

# 1 Introduction

## 1.1 Background

This report provides national, state and territory statistics on alcohol and other drug treatment services; the clients who use these services; the types of drug problems for which treatment is being sought; and the types of treatment provided. It is the second report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). The first report predominantly provided information about the clients who access these treatment services – this report provides more information about the treatment services themselves.

The AODTS–NMDS has been implemented to assist in monitoring and evaluating key objectives of the *National Drug Strategic Framework 1998–99 to 2003–04* and to assist in the planning, management and quality improvement of alcohol and other drug treatment services. In general, it aims to provide ongoing information on the demographics of clients who use these services, the treatment they receive and administrative information about the agencies that provide alcohol and other drug treatment<sup>1</sup>.

It is important that alcohol and other drug problems and the responses to these in Australia are regularly monitored so that existing harm-reduction strategies can be assessed and new strategies developed. While no one data collection can cover all information relating to alcohol and drug use and treatment in Australia, there is a range of available information that collectively can be used to provide an overall picture (see Chapter 6).

There is an expectation in the community that an adequate range of treatment services will be accessible for all drug users and their families, regardless of age, ethnic origin, gender, sexual preference and location (Ministerial Council on Drug Strategy 1998). The data provided in this report will be used in conjunction with other information sources to inform debate, policy decisions and planning processes that occur within the alcohol and other drug treatment sector.

## 1.2 Alcohol and other drug treatment activities

### Data sources

This report uses data drawn from the AODTS–NMDS (see Section 1.3 for details of this collection). Within Australia there is a diverse range of alcohol and other drug treatment services and not all of these are currently included in the scope of the AODTS–NMDS. More detailed information on these data sources is available in Chapter 6.

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<sup>1</sup> Detailed information about the historical development of the AODTS–NMDS can be found in: *Alcohol and Other Drug Treatment Services: Development of a National Minimum Data Set* (Grant & Petrie 2001).

## Types of treatment

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

The AODTS-NMDS covers a wide variety of treatment interventions and includes, among others, detoxification and rehabilitation programs, pharmacotherapy and counselling treatments, and information and education courses. A summary is provided below on each of these treatments.

## Assessment

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

## Detoxification

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

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

The following list contains the main types of opiate detoxification programs that are available (Ghodse 2002). These programs are not distinguished within the AODTS-NMDS collection but are grouped into the general heading 'withdrawal maintenance (detoxification)'.

**Non-opiate treatment** includes neuroleptic drugs which reduce the symptoms of withdrawal, beta-adrenoreceptor blocking drugs which abolish the euphoric effect and reduce cravings, or other drugs such as clonidine which suppress the autonomic signs of withdrawal but are less successful at reducing subjective discomfort. These drugs are administered for periods of 5 days up to 3 weeks. They are suitable for clients who are not opiate dependent or who do not want to use opiates in their withdrawal program. Clients are usually treated on an out-patient basis.

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

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

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

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

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

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

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

## **Pharmacotherapy treatment**

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

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

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

Maintenance therapy is most commonly used for opiate addiction but can also be used for addiction to alcohol or other illicit drugs. There are two main drugs generally prescribed for opiate addiction, with methadone being the most common maintenance drug used in Australia. As a synthetic opioid agonist it has reduced but similar effects to heroin and, although it is not a cure for heroin dependence, it can lead to improvements in the client's mental and physical health and the stability of their lifestyle. It is usually provided in syrup

form and the effect lasts for around 24 hours, consequently most clients must attend on a daily basis to receive their treatment.

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

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

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

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

## **Counselling**

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

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

Types of counselling include motivational interviewing, cognitive and behavioural techniques such as problem-solving skills, drink and drug refusal skills, relapse prevention, contingency management and aversive conditioning, and other skills-based training such as anger or sleep management, relaxation, assertiveness training and vocational rehabilitation (Ghodse 2002). The treatment can be provided at the individual or group level and by a range of specialists such as psychologists, social workers, community nurses, drug and alcohol workers, medical practitioners, Alcoholics Anonymous or Narcotics Anonymous and others (New South Wales Health Department 2000).

