

1 Introduction

This report presents national, state and territory data about alcohol and other drug treatment services and their clients, including information about the type of drug problems for which treatment is sought and the types of treatment provided. This is the fourth report in the series of annual publications on Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) (AIHW 2002a, 2003a, 2004a).

1.1 Background

The AODTS-NMDS was implemented to help monitor and evaluate key objectives of the National Drug Strategic Framework 1998–99 to 2003–04 and to help plan, manage and improve the quality of alcohol and other drug treatment services (see AIHW: Grant & Petrie (2001) for historical development of the AODTS-NMDS). The AODTS-NMDS will continue to support the National Drug Strategy 2004–09, particularly as trend data become available in the coming years.

Since 1985, Australia's drug strategies have been based on the principle of minimising harm caused by licit drugs, illicit drugs and other substances. The principle of harm minimisation incorporates strategies to reduce drug-related harm to individuals and communities as well as supply and demand reduction strategies. No single data collection can provide all of the information relating to national treatment objectives. This report therefore also presents information from a range of other data sources to provide context to the AODTS-NMDS data and present a more complete picture of the current state of alcohol and other drug treatment services in Australia today (see Chapter 7).

The data presented in this report, in conjunction with other information sources, can be used to inform issues of access to treatment services and more generally to inform debate, policy decisions and planning processes that occur within the alcohol and other drug treatment sector.

1.2 Collection method and data included

The AODTS-NMDS collection for 2003–04 consists of de-identified unit record data for treatment agencies and closed treatment episodes. Each agency record consists of three data items and each treatment episode record consists of 20 data items. The treatment episode data items collect demographic information on clients, along with information about their drug use behaviour and the types of treatment received. See Appendix 1 for a full list of data items included in the national collection for 2003–04. The methods of collecting data vary across the country. Appendix 2 outlines the policy and administrative features of the AODTS-NMDS collection within each jurisdiction. The most common feature across jurisdictions is the requirement for agencies to collect and provide treatment service data consistent with the AODTS-NMDS specifications.

Responsibility for the collection

The AODTS–NMDS is a nationally agreed set of common data items collected by all in-scope service providers, collated by relevant health authorities and compiled into a national data set by the Australian Institute of Health and Welfare (AIHW). The AIHW is the data custodian for the national data set and performs a coordinating role as national secretariat to the collection. The Intergovernmental Committee on Drugs AODTS–NMDS Working Group is responsible for the ongoing development and maintenance of the national collection. The Working Group has representatives from the Australian Government, each state and territory government, and organisations such as the Australian Institute of Health and Welfare, the Australian Bureau of Statistics and the National Drug and Alcohol Research Centre. The key responsibilities of each authority in regard to the AODTS–NMDS collection follow.

Government health authorities

It is the responsibility of the Australian Government and state and territory government health authorities to establish and coordinate the collection of data from their alcohol and other drug treatment service providers. To ensure that the AODTS–NMDS is effectively implemented and collected, these authorities are responsible for providing data according to agreed formats and timeframes, participating in data development related to the collection, and providing advice to the IGCD AODTS–NMDS Working Group about emerging issues which may affect the AODTS–NMDS.

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

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

Alcohol and other drug treatment agencies

Publicly funded alcohol and other drug treatment agencies are responsible for collecting the agreed data elements and forwarding this information to the appropriate health authority as arranged. Agencies need to ensure that the required information is accurately recorded, and should inform their health authority if they have difficulty collecting the information. They must ensure that their clients are generally aware of the purpose for which the information is being collected, the fact that the collection of the information is authorised or required, and whether any personal information is passed on to another agency. Treatment agencies are also responsible for ensuring that their data collection and storage methods comply with existing privacy principles. In particular, they are responsible for maintaining the confidentiality of their clients' data and/or ensuring that their procedures comply with relevant state, territory and federal government legislation.

AIHW

Under a memorandum of understanding with the Australian Government Department of Health and Ageing, the AIHW is responsible for the management of the AODTS–NMDS. The AIHW maintains a coordinating role in the collection, including providing the secretariat for the responsible working group, undertaking data development work, and

highlighting national and jurisdictional implementation and collection issues. The AIHW is also the data custodian of the national collection and prepares annual reports (at national and state/territory levels) and online interactive data cubes, in consultation with the Working Group.

1.3 Scope of the AODTS–NMDS

Agencies and clients included

The agencies, clients and treatment activities that were included in the 2003–04 AODTS–NMDS collection are as follows:

- All publicly funded (at state, territory and/or Australian government level) government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services, including residential and non-residential agencies. Specialist alcohol and drug units based in acute care hospitals or psychiatric hospitals were included if they provided treatment to non-admitted patients (e.g. outpatient services).
- All clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during the relevant reporting period (1 July 2003 to 30 June 2004).

Agencies and clients excluded

There is a diverse range of alcohol and other drug treatment services in Australia and not all of these are currently included in the scope of the AODTS–NMDS. For example, agencies whose sole activity is to prescribe and/or dose opioid maintenance pharmacotherapies and Aboriginal and Torres Strait Islander substance use services are not within the scope of the AODTS–NMDS. Data sources relating to these services, along with a range of other supporting data sources, are detailed in Chapter 7.

Specifically, agencies and clients excluded from the AODTS–NMDS collection are:

- agencies whose sole activity was to prescribe and/or dose for opioid maintenance pharmacotherapy treatment
- clients who were on an opioid maintenance pharmacotherapy program and who were not receiving any other form of treatment that fell within the scope of the AODTS–NMDS
- agencies for which the main function was to provide accommodation or overnight stays such as ‘halfway houses’ and ‘sobering-up shelters’
- agencies for which the main function was to provide services concerned with health promotion (e.g. needle and syringe exchange programs)
- treatment services based in prisons or other correctional institutions
- clients receiving treatment from services based in prisons or other correctional institutions
- clients receiving support from the majority of Australian government-funded Indigenous substance use services or Aboriginal primary health care services that also provide treatment for alcohol and other drug problems

- alcohol and drug treatment units in acute care or psychiatric hospitals that provided treatment only to admitted patients
- admitted patients in acute care or psychiatric hospitals
- people who sought advice or information but who were not formally assessed and accepted for treatment
- private treatment agencies that did not receive public funding
- clients aged under 10 years, irrespective of whether they were provided with services, or received these services from agencies included in the collection.

Some people who are concerned about their alcohol or other drug use may approach a general practitioner or pharmacy for advice and/or treatment rather than attending a specialist alcohol and other drug treatment service. Thus the estimates in this report do not reflect the total number of people in Australia receiving treatment for alcohol and other drug use. (See Section 1.5 for more details on some of these exclusions.)

1.4 Counts in the collection

The main unit of measurement for the 2003–04 AODTS–NMDS collection is closed (or completed) treatment episodes (the 2000–01 AODTS–NMDS focused on client registrations and a small amount of data are presented in this report on client registrations for continuity). The ‘closed treatment episode’ concept is included in the national collection because it best reflects clinical practice within the alcohol and other drug treatment sector and it enhances the quality of information on service use. This measure allows information to be reported about the nature of treatment received by clients, including the length of the treatment episode. Technical notes, including a discussion of the use of client registration and closed treatment episode data, are included in Appendix 3.

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

The following counting rules have been used for the data included in this report.

Closed treatment episodes

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

- it must have a defined date of commencement and cessation
- during the period of contact there must have been no change in:
 - the principal drug of concern
 - the treatment delivery setting
 - the main treatment type
- a treatment episode may cease for a number of valid reasons such as the treatment being completed or the client ceasing to participate without notice. A treatment episode is deemed to have terminated in the event that there has been no (service) contact between the client and the treatment agency for a period of 3 months or more, unless the period of non-contact was planned between the client and the treatment agency.

If a client receives treatment in multiple settings, in some cases a separate treatment episode is reported for each setting. Therefore, it is possible that more than one treatment episode may be in progress for a client at any one time. It is possible for each of these episodes to have different dates of commencement and cessation.

1.5 Nature of the 2003–04 AODTS–NMDS collection

In 2003–04 the overall quality and comprehensiveness of the AODTS–NMDS data continued to improve. Data quality issues relating to the scope and completeness of the 2003–04 NMDS collection are detailed further in Chapter 8. When interpreting the 2003–04 data in this report it is important to consider a number of features of the collection.

Firstly, the national collection is a compilation of agency administrative data from state and territory health authorities. There is some diversity across Australian jurisdictions in the data collection systems and practices in place within the alcohol and other drug treatment sector.

Secondly, national implementation of the AODTS–NMDS collection has been done in stages. Care should be taken when comparing data across collection years for the following reasons:

- In the first year of the collection (2000–01) there was a mix of client registration and treatment episode data, and one jurisdiction (Queensland) was unable to supply data. For the 2001–02 collection period, Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data. All other jurisdictions supplied treatment episode data.
- The total number of agencies may have increased in 2003–04, compared with 2002–03, as a result of methodological changes (i.e. moving from collecting data at the administrative or management level to the service outlet level) and increased coverage of in-scope agencies.

Thirdly, readers should be aware of the following general features of the 2003–04 AODTS–NMDS data:

- Reported numbers for each state/territory include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). As in the 2002–03 AODTS–NMDS annual report, federal government data are not analysed separately under the title ‘other’.
- Reported numbers do not include the majority of Australian Government-funded Indigenous substance use services (3 out of 42 were included) or Aboriginal primary health care services (6 out of 140 were included) that also provide treatment for alcohol and other drug problems. These services are generally not under the jurisdiction of the state or territory health authority and are not included in the specific program under which the Australian Government currently reports NMDS data. In addition, the data collections relating to these services have a different collection basis to the AODTS–NMDS. As a result, most of these data are not currently included in the AODTS–NMDS collection. Therefore the number of Indigenous clients in this report underrepresents the total number of Indigenous Australians who received treatment for alcohol and other drug problems during 2003–04.

Finally, the reader should be aware of the following data completeness issues in 2003–04:

- As in 2002–03, data were provided from Queensland government AODTS agencies and/or police diversion clients but not for other non-government funded agencies.

- In the Australian Capital Territory, a data collection error resulted in the exclusion of one large service provider and, hence, the overall closed treatment episode number for 2003–04 for the Australian Capital Territory may be undercounted.

Reported numbers do not include agencies delivering pharmacotherapy services, where their sole activity is to prescribe and/or dose for opioid maintenance pharmacotherapy treatment. Approximately 39,000 clients were recorded as receiving these services throughout Australia in 2003–04, an unknown proportion of whom may also have accessed the services included in the AODTS–NMDS (see Section 7.4).

1.6 Outputs from the AODTS–NMDS collection

The AODTS–NMDS collections provide national data on government-funded alcohol and other drug treatment services in Australia. AODTS–NMDS data outputs are designed to provide useful information to government health authorities, researchers and the broader community, as well as to provide an important form of feedback to treatment agencies that took part in the collection.

