

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 their relationship to a selection of variables of interest, in particular the principal drug of concern. Data presented in this chapter relate to all closed treatment episodes, that is, for clients seeking treatment for their own or someone else's alcohol or other drug use, except for Section 5.2 which relates to episodes for clients seeking treatment for their own drug use.

Box 5.1: Key definitions and counts for treatment programs, 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.*

***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 2003–04, main treatment type was reported for **136,869** treatment episodes..*

Caution should be used when comparing the number of closed treatment episodes for main treatment type in 2003–04 and 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. Details of each treatment type included in the AODTS–NMDS are included in Appendix 5.

***Main treatment type and principal drug of concern.** In 2003–04, data on the combination of these two data items were reported for **129,331** 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 type (up to three other treatment types can be recorded for each client). In 2003–04, there were **16,230** closed treatment episodes which provided a total of **19,889** other treatment types. In 2003–04, closed treatment episodes from Victoria and the Northern Territory were excluded from any analysis involving 'other treatment types' as Victoria and the Northern Territory 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 2003–04, there were a total of **156,758** 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 2003–04, counselling (38%), withdrawal management (detoxification) (18%) and assessment only (15%) were the most common main treatment types provided within alcohol and other drug treatment services (Table 5.1). In 2003–04 a slightly higher proportion of closed treatment episodes were for assessment only (15% in 2003–04, compared with 13% in 2002–03) and a slightly lower proportion for counselling (38% in 2003–04, compared with 42% in 2002–03).

In 2003–04, counselling was the most common main treatment type reported in all jurisdictions except Queensland and South Australia. In Tasmania, counselling as the main treatment accounted for 63% of all treatment episodes, in Western Australia, 50%, and in Victoria and the Australian Capital Territory, 47% each. South Australia reported the lowest proportion of treatment episodes where counselling was the main treatment (23%) and the highest proportion of treatment episodes where rehabilitation was the main treatment type (21%).

In Queensland, the most common main treatment types were information and education only (37%), followed by counselling (28%). This pattern of main treatment in Queensland relates largely to the scope of the 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).

Nationally, close to 3,000 closed treatment episodes were provided where the main treatment type was pharmacotherapy. This is a small proportion of pharmacotherapy treatment, as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid maintenance pharmacotherapies are excluded from the AODTS–NMDS (see also Section 7.4).

Table 5.1: Closed treatment episodes by main treatment type and jurisdiction, Australia, 2003–04 (per cent)

| Main treatment type | NSW | Vic | Qld ^{(a)(b)} | WA | SA | Tas | ACT ^(c) | NT | Australia | Total (no.) | Australia 2002–03 |
|--|---------------|---------------|-----------------------|---------------|--------------|--------------|--------------------|--------------|--------------|----------------|-------------------|
| Withdrawal management (detoxification) | 23.3 | 22.2 | 7.9 | 6.6 | 19.8 | 2.5 | 36.1 | 8.4 | 18.4 | 25,123 | 18.9 |
| Counselling | 28.9 | 47.1 | 27.7 | 50.2 | 22.7 | 62.8 | 47.2 | 24.6 | 37.6 | 51,514 | 41.5 |
| Rehabilitation | 10.0 | 3.8 | 5.7 | 16.4 | 20.8 | 4.5 | 13.1 | 14.9 | 8.6 | 11,717 | 7.5 |
| Support and case management only | 8.3 | 13.0 | 6.4 | 1.1 | 3.8 | 1.7 | 3.1 | 0.9 | 8.4 | 11,494 | 6.9 |
| Information and education only | 2.0 | 0.7 | 37.2 | 9.7 | 1.3 | 11.1 | 0.4 | 23.9 | 7.6 | 10,465 | 8.0 |
| Assessment only | 22.3 | 10.2 | 11.5 | 9.8 | 22.8 | 5.9 | 0.0 | 24.3 | 14.9 | 20,414 | 12.7 |
| Other ^(d) | 5.1 | 3.0 | 3.6 | 6.1 | 8.8 | 11.5 | 0.1 | 3.0 | 4.5 | 6,142 | 4.4 |
| 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) | 42,529 | 47,638 | 18,466 | 14,256 | 7,613 | 2,357 | 1,318 | 2,692 | .. | 136,869 | 130,930 |
| <i>Per cent of closed treatment episodes</i> | 31.1 | 34.8 | 13.5 | 10.4 | 5.6 | 1.7 | 1.0 | 2.0 | 100.0 | .. | |

(a) 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 the reason for cessation as 'ceased to participate 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.

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

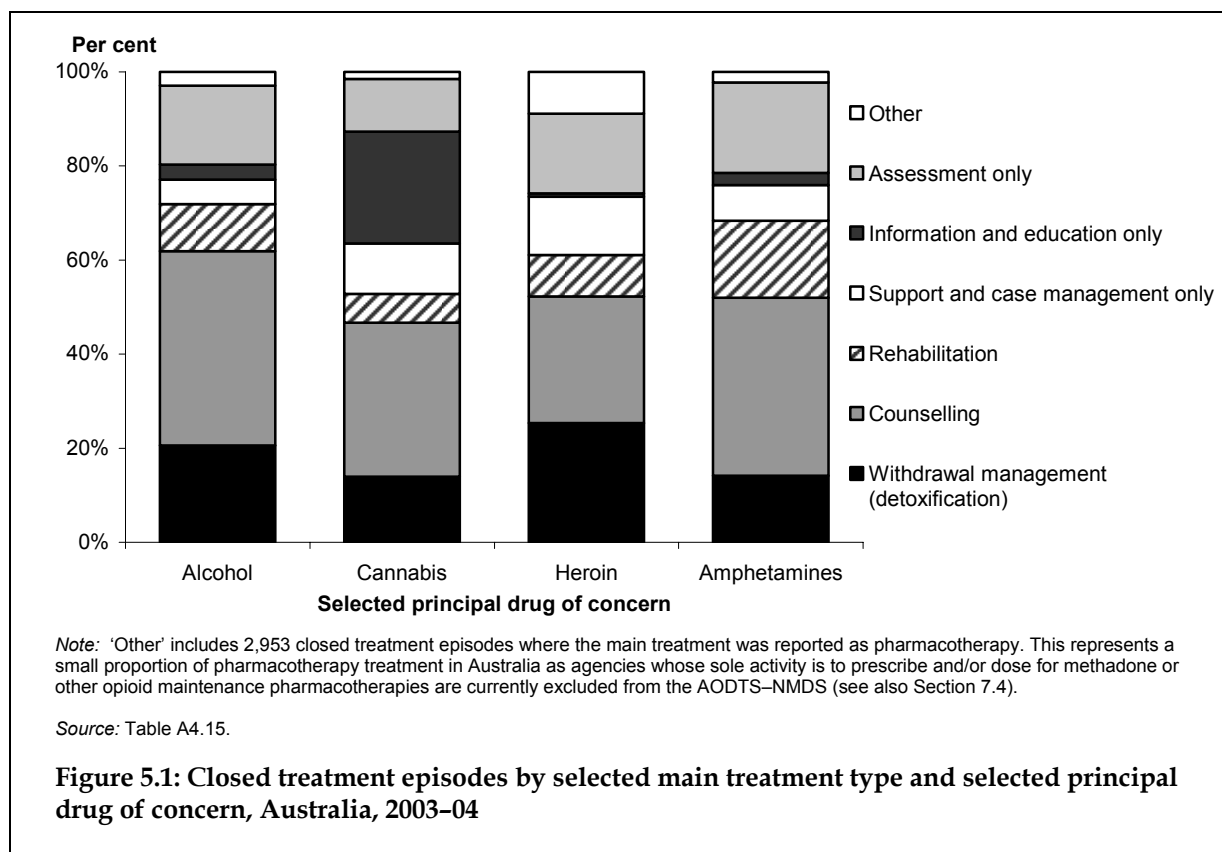
(c) The total number of closed treatment episodes for the ACT may be undercounted due to the exclusion of data from one large service provider because of a data collection error.

(d) 'Other' includes 2,953 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 with the principal drug of concern the client sought treatment for. Overall, counselling accounted for the highest proportion of closed treatment episodes for all principal drugs of concern except benzodiazepines (Table A4.15 and Figure 5.1). Where alcohol was the principal drug, the next most common treatment type was withdrawal management (detoxification) (21% of treatment episodes), followed by assessment only (17%) and rehabilitation (10%). For treatment episodes where cannabis was reported as the principal drug, counselling (33%) was the most common treatment, followed by information and education only (24%), withdrawal management (detoxification) (14%) and assessment only (11%).

The most common treatment types reported for treatment episodes where heroin was the principal drug of concern were counselling (27%), withdrawal management (detoxification) (25%), assessment only (17%) and support and case management only (12%). For treatment episodes where amphetamines were reported as the principal drug, the most common treatments were counselling (38%), followed by assessment only (19%), rehabilitation (16%) and withdrawal management (detoxification) (14%).



Duration of treatment episode—principal drug of concern

Duration of a closed treatment episode is determined 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.

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 in 2003–04 was 16, similar to the figure for 2002–03 (17) (Table 5.2). The highest median number of treatment days within a treatment episode occurred where the principal drug of concern was heroin (21), followed by treatment episodes where amphetamines was the principal drug (19), then alcohol (17) and cannabis (12).

The category 'other' treatment had the highest median number of treatment days per treatment episode (47). 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 (45). This varied slightly with the principal drug. For treatment episodes where the client was receiving counselling as the main treatment, the median number of days per treatment episode was highest when heroin was the principal drug of concern (57), compared with 44 when alcohol was the principal drug, 43 for amphetamines and 41 for cannabis.

The median length of time spent on support and case management was longest where the principal drug of concern was amphetamines (55 days) and shortest where alcohol was the principal drug (29 days). For rehabilitation treatment, the overall median number of treatment days per treatment episode was 30, ranging from 28 when amphetamines and cannabis were the principal drug to 35 for heroin.

Table 5.2: Duration of closed treatment episodes^(a) by main treatment type and selected principal drugs of concern, Australia, 2003–04

| Main treatment type | Alcohol | Heroin | Cannabis | Amphetamines | Total ^(b) | Total 2002–03 |
|---|---------------|---------------|---------------|---------------|----------------------|------------------|
| (median number of days) | | | | | | |
| Withdrawal management (detoxification) | 7 | 7 | 9 | 7 | 8 | 7 |
| Counselling | 44 | 57 | 41 | 43 | 45 | 44 |
| Rehabilitation | 32 | 35 | 28 | 28 | 30 | 32 |
| Support and case management only | 29 | 45 | 52 | 55 | 43 | 43 |
| Information and education only | 1 | 1 | 1 | 1 | 1 | 1 |
| Assessment only | 1 | 8 | 7 | 1 | 2 | 1 |
| Other ^(c) | 21 | 92 | 29 | 6 | 47 | 55 |
| Total (median number of days) | 17 | 21 | 12 | 19 | 16 | 17 |
| Total (number of treatment episodes) | 48,500 | 23,326 | 28,427 | 14,208 | 129,331 | 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 7.

(c) 'Other' includes 2,953 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 2003–04, the most common sources of referral to services were self-referrals (40% of treatment episodes), followed by referrals from alcohol and other drug treatment services (11%) (Table 5.3). Compared with 2002–03, closed treatment episodes in 2003–04 were slightly more likely to have resulted from self-referral (41% compared with 37% respectively) (AIHW 2004a). Section 4.6 contains further information on source of referral, specifically in relation to principal drug of concern.

As noted in Section 3.2, a very high proportion of closed treatment episodes were for clients seeking treatment for their own drug use (95%), 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 (46%) followed by referrals from family members or friends (17%), compared with episodes relating to clients seeking treatment for their own drug use (40% and 5% respectively).

Table 5.3: Closed treatment episodes by client type and source of referral, Australia, 2003–04

| Source of referral | Own drug use | | Others' drug use | | Total | |
|--|----------------|--------------|------------------|--------------|----------------|--------------|
| | No. | % | No. | % | No. | % |
| Self | 51,894 | 40.1 | 3,465 | 46.0 | 55,359 | 40.4 |
| Family member/friend | 6,537 | 5.1 | 1,285 | 17.0 | 7,822 | 5.7 |
| GP/medical specialist | 8,438 | 6.5 | 398 | 5.3 | 8,836 | 6.5 |
| Psychiatric and/or other hospitals | 4,797 | 3.7 | 174 | 2.3 | 4,971 | 3.6 |
| Community mental health services ^(a) | 2,561 | 2.0 | 87 | 1.2 | 2,648 | 1.9 |
| Alcohol & other drug treatment services ^(a) | 14,989 | 11.6 | 554 | 7.3 | 15,543 | 11.4 |
| Other community/health care services ^(b) | 5,700 | 4.4 | 490 | 6.5 | 6,190 | 4.5 |
| Community-based corrections | 12,237 | 9.5 | 109 | 1.4 | 12,346 | 9.0 |
| Police diversions | 8,841 | 6.8 | 208 | 2.8 | 9,049 | 6.6 |
| Court diversions | 2,221 | 1.7 | 18 | 0.2 | 2,239 | 1.6 |
| Other | 10,569 | 8.2 | 649 | 8.6 | 11,218 | 8.2 |
| Not stated | 547 | 0.4 | 101 | 1.3 | 648 | 0.5 |
| Total | 129,331 | 100.0 | 7,538 | 100.0 | 136,869 | 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/outpatient clinic; and other community service agency.

When closed treatment episodes for clients seeking treatment for their own drug use are considered, the most common main treatments received were counselling (35%), withdrawal management (detoxification) (19%) and assessment only (16%) (Table 5.4). These proportions are very similar to those for the treatment population overall (Section 5.1)

Of the treatment types used by people seeking treatment for others' drug use, the highest proportion of closed treatment episodes were for counselling (80%), then information and education only (9%). As might be expected, some treatment types, such as withdrawal management (detoxification) and rehabilitation, are only very rarely used by clients receiving treatment for someone else's drug use.

