5 Treatment programs

'Main treatment type' is the main activity determined at assessment by the treatment agency to treat the client's principal alcohol and/or other drug problem. This chapter focuses on these treatment types and programs, and examines them and their relationship to a selection of variables of interest. The chapter begins with a summary of clients' main treatment types and the combination of main treatment type with principal drug of concern.

Box 5.1: Key definitions and counts for treatment programs, 2002–03

Closed treatment episode *refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2002–03 there were* ***130,930*** *closed treatment episodes.*

Main treatment type *refers to the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. In 2002–03, main treatment type was reported for* ***130,930*** *treatment episodes..*

Caution should be taken when comparing the number of closed treatment episodes for main treatment type in 2002–03 with those of 2001–02: in 2001–02 records from South Australia were excluded from tables using main treatment type as South Australia did not provide this data item.

Main treatment type with principal drug of concern *In 2002–03, data on the combination of these two data items were reported for* ***123,032*** *closed treatment episodes. This count excludes closed treatment episodes for clients seeking treatment for the drug use of others.*

Other treatment type *refers to all other forms of treatment provided to the client in addition to the main treatment (the client can have up to three other treatment types). In 2002–03, there were* ***16,108*** *closed treatment episodes which provided a total of* ***20,245*** *other treatment types. In 2002–03, closed treatment episodes from Victoria are excluded from any analysis involving 'other treatment types' as Victoria did not provide data for 'other treatment types'.*

All treatment types *refers to all treatment types reported by a client including main treatment and other treatment. In 2002–03, there were a total of* ***151,175*** *treatment types reported, either as a main or other treatment type.*

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

5.1 Jurisdictions and treatment programs

Nationally in 2002–03, counselling (42%), withdrawal management (detoxification) (19%) and assessment only (13%) were the most common main treatment types provided within alcohol and other drug treatment services (Table 5.1)[3]. Compared to 2001–02, in 2002–03 a slightly lower proportion of treatment episodes were for assessment only (13% in 2002–03, compared to 15% in

[3] In 2002–03, a very small number of closed treatment episodes (2,064) involved pharmacotherapy as the main treatment type. Throughout this chapter these episodes are included in the main treatment type category 'other'. It is important to note that agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS. Data on pharmacotherapy services in Australia are discussed in Section 7.4.

2001–02) and a slightly higher proportion for counselling (42% in 2002–03, compared to 39% in 2001–02).

In 2002–03, counselling was the most common main treatment type reported in all jurisdictions except for Queensland and the Australian Capital Territory. In Western Australia, counselling as the main treatment accounted for 58% of all treatment episodes, Tasmania 56% and Victoria 49%. The Australian Capital Territory reported the lowest proportion of treatment episodes where counselling was the main treatment (16%) and the highest proportion of treatment episodes where withdrawal management (detoxification) was the main treatment (51%).

South Australia reported an even spread of treatment episodes across most treatment types, with both counselling and rehabilitation each accounting for 23% of treatment episodes and withdrawal management (detoxification) and assessment only 22% each. In Queensland, the highest proportion of closed treatment episodes were for information and education only (45%), followed by counselling (29%). This pattern of main treatment in Queensland relates largely to the scope of their collection in 2002–03 (namely the inclusion of police diversion and government-provided services but not non-government-funded services; see Section 1.3 for further details).

Table 5.1: Closed treatment episodes by main treatment type and jurisdiction, Australia, 2002–03 (per cent)

Main treatment type	NSW	Vic	Qld[a]	WA	SA	Tas	ACT	NT	Australia	Total (no.)
Withdrawal management (detoxification)	22.6	21.0	5.4	9.7	21.6	15.7	50.7	8.9	18.9	24,767
Counselling	37.9	48.6	29.2	58.0	23.3	55.7	15.8	24.7	41.5	54,395
Rehabilitation	9.0	3.7	7.4	6.1	22.6	5.3	7.4	17.4	7.5	9,865
Support and case management only	6.0	11.2	4.2	0.7	2.5	3.2	15.8	3.7	6.9	9,097
Information and education only	2.8	0.3	45.1	13.8	1.9	0.8	0.1	21.4	8.0	10,478
Assessment only	17.3	10.6	5.6	9.5	21.8	7.5	4.4	19.9	12.7	16,632
Other[b]	4.4	4.6	3.1	2.1	6.3	11.8	5.8	4.1	4.4	5,696
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**41,166**	**45,306**	**14,195**	**14,222**	**7,440**	**2,568**	**3,001**	**3,032**	**130,930**	130,930
Per cent of closed treatment episodes	***31.4***	***34.6***	***10.8***	***10.9***	***5.7***	***2.0***	***2.3***	***2.3***	***100.0***	***. .***

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

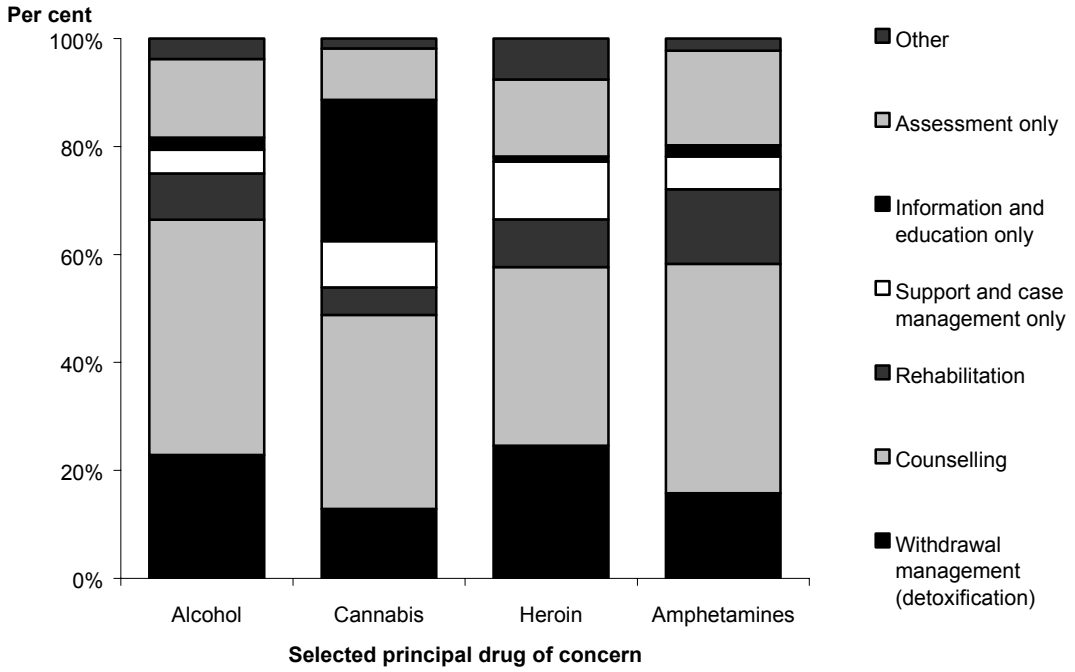
(b) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.2 Main treatment for selected principal drugs

The main treatment type varied depending on the principal drug of concern the client sought treatment for. Overall, counselling accounted for the highest proportion of closed treatment episodes when alcohol (44%), cannabis (36%), heroin (33%) or amphetamines (43%) were the principal drug of concern (Figure 5.1). Where alcohol was the principal drug, the next most common treatment type was withdrawal management (detoxification) (23% of treatment episodes), followed by assessment only (15%) and rehabilitation (9%).

For treatment episodes where cannabis was reported as the principal drug, information and education only followed counselling as the next most common treatment (26%), with withdrawal management (detoxification) and assessment only the next most common treatments (13% and 10% respectively).

The most common treatment types reported for treatment episodes where heroin was the principal drug of concern were counselling (33%), withdrawal management (detoxification) (25%), assessment only (14%) and other (7%). For treatment episodes where amphetamines were reported as the principal drug, following counselling, assessment only (18%), withdrawal management (detoxification) (16%) and rehabilitation (14%) were the most common treatments.



Note: 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

Source: Table A4.14.

Figure 5.1: Closed treatment episodes by selected main treatment type and selected principal drug of concern, Australia, 2002–03

Duration of treatment episode—principal drug of concern

Duration of a closed treatment episode is determined in the AODTS–NMDS by calculating the number of days between the date the client commenced a treatment episode and the date the client ended the treatment episode. The following analysis investigates duration using the 'median number of days' per treatment episode for principal drug of concern.

The duration of a treatment episode may depend on the type of treatment received and the principal drug of concern for which treatment is provided. Overall, the median number of days for a treatment episode was 17 days (Table 5.2). The highest median number of treatment days within a treatment episode occurred where the principal drug of concern was heroin (22 days), followed by treatment episodes where either alcohol or amphetamines were the principal drug

of concern (17 days). Treatment episodes where the principal drug was cannabis had the lowest median treatment days (11 days) of the four drugs considered.

The category 'other' treatment had the highest number of treatment days per treatment episode (55 days). This is largely due to the inclusion of treatment episodes where pharmacotherapy was identified as the main treatment type.

Counselling had the second highest median number of treatment days per treatment episode (44 days). This varied slightly when principal drug was considered. For treatment episodes where the client was receiving counselling as their main treatment, the median number of days per treatment episode was highest when heroin was the principal drug of concern (52 days), compared to 44 days when alcohol was the principal drug, 43 days for cannabis and 42 days for amphetamines.

The median length of time spent on support and case management was longest where the principal drug of concern was heroin (51 days) and shortest where alcohol was the principal drug (32 days). For rehabilitation treatment, the overall median number of treatment days per treatment episode was 32 days, ranging from 26 days when amphetamines were the principal drug to 39 days for heroin.

Table 5.2: Duration of closed treatment episodes by main treatment type and selected principal drugs of concern, Australia, 2002–03[(a)]

Main treatment type	Alcohol	Heroin	Cannabis	Amphetamines	Total[(b)]
			(median number of days)		
Withdrawal management (detoxification)	7	7	9	6	7
Counselling	44	52	43	42	44
Rehabilitation	35	39	29	26	32
Support and case management only	32	51	49	40	43
Information and education only	3	1	1	1	1
Assessment only	1	8	2	1	1
Other[(c)]	43	87	32	25	55
Total (median number of days)	**17**	**22**	**11**	**17**	**17**
Total (number of treatment episodes)	**46,747**	**22,642**	**27,106**	**13,213**	**123,032**

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

(b) Includes not stated for Principal drug of concern and balance of principal drugs of concern coded according to ASCDC. See Appendix 6.

(c) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.3 Client type, source of referral and treatment programs

Overall in 2002–03, the most common referrals to services were self-referrals (37% of treatment episodes), followed by referrals from alcohol and other drug treatment services (12%) and referrals from community-based corrections (10%) and police and court diversions (9%) (Table 5.3). Compared to 2001–02, treatment episodes in 2002–03 were slightly more likely to have resulted from self- referral (37% in 2002–03, compared to 35% in 2001–02) and referral via policy and court diversions (9% in 2002–03, compared to 8% in 2001–02).