Each year the AODTS–NMDS data are processed and published in a detailed and comprehensive national report – this being the report for 2003–04 data – which is made available to the public free of charge on the AIHW website <www.aihw.gov.au> or in hard copy for a small fee.

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

Further to this, the AIHW has an interactive alcohol and other drug treatment data site, <www.aihw.gov.au/drugs/datacubes/index.html> containing subsets of national information on alcohol and other drug treatment services from the 2003–04 collection. This also allows anyone who has access to the Internet to view a subset of the AODTS–NMDS data via the web interface. The user can look up figures and present them in a way suitable to their needs.

Each year the agencies that contribute data via the AODTS–NMDS receive a state/territory briefing containing data specifically designed to be relevant to their jurisdiction. In addition, these agencies are surveyed each year with the aim of discovering special areas of interest to treatment agencies. This input feeds into the AODTS–NMDS reporting, and in particular the special theme chapter in this report – Chapter 6 on amphetamines.

1.7 Recent drug use

This section provides a brief overview of drug use patterns in the Australian population, as background to the data on treatment services in the remainder of the report. Data from the 2004 National Drug Strategy Household Survey (NDSHS) are the most recent population data on this topic, and are presented in Table 1.1 together with data from the 2001 NDSHS and 2003–04 AODTS–NMDS. More detailed information about the 2004 NDSHS and its findings can be found in the publications *2004 National Drug Strategy Household Survey: First Results* (AIHW 2005a) and *2004 National Drug Strategy Household Survey: Detailed Findings* (AIHW 2005e).

The 2004 NDSHS estimated that 84% of Australians aged 14 years and over recently consumed alcohol and just over one-fifth (21%) smoked tobacco (Table 1.1). Between 2001 and 2004, a significant increase was observed in the proportion of persons who recently consumed alcohol (from 82% in 2001 to 84% in 2004) and significant decrease in the proportion of persons who recently smoked tobacco (23% to 21% respectively). The proportion of the population recently using ecstasy increased significantly from 2.9% in 2001 to 3.4% in 2004.

In 2004, lower proportions of people aged 14 years and over reported using cannabis (11%) and amphetamines (3%) than in 2001. Less than 1% of people reported using heroin or methadone in the last 12 months (0.2% and 0.1% respectively).

Table 1.1: Summary of selected drugs recently^(a) used, and principal drugs for which treatment was sought, Australia (per cent)

Drug/behaviour	Recent use, population aged 14 years and over^(b) 2001	Recent use, population aged 14 years and over^(b) 2004	Closed treatment episodes for clients aged 10 years and over 2003–04
Tobacco	23.2	20.7 #	1.5
Alcohol	82.4	83.6 #	37.5
Illicits			
Marijuana/cannabis	12.9	11.3	22.0
Heroin	0.2	0.2	18.0
Methadone ^(c)	0.1	0.1	1.9
Meth/amphetamines (speed)	3.4	3.2	11.0
Cocaine	1.3	1.0 #	0.2
Ecstasy ^(d)	2.9	3.4 #	0.4
<i>Any illicit drug</i> ^(e)	16.9	15.3 # ^(f)	60.5
None of the above	14.7	13.7 #	n.a.

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

(b) Proportion of population aged 14 years and over from 2001 and 2004 National Drug Strategy Household Surveys.

(c) Non-maintenance.

(d) Before 2004, this category included substances known as 'designer drugs'.

(e) 'Any illicit drug' for 2001 and 2004 NDSHS includes the illicit drugs listed plus pain-killers/analgesics, tranquilisers/sleeping pills, steroids, barbiturates, inhalants, other opiates/opioids when used for non-medical purposes, hallucinogens and injected drugs.

(f) In 2004, also includes GHB and ketamine.

2001 result significantly different from 2004 result (2-tailed $\alpha = 0.05$).

Source: AIHW 2005a.

In the 2003–04 AODTS–NMDS collection, alcohol (38%) was the most common principal drug of concern in treatment episodes for clients aged 10 years and over (Table 1.1). This reflects the pattern of consumption among the Australian population where alcohol was the most common drug used. Tobacco was nominated as the second most used drug in the population (21%), yet accounted for less than 2% of closed treatment episodes for clients seeking treatment for its use. These differences in treatment for tobacco (nicotine) are perhaps not surprising given that most 'treatment' for nicotine addiction is through pharmacies, general practitioners (e.g. advice and nicotine patches) or 'quit' lines.

Although very low proportions of the general population reported using heroin (0.2%), 18% of closed treatment episodes of alcohol and other drug treatment services had heroin nominated as the principal drug of concern. The differences in results from the two sources of data reflect the nature of the treatment services captured by the AODTS-NMDS. These services focus on the people who have a problem with their drug use, whereas the household survey data cover all people who consume alcohol or use tobacco or other drugs regardless of whether or not they think they have a problem. Further to this, agencies whose sole purpose is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are currently excluded from the AODTS-NMDS, and so the collection may exclude many clients receiving treatment for heroin. See Section 7.4 for information about the estimated numbers of clients receiving treatment from pharmacotherapy programs in Australia.

2 Treatment agency profile

This chapter presents the main features of the alcohol and other drug treatment agencies that supplied data for the 2003–04 AODTS–NMDS collection. The number of treatment agencies does not necessarily equate to the number of service delivery outlets as some treatment agencies were reported only under the main administrative centre of the service.

2.1 Establishment sector

A total of 622 alcohol and other drug treatment agencies contributed data for the period 2003–04, with the largest proportion of agencies in New South Wales (42%), Victoria (23%) and Queensland (15%). This split was similar in 2002–03 where 39% of agencies were located in New South Wales, 25% in Victoria and 16% in Queensland.

Over half of all agencies identified as non-government providers (52% or 322 out of 622), with the largest proportion of non-government agencies being located in Victoria (143 or 100% of agencies), Western Australia (25 or 74% of agencies), Tasmania (9 or 75% of agencies), the Australian Capital Territory (8 or 100% of agencies) and the Northern Territory (15 or 79% of agencies). In contrast, agencies were more likely to be in the government sector in New South Wales (193 or 75% of agencies) and South Australia (42 or 79% of agencies). In Queensland, approximately half of all agencies were provided by the government sector (52%) but this relates to the current exclusion of non-government agencies, except for those providing police diversion programs and those provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program (funded by the Australian Government) (see Section 1.3).

Table 2.1: Treatment agencies by sector of service and jurisdiction, Australia, 2003–04

Service type	NSW	Vic	Qld ^(a)	WA	SA	Tas	ACT ^(b)	NT	Australia
	(number)								
Government	193	0	49	9	42	3	0	4	300
Non-government	66	143	45	25	11	9	8	15	322
Total	259	143	94	34	53	12	8	19	622
<i>Total 02–03</i>	<i>229</i>	<i>148</i>	<i>96</i>	<i>28</i>	<i>50</i>	<i>11</i>	<i>6</i>	<i>19</i>	<i>587</i>
	(per cent)								
Government	64.1	0.0	16.3	3.0	14.0	1.0	0.0	1.3	100.0
Non-government	20.5	44.4	14.0	7.8	3.4	2.8	2.5	4.7	100.0
Total	41.6	23.0	15.1	5.5	8.5	1.9	1.3	3.0	100.0
<i>Total 02–03</i>	<i>39.0</i>	<i>25.2</i>	<i>16.4</i>	<i>4.8</i>	<i>8.5</i>	<i>1.9</i>	<i>1.0</i>	<i>3.2</i>	<i>100.0</i>

(a) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(b) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data-collection error.

The number of treatment agencies reporting under the AODTS-NMDS increased from 587 agencies in 2002–03 to 622 agencies in 2003–04. However, much of this increase related to methodological changes and increased coverage of in-scope agencies (see Section 1.3 for further details). The overall response rate for in-scope treatment agencies was 96% (see Chapter 8 for further details).

2.2 Location of treatment agencies

In 2003–04, treatment agencies were mostly located in major cities (57%) and inner regional areas (26%) (Table 2.2), as in the previous reporting period (56% and 25% respectively) (AIHW 2004a). The number of agencies located in major cities, however, may be over-represented as some treatment agencies, particularly several of those in non-metropolitan areas, were reported under the main administrative centre of the service. The bulk of the Australian population lives in major cities (66%), 31% in regional areas and 3% in remote areas (AIHW 2004b).

A significant proportion of treatment agencies in the Northern Territory (53%) and, to a lesser extent, Queensland (13%) were located in remote or very remote areas.

Table 2.2: Treatment agencies by geographical location^(a) and jurisdiction, Australia, 2003–04

Location	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia
	(number)								
Major cities	161	88	33	23	38	0	8	0	351
Inner regional	78	45	23	4	6	7	0	0	163
Outer regional	20	10	26	5	8	5	0	9	83
Remote	0	0	7	2	1	0	0	8	18
Very remote	0	0	5	0	0	0	0	2	7
Not stated	0	0	0	0	0	0	0	0	0
Total	259	143	94	34	53	12	8	19	622
	(per cent)								
Major cities	62.2	61.5	35.1	67.6	71.7	0.0	100.0	0.0	56.5
Inner regional	30.1	31.5	24.5	11.8	11.3	58.3	0.0	0.0	26.2
Outer regional	7.7	7.0	27.7	14.7	15.1	41.7	0.0	47.4	13.3
Remote	0.0	0.0	7.4	5.9	1.9	0.0	0.0	42.1	2.9
Very remote	0.0	0.0	5.3	0.0	0.0	0.0	0.0	10.5	1.1
Not stated	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

(a) The geographical location of treatment agencies in the 2003–04 AODTS-NMDS has been analysed using the Remoteness Areas of the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 6 for information on how these categories are derived).

(b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data-collection error.

3 Client profile

This chapter provides a profile of clients receiving alcohol and other drug treatment services in 2003–04, the main analysis focusing on ‘closed treatment episodes’ (Box 3.1).

3.1 Closed treatment episodes and client registrations

In 2003–04 there were 136,869 closed treatment episodes in alcohol and other drug services reported in the AODTS–NMDS collection. These episodes related to an estimated 115,163 client registrations (see Box 3.1). On average, each of these registrations accounted for 1.2 treatment episodes during the year.

The number of closed treatment episodes in the 2003–04 AODTS–NMDS collection was higher than in 2002–03 (136,869, compared with 130,930). However, it is likely that this increase relates mostly to the increasing comprehensiveness of the AODTS–NMDS collection in 2003–04, rather than indicating an overall increase in clients being treated.

Box 3.1: Key definitions and counts for closed treatment episodes and registrations, 2003–04

Closed treatment episode refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2003–04 there were **136,869** closed treatment episodes.

Client registrations refers to the estimated number of clients who were registered or reregistered for alcohol and other drug treatment services. In 2003–04 there were an estimated **115,163** client registrations.