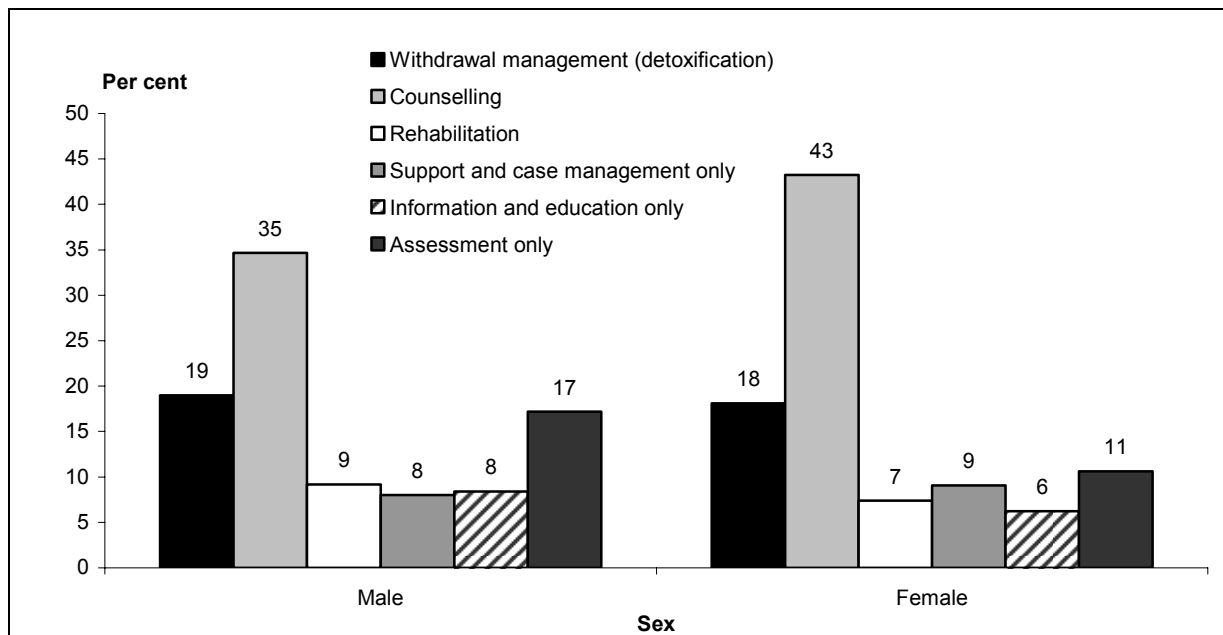
Table 5.4: Closed treatment episodes by client type and main treatment type, Australia, 2003–04

| Main treatment type | Own drug use | | Others' drug use | | Total | |
|--|----------------|--------------|------------------|--------------|----------------|--------------|
| | No. | % | No. | % | No. | % |
| Withdrawal management (detoxification) | 25,123 | 19.4 | — | — | 25,123 | 18.4 |
| Counselling | 45,454 | 35.1 | 6,060 | 80.4 | 51,514 | 37.6 |
| Rehabilitation | 11,688 | 9.0 | 29 | 0.4 | 11,717 | 8.6 |
| Support and case management only | 11,157 | 8.6 | 337 | 4.5 | 11,494 | 8.4 |
| Information and education only | 9,788 | 7.6 | 677 | 9.0 | 10,465 | 7.6 |
| Assessment only | 20,195 | 15.6 | 219 | 2.9 | 20,414 | 14.9 |
| Other ^(a) | 5,926 | 4.6 | 216 | 2.9 | 6,142 | 4.5 |
| Total | 129,331 | 100.0 | 7538 | 100.0 | 136,869 | 100.0 |

(a) 'Other' includes 2,953 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 2003–04, the main treatment type varied with the sex and age group of the client (Figures 5.2 and 5.3). Of closed treatment episodes where the clients were female, a higher proportion involved counselling as the main treatment (43%) than for males (35%). Male clients were more likely to receive assessment only as their main treatment (17% of treatment episodes for males, compared with 11% for females), and slightly more likely to receive rehabilitation (9% compared with 7%), and information and education only (8% compared with 6%). The proportion of treatment episodes for male and female clients receiving support and case management only were 8% and 9%, respectively.



Source: Table A4.16.

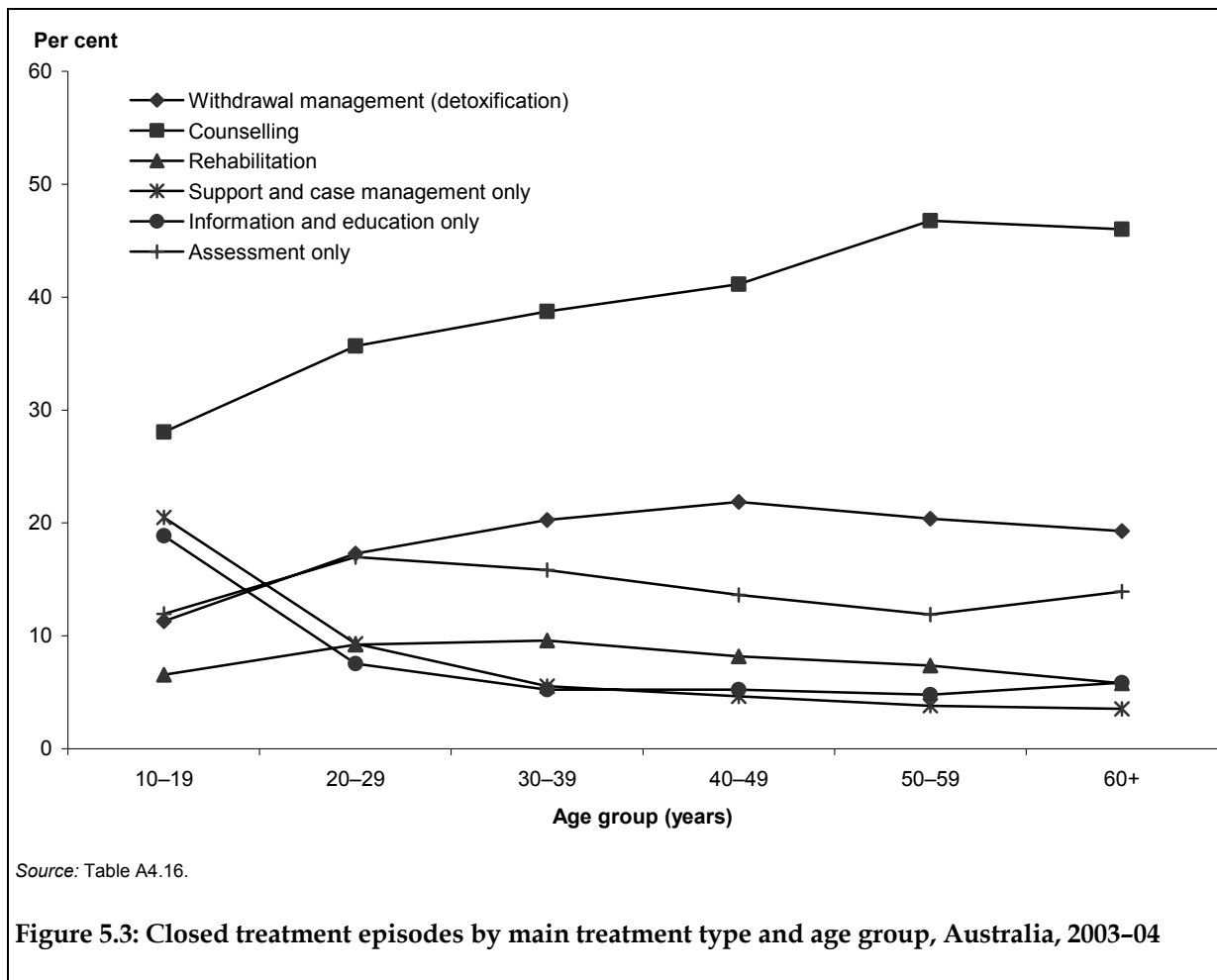
Figure 5.2: Closed treatment episodes by selected main treatment type and sex, Australia, 2003-04

Overall, counselling accounted for 38% of closed treatment episodes nationally; however, this proportion varied when age group was considered (Figure 5.3). In 2003-04, the proportion of treatment episodes where counselling was the main treatment increased with the age of the client, from 28% of closed treatment episodes for clients aged 10-19 years to 47% of episodes for clients aged 50-59 years.

Withdrawal management (detoxification) was most common treatment type in episodes where the clients were aged 40-49 years (22%), followed by those aged in the 50-59 age group (20%). Withdrawal management was least common among the younger age groups – 11% of treatment episodes for clients in the 10-19 age group and 17% 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 6% and 10% of treatment episodes for all age groups, higher in the 20-29 and 30-39 age groups (9% and 10% respectively) and lower in clients aged 60 and over (6%).

As shown in Section 5.2, different principal drugs of concern show different distributions of main treatment types, and, as Figure 5.3 shows, different age groups show different distributions of main treatment types. The distribution of main treatment types over age could be related to the most common principal drug of concern for each age group. For example, cannabis was the principal drug of concern with the highest rate of information and education only as a treatment type, and, in the 10-19 age group, cannabis was the most common principal drug of concern. Cannabis was more common in the 10-19 age group compared with the 20-29 age group. Figure 5.3 shows that information and education only also showed a large drop between these age groups.



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. Closed treatment episodes involving Aboriginal and Torres Strait Islander clients were less likely to have withdrawal management (detoxification) (11% of treatment episodes for Indigenous clients, compared with 20% of episodes for other Australians) or counselling as the main treatment (33% compared with 38%) (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% and 20% respectively), compared with episodes for other Australian clients (7% and 14% respectively).

Compared with 2002-03, there has been a decrease in the proportion of closed treatment episodes for Indigenous clients receiving counselling (38% in 2002-03 to 33% in 2003-04), and an increase in the proportion receiving assessment only (from 15% to 20%) (AIHW 2004a). A similar change can be observed for treatment episodes of other Australians across the collection period – counselling decreased from 42% to 38%.

Table 5.5: Closed treatment episodes by main treatment type and Indigenous status, Australia, 2003–04

| Main treatment type | Indigenous | | Non-Indigenous | | Not stated | | Total | |
|--|---------------|--------------|----------------|--------------|--------------|--------------|----------------|--------------|
| | No. | % | No. | % | No. | % | No. | % |
| Withdrawal management (detoxification) | 1,503 | 11.4 | 22,480 | 19.5 | 1,140 | 13.7 | 25,123 | 18.4 |
| Counselling | 4,371 | 33.0 | 43,925 | 38.1 | 3,218 | 38.8 | 51,514 | 37.6 |
| Rehabilitation | 1,295 | 9.8 | 9,962 | 8.6 | 460 | 5.5 | 11,717 | 8.6 |
| Support and case management only | 1,188 | 9.0 | 9,621 | 8.3 | 685 | 8.3 | 11,494 | 8.4 |
| Information and education only | 1,933 | 14.6 | 7,757 | 6.7 | 775 | 9.3 | 10,465 | 7.6 |
| Assessment only | 2,581 | 19.5 | 16,279 | 14.1 | 1,554 | 18.7 | 20,414 | 14.9 |
| Other ^(a) | 367 | 2.8 | 5,314 | 4.6 | 461 | 5.6 | 6,142 | 4.5 |
| Total | 13,238 | 100.0 | 115,338 | 100.0 | 8,293 | 100.0 | 136,869 | 100.0 |
| Per cent of closed treatment episodes | 9.7 | .. | 84.3 | .. | 6.1 | .. | 100.0 | .. |

(a) 'Other' includes 2,953 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 Geographical location and treatment program

In 2003–04, across all areas – except for very remote areas – counselling was the most commonly reported main treatment type, accounting for 36% of treatment episodes in major cities, 44% in inner regional, 38% in outer regional and 47% in remote areas (Table 5.6). In very remote areas, rehabilitation was the most common treatment type (49% of treatment episodes). The spread of other treatment types varied by geographical location of the treatment agency. In major cities, withdrawal management (detoxification) was the second most common treatment (22%), followed by assessment (15%). In outer regional and very remote areas, information and education only was the second most prominent treatment type (29% and 23% respectively), followed by assessment only in outer regional areas (11%), and withdrawal management (detoxification) in very remote areas (9%). As noted in Section 4.5, caution should be used when interpreting geographical data.

Compared with 2002–03, the largest shift in distribution of main treatment by geographical location is observed in episodes based in very remote areas. In 2002–03, 22% of treatment episodes in very remote areas involved clients receiving withdrawal management (detoxification); this dropped to 9% in 2003–04 (AIHW 2004a). Other observed changes in distribution involve episodes in inner regional areas, where the proportion of episodes with counselling as main treatment dropped from 50% in 2002–03 to 44% in 2003–04; and assessment only, where the proportion of episodes increased from 8% in 2002–03 to 15% in 2003–04.

Table 5.6: Closed treatment episodes by main treatment type and geographical location,^(a) Australia, 2003–04 (per cent)

| Main treatment type | Major cities | Inner regional | Outer regional | Remote | Very remote | Total ^(b) | Total (number) ^(b) |
|--|---------------|----------------|----------------|--------------|-------------|----------------------|-------------------------------|
| Withdrawal management (detoxification) | 21.7 | 12.2 | 7.5 | 9.4 | 9.2 | 18.4 | 25,123 |
| Counselling | 35.6 | 44.0 | 38.3 | 46.8 | 5.7 | 37.6 | 51,514 |
| Rehabilitation | 9.5 | 6.9 | 4.1 | 12.0 | 49.4 | 8.6 | 11,717 |
| Support and case management only | 8.1 | 10.6 | 6.7 | 0.9 | 4.6 | 8.4 | 11,494 |
| Information and education only | 4.6 | 8.4 | 28.6 | 13.9 | 23.0 | 7.6 | 10,465 |
| Assessment only | 15.4 | 15.2 | 10.5 | 16.4 | 8.0 | 14.9 | 20,414 |
| Other | 5.1 | 2.8 | 4.2 | 0.6 | 0.0 | 4.5 | 6,142 |
| Total | 94,981 | 27,767 | 12,389 | 1,645 | 87 | .. | 136,869 |
| Per cent of closed treatment episodes | 69.4 | 20.3 | 9.1 | 1.2 | 0.1 | 100.0 | .. |

(a) The geographical location of treatment agencies in the 2003–04 AODTS–NMDS has been analysed using the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 6).

(b) Includes 'not stated' for geographical location.

(c) 'Other' includes 2,953 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 and the Northern Territory were excluded as they did not provide data for 'other treatment type'.

In 2003–04, of the 86,539 closed treatment episodes where clients were seeking treatment, 16,230 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 – where withdrawal management (detoxification) was the main treatment type, 45% of clients reported at least one other treatment; where another treatment type was recorded, 44% of clients reported at least one other treatment type; and where rehabilitation was the main treatment, 36% of clients reported more than one treatment type. Where counselling was the main treatment, only 15% of clients reported at least one other treatment type.

