

3 Existing national alcohol and other drug treatment services data

At present it is not possible to compare or combine data about the clients and activities of alcohol and other drug treatment service providers within different States and Territories (Rankin & Copeland 1997). The NMDS is essentially a response to this lack of nationally consistent information. However, there are a few national data collections that do provide informative data on alcohol and other drug treatment services. These collections are outlined below with some summary data and limitations of the data noted.

3.1 The National Hospital Morbidity Database

The National Hospital Morbidity Database is a patient-level data set that is collected on admitted patients in public and private hospitals in Australia and collated by the Australian Institute of Health and Welfare (AIHW). The only exceptions are public hospitals not within the jurisdiction of a State or Territory health authority or the Department of Veterans' Affairs, for example hospitals operated by the Department of Defence or correctional authorities. All data collected on admitted patients are agreed as part of the NMDS—admitted patient care, and data definitions are published in the *National Health Data Dictionary* (AIHW 2000a). Data are validated in conjunction with the State and Territory health authorities and the Department of Veterans' Affairs, and a comprehensive summary of the data is reported annually in the *Australian Hospital Statistics* series (see AIHW 2000b).

Data collected in this database include administrative details, demographic information on patients, and clinical information including diagnoses and medical procedures. The collection of morbidity data is separation-based, that is, all data are reported at the completion of each episode of care and each admission or re-admission generates a separate patient record. Where a patient receives only one type of care in a hospital, the episode of care length will be equivalent to the hospital stay length. Where patients receive different types of care, the patient will be statistically separated from the hospital and re-admitted into a second phase (or episode) of care.

The principal diagnosis is the diagnosis established to be chiefly responsible for occasioning the patient's episode of care in hospital. Data on principal diagnoses provide information on the diseases and conditions for which hospitalisations occur and can provide an indirect measure of community morbidity (AIHW 1999a). In addition to the principal diagnosis, additional diagnoses—which can include comorbidity—can be recorded for each separation.

The following figures and tables present information on the diagnoses reported for alcohol and drug related health conditions for the 1997–98 financial year. Principal diagnoses are classified, coded and reported using the Australian version of the *International Classification of Diseases, 9th Revision, Clinical Modification* (ICD–9–CM) (National Coding Centre 1996). Figure 3.1 presents the number of hospital separations for patients who had a principal diagnosis of alcohol dependence syndrome (ICD–9–CM 303) during 1997–98 by sex and age. The figure shows that male patients had a higher proportion of hospital separations for alcohol dependence syndrome than female patients (67.3% compared to 32.7%), and that the majority of separations are reported for both male and female patients within the age range of 35–54 years.