It is important to note that neither number of closed treatment episodes or estimated number of client registrations equates to the total number of persons in Australia receiving treatment for alcohol and other drug use. Using the current collection methodology, it is not possible to reduce duplication in client registrations that can occur where, for example, a client attends a number of different agencies throughout the collection period or reregisters with the same agency and is assigned a new record number. See Appendix 3 for more information on treatment episodes and client registrations.

Caution should be exercised when comparing the client registration data in 2000–01 with those of 2001–02 to 2003–04 as the method for calculating ‘registrations’ has changed. In the 2000–01 collection, registrations were based on all new or returning clients who registered or reregistered for treatment during the reporting period. For the 2001–02 to 2003–04 collections, registrations were based on the number of episodes closed within the reporting period.

See Section 1.2 and Boxes 4.1 and 5.1 for other related definitions.

3.2 Client type and jurisdictions

Overall, 95% of all closed treatment episodes in 2003–04 involved clients seeking treatment for their own alcohol or other drug use (Table 3.1). This is very similar to 2002–03, where 94% of closed treatment episodes involved clients seeking treatment for their own drug use

(AIHW 2004a). This proportion of episodes was observed in most states and territories except Western Australia, the Northern Territory and Tasmania, where 88%, 87% and 68% respectively of closed treatment episodes were for the client's own drug use.

Accordingly, less than 10% of closed treatment episodes in most states and territories were related to another person's drug use. However, 32% of all closed treatment episodes in Tasmania, and 13% in both Western Australia and the Northern Territory were for clients receiving treatment for another person's alcohol or drug use.

Overall, the majority of the 136,869 closed treatment episodes were recorded in Victoria (35%), followed by New South Wales (31%), Queensland (14%) and Western Australia (10%).

Table 3.1: Closed treatment episodes by client type and jurisdiction, Australia, 2003–04^(a)

Client type	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT ^(c)	NT	Australia 03–04	Australia 2002–03
	(number)									
Own drug use	41,426	45,030	17,912	12,479	7,234	1,596	1,317	2,337	129,331	123,032
Other's drug use	1,103	2,608	554	1,777	379	761	—	355	7,538	7,898
Total	42,529	47,638	18,466	14,256	7,613	2,357	1,318	2,692	136,869	130,930
	(per cent)									
Own drug use	97.4	94.5	97.0	87.5	95.0	67.7	99.9	86.8	94.5	94.0
Other's drug use	2.6	5.5	3.0	12.5	5.0	32.3	0.1	13.2	5.5	6.0
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Per cent of all closed treatment episodes	31.1	34.8	13.5	10.4	5.6	1.7	1.0	2.0	100.0	

(a) Small cell sizes have been suppressed to preserve confidentiality. These are marked with a '—'.

(b) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.

(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

3.3 Age and sex

In 2003–04, the majority of closed treatment episodes were for clients aged between 20 and 29 years who were accessing treatment services (44,684 or 33%), with over one-quarter of all treatment episodes (28%) provided for clients in the 30–39 years age group (Table 3.2). Thirteen per cent of treatment episodes were for clients aged between 10 and 19 years and a small proportion of episodes were for clients aged over 60 years (2%). This age distribution is almost identical to that in 2002–03.

As was the case in 2002–03, male clients in 2003–04 accounted for close to two-thirds (65% or 89,348) of all closed treatment episodes. Of treatment episodes for male clients, just over a third (34% or 30,386 of 89,348) were for clients aged 20–29 years, with over a quarter (28% or 25,201) for clients in the 30–39 years age group. Over three-quarters (79% or 70,351) of all closed treatment episodes with a male client involved men between 20 and 49 years. The age distribution was similar for males and females.

Females were more likely than males to be seeking treatment for someone else's drug use. Around three-quarters (74% or 5,601 of 7,538) of treatment episodes for someone else's drug use were for female clients. Female clients aged 40 years and over were more likely than younger women to seek treatment for the substance use of another person. For example, 17% of treatment episodes for females aged 40–49 years, 33% for females aged 50–59 years and 36% for females aged 60 years and over were for treatment related to someone else's substance use, compared with 9% for females aged 10–19 years, 5% of treatment episodes for females aged 20–29 years, and 8% for females aged 30–39 years.

Table 3.2: Closed treatment episodes by sex and age group, Australia, 2003–04

	Age group (years)						Total ^(a)
	10–19	20–29	30–39	40–49	50–59	60+	
	(number)						
Males							
Own drug use	10,815	30,135	24,913	14,357	5,017	1,677	87,419
Other's drug use	331	251	288	407	401	183	1,929
<i>Total males</i>	<i>11,146</i>	<i>30,386</i>	<i>25,201</i>	<i>14,764</i>	<i>5,418</i>	<i>1,860</i>	<i>89,348</i>
Females							
Own drug use	5,361	13,595	11,922	7,287	2,473	814	41,829
Other's drug use	538	674	1,025	1,502	1,207	462	5,601
<i>Total females</i>	<i>5,899</i>	<i>14,269</i>	<i>12,947</i>	<i>8,789</i>	<i>3,680</i>	<i>1,276</i>	<i>47,430</i>
Persons^(b)							
Own drug use	16,190	43,757	36,853	21,654	7,497	2,493	129,331
Other's drug use	869	927	1,313	1,910	1,610	647	7,538
Total persons	17,059	44,684	38,166	23,564	9,107	3,140	136,869
	(per cent)						
Males							
Own drug use	12.4	34.5	28.5	16.4	5.7	1.9	100.0
Other's drug use	17.2	13.0	14.9	21.1	20.8	9.5	100.0
<i>Total males</i>	<i>12.5</i>	<i>34.0</i>	<i>28.2</i>	<i>16.5</i>	<i>6.1</i>	<i>2.1</i>	<i>100.0</i>
Females							
Own drug use	12.8	32.5	28.5	17.4	5.9	1.9	100.0
Other's drug use	9.6	12.0	18.3	26.8	21.5	8.2	100.0
<i>Total females</i>	<i>12.4</i>	<i>30.1</i>	<i>27.3</i>	<i>18.5</i>	<i>7.8</i>	<i>2.7</i>	<i>100.0</i>
Persons^(b)							
Own drug use	12.5	33.8	28.5	16.7	5.8	1.9	100.0
Other's drug use	11.5	12.3	17.4	25.3	21.4	8.6	100.0
Total persons	12.5	32.6	27.9	17.2	6.7	2.3	100.0

(a) Includes 'not stated' for age.

(b) Includes 'not stated' for sex.

3.4 Indigenous status

Of the 136,869 closed treatment episodes in 2003–04, 13,238 (or 10%) involved clients identified as being Aboriginal and/or Torres Strait Islander peoples (Table 3.3). This is a higher proportion than the overall proportion of Aboriginal and Torres Strait Islander peoples in the Australian population (2.4%; ABS 2004). For a number of reasons the data on Aboriginal and Torres Strait Islander clients in the AODTS treatment population should be interpreted with caution. The overall proportion of episodes relating to clients identified as being Aboriginal and Torres Strait Islander peoples is only slightly higher than the proportion of episodes where Indigenous status was ‘not stated’. Further, the majority of dedicated substance use services for Aboriginal and Torres Strait Islander peoples are not included in the AODTS–NMDS collection (see Section 7.5 for data on these services).

Compared with 2002–03, in 2003–04 a similar percentage of treatment episodes were for clients who identified as being from an Aboriginal and/or Torres Strait Islander background (10%, compared with 9%). The proportion of closed treatment episodes where ‘not stated’ was reported for Indigenous status remained at 6% across reporting periods (AIHW 2004a).

Table 3.3: Closed treatment episodes by age group, Indigenous^(a) status and sex, Australia, 2003–04

Age group (years)	Indigenous ^(b)		Non-Indigenous ^(b)		Not stated ^(b)		Total		
	Males	Females	Males	Females	Males	Females	Males	Females	Persons ^(c)
	(number)								
10–19	1,793	832	8,748	4,776	605	291	11,146	5,899	17,059
20–29	2,698	1,420	25,876	11,923	1,812	926	30,386	14,269	44,684
30–39	2,517	1,443	21,188	10,676	1,496	828	25,201	12,947	38,166
40–49	1,207	652	12,714	7,570	843	567	14,764	8,789	23,564
50–59	293	152	4,801	3,292	324	236	5,418	3,680	9,107
60+	49	40	1,670	1,151	141	85	1,860	1,276	3,140
Not stated	64	68	448	442	61	60	573	570	1,149
Total	8,621	4,607	75,445	39,830	5,282	2,993	89,348	47,430	136,869
	(per cent)								
10–19	20.8	18.1	11.6	12.0	11.5	9.7	12.5	12.4	12.5
20–29	31.3	30.8	34.3	29.9	34.3	30.9	34.0	30.1	32.6
30–39	29.2	31.3	28.1	26.8	28.3	27.7	28.2	27.3	27.9
40–49	14.0	14.2	16.9	19.0	16.0	18.9	16.5	18.5	17.2
50–59	3.4	3.3	6.4	8.3	6.1	7.9	6.1	7.8	6.7
60+	0.6	0.9	2.2	2.9	2.7	2.8	2.1	2.7	2.3
Not stated	0.7	1.5	0.6	1.1	1.2	2.0	0.6	1.2	0.8
Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Per cent of treatment population	6.3	3.4	55.1	29.1	3.9	2.2	65.3	34.7	100.0

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

(b) There were 10 closed treatment episodes for Indigenous people where sex was not stated, 63 episodes for non-Indigenous people where sex was not stated and 18 episodes where Indigenous status and sex were not stated.

(c) Includes ‘not stated’ for sex.

Indigenous clients tended to have a younger age profile than other Australian clients. Aboriginal and Torres Strait Islander males aged 10–19 years accounted for 21% of all Indigenous male treatment episodes, whereas other Australian males 10–19 years accounted for only 12% of all other Australian males. This pattern was similar for female clients aged 10–19 years, but not so marked (18% for Indigenous females, compared with 12% for other Australian females). In contrast, treatment episodes involving clients older than 40 years were less common for Aboriginal and Torres Strait Islander clients than for other clients. This finding may relate to differences in the underlying age structures of the two populations, with Aboriginal and Torres Strait Islander peoples having a younger age profile than other Australians.

3.5 Country of birth and preferred language

The majority of closed treatment episodes in 2003–04 and in 2002–03 involved clients born in Australia (86% of closed treatment episodes in each year) (Table 3.4). Clients born in other countries were represented in only a very small proportion of closed treatment episodes, with England (3%) and New Zealand (2%) being the next most common countries of birth.

English was the most frequently reported preferred language – 95% of treatment episodes involved clients who indicated English as their preferred language (Table A4.4). Of closed treatment episodes, 1% involved clients with an Australian Indigenous language as their preferred language. Other preferred languages were relatively uncommon, each accounting for less than 1% of treatment episodes.