The total proportion of episodes with other treatment types remained stable between 2002–03 and 2003–04. However, the proportion of episodes with another treatment type also used differed for withdrawal management (detoxification), falling from 45% to 35% between the reporting periods, and rehabilitation, increasing from 36% to 45%.

The nature of some treatments – such as support and case management only, information and education only and assessment only – means that they cannot be reported as a secondary treatment type, so 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^(a), 2003–04

| Main treatment type | With other treatment type | With no other treatment type | Total episodes | Proportion of episodes with other treatment type (%) | Proportion of episodes with other treatment type 2002–03 (%) |
|--|---------------------------|------------------------------|----------------|--|--|
| Withdrawal management (detoxification) | 6,468 | 7,876 | 14,344 | 45.1 | 35.1 |
| Counselling | 4,251 | 24,162 | 28,413 | 15.0 | 16.6 |
| Rehabilitation | 3,466 | 6,051 | 9,517 | 36.4 | 45.1 |
| Support and case management only | — | 5,255 | 5,255 | — | — |
| Information and education only | — | 9,464 | 9,464 | — | — |
| Assessment only | — | 14,901 | 14,901 | — | — |
| Other ^(b) | 2045 | 2,600 | 4,645 | 44.0 | 46.1 |
| Total | 16,230 | 70,309 | 86,539 | 18.8 | 18.8 |

(a) Excludes 47,638 closed treatment episodes from Victoria and 2,692 closed treatment episodes from Northern Territory as these jurisdictions did not provide data for 'other treatment type'.

(b) 'Other' includes 2,953 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 16,230 closed treatment episodes that did report at least one other treatment type, 19,889 other treatment types were reported (clients are able to report up to four other treatment types) (Table A4.14). This equates to an average of 1.2 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 a treatment episode can end. When all closed treatment episodes are considered, the most common reason for ending a treatment episode was because the treatment was completed (53%), 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 (64% of episodes with this treatment type) and withdrawal management (detoxification (61%), and less likely where the main treatment type was information and education only (36%) (Table 5.8). The low proportion of completed episodes of information and education only related to the fact that the majority of these treatment episodes ended at expiation (54%). This finding may be expected, since expiation, as defined in the AODTS–NMDS, refers to when a client has atoned for the offence by completing a recognised education or information program. This relates closely to the use of expiation for

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).

cannabis use—69% of all treatment episodes where information and education was the main treatment type involved cannabis as the principal drug of concern⁵ (Table A4.15).

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 (15% and 11% of treatment episodes respectively).

Table 5.8: Closed treatment episodes by main treatment type and selected reason for cessation, Australia, 2003–04 (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) | 61.2 | 5.7 | 10.0 | 11.1 | 1.9 | 9.8 | 100.0 | 25,123 |
| Counselling | 52.0 | 4.3 | 25.4 | 2.2 | 3.1 | 12.5 | 100.0 | 51,514 |
| Rehabilitation | 40.1 | 7.0 | 14.7 | 14.5 | 2.2 | 20.7 | 100.0 | 11,717 |
| Support and case management only | 60.2 | 8.2 | 14.2 | 1.7 | 2.3 | 12.6 | 100.0 | 11,494 |
| Information and education only | 35.9 | 1.8 | 2.9 | 0.7 | 53.6 | 3.6 | 100.0 | 10,465 |
| Assessment only | 63.5 | 14.8 | 7.7 | 0.9 | 7.3 | 5.5 | 100.0 | 20,414 |
| Other ^(c) | 41.1 | 15.5 | 21.5 | 2.1 | 3.8 | 14.7 | 100.0 | 6,142 |
| Total (per cent) | 53.3 | 7.0 | 16.2 | 4.5 | 7.3 | 11.1 | 100.0 | .. |
| Total (number) | 73,001 | 9,581 | 22,145 | 6,214 | 9,940 | 15,151 | .. | 136,869 |

(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 2,953 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, 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 to participate at expiation'. It is possible that the principal drug of concern is not actually cannabis and it is expected 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 (68%) of treatment episodes occurred at a non-residential facility⁶ (Table 5.9). One-fifth (20%) of treatment episodes occurred in residential facilities and 7% in an outreach setting such as a mobile van service.

Closed treatment episodes conducted in residential facilities or home settings were most likely to involve withdrawal management (detoxification) as the main treatment type (53% and 74% respectively). The next most likely treatment in a residential treatment facility was rehabilitation (29%), and for home settings, the next most likely treatment types were counselling (12%) and assessment only (9%).

Of treatment episodes that were conducted in a non-residential treatment facility, the majority of episodes had counselling as the main treatment (52%), followed by assessment only (17%), withdrawal management (detoxification) (8%) and information and education only (8%). A high proportion of treatment episodes that were conducted in an outreach setting reported support and case management only as their main treatment (53%), followed by information and education only (16%) and counselling (13%).

Table 5.9: Closed treatment episodes by main treatment type and treatment delivery setting, Australia, 2003–04 (per cent)

| Main treatment type | Non-residential treatment facility | Residential treatment facility | Home | Outreach setting | Other | Total |
|--|------------------------------------|--------------------------------|--------------|------------------|--------------|----------------|
| Withdrawal management (detoxification) | 8.3 | 53.4 | 74.0 | 2.6 | 0.9 | 18.4 |
| Counselling | 51.8 | 2.2 | 11.7 | 12.5 | 32.4 | 37.6 |
| Rehabilitation | 3.4 | 28.8 | 0.6 | 2.1 | 14.1 | 8.6 |
| Support and case management only | 6.4 | 0.7 | 1.9 | 53.4 | 4.5 | 8.4 |
| Information and education only | 8.0 | 1.7 | 1.6 | 15.8 | 28.8 | 7.6 |
| Assessment only | 17.1 | 9.9 | 9.2 | 11.1 | 13.1 | 14.9 |
| Other ^(a) | 5.1 | 3.4 | 1.0 | 2.6 | 6.1 | 4.5 |
| Total (per cent) | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Total (number) | 92,933 | 27,281 | 3,435 | 9,585 | 3,635 | 136,869 |
| Per cent of closed treatment episodes | 67.9 | 19.9 | 2.5 | 7.0 | 2.7 | 100.0 |

(a) 'Other' includes 2,953 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).

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

Duration of treatment episode—treatment delivery setting

Overall, when all closed treatment episodes are considered, the median number of treatment days⁷ for a treatment episode was 17⁷ (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 (24 and 23 respectively). Treatment episodes where the treatment delivery setting was a client's home had a median length of treatment of 18 days, whereas clients receiving treatment in residential treatment facilities had a median length of 7 treatment days.

Overall, the median length of time spent on support and case management was 43 days. This varied by treatment delivery setting—45 days for those receiving treatment in an outreach setting, 44 days for non-residential treatment facilities, 22 days for residential treatment facilities and 11 days for home.

The median duration of treatment episodes involving withdrawal management (detoxification) was 8 days. The highest median length for this treatment type was for clients receiving services at home or in a non-residential treatment facility (19 and 17 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, 2003–04

| Main treatment type | Non-residential treatment facility | Residential treatment facility | Home | Outreach setting | Other | Total |
|---|------------------------------------|--------------------------------|--------------|------------------|--------------|----------------|
| | (median number of days) | | | | | |
| Withdrawal management (detoxification) | 17 | 6 | 19 | 4 | 11 | 8 |
| Counselling | 44 | 7 | 61 | 33 | 63 | 44 |
| Rehabilitation | 26 | 30 | 31 | 15 | 39 | 30 |
| Support and case management only | 44 | 22 | 11 | 45 | 17 | 43 |
| Information and education only | 1 | 1 | 1 | 1 | 1 | 1 |
| Assessment only | 4 | 1 | 1 | 1 | 1 | 2 |
| Other ^(b) | 41 | 111 | 13 | 6 | 1 | 45 |
| Total | 24 | 7 | 18 | 23 | 11 | 17 |
| Total (number of treatment episodes) | 92,933 | 27,281 | 3,435 | 9,585 | 3,635 | 136,869 |

(a) As stated in Section 5.2, 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 a treatment episode. This analysis investigates duration using the 'median number of days' per treatment episode for treatment delivery setting.

(b) 'Other' includes 2,953 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).

7. The median number of treatment days for a treatment episodes in this section is different from that presented in Table 5.2, as the median number of treatment days for a treatment episode in Table 5.2 was calculated excluding clients seeking treatment for the drug use of others.

Treatment delivery setting and principal drug of concern

In 2003–04, for treatment episodes where the treatment delivery setting was either a non-residential treatment facility, a residential treatment facility, the client's home, or an outreach setting, the principal drug of concern of the client was most likely to be alcohol (38%, 39%, 39% and 31% respectively) (Table 5.11). This was also the case in 2002–03 (38%, 43%, 38% and 24% respectively) (AIHW 2004a). The next most common principal drug for clients in non-residential facilities, at home and in outreach settings was cannabis (24%, 23% and 26% respectively), followed by heroin for all three treatment delivery settings (16%, 15% and 15% respectively). This pattern was reversed for residential treatment facilities, where the second most common principal drug of concern was heroin (25%), and the third was cannabis (14%). For treatment episodes where the delivery setting was an 'other' delivery setting, the most common principal drug was cannabis (34%), followed by alcohol (21%), amphetamines (19%) and heroin (18%).

These patterns largely reflect the fact that alcohol, cannabis, heroin and amphetamines are the four most common principal drugs of concern in the AODTS–NMDs for 2003–04.

Table 5.11: Closed treatment episodes by principal drug of concern and treatment delivery setting, Australia, 2003–04^(a) (per cent)

| Principal drug of concern | Non-residential treatment facility | Residential treatment facility | Home | Outreach setting | Other | Total |
|--|------------------------------------|--------------------------------|--------------|------------------|--------------|----------------|
| Alcohol | 38.3 | 39.3 | 38.8 | 30.8 | 20.5 | 37.5 |
| Amphetamines | 10.7 | 12.7 | 8.5 | 6.4 | 18.9 | 11.0 |
| Benzodiazepines | 2.0 | 2.6 | 3.8 | 0.9 | 2.0 | 2.1 |
| Cannabis | 23.5 | 14.0 | 23.1 | 26.1 | 33.5 | 22.0 |
| Cocaine | 0.2 | 0.2 | 0.1 | 0.1 | 0.4 | 0.2 |
| Ecstasy | 0.4 | 0.2 | 0.2 | 0.7 | 0.4 | 0.4 |
| Heroin | 16.4 | 24.7 | 15.3 | 14.5 | 18.2 | 18.0 |
| Methadone | 1.8 | 1.8 | 1.6 | 2.3 | 2.0 | 1.9 |
| Nicotine | 1.3 | 0.2 | 0.7 | 8.8 | 1.3 | 1.5 |
| Other drugs ^(b) | 4.7 | 4.1 | 7.7 | 9.3 | 2.2 | 4.9 |
| Not stated | 0.6 | 0.1 | 0.2 | 0.2 | 0.5 | 0.5 |
| Total (per cent) | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Total (number) | 86,350 | 27,170 | 3,358 | 8,920 | 3,533 | 129,331 |
| Per cent of closed treatment episodes | 66.8 | 21.0 | 2.6 | 6.9 | 2.7 | 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 7.

6 Special theme: Amphetamines

Previous chapters of this report have profiled clients seeking treatment from government-funded alcohol and other drug treatment services in 2003–04, the types of drugs for which they sought treatment and the types of treatment they receive. This special theme chapter focuses on closed treatment episodes where amphetamines were the principal drug of concern for a client. This theme was selected on the basis of feedback received from the agencies via the 2004 Survey of Treatment Agencies. The analysis presented in Sections 6.2 and 6.3 examines those treatment episodes that involve clients who sought treatment for their own drug use.

Box 6.1: Key definitions and counts for closed treatment episodes and treatment programs, 2003–04

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 there were:

- **14,208** closed treatment episodes for clients who nominated amphetamines as their principal drug of concern
- **114,491** closed treatment episodes for clients who nominated a principal drug of concern other than amphetamines
- **632** closed treatment episodes for clients who did not nominate a principal drug of concern.

Other drugs of concern refer to any other drugs apart from the principal drug of concern that clients perceive as being a health concern. Up to five other drugs of concern can be recorded for each client.

- **16,754** other drugs of concern were recorded where amphetamines were nominated as the principal drug of concern
- **94,133** other drugs of concern were recorded where principal drugs of concern, other than amphetamines, were nominated.

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

6.1 Introduction

What are amphetamines?

‘Amphetamines’ refers to a group of psychostimulant drugs which includes methamphetamine. Amphetamines can be legally prescribed to help treat disorders such as epilepsy and narcolepsy, as well as attention deficit disorder. Illicitly, amphetamines are used, generally, to increase endurance, reduce tiredness, improve performance and to help stay awake for long periods of time. Amphetamines have long been associated with

clubbing, dance parties and 'raves', and long-distance truck driving, where the use of the stimulant allows people to keep active for longer periods of time.

Common names for amphetamines and methamphetamines include 'speed', 'ice', 'crystal', 'whiz' and 'uppers'. Amphetamines are commonly swallowed, injected or smoked, but, this depends on the form of amphetamines being taken. There are five distinct forms of amphetamines:

- powder (e.g. 'speed')
- liquid (e.g. 'ox blood', 'liquid red')
- base (e.g. 'paste', 'pure', 'meth')
- crystal (e.g. 'ice', 'crystal meth', 'shabu', 'glass')
- pharmaceutical or prescribed tablets (duromine, dexamphetamine, Ritalin).

As with most drugs, the effects of amphetamines depend on the strength of the dose and the characteristics of the individual using the drug – such as, height, weight, health. The most common and immediate effects experienced after taking amphetamines include:

- speeding up of bodily functions such as accelerated heart rate and breathing, and rise in blood pressure
- more energy and alertness, including a boost in confidence, becoming talkative, increased endurance and becoming excited
- reduction or loss of appetite
- other physical effects such as dilated pupils, dry mouth, sweating, jaw clenching and teeth grinding.

Long-term or regular use of amphetamines may lead to significant health problems including anxiety and tension, high blood pressure, amphetamine psychosis – which includes hallucinations, paranoia, and other symptoms similar to schizophrenia – reduced immunity, and risk of damage to brain cells (Better Health Channel 2004).

Amphetamine use in Australia

According to the 2004 National Drug Strategy Household Survey (AIHW 2005a), of Australians aged 14 years and over:

- 9.1% had used amphetamines⁸ at some stage in their lifetime, and 3.2% had used them in the previous 12 months (Table 6.1)
- the age group most likely to have ever used amphetamines was the 20–29-year age group (21.1%)
- males were more likely than females to have used amphetamines in the last 12 months (4.0% and 2.5% respectively); however, females aged between 14 and 19 years were slightly more likely to be recent users than males in the same age group (4.9% and 4.0% respectively)
- of those who had ever used amphetamines, the average age of initiation was 20.8.

