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Alcohol and other drug treatment services in Australia 2018–19

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Contents

Summary

Alcohol and other drug (AOD) treatment services across Australia provide a broad range of treatment services and support to people who use alcohol or drugs, and to their families and friends. This report presents information for 2018–19 about publicly funded AOD treatment service agencies, the people they treat and the treatment provided.

Around 137,000 clients sought AOD treatment in 2018–19

In 2018–19:

- around 137,000 clients aged 10 and over (a rate of 623 clients per 100,000 people) received treatment, a 19% rise since 2014–15 (115,000 clients)
- around two-thirds of clients were male (64%), and over half of clients were aged 20–39 (54%)
- 1 in 6 (17%) clients aged 10 and over identified as Indigenous Australian, representing a rate of 3,580 clients per 100,000 people, compared with 515 clients per 100,000 for non-Indigenous Australians
- treatment agencies provided about 220,000 closed treatment episodes—an average of 1.6 episodes per client
- around 4 in 5 (79%) episodes ended within 3 months
- less than 1% (3,169) of clients received treatment in every collection year from 2014–15.

Over two thirds of all treatment episodes within the amphetamines group were for methamphetamines only

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs of concern for clients since the beginning of the collection.

In 2018–19, among clients seeking treatment for their own alcohol or drug use:

- alcohol was the most common principal drug of concern (36% of episodes), followed by amphetamines (28%), cannabis (20%), and heroin (5%)
- around two thirds (66%) of treatment episodes within the amphetamines group were for methamphetamines as a principal drug of concern
- alcohol was the most common principal drug of concern for clients aged 40 and over (56%), while cannabis was the most common for clients aged 10–19 (58%)
- most clients with heroin as a principal drug of concern were aged 30–49.

Treatment episodes for amphetamines increased nearly 6-fold over 10 years

Over the 10-year period to 2018–19:

- the number of treatment episodes for amphetamines increased nearly 6-fold from 10,000 episodes to 58,200 episodes nationally
- where amphetamines were the principal drug of concern, the number of episodes where the method of use was smoking, inhaling, or injecting increased over 6-fold, from around 8,000 episodes to 52,200 episodes

- almost two thirds (38,470 episodes) of all treatment episodes within the amphetamines group were for methamphetamines only in 2018–19, increasing from 12% (1,243 episodes) in 2009–10
- the proportion of episodes where alcohol was the most common principal drug of concern decreased from 48% to 36%
- the number of heroin treatment episodes fell from around 13,900 to 10,900 treatment episodes.

Counselling continues to be the most common type of treatment

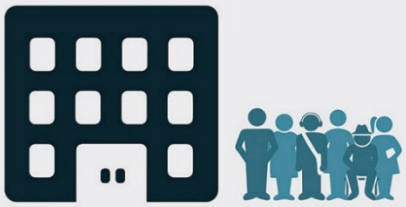
Since 2009–10 the proportion of episodes for each of the four most common main treatment types have fluctuated.

- Counselling has continued to be the most common treatment type (39% of episodes in 2018–19).
- There have been increases in the proportion of episodes for both support and case management only (from 9% to 12%) and assessment only (14% to 19%).
- There has been a decline in the proportion of treatment episodes with withdrawal management (from 17% to 11%) and counselling (42% to 39%) as the main treatment type.

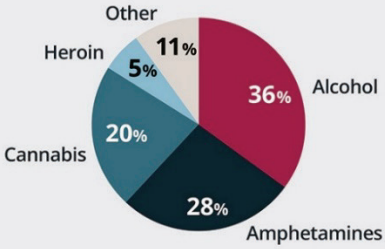
In 2018–19:

1,283 publicly funded AOD treatment agencies provided

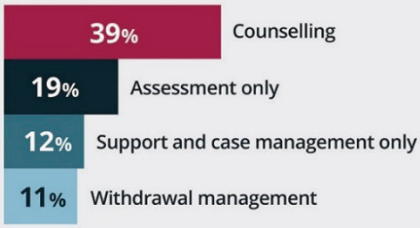
219,933 closed treatment episodes to **136,999** clients aged 10+



Alcohol is the most common drug for which people seek treatment



Counselling is the most accessed treatment type



More than half of clients are **aged**

and

around **2 in 3** are male

Around **1 in 6** clients are Aboriginal and/or Torres Strait Islander

Source: AIHW 2020. *Alcohol and Other Drug Treatment Services in Australia 2018–19: key findings.*

AIHW

1 Introduction

Alcohol and other drug (AOD) treatment services provide treatment and support to people receiving treatment for their alcohol or drug use and support for their families and friends. Many types of treatment are available in Australia, with most aiming to reduce harms related to alcohol or drug use. Some treatments specifically aim to help clients develop skills that facilitate drug-free lifestyles and prevent relapse; these typically use abstinence-oriented interventions in a structured, substance-free setting (AIHW 2011).

This report presents national information for 2018–19 about publicly funded AOD treatment service agencies, the people they treated, and the treatment they provided. Between 2014–15 and 2018–19, the estimated number of clients who received treatment increased by 19% (from 114,912 clients to 136,999). Of those clients who received treatment in 2018–19, under 1% (3,169) of clients received treatment in every collection year from 2014–15 to 2018–19.

1.1 Drug use in Australia

The use and misuse of licit and illicit drugs imposes a heavy financial cost on the Australian community. In recent years, the separate costs of tobacco ($136.9 billion in 2015–16), opioid ($15.76 billion in 2015–16), methamphetamine (over $5 billion in 2013–14) and alcohol use ($14.35 billion in 2010) in Australia have been estimated, utilising different methodologies (Whetton et al. 2020, Whetton et al. 2019, Whetton et al. 2016, Manning, Smith & Mazerolle 2013).

The 2016 National Drug Strategy Household Survey found alcohol and tobacco to be the most common drugs used in Australia, with 77% of Australians aged 14 and over drinking alcohol in the previous 12 months and 12% smoking tobacco daily (AIHW 2017). Nearly 1 in 5 (17%) people drank at levels that increased the risk of health-related harms over their lifetime (more than 2 standard drinks per day on average), while one-quarter (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 2016, just over 2 in 5 people (43%) aged 14 and over reported using illicit drugs in their lifetime, while 1 in 7 (16%) reported using illicit drugs within the previous 12 months (AIHW 2017). Cannabis was the most commonly used illicit drug: more than 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 (11.9%) and hallucinogens (9.4%) were the second and third most commonly used illicit substances for lifetime use, while pain-killers (analgesics) for non-medical purposes (3.6%) and ecstasy (2.2%) were the second and third most common substances reported for recent use.

1.2 National Drug Strategy

Australia has had a coordinated approach to dealing with alcohol and other drugs since 1985. The National Drug Strategy (NDS) 2017–2026 is the 7th and latest iteration of the cooperative strategy between the Australian Government, state and territory governments, and the non-government sector. The NDS provides a framework that identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments—in partnership with service providers and the community—and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply, and harm reduction strategies.

The NDS has an overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (NDSC 2017):

- **demand reduction:** to prevent the uptake and/or delay the onset of use of alcohol, tobacco, and other drugs; reduce the misuse of alcohol, tobacco, and other drugs in the community; and support people to recover from dependence through evidence-informed treatment
- **supply reduction:** to prevent, stop, disrupt, or otherwise reduce the production and supply of illegal drugs; and to control, manage, and/or regulate the availability of illegal drugs
- **harm reduction:** to reduce the adverse health, social and economic consequences of the use of drugs for consumers, their families, and the wider community.

Harm reduction actions in the strategy include (NDSC 2017):

- increasing access to pharmacotherapy treatment to reduce drug dependence and reduce the health, social, and economic harms to individuals and the community that arise from misuse of opioids
- monitoring emerging drug issues to provide advice to the health, law enforcement, education, and social services sectors to inform individuals and the community regarding risky behaviours
- developing and promoting culturally appropriate alcohol, tobacco, and other drug information and support resources for individuals, families, communities, and professionals in contact with people at increased risk of harm from alcohol, tobacco, and other drugs
- providing opportunities for intervention among high-prevalence or high-risk groups and locations, including the implementation of settings-based approaches to modify risk behaviours
- enhancing systems to facilitate greater diversion into health interventions from the criminal justice system, particularly for Aboriginal and Torres Strait Islander people, young people, and other at risk populations who may be experiencing disproportionate harm.

1.3 Alcohol and other drug treatment services

AOD treatment services provide support to people regarding their use of alcohol or drugs through a range of treatments. Treatment objectives can include reduction or cessation of substance use, as well as improving social and personal functioning. Treatment and assistance may also be provided to support the family and friends of people who have problems with alcohol or drug use. Treatment services include detoxification and rehabilitation, counselling, and pharmacotherapy, and are delivered in residential and non-residential settings.

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. Information on publicly funded AOD treatment services in Australia, clients, and drug treatment are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). The AODTS NMDS is one of several NMDSs that collect data under the 2012 National Healthcare Agreement to inform policy and help improve service delivery (COAG 2012).

Other available data sources that support a more complete picture of AOD treatment in Australia include:

- the National Opioid Pharmacotherapy Statistics Annual Data collection https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-2019/contents/introduction
- the National Hospital Morbidity Database https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/drug-related-hospitalisations
- the Online Services Report Database https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/indigenous-health-organisations-aodt-services
- the Specialist Homelessness Services collection https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/shs-drug-and-alcohol-related-issues
- the National Prisoner Health Data collection www.aihw.gov.au/prisoner-health.

1.4 The AODTS NMDS

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government organisations. Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed (see Glossary).

This report provides information on the following types of treatment:

- assessment only
- counselling
- information and education only
- pharmacotherapy
- rehabilitation
- support and case management only
- withdrawal management (see Glossary).

The AODTS NMDS collects data about services provided to people who are seeking assistance for their own alcohol or drug use and those seeking assistance for someone else's alcohol or drug use.

Client information is collected at the episode level in the AODTS NMDS. The collection does not contain a unique identifier for clients, but from 2012–13, a statistical linkage key (SLK) was introduced, which enables the number of clients receiving treatment to be estimated. From 2012–13, SLK data were not available for all clients, so an imputation strategy was developed to estimate the number of clients and enable more complete reporting at the client level. Imputation was applied for the 2012–13, 2013–14 and 2015–16 collection years, because SLKs were missing for a high proportion of treatment episodes. The SLK reporting for 2012–13 contained a number of quality issues and is considered pilot analysis: these data are not included in trend analysis for client data. Further details on the imputation methodology can be found in the technical notes.

Data collected by treatment agencies are forwarded to the relevant state and territory health departments, who then extract required data according the specifications in the AODTS NMDS. Data are submitted to the AIHW annually for national collation and reporting.

Coverage and data quality

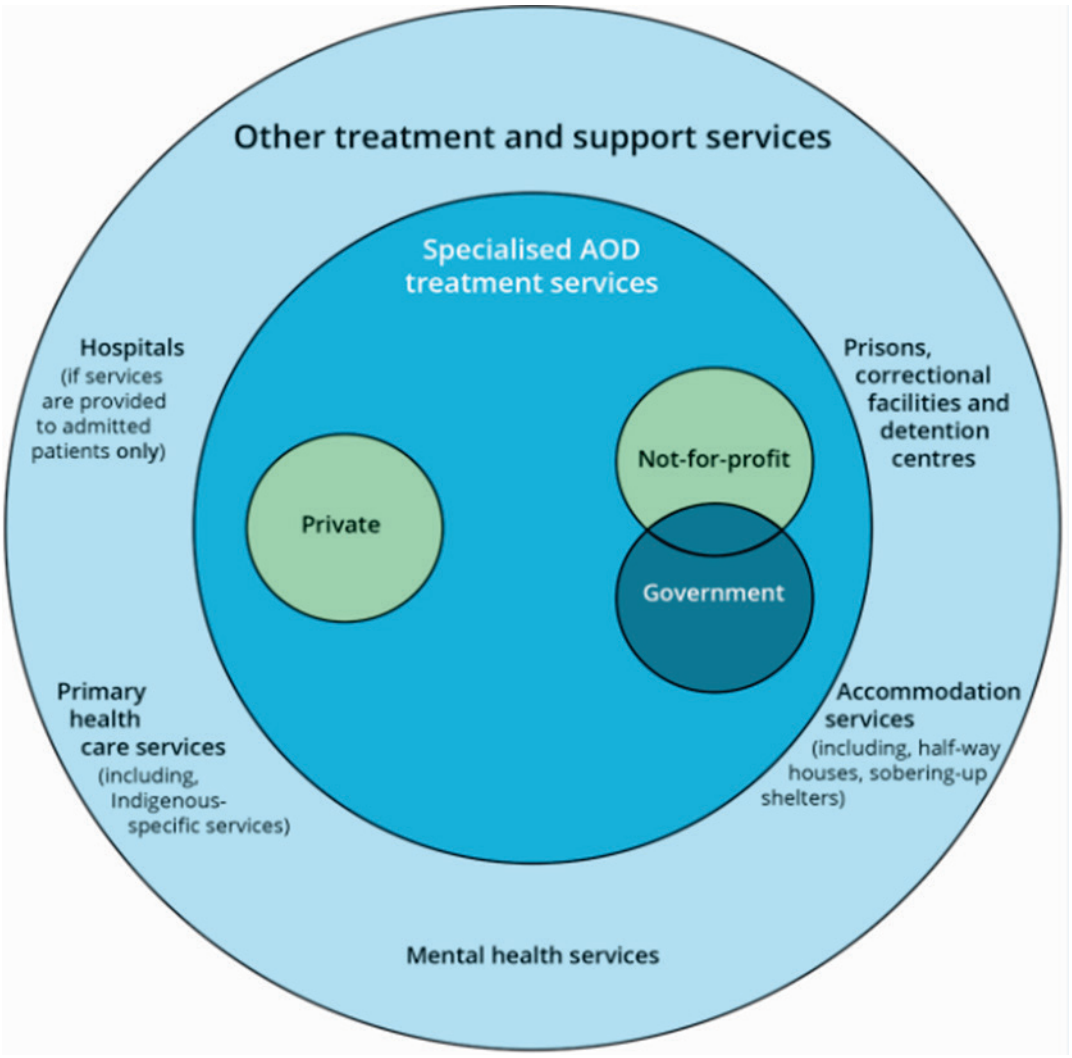
Although the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government organisations, it is difficult to fully quantify the scope of AOD services in Australia.

People receive treatment for alcohol and other drug-related issues in a variety of settings not in scope for the AODTS NMDS. These include:

- services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding
- alcohol and other drug treatment units in acute care or psychiatric hospitals that provide treatment only to admitted patients
- prisons, correctional facilities and detention centres
- primary health-care services, including general practitioner settings, community-based care, Indigenous Australian-specific primary health-care services and dedicated substance use services
- health promotion services (for example, needle and syringe programs)
- accommodation services (for example, halfway houses and sobering-up shelters) (Figure 1.1).

In addition, agencies whose sole function is prescribing or providing dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. These data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection available at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-2019/contents/introduction.

Figure 1.1: Alcohol and other drug treatment and support services in Australia



Note: Those in scope for the AODTS NMDS are shaded darker blue.

Australian Government-funded primary healthcare services and substance use services provided specifically for Indigenous Australian people may be in scope for the AODTS NMDS but the majority of services do not report as they previously reported via the Australian Government-funded Aboriginal and Torres Strait Islander substance use services the Online Services Report (OSR) data collection. The reporting process for these agencies is currently under review.

In 2018–19, 95% (1,283) of in-scope agencies submitted data to the AODTS NMDS. Overall, from 2017–18 to 2018–19, there was an increase of 1 percentage point in the proportion of in-scope agencies that reported to the collection. For the 2014–15 and 2015–16 reporting periods, sector reforms and system issues in some jurisdictions affected the number of in-scope agencies that reported. This led to an under-count of the number of closed treatment episodes reported for these years, so results, especially across reporting years, should be interpreted with caution.

Further details on scope, coverage and data quality is available from the AODTS NMDS Data Quality Statement at https://meteor.aihw.gov.au/content/index.phtml/itemId/727501.

1.5 Accompanying material

The following online information accompanies this report:

- Scope, coverage and data quality at www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services
- Data quality statement at https://meteor.aihw.gov.au/content/index.phtml/itemId/727501
- State and territory summaries at

  https://aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-aus/contents/state-and-territory-summaries
- Supplementary data tables (those with a prefix of 'S' referenced throughout the report) at

  https://aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-and-other-drug-treatment-services-in-austr/data

  Interactive data displays at https://aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-aus/contents

2 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).

Box 2.1: Agencies key facts

In 2018–19:

- a total of 1,283 publicly funded agencies provided data about their treatment services to the AODTS NMDS
- more than 2 in 3 (69%) agencies were non-government
- nearly 3 in 5 (59%) agencies were located in *Major cities.*

Over the 10-year period to 2018–19:

- the number of publicly funded agencies providing AOD treatment increased by 92%.

2.1 Number of agencies

In 2018–19, 1,283 publicly funded AOD treatment agencies reported to the AODTS NMDS an increase of 37% since 2017–18 (Box 2.1). This increase is in part attributable to the increase in Australian Government-funded services commissioned by Primary Health Networks (PHN) reporting data. The number of agencies per state and territory ranged from 16 in the Australian Capital Territory to 440 in New South Wales (Table SA.1).

Over the 10-year period to 2018–19, there has been a 92% increase in the number of reporting agencies (from 670 to 1,283). The increase has largely been driven by increases in reporting agencies in Victoria (from 138 to 404), New South Wales (from 258 to 440), Queensland (118 to 180) and Western Australia (52 to 108) (Table SA.1).

A number of issues can affect the increase or decrease in the number of agencies reporting within jurisdictions, and these include:

- new client management systems improving data provision
- funding of new services
- technical issues with new or old reporting systems
- overburden of reporting on small agencies.

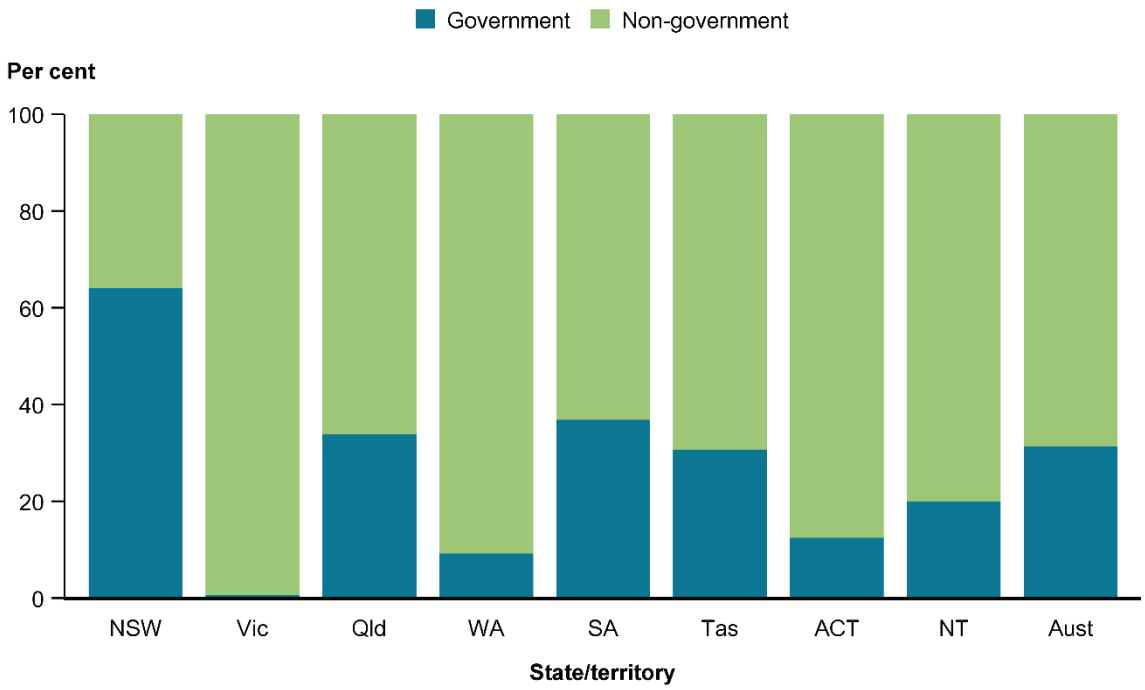
Another impact over reporting years includes the change in reporting from the head-office level to the service outlet level, which increases the number of agencies within one organisation. Most jurisdictions report that they are continuing to work to improve the coverage and quality of data supplied by agencies.

2.2 Service sector

Nationally, in 2018–19, more than 2 in 3 (69% or 881) AOD treatment agencies were non-government, and these agencies provided over two-thirds (71% or 156,239) of closed treatment episodes (Figure 2.1). Over the 10-year period to 2018–19, the proportion of non-government agencies has increased (from 54% to 69%), along with the proportion of closed treatment episodes also provided by non-government agencies (from 61% to 71%) (tables SA.1 and 2).

In New South Wales, the majority of treatment agencies were in the government sector (64%). In the remaining states and territories, most treatment agencies were in the non-government sector, ranging from 63% in South Australia to 99% in Victoria (Table SA.1).

Figure 2.1: Publicly funded AOD treatment agencies by service sector, states and territories, 2018–19



Source: Table SA.1.

2.3 Remoteness area

Nationally, in 2018–19, nearly 3 in 5 (59% or 750) treatment agencies were located in *Major cities* and almost a quarter (24%) were in *Inner regional* areas (Table SA.3). These agencies provided 67% and 20% of all treatment episodes, respectively (Table SA.4). Relatively few agencies were located in *Remote* and *Very remote* areas (5% in total). This pattern was similar across most states and territories, except for Northern Territory where 32% of agencies were located in *Remote* and 20% in *Very remote* areas (Table SA.3).

3 Clients

Client information is collected at the episode level in the AODTS NMDS. The statistical linkage key (SLK) was introduced in 2012–13, which enables the number of clients receiving treatment to be estimated.

Box 3.1: Client key facts

In 2018–19:

- around 137,000 clients aged 10 and over received treatment from publicly funded AOD treatment agencies across Australia
- clients received an average of 1.6 treatment episodes for their own alcohol or drug use
- more than half of all clients (53%) were aged 20–39.

Over the 5–year period to 2018–19:

- 17% (77,988) of clients received treatment in 2018–19 only
- 0.7% (3,169) of clients received treatment in all five collection years (from 2014–15 to 2018–19).