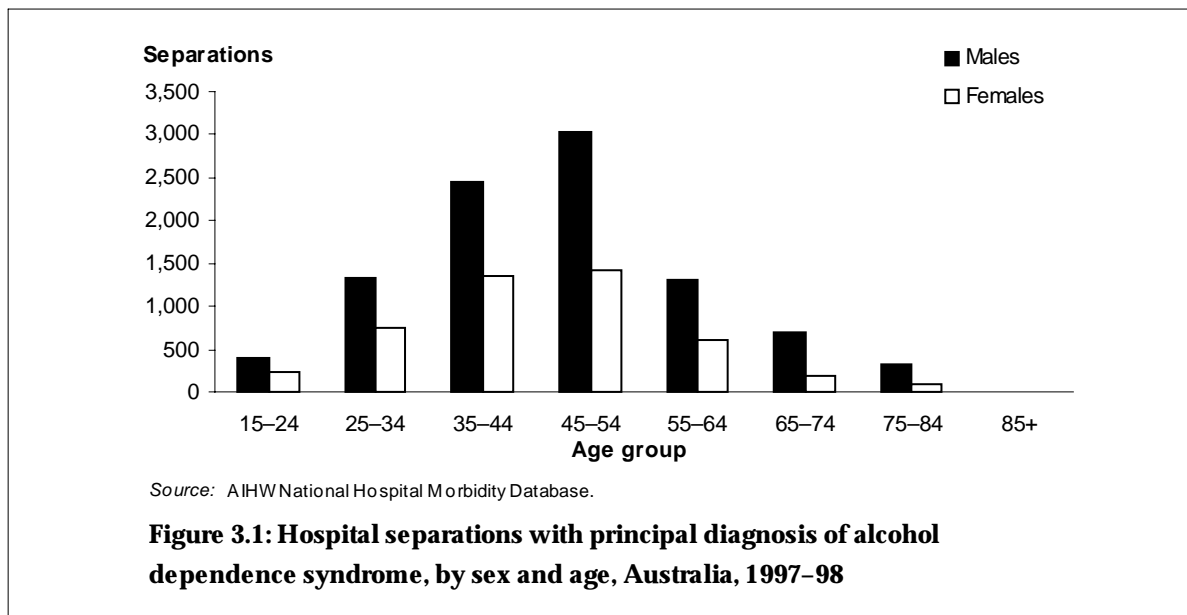
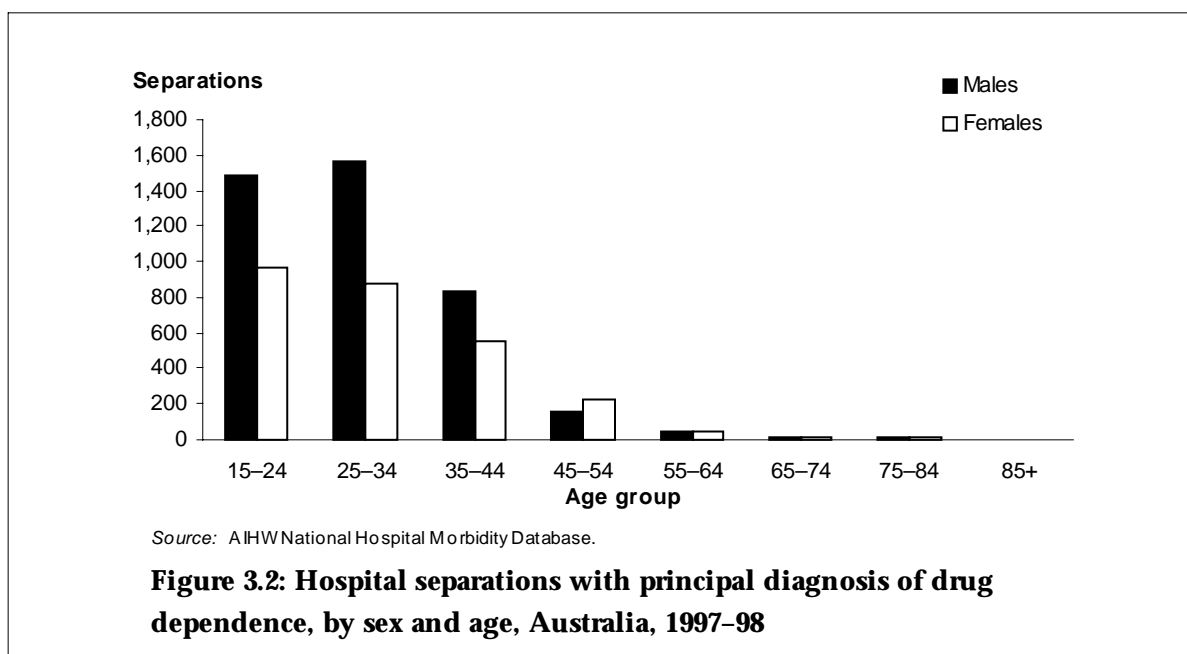


Figure 3.2 shows the number of hospital separations for patients who had a principal diagnosis of drug dependence (ICD-9-CM 304) during the 1997-98 financial year by sex and age. Male patients had a higher proportion of hospital separations for drug dependence than female patients (60.5% compared to 39.5%). Separations for drug dependence are predominantly reported for both male and female patients within the age range of 15-44 years. Only 7.6% of hospital separations for drug dependence are reported for patients 45 years of age and over.