8. The 2004 National Drug Strategy Household Survey refers to this group of drugs as meth/amphetamines. Similarly, within this report, the term 'amphetamines' includes those drugs that are classified as methamphetamines, such as ice, crystal and speed.

Table 6.1: Use of meth/amphetamines: proportion of the population aged 14 years and over, by age group and sex, Australia, 2004 (per cent)

| Age group | Ever used ^(a) | | | Recent use ^(b) | | |
|-----------------|--------------------------|------------|------------|---------------------------|------------|------------|
| | Males | Females | Persons | Males | Females | Persons |
| 14–19 | 6.6 | 6.5 | 6.6 | 4.0 | 4.9 | 4.4 |
| 20–29 | 24.3 | 17.9 | 21.1 | 12.4 | 9.0 | 10.7 |
| 30–39 | 19.8 | 12.3 | 16.0 | 5.7 | 2.5 | 4.1 |
| 40+ | 4.6 | 2.6 | 3.6 | 0.7 | 0.2 | 0.4 |
| Aged 14+ | 11.0 | 7.3 | 9.1 | 4.0 | 2.5 | 3.2 |

(a) Used at least once in lifetime.

(b) Used in the last 12 months.

Source: AIHW 2005a.

Availability of amphetamines

The National Drug Strategy Household Survey also examines the availability of drugs – survey respondents were asked whether they have been offered or had the opportunity to use selected drugs in the preceding 12 months. Under one-tenth of the population (6.8%) were offered or had the opportunity to use amphetamines in 2004. This proportion was similar to 2001 where 7.6% of the population reported the availability of this drug (AIHW 2005a). From the 2004 survey, males were more likely than females to have been offered or had the opportunity to use amphetamines (8.3%, compared with 5.4%), as was the case in 2001 (9.3% and 5.8%).

Data from the Illicit Drug Reporting System (IDRS) are compiled through interviews with injecting drug users and key informants (including professionals) who have regular contact with illicit drug users through their work. Although these data are *not* representative of the population as a whole, they serve as an early warning system for emerging trends in local and national illicit drug markets. Data from the national 2004 IDRS show that:

- the majority of interviewees across Australia reported it was ‘easy’ or ‘very easy’ to obtain amphetamines in all forms (81% for powder, 82% base and 73% for crystal)
- injecting drug users were more likely to obtain (or score) powder most commonly from friends (34%), dealer’s home (20%) or mobile dealers (17%); for base, friends were again the most common place to score (31%), then dealer’s home (24%) or mobile dealers (26%). The proportions reporting common places to score crystal were slightly different – friends (35%), dealer’s home (20%), mobile dealers (16%) or street dealers (15%)
- the median price of amphetamines (based on the participant’s last purchase) varied according to the form of amphetamine purchased and by jurisdiction. For example, in 2004 the median price *per gram* of powder ranged from \$50 in South Australia to \$290 in Tasmania; for a *point* of base from \$25 in South Australia to \$50 in all other jurisdictions (except Victoria); and for a *point* of crystal prices ranged from \$30 in South Australia to \$50 in all other jurisdictions
- the purity of ‘crystal’ was reported as high, ‘base’ purity was medium and the purity of ‘powder’ was mixed with similar patterns of injecting drug users reporting purity as low, medium and high (NDARC 2005).

Data from the Australian Customs Service – as reported in the IDRS report – show an increase in the number of detections of amphetamine-type stimulants at the Australian border (NDARC 2005), with the number of seizures increasing from 51 in 2000–01 to 215 in 2002–03, but decreasing to 140 seizures in 2003–04. Similarly, the weight of the seizures has also increased substantially over the last few years, from 85 kg in 2000–01 to 239 kg in 2002–03. The total weight of seizures was highest in 2001–02 (428 kg).

6.2 Client profile

Sex and age group

Amphetamines were more likely to be reported as the principal drug of concern for younger age groups. Of those closed treatment episodes where amphetamines were the principal drug of concern, a higher proportion of episodes involved people in the 20–29 and 30–39-year age groups (48% and 33% respectively) compared with episodes for all other principal drugs of concern (32% of episodes for 20–29-year-olds and 28% for 30–39-year-olds) (Table 6.2). Clients aged over 40 are more likely to seek treatment for alcohol (Figure 4.2).

Overall, males were more likely than females to receive treatment for their own drug use – 68% of treatment episodes related to male clients and 32% to female clients (Table 6.2). This pattern was very similar for episodes where amphetamines were nominated as the principal drug of concern (67% males and 33% females).

When considering those episodes where amphetamines were nominated as the principal drug, some sex and age differences are observed. For example:

- a higher proportion of female clients aged 10–19 were seeking treatment for amphetamines compared with male clients in the same age group (14% compared with 9%)
- a slightly higher proportion of male clients aged 30–39 were seeking treatment for amphetamines compared with females clients in the same age group (34% and 31%).

Table 6.2: Closed treatment episodes^(a) by principal drug of concern by age group and sex, Australia, 2003–04 (per cent)

| Age group | Amphetamines | | | All other principal drugs of concern | | | Total ^(b) | | |
|--------------------|--------------|--------------|------------------------|--------------------------------------|--------------|------------------------|----------------------|--------------|------------------------|
| | Males | Females | Persons ^(c) | Males | Females | Persons ^(c) | Males | Females | Persons ^(c) |
| 10–19 | 9.1 | 13.6 | 10.6 | 12.8 | 12.7 | 12.8 | 12.4 | 12.8 | 12.5 |
| 20–29 | 48.1 | 47.6 | 48.0 | 32.8 | 30.6 | 32.1 | 34.5 | 32.5 | 33.8 |
| 30–39 | 33.8 | 30.9 | 32.9 | 27.8 | 28.2 | 27.9 | 28.5 | 28.5 | 28.5 |
| 40–49 | 7.6 | 6.4 | 7.2 | 17.5 | 18.8 | 17.9 | 16.4 | 17.4 | 16.7 |
| 50–59 | 0.5 | 0.4 | 0.5 | 6.4 | 6.6 | 6.5 | 5.7 | 5.9 | 5.8 |
| 60+ | 0.1 | 0.1 | 0.1 | 2.2 | 2.2 | 2.2 | 1.9 | 1.9 | 1.9 |
| Not stated | 0.7 | 1.0 | 0.8 | 0.6 | 0.9 | 0.7 | 0.6 | 0.9 | 0.7 |
| Total | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Total (no.) | 9,563 | 4,637 | 14,208 | 77,475 | 36,942 | 114,491 | 87,419 | 41,829 | 129,331 |

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

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

(c) Includes 'not stated' for sex.

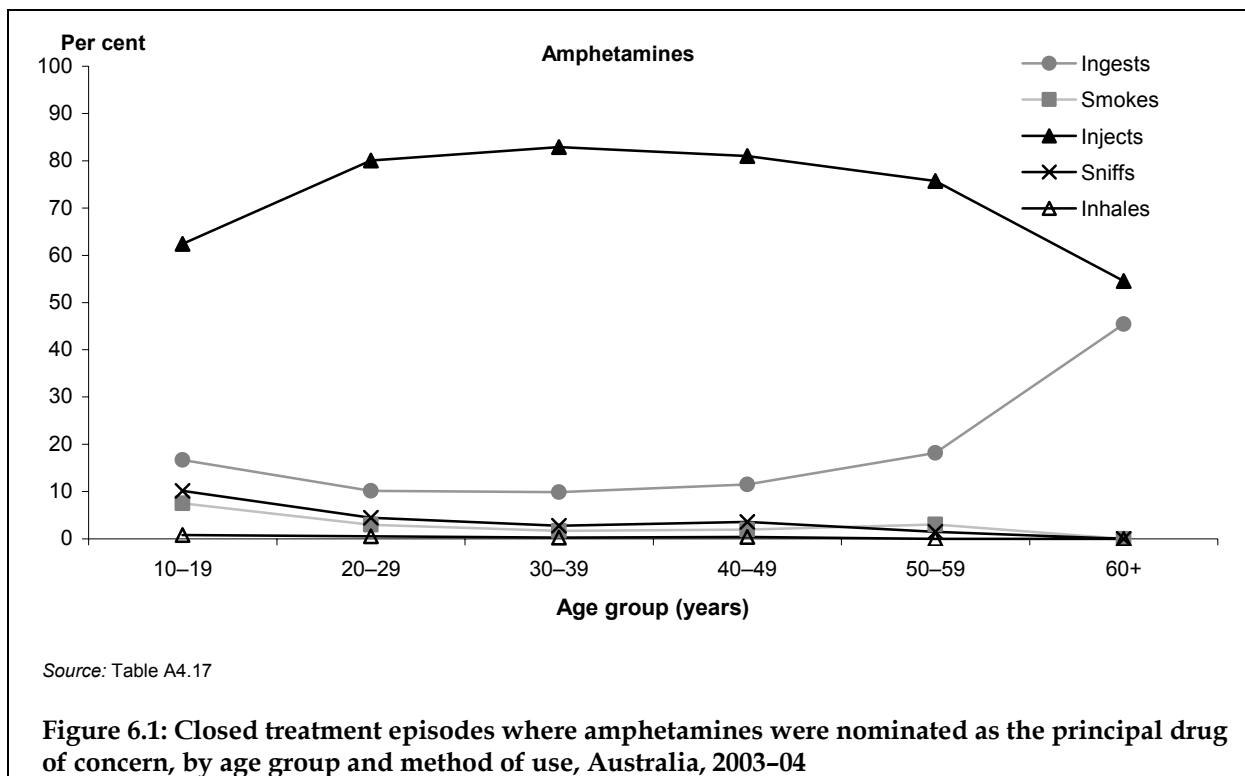
Method of use

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'. Overall, for all closed treatment episodes in 2003–04 the most likely methods of use were ingestion (45%), followed by injection (28%) and smoking (23%) (Table 4.7). Inhaling accounted for 2% of treatment episodes overall, and sniffing was nominated for fewer than 1% of episodes (0.6%).

Where amphetamines were nominated as the principal drug of concern, injecting accounted for 79% of closed treatment episodes within this group, followed by ingesting (11%), sniffing (4%) and smoking (3%), compared with all other drugs of concern, where injecting accounted for 22%, ingesting 49%, sniffing 0.2% and smoking (25%) (Tables A4.17 and A4.18).

Across all age groups, injecting was the most common method of use for closed treatment episodes where amphetamines were the drug of concern (Figure 6.1). This was most marked for the 30–39 age group, with 83% of episodes in this age group nominating injecting as their preferred method of use. Similar proportions were recorded for the 40–49 and 20–29 age groups (81% and 80% respectively).

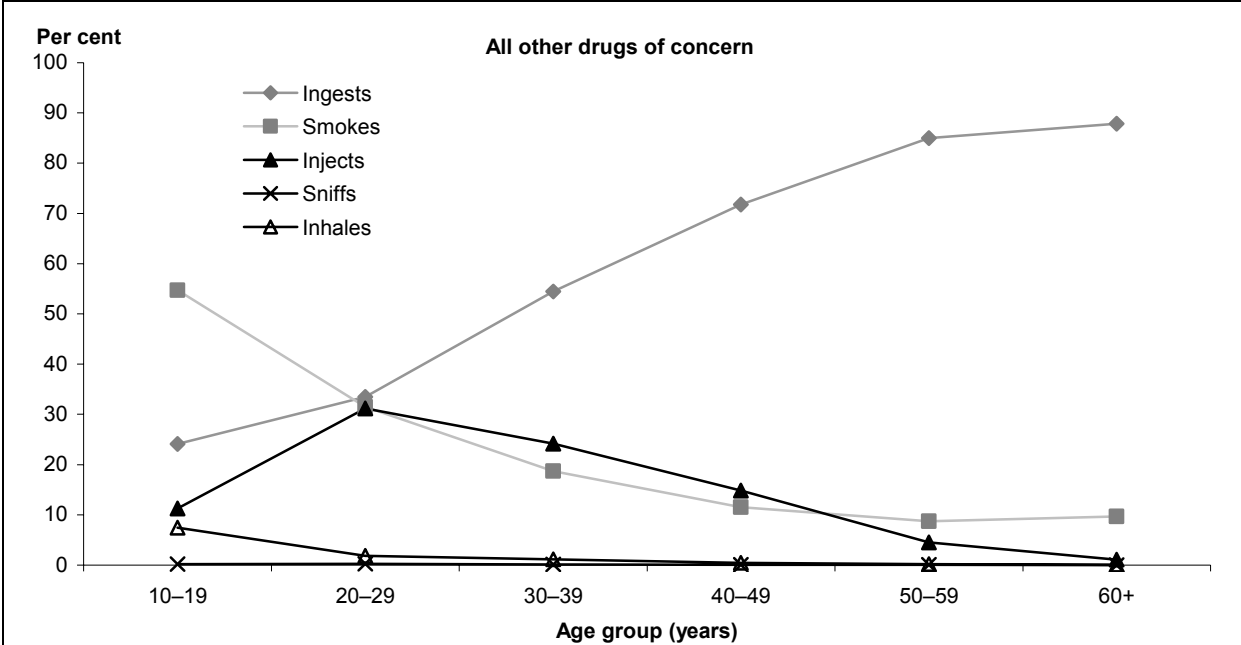
Figure 6.1 also shows higher rates of ingestion in the 50–59 and 60 years and over age groups compared with other age groups (18% and 46% respectively).



For closed treatment episodes where a principal drug of concern other than amphetamines was nominated, the pattern for method of use varies significantly compared with the amphetamines group (Figure 6.2). Overall, in this group, ingesting was the most common method of use, accounting for 50% of closed treatment episodes, followed by smoking (25%) and injecting (21%).

Relationships between age group and method of use illustrated in Figure 6.2 relate to principal drug of concern. For example:

- among episodes where clients are aged between 10 and 19 years, the preferred method of use was smoking (55%); the most common principal drug of concern for this age group is cannabis (49%)
- for episodes where clients are aged 60 years and over, ingesting was the most common method of use (88%); the most common drug of concern for this age group is alcohol (82%).