In 2018–19, around 137,000 clients aged 10 and over received:

- around 220,000 closed treatment episodes from publicly funded AOD treatment agencies across Australia (Box 3.1; Table 3.1)
- alcohol or other drug treatment equating to a rate of 623 clients per 100,000 people in 2018–19, compared with 555 clients per 100,000 in 2014–15 (Table SCR.21).

Between 2014–15 and 2018–19, the estimated number of clients rose from around 114,500 to 137,000, an overall increase of 19%.

Around 1 in 6 (17%) clients were Aboriginal or Torres Strait Islander, this is a rate of 3,580 clients per 100,000, compared with 515 clients per 100,000 non-Indigenous Australians (Table SCR.26).

3.1 Characteristics of clients

Clients can receive treatment for their own or someone else's alcohol or drug use (see Glossary). In 2018–19, around 129,600 clients received treatment for their own alcohol or drug use and around 9,600 received treatment in relation to someone else's alcohol or drug use (Table 3.1).

A small proportion (less than 2% or 2,249 closed treatment episodes) of clients received treatment for their own alcohol or drug use and for someone else's alcohol or drug use in 2018–19.

In 2018–19, clients who received treatment for their own alcohol or drug use received an average of 1.6 treatment episodes, while those receiving treatment for someone else's alcohol or drug use received an average of 1.3 treatment episodes.

Table 3.1: Clients[a], treatment episodes and rates, by client type and state and territory, 2018–19

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Own drug use				
Number of episodes	51,543	58,018	46,218	23,239	11,718	3,579	6,533	6,983	207,831
Number of clients	30,060	30,325	34,267	17,612	8,508	2,586	3,884	3,544	129,601
Episodes per client	1.7	1.9	1.3	1.3	1.4	1.4	1.7	2.0	1.6
Rate of episodes[b] (number per 100,000 population)	733	1,016	1,051	1,027	762	761	1,779	3,334	945
Rate of clients[b] (number per 100,000 population)	428	531	779	779	553	550	1,058	1,692	589
					Other's drug use				
Number of episodes	1,020	6,528	1,613	1,997	216	277	167	284	12,102
Number of clients	848	5,313	900	1,824	184	224	156	199	9,647
Episodes per client	1.2	1.2	1.8	1.1	1.2	1.2	1.1	1.4	1.3
Rate of episodes[b] (number per 100,000 population)	15	114	37	88	14	59	45	136	55
Rate of clients[b] (number per 100,000 population)	12	93	20	81	12	48	42	95	44
					Total				
Number of episodes	52,563	64,546	47,831	25,236	11,934	3,856	6,700	7,267	219,933
Number of clients	30,814	33,699	35,123	19,348	8,681	2,791	4,026	3,716	136,999
Episodes per client	1.7	1.9	1.4	1.3	1.4	1.4	1.7	2	1.6
Rate of episodes[b] (number per 100,000 population)	748	1,130	1,087	1,116	776	820	1,825	3,469	1,000
Rate of clients[b] (number per 100,000 population)	438	590	798	855	565	594	1,096	1,774	623

(a) Client numbers based on client records with a valid SLK. No imputation applied for 2018–19.

(b) The crude rate is based on the preliminary Australian estimated resident population as at 31 December 2019.

Sources: Tables SCR.21 and SCR.27.

Client profile

Most of the 137,000 clients received treatment in a *Major city* via a single AOD agency service.

In 2018–19:

- most clients (94%) received treatment for their own alcohol or drug use and were more likely to be male (64% of clients)
- conversely, clients who received treatment for someone else's alcohol or drug use were more likely to be female (51%) (tables SC.1–2)
- three in five (62%) of all clients lived in *Major cities,* 22% in *Inner regional* areas and 12% in *Outer regional* areas

- however, the rate of clients was highest for those that lived in *Very remote* areas (1,791 clients per 100,000 population), followed by *Remote* areas (1,498 clients per 100,000) and *Outer regional* areas (880 clients per 100,000; Table SCR.29)
- four in five (80%) clients received treatment at a single agency, 14% at 2 agencies, and 6% of clients received treatment at 3 or more agencies (Table SCR.23)
- the number of clients receiving treatment via publicly funded AOD services increased between 2017–18 and 2018–19 (from around 129,800 clients to 137,000 clients) (Table SCR.21).

Age

Clients who received treatment for their own alcohol or drug use tended to be younger, on average, than those who received treatment for someone else's alcohol or drug use.

In 2018–19:

- more than half (53%) of clients who received treatment were aged 20–39
- two thirds (66%) of clients receiving treatment for their own alcohol or drug use, were aged under 40 years, compared with half (50%) of those who received treatment for someone else's alcohol or drug use
- clients aged 60 and over accounted for 4% of clients who received treatment for their own alcohol or drug use, compared with 13% of clients who received treatment for someone else's alcohol or drug use (Table SC.3).

Over the 10-year period to 2018–19:

- the proportion of closed treatment episodes for clients who were aged under 40 years fell from 70% to 64% (Table SE.5)
- the median (midpoint) age for all closed treatment episodes rose from 32 to 34 years
- for treatment episodes provided to clients who received treatment for their own drug use, the median age also rose from 32 years to 34 years
- for treatment episodes related to another's alcohol or drug use, clients were generally older than those receiving treatment for their own drug use over the 10-year period, with the median age fluctuating from 40 years in 2009–10 down to 39 years in 2014–15, rising again to 44 years in 2016–17 and 2017–18, and dropping to 40 years in 2018–19 (Table SE.8).

Indigenous status

Despite comprising only 3% (ABS 2019a) of the Australian population aged 10 and over in 2018–19, clients who identified as Aboriginal or Torres Strait Islander, accounted for 17% of all clients of AOD treatment services. This equates to a crude rate of 3,580 clients per 100,000 Indigenous Australians, compared with 515 clients per 100,000 non-Indigenous Australians (Table SCR.26).

The proportion of clients who identified as Aboriginal or Torres Strait Islander people varied by client type: about 1 in 6 (17%) clients receiving treatment for their own alcohol or drug use and 9% of clients receiving treatment for someone else's alcohol or drug use (Table SC.4).

The most common principal drugs of concern that Indigenous clients received treatment for were alcohol, amphetamines, cannabis, heroin and volatile solvents (Table SC.8).

Country of birth and preferred language

The majority (87%) of AOD clients aged 10 and over were born in Australia, compared to 71% of the general population (Table SC.23; ABS 2019b).

In 2018–19:

- 87% of all clients were born in Australia
- of the clients who received treatment that were born in countries other than Australia, New Zealand and the United Kingdom were most common countries of birth (both 3% of clients) (Table SC.23)
- comparatively, as at 30 June 2018, 4.8% of the Australian population were born in the United Kingdom and 2.3% in New Zealand (ABS 2019b)
- English was the most frequently reported (96%) preferred language among all clients (Table SE.10).

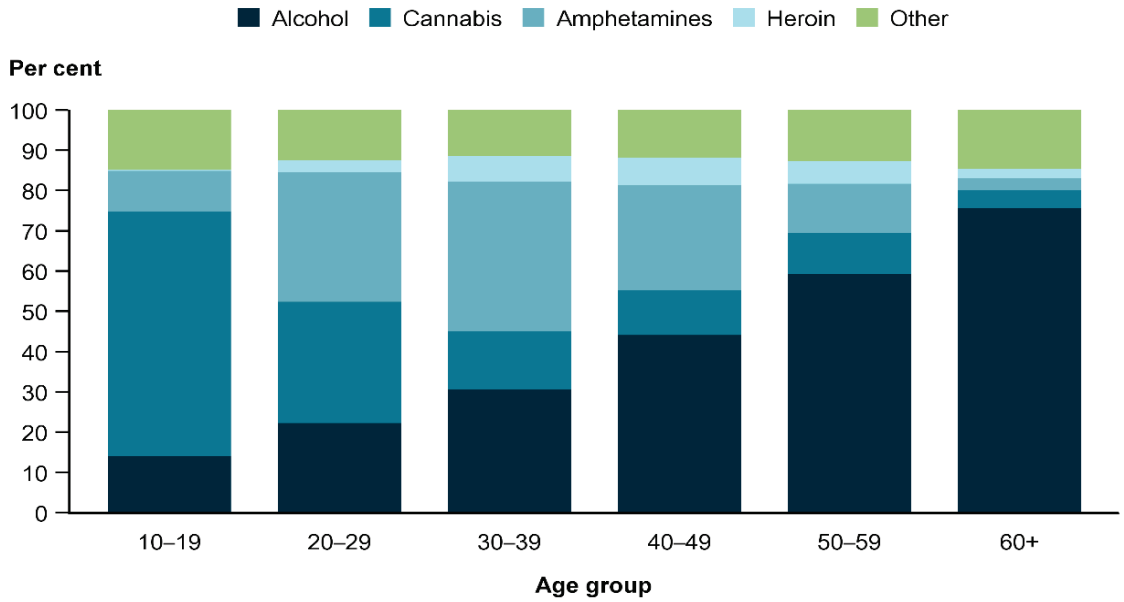
3.2 Clients and drugs of concern

At the client level, in 2018–19, alcohol was the most common principal drug of concern (34% of clients who received treatment for their own alcohol or drug use), followed by amphetamines (27%), cannabis (23%) and heroin (5%) (Table SC.9). AOD treatment services provide treatment for the client's drug that is of most concern for them, this is referred to as their principal drug of concern (See Box 4.2 for key terminology).

The principal drug of concern for which clients received treatment varied substantially with age. Alcohol as a principal drug of concern was more common in the older age groups: 60% of those aged 50–59 and 76% of clients aged 60 and over, whereas it was a principal drug of concern for about 1 in 6 (15%) clients aged 10–19 (Figure 3.1; Table SC.7).

For clients receiving treatment for cannabis, the opposite was true. Those aged 10–19 were most likely to be receiving treatment for cannabis (61%), which was the principal drug of concern for almost two-thirds of clients in this age group, compared with 10% of those aged 50–59 and 4% of those aged 60 and over (Figure 3.1).

Figure 3.1: Clients who received treatment for their own drug use by age group (years) and principal drug of concern, 2018–19



Note: Based on client records with a valid SLK.

Source: Table SC.7.

For clients who received treatment for their own alcohol or drug use in 2018–19:

- where amphetamines were the principal drug of concern, almost 2 in 5 clients were aged 30–39 (38%) and one-third were aged 20–29 (33%)
- where heroin was the principal drug of concern, treatment was more common for clients aged over 30 (82% of clients), comprising 38% of clients aged 30–39 and 30% aged 40–49, compared with 0.7% of clients aged 10–19 (Table SC.7)
- over half of all clients receiving treatment for codeine as the principal drug of concern were female clients (55%), while the proportion of male clients who received treatment for cocaine as a principal drug of concern was 8 times that of females (88% compared with 11%, respectively; Table SC.6)
- almost 9 in 10 (89%) of all clients receiving treatment for volatile solvents as the principal drug of concern, were Aboriginal and Torres Strait Islander clients (Table SC.8).

3.3 Client service use over multiple years

Nationally, over 457,183 clients received at least one closed treatment episode in the 5 most recent collection years (2014–15, 2015–16, 2016–17, 2017–18 and 2018–19; Table SCR.28).

Over the 5 years to 2018–19:

- 73% (332,989) of all clients received treatment in only one of the five years, with 17% (77,988) of all clients receiving treatment in 2018–19 only
- 14% (65,748) of all clients received treatment in any two of the five years, with 3.6% (16,469) of all clients receiving treatment in both 2017–18 and 2018–19

- 4.9% (22,616) of all clients received treatment in any three of the five years, with 1.3% (5,959) of all clients receiving treatment in each year from 2016–17 to 2018–19
- 1.4% (6,713) of all clients received treatment in any four of the five years, with 0.8% (3,520) of all clients receiving treatment in each year from 2015–16 to 2018–19
- 0.7% (3,169) of all clients received treatment in all years from 2014–15 to 2018–19.

For clients who had at least one closed treatment episode in each of the 5 most recent collection years, selected highlights include:

- more than one-quarter (27%) were aged 40–49, compared to 22% among clients who received treatment in the last 2 collection years only
- 10% received treatment for cannabis as their principal drug of concern, compared to 16% among clients who received treatment in the last 2 collection years only
- 17% reported withdrawal management as their most common main treatment type, compared to 10% among clients who received treatment in the last 2 collection years only
- 22% received treatment in a residential treatment facility, compared to 15% among clients who received treatment in the last 2 collection years only (table 3.2).

See Table 3.2 for more information about clients who received treatment in multiple years.

Table 3.2: Summary characteristics of clients[a] receiving treatment in multiple years (%)

	Clients in 2017–18 and 2018–19	Clients from 2016–17 to 2018–19	Clients from 2015–16 to 2018–19	Clients in all five years up to 2018–19
Total proportion of clients	**3.6%**	**1.3%**	**0.8%**	**0.7%**
Sex				
Male	64.2	62.7	61.9	61.9
Female	35.7	37.3	38.1	38.1
Other	0.0	0.0	0.0	0.0
Client type				
Own drug use	95.2	95.7	96.0	96.7
Others drug use	4.8	4.3	4.0	3.3
Indigenous status [b]				
Indigenous	17.7	17.3	16.5	15.5
Non-Indigenous	79.0	79.8	80.7	81.6
Age				
10–19	7.7	5.3	3.6	2.7
20–29	25.5	24.7	24.3	20.7
30–39	30.9	32.1	32.1	32.3
40–49	22.3	23.9	25.2	27.2
50+	13.4	13.9	14.8	17.1
Principal drugs of concern				
Alcohol	35.3	35.7	37.0	40.4
Amphetamines	32.5	34.2	33.4	29.5
Cannabis	15.9	12.9	11.1	9.6
Heroin	6.3	7.4	8.6	9.4
Referral to treatment				
Self/family	40.4	43.3	43.6	45.7
Health service	30.2	29.4	29.5	30.6
Corrections	7.2	6.3	7.5	6.3
Diversion	9.9	8.0	6.7	5.9
Other	12.3	13.1	12.8	11.5
Main treatment type				
Counselling	44.0	40.6	38.5	36.3
Information and education only	4.3	3.4	3.2	3.3
Support and case management only	12.6	12.6	12.5	11.9
Assessment only	15.5	16.3	15.8	15.2
Withdrawal management	10.4	12.6	14.6	17.1
Other[c] [d]	13.1	14.5	15.4	16.2
Treatment setting				
Non-residential treatment facility	64.7	62.6	61.3	60.6
Residential treatment facility	14.9	17.7	20.3	22.5
Other[d]	20.4	19.7	18.4	17.0

(continued)

Table 3.2 (*continued*): Summary characteristics of clients[a] receiving treatment in multiple years (%)

Treatment completion				
Expected/planned completion	56.5	57.0	55.5	57.1
Ended due to unplanned completion	24.1	24.3	23.4	22.8
Other[e]	19.5	18.7	21.2	20.1

(a) Based on valid SLK client data—no imputation applied to data.

(b) The proportion of clients for Indigenous status may not sum to the total, due to missing or not reported data.

(c) Includes pharmacotherapy, other and rehabilitation.

(d) Includes where treatment is delivered in the client's own home or usual place of residence or in an outreach setting.

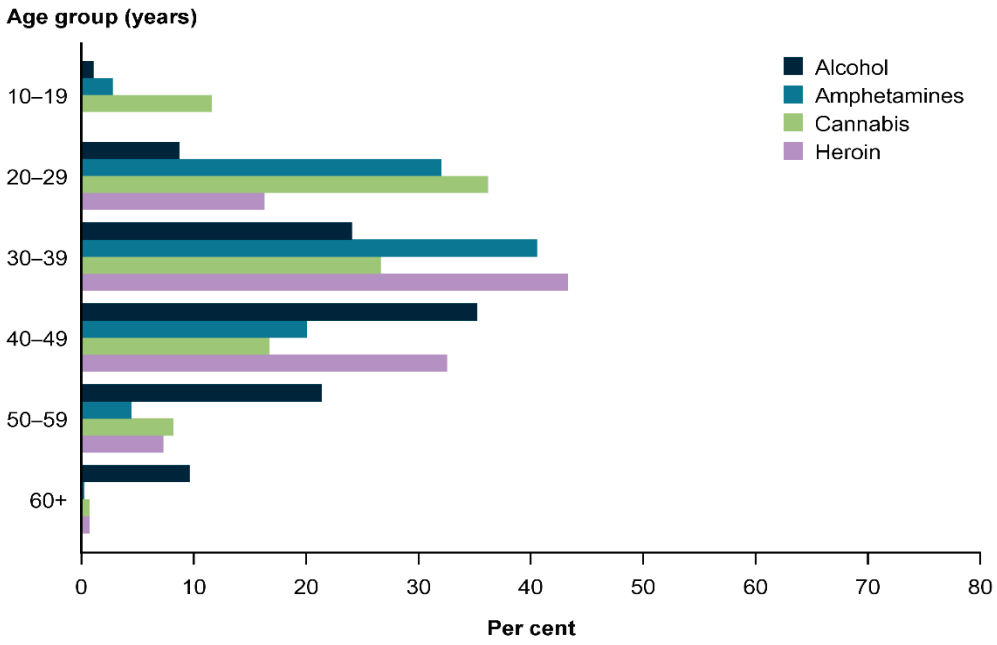
(e) Includes where client is referred to another service/change treatment mode and other.

Sources: Tables SCY_2yr.1–.19, SCY_3yr.1–.19, SCY_4yr.1–.19, SCY_5yr.1–.19.

Clients receiving treatment in all 5 years from 2014–15 to 2018–19 were:

- more likely to be older where heroin was the principal drug of concern: 43% were aged 30–39 and 33% aged 40–49
- more likely to be younger where cannabis was the principal drug of concern: 36% were aged 20–29 and 27% aged 30–39
- most likely to be aged 20–39 where amphetamines were the principal drug of concern (73%)
- more likely to be older where alcohol was the principal drug of concern: only 1% were aged 10–19 but 66% aged 40 or over. Alcohol was the most common principal drug of concern for 2 in 5 clients (40%) (Figure 3.2; Table SCY.29).

Figure 3.2: Clients who received treatment in all 5 years, 2014–15, 2015–16, 2016–17, 2017–18 and 2018–19 by age group (years) and selected drugs of concern (%)



Source: Table SCY.29.

Note: Pharmacotherapy treatment is undercounted. It is also reported in the NOPSAD report.
Source: Table SCY.36.

4 Drugs of concern

People may seek AOD treatment services due to problematic use of alcohol and/or one or more drugs. For most people, however, there is one drug that is of primary 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; these are 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 (Box 4.2).

Box 4.1: Key facts

In 2018–19:

- over 207,800 of closed treatment episodes provided were for clients receiving treatment for their own alcohol or drug use
- nationally, alcohol was the most common principal drug of concern (36% of episodes) followed by amphetamines (28%), cannabis (20%), and heroin (5%) together these four drugs accounted for 89% of all treatment episodes
- alcohol was the most common principal drug of concern in all remoteness areas, with the highest proportion of episodes located in *Very remote* areas (77%), and the lowest proportion in *Major cities* (34%)
- clients whose principal drug of concern was volatile solvents generally spent longer in treatment—the median duration of episodes was 66 days compared with 23 days for all treatment episodes.

Over the 10-year period to 2018–19:

- the top four principal drugs of concern have remained consistent, although from 2015–16, amphetamines replaced cannabis as the second most common principal drug of concern
- the number of closed treatment episodes where amphetamines were the principal drug of concern increased by 480% (rising from around 10,000 episodes up to 58,200)
- almost two thirds (66%) of treatment episodes within the amphetamines group were for methamphetamines as a principal drug of concern, increasing from 12% (1,243 episodes) in 2009–10
- treatment episodes for cannabis rose by 30% (rising from 31,600 to 41,200)
- treatment episodes for cocaine increased by almost 200% (rising from 595 episodes to 1,756)
- the number of episodes for clients injecting, smoking or inhaling amphetamines increased almost over 6-fold from 8,000 episodes in 2009–10 to 52,200 episodes in 2018–19.

Box 4.2: Key terminology

Closed treatment episode

An episode of treatment for alcohol and other drugs is the period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

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; or there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS for a reporting year if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy (through an opioid substitution therapy program) 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

The **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 the person using the substance themselves can accurately report principal drug of concern; therefore these data are not collected from those who seek treatment for someone else's drug use.

Additional drugs of concern refers 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, but these drugs are not necessarily the subject of any treatment within the episode.

All drugs of concern refers 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/planned completion: episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement
- ended due to unplanned completion: episodes where the client ceased to participate against advice, without notice or due to non-compliance
- referred to another service/change in treatment mode: 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 treatment for someone else's drug use.

(continued)

Box 4.2 (continued): Key terminology
The **main treatment type** is the principal activity that is determined at assessment by the treatment provider to be 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 be reported only 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.

Although there are many different drugs for which people receive treatment, the most common principal drugs of concern—alcohol, amphetamines, cannabis and heroin—have accounted for the large majority of services over time (Figure 4.1). Nationally, alcohol has been the most common principal drug of concern up to 2018–19, followed by cannabis up, until 2015–16, when amphetamines became the second most common principal drug of concern. Heroin has maintained its place as the fourth most common principal drug of concern. Due to this consistent trend, the focus of this chapter is on these drugs.

Where a person receives treatment or support for someone else's alcohol or drug use, the principal drug of concern is not collected. As a result, no information is presented in this chapter on treatment received by people for someone else's drug use.

Drugs of concern and treatment provided

In 2018–19, over 207,800 (95%) of closed treatment episodes provided were for clients receiving treatment for their own alcohol or drug use (Table SE.1; Box 4.1).