The volume of acute admitted patient care is indicated by the number of days that patients are treated in hospitals. Table 3.1 presents the number of days of admitted patient care for patients who had a diagnosis of alcohol dependence syndrome, drug dependence or non-

dependent drug use disorder in the 1997–98 reporting period. Male patients had a higher proportion of patient days than female patients for the majority of alcohol and drug disorders with 63% of all patient days recorded for male patients. Male patients had a considerably higher proportion of patient days compared to female patients for principal disorders of *cannabis dependence* (2,779 days compared to 1,000 days), *acute alcoholic intoxication* (8,924 days compared to 3,845 days), and *other and unspecified alcohol dependence* (52,452 days compared to 25,926 days). In contrast, female patients had a higher proportion of patient days than male patients for principal disorders of *barbiturate and similarly acting sedative or hypnotic dependence* (3,922 days compared to 2,411 days), *other specified drug dependence* (279 days compared to 229 days), and *unspecified drug dependence* (978 days compared to 940 days). Table 3.1 also shows that the majority of patient days were recorded for patients in the age range between 35 and 54 years (45% of all patient days).

Comorbidity refers to the occurrence of more than one disorder at the same time. The existence of some conditions can predispose individuals to another condition. For people with mental disorders, comorbidity is common (ABS 1998). Table 3.2 provides information on the number of hospital separations for people whose principal diagnosis is a *mental disorder* (ICD–9–CM 290–302, 306–312) and who have an additional diagnosis of *alcohol or drug dependence* (ICD–9–CM 303–304).

Table 3.2 indicates that comorbidity is particularly common for separations with a principal diagnosis of *personality disorders*, *adjustment reaction*, or *acute reaction to stress*. For example, when looking at separations for patients with a principal diagnosis of *personality disorder*, 4.4% of those separations were associated with an additional diagnosis of *alcohol dependence* and 7.2% with *drug dependence*. For separations with a principal diagnosis of *adjustment reaction*, 5.6% were associated with an additional diagnosis of *alcohol dependence* and 3.5% with *drug dependence*. For separations with a principal diagnosis of *acute reaction to stress*, 4.2% were associated with an additional diagnosis of *alcoholic dependence* and 4.2% with *drug dependence* (see Table 3.2).

Table 3.1: Number of patient days for principal diagnosis of alcohol dependence syndrome, drug dependence and non-dependent drug use disorder in ICD-9-CM 4-digit groupings, by sex and age, Australia, 1997–98

Principal diagnosis	Age group								Total
	15–24	25–34	35–44	45–54	55–64	65–74	75–84	85+	
Acute alcoholic intoxication (303.0)									
Males	302	1,010	2,216	2,823	1,340	914	313	6	8,924
Females	119	568	888	1,294	503	257	167	49	3,845
Other & unspecified alcohol dependence (303.9)									
Males	1,741	6,650	12,184	15,962	7,496	5,553	2,799	67	52,452
Females	765	3,366	7,014	6,521	3,944	3,859	451	6	25,926
Opioid type dependence (304.0)									
Males	3,690	4,362	3,073	492	134	5	1	9	11,766
Females	3,498	2,835	1,840	402	16	—	26	27	8,644
Barbiturate & similarly acting sedative or hypnotic dependence (304.1)									
Males	269	745	538	448	268	66	58	19	2,411
Females	265	776	1,458	789	397	157	80	—	3,922
Cocaine dependence (304.2)									
Males	23	49	63	2	—	—	6	—	143
Females	76	31	8	—	—	—	—	—	115
Cannabis dependence (304.3)									
Males	1,506	960	204	109	—	—	—	—	2,779
Females	461	404	123	12	—	—	—	—	1,000
Amphetamine & other psychostimulant dependence (304.4)									
Males	582	554	174	16	—	—	—	—	1,326
Females	472	270	91	—	—	—	—	—	833
Hallucinogen dependence (304.5)									
Males	18	15	—	—	—	—	—	—	33
Females	8	14	—	—	—	—	—	—	22
Other specified drug dependence (304.6)									
Males	101	56	25	19	28	—	—	—	229
Females	30	16	109	88	26	10	—	—	279
Combinations of opioid type drug with any other (304.7)									
Males	749	670	290	41	27	15	—	—	1,792
Females	596	537	297	133	16	44	—	—	1,623
Combinations of drug dependence excluding opioid type drug (304.8)									
Males	258	334	149	54	20	4	—	—	819
Females	162	102	109	28	11	—	—	—	412
Unspecified drug dependence (304.9)									
Males	453	346	107	34	—	—	—	—	940
Females	373	194	161	80	88	82	—	—	978
Non-dependent (305.0)									
Males	2,742	3,272	2,397	2,069	902	700	171	65	12,318
Females	1,861	1,854	1,703	1,186	516	316	277	142	7,855
Total									
Males	12,434	19,023	21,420	22,069	10,215	7,257	3,348	166	95,932
Females	8,686	10,967	13,801	10,533	5,517	4,725	1,001	224	55,454

Notes: — indicates nil; () indicates the ICD-9-CM 4-digit code.