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

## **Rehabilitation**

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

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

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

## **Information and education**

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

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

## **1.3 The national collection**

The AODTS-NMDS is a subset of alcohol and other drug treatment services information that is routinely collected by the Commonwealth, states and territories to monitor treatment services receiving funding from their jurisdiction. The information collected by the AODTS-NMDS is a nationally agreed set of common data items collected by service providers for clients registered for treatment. The AIHW has the role of data custodian for the national data set. The Intergovernmental Committee on Drugs NMDS Working Group is responsible for the development and implementation of the national collection. Members of the Working Group include representatives from the Commonwealth and each state and territory as well

as from organisations such as the Australian Bureau of Statistics and the National Drug and Alcohol Research Centre.

## **Basis of the collection**

The AODTS–NMDS for 2001–02 consists of de-identified unit record data for both closed treatment episodes and treatment agencies. The treatment episode records consist of 20 data items and the agency records consist of three data items. The treatment episode data items are intended to collect demographic information on the client, and information about their drug use behaviour and the type of treatment received.

The full list of data items included in the national collection for 2001–02 is detailed in Appendix 1.

In this report on 2001–02 data, there is greater emphasis on presenting information related to the treatment received by clients. For example, the move towards counting ‘closed treatment episodes’ rather than client registrations, as occurred in the 2000–01 collection, allows information to be reported about treatment activity (e.g. length of treatment episode).

Chapter 7 of this report details the data quality issues for the 2001–02 NMDS collection.

## **Scope of the collection**

The agencies, clients and treatment activities that have been included or excluded from the AODTS–NMDS collection for 2001–02 are as follows:

### **Agencies and clients included within scope**

- All publicly funded (at state, territory and/or Commonwealth level) government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services, including residential and non-residential agencies. Specialist alcohol and drug units based in acute care hospitals or psychiatric hospitals were included if they provided treatment to non-admitted patients (e.g. out-patient services).
- All clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during the relevant reporting period (1 July 2001–30 June 2002).

### **Agencies and clients excluded**

- Agencies whose sole activity is to prescribe and/or dose for opioid pharmacotherapy maintenance treatment.
- Clients who were on an opioid pharmacotherapy maintenance program and who were not receiving any other form of treatment<sup>2</sup>.
- Agencies for which the primary function is to provide accommodation or overnight stays such as ‘halfway houses’ and ‘sobering-up shelters’.
- Agencies for which the primary function is to provide services concerned with health promotion (e.g. needle and syringe exchange programs).

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<sup>2</sup> Opioid pharmacotherapy maintenance data are featured in Chapter 6 and this additional information should be taken into account when any attempt is made to estimate the total number of clients receiving treatment from all publicly funded alcohol and other drug treatment services.

- Treatment services based in prison or other correctional institutions.
- Clients receiving treatment from services based in prison or other correctional institutions.
- Alcohol and drug treatment units in acute care or psychiatric hospitals that only provide treatment to admitted patients.
- Admitted patients in acute care or psychiatric hospitals.
- People who sought advice or information but were not formally assessed and accepted for treatment.
- Private treatment agencies that do not receive public funding.

Some people who are concerned about their alcohol or other drug use may approach a general practitioner or pharmacy for advice and/or treatment rather than attending a dedicated alcohol and other drug treatment service. The estimates in this report therefore do not reflect the total number of persons in Australia receiving treatment for alcohol and other drug use. A list of other data sources for alcohol and other drug treatment or use is available in Chapter 6.

## Counts in the collection

The 2001–02 report focuses predominantly on ‘closed treatment episodes’ rather than client registrations as occurred in the 2000–01 collection. The use of closed treatment episodes reflects clinical practice within the alcohol and other drug treatment sector and the inclusion of a treatment episode concept in the national collection will enhance the quality of information on service utilisation. Completed (closed) treatment episodes are the unit of measurement used by the collection.

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

The following counting rule has been used for the data included in this report.