As noted in Section 3.3, a very high proportion of closed treatment episodes were for clients seeking treatment for their own drug use (94%), and therefore the pattern of referral for this client group is expected to mirror the overall referral patterns. However, the referral pattern for clients seeking treatment for others' drug use was different from those seeking treatment for their own drug use. Where treatment is sought for someone else's drug use, a higher proportion of closed treatment episodes were self-referred (47%), followed by referrals from family members or friends (16%).

Table 5.3: Closed treatment episodes by client type and source of referral, Australia, 2002–03

	Own drug use		Others' drug use		Total	
Source of referral	**No.**	**%**	**No.**	**%**	**No.**	**%**
Self	45,026	36.6	3,679	46.6	48,705	37.2
Family member/friend	6,324	5.1	1,221	15.5	7,545	5.8
GP/medical specialist	8,319	6.8	291	3.7	8,610	6.6
Psychiatric and/or other hospitals	4,485	3.6	74	0.9	4,559	3.5
Community mental health services[(a)]	2,681	2.2	109	1.4	2,790	2.1
Alcohol & other drug treatment services[(a)]	15,224	12.4	559	7.1	15,783	12.1
Other community/health care services[(b)]	5,286	4.3	583	7.4	5,869	4.5
Community-based corrections	12,569	10.2	146	1.8	12,715	9.7
Police and court diversions	11,687	9.5	263	3.3	11,950	9.1
Other	10,498	8.5	895	11.3	11,393	8.7
Not stated	933	0.8	78	1.0	1,011	0.8
Total	**123,032**	**100.0**	**7,898**	**100.0**	**130,930**	**100.0**
Per cent of closed treatment episodes	***94.0***	***. .***	***6.0***	***. .***	***100.0***	***. .***

(a) Includes residential and non-residential services.

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

When closed treatment episodes for clients seeking treatment for their own drug use are considered, the most common treatments received were counselling (40%), withdrawal management (detoxification) (20%) and assessment only (13%) (Table 5.4). These proportions are very similar to those for the treatment population overall (Section 5.1)

As might be expected, some treatment types, such as withdrawal management (detoxification) and rehabilitation, are not used by clients receiving treatment only for someone else's drug use. Of the treatments used by people seeking treatment for others' drug use, the highest proportion of closed treatment episodes were for counselling (74%), then information and education only (16%). Clients seeking treatment for others' drug use also received support and case management only (4% of treatment episodes) and assessment only (3%).

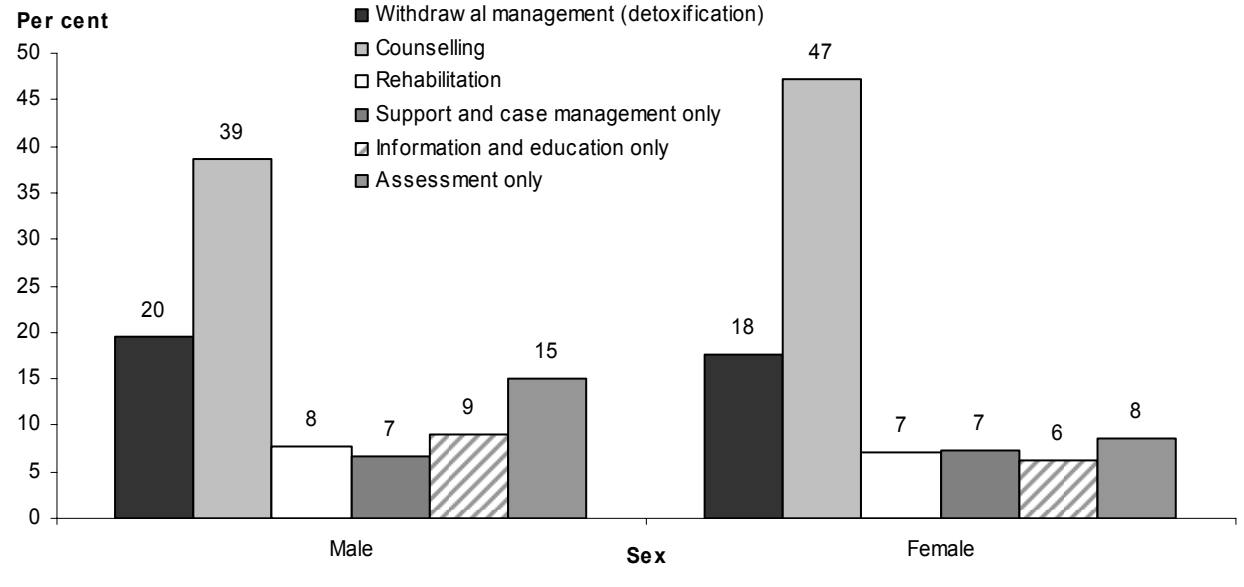
Table 5.4: Closed treatment episodes by client type and main treatment type, Australia, 2002–03

	Own drug use		Others' drug use		Total	
Main treatment type	**No.**	**%**	**No.**	**%**	**No.**	**%**
Withdrawal management (detoxification)	24,767	20.1	—	—	24,767	18.9
Counselling	48,577	39.5	5,818	73.7	54,395	41.5
Rehabilitation	9,865	8.0	—	—	9,865	7.5
Support and case management only	8,774	7.1	323	4.1	9,097	6.9
Information and education only	9,219	7.5	1,259	15.9	10,478	8.0
Assessment only	16,365	13.3	267	3.4	16,632	12.7
Other[(a)]	5,465	4.4	231	2.9	5,696	4.4
Total	**123,032**	**100.0**	**7,898**	**100.0**	**130,930**	**100.0**

(a) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.4 Sex, age and treatment program

In 2002–03, the main treatment type often varied depending on the sex and age group of the client (Figures 5.2 and 5.3). Of treatment episodes where the clients were female, a higher proportion involved counselling as the main treatment (47%) than for males (39%). Male clients were slightly more likely to receive withdrawal management (detoxification) as their main treatment (20% of treatment episodes) than were females (18%), as was the case for assessment only (15% of treatment episodes for males, compared to 9% for females) and information and education only (9% for males and 6% for females). Seven per cent of treatment episodes for males and females were for clients receiving support and case management only.



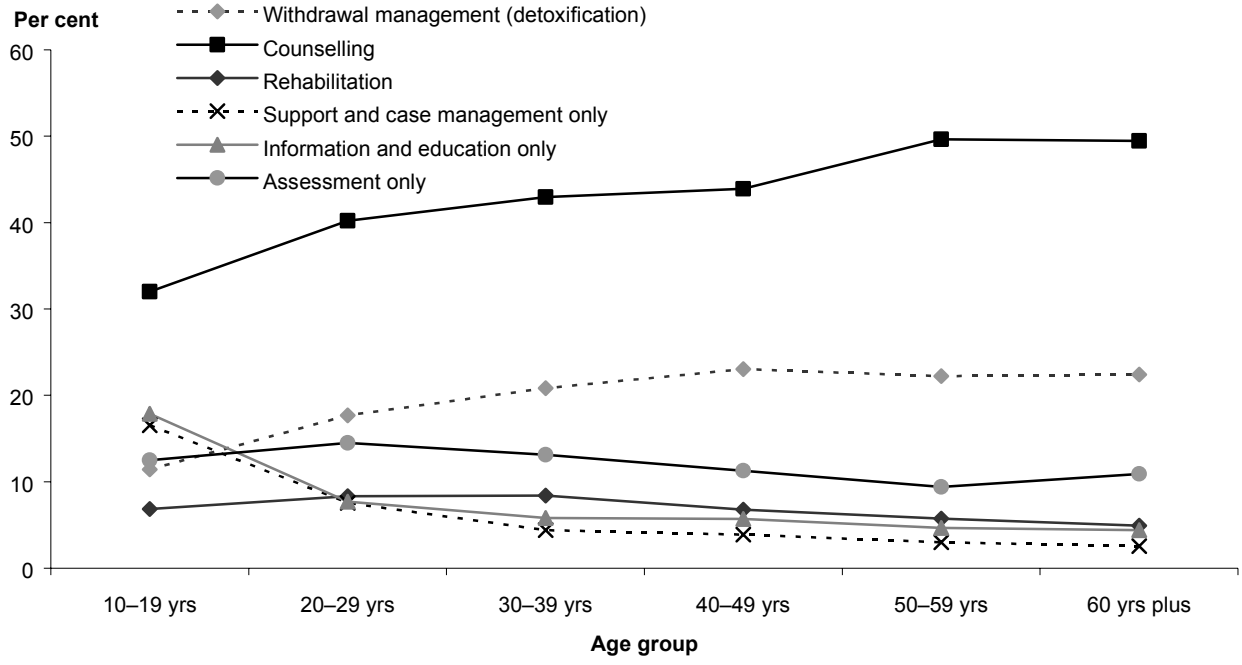
Source: Table A4.15.

Figure 5.2: Closed treatment episodes by selected main treatment type and sex, Australia, 2002–03

Overall, counselling accounted for 42% of closed treatment episodes nationally; however, this proportion varied when age group was considered (Figure 5.3). In 2002–03, the proportion of treatment episodes where counselling was the main treatment increased with the age of the client, from 32% of closed treatment episodes for clients aged between 10 and 19 years to 50% of episodes for clients in the 50–59 and the 60 and over age groups.

Withdrawal management (detoxification) was most common in treatment episodes where the clients were aged between 40 and 49 years (23%), followed by those aged in the 50–59 age group and clients aged 60 years or more (22% of treatment episodes each). Withdrawal management was least common amongst the younger age groups—11% of treatment episodes for clients aged between 10 and 19 years and 18% for those in the 20–29 age group.

Compared with counselling and withdrawal management (detoxification), there was a more even spread of closed treatment episodes across age groups for rehabilitation services. Rehabilitation ranged between 5% and 8% of treatment episodes for all age groups, slightly higher in younger clients (e.g. 8% of closed treatment episodes among those 20–29 years of age) and slightly lower in older clients (e.g. 5% of episodes for clients aged 60 years or more).



Source: Table A4.15.

Figure 5.3: Closed treatment episodes by main treatment type and age group, Australia, 2002–03

5.5 Indigenous status and treatment program

There are a number of differences when comparing treatment types for Aboriginal and Torres Strait Islander clients and other Australians. Specifically, treatment episodes involving Aboriginal and Torres Strait Islander clients were less likely to have withdrawal management (detoxification) as the main treatment (13% of treatment episodes for Indigenous clients, compared to 20% of episodes for other Australians) or counselling as the main treatment (38% for Indigenous clients, compared to 42% for other Australian clients) (Table 5.5). On the other hand, treatment episodes involving Aboriginal and Torres Strait Islander clients were more

likely to have information and education only and assessment only as the main treatments (15% each), compared to episodes for other Australian clients (8% and 12% respectively).