Clients' own drug use

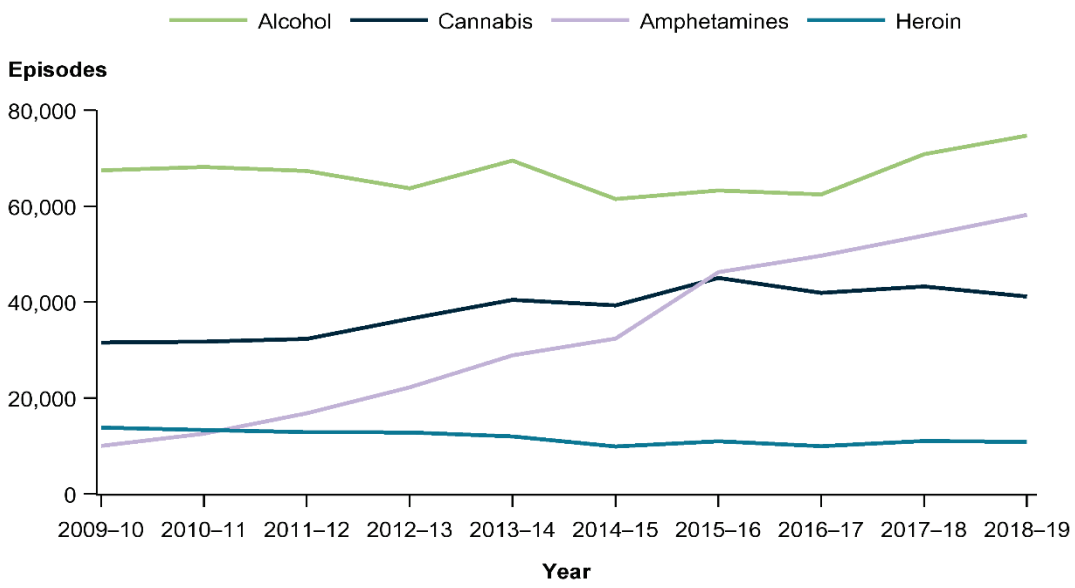
In 2018–19:

- the most common principal drugs of concern were alcohol (36% of episodes), amphetamines (28%), cannabis (20%) and heroin (5%)
- clients reported an additional drug of concern in over 2 in 5 (41%) episodes
- almost one-quarter (24%) of episodes had 1 additional drug of concern, 11% had 2 drugs, 4% had 3 drugs, 2% had 4 drugs, and 1% had 5 additional drugs of concern
- cannabis (17%) and nicotine (16%) were the most common additional drugs of concern (tables SD.6 and SD.8)
- the majority of closed treatment episodes for clients receiving treatment for their own alcohol or drug use were provided by non-residential treatment facilities (65%), followed by residential treatment facilities and outreach settings (both 15%) (*Outreach* includes any public or private location where services are provided away from the main service location, or a mobile service)
- episodes provided for the most common principal drugs of concern (alcohol, amphetamines, cannabis, and heroin) were most likely to be provided by non-residential treatment facilities (64%) (Table SD.12)
- nearly 4 in 5 (79%) episodes ended within 3 months. Around one-quarter (25%) of episodes ended within 1 day and over half (54%) ended within 1 month. Only 8% of episodes lasted 6 months or longer
- the median duration of closed treatment episodes was 23 days (tables SE.21–22).

Since 2009–10:

- the proportion of episodes where alcohol was the principal drug of concern decreased from 48% to 36%
- the proportion of episodes where amphetamines were the principal drug of concern increased (from 7% to 28%) (Table SD.9)
- counselling continues to be the most common main treatment type provided to clients for their own alcohol or drug use, comprising over one-third of episodes since 2009–10. However, since 2012–13, assessment only replaced withdrawal management and support and case management only as the next most common main treatment type (Table ST.4).

Figure 4.1: Closed treatment episodes for own alcohol or drug use, by selected principal drug of concern, 2009–10 to 2018–19



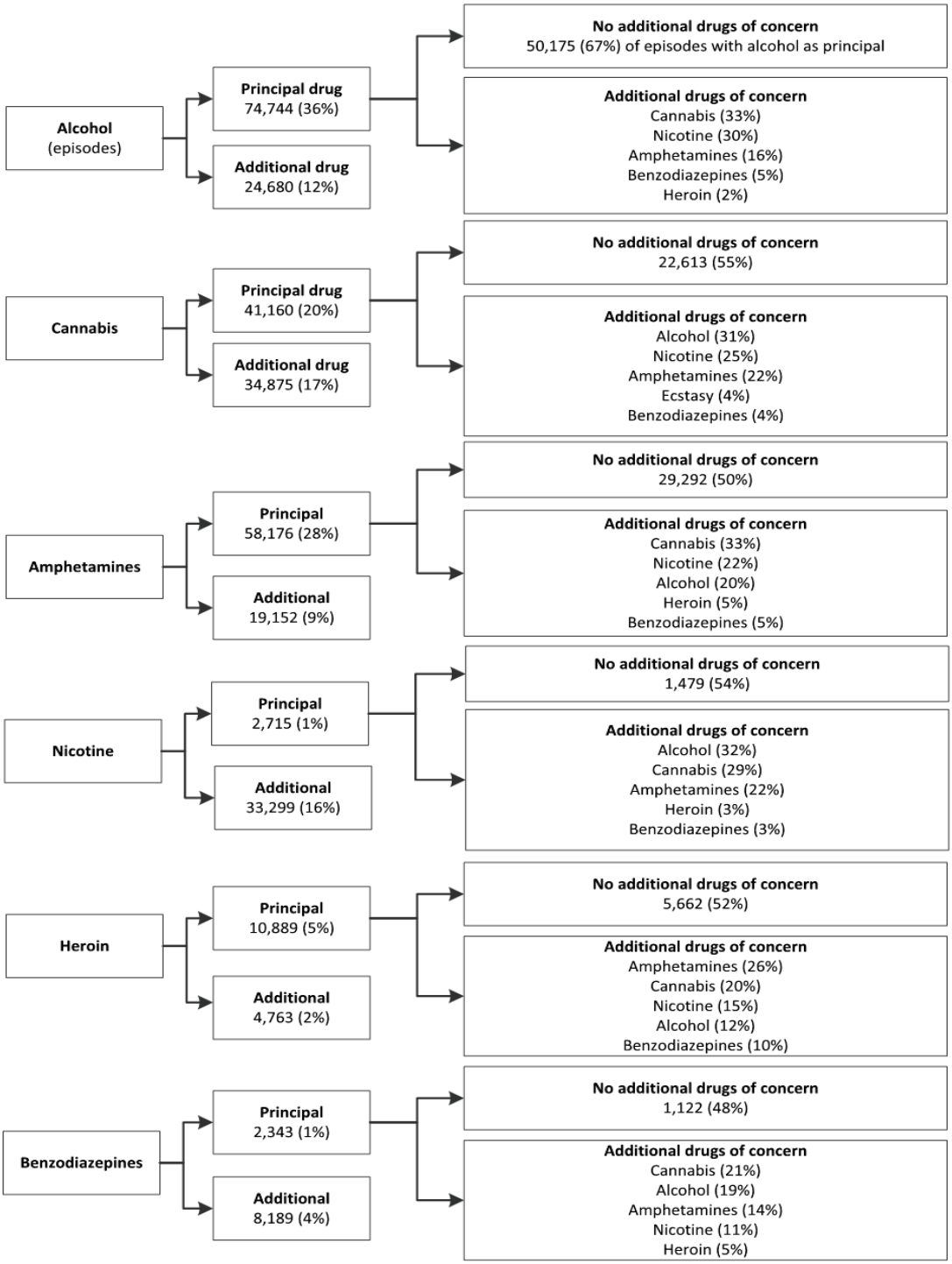
Source: Table SD.2.

Over the 10-year period to 2018–19, substantial shifts in treatment activity were reported (Figure 4.1). For example:

- the number of closed treatment episodes provided to clients receiving treatment for their own alcohol or drug use increased by 49% (from around 139,600 to over 207,800)
- the number of episodes provided for amphetamines as a principal drug of concern increased substantially—rising over 480% (from around 10,000 up to 58,200 episodes)
- treatment episodes provided for cannabis as a principal drug of concern increased by 30% (from 31,600 to 41,200 episodes)
- the number of episodes for heroin fell by 22% (from around 13,900 to 10,900)
- the number of treatment episodes for alcohol fluctuated during this time, but it still remained the top drug of concern nationally (Table SD.2).

Decreases or increases in certain principal drug episodes in particular years can be subject to administrative anomalies in the data. For example, the drop in all treatment episodes in the 2014–15 and 2016–17 collection years may be partly related to system changes resulting in under-reporting or partial reporting of the number of episodes in some jurisdictions.

Figure 4.2: Closed treatment episodes for own alcohol or drug use, by principal drug of concern and additional drugs of concern, 2018–19



Note: Totals might not add to 100% due to rounding.

Sources: Tables SD.6, SD.7 and SD.8.

4.1 Alcohol

In 2018–19, alcohol was a drug of concern (principal or additional) in 48% of closed episodes for a client's own alcohol or drug use and was the most common principal drug of concern (74,744 or 36% of all closed treatment episodes) (Figure 4.2; Table SD.8). At the client level alcohol was the most common principal drug of concern (34%).

In 33% of treatment episodes where alcohol was the principal drug of concern, the client reported additional drugs of concern. This was most commonly cannabis or nicotine (33% and 30%, respectively) (Figure 4.2; tables SD.6–7).

Box 4.3: 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. The NHMRC released revised draft guidelines in December 2019 which are expected to be finalised in the 3rd quarter of 2020.

Results from the 2016 National Drug Strategy Household Survey (AIHW 2017) showed that:

- about 77% 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 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 were more likely than females to drink at risky levels—1 in 6 (17%) aged 14 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 were more likely than females to drink at levels that placed them at risk of harm over their lifetime as well as on a single occasion.

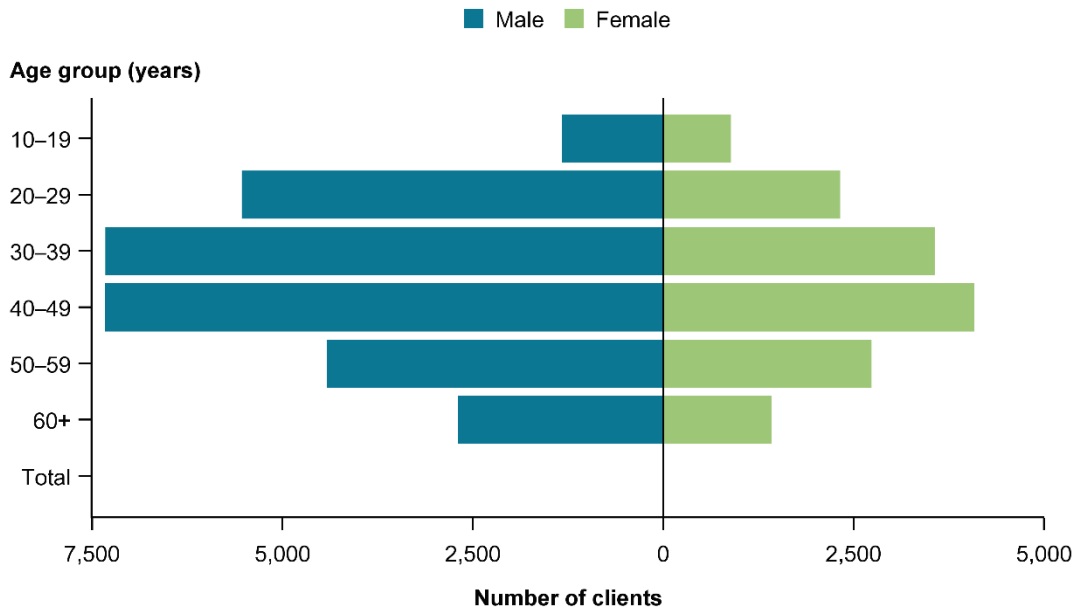
Client demographics

In 2018–19, around two-thirds of clients whose principal drug of concern was alcohol were male (65%) and 1 in 6 were Indigenous Australian people (17%) (tables SC.6 and SC.8).

For clients whose principal drug of concern was alcohol:

- the rate for Indigenous Australian clients receiving treatment fluctuated over the years from 1,434 per 100,000 people in 2014–15 to 1,249 per 100,000 people in 2018–19 (Table SCR.26)
- most clients were aged 40–49 (26% of clients), followed by 30–39 (25%) (Table SC.7)
- just over half (52%) of all clients were aged 40 or over (Figure 4.3).

Figure 4.3: Number of clients where alcohol was a principal drug of concern, by sex and age group, 2018–19



Note: Based on client records with a valid SLK.

Sources: Tables SC.6 and SC.7.

Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for alcohol as a principal drug of concern (tables SCY.1–36):

- 35% of clients received treatment for alcohol in both 2017–18 and 2018–19
  36% of clients received treatment for alcohol from 2016–17 to 2018–19 (3 years)
- 37% of clients received treatment for alcohol from 2015–16 to 2018–19 (4 years)
- 40% of clients received treatment for alcohol in all years from 2014–15 to 2018–19.

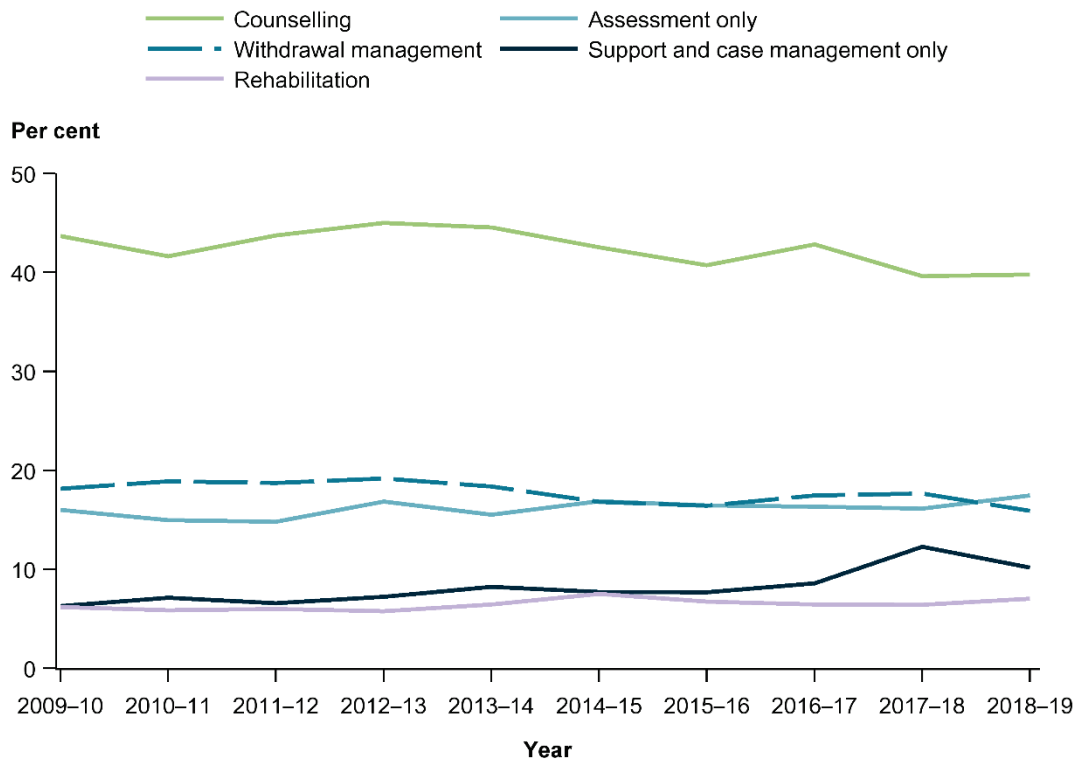
Treatment

Over the 10-year period to 2018–19, 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 4.4).

In 2018–19, for closed treatment episodes where alcohol was the principal drug of concern:

- the most common source of referral was self/family (43%), followed by a health service (37%) (Table SD.21)
- the most common main treatment type was counselling (40%), followed by assessment only (17%) and withdrawal management (16%)
- almost 2 in 3 treatment episodes for withdrawal management were for clients aged 40+ (65%) (Table SD.27).

Figure 4.4: Closed treatment episodes with alcohol as the principal drug of concern, by the top 5 treatment types received, 2009–10 to 2018–19



Source: Table SD.26.

Treatment setting and reason for cessation varied somewhat by treatment type and source of referral. For alcohol-related treatment episodes in 2018–19:

- most took place in a non-residential treatment facility (62%), with almost 1 in 5 (18%) occurring in a residential treatment facility
- treatment setting varied by treatment type: for example, most episodes (85%) with counselling as the main treatment type took place in a non-residential treatment facility, while 60% of episodes with withdrawal management as the main treatment type occurred in a residential facility (Table SD.28)
- more than half (53%) of closed treatment episodes lasted less than 1 month, and 21% ended within 1 day (Table SE.25)
- the median duration of episodes was over 3 weeks (26 days) (Table SD.33)
- almost two–thirds (62%) of episodes ended with a planned cessation, while 21% ended unexpectedly; that is, the client ceased to participate against advice, without notice or due to non-compliance
- both planned (44%) and unexpected cessations (47%) were most common where the referral source was self/family (Table SD.29).

For more information on the groupings for reasons for cessation of treatment, see Appendix A (Table A3).

4.2 Cannabis

In 2018–19, cannabis was a drug of concern (principal or additional) in 37% of episodes and was the third most common principal drug of concern (over 41,100 closed treatment episodes for a client's own drug use, or 20% of clients) (Figure 4.2; tables SD.6 and SD.8).

In almost half (45%) of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern (Table SD.6). This was most commonly alcohol (31%), nicotine (25%) or amphetamines (22%) (Figure 4.2; Table SD.7).

Box 4.4: Cannabis

Cannabis (also called 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 dependence, 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 (NCPIC 2011). According to the 2016 National Drug Strategy Household Survey (AIHW 2017), 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.

Diversion treatment programs

Among diversion clients, diversion episodes are most likely to be for cannabis, followed by amphetamines, alcohol, and heroin (Figure 4.6). Throughout Australia, there are programs that divert people who were apprehended or sentenced for a minor drug offence from the criminal justice system. Many of these diversions result in people receiving drug treatment services. Services vary widely, ranging from short-term assessment, information or education sessions to longer term treatments such as counselling and withdrawal management, which are supported by Australian Government funding and a national framework. Diversion programs in the states and territories have led to the development of systematic approaches to diversion. Some states and territories have also incorporated their own additional drug diversion programs that have different priorities and target groups, including cannabis expiation notice schemes, youth programs and alcohol-related offenders, which have changed over time due to legislative, regulatory and policy frameworks related to drugs and drug use.

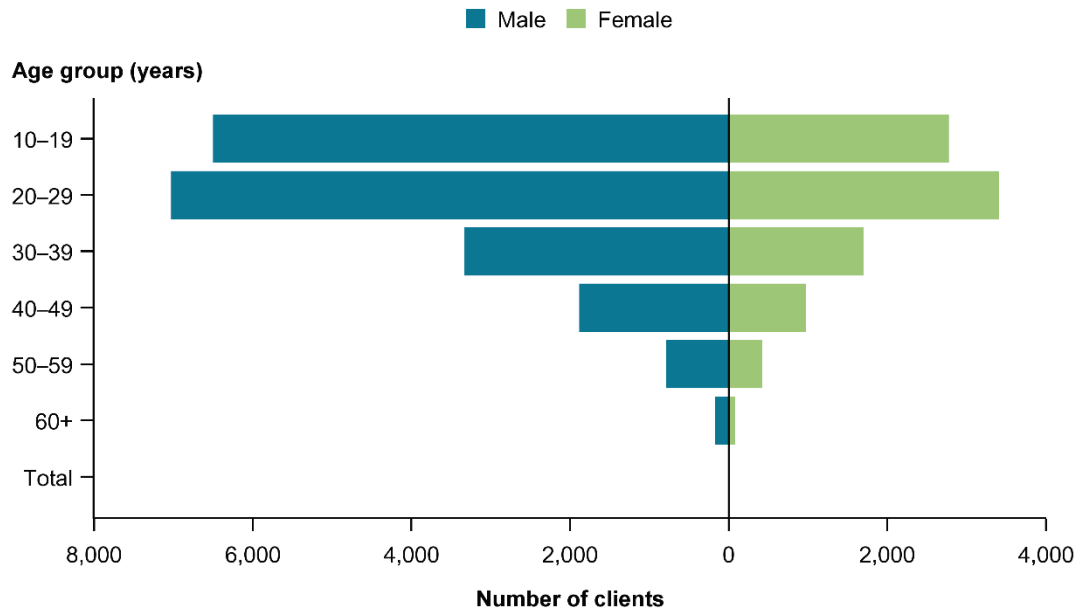
Client demographics

In 2018–19, where cannabis was the principal drug of concern, over two-thirds (68%) of clients were males and nearly 1 in 5 were Indigenous Australian people (19%) (tables SC.6 and SC.8).

For clients whose principal drug of concern was cannabis:

- the rate for Indigenous Australian clients receiving treatment increased over the years from 832 per 100,000 people in 2014–15, to 927 per 100,000 people in 2018–19 (Table SCR.26)
- over two-thirds (68%) of clients were aged 10–29 (Table SC.7)
- male (68%) and female (64%) clients with cannabis as their principal drug of concern were most likely to be aged 10–29 (Figure 4.5).

Figure 4.5: Number of clients where cannabis was a principal drug of concern, by sex and age group, 2018–19



Note: Based on client records with a valid SLK.

Sources: Tables SC.6 and SC.7.

Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for cannabis as a main drug of concern (tables SCY.1–36):

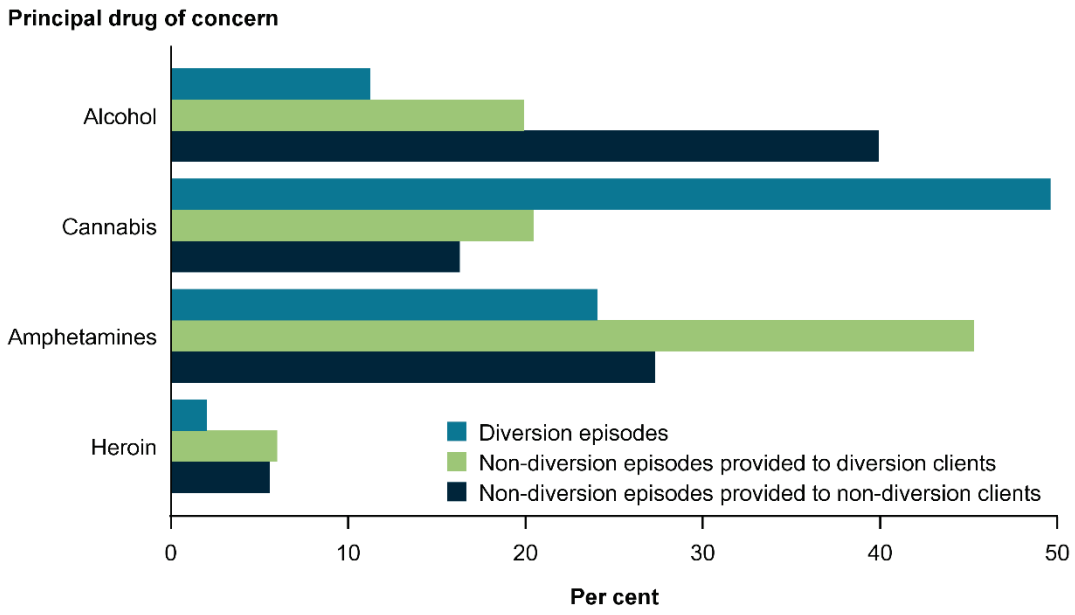
- 16% of clients received treatment for cannabis in both 2017–18 and 2018–19
- 13% of clients received treatment for cannabis from 2016–17 to 2018–19 (3 years)
- 11% of clients received treatment for cannabis from 2015–16 to 2018–19 (4 years)
- 9.6% of clients received treatment for cannabis in all years from 2014–15 to 2018–19.