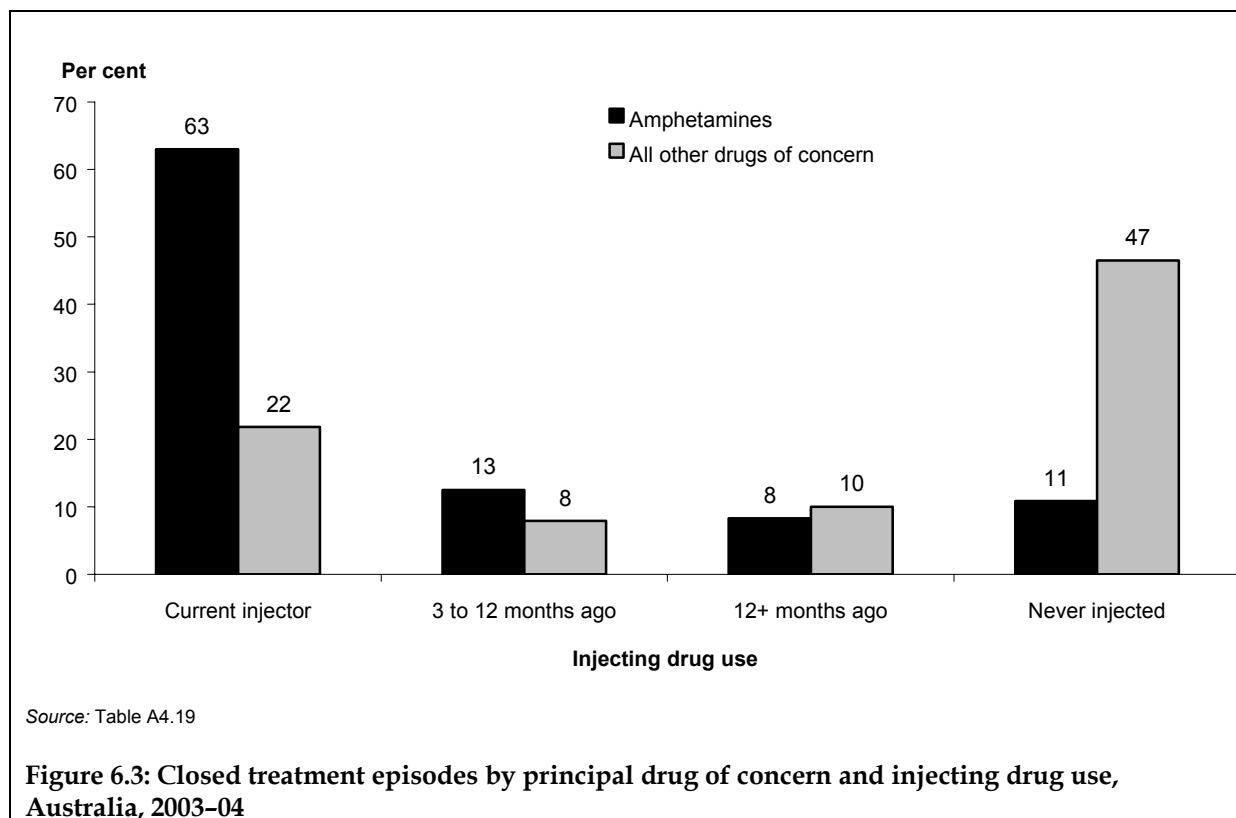
Source: Table A4.18

Figure 6.2: Closed treatment episodes where a principal drug of concern other than amphetamines was nominated by age group and method of use, Australia, 2003-04

Injecting drug use

Overall, 26% of clients in 2003-04 reported that they were current injectors, a further 18% had injected in the past (8% between 3 and 12 months ago and 10% 12 or more months ago) and 43% had never injected (Table A4.19). Clients nominating amphetamines as the principal drug of concern were more likely than those nominating all other principal drugs of concern to be current injectors (63% and 22% respectively) and less likely to have never injected (11% and 47% respectively) (Figure 6.3). The proportion of clients ever having injected in the past was similar for each group: 21% of episodes where amphetamines were the principal drug of concern compared with 18% of episodes where a principal drug other than amphetamines was selected.

Note that caution should be used when interpreting data for 'injecting drug use' due to the high 'not stated' response for this item (13% of overall closed treatment episodes).



Other drugs of concern

As stated in Section 4.7, of closed treatment episodes where amphetamines were nominated as the principal drug of concern, 9,583 episodes (or 67%) had at least one other drug of concern reported (Tables 4.5 and 6.3). From these episodes, 16,754 other drugs of concern were recorded (clients are able to report up to five other drugs of concern), equating to 1.7 other drugs of concern per treatment episode.

For closed treatment episodes where a drug other than amphetamines was nominated as the principal drug of concern, 58,882 episodes (or 51%) had at least one other drug of concern reported. From these episodes, 94,133 other drugs of concern were recorded, equating to 1.6 other drugs of concern per treatment episode.

Of the 16,754 other drugs of concern recorded for clients who nominated amphetamines as their principal drug of concern, 37% of these were cannabis, 21% alcohol, 10% nicotine and 9% heroin (Table 6.3). Of the other drugs of concern recorded for clients who nominated a principal drug of concern other than amphetamines, 24% of other drugs were cannabis, 18% nicotine, 16% amphetamines, 15% alcohol and 9% benzodiazepines.

Table 6.3: Other drugs of concern where the principal drug of concern is amphetamines and where the principal drug of concern is not amphetamines, Australia, 2003–04^(a)

| Other drugs of concern | Amphetamines | | All other principal drugs of concern | | All principal drugs of concern | |
|----------------------------|---------------|--------------|--------------------------------------|--------------|--------------------------------|--------------|
| | No. | % | No. | % | No. | % |
| Alcohol | 3,506 | 20.9 | 14,188 | 15.1 | 17,694 | 16.0 |
| Amphetamines | 61 | 0.4 | 14,989 | 15.9 | 15,050 | 13.6 |
| Benzodiazepines | 1,065 | 6.4 | 8,517 | 9.0 | 9,582 | 8.6 |
| Cannabis | 6,206 | 37.0 | 22,696 | 24.1 | 28,902 | 26.1 |
| Cocaine | 403 | 2.4 | 1,161 | 1.2 | 1,564 | 1.4 |
| Ecstasy | 1,033 | 6.2 | 2,606 | 2.8 | 3,639 | 3.3 |
| Heroin | 1,490 | 8.9 | 4,319 | 4.6 | 5,809 | 5.2 |
| Methadone | 175 | 1.0 | 1,899 | 2.0 | 2,074 | 1.9 |
| Nicotine | 1,666 | 9.9 | 17,354 | 18.4 | 19,020 | 17.2 |
| Other drugs ^(b) | 1,149 | 6.9 | 6,404 | 6.8 | 7,553 | 6.8 |
| Total | 16,754 | 100.0 | 94,133 | 100.0 | 110,887 | 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.

Source of referral

People seeking treatment for amphetamines as the principal drug of concern were more likely than those nominating other drugs of concern to be referred to treatment by a family member or friend (8%, compared with 5%) or from a correctional service (12%, compared with 9%), and less likely to be referred to treatment by a general practitioner or medical specialist (4%, compared with 7%) or through police diversion (3%, compared with 7%). For both groups, self-referring to treatment was the most common source of referral (42% of episodes where amphetamines were the principal drug and 40% of episodes for all other principal drugs of concern) (Table 6.4).

Table 6.4: Closed treatment episodes by principal drug of concern and source of referral, Australia, 2003–04 ^(a)

| Source of referral | Amphetamines | | All other principal drugs of concern | | Total ^(b) | |
|--|---------------|--------------|--------------------------------------|--------------|----------------------|--------------|
| | No. | % | No. | % | No. | % |
| Self | 5,919 | 41.7 | 45,654 | 39.9 | 51,894 | 40.1 |
| Family member/friend | 1,113 | 7.8 | 5,411 | 4.7 | 6,537 | 5.1 |
| General practitioner/medical specialist | 589 | 4.1 | 7,791 | 6.8 | 8,438 | 6.5 |
| Hospital | 494 | 3.5 | 4,284 | 3.7 | 4,797 | 3.7 |
| Community health care centre | 265 | 1.9 | 2,282 | 2.0 | 2,561 | 2.0 |
| Alcohol and other drug treatment service | 1,509 | 10.6 | 13,421 | 11.7 | 14,989 | 11.6 |
| Other community/health care service | 716 | 5.0 | 4,967 | 4.3 | 5,700 | 4.4 |
| Correctional service | 1,715 | 12.1 | 10,471 | 9.1 | 12,237 | 9.5 |
| Police diversion | 486 | 3.4 | 8,296 | 7.2 | 8,841 | 6.8 |
| Court diversion | 478 | 3.4 | 1,743 | 1.5 | 2,221 | 1.7 |
| Other | 855 | 6.0 | 9,697 | 8.5 | 10,569 | 8.2 |
| Not stated | 69 | 0.5 | 474 | 0.4 | 547 | 0.4 |
| Total | 14,208 | 100.0 | 114,491 | 100.0 | 129,331 | 100.0 |

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

(b) Total includes 'not stated' for principal drug of concern.

6.3 Treatment programs

Main treatment type

Clients who nominated amphetamines as their principal drug of concern were more likely to receive rehabilitation (16%) and assessment only (19%), compared with clients who nominated a principal drug other than amphetamines (8% and 15% respectively) (Table 6.5). Conversely, clients with a principal drug other than amphetamines were more likely than those who nominated amphetamines as their principal drug to receive withdrawal management (detoxification) and information and education only (20% and 8%, compared with 14% and 3% respectively). A similar proportion of episodes were for clients receiving counselling as their main treatment (38% of episodes where amphetamines were the drug of concern, compared with 35% of episodes for all other principal drugs of concern).

Table 6.5: Closed treatment episodes by principal drug of concern and main treatment type, Australia, 2003–04^(a)

| Main treatment type | Amphetamines | | All other principal drugs of concern | | Total ^(b) | |
|--|---------------|--------------|--------------------------------------|--------------|----------------------|--------------|
| | No. | % | No. | % | No. | % |
| Withdrawal management (detoxification) | 2,003 | 14.1 | 23,102 | 20.2 | 25,123 | 19.4 |
| Counselling | 5,380 | 37.9 | 39,947 | 34.9 | 45,454 | 35.1 |
| Rehabilitation | 2,327 | 16.4 | 9,349 | 8.2 | 11,688 | 9.0 |
| Support and case management | 1,081 | 7.6 | 10,046 | 8.8 | 11,157 | 8.6 |
| Information and education only | 366 | 2.6 | 9,379 | 8.2 | 9,788 | 7.6 |
| Assessment only | 2,734 | 19.2 | 17,236 | 15.1 | 20,195 | 15.6 |
| Other ^(c) | 317 | 2.2 | 5,432 | 4.7 | 5,926 | 4.6 |
| Total | 14,208 | 100.0 | 114,491 | 100.0 | 129,331 | 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.

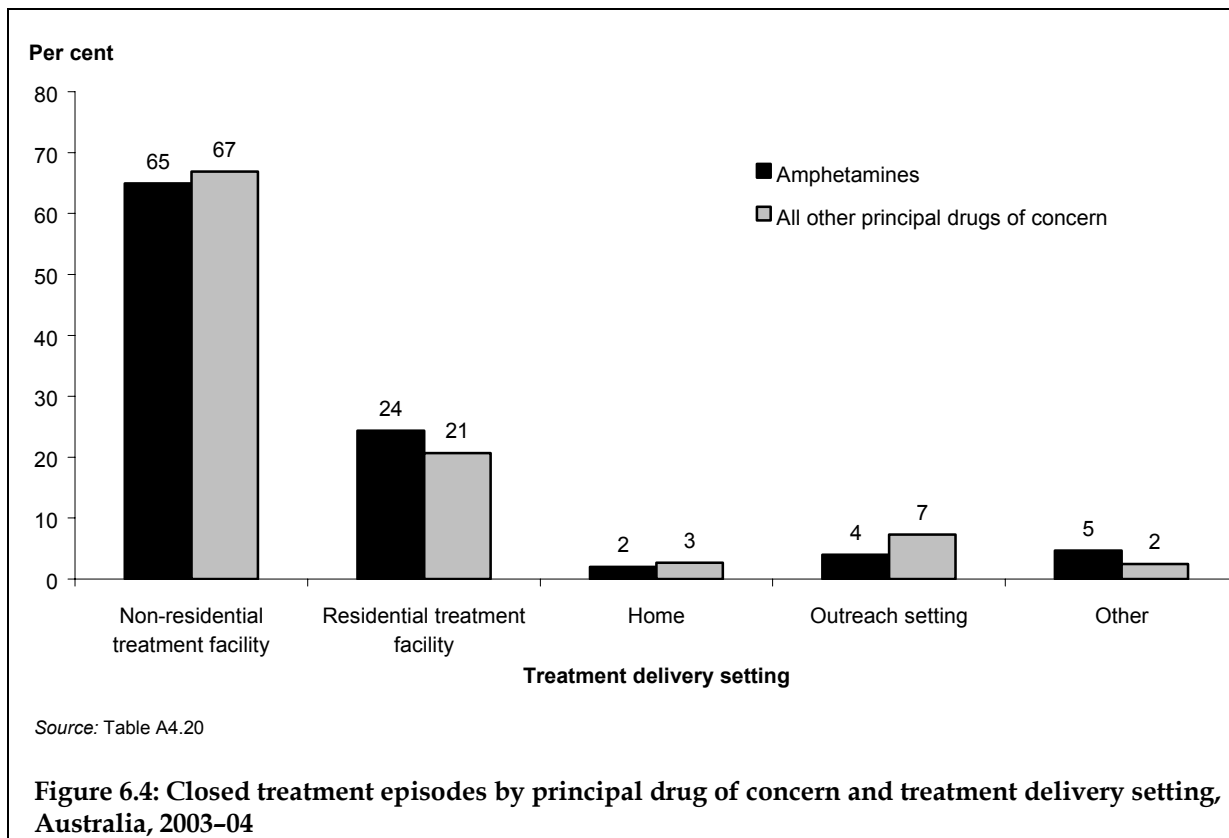
(c) 'Other' includes 2,953 closed treatment episodes (64 episodes for amphetamines group, 2,885 episodes for all other drugs of concern group and 4 episodes not stated) where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia 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

Overall in 2003–04, just over two-thirds of all closed treatment episodes were conducted in non-residential treatment facilities (67%), around one-fifth in residential treatment facilities (21%) and 7% in outreach settings⁹ (Table A4.20).