Source: AIHW National Hospital Morbidity Database.

Table 3.2: Hospital separations with principal diagnosis of a mental disorder and additional diagnosis of alcohol or drug dependence, Australia, 1997–98

Principal diagnosis	Additional diagnosis	No. separations	% separations
Senile & presenile organic psychotic conditions (290)	Alcohol dependence	76	1.0
	Drug dependence	87	1.2
Transient organic psychotic conditions (293)	Alcohol dependence	150	2.7
	Drug dependence	63	1.1
Other organic psychotic conditions (294)	Alcohol dependence	62	1.6
	Drug dependence	24	0.6
Schizophrenic disorders (295)	Alcohol dependence	795	2.3
	Drug dependence	1,070	3.1
Affective disorders (296)	Alcohol dependence	1,613	2.7
	Drug dependence	1,427	2.4
Paranoid states (297)	Alcohol dependence	63	2.9
	Drug dependence	54	2.5
Other nonorganic psychoses (298)	Alcohol dependence	98	2.3
	Drug dependence	177	4.1
Neurotic disorders (300)	Alcohol dependence	626	2.8
	Drug dependence	699	3.1
Personality disorders (301)	Alcohol dependence	365	4.4
	Drug dependence	590	7.2
Sexual deviations & disorders (302)	Alcohol dependence	8	2.8
	Drug dependence	3	1.1
Physiological malfunction arising from mental factors (306)	Alcohol dependence	7	1.3
	Drug dependence	7	1.3
Special symptoms or syndrome, not elsewhere classified (307)	Alcohol dependence	26	0.3
	Drug dependence	84	1.0
Acute reaction to stress (308)	Alcohol dependence	169	4.2
	Drug dependence	172	4.2
Adjustment reaction (309)	Alcohol dependence	1,102	5.6
	Drug dependence	690	3.5
Specific nonpsychotic mental disorders due to organic brain damage (310)	Alcohol dependence	48	2.6
	Drug dependence	24	1.3
Depressive disorder, not elsewhere classified (311)	Alcohol dependence	337	3.7
	Drug dependence	209	2.3
Disturbance of conduct, not elsewhere classified (312)	Alcohol dependence	26	1.2
	Drug dependence	22	1.0

Notes: — indicates nil; () indicates the ICD-9-CM 4-digit code.

Source: AIHW National Hospital Morbidity Database.

Table 3.3 presents information on the number of separations with a principal diagnosis of *alcohol dependence, drug dependence* or *non-dependent drug use disorder* (ICD-9-CM 303-305) with an additional diagnosis of a *mental disorder* (ICD-9-CM 290-302, 306-312).

For separations with a principal diagnosis of *alcohol dependence syndrome*, 9.6% were associated with an additional diagnosis of *neurotic disorders*, 7.3% with an additional diagnosis of *depressive disorder not elsewhere classified*, and 6.0% with an additional diagnosis of *personality disorders*. For those separations with a principal diagnosis of *drug dependence*, 7.0% were associated with an additional diagnosis of *personality disorders* and 6.2% had an additional diagnosis of *neurotic disorders*.

For those separations with a principal diagnosis of *non-dependent drug use disorder*, 7.4% were associated with an additional diagnosis of *personality disorders* and 7.1% had an additional diagnosis of *neurotic disorders*.