Treatment

In 2018–19, for episodes where cannabis was the principal drug of concern:

- the most common sources of referral were diversion (that is, referred from the criminal justice system into AOD treatment for drug or drug-related offences) and self/family (both 28%) (Table SD.37)
- over half (50%) of all episodes arising from treatment referrals diverted from the criminal justice system related to cannabis (Figure 4.6)
- some diversion clients also received treatment episodes where the source of referral was not related to diversion within the same year, such as amphetamines (24% of episodes for diversion only and 45% receiving diversion and non-diversion treatment episodes) (see Glossary and Appendix A) (Figure 4.6; Table SE.27)
- counselling was the most common main treatment type (38%), followed by information and education only (20%) (Table SD.42).

Figure 4.6: Closed treatment episodes, by selected principal drug of concern and diversion client type, 2018–19



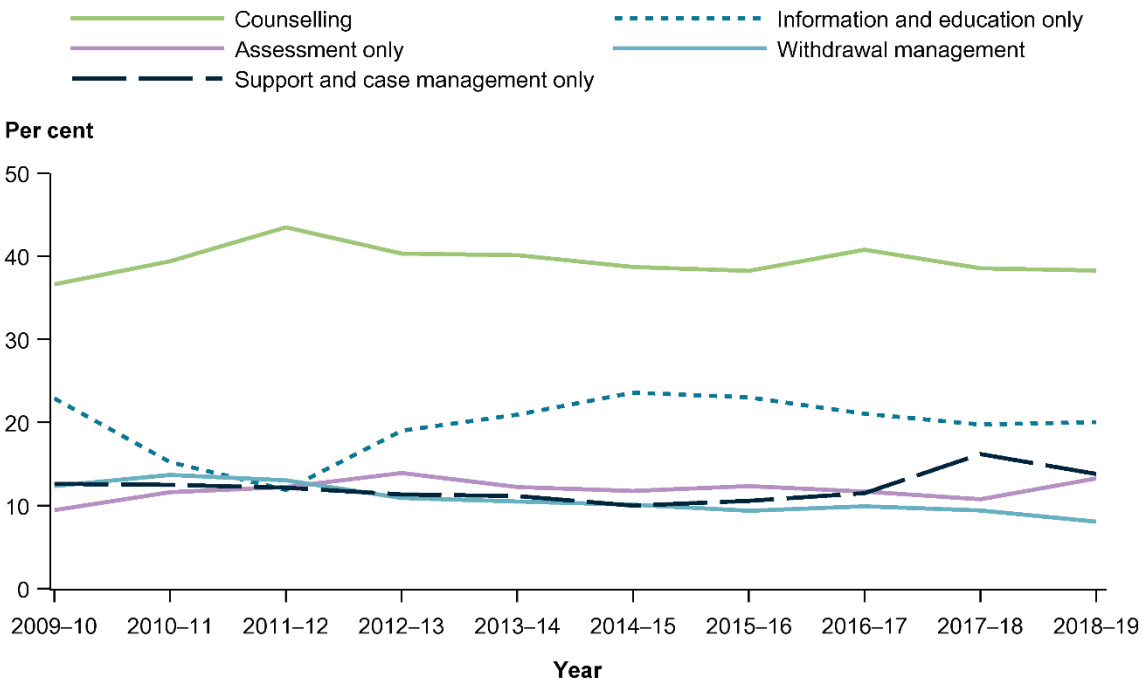
Source: Table SE.27.

For treatment episodes where cannabis was the principal drug of concern in 2018–19:

- treatment was most likely to take place in a non-residential treatment facility (68%)
- most (81%) episodes where counselling was the main treatment type took place in a non–residential treatment facility (Table SD.44)
- almost 3 in 5 (58%) episodes lasted less than 1 month, and 34% ended within 1 day (Table SE.25)
- the median duration of a treatment episode was 17 days (Table SD.47)
- treatment duration varied by treatment type: support and case management as the main treatment type had a median duration of 7 weeks (50 days), rehabilitation lasted around 5 weeks (33 days), and the median duration for counselling was 8 weeks (57 days)
- information and education only/assessment only had the shortest duration (1 day)
- almost three–quarters (69%) of closed episodes ended with an expected cessation; where clients were diverted from the criminal justice system, almost two-fifths (38%) of episodes ended with an expected cessation
- almost 1 in 5 (19%) episodes ended unexpectedly (Table SD.45).

Since 2009–10, counselling has remained the most common form of treatment, accounting for around 40% of treatment episodes annually, followed by information and education only increasing as a result of diversion programs (Figure 4.7; Table SD.42).

Figure 4.7: Closed treatment episodes with cannabis as the principal drug of concern, by the top 5 treatment types received, 2009–10 to 2018–19



Source: Table SD.42.

4.3 Amphetamines

In 2018–19, amphetamines were a drug of concern (principal or additional) in 37% of closed treatment episodes (Figure 4.2; Table SD.8). Amphetamines were the second most common principal drug of concern for the fourth consecutive year (28% of treatment episodes and 27% of clients), having surpassed cannabis for the first time in 2015–16 (over 46,200 episodes) and increasing to around 58,200 episodes in 2018–19 (Figure 4.2; Table SD.8).

Box 4.5: 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 2016 National Drug Strategy Household Survey (AIHW 2017), 1 in 16 (6.3%) Australians aged 14 and over have used meth/amphetamines for non-medical purposes at some point in their lifetime, while 1 in 70 (1.4%) have used them in the previous 12 months.

The AODTS NMDS data available for amphetamines correspond to the Australian Standard Classification of Drugs of Concern (ASCDC) for the general 'amphetamines' classification, in which methylamphetamine is a sub-classification. Data on different forms of amphetamines—methylamphetamine specifically—have not been separately reported over time due to the nature of the classification structure used in this collection. This report provides information on methylamphetamines as a principal drug of concern for the first time.

A client's usual method of administering their principal drug of concern can provide an indication of the form a client used, particularly for amphetamines. For example, those smoking (clients who report either smoking or inhaling amphetamines) are most likely to be using the crystal form, and those ingesting or snorting are most likely to be using the powder form. For clients injecting amphetamines, it is less clear as each of the base, crystal, powder, or liquid forms, can all be injected. But, according to the most recent data from the IDRS, of injecting users who were injecting methamphetamines, crystal was the form most often used in the month preceding interview (NDARC 2019).

According to the 2016 National Drug Strategy Household Survey (AIHW 2017), the proportion of the adult population using methamphetamine fell from 2.1% in 2010 to 1.4% in 2016. However, among recent consumers of methamphetamine, there was a change in the main form used, with a significant increase in the use of crystal methamphetamine or 'ice' (from 22% to 57% over the same period).

Box 4.6: Reporting methamphetamine over time

The Australian Standard Classification of Drugs of Concern, 2011 (ASCDC, ABS 1248.0) is set up with 3 levels of classification; which include the broad group e.g. *Stimulants and hallucinogens*, narrow group and base-level categories, which are the most detailed.

Data available in the AODTS NMDS reports the narrow group 'amphetamines' classification. Base-level categories within this narrow group include:

- Amphetamine
- Dexamphetamine
- Methamphetamine

(continued)

- Amphetamine analogues
- Amphetamines, not elsewhere classified (nec)
- Amphetamines, not further defined (nfd).

Changes to coding for methamphetamines has been difficult due to jurisdictional differences in client management systems, and the use of only broad or narrow group coding by some agencies. This has improved over time due to advancements in workforce training, agency coding practices and new system updates.

In 2018–19, where amphetamines were the principal drug of concern:

- almost two thirds (66% or 38,470 episodes) of treatment episodes within the amphetamines group were for methamphetamines as a principal drug of concern
- smoking/inhaling was the most common usual method of use (51% of episodes) for amphetamines, followed by injecting (39%) (Table SD.55)
- smoking/inhaling was the most common usual method of use (50% of episodes) for methamphetamines only, followed by injecting (42%).

Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode. In 2018–19, where amphetamines were the principal drug of concern:

- clients reported additional drugs of concern in half (50%) of episodes
- additional drugs of concern were most commonly cannabis (33%), nicotine (22%) and alcohol (20%) (Figure 4.2; tables SD.6–SD.7).

Over the 10-year period to 2018–19:

- the number of treatment episodes for amphetamines increased nearly 6-fold (10,000 episodes to 58,200 episodes nationally) (Table SD.2)
- almost two thirds (66% or 38,470) of closed treatment episodes within the amphetamines group were for methamphetamines only, increasing from 12% (1,243 episodes) in 2009–10 and 50% (24,733 episodes) in 2016–17 (table 4.1)
- reporting for amphetamines *not further defined* (nfd) decreased; from 2009–10 to 2014–15, amphetamines nfd contained the largest proportion of episodes for the amphetamines group (due to some client management systems not set up to report methamphetamines as a base level category) (table 4.1)
- reporting for methamphetamines increased over the same period.

The rise in reported episodes for methamphetamines can be attributed to a combination of factors including improvements in agency coding practices for methamphetamines, treatment system updates and increases in funded treatment services (table 4.1).

Table 4.1: Closed treatment episode proportions for Amphetamine (ASCDC) base-line groups, 2009–10 to 2018–19 (per cent)

	2009–10	2010–11	2011–12	2012–13	2013–14	2014–15	2015–16	2016–17	2017–18	2018–19
Amphetamines nfd	**82.9**	**82.2**	**70.2**	**68.3**	**51.4**	**47.1**	41.3	40.6	41.2	25.7
Methamphetamine	12.4	12.2	16.5	18.2	24.8	36.9	**45.8**	**49.8**	**51.4**	**66.1**
Other amphetamines	4.7	5.7	13.3	13.5	23.8	16.0	12.8	9.6	7.4	8.2
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

Note: Other amphetamine category includes Amphetamine analogues, Dexamphetamine, Amphetamines not elsewhere classified.

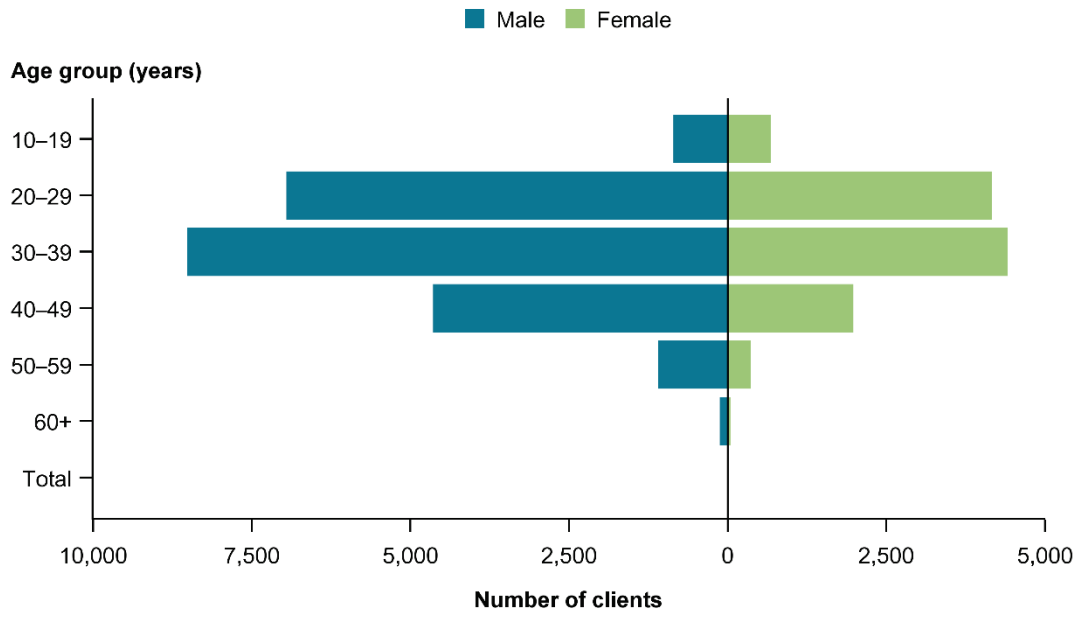
Client demographics

In 2018–19, almost two-thirds of clients receiving treatment for amphetamines as a principal drug of concern were male (65%) and about 1 in 6 (17%) clients were Indigenous Australian people (tables SC.6 and SC.8).

For clients whose principal drug of concern was amphetamines:

- the rate for Indigenous Australian clients receiving treatment steadily increased over the years from 2014–15 (530 per 100,000 people) to 2018–19 (1,014 per 100,000 people)
- while a small number of amphetamine-related episodes (5,809) for Indigenous Australian clients were reported nationally, this represents a relatively large proportion of the Indigenous Australian population across Australia (Table SC.8)
- most clients were aged 20–39 (71%), followed by those aged 40–49 (20%) (Table SC.7)
- male (71%) and female (76%) clients with amphetamines as their principal drug of concern were most likely to be aged 20–39 (Figure 4.8).

Figure 4.8: Number of clients with amphetamines as the principal drug of concern, by age group (years) and sex, 2018–19



Note: Based on client records with a valid SLK.

Sources: Tables SC.6 and SC.7.

Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for amphetamines as a principal drug of concern (tables SCY.1–36):

- 32% of clients received treatment for amphetamines in both 2017–18 and 2018–19
- 34% of clients received treatment for amphetamines from 2016–17 to 2018–19 (3 years)
- 33% of clients received treatment for amphetamines from 2015–16 to 2018–19 (4 years)
- 30% of clients received treatment in all years from 2014–15 to 2018–19.

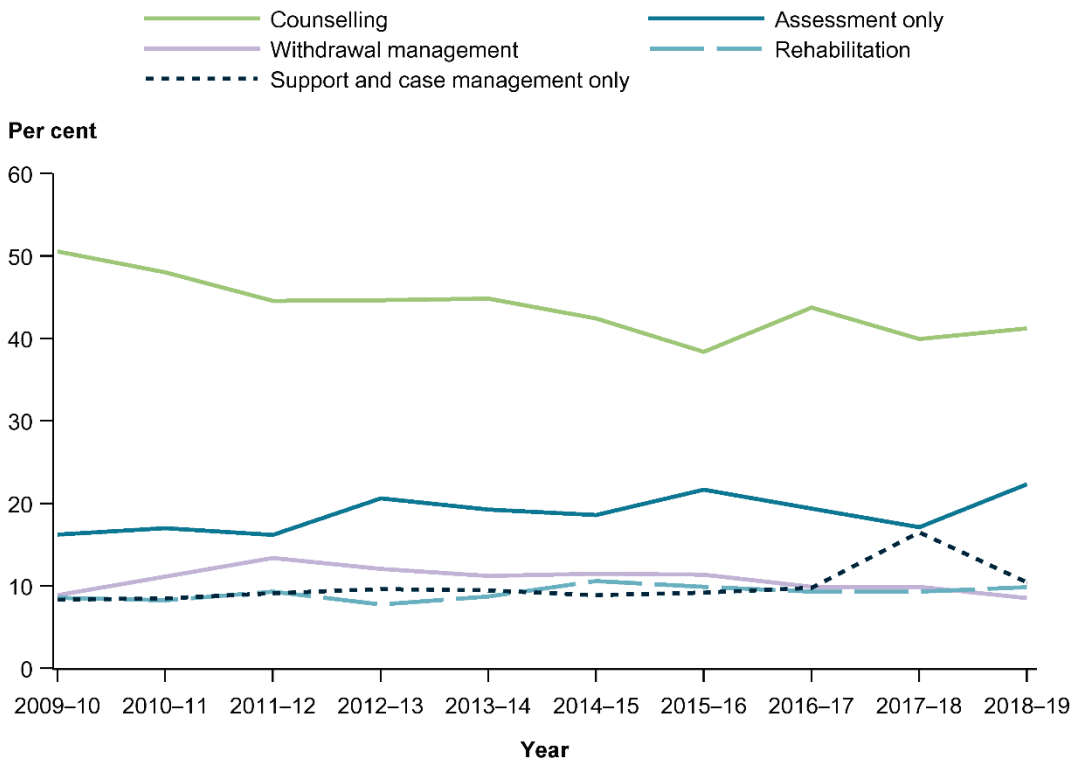
Treatment

In 2018–19, for treatment episodes where amphetamines were the principal drug of concern:

- the most common source of referral was self/family (38%), followed by health services (25%), and diversion (13%) (Table SD.53)
- over one-quarter (28%) of all episodes arising from treatment referrals diverted from the criminal justice system related to amphetamines (SD.13)
- the most common main treatment type was counselling (41% of episodes), followed by assessment only (22%), and support and case management (10%)
- treatment was most likely to take place in a non-residential treatment facility (63% of episodes) (Tables SD.58 and SD.60).

Over the 10-year period to 2018–19, the proportion of episodes where counselling was the main treatment type for amphetamines as the principal drug of concern peaked at 51% in 2009–10, falling to 41% in 2018–19 (Figure 4.9; Table SD.58).

Figure 4.9: Closed treatment episodes with amphetamines as the principal drug of concern, by the top 5 treatment types received, 2009–10 to 2018–19



Source: Table SD.58.

For treatment episodes where amphetamines were the principal drug of concern in 2018–19:

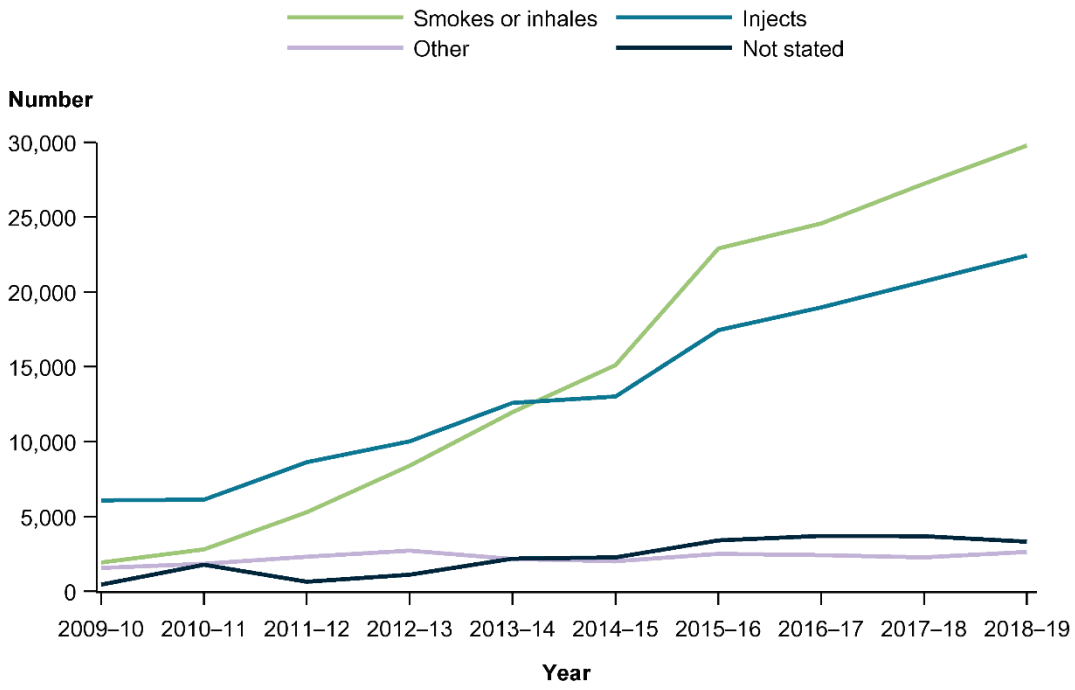
- over half (52%) of the episodes lasted less than 1 month (21% ended within 1 day) (Table SE.25)
- the median duration of episodes was 4 weeks (28 days) (Table SE.23)
- episode duration varied widely depending on the main treatment type—episodes with a main treatment type of counselling had a median duration of 9 weeks (63 days), rehabilitation had median duration of just under 6 weeks (39 days) and most episodes with withdrawal management ended within 1 week (7 days) (Table SD.64)
- over half (54%) of episodes ended with an expected cessation
- expected cessations were most common for episodes where self/family was the referral source (38%)
- around one-quarter (26%) of episodes ended unexpectedly (Table SD.61).

Over the 10-year period to 2018–19, the number of episodes for clients smoking/inhaling amphetamines increased over 15-fold, from 1,900 episodes in 2009–10 to 29,800 episodes in 2018–19. Similarly, the number of episodes where clients injected amphetamines increased from 1,800 to 22,400 (Table SD.55, Figure 4.10).

Injecting as a method of use for amphetamines has been rising since 2011–12, which may be attributed to patterns arising from an increase in the availability of crystal methamphetamines,

as well as an increase in treatment episodes, and for injecting clients who might have been using amphetamines and heroin interchangeably (AIHW 2015).

Figure 4.10: Closed treatment episodes for own drug use with amphetamines as the principal drug of concern, by method of use, 2009–10 to 2018–19



Note: 'Other' includes 'ingests', 'sniffs' and 'other'.

Source: Table SD.55.

4.4 Heroin

In 2018–19, heroin was a drug of concern (principal or additional) in 7% of closed treatment episodes and was reported in 5% of episodes as a principal drug of concern. This made it the 4th most common principal drug of concern (around 10,900 closed treatment episodes and 5% of clients) (Figure 4.2; tables SC.6 and SD.8).

In almost half (48%) of episodes with heroin as the principal drug of concern, the client reported one or more additional drugs of concern. This was most commonly amphetamines (26%) and cannabis (20%) (tables SD.6–7).

Box 4.7: Heroin

Heroin is an opioid drug; opioids 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).

People who seek treatment for heroin use can take part in 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 2016 National Drug Strategy Household Survey showed that:

- 1.3% of people in Australia aged 14 and over had used heroin in their lifetime and 0.2% had used it in the previous 12 months.
- there was no significant change in the proportion of people using heroin between 2013 and 2016 (AIHW 2017).

Results from the 2019 National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection reported that clients receive pharmacotherapy treatment for a range of opioid drugs. These include illicit opioids (such as heroin) and pharmaceutical opioids available by prescription (such as oxycodone) or through illicit means. From 1 February 2018, all formerly over-the-counter (non-prescription) codeine-containing medicines for pain relief, cough and colds became available by prescription only.