Table 5.5: Closed treatment episodes by main treatment type and Indigenous status, Australia, 2002–03

	Indigenous[a]		Non-Indigenous		Not stated		Total	
Main treatment type	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Withdrawal management (detoxification)	1,597	13.1	22,164	20.0	1,006	12.8	24,767	18.9
Counselling	4,580	37.7	46,651	42.1	3,164	40.3	54,395	41.5
Rehabilitation	1,189	9.8	8,308	7.5	368	4.7	9,865	7.5
Support and case management only	849	7.0	7,466	6.7	782	10.0	9,097	6.9
Information and education only	1,828	15.0	8,279	7.5	371	4.7	10,478	8.0
Assessment only	1,797	14.8	13,206	11.9	1,629	20.8	16,632	12.7
Other[b]	308	2.5	4,858	4.4	530	6.8	5,696	4.4
Total	**12,148**	**100.0**	**110,932**	**100.0**	**7,850**	**100.0**	**130,930**	**100.0**
Per cent of closed treatment episodes	***9.3***	***. .***	***84.7***	***. .***	***6.0***	***. .***	***100.0***	***. .***

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

(b) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.6 Geographic location and treatment program

In 2002–03, across all areas—except for very remote areas—counselling was the most commonly reported main treatment (accounting for 39% of treatment episodes in major cities, 50% in inner regional, 42% in outer regional and 45% in remote areas) (Table 5.6). In very remote areas, rehabilitation was the most common treatment type (35% of treatment episodes). The spread of other treatment types varied by geographic location of the treatment agency. In major cities and inner regional areas, withdrawal management (detoxification) was the second most common treatment (22% and 13% respectively), followed by assessment only in major cities (15%) and information and education only in inner regional areas (10%). In outer regional, remote and very remote areas, information and education only was the second most prominent treatment type (27%, 17% and 28%respectively), followed by withdrawal management (detoxification) in outer regional and very remote areas (9% and 22% respectively) and assessment only in remote areas (12%). As noted in Section 4.5 caution should be taken when interpreting geographical data.

Table 5.6: Closed treatment episodes by main treatment type and geographic location,[a] Australia, 2002–03 (per cent)

Main treatment type	Major cities	Inner regional	Outer regional	Remote	Very remote	Total [b]	Total (number)[b]
Withdrawal management (detoxification)	21.9	13.0	8.9	7.7	21.8	18.9	24,767
Counselling	39.1	50.1	42.4	44.8	7.0	41.5	54,395
Rehabilitation	8.1	6.3	4.4	15.2	34.5	7.5	9,865
Support and case management only	6.6	8.6	7.2	2.8	2.8	6.9	9,097
Information and education only	4.9	10.2	27.1	16.5	27.5	8.0	10,478
Assessment only	14.6	8.4	6.8	11.5	4.9	12.7	16,632
Other[c]	4.8	3.4	3.2	1.5	1.4	4.4	5,696
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**130,930**
Per cent of closed treatment episodes	***70.8***	***19.0***	***8.6***	***1.3***	***0.1***	***100.0***	**. .**

(a) The geographic location of treatment agencies in the 2002–03 AODTS–NMDS has been analysed using the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 5).

(b) Includes not stated for geographic location.

(c) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.7 Additional treatments

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

In 2002–03, of the 85,624 closed treatment episodes where clients were seeking treatment, 16,108 episodes (19%) reported at least one other treatment type—that is, a main treatment type and at least one other treatment type (Table 5.7). This proportion varied with the main treatment type—in closed treatment episodes where rehabilitation was the main treatment type, 45% of clients reported at least one other treatment; and where withdrawal management (detoxification) was the main treatment, 35% of clients reported more than one treatment type. Where counselling was the main treatment, only 17% of clients reported at least one other treatment type.

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

Table 5.7: Number of closed treatment episodes by main treatment type, with or without other treatment type, Australia, 2002–03[(a)]

Main treatment type	With other treatment type	With no other treatment type	Total episodes	Proportion of episodes with other treatment type
Withdrawal management (detoxification)	5,361	9,894	15,255	35.1
Counselling	5,386	27,006	32,392	16.6
Rehabilitation	3,693	4,500	8,193	45.1
Support and case management only	—	4,011	4,011	—
Information and education only	—	10,341	10,341	—
Assessment only	—	11,814	11,814	—
Other[(b)]	1,668	1,950	3,618	46.1
Total	**16,108**	**69,516**	**85,624**	**18.8**

(a) Excludes 45,306 closed treatment episodes from Victoria, as it did not provide data for 'other treatment type'.

(b) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

From the 16,108 closed treatment episodes that did report at least one other treatment type, 20,245 other treatment types were reported (clients are able to report up to four other treatment types) (Table A4.13). This equates to an average of 1.3 other treatments for clients of these treatment episodes.

5.8 Reason for cessation and treatment program

As described in Section 4.9, in the AODTS–NMDS there are a number of reasons why a treatment episode can end. Overall, the most common reason for ending a treatment episode was because the treatment was completed (52%), followed by treatment ending where the client ceased to participate without notice to the treatment agency (16%)[4] (Table 5.8).

The reason for cessation of a treatment episode differs by main treatment type. Treatment was relatively more likely to be completed where the main treatment type was assessment only (73% of episodes with this treatment type) and less likely where the main treatment type was rehabilitation (35%) or information and education only (26%) (Table 5.8). The low proportion of episodes for information and education ending in completion related to the fact that the majority of these treatment episodes ended at expiation (62%). This finding may be expected as expiation, as defined in the AODTS–NMDS, refers to when a client has expiated their offence by completing a recognised education or information program. This relates closely to the use of

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

expiation for cannabis use—77% of all treatment episodes where information and education was the main treatment type involved cannabis as the principal drug of concern[5].

A relatively high proportion of treatment episodes for counselling were recorded as ending because the client ceased to participate without notice (25% of all episodes for counselling). Rehabilitation and withdrawal management (detoxification) were the treatment types with the highest proportion of episodes ending with a client ceasing to participate against advice (16% and 11% of treatment episodes respectively).

Table 5.8: Closed treatment episodes by main treatment type and selected reason for cessation, Australia, 2002–03 (per cent)

Main treatment type	Treatment completed	Transferred to another service provider	Ceased to participate without notice	Ceased to participate against advice	Ceased to participate at expiation	Other[(a)]	Total[(b)]	Total (no.)
Withdrawal management (detoxification)	60.1	4.9	9.8	11.6	0.7	10.9	100.0	24,767
Counselling	49.0	7.0	25.4	2.3	1.0	13.5	100.0	54,395
Rehabilitation	34.7	5.9	13.8	16.1	1.0	26.0	100.0	9,865
Support and case management only	57.9	9.2	11.4	2.0	0.6	17.6	100.0	9,097
Information and education only	25.7	1.9	2.3	1.1	61.6	6.7	100.0	10,478
Assessment only	73.3	11.5	4.5	1.1	0.5	8.3	100.0	16,632
Other[(c)]	48.7	10.3	18.4	2.1	0.5	14.6	100.0	5,696
Total (per cent)	**51.9**	**7.0**	**15.8**	**4.8**	**5.7**	**13.1**	**100.0**	**. .**
Total (number)	**67,892**	**9,144**	**20,654**	**6,314**	**7,454**	**17,118**	**130,930**	**. .**

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

(b) Includes not stated for reason for cessation.

(c) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

[5] In Queensland a client undergoing Police Diversion automatically has the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and reason for cessation as 'ceased to participate at expiation'. It is possible that the principal drug of concern is not actually cannabis and it is anticipated that future modifications to data collection processes will enable this to be reflected.

5.9 Treatment delivery setting and treatment program

Treatment delivery setting refers to the setting in which the main treatment is provided—settings include non-residential or residential facilities, homes, outreach settings or other settings. Just over two-thirds (67%) of treatment episodes occurred at a non-residential facility[6] (Table 5.9). About one-fifth (21%) of treatment episodes occurred in residential facilities and 7% in an outreach setting such as a mobile van service.

Treatment episodes conducted in residential facilities or home settings were most likely to be for withdrawal management (detoxification) (56% and 68% respectively). The next most likely treatment in a residential treatment facility was rehabilitation (27%), while, for home settings, the next most likely treatment type was counselling (16%) or assessment only (10%).

Of treatment episodes that were conducted in a non-residential treatment facility, the majority of episodes had counselling as the main treatment (56%), followed by assessment only (16%) and withdrawal management (detoxification) and information and education only (8% each).

A high proportion of treatment episodes that were conducted in an outreach setting reported support and case management only as their main treatment (45%). The next most common treatments for this delivery setting were counselling (28%) and information and education only (16%).

Table 5.9: Closed treatment episodes by main treatment type and treatment delivery setting, Australia, 2002–03 (per cent)

Main treatment type	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Withdrawal management (detoxification)	7.8	55.6	68.3	2.8	2.6	18.9
Counselling	56.2	4.7	15.9	27.7	17.7	41.5
Rehabilitation	2.2	27.1	0.6	2.1	7.6	7.5
Support and case management only	5.1	0.6	2.8	45.3	1.3	6.9
Information and education only	8.1	2.6	1.7	15.6	45.1	8.0
Assessment only	15.7	5.8	10.0	5.1	16.0	12.7
Other[(a)]	4.9	3.5	0.6	1.4	9.6	4.4
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**88,178**	**27,827**	**3,066**	**9,474**	**2,385**	**130,930**
Per cent of closed treatment episodes	***67.3***	***21.3***	***2.3***	***7.2***	***1.8***	***100.0***

(a) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

Duration of treatment episode—treatment delivery setting

Overall, the median number of treatment days for a treatment episode was 17 days (Table 5.10). The highest median number of days within a treatment episode occurred where the treatment delivery was either in a non-residential treatment facility or in an outreach setting (26

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

and 25 days respectively). Treatment episodes where the treatment delivery setting was a client's home had a median length of treatment of 16 days, while clients receiving treatment in residential treatment facilities had a median length of 7 treatment days.

The category 'other' treatment had the highest number of treatment days per treatment episode (51 days). This is largely due to the inclusion of treatment episodes where pharmacotherapy was identified as the main treatment type.

Overall, the median length of time spent on support and case management was 43 days. This varied by treatment delivery setting—46 days for those receiving treatment in an outreach setting, 39 days for non-residential treatment facilities, 21 days for home and 8 days for residential treatment facilities.

The median duration of treatment episodes involving withdrawal management (detoxification) was 7 days. The highest median length for this treatment type was for clients receiving services in a non-residential treatment facility or at home (17 and 16 days respectively). The shortest median duration for this treatment type was for clients receiving treatment through an outreach setting (4 days).

Table 5.10: Duration[(a)] of closed treatment episodes by main treatment type and treatment delivery setting, Australia, 2002–03

Main treatment type	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
			(median number of days)			
Withdrawal management (detoxification)	17	6	16	4	5	7
Counselling	47	22	64	29	30	45
Rehabilitation	24	35	29	4	32	32
Support and case management only	39	8	21	46	19	43
Information and education only	1	3	1	1	1	1
Assessment only	2	1	1	1	1	1
Other[(b)]	42	113	23	3	31	51
Total	**26**	**7**	**16**	**25**	**1**	**17**
Total (number of treatment episodes)	**88,178**	**27,827**	**3,066**	**9,474**	**2,385**	**130,930**

(a) As stated in Section 5.3, duration of a closed treatment episode is determined in the AODTS–NMDS by calculating the number of days between the date the client commenced a treatment episode and the data the client ended a treatment episode. This analysis investigates duration using the 'median number of days' per treatment episode for treatment delivery setting.