### Closed treatment episodes

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

- it must have a defined date of commencement and cessation;
- during the period of contact there has been no change in:
  - the principal drug of concern;
  - the treatment delivery setting;
  - the main treatment type; and
- a treatment episode is deemed to have terminated in the event that there has been no (service) contact between the client and the treatment agency for a period of three months or more, unless the period of non-contact was planned between the client and the treatment agency.

If a client receives treatment in multiple settings a separate treatment episode must be reported for each setting. Therefore, it is possible that more than one treatment episode may

be in progress for a client at any one time. It is possible for each of these episodes to have different dates of commencement and cessation.

## **Estimates of number of client registrations**

Counts in this report also include estimates of the number of client registrations as well as the number of closed treatment episodes. However, it is important to keep in mind that these are estimates only of the numbers of clients within agencies because a client may attend a number of different agencies throughout the collection period. As most jurisdictions do not have unique person identifiers across all the agencies in their jurisdiction, it is possible for the same person to be counted more than once.

These estimates therefore do not reflect the total number of persons in Australia receiving treatment for alcohol and other drug use.

See Appendix 2 for more information on treatment episodes and the methodology used for obtaining counts of clients.

## **Responsibility for the collection**

### **Government health authorities**

It is the responsibility of the Commonwealth and state and territory health authorities to establish and coordinate the collection of data from their alcohol and other drug treatment service providers. To ensure that the AODTS–NMDS is effectively implemented and collected, these authorities:

- allocate establishment identifiers and ensure that these are consistent with establishment identifiers used in other NMDS collections where appropriate;
- establish a suitable process for collecting client-level information (e.g. use of data entry software) and a process for agencies to deliver the data to the Commonwealth, state or territory authority;
- establish time lines for the delivery of data to the relevant health authority; and
- establish a process to check and validate data at the state/territory level and, where possible, assist and advise on data quality at the agency level.

Some jurisdictions also establish a coding system to be used for the person identifier, whether it is unique to the agency, or is implemented in cooperation with other agencies in the region, the district or across the state or territory.

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

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

### **Alcohol and other drug treatment agencies**

Treatment agencies whose data are included in the national collection collect the agreed data elements and forward this information to the appropriate health authority as arranged. They ensure that the required information is accurately recorded, and inform their health authority if they have difficulty collecting the information. They must ensure that their clients are generally aware of the purpose for which the information is being collected; the

fact that the collection of the information is authorised or required; and whether any personal information is passed on to another agency. Treatment agencies are also responsible for ensuring that their data collection and storage methods comply with existing privacy principles. In particular, they are responsible for maintaining the confidentiality of their clients' data and need to ensure that their procedures comply with any existing legislation within their state or territory.

### **AIHW role**

Under a memorandum of understanding with the Australian Government Department of Health and Ageing the AIHW is responsible for the management of the AODTS-NMDS. The AIHW maintains a coordinating role in the project, including providing the secretariat for the NMDS working group, undertaking data development work, and highlighting national and jurisdictional implementation and collection issues. The AIHW is also the data custodian of the collection and prepares the annual report, in consultation with the working group.

## **Outputs from the collection**

### **Reports and bulletins**

Each year following the processing of the AODTS-NMDS data, a detailed and comprehensive national report – such as this one – is produced, published and made available to the public free of charge on the AIHW website <[www.aihw.gov.au/drugs/](http://www.aihw.gov.au/drugs/)> or in hardcopy for a small fee. As well as providing information to government health authorities, researchers and the broader community, data output from the AODTS-NMDS collections is an important form of feedback to treatment agencies that took part in the collection.

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

### **Interactive alcohol and other drug treatment data**

The AIHW has an interactive alcohol and other drug treatment data site containing subsets of national information on alcohol and other drug treatment services from the 2001–02 collection. This site can be found at <[www.aihw.gov.au/drugs/datacubes/index.html](http://www.aihw.gov.au/drugs/datacubes/index.html)> and allows anyone who has access to the Internet to view AODTS-NMDS data via the web interface. The user can look up figures and present them in a way meaningful to their needs. (See Box 1.1 for more information on the contents of this site, and some hints for using it effectively.)