Data for opioid drug of dependence has a high proportion of clients with 'Not stated/not reported' as their opioid drug of dependence (39% of clients in 2019). High rates of 'Not stated/not reported' were shown in New South Wales (64%), Victoria (34%) and the Australian Capital Territory (25%).

For the 61% of clients with a reported opioid drug of dependence, heroin was the most commonly reported drug of dependence (60%) followed by oxycodone (10%) and buprenorphine (7%). Heroin was the most common drug of dependence in all states and territories, except Tasmania and the Northern Territory, where morphine was the most common (AIHW 2020).

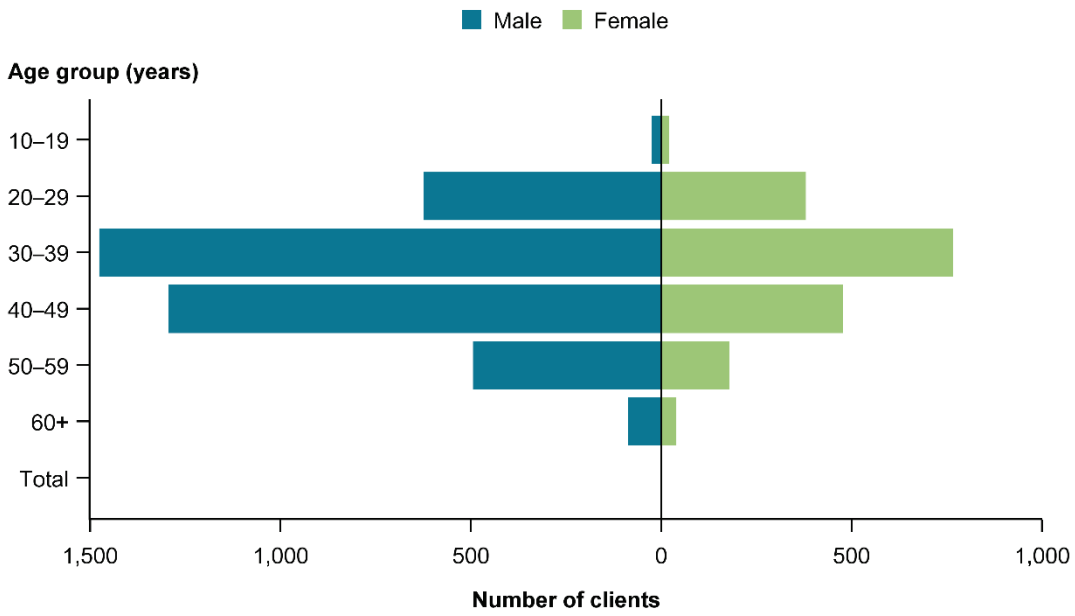
Client demographics

Where heroin was the principal drug of concern, 68% of clients were male and 16% were Indigenous Australian people (tables SC.6 and SC.8).

For clients whose principal drug of concern was heroin:

- the rate for Indigenous Australian clients receiving treatment increased slightly over the years from 2014–15 (133 per 100,000 people) to 2018–19 (172 per 100,000 people)
- most clients with heroin as their principal drug of concern were aged 30–39 (38%), followed by those aged 40–49 (30%) and 20–29 (17%) (Table SC.7)
- male (72%) and female (71%) clients with heroin as their principal drug of concern were most likely to be aged 30–49 (Figure 4.11).

Figure 4.11: Number of clients with heroin as the principal drug of concern, by age group (years) and sex, 2018–19



Note: Based on client records with a valid SLK.

Sources: Tables SC.6 and SC.7.

Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for heroin as a main drug of concern (tables SCY.1–36):

- 6.3% of clients received treatment for heroin in both 2017–18 and 2018–19
- 7.4% of clients received treatment for heroin from 2016–17 to 2018–19 (3 years)
- 8.6% of clients received treatment for heroin from 2015–16 to 2018–19 (4 years)
- 9.4% of clients received treatment for heroin in all years from 2014–15 to 2018–19.

Treatment

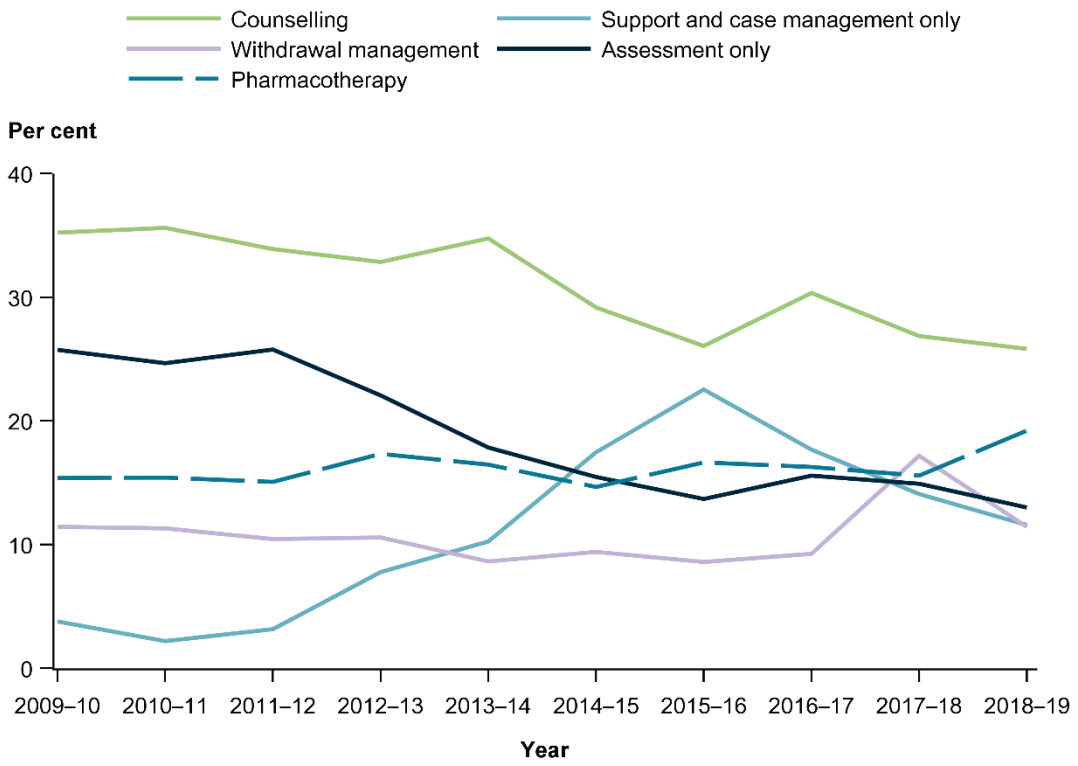
In 2018–19, for treatment episodes where heroin was the principal drug of concern:

- the most common source of referral was self/family (45%), followed by a health service (29%), and correction programs and diversion (both 6%) (Table SD.85)
- the most common main treatment types were counselling (26%), followed by assessment only (19%) and pharmacotherapy (12%) (Table SD.90)
- treatment episodes were most likely to take place in a non-residential treatment facility (69%) (Table SD.92).

Over the 10-year period to 2018–19, the proportion of episodes with withdrawal management as the main treatment type decreased by half (from 26% to 13%), with pharmacotherapy treatment episodes increasing from 4% to 12% (Figure 4.12; Table SD.90). The decrease in 2015–16 for pharmacotherapy treatment can be attributed to jurisdictional coding practices/system changes resulting in under-reporting at the national level for pharmacotherapy as a treatment type.

The increase in the proportions for pharmacotherapy is mostly due to changes in the AODTS NMDS reporting specifications introduced for the first time in 2011–12 to allow pharmacotherapy to be reported as a main treatment, in combination with some other form of treatment.

Figure 4.12: Closed treatment episodes with heroin as the principal drug of concern, by the top 5 treatment types received, 2009–10 to 2018–19



Source: Table SD.90.

For treatment episodes where heroin was the principal drug of concern in 2018–19:

- injecting was the most common method of use (79% of episodes) (Table SD.87)
- around 3 in 5 (60%) episodes, the client reported they had injected drugs in the previous 3 months, while 10% reported they last injected 3–12 months ago (Table SD.88)
- more than half (55%) of the episodes lasted less than 1 month and 24% ended within 1 day; these were mostly for the main treatment types of assessment only, information and education only, and counselling (Table SE.25)
- the median duration of episodes was just under 3 weeks (19 days)
- episodes with counselling as the main treatment lasted about 9 weeks (65 days), while episodes with support and case management lasted just over 2 weeks (15 days) (Table SD.96)
- almost 3 in 5 (59%) episodes ended with an expected cessation (Table SD.93).

Over the 10-year period to 2018–19, the proportion of episodes where heroin was the principal drug of concern halved, falling from 10% to 5% (Table SD.2).

4.5 Pharmaceuticals

In 2018–19, pharmaceutical drugs were reported as drugs of concern (principal or additional) in 13% of all episodes and were reported in up to 5% of episodes as a principal drug of concern for a client's own use (around 9,800 of closed treatment episodes) (Table SD.9). Pharmaceuticals were more likely to be reported as an additional drug of concern in closed treatment episodes (8% of episodes).

In almost half (48%) of episodes with pharmaceutical drugs as the principal drug of concern, the client reported additional drugs of concern. This was most commonly cannabis (17%), amphetamines (16%) and nicotine (14%) (Tables SD.6–7). Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode.

Box 4.8: Pharmaceuticals

Pharmaceuticals are drugs that are available from a pharmacy—over the counter or by prescription—which may be subject to misuse (MCDS 2011). Results from the National Drug Strategy Household Survey showed that in 2016 just under 1 in 20 (4.8%) Australians reported misuse, non-medical, or extra-medical use of a pharmaceutical in the last 12 months (pain-killers/analgesics and other opioids, tranquillisers/sleeping pills, steroids, or methadone/buprenorphine) (AIHW 2017). Pharmaceuticals are not listed as a broad drug group in the ASCDC classification. In the AODTS NMDS report, 10 drug types were identified as making up the group 'pharmaceuticals' for the purposes of this analysis: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics. Further information corresponding to the Australian Standard Classification of Drugs of Concern (ASCDC) codes and classifications is in Appendix A. Of these drugs, the most common classes are benzodiazepines and opioids (e.g., codeine). In February 2018, medicines containing codeine were no longer sold over-the-counter in pharmacies and were available by prescription only.

Opioids

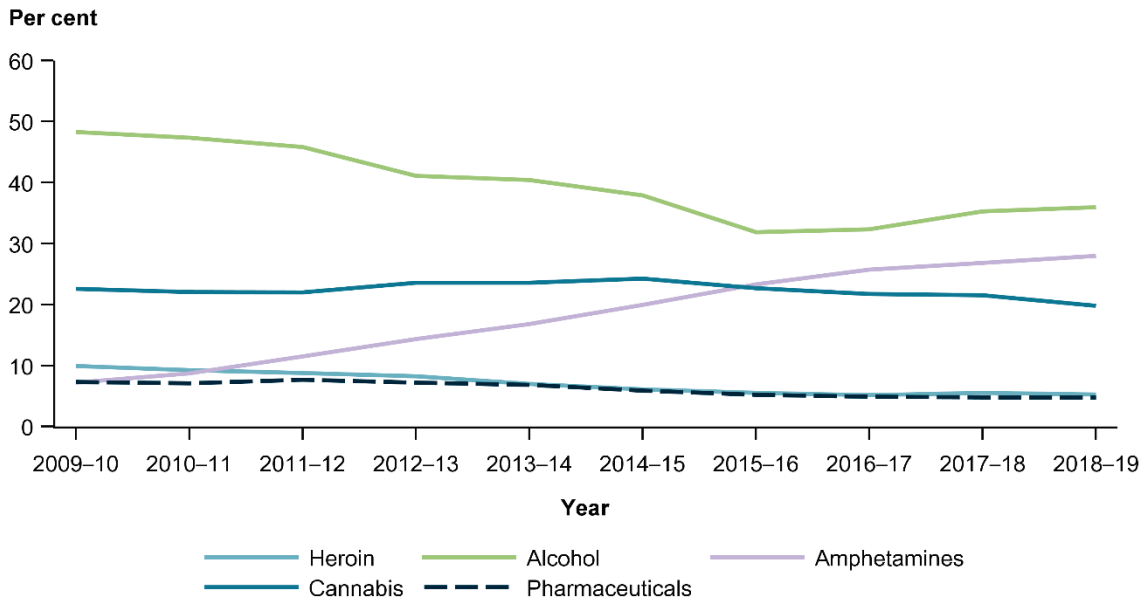
Opioids are a class of depressant drugs originally derived from the opium poppy, including both heroin and medicinal (pharmaceutical) opioids such as morphine and oxycodone. Pharmaceutical opioids are commonly prescribed for pain relief as they have strong analgesic effects; however, these drugs also produce effects including sedation and euphoria, and can be associated with negative health outcomes such as dependence and overdose (ADF 2020). Some people may purchase opioids illegally, or use their own medicine to become intoxicated; for example, by taking a higher dose than recommended.

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 people who use opioids. Some people use benzodiazepines illegally to become intoxicated or to come down from the effects of stimulants, such as amphetamines or cocaine (ADF 2013).

Over the 10-year period to 2018–19, the proportion of treatment episodes with a pharmaceutical drug as the principal drug of concern increased from 7% in 2009–10 to 8% in 2011–12, and then fell to 5% in 2018–19 (Figure 4.13).

Figure 4.13: Proportion of closed treatment episodes for the top 5 principal drugs of concern, 2009–10 to 2018–19 (%)



Source: Table SD.9

In 2018–19:

- among treatment episodes with a pharmaceutical as the principal drug of concern, the most common single drug type was benzodiazepines and the most common drug class was opioids (codeine, morphine, buprenorphine, methadone, oxycodone, and other opioids)
- opioids were the principal drug of concern in 3% of all treatment episodes (5,358 episodes) and an additional drug of concern in 3% of episodes (6,374)
- benzodiazepines were a principal drug of concern in 1% of all treatment episodes (2,343) and an additional drug of concern in 4% of episodes (8,189).

In 2018–19, among treatment episodes with a pharmaceutical drug as the principal drug of concern:

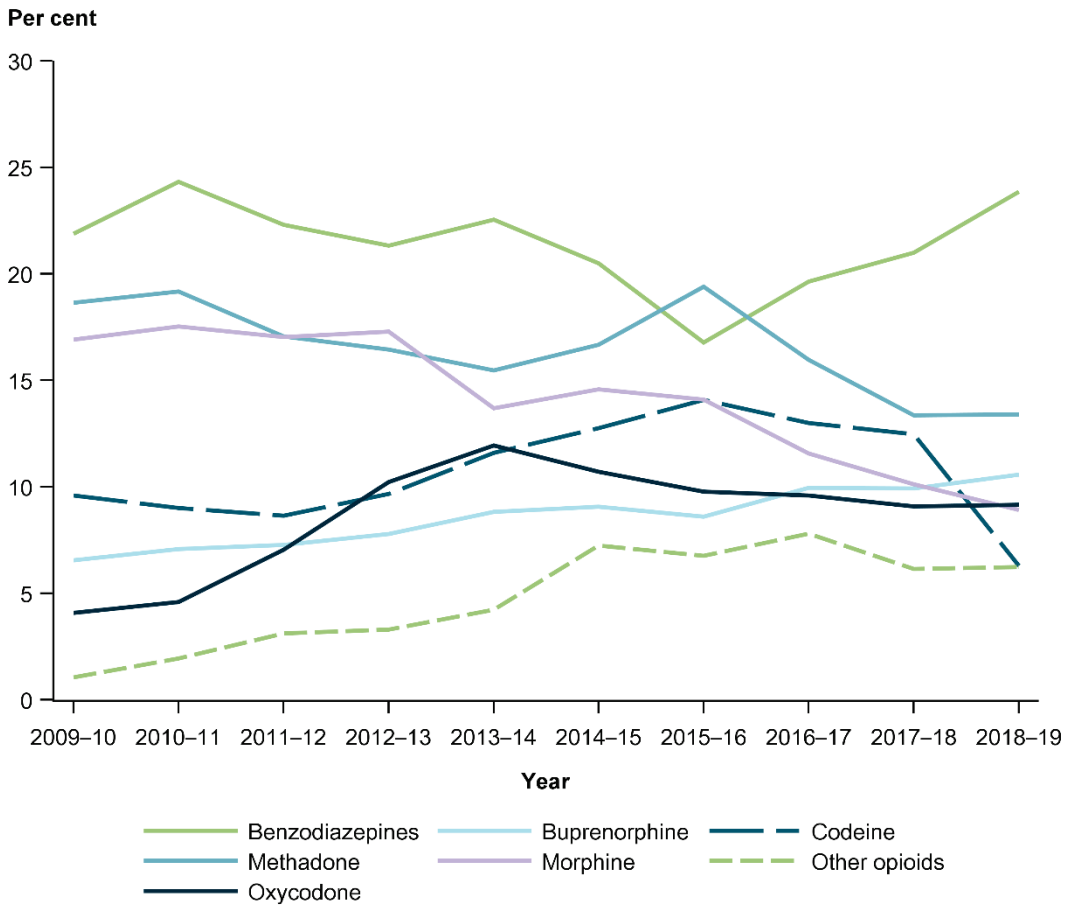
- opioids accounted for over half (55%) of treatment episodes
- one-quarter (25%) of closed episodes were for benzodiazepines and 13% were for methadone and buprenorphine, respectively (Figure 4.14; Table SD.146).

From 2009–10 to 2018–19:

- the proportion of episodes with benzodiazepines as the principal drug decreased by 1 percentage point (Table SD.9)
- the most common principal drugs of concern in combination with benzodiazepines as an additional drug of concern were cannabis (21%), alcohol (19%) and amphetamines (14%) (Table SD.7)
- treatment episodes for codeine decreased from 981 episodes in 2009–10 to 618 in 2018–19. The number of codeine episodes peaked in 2015–16 (1,448 episodes) and has then steadily declined, almost halving from 2017–18 (1,203) to 2018–19 (618)

- oxycodone treatment episodes more than doubled from 4% in 2009–10 to 9% in 2018–19, though this has steadily declined since 2013–14 (12%)
- treatment episodes for methadone fell from 19% to 13%, and for morphine decreased from 17% to 9% (Figure 4.14; tables SD.9 and Table SD.146).

Figure 4.14: Proportion of closed treatment episodes for selected pharmaceutical drugs of concern, 2009–10 to 2018–19 (%)



Source: Table SD.9.

Client demographics

Where pharmaceuticals were the principal drug of concern in 2018–19, two-thirds (66%) of the clients were male and around 1 in 8 were Indigenous Australians (16%). Where the principal drug of concern was benzodiazepines, around 3 in 5 (60%) clients were male, and 6% were Indigenous Australians (Tables SC.6 and SC.8).

For clients whose principal drug of concern was a pharmaceutical drug:

- female clients were more likely to report specific pharmaceutical drug types than male clients; for example, a higher proportion of female (55%) than male clients (45%) received treatment for codeine as their principal drug of concern (Table SC.6)

- the most common age group for clients seeking treatment for pharmaceuticals as a principal drug of concern were aged 30–39 (31%), followed by clients aged 40–49 (24%) and 20–29 (21%) (Table SC.7)
- around 3 in 5 clients (62%) with benzodiazepines as the principal drug of concern were aged over 30 years (table SC.7).

Treatment

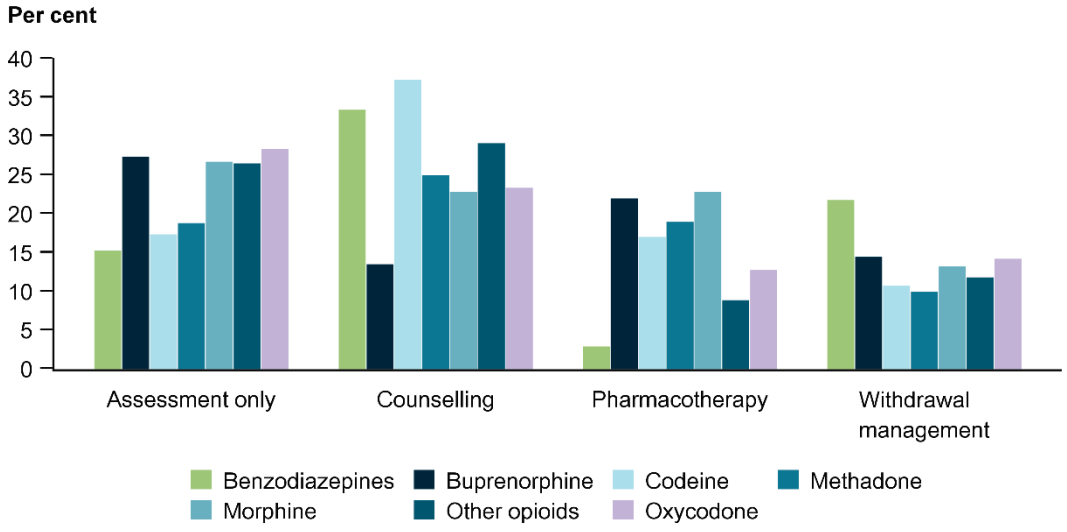
In 2018–19, for treatment episodes where pharmaceuticals were the principal drug of concern:

- around 2 in 5 referrals were from self/family (44%), followed by a health service (41%) (Table SD.149)
- the most common main treatment type was counselling (27%), followed by assessment only (21%), withdrawal management (14%), followed by pharmacotherapy (11%) (Table SD.148).

The relative proportions of treatment episodes for each main treatment type by individual pharmaceuticals varied substantially. For example:

- over 1 in 3 episodes with counselling as the main treatment type were for benzodiazepines (33%) and codeine (37%)
- where the main treatment was withdrawal management, the most common principal drug of concern was benzodiazepines (36%), followed by buprenorphine (11%)
- the principal drugs where pharmacotherapy was a main treatment ranged from 3% for benzodiazepines, 22% for buprenorphine and 23% for morphine (Figure 4.15)
- benzodiazepines had the highest proportion of episodes for assessment only (17%); in 2017–18, oxycodone (32%, down to 12% in 2018–19) accounted for the highest proportion of episodes for assessment only (Figure 4.15; Table SD.148).

