against advice:** where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- **ceased to participate at expiation:** where the client has fulfilled their obligation to satisfy expiation requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment

- **ceased to participate by mutual agreement:** where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area
- **ceased to participate involuntarily:** where the service provider stops the treatment due to non-compliance with the rules or conditions of the program
- **ceased to participate without notice**
- **change in the delivery setting**
- **change in the principal drug of concern**
- **change in the main treatment type**
- **death**
- **drug court or sanctioned by court diversion service:** where the client is returned to court or jail due to non-compliance with the program
- **imprisoned (other than sanctioned by a drug court or diversion service)**
- **treatment completed:** where the treatment was completed as planned
- **transferred to another service provider:** this includes situations where the service provider is no longer the most appropriate and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment.

referral source: the source from which the client was transferred or referred to the alcohol and other drug treatment service.

standard drink: contains 10 grams of alcohol (equivalent to 12.5 millilitres of alcohol). Also referred to as a full serve.

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

- **assessment only:** where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types
- **counselling:** is the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013)
- **information and education only**
- **pharmacotherapy, where the client receives another type of treatment in the same treatment episode:** includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy
- **rehabilitation:** focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential

treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011)

- **support and case management only:** support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007)
- **withdrawal management (detoxification):** includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

tobacco: see *nicotine*.

treatment episode: the period of contact between a client and a treatment provider or a team of providers. Each treatment episode has 1 principal drug of concern and 1 main treatment type. If the principal drug or main treatment changes, then a new episode is recorded.

unexpected cessation: includes episodes where the client ceased to participate against advice, without notice or due to non-compliance.

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Related publications

This report, *Alcohol and other drug treatment services in Australia 2013–14*, is part of an annual series. This publication, as well as past and future reports in this series, can be downloaded free from the AIHW website, <www.aihw.gov.au/alcohol-and-other-drugs-publications/>. The website also includes information on ordering printed copies.

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

- AIHW (Australian Institute of Health and Welfare) 2014. Alcohol and other drug treatment and diversion from the Australian criminal justice system 2012–13. Bulletin no. 125. Cat. no. AUS 186. Canberra: AIHW.
- AIHW 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.
- AIHW 2014. National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results from December 2013. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series. Cat. no. IHW 146. Canberra: AIHW.
- AIHW 2015. Aboriginal and Torres Strait Islander health organisations: Online Services Report—key results 2013–14. Aboriginal and Torres Islander health services report No. 6. Cat. no. IHW 152. Canberra: AIHW.
- AIHW 2015. National opioid pharmacotherapy statistics 2014. Bulletin no. 128. Cat. no. AUS 190. Canberra: AIHW.

Around 119,000 clients were estimated to have received over 180,700 treatment episodes from 795 publicly funded alcohol and other drug treatment agencies in 2013-14. Alcohol was the most common drug leading clients aged 30 and over to seek treatment, while cannabis was most common for clients aged 10–29. Over the 5 years from 2009–10, there has been an increase in the proportion of episodes where amphetamines were the principal drug on concern (from 7% to 17%) and an increase in smoking/inhaling as the method of administration for amphetamines. A majority of treatment episodes had a duration of three months or less, and counselling remains the most common treatment type.