Nearly one-quarter of treatment episodes where clients nominated amphetamines as their principal drug of concern were conducted in a residential treatment facility (24%), compared with just over one-fifth of the episodes where clients nominated a principal drug other than amphetamines (21%) (Figure 6.4). Closed treatment episodes where a principal drug of concern other than amphetamines was recorded were more likely to receive treatment in a non-residential treatment facility (67%) or in an outreach setting (7%), compared with clients who nominated amphetamines as their principal drug of concern (65% and 4% respectively). A similar proportion of closed treatment episodes in both groups had treatment delivered at home: 2% of episodes where amphetamines were the principal drug and 3% of episodes where all other principal drugs were reported.

9. These proportions are different from those reported in Chapter 5, as data in this chapter exclude clients who are seeking treatment for the drug use of others.



Reason for cessation of treatment episode

In 2003-04, among closed treatment episodes where clients were seeking treatment for their own drug use, where amphetamines were the principal drug of concern, 46% of episodes ceased because the treatment was completed, compared with 54%¹⁰ for other principal drugs of concern (Table 6.6). The next most common reason for ceasing treatment for both groups was where the client ceased to participate without notice to the treatment agency (22% and 15% respectively).

A higher proportion of closed treatment episodes where the principal drug of concern was a drug other than amphetamines ended treatment at expiation—that is, where the client had atoned for the offence by completing a recognised education or information program—compared with episodes where the principal drug was amphetamines (8% compared with 5%). For both groups, a very small proportion of treatment episodes ceased because the client died (Table 6.6).

10. These proportions are different from those reported in Chapter 5, as data in this chapter exclude clients who are seeking treatment for the drug use of others.

Table 6.6: Closed treatment episodes by principal drug of concern and selected reason for cessation, Australia, 2003–04^(a)

| Reason for cessation | Amphetamines | | All other principal drugs of concern | | Total ^(b) | |
|---|---------------|--------------|--------------------------------------|--------------|----------------------|--------------|
| | No. | % | No. | % | No. | % |
| Treatment completed | 6,551 | 46.1 | 61,807 | 54.0 | 68,671 | 53.1 |
| Change in main treatment type | 209 | 1.5 | 2,579 | 2.3 | 2,788 | 2.2 |
| Change in delivery setting | 260 | 1.8 | 885 | 0.8 | 1,145 | 0.9 |
| Change in principal drug of concern | 15 | 0.1 | 195 | 0.2 | 210 | 0.2 |
| Transferred to another service provider | 1,132 | 8.0 | 8,068 | 7.0 | 9,342 | 7.2 |
| Ceased to participate against advice | 833 | 5.9 | 5,252 | 4.6 | 6,100 | 4.7 |
| Ceased to participate without notice | 3,063 | 21.6 | 17,642 | 15.4 | 20,787 | 16.1 |
| Ceased to participate involuntary (non-compliance) | 544 | 3.8 | 2,289 | 2.0 | 2,849 | 2.2 |
| Ceased to participate at expiation | 663 | 4.7 | 8,987 | 7.8 | 9,712 | 7.5 |
| Ceased to participate by mutual agreement | 434 | 3.1 | 3,052 | 2.7 | 3,488 | 2.7 |
| Drug court and/or sanctioned by court diversion service | 91 | 0.6 | 146 | 0.1 | 237 | 0.2 |
| Imprisoned, other than drug court sanctioned | 80 | 0.6 | 545 | 0.5 | 625 | 0.5 |
| Died | 7 | 0.0 | 131 | 0.1 | 138 | 0.1 |
| Other | 218 | 1.5 | 2,278 | 2.0 | 2,496 | 1.9 |
| Not stated | 108 | 0.8 | 635 | 0.6 | 743 | 0.6 |
| Total | 14,208 | 100.0 | 114,491 | 100.0 | 129,331 | 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.

7 Other data collections

This chapter briefly describes a range of relevant Australian data collections that provide context for 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 was estimated that, in 1998, 17,671 deaths and 185,558 hospital separations were related to drug use (AIHW: 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, were estimated in 1996 to 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

This section identifies, and briefly describes data collections that relate to alcohol and other drug treatment services and drug use in Australia.

Key data collections relating to alcohol and other drug treatment services

- Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS-NMDS) (annual, from 2000-01).
- 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) (annual, from 1999-2000, except for 2001-02).
- 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).

- National Opioid Pharmacotherapy Statistics Annual Data Collection provides 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) (annual, from 1993).
- National Mortality database (held by AIHW) for deaths related to alcohol, tobacco and illicit drug use (see Section 7.3) (annual).

Key population surveys relating to drug use and treatment

- National Drug Strategy Household Survey (see Section 7.3) (approximately triennial, from 1985).
- Australian Secondary School Alcohol and Drugs Survey (ASSADS) (1996, 1999 and 2002) 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 (approximately triennial, from 1996).

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 (irregular, from 1990).
- 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 tackle 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 (ongoing).
- 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 used, substance being treated for and reasons for entering treatment (AIC 2005) (quarterly).
- 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 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) (irregular).

- 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 to describe issues in detail, and is not based on a representative sample of intravenous drug users (NDARC 2005). 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. 2004) (annual).
- Bettering the Evaluation and Care of Health (BEACH) survey data: 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, AIHW: Britt et al. 2004) (annual).
- 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) (ongoing).
- 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 2005c) (annual).
- 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.

Detailed information on a range of data sources relating to substance use and mental health disorders is available from the AIHW publication *National Comorbidity Initiative: A Review of Data Collections Relating to People with Coexisting Substance Use and Mental Health Disorders* (2005d). Also, information on a range of national data sources relating to alcohol is available from the AIHW publication *A Guide to Australian Alcohol Data* (AIHW 2004c) <www.aihw.gov.au> and 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).

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 2 to 3 years from 1985 onwards, with the most recent survey in 2004. The 1998, 2001 and 2004 surveys have been managed by the AIHW on behalf of the Australian Government Department of Health and Ageing.

In 2004, almost 30,000 participants aged 12 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. Participants in the 2004 survey were asked about their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours (AIHW 2005a and AIHW 2005e).

The 2004 survey estimated that 84% of Australians aged 14 years and over recently consumed alcohol and just over one-fifth (21%) smoked tobacco (Table 7.1). Illicit drugs were used by less than one in five Australians (15%) in the last 12 months. Marijuana/cannabis (11%) was the most commonly used illicit drug in 2004, with 11% of the population aged 14 years and over 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 ecstasy (3%), cocaine (1%), hallucinogens (1%) or heroin (0.2%).

Between 1993 and 2004, the proportion of the population who had recently consumed alcohol increased from 73% to 84%, and this proportion increased significantly between 2001 (82%) and 2004 (84%) (Table 7.1). Between 1998 and 2004, there was a decline in the proportion of persons who had recently smoked tobacco (25% down to 21%).

With few exceptions, the proportion of the population using illicit drugs generally declined between 1993 and 2004. For example, the proportion of the population aged 14 years and over recently using marijuana/cannabis declined between 1993 and 2004 (13% to 11%). Overall, the use of any illicit drugs in the last 12 months prior to the NDSHS being conducted dropped from 17% in 2001 to 15% in 2004.

Table 7.1: Summary of drugs recently^(a) used by the population aged 14 years and over, Australia, 1993–2004 (per cent)

| Drug | 1993 | 1995 | 1998 | 2001 | 2004 |
|--|-------------|-------------|-------------|-------------|-----------------------------|
| Tobacco | n.a. | n.a. | 24.9 | 23.2 | 20.7 # |
| Alcohol | 73.0 | 78.3 | 80.7 | 82.4 | 83.6 # |
| Illicits | | | | | |
| Marijuana/cannabis | 12.7 | 13.1 | 17.9 | 12.9 | 11.3 # |
| Painkillers/analgesics ^(b) | 1.7 | 3.5 | 5.2 | 3.1 | 3.1 |
| Tranquillisers/sleeping pills ^(b) | 0.9 | 0.6 | 3.0 | 1.1 | 1.0 |
| Steroids ^(b) | 0.3 | 0.2 | 0.2 | 0.2 | – # |
| Barbiturates ^(b) | 0.4 | 0.2 | 0.3 | 0.2 | 0.2 |
| Inhalants | 0.6 | 0.6 | 0.9 | 0.4 | 0.4 |
| Heroin | 0.2 | 0.4 | 0.8 | 0.2 | 0.2 |
| Methadone ^(c) | n.a. | n.a. | 0.2 | 0.1 | 0.1 |
| Other opiates ^(b) | n.a. | n.a. | n.a. | 0.3 | 0.2 |
| Meth/amphetamines (speed) ^(b) | 2.0 | 2.1 | 3.7 | 3.4 | 3.2 |
| Cocaine | 0.5 | 1.0 | 1.4 | 1.3 | 1.0 # |
| Hallucinogens | 1.3 | 1.8 | 3.0 | 1.1 | 0.7 # |
| Ecstasy ^(d) | 1.2 | 0.9 | 2.4 | 2.9 | 3.4 # |
| Injected drugs | 0.5 | 0.6 | 0.8 | 0.6 | 0.4 |
| <i>Any illicit</i> | <i>14.0</i> | <i>17.0</i> | <i>22.0</i> | <i>16.9</i> | <i>15.3 #^(e)</i> |
| None of the above | 21.0 | 17.8 | 14.2 | 14.7 | 13.7 # |

(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) Non-maintenance.

(d) This category included substances known as 'designer drugs' prior to 2004.

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

n.a. not available

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

Source: National Campaign Against Drug Abuse Household Survey 1993; National Drugs Strategy Household Survey 1995, 1998, 2001, 2004.

People aged 20–29 years were more likely to have used an illicit drug in the last 12 months – 32% of 20–29-year-olds compared with 21% of 14–19-year-olds, 20% 30–39-year-olds, and 8% of people aged 40 years and over (Table 7.2).

People in the younger age groups (14–19 years and 20–29 years) were more likely to have used marijuana/cannabis, inhalants, heroin and hallucinogens in the last 12 months compared with older people. Persons aged 20–29 years were more likely to have used each illicit substance in Table 7.2 when compared with persons aged 14–19 years. Cocaine is the only drug that was more likely to have been used by people in the 30–39 age group than people in the 14–19 age group. People in the 40 years and over age group were less likely than younger people to have used each illicit substance.

Table 7.2: Summary of illicit drugs used in the last 12 months by persons aged 14 years and over by age group, Australia 2004 (per cent)

| Drug | Age group | | | | All ages |
|--|-------------|-------------|-------------|-----------|----------|
| | 14–19 years | 20–29 years | 30–39 years | 40+ years | |
| Marijuana/cannabis | 17.9 | 26.0 | 15.9 | 3.9 | 11.3 |
| Prescribed drugs ^(a) | 4.0 | 5.1 | 3.9 | 3.3 | 3.8 |
| Inhalants | 1.0 | 1.1 | 0.4 | 0.1 | 0.4 |
| Heroin, methadone and/or other opiates | 0.6 | 0.7 | 0.5 | 0.1 | 0.3 |
| Meth/amphetamines (speed) | 4.4 | 10.7 | 4.1 | 0.4 | 3.2 |
| Cocaine | 1.0 | 3.0 | 1.8 | 0.2 | 1.0 |
| Hallucinogens | 1.5 | 2.3 | 0.7 | 0.1 | 0.7 |
| Ecstasy | 4.3 | 12.0 | 4.0 | 0.3 | 3.4 |
| <i>Any illicit drug</i> ^(b) | 21.3 | 31.5 | 20.2 | 7.4 | 15.3 |

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

(b) Includes all drugs listed above, plus injected drugs, inhalants, GHB and ketamine.

Source: 2004 National Drug Strategy Household Survey, AIHW analysis.

Alcohol and other drug treatment reported by the population

The NDSHS is able to provide a separate measure of participation in alcohol and other drug treatment programs to the AODTS-NMDS. Participants in the 2004 NDSHS were asked to indicate whether they had taken part in a treatment program. Table 7.3 presents the number and percentage of participants who reported that they had taken part in an alcohol or other drug treatment program in the 12 months before the survey. Approximately 3% of people aged 14 years and over had participated in a treatment program in the last 12 months. The most common treatments accessed were smoking programs (e.g. Quit) (2%), followed by prescription drugs (e.g. GP-supervised) and counselling (both 1%).

Unlike the data taken from the AODTS-NMDS, the results from the 2004 NDSHS are self-reported data. The results should be interpreted with caution, and used only as a rough indication of the proportion of the Australian population 14 years and over who had participated in a treatment program.

Table 7.3: Participation in alcohol or other drug treatment programs, persons aged 14 years and over, Australia, 2004

| Type of program | Participants | |
|---|----------------|------------|
| | (Number) | (Per cent) |
| Smoking (e.g. Quit) | 275,600 | 1.7 |
| Alcohol (e.g. AA) | 48,200 | 0.3 |
| Detoxification centre | 11,600 | < 0.1 |
| Methadone maintenance | 16,000 | 0.1 |
| Prescription drugs (e.g. GP-supervised) | 97,600 | 0.6 |
| Counselling | 96,500 | 0.6 |
| Therapeutic community | 8,300 | < 0.1 |
| Naltrexone | 6,900 | < 0.1 |
| Other | 29,600 | 0.2 |
| Any treatment program | 464,600 | 2.8 |

Source: AIHW analysis of 2004 National Drug Strategy Household Survey.

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. Various estimates of mortality attributable to alcohol, tobacco and illicit drugs have been calculated. For example,

- Ridolfo and Stevenson estimated that, in 1999 19,000 deaths in Australia were attributable to tobacco use and a further 1,000 deaths were attributable to the use of illicit drugs (AIHW: Ridolfo & Stevenson 2001)
- the National Drug Research Institute at Curtin University estimated that, in 2001, 3,000 deaths in Australia were attributable to alcohol consumption at risky and high-risk levels (Chikritzhs et al. 2003).

Updated estimates of mortality attributable to misuse of alcohol and the use of tobacco and illicit drugs are currently being undertaken and will be available in late 2005.

Morbidity

There were 72,803 hospital separations reported in 2003–04 with a substance use disorder as the principal diagnosis (Table 7.4). This represents 1.1% of all separations in Australia in that year (AIHW 2005b). This section refers only to these separations. 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.

Hospital separations by drugs of concern

As in previous years, sedatives and hypnotics accounted for the highest number of hospital separations (43,537 or 60% of all separations), with alcohol the main contributor in this category (34,091 or 47% of all separations) (Table 7.4). Fifteen per cent (or 11,082) of all separations reported were for analgesics, with opioids (heroin, opium and methadone) accounting for more than half of this group (6,058 or 8% of all separations). Antidepressants and antipsychotics accounted for 9% (or 6,572) of all separations.