Table 3.3: Hospital separations with principal diagnosis of alcohol dependence, drug dependence or non-dependent drug use and additional diagnosis of a mental disorder, Australia, 1997-98

Principal diagnosis	Additional diagnosis	No. separations	% separations
Alcohol dependence syndrome (303)	Senile & presenile organic psychotic conditions (290)	13	0.1
	Transient organic psychotic conditions (293)	18	0.1
	Other organic psychotic conditions (294)	32	0.2
	Schizophrenic disorders (295)	215	1.5
	Affective disorders (296)	765	5.4
	Paranoid states (297)	20	0.1
	Other nonorganic psychoses (298)	20	0.1
	Neurotic disorders (300)	1,362	9.6
	Personality disorders (301)	853	6.0
	Sexual deviations & disorders (302)	13	0.1
	Physiological malfunction arising from mental factors (306)	—	—
	Special symptoms or syndrome, not elsewhere classified (307)	47	0.3
	Acute reaction to stress (308)	95	0.7
	Adjustment reaction (309)	659	4.6
	Specific nonpsychotic mental disorders due to organic brain damage (310)	32	0.2
	Depressive disorder, not elsewhere classified (311)	1,036	7.3
	Disturbance of conduct, not elsewhere classified (312)	67	0.5
Drug dependence (304)	Senile & presenile organic psychotic conditions (290)	2	—
	Transient organic psychotic conditions (293)	3	—
	Other organic psychotic conditions (294)	4	0.1
	Schizophrenic disorders (295)	100	1.5

(continued)

Table 3.3(continued): Hospital separations with principal diagnosis of alcohol dependence, drug dependence or non-dependent drug use and additional diagnosis of a mental disorder, Australia, 1997–98

Principal diagnosis	Additional diagnosis	No. separations	% separations
	Affective disorders (296)	195	2.9
	Paranoid states (297)	17	0.2
	Other nonorganic psychoses (298)	14	0.2
	Neurotic disorders (300)	420	6.2
	Personality disorders (301)	479	7.0
	Sexual deviations & disorders (302)	2	—
	Physiological malfunction arising from mental factors (306)	3	—
	Special symptoms or syndrome, not elsewhere classified (307)	50	0.7
	Acute reaction to stress (308)	28	0.4
	Adjustment reaction (309)	117	1.7
	Specific nonpsychotic mental disorders due to organic brain damage (310)	8	0.1
	Depressive disorder, not elsewhere classified (311)	299	4.4
	Disturbance of conduct, not elsewhere classified (312)	31	0.5
Non-dependent drug use disorder (305)	Senile & presenile organic psychotic conditions (290)	6	0.1
	Transient organic psychotic conditions (293)	19	0.3
	Other organic psychotic conditions (294)	13	0.2
	Schizophrenic disorders (295)	128	2.0
	Affective disorders (296)	209	3.3
	Paranoid states (297)	15	0.2
	Other organic psychoses (298)	12	0.2
	Neurotic disorders (300)	452	7.1
	Personality disorders (301)	476	7.4
	Sexual deviations & disorders (302)	4	0.1
	Physiological malfunction from mental factors (306)	1	—
	Special symptoms or syndrome, not elsewhere classified (307)	40	0.6
	Acute reaction to stress (308)	50	0.8
	Adjustment reaction (309)	222	3.5
	Specific nonpsychotic mental disorders due to organic brain damage (310)	6	0.1
	Depressive disorder, not elsewhere classified (311)	257	4.0
	Disturbance of conduct, not elsewhere classified (312)	56	0.9

Notes: —, indicates nil; () indicates the ICD-9-CM 4-digit code.

Source: AIHW National Hospital Morbidity Database.

3.1.1 Limitations of data

- Data are not collected for those public hospitals not within the jurisdiction of a State or Territory health authority or the Department of Veterans' Affairs. Data are also not complete from a small number of private hospitals, although coverage of these hospitals is improving.
- The data collection relates to admitted patients only and does not include information on clients in residential services (outside the acute care hospital setting), non-residential/outpatient services, community-based settings or other specialised services.
- All data in this database are based on episodes of care and hospital separations, not individual patients. Hence, a patient entering hospital three times in a year will generate three records. Data on the number of individuals being treated is not available, nor is there any data that describes an individual's passage through the health system.

3.2 Survey of clients of treatment service agencies

In March 1990, the first national survey of clients of treatment service agencies in Australia was conducted. The aim of the survey was to obtain information on the characteristics of clients being treated for problems related to drug use. A study of these characteristics was viewed under the National Campaign Against Drug Abuse (NCADA), now the National Drug Strategy (NDS), as an important tool to complement other relevant data sources. The characteristics of clients receiving treatment could then be compared with other data and used for planning and evaluation purposes (Torres, Mattick, Chen & Baillie 1995). The survey has subsequently been conducted in 1992 and 1995 which has allowed trends to be monitored in client characteristics, patterns of drug use and treatment seeking.