Figure 4.15: Proportion of main treatment type for selected pharmaceuticals as the principal drug of concern, 2018–19 (%)



Source: Table SD.148

For treatment episodes where pharmaceuticals were the principal drug of concern in 2018–19:

- clients were more likely to have ever injected a pharmaceutical drug (21%) than for treatment episodes for most other drugs of concern (16%) (Table SD.10)
- in almost one-quarter of treatment episodes (24%), clients reported injecting within the last 3 months and 12% reported injecting over 12 months ago (Table SD 11)
- over half (55%) of treatment episodes ended with an expected cessation, while 1 in 5 (19%) ended unexpectedly (table SD.150)
- steroids had the highest proportion (79%) of treatment episodes ending with an expected cessation, followed by benzodiazepines and methadone (both 58%) (table SD.150)
- the proportion of treatment episodes ending with an unexpected cessation was highest for morphine (24%), followed by codeine (23%) and oxycodone (22%), and was lowest for steroids (6%).

In 2018–19, for treatment episodes where benzodiazepines were the principal drug of concern:

- the most common source of referral was self/family (44%), followed by a health service (41%) (Table 4.1)
- the most common main treatment type was counselling (33%), followed by withdrawal management (22%) and assessment only (15%) (table SD.106)
- almost two-thirds (65%) of treatment episodes were in a non-residential treatment facility
- counselling was the main treatment provided (45% of episodes) in a non-residential treatment facility, followed by assessment only (13%) (Table SD.110)
- nearly 3 in 5 (57%) episodes lasted less than 1 month, and 81% of episodes lasted 3 months or less (Table SE.25)
- the median duration of episodes was 3 weeks (21 days) (table SD.111), an increase of 7 days from 2017–18
- almost 3 in 5 (58%) episodes ended with an expected cessation, while 19% ended unexpectedly
- expected cessations were most common for episodes where the main treatment type was counselling (28%) or withdrawal management (23%) (Table SD.110).

4.6 Selected other drugs

A number of drugs make up a smaller proportion of closed treatment episodes. These drugs may be less prominent in treatment services because they are relatively uncommon, or people who use them may be less likely to seek treatment than people who use other substances. Information about treatment for nicotine, ecstasy and cocaine is included in this section, not just because of their prevalence among the population, but also the increased harms that these substances bring to an individual and/or the community (see Box 4.9).

Box 4.9: Drug descriptions

Nicotine

Nicotine is the stimulant drug in tobacco smoke. It is highly addictive and causes dependency (ADCA 2013). Tobacco use (9%) was the highest risk factor contributing to the total burden of disease and injury in Australia in 2011 (AIHW 2016). The health effects of smoking include premature death and tobacco-related illnesses such as cancer, chronic obstructive pulmonary disease and heart disease.

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).

Cocaine

Cocaine is a stimulant drug, originally derived from the leaves of the coca plant, that is typically snorted or injected. The effects of cocaine have a rapid onset, generally appearing seconds or minutes, and dissipate within about 30 minutes after consumption. The acute effects of cocaine include euphoria and increased alertness, as well as undesirable outcomes including insomnia, cardiac arrhythmia, and stroke. Chronic use is associated with both psychological and physical health problems, including erosion of the nasal cavity, anxiety, psychosis, and cardiac arrest (ADCA 2013).

Results from the National Drug Strategy Household Survey showed that in 2016:

- almost 1 in 7 Australians were current smokers and 1 in 8 were daily smokers
- although smoking rates have been on a long-term downward trend, for the first time in over 2 decades, the daily smoking rate among people aged 14 and older did not decline significantly between 2013 and 2016 (from 13% to 12%)
- 2% of Australians aged 14 and over had used ecstasy in the previous 12 months, and 3% had used cocaine
- cocaine and ecstasy were the third and fourth most common illicit drugs, respectively
- from 2013 to 2016, there were no significant changes in the use of ecstasy (2.5% in 2013 and 2.2% in 2016) or cocaine (2.1% and 2.5%).

The selected drugs of concern—nicotine, ecstasy and cocaine—were more likely to be reported as an additional drug of concern rather than a principal drug of concern (tables 4.2 and SD.8). For example, nicotine was reported as a principal drug of concern in only 1.3 % of treatment episodes, but was listed as an additional drug of concern in 16% of episodes.

Table 4.2: Summary characteristics of other selected drugs of concern, 2018–19 (%)

	Nicotine	Ecstasy	Cocaine
Client data			
Sex[a]			
Male	59.8	78.7	88.3
Female	39.7	20.9	11.4
Indigenous status[a] [b]			
Indigenous	12.0	5.0	4.0
Non-Indigenous	85.0	90.1	92.2
Age[a]			
10–19	18.9	34.9	8.0
20–29	22.5	56.1	51.0
30–39	20.5	6.8	26.0
40–49	18.6	1.7	11.7
50+	19.5	0.5	3.2
Closed treatment episodes			
Drugs of concern			
Principal drug of concern	1.3	0.6	0.8
Additional drug of concern	16.0	1.7	1.5
Referral to treatment			
Self/family	20.9	17.7	38.3
Health service	27.5	12.8	18.7
Corrections	2.4	3.5	6.0
Diversion	34.1	58.4	24.8
Other	15.0	7.6	12.2
Main treatment type			
Counselling	27.8	24.6	41.9
Information and education only	13.3	43.7	13.8
Assessment only	35.1	16.8	21.9
Withdrawal management	8.7	2.0	4.3
Other[c]	15.1	13.0	18.1
Treatment setting			
Non-residential treatment facility	70.1	81.2	77.0
Residential treatment facility	2.4	3.5	11.1
Other[d]	27.6	15.3	12.0
Treatment completion			
Expected cessation	77.0	83.0	64.6
Unexpected cessation	10.3	9.8	19.9
Other[e]	12.7	7.3	15.5
Median duration (episodes)	**2 days**	**1 day**	**28 days**

(a) Based on valid SLK client data.

(b) The proportion of clients for Indigenous status may not sum to the total, due to missing or not reported data.

(c) Includes support and case management only, pharmacotherapy, other and rehabilitation.

(d) Includes where treatment is delivered in the client's own home or usual place of residence or in an outreach setting.

(e) Includes administrative cessation.

Sources: Tables SC.6–8, SD.9, SD.66, SD.69, SD.73, SD.76–79, SD.117–118, SD.121–127, SD.130, SD.133–134, SD.137–143.

The proportion of episodes with nicotine, ecstasy or cocaine as the principal drug of concern has remained stable at around 1%–2% for each drug each year since 2014–15 (Table SD.9). Typically, these 3 principal drugs of concern have together contributed around 2%–3% of the total number of treatment episodes each year since 2014–15.

Over the 10-year period to 2018–19, the proportion of closed treatment episodes for these drugs listed as an additional drug of concern varied:

- ecstasy decreased from 5% to 2%
- cocaine remained relatively stable across the period at 1–2%
- nicotine increased from 19% in 2009–10 to 23% in 2012–13, and then fell to 16% in 2018–19 (Table SD.9).

Nicotine

In 2018–19, nicotine was a principal drug of concern in just 1.3% of treatment episodes (2,715), but was listed as an additional drug of concern in 16% of episodes (33,299) (tables 4.2 and SD.9). Since 2009–10, the proportion of episodes with nicotine as the principal drug has remained stable at 1%–2% (Table SD.9).

The low proportion of episodes in which nicotine was the principal drug of concern likely relates to the wide availability of support and treatment for nicotine use within the community. For example, general practitioners, pharmacies, helplines, and web services all offer support for nicotine use. Additionally, people might view AOD treatment services as being most appropriate for drug use that is beyond the expertise of general practitioners. However, therapy to quit smoking is becoming an integral part of some AOD services as a parallel treatment with other drugs of concern.

Client demographics

Where nicotine was the principal drug of concern:

- 60% of clients were male and 12% were Indigenous Australians
- over 3 in 5 clients were aged under 40 years (62%) and 20% were aged 50 and over (tables 4.2, SC.6–8).

Nicotine was more commonly reported as an additional drug of concern (16%) than a principal drug of concern; most treatment episodes with nicotine an additional drug of concern occurred when the principal drug of concern was alcohol (34% of nicotine ADOC episodes), amphetamines (33%), or cannabis (23%) (tables SD.7–8).

Treatment

For treatment episodes where nicotine was the principal drug of concern in 2018–19:

- the most common source of referral was a police or court diversion program (34%), followed by referrals from health services (28%) and self/family (21%) (Table 4.2)
- assessment only (35%), counselling (28%), and information and education only (13%) were the most common main treatment types (tables 4.2 and SD.74)
- around 7 in 10 (70%) treatment episodes took place in a non-residential treatment facility (Table SD.76)
- almost half (49%) of episodes ended within 1 day, and 66% lasted less than 1 month (Table SE.25)
- the median duration of episodes was 2 days (tables 4.1 and SD.79)

- over three–quarters (77%) of episodes ended with an expected cessation, while 10% ended unexpectedly
- expected cessations were most common where the main treatment type was assessment only (37%), and least likely for rehabilitation (1%) (Table SD.78).

Ecstasy

Ecstasy was a principal drug in less than 1% of episodes (1,226 closed episodes) and an additional drug of concern in 2% (3,530) of closed episodes in 2018–19.

The proportion of episodes with ecstasy as a principal drug has remained stable at up to 1% of all closed treatment episodes since 2009–10, but as an additional drug of concern it decreased from 5% of episodes in 2009–10 to 2% in 2018–19 (tables 4.2 and SD.9).

Client demographics

Where ecstasy was the principal drug of concern:

- over 7 in 10 (79%) clients were male and 5% were Indigenous Australian people
- over half of the clients (55%) were aged 20–29 and 35% were aged 10–19 (tables 4.2 and SC.6–8).

Ecstasy was more likely to be reported as an additional drug of concern than a principal drug of concern; most treatment episodes with ecstasy as an additional drug of concern were for the principal drug of concern cannabis (36%), amphetamines (32%), or alcohol (21%) (Figure 4.2; tables SD.7–8).

Treatment

For treatment episodes where ecstasy was the principal drug of concern in 2018–19:

- in nearly 3 in 5 (58%) of treatment episodes, the client's source of referral was from police and court diversion (tables 4.2 and SD.125)
- the most common main treatment type was information and education only (44%), followed by counselling (25%), and assessment only (17%) (Table SD.121)
- most treatment episodes took place in a non-residential facility (81%) (Table SD.124)
- almost three–quarters (71%) of episodes lasted less than 1 month, and 54% ended within 1 day (Table SE.25)
- the median duration of episodes was 1 day (tables 4.2 and SD.127)
- over 4 in 5 (83%) episodes ended with an expected cessation, while 10% ended unexpectedly
- expected cessations were most common where the main treatment type was information and education only (44%) (Table SD.126).

Cocaine

Cocaine was a principal drug in less than 1% of episodes (1,756 closed episodes) and an additional drug of concern in 2% (3,145 of closed episodes) in 2018–19.

Though the proportion of episodes with cocaine as a principal drug has remained at less than 1% of all closed treatment episodes since 2009–10, the number of treatment episodes has

increased by almost 200% from 2009–10 (595 episodes) to 2018–19 (1,756). The proportion of treatment episodes with cocaine as an additional drug of concern has remained relatively stable at 1–2% since 2009–10 (tables 4.2 and SD.9).

Client demographics

Where cocaine was the principal drug of concern:

- over 4 in 5 (88%) clients were male and 4% were Indigenous Australian people
- over half of the clients (51%) were aged 20–29, and 26% were aged 30–39
- fewer than 1 in 20 clients (3%) were aged 50 or over (tables 4.2 and SC.6–8).

Cocaine was more likely to be reported as an additional drug of concern than a principal drug of concern; most treatment episodes with cocaine as an additional drug of concern were for amphetamines (35%), alcohol (32%), and cannabis (18%) (Figure 4.2; tables SD.7–8).

Treatment

For treatment episodes where cocaine was the principal drug of concern in 2018–19:

- around 2 in 5 clients (38%) were referred by self/family, followed by diversion (25%) and health service referral (19%) being the next most common sources of referral (tables 4.2 and SD.133)
- the most common main treatment types were counselling (42%), assessment only (22%), and information and education only (14%) (Table SD.137–138)
- treatment was most likely to take place in a non-residential treatment facility (77%) (Table SD.140)
- over half (52%) of episodes lasted less than 1 month (27% ended within 1 day) and 80% ended within 3 months (Table SE.25)
- the median duration of treatment episodes was 28 days, though this varied by treatment type; for example, median duration was 1 day for information and education only, and 71 days for counselling (tables 4.2 and SD.143)
- over half (65%) of treatment episodes ended with an expected cessation, while 20% ended with an unplanned completion (SD.134)
- expected cessations were most common where the main treatment type was counselling (37%) (Table SD.142).

5 Treatment provided

There are a number of treatment types available to assist people with problematic alcohol or drug use in Australia. Most aim to reduce the harm of alcohol or drug use, while others use a structured drug-free setting with abstinence-oriented interventions.

This chapter presents 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 4.2). Treatment is available to help people tackle their own alcohol or drug use, and to support the family and friends of people using alcohol or drugs.

Box 5.1: Treatment provided: key facts

In 2018–19, for closed treatment episodes for **all** clients:

- counselling was the most common treatment type nationally (39%)
- self/family was the most common source of referral (38%)
- around 4 in 5 (79%) episodes ended within 3 months
- around 3 in 5 (61%) episodes had an expected/planned completion.

With regard to treatment provided for own drug use and support for someone else's alcohol or drug use:

- most clients for whom treatment was provided for a client's own alcohol or drug use were male (66%), whereas just over half of clients seeking support for someone else's alcohol or drug use were female (51%)
- most (66%) clients seeking treatment for their own alcohol or drug use were aged 10–39, while half (50%) of clients seeking support for someone else's use were aged 40 and over
- the median duration of episodes for clients' own alcohol or drug use was 3 weeks (23 days).

Over the 10-year period to 2018–19:

- the proportion of episodes for the most common main treatment types fluctuated
- the proportion of episodes with a main treatment type of support and case management only increased from 9% in 2009–10 to 12% in 2018–19, and episodes with assessment only rose from 14% to 19%
- the proportion of episodes with withdrawal management as the main treatment type fell from 17% to 11% of episodes, and counselling declined slightly from 42% to 39%
- the median duration of closed episodes for the client's own alcohol or drug use fluctuated between approximately 2 and 3 weeks across the period
- the proportion of episodes with an expected cessation decreased from 68% to 61%.

5.1 Referral to treatment

In 2018–19, the most common source of referral for clients overall was self/family (32%). This was consistent for all treatment types, with the exception of information and education only, where police and court diversion was the most common source of referral (64%) (Table SC.18).

The most common source of referral for treatment episodes was self/family for both clients receiving treatment for their own drug use (38%) and clients receiving treatment for someone else's alcohol or drug use (44%).

Referral episodes from a health service were also common for both groups (30% and 16%, respectively), while referral episodes from police or court diversion programs accounted for 13% of episodes for clients receiving treatment for their own alcohol or drug use. Clients referred by diversion programs were comparatively younger than for other referral sources: 22% of these episodes were for clients aged 10–19, 34% were for clients aged 20–29, and 23% were for clients aged 30–39 (Table SE.16).

In 2018–19, the source of referral varied according to clients' principal drugs of concern (Table 5.1). For example:

- Self/family was the most common source of referral for treatment episodes relating to most principal drugs of concern, including alcohol (43%), amphetamines (38%), and heroin (45%).
- Where cannabis was the principal drug of concern, diversion and self/family accounted for equal proportions of referrals (28% of episodes each).
- Referral via diversion was less common among clients receiving treatment for alcohol (4% of episodes), heroin (6%), or amphetamines (13%), compared with cannabis (28%).
- Over half (58%) of treatment episodes for clients whose principal drug of concern was ecstasy were referred to treatment through police or court diversion programs, the highest proportion of any principal drug of concern (see Chapter 4 for further information regarding drugs of concern).

Table 5.1: Closed treatment episodes, by principal drug of concern and source of referral, 2018–19 (%)

Principal drug of concern	Self/family	Health service	Corrections	Diversion	Other	Total
Analgesics						
Codeine	47.4	43.9	0.8	2.3	5.7	100
Morphine	50.7	33.5	9.9	1.9	3.9	100
Buprenorphine	44.1	41.0	7.2	1.3	6.4	100
Heroin	45.3	28.7	6.2	6.5	13.4	100
Methadone	38.6	43.2	5.8	4.3	8.1	100
Total analgesics	*45.0*	*31.8*	*6.2*	*5.5*	*11.5*	*100*
Sedatives and hypnotics						
Alcohol	42.8	37.2	4.4	4.4	11.2	100
Benzodiazepines	43.9	40.9	2.4	4.5	8.4	100
Total sedatives and hypnotics	*42.8*	*37.3*	*4.3*	*4.4*	*11.1*	*100*
Stimulants and hallucinogens						
Amphetamines	37.6	24.8	9.3	12.7	15.7	100
Ecstasy	17.7	12.8	3.5	58.4	7.6	100
Cocaine	38.3	18.7	6.0	24.8	12.2	100
Nicotine	20.9	27.6	2.4	34.1	15.0	100
Total stimulants and hallucinogens	*36.5*	*24.5*	*8.8*	*14.8*	*15.4*	*100*
Cannabis	**27.9**	**25.6**	**5.8**	**28.0**	**12.7**	**100**
Volatile solvents	**9.1**	**36.6**	**4.3**	**15.3**	**34.7**	**100**

Source: Table SD.17.

Over the 10-year period to 2018–19:

- the proportion of treatment episodes with self/family referrals for clients' own alcohol or drug use increased from 37% in 2009–10 to 42% in 2013–14, before falling to 38% in 2018–19
- self/family referrals for someone else's alcohol or drug use followed a similar trend, increasing from 60% in 2009–10 to 64% in 2014–15 and then steadily decreasing to 44% in 2018–19
- the proportion of treatment episodes with a referral from a health service increased for clients seeking treatment for their own alcohol or drug use (from 27% to 30%), and decreased for clients seeking support for someone else's alcohol or drug use (from 23% to 16%) (Table SE.15)
- for episodes where the principal drug of concern was alcohol, referrals from self/family increased from 40% to 43% (Table SD.17)
- where cannabis was reported as the principal drug of concern, the proportion of diversion referrals decreased from 35% in 2009–10 to 28% in 2018–19) (Table SD.17).

5.2 Duration of treatment

In 2018–19, around 4 in 5 closed treatment episodes ended within 3 months for both clients receiving treatment for their own alcohol or drug use and for someone else's alcohol or drug use (79% and 80%, respectively). The proportion of treatment episodes for a clients' own alcohol or drug use that ended within 3 months remained stable at around 80% over the 10 years to 2018–19 (Table SE.21).

Nationally, the median duration of closed episodes was just over 3 weeks (23 days) for clients' own alcohol or drug use and just under 2 weeks (14 days) for clients receiving support for someone else's alcohol or drug use. The median duration of closed treatment episodes for a clients' own alcohol or drug use fluctuated slightly over the 10 years, ranging from 16 days in 2015–16 to 25 days in 2011–12 (Table SE.22). The median duration of treatment episodes for clients seeking support for someone else's alcohol or drug use decreased by half from the previous year, from 31 days in 2017–18 to 14 days in 2018–19.

5.3 Treatment completion

Reasons for clients no longer receiving treatment from an AOD treatment service include expected cessations (for example, treatment program completed), unplanned cessations (for example, the client ceased to participate in the treatment program without notice) and administrative cessation (for example, client transferred to another service provider) (see Glossary and Box 4.1).

In 2018–19, around 3 in 5 (61%) treatment episodes for a client's own alcohol or drug use were expected (planned) completions. One-fifth (21%) of treatment episodes ended due to unplanned completion, 7% were referred to another service or changed treatment mode, and the remaining 10% of cessations were for other reasons. This pattern differed slightly for clients who received support for someone else's alcohol or drug use. For example, treatment episodes that ended due to unplanned completion were lower, being 9% compared with 21% for treatment episodes for own alcohol or drug use (Table 5.2).

Table 5.2: Closed treatment episodes, by reason for cessation and client type, 2018–19 (%)

Reason for cessation	Own drug use	Other's drug use
Expected (planned) completion	60.9	55.4
Ended due to unplanned completion	21.4	9.1
Referred to another service/change in treatment mode	7.4	3.7
Other	10.4	31.9
Total	**100.0**	**100.0**

Source: Table SE.18.

In 2018–19:

- treatment episodes with an expected cessation were highest where ecstasy was the principal drug of concern (83%), followed by nicotine (77%) and volatile solvents (76%)
- the lowest proportion of expected cessations were for episodes with morphine as the principal drug of concern (43%)

- treatment episodes for amphetamines as the principal drug of concern had the highest proportion of unplanned cessations (27%), followed by morphine (24%), codeine (23%), and heroin (20%)
- treatment episodes for ecstasy as the principal drug of concern had the lowest proportion of unplanned cessations (10%) (Table 5.3).

Table 5.3: Closed treatment episodes for selected drugs, by principal drug of concern and reason for cessation, 2018–19 (%)

Principal drug of concern	Expected (planned) completion	Ended due to unplanned completion	Referred to another service/change in treatment mode	Other	Total
Analgesics					
Codeine	57.4	22.8	12.9	6.8	100
Morphine	42.7	24.5	22.7	10.1	100
Buprenorphine	49.1	18.2	21.7	11.0	100
Heroin	58.6	20.1	8.7	12.7	100
Methadone	58.2	16.7	13.9	11.2	100
Total analgesics	*56.9*	*20.0*	*11.1*	*12.0*	*100*
Sedatives and hypnotics					
Alcohol	62.3	20.6	8.3	8.8	100
Benzodiazepines	58.4	18.6	10.2	12.9	100
Total sedatives and hypnotics	*62.2*	*20.6*	*8.3*	*8.9*	*100*
Stimulants and hallucinogens					
Amphetamines	53.9	26.6	6.8	12.7	100
Ecstasy	83.0	9.8	2.2	5.1	100
Cocaine	64.6	19.9	4.9	10.7	100
Nicotine	77.0	10.3	3.1	9.6	100
Total stimulants and hallucinogens	*55.7*	*25.4*	*6.5*	*12.4*	*100*
Cannabis	**68.7**	**18.5**	**5.0**	**7.8**	**100**
Volatile solvents	**76.4**	**10.4**	**3.9**	**9.3**	**100**

Source: Table SE.12.

During the 10 years to 2018–19:

- treatment episodes that ended in an expected cessation have decreased overall, falling by 7 percentage points (Table SD.16)
- the proportion of treatment episodes ending in an expected cessation increased for some substances, with the largest rises being for volatile solvents (up 19 percentage points)
- decreases in expected cessation were reported for treatment episodes where amphetamines (down 11 percentage points), codeine (9 percentage points), and morphine (8 percentage points)

- unplanned cessations increased for episodes where the principal drug of concern was codeine (4 percentage points) or amphetamines (3 percentage points), and decreased by 6 percentage points for volatile solvents episodes and 5 percentage points for nicotine (Table SD.16)
- the proportion of treatment episodes for someone else's drug use with an expected cessation was the lowest since 2009–10, decreasing from 74% in 2017–18 to 55% in 2018–19 (Table SE.18).