Table 3.4: Closed treatment episodes by country of birth^(a), Australia

Country of birth	2003–04		2002–03	
	No.	%	No.	%
Australia	117,036	85.5	111,722	85.3
England	3,388	2.5	3,460	2.6
New Zealand	2,710	2.0	2,493	1.9
Viet Nam	1,353	1.0	1,227	0.9
Scotland	750	0.5	736	0.6
Ireland	495	0.4	438	0.3
Germany	355	0.3	378	0.3
South Africa	319	0.2	306	0.2
Italy	316	0.2	366	0.3
United States of America	299	0.2	353	0.3
All other countries	6,378	4.7	6,205	4.7
Not elsewhere classified	409	0.3	377	0.3
Inadequately described	871	0.6	530	0.4
Not stated	2,190	1.6	2,339	1.8
Total	136,869	100.0	130,930	100.0

(a) The countries listed here are the 10 most frequently recorded countries; all other countries are combined in the row labelled 'All other countries'.

4 Drugs of concern

This chapter examines the profile and characteristics of clients in relation to the principal drug of concern nominated by them when using treatment services in 2003–04. The analysis is based on ‘closed treatment episodes’.

The principal drug of concern refers to the main substance that clients state led them to seek treatment from the alcohol and other drug treatment agency. This section reports only on those 129,331 episodes where clients were seeking treatment for their own substance use. It is reasoned that only substance users themselves can accurately report on the principal drug of concern to them.

Box 4.1: Key definitions and counts for closed treatment episodes and drugs, 2003–04

Closed treatment episodes refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2003–04 there were **136,869** closed treatment episodes.

Principal drug of concern refers to the main substance that clients state led them to seek treatment from the alcohol and other drug treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses 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 2003–04, **129,331** closed treatment episodes were reported for principal drug of concern.

Other drugs of concern refers to any other drugs apart from principal drug of concern which clients perceive as being a health concern. Clients can nominate up to five other drugs of concern. In 2003–04, there were **110,887** other drugs of concern (apart from principal drug of concern) reported.

All drugs of concern refers to all drugs reported by clients including principal drug of concern and all other drugs of concern. In 2003–04, there were a total of **240,218** drugs of concern reported, either as a principal or other drug of concern.

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

4.1 Jurisdictions and principal drug of concern

Nationally in 2003–04, alcohol (38%) and cannabis (22%) were the most common principal drugs of concern in treatment episodes, followed by heroin (18%) and amphetamines (11%).² Overall, less than 1% of closed treatment episodes were for the principal drugs ecstasy and cocaine (0.4% and 0.2% respectively) (Table 4.1). The distribution of principal drug of concern across treatment episodes was almost identical in 2002–03 (AIHW 2004a).

2. The AODTS–NMDS collection excludes agencies whose sole purpose is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies. Therefore, the collection excludes many clients receiving treatment for heroin.

Alcohol was the most common principal drug of concern reported in most jurisdictions. Alcohol as the principal drug accounted for 77% of all treatment episodes in the Northern Territory, 47% in South Australia and 41% in New South Wales. Queensland reported the lowest proportion of treatment episodes where alcohol was the principal drug (26%) and the highest proportion of treatment episodes where cannabis was the principal drug (40%). The pattern of principal drugs in Queensland relates largely to the scope of collection in 2003–04 (namely the inclusion of police diversion and government-provided services but not non-government-funded services; see Section 1.3 for further details). In Tasmania and the Australian Capital Territory, the most common principal drug was cannabis, accounting for 37% and 30% respectively of closed treatment episodes.

After alcohol, the three most commonly nominated drugs of concern nationally – cannabis, heroin and amphetamines – varied in their ‘position’ from state to state. Heroin was second in Victoria (23% of treatment episodes) and New South Wales (21%), followed by cannabis in Victoria (22%) and New South Wales (16%) (Table 4.1). In Western Australia and South Australia, amphetamines were second (26% and 17% respectively), followed by cannabis in Western Australia (22%) and heroin in South Australia (15%).

Nationally, only a small proportion of closed treatment episodes were for clients who identified nicotine as their principal drug of concern (1.5% or 2,001 treatment episodes). It is important to note, however, that this does not equate to the total number of clients receiving treatment for nicotine use but, rather, to the number of clients who attended a government-funded alcohol and other drug treatment service and nominated nicotine as their principal drug of concern. The relatively low rate of treatment for nicotine identified in this data collection is not surprising, because in most states and territories the majority of people with a nicotine addiction obtain treatment through pharmacies, general practitioners (e.g. advice and nicotine patches) or ‘quit’ lines. Tasmania recorded the highest proportion of episodes where nicotine was reported as the principal drug of concern (13%), and South Australia and Western Australia the lowest proportion (0.4% each).

In two jurisdictions, there were principal drugs of concern that were notably higher than the corresponding national figures:

- In the Northern Territory, alcohol was the principal drug of concern in 77% of closed treatment episodes, the highest of all jurisdictions, and just over double the national figure of 38%.
- In Western Australia, amphetamines were the principal drug of concern in 26% of closed treatment episodes, the highest of all jurisdictions, and just over double the national figure of 11%. More specific information on amphetamines can be found in Chapter 6.

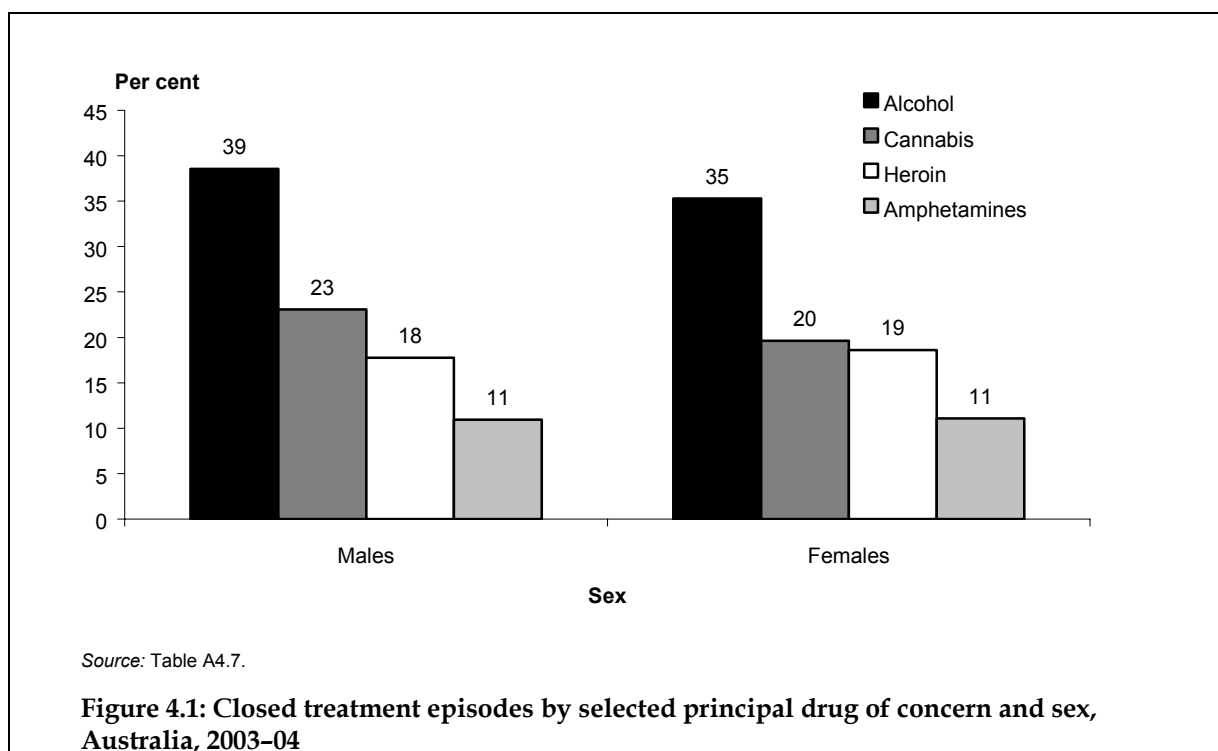
Table 4.1: Closed treatment episodes by principal drug of concern and jurisdiction, Australia, 2003–04^(a) (per cent)

Principal drug	NSW	Vic	Qld ^{(b)(c)}	WA	SA	Tas	ACT ^(d)	NT	Australia	Total (no.)	Australia a 2002– 03
Alcohol	41.2	37.1	26.3	32.6	46.6	28.9	22.4	77.2	37.5	48,500	38.0
Amphetamines	10.9	6.5	10.3	25.6	17.3	8.5	17.5	4.5	11.0	14,208	10.7
Benzodiazepines	2.5	2.4	1.0	1.5	2.1	1.0	3.3	0.4	2.1	2,711	2.1
Cannabis	16.1	22.3	39.5	22.0	10.2	37.0	29.5	7.9	22.0	28,427	22.0
Cocaine	0.4	0.1	0.1	0.2	0.1	0.1	0.8	0.1	0.2	272	0.3
Ecstasy	0.3	0.4	0.5	0.4	0.4	0.7	0.8	0.2	0.4	508	0.3
Heroin	21.4	23.3	7.6	9.9	14.7	0.8	20.2	0.9	18.0	23,326	18.4
Methadone	2.5	1.2	2.4	1.6	1.6	3.0	2.7	0.7	1.9	2,404	1.8
Nicotine	1.3	0.8	4.4	0.4	0.4	12.5	0.5	1.3	1.5	2,001	1.4
All other drugs ^(e)	2.0	5.8	7.8	5.5	6.5	7.1	2.4	6.8	4.9	6,342	4.4
Not stated	1.4	0.0	0.0	0.4	0.0	0.5	0.0	0.0	0.5	632	0.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..	100.0
Total (number)	41,426	45,030	17,912	12,479	7,234	1,596	1,317	2,337	..	129,331	123,032

- (a) Excludes treatment episodes for clients seeking treatment for the drug use of others.
- (b) In Queensland, clients undergoing police diversion 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 expected that future modifications to data collection processes will enable this possibility to be reflected.
- (c) The total number of closed treatment episodes for Queensland may be undercounted due to the exclusion of the majority of non-government agencies.
- (d) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.
- (e) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7 and Table A4.5.