To be included in the survey, agencies had to be identified as providing one or more face-to-face specialist treatment services to clients with alcohol and/or other drug problems. The range of treatment interventions covered by this definition was very wide, including among others a variety of outpatient treatment services, residential rehabilitation programs, detoxification, therapeutic communities, methadone maintenance plus an additional service, and smoking cessation programs. The third national survey of clients of treatment service agencies collected information from 498 agencies representing a response rate of 92% of all agencies that had been listed from available federal, State and Territory government and non-government organisation directories. The response rates for the 1990 and 1992 surveys were 85% and 93% respectively. All agencies participating in the survey were required to complete their surveys on the same day (referred to as census day), and they were required to provide information about all the clients to whom they provided face-to-face treatment on the day of the survey.

The information collected in the survey included:

- client status (substance user or relative/friend of user)
- age
- gender
- country of birth
- language spoken by the client at home
- employment status
- service provided to the client

- principal drug problem of the substance user
- illicit drugs injected by the substance user in the past 12 months
- postcode of the client's usual residence.

In the latest survey a total of 5,212 clients had been treated on census day, and of them the majority were in treatment for their own substance use (92%). The mean age was 33.8 years for substance users and the majority of users were male (71%). Alcohol use was the most common presenting problem, followed by opiate use (See Table 3.4).

Table 3.4: Characteristics of clients of treatment services in 1990, 1992 and 1995

Client characteristics	1990	1992	1995
Total number of clients	6,175	5,730	5,212
Client type			
Substance users (%)	90	91.8	91.6
Relative/friend (%)	10	7.8	8.3
Mean age (years)	34.4	34.3	33.8
Male (%)	66.4	72.1	70.6
Born in Australia (%)	83.3	85.4	85.7
Principal drug problems			
Alcohol (%)	55.2	51.7	49.3
Opiates (%)	33.7	33.2	33.6
Tobacco (%)	7.9	8.5	4.8
Cannabis (%)	4.1	6.0	6.7
Amphetamines (%)	3.9	4.3	6.5

Source: Clients of treatment service agencies March 1995 census findings (Torres et al. 1995).

3.2.1 Limitations of data

- Clients of non-residential services who were not seen on census day are excluded.
- Over a third of the agencies surveyed (38%) reported that the clients seen on census day were not typical of their client load.
- The collection of data is based on survey methods, rather than the extraction of administrative data, the former placing a greater burden on those agencies required to report the data.

3.3 National Survey of Mental Health and Wellbeing

The National Survey of Mental Health and Wellbeing (NSMHWB) was conducted by the ABS in 1997 on a representative sample of adults living in private dwellings in all States and Territories of Australia. Approximately 10,600 people aged 18 years or over participated in the survey, which represented a response rate of 78% (ABS 1998).

The main objective of the survey was to inform governments about the need for improvements in mental health service delivery in the Australian community, and was also designed to provide information on the prevalence of a range of major mental disorders affecting Australian adults. In addition, the survey covered demographic and socioeconomic

characteristics, physical conditions and disability associated with mental disorders (ABS 1998).

The survey collected information on a range of major mental disorders including anxiety disorders, affective disorders and substance use disorders. Substance use disorders were defined as harmful use and/or dependence on drugs and/or alcohol. Four drug categories, including both illegal and prescription drugs, were identified in the survey:

- sedatives, e.g. barbiturates, librium, serepax, sleeping pills, valium;
- stimulants, e.g. amphetamines, dexedrine, speed;
- cannabis, e.g. marijuana and hashish; and
- opioids, e.g. heroin, methadone, opium.

Details of the survey have been reported in the publication *Mental Health and Wellbeing Profile of Adults, Australia 1997* (ABS 1998).

Table 3.5 shows that men were more than twice as likely as women to have a substance use disorder (11% compared with 5%). Young men aged 18–24 years had the highest prevalence of substance use disorders (22%). For both men and women the prevalence of substance use disorders declined with age from 16% of persons aged 18–24 years to 8% of persons aged 35–44 years, to 1% of those aged 65 years and over.