5.4 Treatment types

Counselling was the most common treatment type provided to all clients in 2018–19 (39% of all treatment episodes), followed by assessment only (19%) and support and case management only (12%). This pattern was consistent for episodes in which clients received treatment for their own alcohol or drug use, while for episodes where clients received treatment for someone else's alcohol or drug use the most common treatment type was counselling (52%), followed by support and case management only (25%) and assessment only (11%) (Table SE.13).

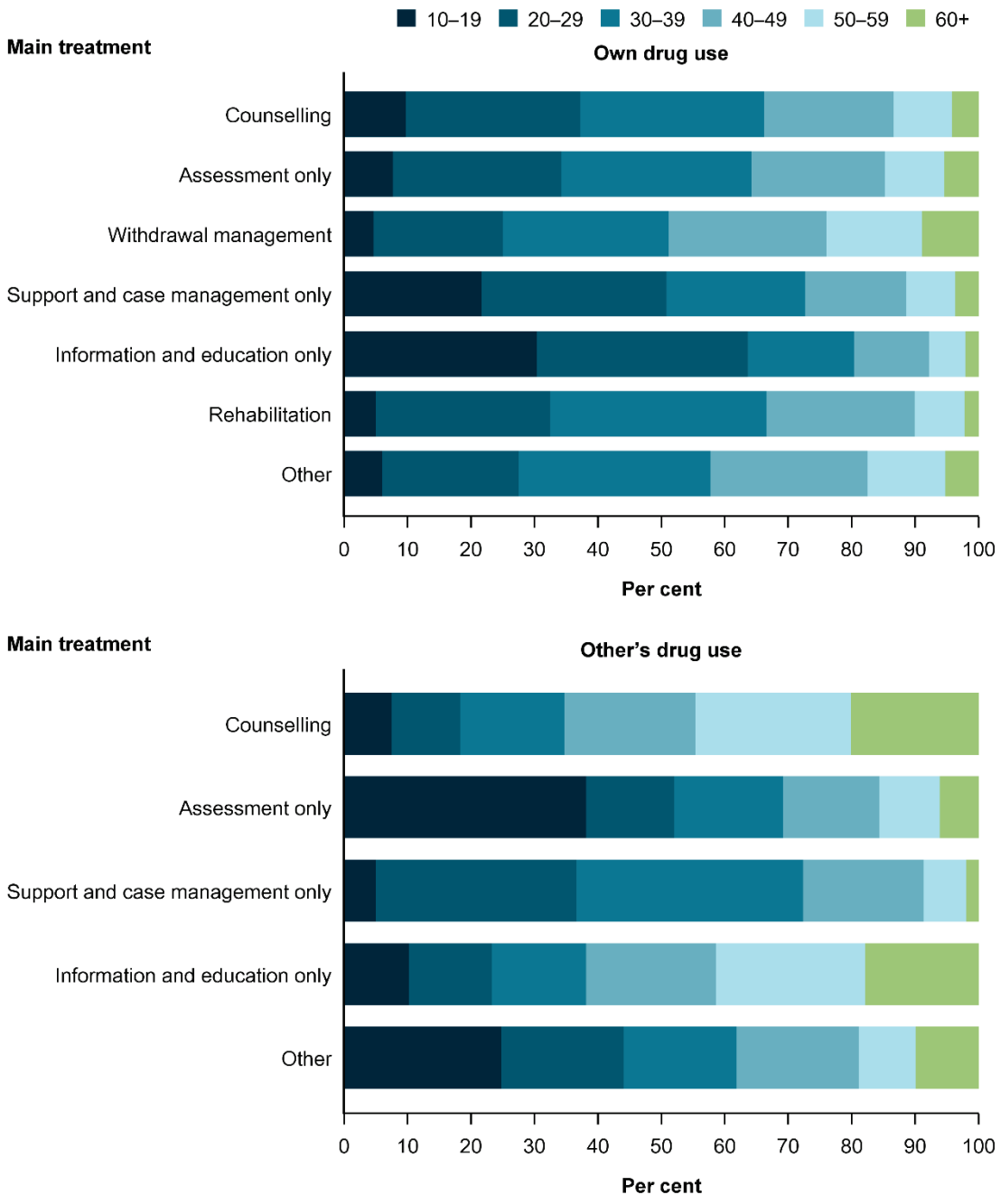
Clients can receive treatment for their own or someone else's alcohol or drug use (see Glossary). Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not available for clients seeking treatment for someone else's alcohol or drug use.

In 2018–19, around 128,300 (94%) clients received treatment for their own alcohol or drug use and around 8,700 (6%) received treatment in relation to someone else's alcohol or drug use (Section 2.1; Table SC.1).

In 2018–19, the majority of clients seeking treatment for their own alcohol or drug use were aged 20–49 for all treatment types (ranging from 67% to 85%), with the exception of information and education only, where the majority of clients were aged 10–39 (81%) (Figure 5.1).

Among clients seeking support for someone else's alcohol or drug use, the age of clients varied by main treatment type. Almost 1 in 3 clients receiving counselling for someone else's alcohol or drug use were aged 40 or older (65%), while the highest proportions of those receiving assessment only for someone else's alcohol or drug use were aged 10–19 (38%) (Figure 5.1; Table SC.16).

Figure 5.1: Main treatment type, by client type and age group (years), 2018–19



Source: Table SC.16.

Generally, the total number of treatment episodes delivered each year has increased over the life of the AODTS NMDS collection. The proportion of closed treatment episodes have remained relatively constant for counselling, the most common main treatment type reported for all clients. For clients' own alcohol or drug use, treatment types such as withdrawal management and counselling are the most commonly reported treatment types over time, excluding assessment only; as it refers that there is no treatment provided to the client other than an assessment. Some changes in data can be influenced by system changes, coding practices or actual changes in treatment policies or capacity within jurisdictions, which may contribute to variation over time.

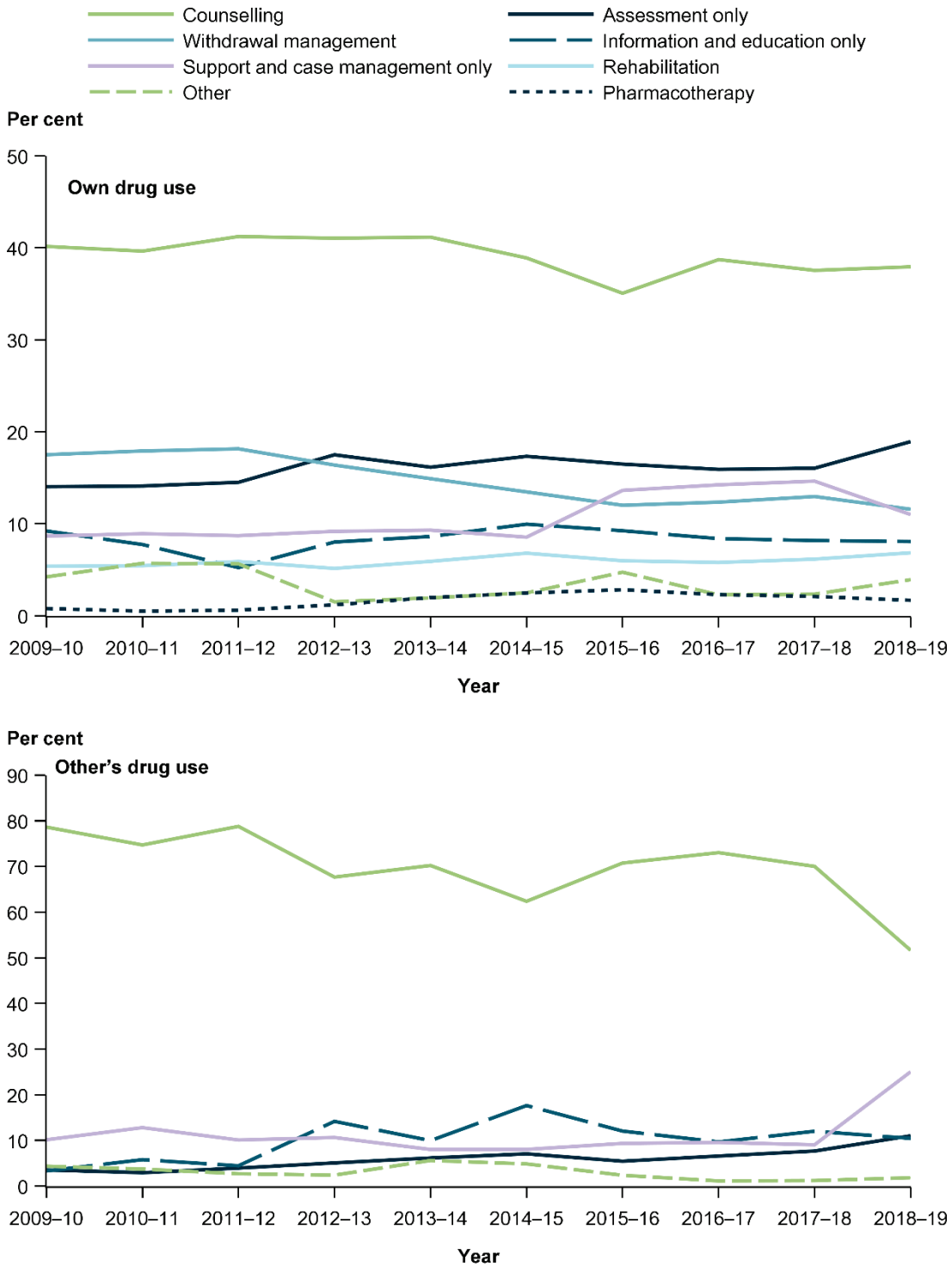
For treatment episodes provided for a **client's own alcohol or drug use** over the 10-year period:

- the proportion of episodes for each main treatment type has fluctuated since 2009–10
- counselling continues to be the most common main treatment type provided to clients, comprising about 2 in 5 episodes over this time
- the proportion of episodes with counselling as the main treatment type decreased from 40% in 2009–10 to 35% in 2015–16, but then rose to 38% in 2018–19
- the number of treatment episodes with a main treatment of withdrawal management steadily declined from 18% in 2009–10 to 12% in 2018–19) (Table ST.4).

For treatment episodes provided for those **seeking support for someone else's alcohol or drug use:**

- counselling, information and education only, support and case management only and assessment only have remained the most common main treatment types since 2009–10
- the proportion of treatment episodes providing counselling as the main treatment type fell from 79% in 2009–10 to 52% in 2018–19
- episodes with support and case management only as the main treatment type more than doubled, rising from 10% in 2009–10 to 25% in 2018–19) (Figure 5.2; Table ST.4).

Figure 5.2: Closed treatment episodes, by client type and main treatment type, 2009–10 to 2018–19



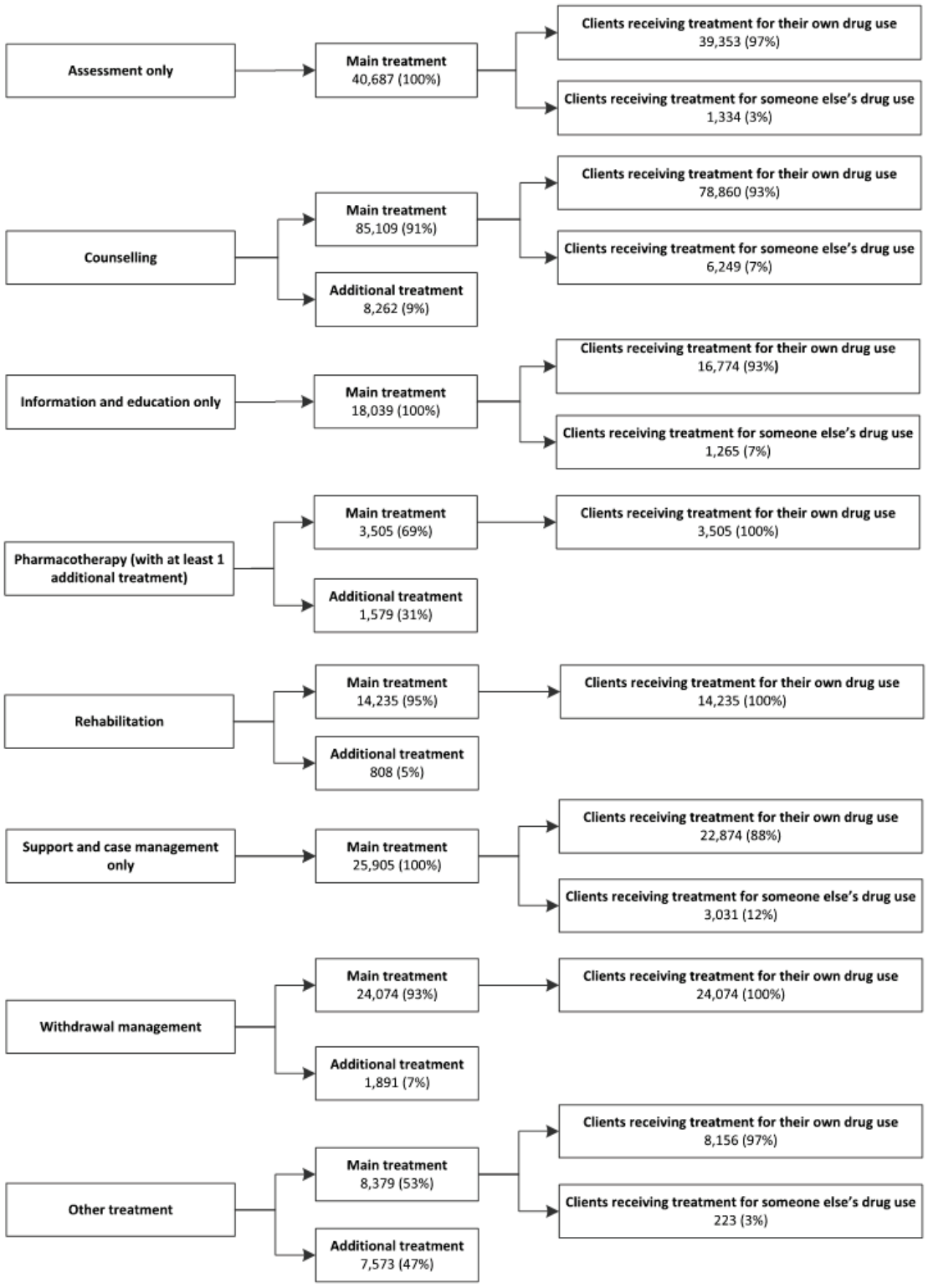
Note: Withdrawal, rehabilitation and pharmacotherapy treatment is not available for clients seeking treatment for others drug use.

Source: Table ST.4.

In 2018–19:

- counselling was the most common treatment type across all remoteness areas, ranging from 36% in *Major cities* to 53% in *Remote* areas
- withdrawal management as a main treatment type for own alcohol or drug use was more common in *Major cities* (13%) than in other areas
- the lowest proportion of treatment episodes for withdrawal management was in *Very remote* areas (1%)
- the lowest proportion of treatment episodes with support and case management only as a main treatment type was in *Remote* areas (3%) (Table SA.9).

Figure 5.3: Summary treatment characteristics (main and additional) of closed episodes, 2018–19



Sources: Table ST.1.

Counselling

Counselling is the most common treatment type for problematic alcohol and/or other drug use and can include cognitive behavioural therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013).

In 2018–19, counselling was reported as a main treatment type in 39% (85,109) of all treatment episodes. Almost 2 in 5 (38%) treatment episodes for clients seeking support for their own drug use involved counselling as the main treatment. For treatment episodes where the client sought support for someone else's drug use, this proportion was 52%; this represents a decline from 70% in 2017–18 (Table ST.4). Episodes of counselling as a main treatment type were most commonly provided to clients whose principal drug of concern was alcohol (38%), amphetamines (30%), or cannabis (20%) (Table ST.22).

Client profile

For treatment episodes where the main treatment was counselling:

- in almost two-thirds (66%) of episodes for own alcohol or drug use the client was male, while 55% of episodes for someone else's alcohol or drug use were for females (Table ST.19)
- over half (56%) of episodes for own use involved clients who were aged 20–39, while 63% of episodes for someone else's use, were for people aged 40 and over (Table ST.20)
- for clients seeking treatment for their own alcohol or drug use, around 1 in 10 (12%) closed treatment episodes were for Indigenous Australian clients
- for episodes where clients received counselling for someone else's alcohol or drug use, 7% of clients identified as Indigenous Australian people (Table ST.21).

Treatment profile

Counselling treatment for clients' own alcohol or drug use and for someone else's use:

- around 1 in 7 episodes with a main treatment type of counselling lasted 1 day (12% for both own alcohol or drug use and someone else's use), while over half lasted between 30 days and up to 6 months (57% and 52%, respectively) (Table ST.26)
- counselling episodes were longer than other treatment types, with a median length of 63 days (Table SE.24).

Over the 10-year period to 2018–19:

- for clients received counselling for their own alcohol or drug use, the proportion of treatment episodes that ended within 1 month fell from 36% to 29%
- the proportion of episodes lasting more than 1 month increased from 64% to 71%
- for clients receiving counselling for someone else's alcohol or drug use, the proportion of closed episodes lasting 1 day fell from 15% to 12%; the proportion lasting 6 months was 14% in both 2009–10 and 2018–19, though this fluctuated over the 10 years (Table ST.27).

Assessment only

Although all service providers would normally include an assessment component in all treatment types, assessment only episodes are those for which only an assessment has been provided to the client.

In 2018–19, 19% (40,687) of all treatment episodes reported a main treatment type of assessment only. Almost 1 in 5 (19%) treatment episodes for clients seeking help for their own alcohol or drug use received an assessment only as a main treatment; this proportion was 11% for clients seeking help for someone else's alcohol or drug use (Table ST.4). Assessment only treatment episodes were most commonly provided to clients whose principal drug of concern was either alcohol or amphetamines (both 33%), or cannabis (14%) (Table ST.44).

Client profile

For treatment episodes with a main treatment type of assessment only:

- around 4 in 5 males (79%) who sought treatment for their own alcohol or drug use were aged 20–49, with a similar proportion of females (78%)
- most clients who received assessment only for someone else's alcohol or drug use were male (46%); around three-quarters (74%) of those males were aged 10–39 (Table ST.41)
- 16% of assessment only treatment episodes for clients' own alcohol or drug use were for Indigenous clients and 35% of assessment only episodes for someone else's use, were for Indigenous clients (Table ST.43)
- around half (52%) of assessment only episodes lasted just 1 day for clients seeking treatment for their own alcohol or drug use, compared to 61% for clients seeking treatment for someone else's use (81%) (Table ST.45).

Over the 10-year period from 2009–10 to 2018–19:

- among clients seeking treatment for their own alcohol or drug use, the proportion of treatment episodes for clients aged 20–29 decreased from 34% to 27%
- the proportion of assessment only episodes for those aged 60 and over increased steadily over the 10 years, rising from 2% in 2009–10 to 5% in 2018–19
- for clients seeking support for someone else's alcohol or drug use, the proportion of treatment episodes where clients were aged 10–19 rose from 10% to 38% (Table ST.42)
- the proportion of treatment episodes that lasted just 1 day fluctuated across the period, ranging from 45% in 2009–10 to 69% in 2012–13
- from 2017–18 to 2018–19, the proportion of episodes that ended within 1 day decreased from 68% to 52%
- for clients seeking treatment for their own alcohol or drug use, the proportion of closed episodes lasting 1 day rose from 45% to 52%
- for those clients seeking treatment for someone else's alcohol or drug use, the proportion of closed episodes lasting 1 day fluctuated, but was at its lowest in 2018–19 (62%)
- the proportion of all episodes lasting 2–29 days decreased from 32% in 2009–10 to 21% in 2017–18, before rising to 35% in 2018–19
- for clients seeking treatment for their own alcohol or drug use, the proportion of assessment only episodes that lasted 2–29 days increased from 9% to 30%
- the proportion of all assessment only treatment episodes lasting 3 months or more fell from 8% to 2%. (Table ST.46).

It is important to note that these trends are influenced by differences in jurisdictional service delivery practices and data quality changes over time.

Withdrawal management

Withdrawal management (detoxification) includes medicated and non-medicated treatment to help manage, reduce or stop the use of a drug of concern. This type of treatment is not available for clients seeking treatment for someone else's alcohol or drug use.

In 2018–19, 12% (24,074) of closed treatment episodes for a clients' own alcohol or drug use involved withdrawal management as the main treatment type (Table ST.4). Of these, most treatment episodes were for alcohol (49%), amphetamines (21%), or cannabis (14%) (Table ST.33).

Client profile

For episodes provided to clients whose main treatment was withdrawal management:

- almost two-thirds (61%) of episodes were provided to male clients and 1 in 10 (10%) were for Indigenous Australian clients (tables ST.30 and ST.32)
- almost three-quarters (73%) of all withdrawal management treatment episodes were provided for those aged 20–29 (21%), 30–39 (27%) or 40–49 (25%) (Table ST.31).

Treatment profile

For withdrawal management treatment episodes provided for a client's own alcohol or drug use:

- over 4 in 5 treatment episodes (85%) ended within 1 month (Table ST.38)
- median treatment episode duration has remained at 8 days since 2011–12 (Table SE.24)
- most episodes (71%) ended due to an expected (planned) completion (Table ST.12).

Over the 10-year period to 2018–19:

- the proportion of closed withdrawal management episodes ending within 1 month rose from 75% in 2009–10 to 85% in 2018–19 (Table ST.38)
- the proportion of episodes lasting longer than 1 month fell from 25% to 15% (Table ST.38).

Support and case management only

Support includes activities such as providing emotional support to a client who occasionally calls an agency worker. 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 encompasses assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007).

In 2018–19, around 13% (25,905) of all closed treatment episodes reported a main treatment type of support and case management only. Where clients received treatment for their own alcohol or drug use, 12% of closed treatment episodes involved support and case management only as the main treatment; this figure was 25% where clients received support for someone else's alcohol or drug use (Table ST.4).

Most support and case management only episodes were provided to clients whose principal drug of concern was alcohol (33%), amphetamines (26%) or cannabis (25%) (Table ST.52).