Table 7.4: Same-day and overnight separations with a principal diagnosis related to substance use disorders, by drug of concern, Australia, 2003–04

| Drug of concern identified in principal diagnosis ^(a) | Same-day separations | Overnight separations | Total separations ^(b) |
|---|----------------------|-----------------------|----------------------------------|
| Analgesics | | | |
| Opioids (includes heroin, opium & methadone) | 1,588 | 4,470 | 6,058 |
| Non-opioid analgesics (includes paracetamol) | 1,527 | 3,497 | 5,024 |
| <i>Total</i> | <i>3,115</i> | <i>7,967</i> | <i>11,082</i> |
| Sedatives & hypnotics | | | |
| Alcohol | 16,369 | 17,722 | 34,091 |
| Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes alcohol) | 3159 | 6287 | 9,446 |
| <i>Total</i> | <i>19,528</i> | <i>24,009</i> | <i>43,537</i> |
| Stimulants & hallucinogens | | | |
| Cannabinoids (includes cannabis) | 544 | 2,128 | 2,672 |
| Hallucinogens (includes LSD & ecstasy) | 96 | 94 | 190 |
| Cocaine | 114 | 74 | 188 |
| Tobacco & nicotine | 34 | 32 | 66 |
| Other stimulants (includes amphetamines, volatile nitrates & caffeine) | 1,347 | 3,031 | 4,378 |
| <i>Total</i> | <i>2,135</i> | <i>5,359</i> | <i>7,494</i> |
| Antidepressants & antipsychotics | 1855 | 4717 | 6,572 |
| Volatile solvents | 381 | 461 | 842 |
| Other & unspecified drugs of concern | | | |
| Multiple drug use | 746 | 2,291 | 3,037 |
| Unspecified drug use & other drugs not elsewhere classified | 106 | 133 | 239 |
| <i>Total</i> | <i>852</i> | <i>2,424</i> | <i>3,276</i> |
| Total (number) | 27,866 | 44,937 | 72,803 |

(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 2003–04.

Same-day versus overnight separations

Overnight separations were more common than same-day separations, accounting for 62% of all separations (Table 7.4). Separations were relatively more likely to be overnight when the principal drug identified was cannabis (80% of such separations were overnight), for multiple drug use (75%), or for an opioid (74%). The highest proportion of same-day and overnight separations was for separations where the principal diagnosis was alcohol (59% of same-day separations and 39% of overnight separations).

7.4 National pharmacotherapy statistics

The first part of this section presents information on pharmacotherapy statistics collected by state and territory governments and provided to the AIHW. The second part provides some information on the small number of treatment episodes relating to opioid maintenance pharmacotherapies, collected as part of the AODTS-NMDS.

National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection 2004

Methadone maintenance was endorsed as an effective treatment for opioid dependence in 1985. The National Pharmacotherapy Policy for People Dependent on Opioids 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 (Commonwealth of Australia 2004). The broad goal of treatment for opioid dependence is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use (Commonwealth of Australia 2004).

Data on the clients participating in opioid pharmacotherapy programs are routinely collected by the state and territory health departments and, since the 2004 collection, provided annually to the Australian Institute of Health and Welfare (before 2004 data were provided directly to the Australian Government Department of Health and Ageing). Data items collected for the NOPSAD collection include:

- number of clients registered with public and private prescribers and correctional institutions in each state and territory
- number of clients collecting doses at pharmacies, public clinic, private clinics, correctional facilities and other outlets in each jurisdiction
- number of registered prescribers authorised to script for pharmacotherapy treatment.

Numbers of pharmacotherapy clients have been collected since 1986, with the most recent data being from 2004. The type of data collected has varied in terms of detail over this period of time.

Table 7.5: Number of pharmacotherapy clients by state and territory, Australia, 1998–2004^(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 |
| 2004 | 15,719 | 10,003 | 4,470 | 4,437 | 2,706 | 576 | 748 | 82 | 38,741 |

(a) The number of clients on the program at 30 June each year, except for Western Australia, when the number of clients treated throughout the year 2004 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 NOPSAD collection held at the Australian Institute of Health and Welfare, 2005.

Number of pharmacotherapy clients by prescriber type

Nationally, 38,741 clients were receiving pharmacotherapy treatment as at 30 June 2004 (Table 7.6). Of these, the majority of clients received treatment in New South Wales (41%), followed by Victoria (26%), Queensland and Western Australia (12% each), and South Australia (7%). The Australian Capital Territory and Tasmania accounted for 2% each, and the Northern Territory accounted for less than 1% of all the clients receiving pharmacotherapy treatment.

Of the overall 38,741 clients receiving pharmacotherapy treatment, 69% received the treatment from a private prescriber, 24% from a public prescriber and 6% from a correctional facility.

Victoria accounted for the highest proportion of clients prescribed for by private prescribers (97% or 9,700 of 10,003), followed by Tasmania (74%), New South Wales (72%), Western Australia (63%) and South Australia (56%). In contrast, clients scripted by public prescribers were most common in the Northern Territory (82%), Queensland (80%) and the Australian Capital Territory (79%). The category 'public/private prescribers' refers to New South Wales prescribers working in dual clinics, which are private clinics receiving some public funding, and where client data cannot be segregated into either section. Clients scripted by 'public/private prescribers' accounted for 1% of all clients in New South Wales.

Clients being prescribed for at correctional facilities were most common in Western Australia (10%), South Australia and New South Wales (9% each), and the Northern Territory (6%).

Table 7.6: Proportion of pharmacotherapy clients by prescriber, states and territories, Australia, 2004^(a) (per cent)

| Prescriber | NSW | Vic | Qld | WA | SA | Tas | ACT | NT ^(b) | Australia |
|--|---------------|---------------|--------------|--------------|--------------|--------------|--------------|-------------------|---------------|
| Public prescriber | 18.1 | — | 79.9 | 26.8 | 35.0 | 24.5 | 78.9 | 81.7 | 24.1 |
| Private prescriber | 71.6 | 97.0 | 19.1 | 63.2 | 56.0 | 74.1 | 18.0 | 12.2 | 68.9 |
| Public/private prescriber ^(c) | 1.4 | — | — | — | — | — | — | — | 0.6 |
| Correctional facilities | 8.9 | 3.0 | 1.0 | 10.0 | 9.0 | 1.4 | 3.1 | 6.1 | 6.4 |
| Total (per cent) | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Total (number) | 15,719 | 10,003 | 4,470 | 4,437 | 2,706 | 576 | 748 | 82 | 38,741 |

(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) Northern Territory data exclude the number of pharmacotherapy patients receiving treatment at the public clinic in Alice Springs.

(c) 'Public/private prescribers' refers to prescribers in dual clinics, which are private clinics receiving some public funding, where patients cannot be segregated into public or private.

Source: Unpublished data from the 2004 NOPSAD collection held at the Australian Institute of Health and Welfare, 2005.

Number of pharmacotherapy clients by dosing point

Nationally, 38,989 clients were being dosed as at 30 June 2004 – this total is different from that in Table 7.6 as clients in Queensland dosing at more than one dosing point are counted at each point, and therefore counted more than once (Table 7.7). The distribution of clients across jurisdictions by dosing point mirrored the distribution by prescriber type (Table 7.6). Overall, New South Wales accounted for most clients being dosed for pharmacotherapies (40%), followed by Victoria (26%), Queensland (12%), Western Australia (11%), and South Australia (7%). The Australian Capital Territory and Tasmania accounted for 2% each, and the Northern Territory accounted for less than 1%.

Of the 38,989 clients, the majority were dosed at pharmacies (69%, or 26,738), followed by public clinics (12%), private clinics (8%), correctional facilities (6%) and public/private prescribers (1%). Four per cent of all clients were dosed at a location other than a pharmacy, public or private clinic, correctional facility or public/private prescriber. In most jurisdictions, 'other' dosing point related to clients dosing in a hospital setting. In New South Wales, this category was also used for clients for whom the dosing point has not been registered. In the Northern Territory, clients dosing at public clinics or pharmacies cannot be distinguished and thus 'other' comprises clients receiving doses from either a public clinic or a pharmacy.

Table 7.7: Proportion of pharmacotherapy clients by dosing site, states and territories, Australia, 2004^(a) (per cent)

| Dosing site | NSW ^(b) | Vic ^(c) | Qld ^(d) | WA | SA | Tas | ACT | NT ^(e) | Australia |
|--|--------------------|--------------------|--------------------|--------------|--------------|--------------|--------------|-------------------|---------------|
| Pharmacies | 40.6 | 94.6 | 83.0 | 80.5 | 87.7 | 96.2 | 63.6 | — | 68.6 |
| Public clinics | 22.5 | — | 9.3 | 9.5 | 3.1 | 2.4 | 33.3 | — | 12.2 |
| Private clinics | 18.7 | 1.4 | — | — | — | — | — | — | 7.9 |
| Correctional facilities | 8.4 | 3.0 | 0.8 | 10.0 | 9.0 | 1.4 | 3.1 | 6.1 | 6.1 |
| Public/private prescriber ^(f) | 2.8 | — | — | — | — | — | — | — | 1.1 |
| Other | 7.0 | 1.0 | 6.9 | — | 0.2 | — | — | 93.9 | 4.1 |
| Total (per cent) | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 | 100.0 |
| Total (number) | 15,719 | 10,003 | 4,718 | 4,437 | 2,706 | 576 | 748 | 82 | 38,989 |

- (a) Number of clients on the program at 30 June 2004, except for Western Australia, where the number of clients treated through the year is reported.
- (b) Due to a lag in the recording of program end date for some persons, numbers in NSW may be higher than the actual number of people in the program as at 30 June 2004. The total of 'Other' includes 771 people who are missing information about their current dosing. A dosing point may be listed as missing where the payment type has been identified (public or private), the dosing point type has not been identified (pharmacy or clinic) or the drug type has not been identified (for pharmacotherapy statistics). The remaining 332 people received treatment in a hospital setting.
- (c) In Victoria, specialist methadone services are considered 'private clinics', although they are agencies receiving state government funding. The total for 'Other' refers to 97 clients dosed in public hospitals while in treatment for unrelated conditions.
- (d) In Queensland, the total for 'Other' comprises 297 clients receiving doses at public hospital pharmacies, 24 clients receiving doses from doctors and 5 clients receiving doses from other dosing sites. For Queensland there are 248 more clients than in Table 7.6 because, a person who is dosed at more than one dosing point during the month is counted at each point, and therefore counted more than once.
- (e) In the Northern Territory, the number of people dosing at public clinics or pharmacies cannot be distinguished. 'Other' comprises 77 people receiving doses from either a public clinic or a pharmacy. Clients dosing at the public clinic in Alice Springs are excluded from the count.
- (f) 'Public/private prescriber' refers to prescribers in dual clinics in NSW, which are private clinics receiving some public funding, where clients cannot be segregated into public or private.

Source: Unpublished data from the 2004 NOPSAD collection held at the Australian Institute of Health and Welfare, 2005.

Number of pharmacotherapy prescribers

Every jurisdiction has a registration process through which a general practitioner is authorised to prescribe a pharmacotherapy drug. This registration process usually involves attending a training course on prescribing pharmacotherapies and/or passing an exam.

As methadone was the first drug used for opioid pharmacotherapy treatment, jurisdictions first authorised their prescribers to script for this drug only. With the introduction of buprenorphine as an opioid pharmacotherapy drug, the registration process in most jurisdictions changed to allow for the prescription of both drug types. Further to this, some prescribers – for various reasons – are authorised to prescribe buprenorphine only. Table 7.8 footnotes detail the jurisdiction authorisation differences.

The data presented in Table 7.8 relate to all registered prescribers, except for prescribers in New South Wales, Queensland and South Australia. Prescribers in these states relate to 'active' prescribers only – that is, prescribers who are scripting at least one client as at 30 June 2004.

Nationally, 1,259 practitioners were authorised to prescribe at 30 June 2004 (Table 7.8). Of these, 34% (or 428) were registered to prescribe methadone only, and 2% were registered to prescribe buprenorphine only. Those registered to prescribe both methadone and buprenorphine accounted for 64% of the total pharmacotherapy prescribers. Prescribers in South Australia and the Northern Territory follow a single accreditation process which allows them to prescribe both methadone and buprenorphine.

The majority of prescribers were located in Victoria (34% or 422), followed by New South Wales (31%), Western Australia (11%), Queensland (8%), Tasmania (7%) and South Australia

(5%). The Australian Capital Territory and the Northern Territory had the lowest percentages of prescribers (3% and 1% respectively).

Table 7.8: Number of prescribers registered^(a) to prescribe pharmacotherapy drugs by drug type and jurisdiction, Australia (as at 30 June 2004)

| | NSW | Vic ^(b) | Qld | WA | SA ^(c) | Tas ^(d) | ACT | NT | Total | Total (%) |
|-----------------------------|-------------|--------------------|------------|-------------|-------------------|--------------------|------------|------------|--------------|--------------|
| Methadone only | 173 | 119 | 12 | 49 | — | 48 | 27 | — | 428 | 34.0 |
| Buprenorphine only | 17 | — | 1 | 2 | — | — | — | — | 20 | 1.6 |
| Methadone and buprenorphine | 203 | 303 | 89 | 86 | 65 | 39 | 13 | 13 | 811 | 64.4 |
| Total (number) | 393 | 422 | 102 | 137 | 65 | 87 | 40 | 13 | 1,259 | 100.0 |
| Total (%) | 31.2 | 33.5 | 8.1 | 10.9 | 5.2 | 6.9 | 3.2 | 1.0 | 100.0 | — |

(a) Data presented in this table relate to all registered prescribers, except in New South Wales, Queensland and South Australia, where active prescribers are counted—that is, prescribers who are scripting at least one client at 30 June 2004.

(b) In Victoria, prior to the development of the current training course, prescribers were trained and approved indefinitely to prescribe methadone only, and had to apply separately to become approved to prescribe buprenorphine. Since the implementation of the new training, all prescribers undertaking the training in Victoria are approved indefinitely to prescribe methadone and buprenorphine. In Victoria, no prescriber is authorised to prescribe only buprenorphine.

(c) In South Australia, prescribers are authorised to prescribe both methadone and buprenorphine. The number of prescribers for South Australia relates only to authorised private and prison active prescribers. This number excludes prescribers working in government drug treatment clinics who are accredited automatically only while employed in that facility.

(d) In Tasmania, training is provided separately for each pharmacotherapy drug.

Source: AIHW analysis of 2004 NOPSAD collection.