(b) 'Other' includes 2,064 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

Treatment delivery setting and principal drug of concern

For treatment episodes where the delivery setting was either a non-residential treatment facility, a residential treatment facility or the client's home, the principal drug of concern to the client was most likely to be alcohol (38%, 43% and 38% respectively) (Table 5.11). The next most common principal drug for clients in non-residential facilities and at home was cannabis (24% and 21% respectively), followed by heroin for both treatment settings (17% each). The second

most common principal drug of concern where the treatment delivery setting was a residential treatment facility was heroin (24%), then amphetamines and cannabis (12% each).

For treatment episodes where the delivery setting was either an outreach setting or an 'other' delivery setting, the most common principal drug was cannabis (28% and 47% respectively). The next most common principal drug of concern for clients receiving treatment through an outreach setting was alcohol (24%), then heroin (15%) and amphetamines (11%). This pattern was repeated for those receiving treatment through 'other' delivery settings (26%, 9% and 9% respectively).

These patterns reflect the fact that alcohol, cannabis, heroin and amphetamines are the four most common principal drugs of concern in the AODTS–NMDS for 2002–03.

Table 5.11: Closed treatment episodes by principal drug of concern and treatment delivery setting, Australia, 2002–03[(a)] (per cent)

Principal drug of concern	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Alcohol	38.1	42.8	38.2	23.9	25.9	38.0
Amphetamines	10.3	11.9	11.1	11.3	9.1	10.7
Benzodiazepines	2.1	2.2	4.4	1.3	1.0	2.1
Cannabis	24.1	12.2	21.0	28.0	46.5	22.0
Cocaine	0.3	0.3	0.1	0.4	0.3	0.3
Ecstasy	0.4	0.1	0.2	0.7	0.2	0.3
Heroin	17.0	24.3	16.9	15.4	8.8	18.4
Methadone	1.7	1.7	1.9	2.8	1.7	1.8
Nicotine	1.1	0.5	0.4	7.8	1.2	1.4
Other drugs[(b)]	4.2	3.7	5.6	8.4	4.3	4.4
Not stated	0.7	0.4	0.2	0.2	1.0	0.5
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**81,714**	**27,727**	**2,989**	**8,346**	**2,256**	**123,032**
Per cent of closed treatment episodes	***66.4***	***22.5***	***2.4***	***6.8***	***1.8***	***100.0***

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

(b) Includes not stated for principal drug of concern, and balance of principal drugs of concern coded according to ASCDC. See Appendix 6.

6 Special theme—clients aged 10–29 years

Previous chapters of this report have profiled clients who seek treatment from government-funded alcohol and other drug treatment services, the types of drugs for which they seek treatment and the types of treatment they receive. This special theme chapter shifts the focus to younger clients (aged between 10 and 29 years), comparing their characteristics and treatment experiences to older clients (aged 30 years and over). This theme was selected on the basis of feedback received from the agencies that provide data for the AODTS–NMDS via the 2003 Survey of Treatment Agencies.

Further information about the use of and perceptions about use of drugs among different age groups within the Australian population is included in Section 7.3 on the National Drug Strategy Household Survey.

Box 6.1: Key definitions and counts for closed treatment episodes and treatment programs, 2002–03

Closed treatment episode *refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2002–03 there were:*

- ***15,968*** *closed treatment episodes for clients aged 10–19 years;*
- ***43,529*** *closed treatment episodes for clients aged 20–29 years; and*
- ***69,158*** *closed treatment episodes for clients aged 30 years or more.*

Principal drug of concern *refers to the main substance that the client states led him or her to seek treatment from the alcohol and other drug treatment agency. Within this report, only clients seeking treatment for their own substance use are included in analysis involving principal drug of concern. It is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2002–03 there were:*

- ***15,045*** *closed treatment episodes for clients aged 10–19 years reporting a principal drug;*
- ***42,606*** *closed treatment episodes for clients aged 20–29 years reporting a principal drug; and*
- ***63,484*** *closed treatment episodes for clients aged 30 years or more reporting a principal drug.*

Main treatment type *refers to the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. In 2002–03 the number of closed treatment episodes reporting a main treatment is the same as the 'closed treatment episode' count above.*

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

6.1 Client profile

Client type and sex

Of the 130,930 closed treatment episodes in 2002–03, approximately 12% (15,955) were for clients aged 10–19 years, 33% (43,478) were for clients aged 20–29 years and 53% (69,076) for clients aged 30 years or more (Table 6.1).

Among the treatment population overall, males were more likely than females to receive treatment—65% of treatment episodes relating to male and 35% to female clients of all ages. This pattern was slightly accentuated among the younger treatment population—males accounting for 68% of 10–19 year olds and 67% of 20–29 year olds receiving treatment.

Overall, clients aged under 30 years of age were less likely than clients aged 30 years or more to receive treatment for someone else's drug problem—3% (or 1,846 from 59,433) of treatment episodes among clients aged 10–29 years, compared with 8% (or 5,659 from 69,076) of treatment episodes among clients aged 30 years or more. However, this pattern varied within the younger age groups and between the sexes. Among females, clients aged 30 years or more were substantially more likely to seek treatment in relation to another person's drug use (16%, compared to 4% of female clients aged 20–29 years and 8% of female clients aged 10–19 years). In contrast, while males aged 30 years or more were more likely than those aged 20–29 years to receive treatment for someone else's drug problem (4%, compared to 1%), they were marginally less likely to do so than males aged 10–19 years (5%).

Table 6.1: Closed treatment episodes by age group by client type and sex, Australia, 2002–03

	10–19 years		20–29 years		30 years and over		Total[a]		
Client type	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Males**	**Females**	**Persons[b]**
					(Number)				
Own drug use	10,340	4,692	28,980	13,575	42,483	20,934	82,932	39,954	123,032
Others' drug use	491	432	329	594	1,662	3,997	2,605	5,277	7,898
Total	**10,831**	**5,124**	**29,309**	**14,169**	**44,145**	**24,931**	**85,537**	**45,231**	**130,930**
					(Per cent)				
Own drug use	95.5	91.6	98.9	95.8	96.2	84.0	97.0	88.3	94.0
Others' drug use	4.5	8.4	1.1	4.2	3.8	16.0	3.0	11.7	6.0
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent of closed treatment episodes	***8.3***	***3.9***	***22.4***	***10.8***	***33.7***	***19.0***	***65.3***	***34.5***	***100.0***

(a) Includes 2,275 closed treatment episodes where age was not stated.

(b) Includes 162 closed treatment episodes where sex was not stated.

Indigenous status

As noted in Chapter 3, 12,136 closed treatment episodes (or 9% of the 130,930 closed treatment episodes in 2002–03) involved clients who identified as Aboriginal and Torres Strait Islander people (Table 3.3), which is higher than the overall proportion of Aboriginal and Torres Strait Islander people in the total Australian population (2.4%; ABS 2004)[7]. The percentage of treatment episodes for clients aged 10–19 years was higher for Aboriginal and Torres Strait Islander clients (17%) than for other Australians (12% in the same age group) (Table A4.16). However, treatment episodes for clients aged over 30 years were relatively less common among Aboriginal and Torres Strait Islander clients (46% of Aboriginal and Torres Strait Islander clients were aged over 30 years) compared to other Australian clients (53% of other Australian clients were aged over 30 years). It is likely that these patterns relate to differences in the underlying age structure of Aboriginal and Torres Strait Islander people in the general population, with Indigenous people having a younger age profile than other Australians.

6.2 Drugs of concern

Principal drug of concern

Young clients have a markedly different profile in terms of their principal drug of concern (Table 6.2). For example:

- clients aged under 30 years were much more likely than older clients to receive treatment related to cannabis—50% of treatment episodes among the 10–19 age group and 26% among the 20–29 age group had cannabis as the principal drug of concern, compared to 13% of treatment episodes for clients aged 30 years or more;
- clients aged under 30 years were also somewhat more likely to receive treatment related to amphetamines (accounting for 11% of treatment episodes among 10–19 year olds and 15% among 20–29 year olds, compared to 8% among clients aged 30 years or more);
- clients aged under 30 years were far less likely to receive treatment for alcohol as the principal drug of concern (accounting for 17% of treatment episodes among 10–19 year olds, 22% among 20–29 year olds and 54% among clients aged 30 years or more); and
- the age group most likely to be receiving treatment for heroin was the 20–29 age group—27% of all treatment episodes in this age group were for heroin, compared to 12% among clients aged 10–19 years and 14% among clients aged 30 years or more.

[7] As also noted in Chapter 3, data on Aboriginal and Torres Strait Islander people in the AODTS treatment population should be interpreted with caution. The overall proportion of episodes relating to clients reported as being of Aboriginal and/or Torres Strait Islander origin is only slightly higher than the proportion of episodes where Indigenous status was 'not stated'. Further, the majority of dedicated Indigenous substance use services are not included in the AODTS–NMDS collection (see Section 1.3 for further details).

Table 6.2: Closed treatment episodes by age group and principal drug of concern, Australia, 2002–03[a]

Principal drug of concern	10–19 years	20–29 years	30 years or more	Total[b]	10–19 years	20–29 years	30 years or more	Total[b]
	(Number)				(Per cent)			
Alcohol	2,616	9,432	34,233	46,747	17.4	22.1	53.9	38.0
Amphetamines	1,599	6,498	4,863	13,213	10.6	15.3	7.7	10.7
Benzodiazepines	108	777	1,686	2,609	0.7	1.8	2.7	2.1
Cannabis	7,466	11,218	7,924	27,106	49.6	26.3	12.5	22.0
Cocaine	26	126	146	323	0.2	0.3	0.2	0.3
Ecstasy	87	219	88	416	0.6	0.5	0.1	0.3
Heroin	1,855	11,439	9,095	22,642	12.3	26.8	14.3	18.4
Methadone	80	861	1,206	2,173	0.5	2.0	1.9	1.8
Nicotine	213	171	1,221	1,693	1.4	0.4	1.9	1.4
All other drugs[c]	894	1,624	2,698	5,434	5.9	3.8	4.2	4.4
Not stated/ missing	101	241	324	676	0.7	0.6	0.5	0.5
Total	**15,045**	**42,606**	**63,484**	**123,032**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Includes not stated for age.

(c) Includes balance of principal drug of concern coded according to the ASCDC. See Appendix 6.

'Party drugs'

'Party drugs' are a group of drugs commonly used at dance parties, raves and night clubs. Party drugs include, but are not limited to: ecstasy, LSD, Ketamine, amphetamines (including methamphetamines such as speed, crystal and base), GHB and cocaine. These drugs—mainly stimulants—are used to enhance the party environment by making the music sound different, lights appear brighter and, due to the stimulant effect, enable the user to dance for longer periods, giving them more energy and the ability to stay awake. The potential for harm when using 'party drugs' may range from general confusion through to psychosis and, in extreme cases, death (NDARC 2000).

In 2002–03 there were 13,991 closed treatment episodes relating to drugs often referred to as 'party drugs' or 'club drugs' (Table 6.3). These treatment episodes represent a relatively small proportion of all treatment received and reported under the AODTS–NMDS, accounting for about 11% of all treatment episodes in 2002–03 for which a principal drug was reported.