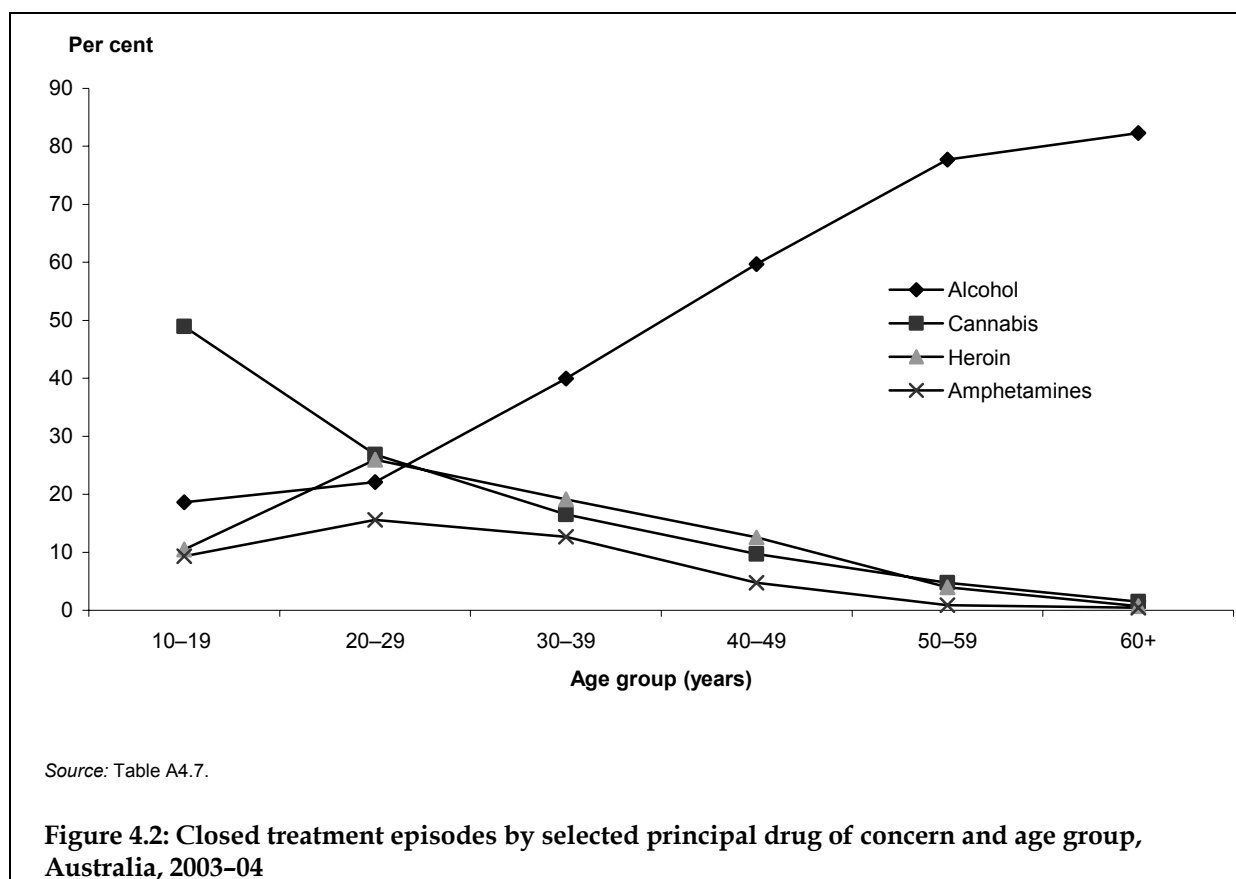
4.2 Sex, age and principal drug of concern

In 2003–04, the principal drug of concern in treatment episodes was similar between sexes (Figure 4.1). For all closed treatment episodes, alcohol was the most commonly recorded principal drug of concern for both sexes (39% for males and 35% for females), followed by cannabis (23% for males and 20% for females) and heroin (18% for males and 19% for females). The proportion of treatment episodes where amphetamines were recorded as the principal drug was 11% for both sexes.



The principal drug of concern in a treatment episode was strongly related to the client's age. For closed treatment episodes involving 20-29-year-olds, there was a fairly even distribution of drugs of concern, with younger clients much more likely to report cannabis as the drug of concern, and older clients more likely to report alcohol (Figure 4.2). Specifically:

- For treatment episodes of clients in the 10-19 age group, the most commonly reported principal drug was cannabis (49%) (Figure 4.2). This proportion varied by sex – 54% for males in this age group and 39% for females (Table A4.7). Although 11% of all treatment episodes among the 10-19 age group had heroin as the principal drug, females were more likely than males to be seeking treatment for this drug (16% compared with 8%).
- Overall, for treatment episodes of clients in the 20-29 age group, cannabis was the drug most commonly recorded (27%), followed closely by heroin (26%) and then alcohol (22%). This general pattern was reflected for males in this age group (28%, 25% and 24% respectively). However, for treatment episodes involving female clients, the most commonly reported principal drug was heroin (29%), followed by cannabis (24%) and alcohol (18%).
- Overall, alcohol was the drug most likely to be reported as the principal drug of concern (38% of closed treatment episodes), but this proportion was even higher for clients aged over 30 (52% or 35,522 of 68,497) and peaked for males and females aged 60 and over (85% and 76%, respectively).



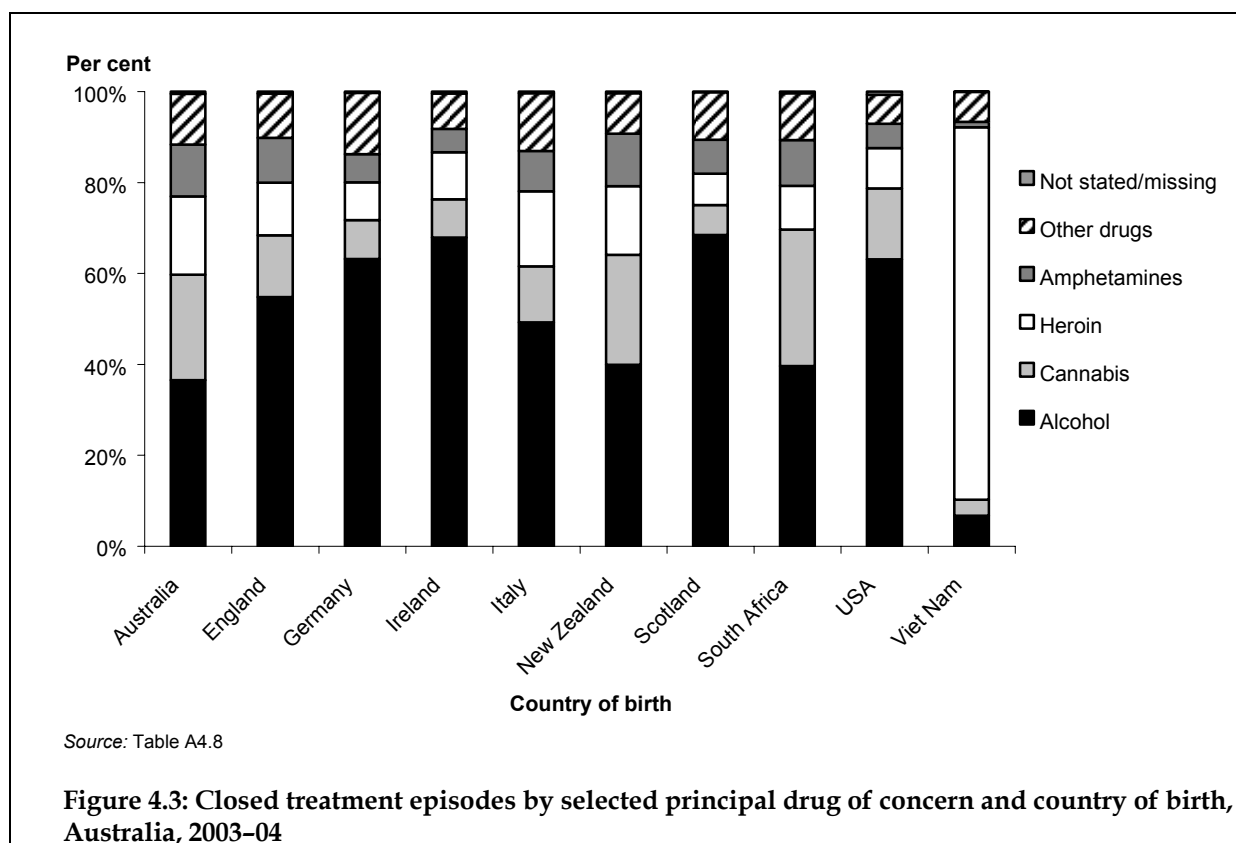
4.3 Country of birth and principal drug of concern

The distribution of the principal drug of concern varied somewhat with the client’s country of birth (Figure 4.3). For closed treatment episodes where clients reported being born in Australia, 37% reported alcohol as their principal drug of concern, followed by cannabis (23%) and heroin (17%). This pattern was reflected for clients born in a number of other countries, including New Zealand (40% alcohol, 24% cannabis and 15% heroin), South Africa (40%, 30% and 10% respectively), and England (55%, 14% and 12% respectively).

The countries of birth reporting the highest proportion of closed treatment episodes for alcohol as the principal drug were Scotland, Ireland and Germany (68%, 68% and 63% respectively); alternatively, closed treatment episodes for clients born in Viet Nam reported the lowest proportion of episodes where alcohol was the principal drug (7%). Viet Nam is also the country of birth with the highest proportion of episodes where the principal drug of concern is heroin (82%).

The highest proportions of treatment episodes where amphetamines were reported as the principal drug of concern were for clients born in New Zealand and Australia (12% and 11% respectively), followed by South Africa and England (10% each).

It is important to note that the age distributions of migrants from these countries are not the same. For example, migrants from the United Kingdom and European countries are likely to be older than those from many Asian countries (ABS 2003). Given the strong relationship between age and principal drug of concern, it is not surprising that alcohol is the most likely drug of concern for most European migrants seeking treatment.



4.4 Indigenous status and principal drug of concern

Overall, closed treatment episodes involving Aboriginal and Torres Strait Islander clients were most likely to involve alcohol (46%), cannabis (22%), heroin (11%) and amphetamines (9%) – that is, the same four principal drugs of concern as the population overall – but with alcohol more likely to be nominated (46%, compared with 37%) and heroin less so (11%, compared with 18%) (Table 4.2). As previously noted, data relating to Indigenous status should be interpreted with caution for a number of reasons, including the relatively high proportion of treatment episodes where Indigenous status was ‘not stated’ (6%) (see Section 1.5 for further details). Further, for some principal drugs of concern, the number of treatment episodes where Indigenous status was ‘not stated’ was higher than the number of episodes where the client identified as being an Aboriginal or Torres Strait Islander person. For example, in 23 episodes where ecstasy was the principal drug of concern reported, the client identified as being an Indigenous person, compared with 35 episodes where Indigenous status was ‘not stated’.