### **Box 1.1: Interactive alcohol and other drug treatment data**

*Interactive data are presented on the AIHW's web site as 'data cubes'. National 2001–02 data relating to AODTS clients (e.g. age, sex, Indigenous status, client type.), their drug-related information (e.g. principal drug of concern, method of use), their treatment programs (e.g. treatment type, service delivery setting, reason for cessation) and the treatment agencies they attend (e.g. geographic location and sector) are included within the cubes.*

*The site for the cubes is <<http://www.aihw.gov.au/drugs/datacubes/index.html>>.*

*Due to the multi-dimensional nature of the alcohol and other drug treatment data cubes, extra steps have been taken to ensure the confidentiality of the data. This means that only a selection of variables has been included within the cubes, and data are not available by state/territory.*

*Following are some handy hints to access the data cubes and obtain data as required:*

**Definition function** *By clicking the word 'definitions' located at the top of the screen, a pop-up window is opened providing definitions for variables and categories. The source of these definitions is Guidelines for the NMDS for alcohol and other drug treatment services 2001–02.*

**Selecting and changing variables** *The data cube is initially populated with the first two variables listed on the dimension toolbar found above the data cube. To change these variables, click on the down arrow situated next to the variable name on either the last column or row of the cube and scroll down to select the variable you would like presented.*

**Graphically presenting the data** *To view the data presented in the table in a graphical representation, select one of the five graph symbols located on the bottom toolbar of the cube. Once selected, the variables of the graph may be changed by using the drop-down menus, which appear next to the graph.*

**Saving and exporting the data** *Once the data cube has been customised to your needs, there are various avenues for saving the data. These include printing the table, exporting the data as comma-separated value (.csv) tables which can be opened in other applications such as Microsoft Excel, and bookmarking the table so it can be opened at a future time. Comments and feedback relating to the use of the interactive alcohol and other drug treatment data cubes can be made by email to [drugs@aihw.gov.au](mailto:drugs@aihw.gov.au).*

## **1.4 The national collection**

The national collection is a compilation of agency administrative data from state and territory health authority systems. There is some diversity in the data collection systems and practices that are in place within the alcohol and other drug treatment sector across Australian jurisdictions. In addition, although there has been national agreement on the definitions and standards for the data items that comprise the AODTS–NMDS, this does not ensure that there is perfect comparability of the data across states and territories, nor across agencies within states and territories.

National implementation of the AODTS–NMDS collection has been staggered. In the first year of the collection (2000–01), there was a mix of client registration and treatment episode data and one jurisdiction (Queensland) was unable to supply data. For the 2001–02 collection period, Queensland Health supplied data for police diversion clients only and South Australia supplied client registration data not treatment episode data (see Section 7.1 for further details). All other jurisdictions supplied treatment episode data.

The AODTS–NMDS pilot-test year (2000–01) provided a firm basis and framework for ensuring that the quality of the information contained in the national collection has improved for this second year of collection and will continue to improve in future years.

For the data in this report the following caveats should be remembered:

These figures do not include the majority of Commonwealth-funded Indigenous substance use services (five out of 43 were included) or Aboriginal primary health care services (seven out of 133 were included) that also provide treatment for alcohol and other drug problems. These services are generally not under the jurisdiction of the state or territory health authority and the Commonwealth currently only reports NMDS data from one specific program. In addition, these services have a different collection basis to the NMDS. As a result most of these data are not currently included in the AODTS–NMDS collection. Therefore the number of Indigenous clients in this report will under-represent the total number of Indigenous Australians who received treatment for alcohol and other drug problems during 2001–02. Published data on these services are available (see Section 6.2).

These figures do not include all of the services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme. The respective state or territory where the service is located reports many of those services, however some are reported by the Commonwealth. Not all of those agencies under the jurisdiction of the Commonwealth were able to supply data for this report (18 of the 33 services supplied data for 2001–02). It is anticipated that more services will be reported on in future collections. Those reported by the Commonwealth are listed under ‘Other’ in the jurisdiction-based tables.