When we consider 'party drugs' as the principal drug of concern, we see that, overall, treatment episodes involving clients aged 10–29 were more than one and a half times as likely to involve these selected drugs—accounting for 8,575 treatment episodes, compared to 5,265 treatment episodes among clients aged 30 years or more. The 20–29 age group accounted for by far the highest number of treatment episodes relating to these drugs (6,856 treatment episodes).

By far the most common 'party drugs' for which treatment was received were amphetamines, accounting for around 94% of treatment episodes for these drugs. Ecstasy and cocaine were the next most likely 'party drugs' for which treatment was sought; however, the ordering of these drugs varied slightly among the three age groups. Among the younger age groups the second most likely 'party drug' was ecstasy (5% for 10–19 year olds and 3% for 20–29 year olds) and then cocaine (2% each), while for clients aged 30 years or more, cocaine was the second most likely (3%) and then ecstasy (2%). Very few treatment episodes related to other party drugs such as LSD (30 episodes), GHB (1), ketamine (6) and amyl nitrate (2) as a principal drug.

Table 6.3: Closed treatment episodes by age group and principal drug of concern—'party drugs', Australia, 2002–03[(a)]

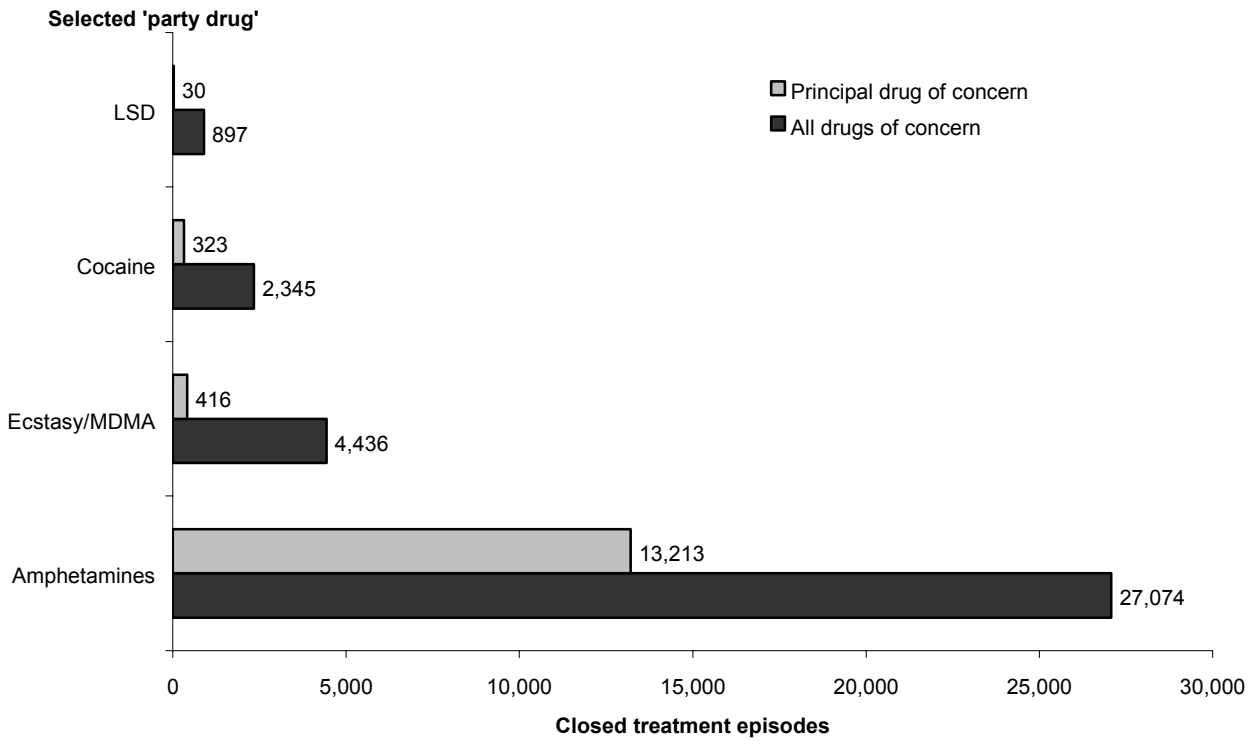
Principal drug of concern	10–19 years		20–29 years		30 years and over		Total[(c)]	
	No.	%	No.	%	No.	%	No.	%
Amphetamines[(b)]	1,599	93.0	6,498	94.8	4,863	92.4	13,213	94.4
Ecstasy	87	5.1	219	3.2	88	1.7	416	3.0
Cocaine	26	1.5	126	1.8	146	2.8	323	2.3
LSD	7	0.4	7	0.1	5	0.1	30	0.2
GHB	0	0.0	1	0.0	0	0.0	1	0.0
Ketamine	0	0.0	5	0.1	1	0.0	6	0.0
Amyl nitrate	0	0.0	0	0.0	2	0.0	2	0.0
Total	**1,719**	**100.0**	**6,856**	**100.0**	**5,265**	**100.0**	**13,991**	**100.0**

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

(b) Amphetamines include methamphetamines such as ice, crystal, base and speed.

(c) Includes not stated for age.

When considering all 'party drugs' of concern (that is, 'party drugs' nominated as the principal drug of concern or as an other drug of concern), a different pattern emerges (Figure 6.1). For all age groups, 29% of closed treatment episodes involved a 'party drug' as one of their drugs of concern, compared to 11% as the principal drug of concern (Table A4.17). This pattern was particularly marked in the case of treatment episodes involving amphetamines (13,213 or 11% of treatment episodes involved amphetamines as the principal drug of concern whereas, 27,074 or 22% included them as a drug of concern), ecstasy (identified in 416 or 0.3% of treatment episodes as the principal drug and 4,436 or 4% as a drug of concern) and cocaine (identified in 323 or 0.3% of treatment episodes as the principal drug and 2,345 or 2% as a drug of concern).

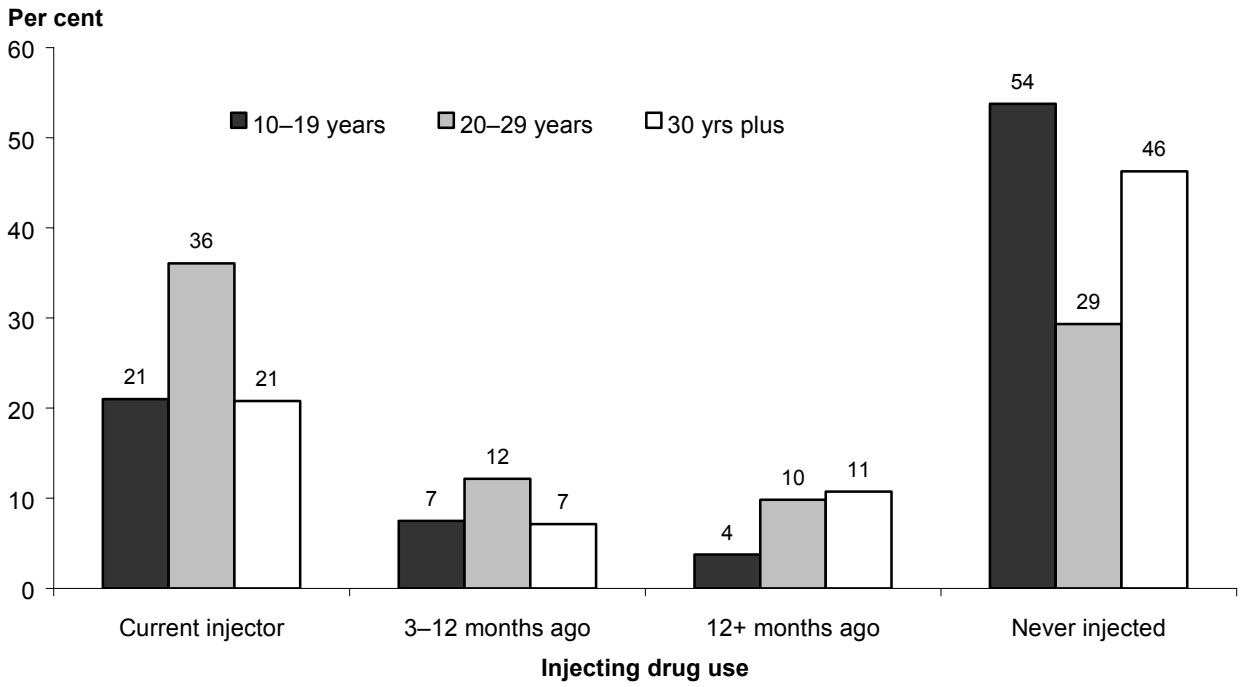


Source: Table A4.17.

Figure 6.1: Closed treatment episodes by principal drug of concern and all drugs of concern, selected 'party drugs', Australia, 2002–03

Injecting drug use

Overall, 26% of clients reported that they were current injectors, a further 19% had injected in the past (9% between 3 and 12 months ago and 10% 12 or more months ago) and 41% had never injected (Table 4.6 or Table A4.18). The 20–29 age group were more likely than the younger and older age groups to be current injectors (36%, compared with 21% for both clients aged 10–19 years and 30 years or more) and less likely to have never injected (29%, compared with 54% and 46% respectively) (Figure 6.2). Note that caution should be taken when interpreting data for 'injecting drug use' due to the high 'not stated' response for this item (14% of treatment episodes).



Source: Table A4.18.

Figure 6.2: Closed treatment episodes by injecting drug use and age group, Australia, 2002–03

Source of referral

Compared to clients aged 30 years or more, younger clients were less likely to self-refer (21% among treatment episodes for 10–19 year olds and 35% for 20–29 year olds, compared with 41% among clients aged 30 years or more), less likely to be referred by a general practitioner or medical specialist (2% and 5%, compared with 9% respectively), and more likely to be referred via community-based corrections (18% and 12%, compared with 7%) or police/court diversion processes (17% and 12%, compared with 6%) (Table 6.4). It is likely that the relatively high proportion of referrals via police/court diversion processes among the younger age groups relates to the higher proportion of treatment for cannabis among younger clients compared with older clients. Cannabis was the principal drug of concern for 50% of clients aged 10–19 and 26% of clients age 20–29 years, compared with 13% for clients aged 30 year or more in 2002–03, and cannabis was the principal drug in 63% of treatment episodes referred by police or court diversion processes (Tables 6.2 and 4.4). This pattern, in turn, is affected by the large number of treatment episodes from Queensland for clients undergoing police diversion (these accounted for more than half of all treatment episodes of this referral type)[8].