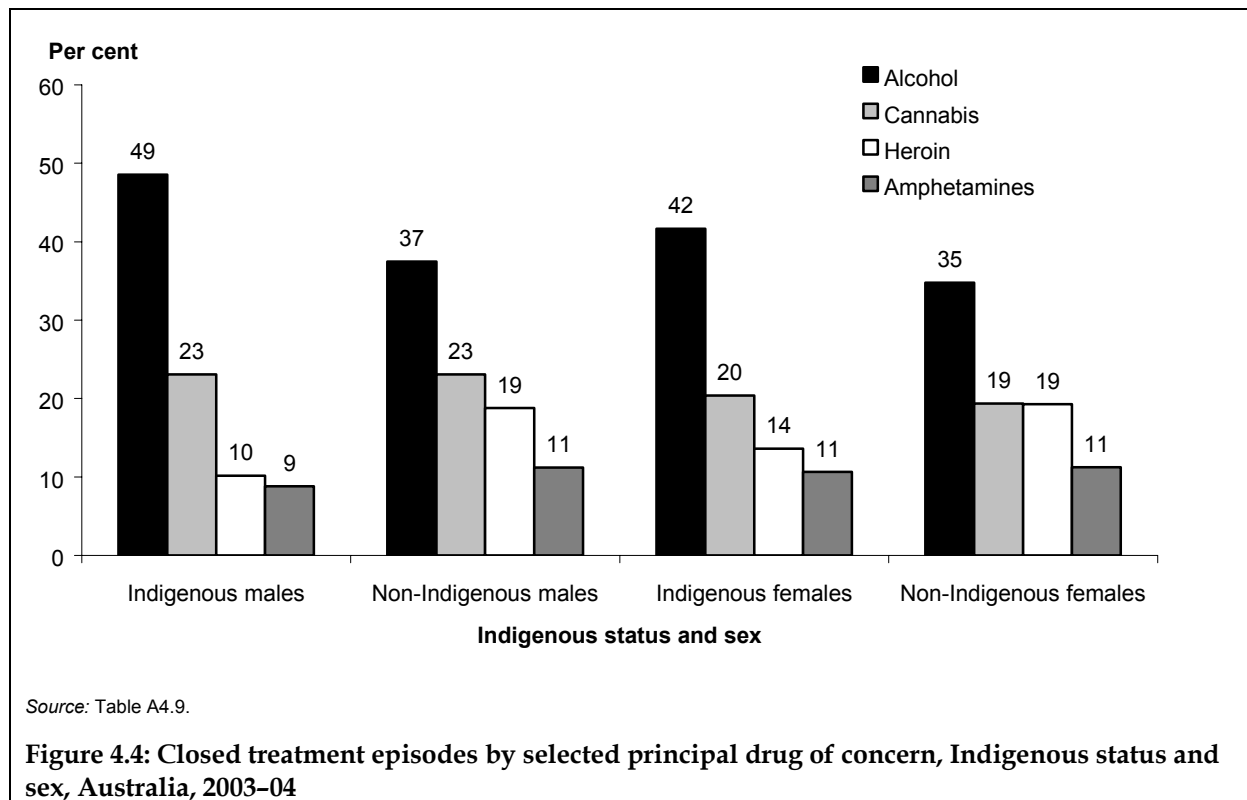
Table 4.2: Closed treatment episodes by principal drug of concern and Indigenous status, Australia, 2003–04^(a)

Principal drug of concern	Indigenous		Non-Indigenous		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Alcohol	5,888	46.2	39,815	36.6	2,797	36.0	48,500	37.5
Amphetamines	1,200	9.4	12,210	11.2	798	10.3	14,208	11.0
Benzodiazepines	154	1.2	2,417	2.2	140	1.8	2,711	2.1
Cannabis	2,825	22.2	23,813	21.9	1,789	23.1	28,427	22.0
Cocaine	14	0.1	240	0.2	18	0.2	272	0.2
Ecstasy	23	0.2	450	0.4	35	0.5	508	0.4
Heroin	1,439	11.3	20,624	18.9	1,263	16.3	23,326	18.0
Methadone	170	1.3	2,070	1.9	164	2.1	2,404	1.9
Nicotine	183	1.4	1,647	1.5	171	2.2	2,001	1.5
All other drugs ^(b)	751	5.9	5,091	4.7	500	6.4	6,342	4.9
Not stated	88	0.7	459	0.4	85	1.1	632	0.5
Total	12,735	100.0	108,836	100.0	7,760	100.0	129,331	100.0
<i>Per cent of Indigenous status</i>	9.8	..	84.2	..	6.0	..	100.0	..

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

The pattern of principal drug of concern among treatment episodes for Aboriginal and Torres Strait Islander clients also varied according to clients' sex (Figure 4.4). Nearly half of all treatment episodes for male clients identifying as Aboriginal or Torres Strait Islander involved alcohol as the principal drug of concern (49%), compared with 37% for other male clients; 42% of closed treatment episodes for female Aboriginal and Torres Strait Islander clients involved alcohol as the principal drug of concern, compared with 35% for other female clients. As part of this pattern of sex differences, treatment episodes for female Indigenous clients were somewhat more likely than those for male Indigenous clients to involve heroin as the principal drug of concern (14% of all treatment episodes compared with 10%). This difference was not found in other clients – 19% of treatment episodes involved heroin as the principal drug of concern for both males and females.



4.5 Geographical location and principal drug of concern

In 2003-04, 70% of all closed treatment episodes related to clients receiving services in major cities, 20% in inner regional and 9% in outer regional areas, with few closed treatment episodes in remote (1%) and very remote areas (0.1%) (see Appendix 6 for information on how these categories are derived). These proportions were nearly identical to those in 2002-03 (72%, 19%, 8%, 1% and 0.1% respectively) (AIHW 2004a). In 2003-04, across all areas, alcohol was the most commonly reported drug of concern (36% major cities, 41% inner regional, 40% outer regional, 71% remote areas and 67% very remote areas – Table 4.3). In most areas, the second most prominent drug of concern reported was cannabis (28% inner regional, 32% outer regional, 13% remote and 31% very remote). In major cities, alcohol, although still the most common principal drug of concern, was nominated in 36% of treatment episodes, followed by heroin 23%, cannabis 19% and amphetamines 12% – a much more even spread than in other regions.

Caution should be used when interpreting geographical data – especially for remote and very remote areas – because of the small population in some areas. In addition, the number of agencies located in major cities may be overrepresented because some treatment agencies, particularly in non-metropolitan areas, were reported only under the main administrative centre of the services. Geographical location may also have an effect on the type of treatment services available, especially in more remote areas, with the focus of the services available possibly targeted to a particular substance.

Table 4.3: Closed treatment episodes^(a) by principal drug of concern and geographical location, Australia, 2003–04 (per cent)

Principal drug of concern	Major cities	Inner regional	Outer regional	Remote	Very remote	Total ^(b)	Total (number) ^(b)
Alcohol	35.6	41.1	40.0	71.2	67.1	37.5	48,500
Amphetamines	11.9	9.7	7.2	6.8	1.2	11.0	14,208
Benzodiazepines	2.4	1.7	1.1	0.8	0.0	2.1	2,711
Cannabis	19.2	27.5	32.0	13.3	30.6	22.0	28,427
Cocaine	0.3	0.1	0.1	0.1	0.0	0.2	272
Ecstasy	0.4	0.2	0.4	0.1	0.0	0.4	508
Heroin	22.8	9.4	2.8	1.1	0.0	18.0	23,326
Methadone	1.8	2.2	2.0	0.6	0.0	1.9	2,404
Nicotine	1.1	2.1	3.6	1.8	0.0	1.5	2,001
All other drugs ^(c)	4.1	5.3	10.6	4.2	1.2	4.9	6,342
Not stated	0.4	0.8	0.3	0.0	0.0	0.5	632
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	..
Total (number)	90,275	26,034	11,519	1,418	85	..	129,331
Per cent of location	69.8	20.1	8.9	1.1	0.1	100.0	..

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

(b) Includes 'not stated' for location.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

4.6 Source of referral and principal drug of concern

In 2003–04, two-fifths of all closed treatment episodes for clients seeking treatment for their own drug use involved clients who were self-referred (40%), followed by referrals from alcohol and other drug treatment services (12%) and correctional services (10%) (Table 4.4). The proportion of closed treatment episodes being self-referred increased slightly from 37% in 2002–03 to 40% in 2003–04. For other sources of referral, the proportion of closed treatment episodes has remained relatively stable.

Of treatment episodes where the client was self-referred, the principal drug of concern was most likely to be recorded as alcohol (39%) or heroin (22%). Much smaller proportions of self-referring clients nominated cocaine (0.2%) or ecstasy (0.3%) as their principal drug of concern. Referrals from alcohol and other drug treatment services were most likely to involve clients who nominated alcohol (39%), heroin (22%) or cannabis (17%) as their principal drug.

Of closed treatment episodes where the client was referred through the court diversion, 25% involved clients who nominated cannabis as their principal drug of concern. A higher proportion of episodes where the client was referred through police diversion involved cannabis (72%). These two diversion types are the only sources of referral where alcohol was not the most commonly noted principal drug of concern.

Of treatment episodes where the client was referred from a hospital, including psychiatric hospitals, the principal drug of concern was most likely to be recorded as alcohol (55%), cannabis (13%) or amphetamines (10%). Referrals from general practitioners or medical specialists were more likely to involve closed treatment episodes where the principal drug of concern was alcohol (47%), cannabis or heroin (12% each).

Table 4.4: Closed treatment episodes^(a) by principal drug of concern and source of referral, Australia, 2003–04

Principal drug of concern	Family member/friend	GP/medical specialist	Hospital	Community mental health service	AODTS	Other community health/care services	Correctional service	Police diversion	Court diversion	Other	Not stated	Total	
	Self												
(number)													
Alcohol	20,029	2,239	3,925	2,639	1,151	5,827	2,112	4,733	1,163	396	4,049	237	48,500
Amphetamines	5,919	1,113	589	494	265	1,509	716	1,715	486	478	855	69	14,208
Benzodiazepines	1,186	94	313	151	85	466	79	100	57	24	143	13	2,711
Cannabis	8,610	1,629	1,003	603	724	2,519	1,284	2,831	6,388	553	2,216	67	28,427
Cocaine	128	28	16	4	3	22	8	39	14	2	8	0	272
Ecstasy	180	57	21	12	10	32	24	50	51	25	46	0	508
Heroin	11,219	941	990	371	135	3,300	679	2,373	452	495	2,291	80	23,326
Methadone	1,049	62	278	124	27	492	57	69	70	24	140	12	2,404
Nicotine	586	81	518	154	43	42	287	30	43	41	173	3	2,001
All other drugs ^(b)	2,667	280	727	226	104	721	437	246	58	183	631	62	6,342
Total^(c)	51,894	6,537	8,438	4,797	2,561	14,989	5,700	12,237	8,841	2,221	10,569	547	129,331
(per cent)													
Alcohol	38.6	34.3	46.5	55.0	44.9	38.9	37.1	38.7	13.2	17.8	38.3	43.3	37.5
Amphetamines	11.4	17.0	7.0	10.3	10.3	10.1	12.6	14.0	5.5	21.5	8.1	12.6	11.0
Benzodiazepines	2.3	1.4	3.7	3.1	3.3	3.1	1.4	0.8	0.6	1.1	1.4	2.4	2.1
Cannabis	16.6	24.9	11.9	12.6	28.3	16.8	22.5	23.1	72.3	24.9	21.0	12.2	22.0
Cocaine	0.2	0.4	0.2	0.1	0.1	0.1	0.1	0.3	0.2	0.1	0.1	0.0	0.2
Ecstasy	0.3	0.9	0.2	0.3	0.4	0.2	0.4	0.4	0.6	1.1	0.4	0.0	0.4
Heroin	21.6	14.4	11.7	7.7	5.3	22.0	11.9	19.4	5.1	22.3	21.7	14.6	18.0
Methadone	2.0	0.9	3.3	2.6	1.1	3.3	1.0	0.6	0.8	1.1	1.3	2.2	1.9
Nicotine	1.1	1.2	6.1	3.2	1.7	0.3	5.0	0.2	0.5	1.8	1.6	0.5	1.5
All other drugs ^(b)	5.1	4.3	8.6	4.7	4.1	4.8	7.7	2.0	0.7	8.2	6.0	11.3	4.9
Total^(c)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
% of referrals	40.1	5.1	6.5	3.7	2.0	11.6	4.4	9.5	6.8	1.7	8.2	0.4	100.0

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

(b) Includes balance of principal drugs of concern coded according to ASCDC.