Table 3.5: Prevalence (per cent) of substance use disorders^(a) by age and sex, Australia, 1997

Sex	Age group (years)						Total
	18–24	25–34	35–44	45–54	55–64	65+	
Males	21.5	15.6	12.0	7.4	5.2	2.1	11.1
Females	10.6	7.0	4.5	3.2	1.2	0.2	4.5
Persons	16.1	11.3	8.2	5.3	3.2	1.1	7.7

(a) During the twelve months prior to interview.

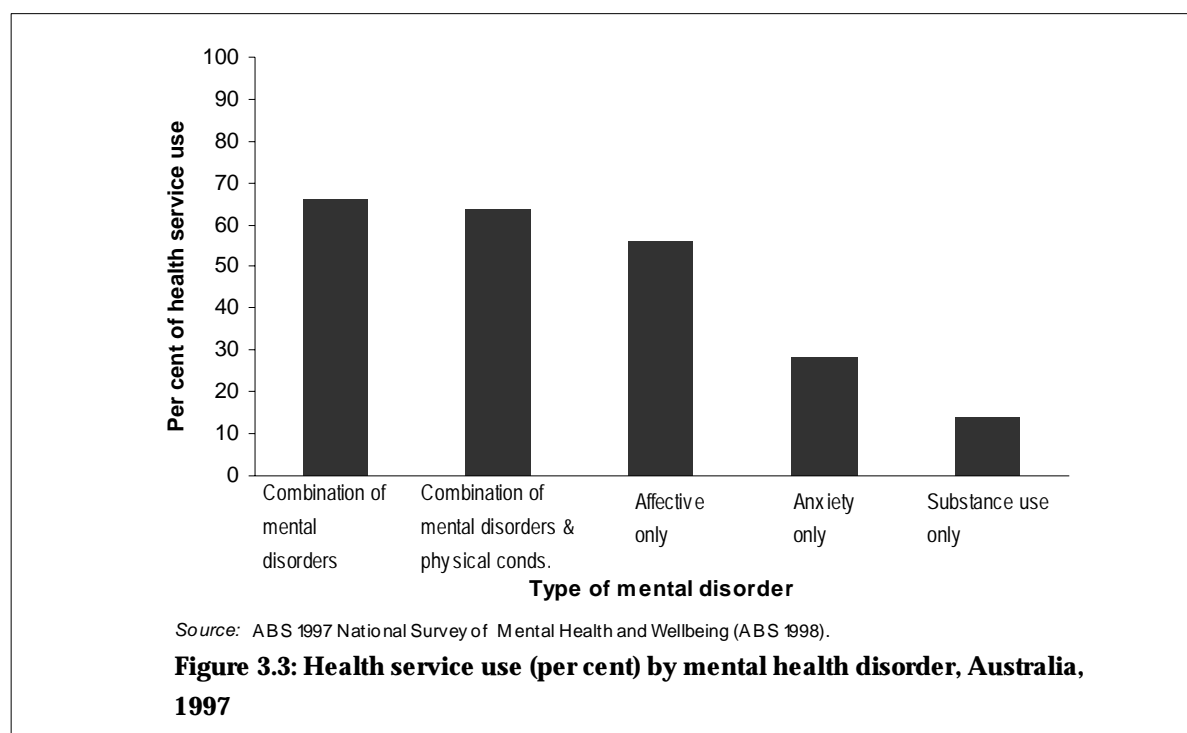
Source: ABS 1997 National Survey of Mental Health and Wellbeing (ABS 1998).

The survey also collected information on admissions to hospitals and consultations with health professionals. The likelihood of using health services for a self-perceived mental health problem was closely related to type of mental disorder. Of those with substance use disorders only, approximately 14% used health services, compared with 56% of those with affective disorders only and 28% of those with anxiety disorders only. Those with combinations of mental disorders were the most likely to use health services (see Figure 3.3).

3.3.1 Limitations of data

- The survey was a once only cross-sectional collection and cannot be used to monitor trends over time.
- The data collected is self-reported and thus is not comparable with administrative data reporting. In addition, self-reported service use cannot be verified.
- Data was collected from a private household sample only, and therefore no information is available from people living in special dwellings (such as hospitals, hostels, boarding

houses or nursing homes) nor from the homeless. Dwellings in remote and sparsely settled parts of Australia were also excluded.