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

Table 6.4: Closed treatment episodes by source of referral and age group, Australia, 2002–03[a]

	10–19 years		20–29 years		30 years and over		Total[b]	
Source of referral	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Self	3,202	21.3	14,941	35.1	25,974	40.9	45,026	36.6
Family member/friend	1,293	8.6	2,254	5.3	2,612	4.1	6,324	5.1
GP/medical specialist	355	2.4	2,014	4.7	5,892	9.3	8,319	6.8
Psychiatric/other hospital	243	1.6	1,117	2.6	3,107	4.9	4,485	3.6
Community mental health service[c]	261	1.7	945	2.2	1,452	2.3	2,681	2.2
AODTS[c]	1,472	9.8	5,401	12.7	8,181	12.9	15,224	12.4
Other community health/care services[d]	981	6.5	1,644	3.9	2,545	4.0	5,286	4.3
Community-based corrections	2,762	18.4	5,057	11.9	4,699	7.4	12,569	10.2
Police/court diversions	2,618	17.4	5,128	12.0	3,918	6.2	11,687	9.5
Other	1,739	11.6	3,789	8.9	4,617	7.3	10,498	8.5
Not stated	119	0.8	316	0.7	487	0.8	933	0.8
Total	**15,045**	**100.0**	**42,606**	**100.0**	**63,484**	**100.0**	**123,032**	**100.0**

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

(b) Includes not stated for age.

(c) Includes residential and non-residential services.

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

6.3 Treatment programs

Main treatment type

Overall, the most common main treatment type for clients was counselling (42%), followed by withdrawal management (detoxification) (19%), assessment only (13%), rehabilitation (8%) and information and education only (8%) (Table 6.5). There were some variations in this treatment pattern according to age group. For example, clients aged under 30 years were somewhat less likely than clients aged 30 years or more to receive counselling as their main treatment type (accounting for 32% of treatment episodes among 10–19 year olds and 40% among 20–29 year olds, compared with 44% among clients aged 30 years or more) or withdrawal management (detoxification) (11% and 18%, compared with 22% respectively). Conversely, younger clients were more likely than older clients to receive support and case management only (accounting for 17% of treatment episodes among 10–19 year olds and 8% among 20–29 year olds, compared with 4% among clients aged 30 years or more) and information and education only (18% and

8%, compared with 6% respectively). These patterns also relate to the most likely principal drug of concern for the different age groups. For example, treatment episodes relating to clients aged 30 years or more were more likely than those for younger clients to relate to alcohol which, in turn, was more likely to be associated with counselling as a main treatment type. In contrast, as noted previously, treatment episodes for the 10–19 age group were far more likely to relate to cannabis, which was in turn more likely to be associated with information and education only as a main treatment type (see Tables 6.2 and A4.15 for more detail).

Table 6.5: Closed treatment episodes by main treatment type and age group, Australia, 2002–03

Main treatment type	10–19 years		20–29 years		30 years and over		Total[a]	
	No.	%	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	1,828	11.4	7,704	17.7	15,065	21.8	24,767	18.9
Counselling	5,111	32.0	17,495	40.2	30,679	44.4	54,395	41.5
Rehabilitation	1,095	6.9	3,629	8.3	5,109	7.4	9,865	7.5
Support and case management only	2,641	16.5	3,278	7.5	2,747	4.0	9,097	6.9
Information and education only[b]	2,851	17.9	3,347	7.7	3,847	5.6	10,478	8.0
Assessment only	1,994	12.5	6,311	14.5	8,283	12.0	16,632	12.7
Other[c]	448	2.8	1,765	4.0	3,328	4.9	5,696	4.4
Total	**15,968**	**100.0**	**43,529**	**100.0**	**69,158**	**100.0**	**130,930**	**100.0**

(a) Includes not stated for age.

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

(c) Other includes 2,064 treatment episodes where the main treatment type was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS–NMDS.

Treatment delivery setting

Overall, around two-thirds of all treatment episodes are conducted in non-residential treatment facilities (67%), around one-fifth in residential treatment facilities (21%) and 7% in outreach settings (see Table 5.9). This pattern varied somewhat for the youngest age group—with a much higher proportion of treatment episodes for 10–19 year olds being conducted in outreach settings (21%, compared to 6% for 20–29 year olds and 4% for clients aged 30 years or more) (Figure 6.3). Clients aged 10–19 years were less likely to receive treatment in non-residential treatment facilities (59% of treatment episodes among 10–19 year olds were in this setting, compared with 69% for both the 20–29 and 30 years or more age groups) and residential treatment facilities (14% for 10–19 year olds, compared with 21% for the 20–29 years and 24% for the 30 years or more age group).

Source: Table A4.19.

Figure 6.3: Closed treatment episodes by treatment delivery setting and age group, Australia, 2002–03

Reason for cessation of treatment episode

In 2002–03, younger clients were a little less likely than older clients to cease treatment because treatment had been completed (51% of treatment episodes for clients aged 10–19 years and 48% for clients aged 20–29 years ceased for this reason, compared with 55% for clients aged 30 years or more) and more likely to cease treatment due to expiation (13% and 7%, compared with 4%) (Table 6.6). Reason for cessation also relates closely to the principal drug of concern, with younger clients more likely to be receiving treatment for cannabis, which in turn is more likely to the subject of a police/court diversion process and therefore more likely to cease due to expiation. There was very little difference between the two broad age groups in all other reasons for cessation of treatment.

Table 6.6: Closed treatment episodes by reason for cessation and age group, Australia, 2002–03

	10–19 years		20–29 years		30 years and over		Total[(a)]	
Reason for cessation	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Treatment completed	8,085	50.6	21,074	48.4	37,873	54.8	67,892	51.9
Change in main treatment	250	1.6	785	1.8	1,097	1.6	2,171	1.7
Change in delivery setting	141	0.9	227	0.5	445	0.6	1,054	0.8
Change in principal drug	65	0.4	83	0.2	122	0.2	277	0.2
Transferred to another service provider	835	5.2	3,209	7.4	4,969	7.2	9,144	7.0
Ceased to participate against advice	590	3.7	2,331	5.4	3,363	4.9	6,314	4.8
Ceased to participate without notice	2,104	13.2	7,440	17.1	10,845	15.7	20,654	15.8
Ceased to participate involuntary (non-compliance)	406	2.5	1,244	2.9	1,293	1.9	2,956	2.3
Ceased to participate at expiation	2,089	13.1	2,933	6.7	2,411	3.5	7,454	5.7
Ceased to participate by mutual agreement	509	3.2	1,088	2.5	2,245	3.2	3,995	3.1
Drug court &/or sanctioned by court diversion	35	0.2	191	0.4	125	0.2	351	0.3
Imprisoned, other than drug court sanctioned	140	0.9	370	0.9	363	0.5	886	0.7
Died	7	0.0	48	0.1	126	0.2	188	0.1
Other	501	3.1	1,760	4.0	2,516	3.6	5,240	4.0
Not stated	211	1.3	746	1.7	1,365	2.0	2,354	1.8
Total	**15,968**	**100.0**	**43,529**	**100.0**	**69,158**	**100.0**	**130,930**	**100.0**

(a) Includes not stated for age.

7 Other data collections

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

7.1 Background

Harmful drug use has many social, health and economic impacts on Australian society. It is estimated that, in 1998, 17,671 deaths and 185,558 hospital separations were related to drug use (633 of the deaths were attributable to alcohol, 12,944 to tobacco and 14,414 to illicit drugs; 43,033 of the hospital separations were attributable to alcohol, 142,525 to tobacco and 14,471 to illicit drugs) (Ridolfo & Stevenson 2001). The economic costs associated with harmful drug use, including prevention, treatment, loss of productivity in the workplace, property crime, theft, accidents and law-enforcement activities, amount to over $18 billion annually (Collins & Lapsley 1996).

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

7.2 Monitoring alcohol and other drug problems

Key data collections relating to alcohol and other drug treatment services

- Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS).
- Aboriginal and Torres Strait Islander substance use specific services data from the Australian Government Department of Health and Ageing. See for example, *Drug and Alcohol Service Report (DASR): 2000–2001 Key Results* (DoHA 2003a).
- Indigenous primary health care services (includes substance use services) data from a joint initiative of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and the National Aboriginal Community Controlled Health Organisations (NACCHO). See, for example, *A National Profile of Australian Government Funded Aboriginal and Torres Strait Islander Primary Health Care Services, Service Activity Reporting: 2000–2001 Key Results* (DoHA 2003b).
- Pharmacotherapy client statistics provide data on the number of pharmacotherapy clients and the type and location of their prescribers (see Section 7.4).

- National Hospital Morbidity database (held by AIHW) on the estimated numbers of hospital episodes and bed days caused by alcohol, cigarettes and illicit drug use in Australia (see Section 7.3).
- National Mortality database (held by AIHW) for deaths related to alcohol, tobacco and illicit drug use (see Section 7.3).

Key population surveys relating to drug use and treatment

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

Other data collections and surveys relating to drug use and treatment

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

- Clients of Treatment Services Agencies (COTSA): a one-day snapshot census of all clients using drug and alcohol treatment services across Australia, conducted in 1990, 1992, 1995 and 2001 (e.g. Shand & Mattick 2002). This census has effectively been superseded by the AODTS–NMDS.
- The Council of Australian Governments Illicit Drug Diversion Initiative (COAG IDDI) provides drug users with the opportunity to be diverted from the criminal justice system to receive education, treatment and support to address their drug problem (DoHA 2004). All government and non-government agencies funded under this initiative are asked to collect data under the COAG IDDI NMDS, and available data are held centrally by the Australian Government Department of Health and Ageing.
- Drug Use Monitoring in Australia (DUMA): an ongoing quarterly collection that measures recent drug use among persons detained by police and includes information on demographic characteristics and financial, criminal, drug use, drug market and treatment activities. Treatment information includes current and previous treatment history, types of treatment utilised, substance being treated for and reasons for entering treatment (AIC 2003).
- Drug Use Careers of Offenders (DUCO): a survey of a random sample from prisons in all states and territories which examines the relationship between drug-using careers and criminal careers. Key objectives are to examine: the relationship between illicit drug use and violent and property crime in the adult and juvenile incarcerated population; links between criminal careers and family background and mental health; and the nature of alcohol and other drug treatment both in and outside of prison. The interviewer-administered questionnaire includes questions on sociodemographic characteristics, past criminal history, past drug history, illicit drug market activity, offender decision-making processes, estimated costs associated with drug use, and use of alcohol and other drug treatment, including perceptions of effectiveness of treatment currently received (AIC 2004).

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

Information on a range of national sources of data relating to illicit drug use is available from the ABS publication *Illicit Drug Use, Sources of Australian Data* (2001). Information on a range of national data sources relating to alcohol is available from the AIHW publication *A Guide to Australian Alcohol Data* (AIHW 2004d) <www.aihw.gov.au>.

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

7.3 Use, mortality and morbidity data

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

National Drug Strategy Household Survey

The National Drug Strategy Household Survey provides information on patterns and trends in the use of alcohol and other drugs in the Australian population. Surveys have been conducted every two to three years from 1985 onwards, with the most recent survey underway in 2004. The 2001 and 2004 surveys have been managed by the AIHW on behalf of the Australian Government Department of Health and Ageing (AIHW 2002b).

In 2001, almost 27,000 participants aged 14 years and over were surveyed from a stratified random sample of households across Australia. As the sample was based on households it excluded homeless and institutionalised persons. The 2001 survey was designed to explore the opinions and perceptions of Australians about a variety of drug-related issues, including personal approval of drug use, the impact of drugs on the general community and on mortality, and perceptions about health risks from alcohol and tobacco consumption. Participants were therefore asked about their knowledge and attitudes towards drugs, their drug consumption histories and related behaviours (AIHW 2002b).