(c) Includes 'not stated' for principal drug of concern.

4.7 Other drugs of concern

In 2003–04, of the 129,331 closed treatment episodes where clients were seeking treatment for their own drug use, 68,465 episodes (53%) involved at least one other drug of concern – that is, episodes involved a principal drug of concern and at least one other drug of concern (Table 4.5). This proportion varied with the principal drug of concern – in closed treatment episodes where the principal drug of concern was ecstasy, amphetamines, or benzodiazepines, more than 65% of episodes included at least one other drug of concern. Treatment episodes where nicotine and alcohol were reported as the principal drug were least likely to report additional drugs of concern (32% and 43% respectively).

Between 2002–03 and 2003–04, cocaine and nicotine experienced the largest changes in proportion of episodes with other drugs of concern. The percentage of episodes where cocaine was the principal drug of concern (that had other drugs of concern) decreased from 71% to 64%, while nicotine increased from 20% to 32% (AIHW 2004a). These data indicate the drugs of concern to clients and should not be used as a proxy indicator for poly-drug use.

Table 4.5: Number of closed treatment episodes^(a) by principal drug of concern, with or without other drug of concern, Australia, 2003–04

Principal drug of concern	With other drugs	With no other drugs	Total closed treatment episodes	Proportion of episodes with 'other drugs' of concern (%)
Alcohol	20,776	27,724	48,500	42.8
Amphetamines	9,583	4,625	14,208	67.4
Benzodiazepines	1,770	941	2,711	65.3
Cannabis	15,300	13,127	28,427	53.8
Cocaine	175	97	272	64.3
Ecstasy	353	155	508	69.5
Heroin	14,568	8,758	23,326	62.5
Methadone	1,470	934	2,404	61.1
Nicotine	643	1,358	2,001	32.1
All other drugs ^(b)	3,713	2,629	6,342	58.5
Not stated	114	518	632	18.0
Total^(b)	68,465	60,866	129,331	52.9

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

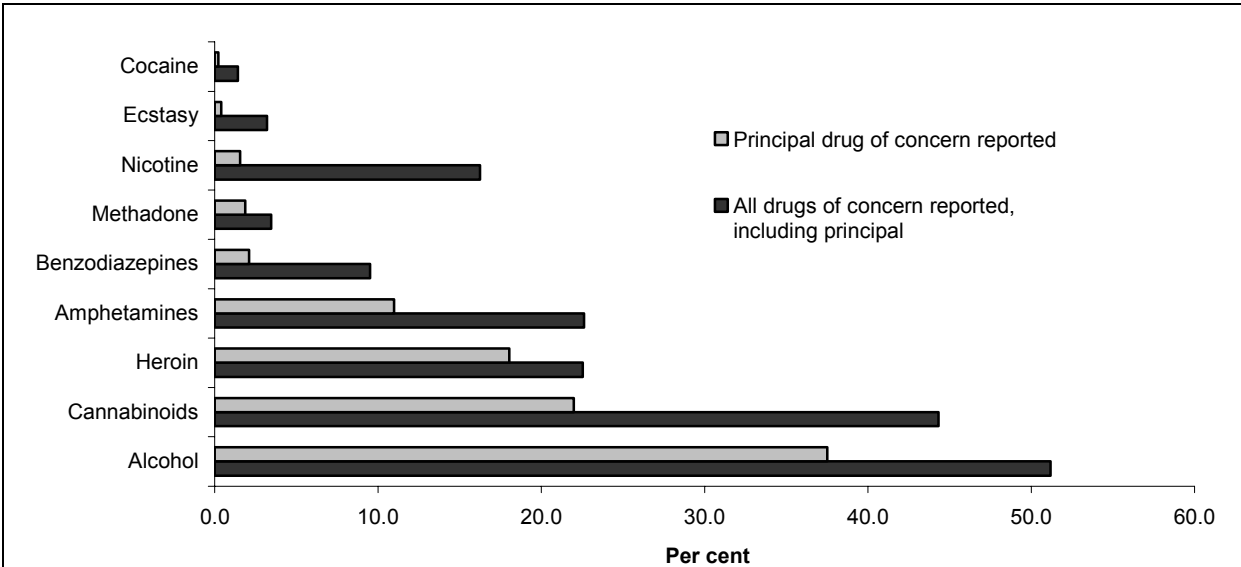
(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

From the 68,465 closed treatment episodes that did involve at least one other drug of concern, 110,887 other drugs of concern were reported (clients are able to report up to five other drugs of concern). This equates to 1.6 other drugs of concern for clients of these treatment episodes.

When considering all drugs of concern, alcohol and cannabis remain the two most commonly reported drugs of concern (Figure 4.5). Alcohol was reported as the principal drug of concern in 38% of treatment episodes and when all drugs are considered, 51% of treatment episodes included alcohol as one of the drugs of concern. A similar pattern can be seen for cannabis (identified in 22% of treatment episodes as the principal drug of concern and in 44% of treatment episodes as one of the drugs of concern) (Table A4.10).

Benzodiazepines were reported as a principal drug of concern in 2% of treatment episodes, yet when all drugs are considered, 10% of treatment episodes included benzodiazepines as one of the drugs of concern. Treatment episodes involving amphetamines also followed this pattern – 11% of treatment episodes involved amphetamines as the principal drug of concern, whereas 23% included them as a drug of concern. Eighteen per cent of closed treatment episodes involved heroin as the principal drug of concern, rising to 23% when all drugs of concern are considered.

Despite being reported as a principal drug of concern in only 2% of treatment episodes, nicotine was the fifth most common overall, reported in 16% of closed treatment episodes as one of the clients’ drugs of concern (see Section 4.1 for further information on nicotine treatment).



Source: Table A4.10.

Figure 4.5: Closed treatment episodes by principal drug of concern and all drugs of concern, Australia, 2003–04

4.8 Injecting drug use and method of use

For the purposes of the AODTS–NMDS collection, ‘injecting drug use’ includes drug administration methods such as intravenous, intramuscular and subcutaneous forms of injection.

Over two-fifths (43%) of closed treatment episodes in 2003–04 involved clients who reported never having injected drugs (Table 4.6). Just over one-quarter (26%) of treatment episodes involved clients who identified themselves as current injectors (i.e. injected within the previous 3 months) and a further 18% involved clients who reported they had injected drugs in the past (8% between 3 months and 12 months ago and 10% 12 or more months ago). Caution should be used, however, when interpreting data for ‘injecting drug use’ due to the high ‘not stated’ response for this item (13% of treatment episodes).

A relatively high proportion of closed treatment episodes for clients in the 20–29 and 30–39 age groups reported being ‘current injectors’ (36% and 30% respectively), with a significant proportion of clients in these age groups also reporting having injected drugs some time in the past (approximately 22% of treatment episodes for each age group).

In only a small proportion of treatment episodes were clients aged 50 years and over reported as being 'current injectors' (5% of episodes in the 50–59 age group and 2% for those aged 60 years and over). A very high proportion of treatment episodes for clients in these age groups were reported as never having injected drugs (72% and 84% respectively).

Table 4.6: Closed treatment episodes^(a) by injecting drug use and age group, Australia, 2003–04

Injecting drug use	10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total
(number)								
Current injector	2,721	15,809	11,042	3,746	361	43	277	33,999
Injected 3–12 months ago	1,042	5,016	3,430	1,134	132	11	87	10,852
Injected 12+ months ago	547	4,241	4,617	2,685	475	22	55	12,642
Never injected	9,393	13,946	12,929	10,845	5,405	2,091	307	54,916
Not stated	2,487	4,745	4,835	3,244	1,124	326	161	16,922
Total persons	16,190	43,757	36,853	21,654	7,497	2,493	887	129,331
(per cent)								
Current injector	16.8	36.1	30.0	17.3	4.8	1.7	31.2	26.3
Injected 3–12 months ago	6.4	11.5	9.3	5.2	1.8	0.4	9.8	8.4
Injected 12+ months ago	3.4	9.7	12.5	12.4	6.3	0.9	6.2	9.8
Never injected	58.0	31.9	35.1	50.1	72.1	83.9	34.6	42.5
Not stated	15.4	10.8	13.1	15.0	15.0	13.1	18.2	13.1
Total persons	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0

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

As part of the AODTS–NMDS, clients are asked to nominate the usual method of administering their principal drug of concern, that is, their 'method of use'. In 2003–04, the most likely methods of use were ingestion (45% of all treatment episodes for clients seeking treatment for their own drug use), followed by injection (28%) and smoking (23%). Sniffing and inhaling were the methods of use for around 1% and 2% of treatment episodes, respectively (Table 4.7).

Most principal drugs of concern involved one main method of use (Table 4.7). Ingestion was the most common method of use when the principal drugs of concern were alcohol (99%), benzodiazepines (92%), ecstasy (86%) or methadone (85%), and least common for heroin (1%). Injecting was most common for heroin (92%), amphetamines (79%), and cocaine (42%), and smoking was most common for nicotine (96%) and cannabis (90%).

Cocaine and 'other drugs' did not appear to have one foremost method of use among clients of agencies. Cocaine was injected (42%), sniffed (37%) and smoked (11%). 'Other drugs' were ingested (40%), injected (35%) or inhaled (15%).