3.4 National Drug Strategy Household Survey

The 1998 National Drug Strategy Household Survey was the most comprehensive survey concerning drug use ever undertaken in Australia. It gathered information from over 10,000 persons aged 14 years and over. The survey comprised questions on drug-related knowledge, awareness, attitudes, use and behaviours. It was the sixth survey conducted under the auspices of the National Drug Strategy. Previous surveys were conducted in 1985, 1988, 1991, 1993 and 1995 and the data collected in these surveys contribute to the development of policies for Australia’s response to drug issues (AIHW 1999b).

On the 1998 survey, one question asked respondents about whether they had ever participated in an alcohol or other drug treatment program. Responses to this item indicated that few people surveyed had participated in an alcohol or other drug treatment program (see Table 3.6). Six per cent of those surveyed had participated in a smoking-related program at some stage with less than 1% of both male and female respondents participating in other treatment programs with the exception of males participating in an alcohol-related program (Higgins, Cooper-Stanbury & Williams 2000).

Table 3.6: Participation in an alcohol or other drug-related treatment program, Australia, 1998

Program type	Never	Yes, but not in last	
		Last 12 months	12 months
(per cent)			
Males			
Smoking program	94	2	4
Alcohol program	98	1	1
Detoxification centre	99	—	1
Methadone maintenance	100	—	—
Prescription drugs treatment	99	1	—
Other	99	—	1
Females			
Smoking program	94	2	4
Alcohol program	100	—	—
Detoxification centre	100	—	—
Methadone maintenance	100	—	—
Prescription drugs treatment	100	—	—
Other	100	—	—

Source: National Drug Strategy Household Survey 1998 (Higgins et al. 2000).

3.4.1 Limitations of data

- The sample was based on private households, therefore homeless and institutionalised persons, and persons residing in non-private dwellings (hotels, motels, boarding houses, etc.) were not included in the survey.
- Self-reported treatment participation cannot be verified.

3.5 Health care for alcohol and other drug problems in general practice

BEACH (Bettering the Evaluation And Care of Health) is a collaborative study between the Australian Institute of Health and Welfare and the University of Sydney. The *BEACH* program has three primary aims:

- to provide a reliable and valid data-collection process for general practice which is responsive to the needs of information users;
- to establish an ongoing database of general practitioner/patient encounter information; and
- to assess patient risk factors and health states and the relationship between these factors and the health service activity (Britt et al. 1999).

During each 12-month period of the study, 1,000 general practitioners are sampled and each GP is required to report details of 100 consecutive general practitioner-patient encounters of all types on structured paper encounter forms. Each form collects information about the consultation, the patient, the patient's problems, and the management for each problem. Problems are coded according to ICPC-2 PLUS, an extension of the *International Classification*

of Primary Care, 2nd Edition (ICPC-2). Problems coded under the broad classification of 'psychological' include alcohol and other drug-related problems. Therefore, this data set may be used to gather information on the types of alcohol and drug problems that patients are presenting to general practitioners, the prevalence with which these problems are presented and the management strategies employed by general practitioners to deal with them (e.g. referrals, treatment, prescriptions).

Tobacco abuse and drug abuse are both in the top 30 problems managed by general practitioners with a clinical treatment (Britt et al. 1999). The most common form of this clinical treatment for alcohol and drug problems is providing counselling and advice (see Britt et al. 1999).

3.5.1 Limitations of data

- The data is collected from a sample of general practitioners only, it is not a comprehensive national coverage of all patients.
- There is no way to verify that clients referred to specialist alcohol and other drug treatment services accessed these services.
- The number of alcohol and drug problems presented are very small and therefore have high sampling variability.

3.6 Conclusion

At present, data providing national statistics about people receiving alcohol and drug treatment services is largely limited to hospital separations or to survey data. The available data in the community setting is particularly limited and it is not possible at present to compare client data and service activity data across States and Territories. A greater availability of comparable and consistent data would enhance the capacity of the alcohol and other drug treatment sector to influence national policy, and would also provide agencies with basic data relating to drug problems and treatment responses that are relevant to their own circumstances.