The 2001 survey found that the most commonly used drugs in 2001 were alcohol (82%), tobacco (23%) and marijuana/cannabis (13%) (Table 7.1). Illicit drugs were used by less than one in five Australians (17%) in the last 12 months, with generally greater proportions of males than females, and 20–29 year olds being recent illicit drug users (AIHW 2002b). Marijuana/cannabis was the most used illicit drug in 2001, with over 2 million Australians aged 14 years and over (or 12.9% of the population of this age) using the drug in the last 12 months. A much smaller proportion of Australians aged 14 years and over had used other illicit drugs such as hallucinogens (1.1%), heroin (0.2%), methadone (0.1%), other opiates (0.3%), amphetamines (3.4%), ecstasy/designer drugs (2.9%) or cocaine (1.3%) in the last 12 months.

Between 1993 and 2001, the proportion of the population recently consuming alcohol increased from 73% to 82%. Between 1998 and 2001, the proportion using tobacco decreased slightly (from 25% to 23%), as did the proportion using any illicit drugs (22% to 17%) (Table 7.1). There were fluctuations in the proportion of the population recently using marijuana/cannabis, with a peak in 1998 of 18%, before a return to 13% in 2001.

The survey also explored drug use behaviour and found that approximately one in ten Australians reported drinking at levels considered risky or high risk for both short- and long-term harm to health. While males were more likely to have recently consumed at levels risky to their short-term health, males and females were similar in terms of consumption levels considered risky to long-term health (AIHW 2002b).

Table 7.1: Summary of drugs recently[(a)] used by the population aged 14 years and over, Australia, 1993–2001 (per cent)

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

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

(b) For non-medical purposes.

(c) Used for non-maintenance purposes.

n.a. not available

Source: AIHW 2002b.

Age patterns

Some data on age patterns from the National Drug Strategy Household Survey are presented here to support the information in Chapter 6 on the younger AODTS population.

Younger survey respondents, particularly those aged 20–29 years, were more likely to approve of the regular use by an adult of selected drugs. For example, of all age groups, people in the 20–29 age group were most likely to personally approve of the regular use of tobacco (54% of 20–29 year old males, compared to 43% of all males; 50% of 20–29 year old females, compared to 37% of all females), alcohol (86% of 20–29 year old males, compared to 81% of all males; 78% of 20–29 year old females, compared to 68% of all females) (Table 7.2). Younger people were also

more likely to approve of the regular use by an adult of a range of illicit drugs such as marijuana/cannabis (32% of 14–19 and 45% of 20–29 year old males, compared to 27% of all males and 27% of 14–19 and 36% of 20–29 year old females, compared to 20% of all females) and ecstasy/designer drugs (7% of 14–19 year old males and 14% of 20–29 year old males, compared to 5% of all males; 5% of 14–19 year old females and 7% of 20–29 year old females, compared to 3% of all females) (AIHW 2002a).

Table 7.2: Personal approval of the regular use by an adult of selected drugs, persons aged 14 years and over by age group and sex, Australia, 2001 (per cent)

	Males			Females		
Drug	**14–19 years**	**20–29 years**	**All ages**	**14–19 years**	**20–29 years**	**All ages**
Tobacco	44.8	53.6	42.5	47.8	50.3	36.8
Alcohol	79.7	85.6	81.4	76.3	78.3	68.0
Illicit drugs						
Marijuana/cannabis	31.6	44.8	27.4	27.3	35.6	20.1
Prescribed drugs[(a)]	9.8	13.2	8.9	9.7	9.3	6.8
Inhalants	0.9	2.5	1.1	1.0	0.6	0.5
Heroin	1.3	2.1	1.5	1.1	1.0	0.6
Amphetamines/speed	5.1	9.4	4.1	5.3	5.7	2.3
Cocaine	3.0	6.0	2.9	2.1	3.7	1.5
Hallucinogens	6.7	12.5	5.7	4.5	6.0	2.5
Ecstasy/designer drugs	6.9	13.7	5.3	4.8	7.3	2.6
Methadone[(b)]	1.6	2.7	1.7	1.1	1.5	0.9

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

(b) Used for non-maintenance purposes.

Source: AIHW 2002b.

Younger people were generally more likely to have had the opportunity to use selected drugs in the past 12 months. For example, 48% of 14–19 year olds and 50% of 20–29 year olds reported having the opportunity to use marijuana/cannabis in the last 12 months, compared to 24% of all people (Table 7.3). These patterns applied to all selected illicit drugs but not to prescribed drugs such as pain-killers/analgesics and sleeping pills (where 39% of the 14–19 age group had had an opportunity to use, compared to 46% overall) (AIHW 2002b).

People aged 20–29 years were more likely to have had the opportunity to use alcohol (96%) in the last 12 months, compared with those aged 14–19 years and of all people (90% each). Further to this, younger people were also more likely than the older surveyed population to experience memory loss after drinking at least once in the previous 12 months—28% of 14–19 year olds and 31% of 20–29 year olds reported this, compared to 18% of 30–39 year olds and 9% of people aged 40 years or more (AIHW 2002b).

Table 7.3: Opportunity to use selected drugs in the past 12 months, persons aged 14 years and over, by age group, Australia 2001

	Age group		
Drug	**14–19 years**	**20–29 years**	**All ages**
Tobacco	70.3	77.7	57.2
Alcohol	89.2	95.5	90.4
Illicit drugs			
Marijuana/cannabis	48.3	50.1	24.2
Prescribed drugs[(a)]	39.4	49.3	46.2
Inhalants	6.8	6.1	3.2
Heroin	3.5	3.4	1.5
Amphetamines/speed	15.8	21.8	7.6
Cocaine	5.5	10.1	3.4
Hallucinogens	9.8	12.6	4.3
Ecstasy/designer drugs	16.4	24.1	7.8

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

Source: AIHW 2002b.

Finally, younger people were more likely to have used an illicit drug in the last 12 months—28% of 14–19 year olds and 36% of 20–29 year olds, compared to 20% of 30–39 year olds and 8% of people aged 40 year or more (Table 7.4). For example, the younger age groups were more likely to have used marijuana/cannabis in the last 12 months (25% of 14–19 year olds and 29% of 20–29 year olds, compared to 16% of 30–39 year olds and 4% of people aged 40 years or more) (AIHW 2002b).

Overall, the younger age groups (14–19 years and 20–29 years) were more likely than the older age groups (30–39 years and 40 years or more) to have taken all listed drugs in the last 12 months, with one exception. In the case of cocaine, the same proportion of people in the 14–19 and the 30–39 age groups were estimated to have used cocaine in the last 12 months (less than 2%), compared to 4% of people aged 30–39 years and less than 1% of people aged 40 years or more.

More information on this topic is available from the report *2001 National Drug Strategy Household Survey: detailed findings* (AIHW 2002b).

Table 7.4: Summary of illicit drugs used in the last 12 months by persons aged 14 years and over by age group, Australia 2001 (per cent)

	Age group				
Drug	**14–19 years**	**20–29 years**	**30–39 years**	**40+ years**	**All ages**
Marijuana/cannabis	24.6	29.3	16.1	4.1	12.9
Prescribed drugs[(a)]	4.4	5.9	3.8	3.0	3.8
Inhalants	1.0	1.0	0.5	0.1	0.4
Heroin, methadone and/or other opiates	0.9	1.1	0.5	0.2	0.5
Amphetamines/speed	6.2	11.2	3.1	0.4	3.4
Cocaine	1.5	4.3	1.5	0.3	1.3
Hallucinogens	2.4	4.0	1.0	0.1	1.1
Ecstasy/designer drugs	5.0	10.4	2.4	0.2	2.9
Any illicit drug	27.7	35.5	20.3	7.5	37.7

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

Source: AIHW 2002b.

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

Mortality

The misuse of alcohol and the use of tobacco and illicit drugs are responsible, directly and indirectly, for a considerable number of accidents, injuries, illnesses and deaths. In 2001, there were 20,624 deaths attributed to the smoking of tobacco, the use of illicit drugs and to alcohol-related diseases (AIHW 2003 unpublished data).

An estimated 15,524 deaths in 2001 were attributable to the smoking of tobacco—10,185 for males and 5,339 for females. The standardised death rate for males (1,229 deaths per million population) was higher than that for females (479 deaths per million population). A total of 36 diseases are attributed to the smoking of tobacco; however, the majority of smoking-related deaths are due to lung cancer, ischaemic heart disease and chronic obstructive pulmonary disease (COPD) (Table 7.5; AIHW 2003 unpublished data).

An estimated 4,279 deaths in 2001 (3,058 for males and 1,221 for females) were attributable to alcohol. The standardised death rate for males (348 deaths per million population) was three times that for females (115 deaths per million population). Alcohol intake also had some benefits through the reduction of heart disease deaths which are not included below. There are 35 diseases, accidents or injuries such as stroke, liver cancer, alcoholic liver cirrhosis, road and fall injuries, drowning and assault that can be partially attributed to the consumption of alcohol.

An estimated 821 deaths in 2001 (573 for males and 249 for females) were attributed to illicit drugs. The standardised death rate for males (60 deaths per million population) was higher than that for females (25 deaths per million population) (AIHW 2003 unpublished data).

Table 7.5: Death rates attributable to tobacco, alcohol and illicit drugs related diseases, Australia, 2001

	Age-standardised death rate per million population		
	Males	Females	Persons
Tobacco	1,229	479	854
Lung cancer	524	190	357
Ischaemic heart disease	111	39	75
COPD	345	139	242
Other	248	111	180
Alcohol harm	348	115	232
Alcohol dependence	25	5	15
Road traffic accidents	39	6	23
Stroke	57	13	35
Liver cirrhosis	52	19	36
Other	176	72	124
Illicit drugs	60	25	42
Heroin and poly drug	37	14	25
Poisoning	7	5	6
Suicide	2	1	1
Other	14	5	9

Notes

1. Age-standardised to the June 2001 Australian population.
2. Attribution of deaths to different drugs estimated using risk ratios and methods from AIHW: Mathers et al. The burden of disease and injury in Australia 1999; and Statistics on drug use in Australia which contains estimates of drug use prevalence in 2001 (AIHW 2002b).

Source: AIHW 2003 unpublished data.

Morbidity

There were 69,875 hospital separations reported in 2002–03 with a substance use disorder as the principal diagnosis (Table 7.6). As in 2001–02, this represents 1.1% of all separations in Australia this year (AIHW 2004b). Separations are reported separately by same day (where the patient was admitted and separated on the same day) and overnight (where the patient spends at least one night in hospital) as well as by drugs of concern. The following sections refer only to those separations that had a substance use disorder as the principal diagnosis.

Separations by drugs of concern

As in previous years, sedatives and hypnotics accounted for the highest number of hospital separations (41,660 or 60% of all separations), with alcohol the main contributor in this category (32,143 or 46% of all separations) (Table 7.6). Fifteen per cent (or 10,782) of all separations reported were for analgesics, with opioids (heroin, opium and methadone) accounting for more than half of this group (5,620 or 8% of all separations). Antidepressants and antipsychotics accounted for 10% (or 6,791) of all separations.