Table 4.7: Closed treatment episodes^(a) by principal drug and method of use, Australia, 2003–04 (per cent)

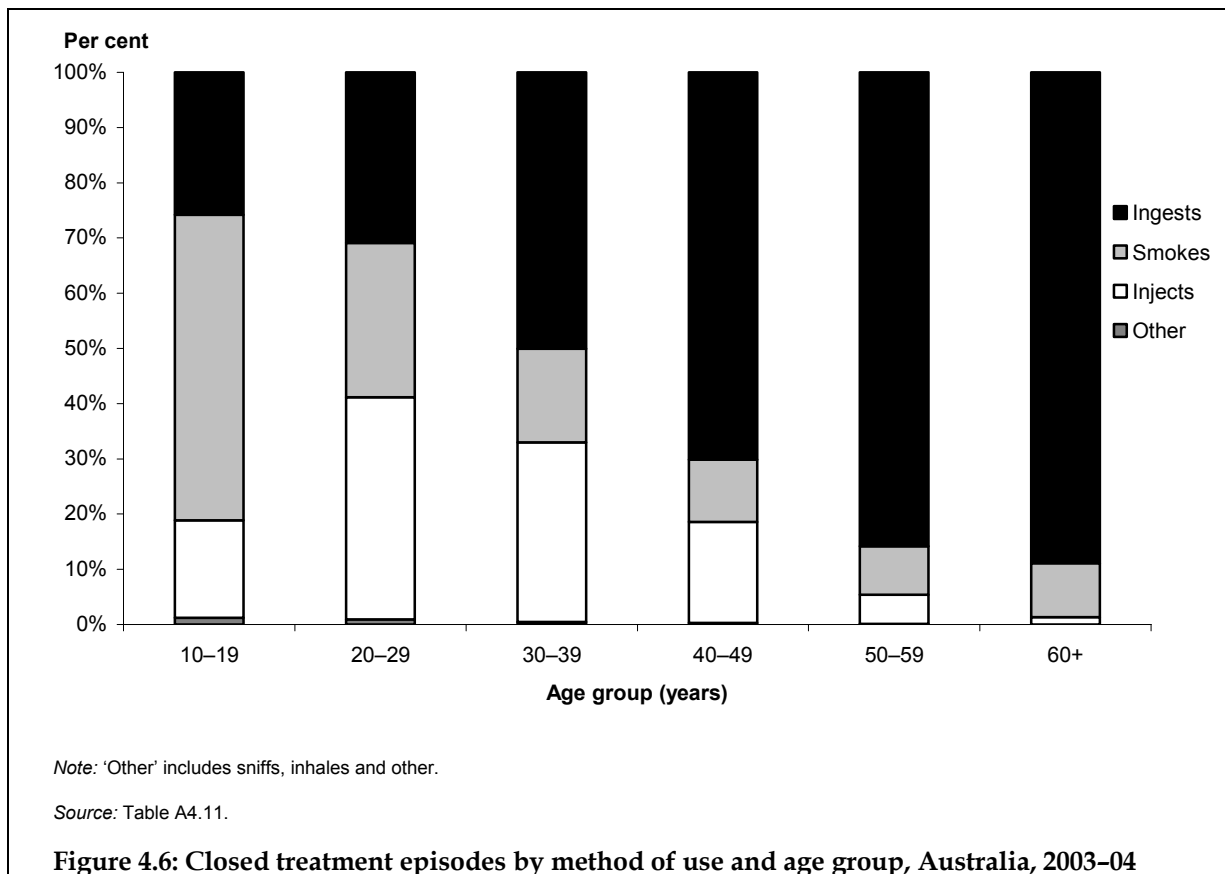
Principal drug of concern	Ingests	Smokes	Injects	Sniffs	Inhales	Other	Not stated	Total
Alcohol	99.1	0.2	0.1	0.0	0.1	0.0	0.6	100.0
Amphetamines	11.0	3.0	79.1	4.4	0.5	0.2	1.9	100.0
Benzodiazepines	92.2	0.2	6.3	0.0	0.0	0.1	1.1	100.0
Cannabis	3.0	90.4	0.4	0.0	3.9	0.2	2.1	100.0
Cocaine	4.0	11.0	42.3	37.1	1.5	0.0	4.0	100.0
Ecstasy	86.2	1.4	9.1	1.6	0.4	0.0	1.4	100.0
Heroin	1.3	4.8	91.7	0.2	0.7	0.1	1.2	100.0
Methadone	84.5	0.2	13.3	0.0	0.0	0.3	1.7	100.0
Nicotine	1.6	96.4	0.4	0.0	1.0	0.1	0.3	100.0
Other drugs ^(b)	39.5	1.8	35.3	0.3	15.1	1.8	6.3	100.0
Not stated/ missing	10.9	1.4	5.5	0.2	0.3	8.2	73.4	100.0
Total	45.1	22.7	27.6	0.6	1.8	0.2	1.8	100.0
Total (numbers)	58,365	29,396	35,742	815	2,354	295	2,364	129,331

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

The most common method of use varied with the client's age (Figure 4.6). The distribution of the different methods of use among age groups was related to the most common principal drug of concern for the age groups.

- For clients aged 10–19 years, smoking was the most common method of use, related to cannabis being the most common principal drug of concern for this age group.
- For clients aged 20–29 years, injecting was the most common method of use, related to heroin being the most common principal drug of concern for this age group.
- For clients aged 30–39 years and over, ingestion was the most common method of use, related to alcohol being the most common principal drug of concern for these age groups.
- Ingestion as a method of use increases in prevalence with age, whereas smoking and injection decrease. This corresponds to alcohol being a more likely principal drug of concern in older years and cannabis, heroin and amphetamines decreasing in likelihood from 20–29 years onwards.



4.9 Reason for cessation and principal drug of concern

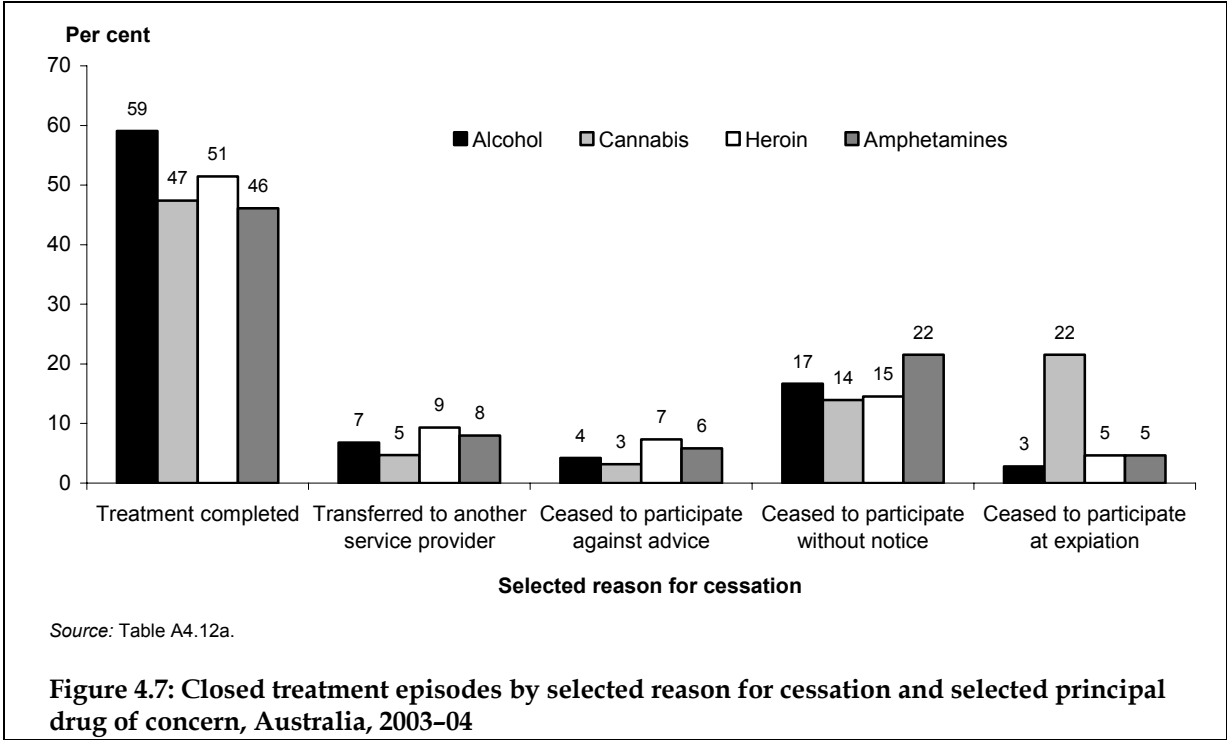
According to the AODTS-NMDS definition, there are a number of reasons a treatment episode can cease. The treatment may be completed, which in the context of this collection means that all of the immediate goals of the treatment plan have been fulfilled. Other reasons include a change in main treatment type for the client; a change in treatment delivery setting; the client ceasing to participate without notice, or by mutual agreement with the service provider; or the client being imprisoned or dying.

The majority of closed treatment episodes in 2003-04 involved clients ending treatment because the treatment was completed (53%; Table A4.12a). The next most common reason for treatment episodes to end was that the client ceased to participate without notice (16%). The client ceasing to participate at expiation – that is, where the client has atoned the offence by completing a recognised education or information program – accounted for 8%, closely followed by the client transferred to another service provider (7%). Only 5% of episodes ended because the client ceased to participate against advice. Nationally, a very small proportion of treatment episodes ceased because the client was imprisoned (0.5%), or because the client had died (0.1%).

This pattern of distribution was similar to that in 2002-03 where 51% involved clients ending because the treatment was completed, 16% where clients ceased to participate without notice, 7% transferred to another service provider, 6% ceased at expiation and 5% ended treatment against the advice of the service provider (AIHW 2004a).

The reason for cessation varied across treatment episodes according to the principal drug of concern. For example, treatment episodes where alcohol was the principal drug of concern were more likely to end because treatment was completed (59%) than treatment episodes where heroin (51%), cannabis (47%) or amphetamines (46%) was the principal drug (Figure 4.7). Just over one-fifth of all treatment episodes with cannabis as the principal drug ceased at expiation (22%). A relatively high proportion of treatment episodes with amphetamines as the principal drug (22%) ended because the client ceased to participate without notice, compared with heroin, alcohol and cannabis, (15%, 17% and 14% respectively).

Examining these figures from another angle we see that, of all treatment episodes ending due to expiation – that is, where the client had expiated their offence by completing a recognised education or information program – 63% involved cannabis as the principal drug of concern³ (Table A4.12b). Accordingly, only a small proportion of treatment episodes where alcohol, heroin or amphetamines was the principal drug ended due to expiation (14% of episodes for alcohol, 11% for heroin and 7% for amphetamines).



3. In Queensland, clients undergoing police diversion automatically have their 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 due to expiation'. It is possible that their principal drug of concern is not actually cannabis. It is expected that future modifications to data collection processes will enable this possibility to be reflected.