## 1.5 Recent drug use

This section provides a brief overview of drug use, as background to the data on treatment services in the rest of the report. According to the 2001 National Drug Strategy Household Survey, 82% of Australians aged 14 years or more consumed alcohol and nearly one-quarter (23%) smoked tobacco. Lower proportions of people in this age group reported using cannabis (13%) and heroin (0.2%). Almost 10% of people aged 14 years or more consumed alcohol at levels that were risky or high risk for long-term harm<sup>3</sup> (see Table 1.1).

Similar to patterns of consumption, in 2001–02 alcohol (35%) was the most common drug nominated by clients aged 10 years or more as their principal drug of concern when seeking treatment from an alcohol or other drug treatment service<sup>4</sup>. In contrast 1.6% nominated tobacco, the next most common drug used in the population. These differences in treatment for nicotine are perhaps not surprising given that most ‘treatment’ for nicotine addiction is through pharmacies, general practitioners (e.g. advice and nicotine patches) or ‘quit’ lines.

While very low proportions of the general population reported using heroin, 17% of clients of alcohol and other drug treatment services nominated heroin as their principal drug of concern. The differences in results from the two sources of data reflect the nature of the treatment services captured by the NMDS. These services focus on the people who have a problem with their drug use, whereas the household survey data cover all people who consume alcohol or use tobacco or other drugs regardless of whether they think they have a problem or not.

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<sup>3</sup> Risky or high risk for long-term harm for males occurs when 5 or more standard drinks are consumed on an average day (3 or more for females) or 29 or more standard drinks are consumed weekly (15 or more for females) (NHMRC 2001). Risky or high risk for short-term harm for males occurs when 7 or more standard drinks are consumed on any one day at least once per year (5 or more for females) (NHMRC 2001).

<sup>4</sup> Client figures for tobacco and alcohol use do not include persons seeking treatment from pharmacies or general practitioners and therefore do not represent the full picture of treatment.

Other information from the 2001 National Drug Strategy Survey showed that, during the 12 months prior to the survey, 405,000 people aged 14 years or more (2.6%) sought treatment to reduce or quit smoking tobacco and 146,000 people (0.9%) received counselling or sought treatment to help reduce their consumption of alcohol. A further 26,000 people aged 14 years or more received treatment at a detoxification centre (AIHW 2002a).

**Table 1.1: Summary of selected drugs recently<sup>(a)</sup> used, and principal drugs for which treatment was sought, Australia, 2001**

Drug/behaviour	User population aged 14 years or more <sup>(b)</sup>	Clients of AODT services aged 10 years or more <sup>(c)</sup>
	(per cent)	
Tobacco	23.2	1.6
Alcohol	82.4	35.4
Risky or high risk for short-term harm	34.4	n.a
Risky or high risk for long-term harm	9.8	n.a
Illicits		
Marijuana/cannabis	12.9	22.1
Heroin	0.2	17.2
Methadone <sup>(d)</sup>	0.1	2.3
Amphetamines <sup>(e)</sup>	3.4	11.0
Cocaine	1.3	0.7
Ecstasy/designer drugs	2.9	0.3
<i>Any illicit<sup>(f)</sup></i>	<i>16.9</i>	<i>61.5</i>
<b>No alcohol, tobacco or illicit drugs</b>	<b>14.7</b>	<b>n.a</b>

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

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

(c) Proportion of clients aged 10 years or more from alcohol and other drug treatment (AODT) services reporting to the 2001–02 AODTS–NMDS. Excludes clients seeking treatment for the drug use of others. Based on client registration data.

(d) Non-maintenance.

(e) For non-medical purposes.

(f) Includes illicit drugs listed above plus painkillers/analgesics and tranquillisers/sleeping pills for non-medical purposes, steroids, barbiturates, inhalants, hallucinogens, injected drugs and other opiates.

Source: AIHW 2002a.