Same-day versus overnight separations

Overnight separations were more common than same-day separations, accounting for 63% of all separations (Table 7.6). Separations were relatively more likely to be overnight when the principal drug identified was an opioid (77% of such separations were overnight), for multiple drug use (77%), tobacco and nicotine (76%) or cocaine (74%). The highest proportion of same-day and overnight separations were for separations where the principal diagnosis was alcohol (57% of same-day separations and 39% of overnight separations).

Table 7.6: Same-day and overnight separations with a principal diagnosis related to substance use disorders, by drug of concern, Australia, 2002–03

Drug of concern identified in principal diagnosis[(a)]	Same-day separations	Overnight separations	Total separations[(b)]
Analgesics			
Opioids (includes heroin, opium & methadone)	1,318	4,302	5,620
Non-opioid analgesics (includes paracetamol)	1,603	3,559	5,162
Total	*2,921*	*7,861*	*10,782*
Sedatives & hypnotics			
Alcohol	14,759	17,384	32,143
Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes alcohol)	3,151	6,366	9,517
Total	*17,910*	*23,750*	*41,660*
Stimulants & hallucinogens			
Cannabinoids (includes cannabis)	700	1,814	2,514
Hallucinogens (includes LSD & ecstasy)	87	82	169
Cocaine	21	59	80
Tobacco & nicotine	16	51	67
Other stimulants (includes amphetamines, volatile nitrates & caffeine)	1,074	2,687	3,761
Total	*1,898*	*4,693*	*6,591*
Antidepressants & antipsychotics	1,956	4,835	6,791
Volatile solvents	405	498	903
Other & unspecified drugs of concern			
Multiple drug use	690	2,271	2,961
Unspecified drug use & other drugs not elsewhere classified	74	113	187
Total	*764*	*2,384*	*3,148*
Total (number)	**25,854**	**44,021**	**69,875**

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

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

Source: AIHW analysis of the National Hospital Morbidity Database 2002–03.

7.4 National pharmacotherapy statistics

The first part of this section presents information about pharmacotherapy statistics collected by state and territory governments and provided to the Australian Government Department of Health and Ageing. This is followed in the second part of the section by some information about the small number of treatment episodes relating to opioid maintenance pharmacotherapies, collected as part of the AODTS–NMDS.

Opioid maintenance pharmacotherapy program data

Methadone maintenance was endorsed as an effective treatment for opioid dependence in 1985. The *National Pharmacotherapy Policy for People Dependent on Opioids* (DoHA personal communication, 2004) recognises that methadone is currently the most common pharmacotherapy used in Australia and is recognised nationally and internationally as an effective method for treating opioid dependence. Buprenorphine has also been used as a maintenance treatment for opioid dependence in Australia since 2000. These opioid pharmacotherapy treatment programs facilitate access to treatment and promote the principle of harm reduction and education of users.

Data on the clients participating in opioid pharmacotherapy maintenance programs are routinely collected by the state and territory health departments and provided each year to the Australian Government Department of Health and Ageing. Data items held include number of clients registered with public and private prescribers and correctional institutions in each state and territory, and number of clients collecting doses at pharmacies, public clinics, private clinics, correctional facilities and other outlets in each state and territory.

Numbers of pharmacotherapy clients have been collected since 1986, with the most recent data being from 2003. The type of data collected has varied in detail over this period of time.

Table 7.7: Number of pharmacotherapy clients by state and territory, Australia, 1998–2003[(a)]

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

(a) The number of clients on the program at 30 June each year, except for Western Australia in 2003, when the number of clients treated throughout the year is reported.

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

Source: Unpublished data from the Australian Government Department of Health and Ageing, 2004.

Table 7.8: Proportion of pharmacotherapy clients by prescriber, states and territories, Australia, 2003[a] (per cent)

Prescriber	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Public prescriber	16.8	0.0	78.1	34.2	33.7	30.3	79.7	79.6	24.5
Private prescriber	68.9	97.4	19.4	60.2	57.8	67.7	17.9	20.4	67.0
Public/private prescriber[b]	2.0	—	—	—	—	—	—	—	0.9
Correctional facilities	11.7	2.6	2.6	5.6	8.5	2.0	2.3	—	7.3
Total (per cent)[c]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**16,165**	**8,685**	**4,289**	**4,079**	**2,486**	**498**	**686**	**98**	**36,986**

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

(b) Public/private prescriber includes hospitals.

(c) Includes 85 clients in New South Wales with missing program type.

Source: Unpublished data from the Australian Government Department of Health and Ageing, 2004.

Table 7.9: Proportion of pharmacotherapy clients by dosing site, states and territories, Australia, 2003[a] (per cent)

Dosing site	NSW[b]	Vic[c]	Qld[d]	WA	SA[e]	Tas[f]	ACT	NT	Australia
Pharmacies	38.3	94.7	79.7	81.6	88.2	95.8	62.2	79.6	65.8
Public clinics	23.8	0.0	10.3	12.8	3.2	0.0	35.4	20.4	14.0
Private clinics	18.5	1.6	0.0	0.0	0.0	0.0	0.0	0.0	8.5
Correctional facilities	12.8	2.6	1.9	5.6	8.5	2.0	2.3	0.0	7.7
Other	4.2	1.0	8.1	0.0	0.1	2.2	0.0	0.0	3.1
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**16,165**	**8,685**	**4,236**	**4,079**	**2,486**	**498**	**686**	**98**	**36,933**

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

(b) Due to a lag in the recording of program end date for some persons, numbers may be higher than the actual number of people in the program as at 30 June 2003. 'Public clinics' include patients dosed in a public hospital in-patient and public hospital out-patient setting. 'Private clinics' include surgeries and private hospital in-patients and out-patients. 'Other' includes 600 people who are missing information about their current dosing point. A dosing point may be listed as missing where the payment type has not been identified (public or private), the dosing point type has not been identified (pharmacy or a clinic) or the drug type has not been identified (for pharmacotherapy statistics).

(c) 'Other' comprises 275 clients receiving doses at hospitals and 70 clients receiving doses from doctors.

(d) For Queensland there are 53 less clients than in Table 7.8 because: (i) if a client changed between pharmacy types then they are counted once for each change; (ii) there are a number of dispensings entered which are currently being checked for data entry errors. 'Other' includes 275 dosings at hospitals and 70 by doctors.

(e) 'Other' comprises 2 clients who were private patients receiving doses from a public hospital pharmacy.

(f) 'Other' comprises 11 clients receiving doses at public hospitals.

Source: Unpublished data from the Australian Government Department of Health and Ageing, 2004.

Data on opioid maintenance pharmacotherapies from the AODTS–NMDS

As outlined in Section 1.3, agencies whose sole activity is to prescribe and/or dose for opioid maintenance pharmacotherapy treatment (and their clients) are excluded from the AODTS–NMDS. In 2002–03 there were, however, 2,064 or 2% of closed treatment episodes where pharmacotherapy was the main treatment type provided (and where the client was seeking treatment for their own drug use). These treatment episodes were provided by AODT agencies that, among other treatment types included in the AODTS–NMDS, also prescribed and/or dosed for methadone or other opioid pharmacotherapies during the collection period. Throughout this report these treatment episodes have been included in the 'other' treatment type category.

Of the 2,064 AODTS–NMDS treatment episodes with pharmacotherapy as the main treatment type, most were provided in Victoria (898 treatment episodes) and South Australia (410), followed by Western Australia (233), Queensland (214), New South Wales (210), the Australian Capital Territory (61) and the Northern Territory (38). No treatment episodes with pharmacotherapy as the main treatment type were reported in Tasmania.

8 Data quality of the AODTS–NMDS in 2002–03

The data transmission process for the 2002–03 AODTS–NMDS collection represented an improvement on that of previous years. Jurisdictions were able to transmit their data to the AIHW much earlier than in previous years and the AIHW also streamlined its data receipt and validation processes with the introduction of new software. These factors have contributed to the more timely release of this annual report and associated data products for the 2002–03 collection.

8.1 Introduction

A range of activities is undertaken in each year of the AODTS–NMDS collection to maximise the quality of the data collected, including:

- communication between the AIHW and jurisdictions prior to the supply of data, including written guidelines and file specifications;
- updating by the AIHW of the guidelines on the validation process to improve data collating and editing (see AIHW 2002c);
- jurisdictions improving their own data quality and checking mechanisms, and providing training to their service providers and written guidelines for collecting the National Minimum Data Set; and
- the validation processes that occur within each jurisdiction prior to forwarding the data to the AIHW, and within the AIHW on receipt of the data.

Comprehensiveness of the data

In 2002–03, data were provided from 589 (94%) of the 628 agencies that were in scope for this collection. More detailed information on the undercount of Indigenous substance use services and Aboriginal health care services, as well as other data caveats, are available in Section 1.3.

Presentation of Australian government data

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

8.2 Data quality

Overall, the quality of the 2002–03 AODTS–NMDS data is better than in previous years (e.g. AIHW 2003a). Nationally, the proportion of responses that were 'not stated', 'missing' or 'unknown' was lower for all data items except country of birth and date of birth.

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

For the client data items:

- 'Indigenous status' was 'not stated' for 6% of responses—with the highest rates in the Tasmanian data (20% missing) and the Victorian and Australian Capital Territory data (8% each).
- Overall, 2% of responses were 'not stated' for 'preferred language'—this proportion was higher in the Australian Capital Territory (8%) and the Northern Territory (7%).
- The Australian Capital Territory had higher proportions of 'not stated' responses, compared to national proportions for all client data items, except for 'date of birth'.

For drug data items:

- 'Injecting drug use' was 'not stated' for 14% of responses—higher in Tasmania (38%), the Australian Capital Territory (22%), the Northern Territory (20%), South Australia (18%) and Victoria (15%).
- Nationally, 2% of responses were 'not stated' for 'method of use'; however, this proportion was higher in the Australian Capital Territory (12%).

For treatment data items, 'reason for cessation' was 'not stated' for 2% of responses—higher in the Northern Territory and the Australian Capital Territory (16% each).

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

Data item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Client data items									
Client type	—	—	—	—	—	—	—	—	**—**
Country of birth	1.7	3.7	0.1	0.4	3.2	—	5.7	0.5	**2.2**
Date of birth/age	0.1	2.7	6.6	0.2	0.5	—	1.0	0.0	**1.7**
Indigenous status	5.1	8.0	4.1	1.3	7.2	19.9	7.7	2.2	**6.0**
Preferred language	0.6	4.1	1.3	0.4	2.7	0.0	7.7	7.1	**2.3**
Sex	0.1	0.1	0.0	0.0	—	—	1.8	—	**0.1**
Source of referral	0.9	0.4	0.2	1.5	1.1	0.1	1.3	1.8	**0.8**
Drug data items[(b)]									
Principal drug of concern	1.3	—	0.0	0.6	—	—	3.5	—	**0.5**
Method of use	2.0	2.1	1.6	0.6	3.2	1.4	11.8	1.8	**2.2**
Injecting drug use	13.2	15.4	11.9	8.8	17.5	37.9	21.8	19.7	**14.4**
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	**—**
Reason for cessation	1.5	1.0	1.4	0.3	0.2	2.2	15.8	16.1	**1.8**
Treatment delivery setting	—	—	—	—	—	—	—	—	—

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

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

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