Client profile

For episodes where the main treatment type was support and case management only:

- around 3 in 5 (60%) of treatment episodes provided to clients for their own alcohol or drug use were for males, 52% were for clients aged 10–29, and 16% were for Indigenous Australian clients
- female clients seeking treatment for their own alcohol or drug use were more likely to be Indigenous Australian people than were male clients (17% compared to 15%) (tables ST.49–51)
- for clients seeking treatment for someone else's alcohol or drug use, 77% of support and case management only episodes were for males, 65% were for clients aged 20–39, and 2% were for Indigenous Australian clients
- for clients seeking treatment for someone else's alcohol or drug use, 2% of male clients and 4% of female clients were Indigenous Australian people (tables ST.49–51).

Over the 10-year period to 2018–19:

- the proportion of episodes with a client aged 10–19 decreased from 31% in 2009–10 to 22% in 2018–19 for clients receiving treatment for their own alcohol or drug use, and from 74% in 2008–09 to 6% for clients seeking support for someone else's alcohol or drug use
- among episodes provided to clients for someone else's alcohol or drug use, the proportion of episodes provided to clients aged 20–39 increased from 17% to 65%
- around 1 in 5 (20%) of clients were aged 40–49 in 2018–19, compared with just 4% in 2009–10 (Table ST.50).

Treatment profile

Among support and case management treatment episodes for clients' own alcohol or drug use and someone else's alcohol or drug use:

- the proportion of episodes lasting over 12 months was higher for clients receiving treatment for their own alcohol or drug use (3%) compared with those receiving support for someone else's alcohol or drug use (less than 1%)
- the proportion of episodes lasting 1 day was higher for clients receiving treatment for someone else's alcohol or drug use (87%) than for their own alcohol or drug use (8%) (Table ST.54).

Over the 10-year period to 2018–19:

- the proportion of closed treatment episodes lasting 1 day for clients seeking treatment for their own alcohol or drug use rose from 5% in 2009–10 to 43% in 2015–16, declining from 33% in 2017–18 to 8% in 2018–19
- the proportion of treatment episodes for someone else's alcohol or drug use that lasted 1 day rose from 10% in 2009–10 to 87% in 2018–19; conversely, episodes lasting between 2 days and 3 months decreased from 78% in 2009–10 to 10% in 2018–19 (Table ST.54).

Information and education only

In 2018–19, information and education only as a main treatment, was reported for 8% (18,039) of all treatment episodes. Over 1 in 12 (8%) treatment episodes for clients seeking help for their own alcohol or drug use received information and education only as a main treatment, compared with 10% for those seeking treatment for someone else's alcohol or drug use (Table ST.4).

Most information and education only episodes were provided to clients whose principal drug of concern was cannabis (49%), alcohol (23%) or amphetamines (13%) (Table ST.52).

Client profile

In 2018–19, treatment episodes where main treatment type was information and education only:

- most clients who received information and education only for their own alcohol or drug use were male (69%), with over half of clients aged 29 years and under (56%)
- almost three-quarters (72%) of clients who sought support for someone else's alcohol or drug use were female, with most clients (53%) aged 40 and over
- over 1 in 5 (22%) closed treatment episodes for clients seeking treatment for their own alcohol or drug use were provided to clients who identified as an Indigenous Australian person, compared with around 8% for episodes where clients sought treatment for someone else's alcohol or drug use (tables ST.57–59).

Over the 10-year period to 2018–19:

- the age profile of all clients receiving information and education only treatment for their own use remained relatively stable
- among clients who sought support for someone else's alcohol or drug use, the proportion who were aged 10–19 fluctuated, rising from 21% in 2009–10 to 57% in 2014–15 before falling to 5% in 2018–19 (tables ST.57–58).

Treatment profile

Among episodes in 2018–19, with information and education as the main treatment, for both clients' own and someone else's alcohol or drug use:

- around three-quarters (74%) of treatment episodes lasted just 1 day for clients seeking treatment for their own alcohol or drug use; for those seeking treatment for someone else's use, this proportion was 56% (Table ST.62).

Over the 10-year period to 2018–19:

- for clients seeking treatment for their own alcohol or drug use, the proportion of closed episodes that lasted just 1 day decreased from 84% to 74%
- the proportion of episodes lasting from 2 days to less than 3 months increased from 13% in 2009–10 to 23% in 2018–19, while the proportion of episodes lasting from 3 months to over 12 months remained relatively stable
- for those clients seeking support for someone else's alcohol or drug use, the proportion of information and education only episodes that lasted just 1 day rose from 50% in 2009–10 to 70% in 2013–14 before falling to 56% in 2018–19 (Table ST.62).

It is important to note that these trends are influenced by differences in jurisdictional program practices over time.

Rehabilitation

Rehabilitation focuses on helping clients to cease their alcohol or drug use, and to prevent psychological, legal, financial, social and physical consequences of substance use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011).

This type of treatment is not available for clients seeking treatment for someone else's alcohol or drug use.

In 2018–19, 7% (14,235) of closed treatment episodes for clients' own alcohol or drug use included rehabilitation as the main treatment type (ST.4). Among rehabilitation treatment episodes, the most common principal drugs of concern were amphetamines (40%), alcohol (37%), and cannabis (11%) (Table ST.68).

Client profile

In 2018–19 episodes with rehabilitation as the main treatment type:

- over 3 in 5 (63%) treatment episodes were provided to male clients, and 23% were provided to Indigenous Australian clients (tables ST.65 and ST.67)
- most (84%) treatment episodes were for clients aged 20–29 (28%), 30–39 (33%), or 40–49 (22%) (Table ST.66).

Treatment profile

Among rehabilitation treatment episodes for a client's own alcohol or drug use:

- more than one-third (35%) of episodes lasted 1–3 months, while a further 30% lasted between 2 days and 1 month
- over the 10-year period to 2018–19, the duration of closed episodes of rehabilitation for those clients seeking treatment for their own alcohol or drug use remained relatively stable, excepting an increase in the proportion of episodes that lasted 1 day (from 6% in 2009–10 to 11% in 2018–19) (Table ST.73).

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.

Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment with an additional treatment provided, are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded.

On a snapshot day in 2019, almost 51,000 clients received pharmacotherapy for opioid dependence, as reported in the National Opioid Pharmacotherapy Statistics Annual Data report (NOPSAD) (AIHW 2020). 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 data presented here are a substantial under-representation. More information on opioid pharmacotherapy in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics: https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/national-opioid-pharmacotherapy-statistics-2019/contents/introduction.

For services that were in scope of the AODTS NMDS in 2018–19, 2% (5,084) of closed episodes for clients' own alcohol or drug use involved pharmacotherapy as a main or additional treatment. Of these episodes, 31% (1,579) reported pharmacotherapy as an additional treatment (tables ST.4, ST.74, and ST.75).

Client profile

In 2018–19, episodes with pharmacotherapy as the main treatment type:

- around two-thirds (66%) of treatment episodes were provided to male clients, and 13% involved Indigenous Australian clients
- around two-thirds (66%) of episodes were for those aged 30–39 (38%) or 40–49 (28%)
- a further 18% were for clients aged 20–29, while just 3% were for clients aged 60 and over (tables ST.76–78).

Treatment profile

For treatment episodes involving pharmacotherapy for a client's own alcohol or drug use:

- almost 1 in 5 (19%) episodes lasted over 12 months, while 26% lasted 3–12 months
- when pharmacotherapy was the main treatment, the most common principal drug of concern were heroin (36%), alcohol (14%), and amphetamines (14%) (tables ST.79 and ST.84)
- when pharmacotherapy was an additional treatment, the most common principal drugs of concern were alcohol (45%), amphetamines (25%), and heroin (10%) (Table ST.80).

Appendix A: Data and methods

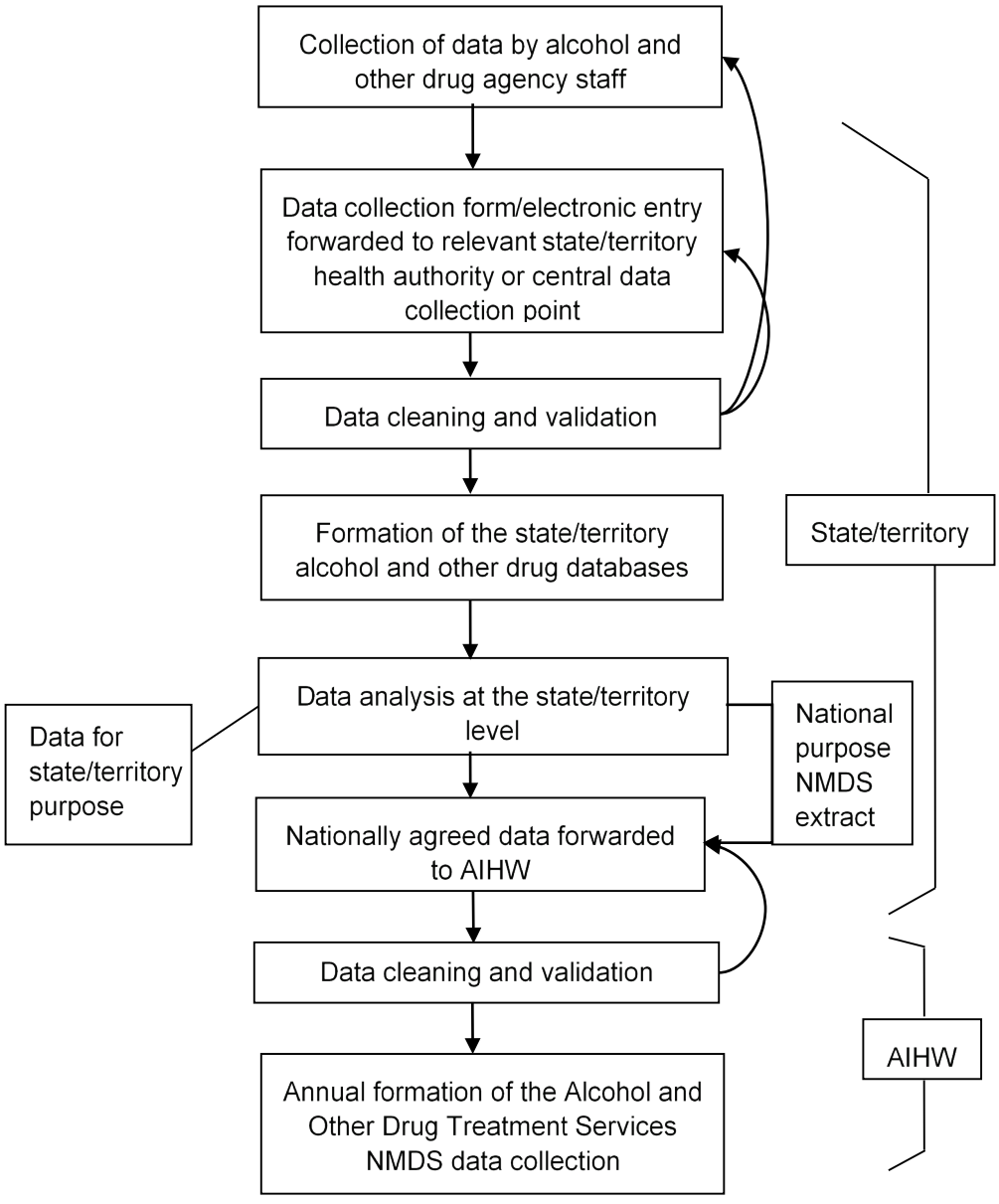
Age

Age is calculated as at the start of the episode.

Data collection process

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning and policy. Figure A1 shows the processes involved in constructing the national data.

Figure A1: Alcohol and other drug treatment data collection flowchart



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 (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	

In this report, pharmaceutical drugs were grouped using 10 drug types, making up the pharmaceuticals group for the purposes of the analysis. These drugs correspond to the ASCDC codes and classifications (Table A2).

Table A2: Pharmaceutical drugs of concern, ASCDC codes and classifications

Drug category	ASCDC code	ASCDC classification (broad group and narrow group/s)	Drug description (ASCDC base level unit/s)
Codeine	1101	**Analgesics** Organic opiate analgesics	Codeine
Morphine	1102	**Analgesics** Organic opiate analgesics	Morphine
Buprenorphine	1201	**Analgesics** Semisynthetic opioid analgesics	Buprenorphine
Oxycodone	1203	**Analgesics** Semisynthetic opioid analgesics	Oxycodone
Methadone	1305	**Analgesics** Synthetic opioid analgesics	Methadone
Benzodiazepines	2400–2499	**Sedatives and hypnotics** Benzodiazepines	Benzodiazepines n.f.d., alprazolam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam, benzodiazepines n.e.c.
Steroids	4000–4999	**Anabolic agents and selected hormones** Anabolic androgenic steroids Beta2 agonists Peptide hormones, mimetics and analogues Other anabolic agents and selected hormones Not further defined	Anabolic agents and selected hormones n.f.d., anabolic androgenic steroids n.f.d., boldene, dehydroepiandrosterone, fluoxymesterone, mesterolone, methandriol, methenolone, nandrolone, oxandrolone, stanozolol, testosterone, anabolic androgenic steroids n.e.c., beta2 agonists n.f.d., eformoterol, fenoterol, salbutamol, beta2 agonists n.e.c., peptide hormones, mimetics and analogues n.f.d., chorionic gonadotrophin, corticotrophin, erythropoietin, growth hormone, insulin, peptide hormones, mimetics and analogues n.e.c., other anabolic agents and selected hormones n.f.d., sulfonylurea hypoglycaemic agents, tamoxifen, thyroxine, other anabolic agents and selected hormones n.e.c.
Other opioids	1100, 1199, 1200, 1299, 1300–1304, 1306–1399	**Analgesics** Organic opiate analgesics Semisynthetic opioid analgesics Synthetic opioid analgesics Not further defined	Organic opiate analgesics n.f.d., organic opiate analgesics n.e.c., semisynthetic opioid analgesics n.f.d., semisynthetic opioid analgesics n.e.c., synthetic opioid analgesics n.f.d., fentanyl, fentanyl analogues, levomethadyl acetate hydrochloride, meperidine analogues, pethidine, tramadol, synthetic opioid analgesics n.e.c.
Other analgesics	0005, 1000, 1400–1499	**Analgesics** Non-opioid analgesics Not further defined	Analgesics n.f.d., non-opioid analgesics n.f.d., acetylsalicylic acid, paracetamol, ibuprofen, non-opioid analgesics n.e.c.
Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999	**Sedatives and hypnotics** Anaesthetics Barbiturates Gamma-hydroxybutyrate (GHB) type drugs and analogues Other sedatives and hypnotics	Sedatives and hypnotics n.f.d., anaesthetics n.f.d., ketamine, nitrous oxide, phencyclidine, propofol, anaesthetics n.e.c., barbiturates n.f.d., amylobarbitone, methylphenobarbitone, phenobarbitone, barbiturates n.e.c., GHB-type drugs and analogues n.f.d., GHB, gamma-butyrolactone, 1,4-butanediol, GHB-type drugs and analogues n.e.c., other sedatives and hypnotics n.f.d., chlormethiazole, kava lactones, zopclone, doxylamine, promethazine, zolpidem, other sedatives and hypnotics n.e.c.

n.f.d—not further defined; n.e.c—not elsewhere classified.

Duration

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

Population rates

In this publication, crude rates were calculated using the ABS's estimated resident population at the midpoint of the data range: that is, rates for 2017–18 data were calculated using the estimated resident population at 31 December 2017.

Reason for cessation

The AODTS NMDS contains data on the reason an episode ended (reason for cessation). In this report, these reasons are grouped (Table A3), but 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 before 2014, so 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 A3: Grouping of cessation reasons, by indicative outcome type

Outcome type	Reason for cessation
Expected/planned completion	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Ended due to unplanned completion	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Referred to another service/change in treatment mode	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 area

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure 2011 (ABS 2011b) to analyse the proportion of AOD treatment agencies by remoteness area. 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 based on their relative access to services.

Examples of urban centres in each remoteness area are:

- *Major cities* Canberra, Newcastle
- *Inner regional* Hobart, Bendigo
- *Outer regional* Cairns, Darwin
- *Remote* Katherine, Mount Isa
- *Very remote* Tennant Creek, Meekatharra.

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

The Australian Statistical Geography Standard ASGS has replaced the Australian Standard Geographical Classification 2006 (ABS 2006), which was used in previous reports to calculate remoteness areas. Therefore, remoteness data for 2011–12 and previous years are not comparable with those for 2012–13 and subsequent years.

Service sectors

From 2008–09, agencies funded by the Department of Health under the Non-Government Organisation Treatment Grants Program (NGOTGP) were classified as non-government agencies. Before this, many of these agencies were classified as government agencies. As a result, trends in service sectors of agencies should be interpreted with caution.

Source of referral: diversion

Throughout Australia, there are programs that divert people who have been apprehended or sentenced for a minor drugs offence from the criminal justice system. Many of these diversions result in clients receiving drug treatment services, who have been referred to treatment agencies as part of a drug diversion program. Since the 1980s, Australian governments have supported programs aimed at diverting from the criminal justice system people who have been apprehended or sentenced with a minor drugs offence.

In Australia, drug diversion program come in two main forms:

- **Police diversion** occurs when an offence is first detected by a law enforcement officer. It usually applies for minor use or possession offences, often relating to cannabis, and can involve the offender being cautioned, receiving a fine and/or having to attend education or assessment sessions.
- **Court diversion** occurs after a charge is laid. It usually applies for offences where criminal behaviour was related to drug use (for example, burglary or public order offence). Bail-based programs generally involve assessment and treatment, while pre- and post-sentence programs (including drug courts) tend to involve intensive treatment and are aimed at repeat offenders.

Trends

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

Imputation methodology for AOD 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. An SLK was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continuing to ensure the privacy of these individuals receiving treatment.

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 several 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.

To ensure an accurate representation of the AODTS client population, imputation was applied to the 2012–13, 2013–14 and 2015–16 AODTS NMDS to account for the proportion of valid SLKs being less than 95% for these years. The national rate of valid SLKs for these years was largely affected by low proportions of valid SLKs in New South Wales.

Refer to technical notes online for further detail on methodology for imputation.

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

Abbreviations

ACT	Australian Capital Territory
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
GHB	gamma hydroxybutyrate
MDMA	3, 4-methylenedioxymethamphetamine
NDS	National Drug Strategy
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
SLK	statistical linkage key
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Symbols

—	nil or rounded to zero
. .	not applicable
n.a.	not available
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data.

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 www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/alcohol-other-drug-treatment-services-2018-19/data

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.

alcohol: A central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgement, coordination and balance more difficult.

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): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGS replaced the ASGC in July 2011.

benzodiazepines: Also known as minor tranquillisers, these drugs 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®) and 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 treatment and/or assistance in relation to the alcohol and/or other drug use of another person.

client counts: Includes:

- distinct clients—where the total number refers to the actual number of clients counted
- estimated clients—where the number of clients is estimated using imputed numbers (see imputation methodology).

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 when treatment is ceased (see **reason for cessation**).

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

diversion client type: Clients who received at least 1 AOD treatment episode during a collection year resulting from a referral by a police or court diversion program. The 2 subtypes in this group are:

- diversion only clients—received treatment as a result of diversion referrals only
- diversion client with non-diversion episodes—received at least 1 treatment episode resulting from a diversion referral, but also received at least 1 treatment episode resulting from a non-diversion referral in a collection year.

ecstasy (MDMA): 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 and the love drug.

GHB: stands for gamma hydroxybutyrate, which is a central nervous system depressant. Common names for GHB include, G, Grievous Bodily Harm, fantasy, liquid E, liquid ecstasy and blue nitro.

government agency: An agency that operates from the public accounts of the Australian Government or a state or territory government, is part of the general government sector and is 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. Common names for heroin include 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—drugs that are prohibited from manufacture, sale or possession in Australia, such as cannabis, cocaine, heroin and MDMA (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, such as 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, such as kava, or inhalants such as petrol, paint or glue (but not including tobacco or alcohol).

licit drug use: The use of legal drugs in a legal manner, including tobacco smoking and alcohol consumption.

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

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

method of use for principal drug of concern: The client's usual method of administering the principal drug of concern as stated by the client. Includes: ingests, smokes, injects, sniffs (powder), inhales (vapour), other and not stated.

nicotine: The highly addictive stimulant drug in tobacco.

non-government agency: An agency that receives some government funding, but is not controlled by the government, and is directed by a group of officers or an executive committee. A non-government agency 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 the client ceased to receive a treatment episode from an alcohol and other drug treatment service. The client can have:

- completed treatment—where the treatment was completed as planned
- a change in the main treatment type
- a change in the delivery setting
- a change in the principal drug of concern
- been transferred to another service provider—including 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
- ceased to participate against advice—here 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 without notice
- 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 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
- been to a drug court or sanctioned by court diversion service—where the client is returned to court or jail due to non-compliance with the program
- been imprisoned (other than sanctioned by a drug court or diversion service)
- died.

The grouped categories used in the report for **reason for cessation:**

- referred to another service/change in treatment mode: 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
- ended due to planned completion: Includes episodes where the client completed treatment—ceased to participate at expiation or by mutual agreement
- ended due to unplanned completion: Includes episodes where the client ceased to participate against advice, without notice, or due to non-compliance.

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.

tobacco: A plant, *Nicotiana tabacum*, whose leaves are dried and used for smoking and chewing and in snuff. Its major pharmacologically active substance is the alkaloid nicotine (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.

treatment type: The type of activity that is used to treat the client's alcohol or other drug use, which includes:

- assessment only—where only assessment is provided to the client (service providers would normally include an assessment component in all treatment types)
- counselling—can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
- information and education only—where only information and education is provided to the client (service providers would normally include an information and education component in all treatment types)
- pharmacotherapy—where the client receives another type of treatment in the same treatment episode and includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who experience dependence on 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 to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in several ways, including residential treatment services, therapeutic communities and community-based rehabilitation services
- support and case management only—support includes helping a client who occasionally calls an agency worker for emotional support, while 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
- withdrawal management (detoxification)—includes medicated and non-medicated treatment to help manage, reduce or stop the use of a drug of concern.

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List of tables

List of figures

List of boxes

In 2018–19, 1,283 publicly funded alcohol and other drug (AOD) treatment services provided just under 220,000 treatment episodes to an estimated 137,000 clients. The four most common drugs that led clients to seek treatment for their own drug use were alcohol (36% of all treatment episodes), amphetamines (28%), cannabis (20%) and heroin (5%). Almost two-thirds (64%) of all clients receiving treatment were male, and the median age of clients was 34 years.

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