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 2003–04 there were, however, 2,953 or 2.3% of closed treatment episodes where pharmacotherapy was the main treatment type provided (and where clients were 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 2,953 AODTS–NMDS treatment episodes with pharmacotherapy as the main treatment type, most were provided in Victoria (878 treatment episodes) and Western Australia (703), followed by South Australia (600), Queensland (498), New South Wales (165), the Northern Territory (61), Tasmania (47) and the Australian Capital Territory (1).

7.5 Alcohol and other drug treatment services provided by services funded to assist Aboriginal and Torres Strait Islander peoples

Reported numbers in the 2003–04 annual report on the AODTS–NMDS do not include the majority of Australian government-funded Aboriginal and Torres Strait Islander substance use services or Aboriginal and Torres Strait Islander primary health care services. 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 AODTS–NMDS data. Data are collected in relation to these services under two data collections:

- Drug and Alcohol Service Report (DASR), coordinated by the Office of Aboriginal and Torres Strait Islander Health (OATSIH) in the Australian Government Department of Health and Ageing (DoHA). The DASR collects information from all Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services. In 2003–04, 41 services (98% of funded services) provided DASR data. Of these, 29 were classified as residential substance use services and 12 were classified as non-residential.
- Service Activity Reporting (SAR), a joint collection by the National Aboriginal Community Controlled Health Organisation (NACCHO) and OATSIH. The SAR collects information from Aboriginal and Torres Strait Islander primary health care services that receive Australian Government funding. In 2002–03, 134 services (98% of funded services) provided SAR data.

A selection of data from these collections is presented below to provide a broader picture of the types of treatment services being accessed by the Australian population for drug and alcohol problems. Note that the SAR, DASR and AODTS–NMDS have different collection purposes, scope and counting rules. For example, the SAR and DASR collect service-level estimates for client numbers and episodes of care whereas the AODTS–NMDS collects unit records for closed treatment episodes (and some data on client registrations). The definitions for ‘closed treatment episodes’ (AODTS–NMDS) and ‘episodes of care’ (SAR/DASR), and the definitions for ‘client registrations’ (AODTS–NMDS) and ‘estimated client numbers’ (SAR/DASR) are not consistent (see Box 7.1).

In 2003–04, 3 of 42 Australian Government-funded services reporting in the DASR also reported under the AODTS–NMDS and 6 out of 140 Aboriginal and Torres Strait Islander primary health care services, reporting in the SAR, also reported under the AODTS–NMDS. From these 9 agencies, approximately 2,000 closed treatment episodes were reported in the 2003–04 AODTS–NMDS, with 95% of these closed treatment episodes relating to clients who identified as being Aboriginals and/or Torres Strait Islanders.

Box 7.1: Comparison of treatment episode definitions in the SAR, DASR and AODTS–NMDS

The **DASR** definition of ‘episode of care’ starts at admission and ends at discharge (from residential treatment/rehabilitation and sobering-up/respite). In the case of ‘other care’, the definition of ‘episode of care’ relates more to the number of visits or phone calls undertaken with clients. In contrast to the definition of ‘closed treatment episode’ used in the AODTS–NMDS, the definition used in the DASR collection does not require agencies to commence a new ‘episode of care’ when the main treatment type (‘treatment type’) or primary drug of concern (‘substance/drug’) changed. It is therefore likely that the DASR concept of ‘episode of care’ produces smaller estimates of activity than the AODTS–NMDS concept of ‘closed treatment episode’.

The **SAR** definition of ‘episode of care’ relates to each time a person sees someone from the health clinic for health care. If a person sees more than one staff member on the same day this is considered one episode and there can only ever be one episode of care on a single day. However, if a person sees staff members (the same or different staff members) on 2 days, this is considered two episodes. In contrast to the AODTS–NMDS definition of ‘closed treatment episode’, the SAR definition of ‘episode of care’ does not relate to a period of specific treatment (e.g. for a particular drug of concern). It is therefore likely that the SAR concept of ‘episode of care’ produces larger estimates of activity than the AODTS–NMDS concept of ‘closed treatment episode’.

The DASR and SAR collections record information about clients of any age, whereas the AODTS–NMDS reports only about clients aged 10 years and over. The comparative information presented in this section should therefore be interpreted with caution.

Australian Government-funded Aboriginal and Torres Strait Islander substance use services (DASR)

In 2003–04, an estimated 24,900 clients were seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (Table 7.9). Of these clients, 85% identified as being Aboriginals and/or Torres Strait Islanders. The majority of clients accessed services in South Australia (41%), Queensland (30%) and the Northern Territory (13%).

Table 7.9: Estimated number of clients seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (DASR) by jurisdiction and Indigenous status, 2003–04

| | Estimated number of clients | | | | | |
|-------------------------|-----------------------------|--------------|--------------|---------------|--------------|---------------|
| | NSW & Vic | Qld | WA | SA | NT | Australia |
| Indigenous | 1,300 | 5,500 | 2,300 | 9,200 | 3,000 | 21,200 |
| Non-Indigenous | 300 | 2,000 | 200 | 900 | 200 | 3,600 |
| Total | 1,600 | 7,500 | 2,500 | 10,100 | 3,200 | 24,900 |
| Total (per cent) | 6 | 30 | 10 | 41 | 13 | 100 |

Note: Totals may not add up as figures are rounded to the nearest hundred.

Source: Australian Government Department of Health and Ageing analysis of the 2003–04 Drug and Alcohol Service Reporting collection.

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2003–04, an estimated 4,000 episodes of care were provided to clients in residential treatment/rehabilitation services (Table 7.10). Of these, 68% of episodes of care were for male clients.

In 2003–04, there were 6,700 estimated episodes of care for clients accessing sobering-up or residential respite services. Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation. Residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. Close to two-thirds (65%) of episodes of care were for male clients.

‘Other care’ refers to services such as counselling and therapy, after-care follow-up and preventive care, all of which are not residential-based. In 2003–04, there were an estimated 42,500 episodes for other care services. The number of episodes of care for this service group is much higher than for residential-based services because of the way ‘episodes’ are counted for these services (see Box 7.1). Nearly two-fifths (39%) of episodes for other care were for female clients.

Table 7.10: Estimated number of ‘episodes of care’^(a) provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (DASR) by sex, and treatment type, 2003–04

| | Estimated number of ‘episodes of care’ | | | | | |
|---|--|------|--------|------|--------|-------|
| | Male | | Female | | Total | |
| | No. | % | No. | % | No. | % |
| Residential treatment/rehabilitation ^(b) | 2,700 | 68.2 | 1,300 | 31.8 | 4,000 | 100.0 |
| Sobering-up/residential respite ^(c) | 4,300 | 64.9 | 2,300 | 35.1 | 6,700 | 100.0 |
| Other care ^(d) | 26,000 | 61.1 | 16,500 | 38.9 | 42,500 | 100.0 |

- (a) Estimated episodes of care refers to the number of episodes of the service. It does not always equate to the total number of clients in all programs as some clients may be in multiple programs.
- (b) Includes people who were officially clients of the service, that is, people who received treatment/rehabilitation in a residential setting and had their own file/record.
- (c) Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation. Respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation.
- (d) Clients receiving ‘other care’ received non-residential care (e.g. counselling, assessment, treatment, education, support, home-visits and/or mobile assistance patrol/night patrol) or follow-up from residential services after discharge.

Note: Figures have been rounded to the nearest hundred.

Source: Australian Government Department of Health and Ageing analysis of the 2003–04 Drug and Alcohol Service Reporting.

During 2003–04, all (100%) Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services reported providing treatment or assistance for client alcohol use (Table 7.11). Other common substances/drugs for which services provided treatment or assistance included cannabis (93%), multiple drug use (78%), amphetamines (66%) and tobacco/nicotine (56%).

Table 7.11: Substances/drugs for which treatment/assistance was provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services, 2003–04

| Substance/drug | Percentage of services that provided treatment/assistance for this substance/drug |
|--|---|
| Alcohol | 100% |
| Cannabis (marijuana, gunja, yamdi) | 93% |
| Multiple drug use (two or more drugs/substances) | 78% |
| Amphetamines (speed, uppers) | 66% |
| Tobacco/nicotine | 56% |
| Heroin | 54% |
| Benzodiazepines (sleeping pills, Valium, Rohypnol) | 46% |
| Other solvents/inhalants (chroming, paint, glue, aerosol cans) | 44% |
| Petrol | 41% |
| Barbiturates (downers, Phenobarbital, Amytal) | 32% |
| Methadone | 29% |
| Ecstasy/MDMA | 29% |
| Morphine | 22% |
| Cocaine (coke, crack) | 22% |
| LSD (acid, trips) | 12% |
| Other | 12% |
| Steroids/anabolic agents | 7% |
| Kava | 2% |

Source: Australian Government Department of Health and Aging analysis of the 2003–04 Drug and Alcohol Service Reporting.

Australian Government-funded Aboriginal and Torres Strait Islander primary health care services (SAR)

Aboriginal and Torres Strait Islander primary health care services provide a wide variety of health care services including extended care roles (e.g. diagnosis and treatment of illness and disease, 24-hour emergency care, dental/hearing/optometry services), preventive health care (e.g. health screening for children and adults), health-related community support (e.g. school-based activities, transport to medical appointments) and support in relation to substance use issues. It is not possible to estimate the number of clients who attended Aboriginal and Torres Strait Islander primary health care services and received alcohol or other drug treatment. Similarly, it is not possible to estimate the number of reported episodes of care that related solely or partially to alcohol or other drug treatment.

Aboriginal and Torres Strait Islander primary health care services tackle a range of substance use issues. In many cases, substance use issues are covered on an individual client basis as they arise during client care. Table 7.12 shows the proportion of services that covered substance use issues on an individual basis as they arise by substance/drug type. Most services covered issues relating to alcohol (96%), tobacco/nicotine (85%) or cannabis (81%) on an individual basis as they arose. Around about half of all primary health care services had clients raise issues for substances such as petrol and multiple drug use (53% each), solvents and inhalants (51%) and benzodiazepines (50%).

Table 7.12: Substances/drugs for which Australian Government-funded Aboriginal and Torres Strait Islander primary health care services cover substance use issues on an individual basis as they arise, 2002–03

| Substance/drug | Percentage of services that cover substance use issues on an individual basis as they arise |
|--|--|
| Alcohol | 96% |
| Tobacco/nicotine | 85% |
| Cannabis (marijuana, gunja, yamdi) | 81% |
| Petrol | 53% |
| Multiple drug use (two or more drugs/substances) | 53% |
| Other solvents/inhalants (chroming, paint, glue, aerosol cans) | 51% |
| Benzodiazepines (sleeping pills, Valium, Rohypnol) | 50% |
| Heroin | 43% |
| Methadone | 39% |
| Amphetamines (speed, uppers) | 37% |
| Barbiturates (downers, Phenobarbital, Amytal) | 30% |
| Morphine | 28% |
| Ecstasy/MDMA | 23% |
| Cocaine (coke, crack) | 22% |
| LSD (acid, trips) | 12% |
| Kava | 10% |
| Steroids/anabolic agents | 10% |
| Other | 7% |

Source: Australian Government Department of Health and Ageing analysis of 2002–03 Service Activity Reporting.

8 Data quality of the AODTS–NMDS in 2003–04

8.1 Introduction

Several activities are undertaken in each year of the AODTS–NMDS collection to maximise the quality of the data collected, including:

- communication between the AIHW and jurisdictions before the supply of data, including written guidelines and file specifications
- agreeing on guidelines on the validation process to improve data collating and editing (see AIHW 2003b)
- 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
- the validation processes that occur in each jurisdiction before forwarding the data to the AIHW, and in the AIHW on receipt of the data.

Comprehensiveness of the data

In 2003–04, data were provided from 545 (96%) of the 565 agencies that were in scope for this collection. This calculation excludes Queensland agencies as the number of missing non-government-funded agencies has not been recorded.

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 and territory in 2003–04 include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). As in 2002–03, 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 AODTS–NMDS data has improved across collection periods (Table 8.1). Nationally, the proportion of responses that were ‘not stated’, ‘missing’ or ‘unknown’ has varied across data items.

Proportions of those responses that were ‘not stated’, ‘missing’ or ‘unknown’ in 2003–04 and 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 (18% missing), South Australia (9%) and Victoria (8%).
- Overall, 2% of responses were ‘not stated’ for ‘preferred language’ – this proportion was higher in the Northern Territory (5%) and South Australia (4%).

For drug data items:

- ‘Injecting drug use’ was ‘not stated’ for 13% of responses – higher in the Northern Territory (41%), Tasmania (29%), Queensland and Victoria (16% each) and South Australia (15%).

For treatment data items, ‘reason for cessation’ was ‘not stated’ for 0.6% of responses – higher in the Northern Territory (9%), Tasmania (2%) and Queensland (2%).

Compared with 2002–03, the national proportion of responses that were ‘not stated’, ‘missing’ or ‘unknown’ has dropped slightly for most variables. The largest shifts from 2002–03 to 2003–04 were seen in ‘injecting drug use’, ‘reason for cessation’ and ‘date of birth/age’ (14.4% to 13.1%, 1.8% to 0.6% and 1.7% to 0.8% respectively).

The Australian Capital Territory saw large drops in ‘not stated’ responses in ‘method of use’ and ‘reason for cessation’ (12% to 0.3% and 16% to 1% respectively); however, this may be related to the exclusion of data from one large service provider. Tasmania, Western Australia, South Australia and New South Wales had their largest shifts in ‘injecting drug use’ (38% to 29%, 9% to 2%, 18% to 15%, and 13% to 10% respectively), but, these figures increased in Queensland and the Northern Territory (12% to 16% and 20% to 41% respectively).

8.3 Data transmission

The data transmission process for the 2003–04 AODTS–NMDS collection represented an improvement on that of previous years. Most 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 2003–04 collection.

Table 8.1: Not stated/missing/unknown responses for data items by jurisdiction, Australia, 2003–04 and 2002–03^(a) (per cent)

| Data item | NSW | Vic | Qld | WA | SA | Tas | ACT ^(b) | NT | Australia |
|--------------------------------------|------|------|------|-----|------|------|--------------------|------|-------------|
| 2003–04 | | | | | | | | | |
| Client data items | | | | | | | | | |
| Client type | — | — | — | — | — | — | — | — | — |
| Country of birth | 1.7 | 3.2 | 2.0 | 0.2 | 4.6 | 0.0 | 1.5 | 0.2 | 2.2 |
| Date of birth/age | 0.1 | 1.8 | 0.2 | 1.2 | 0.1 | 0.0 | 1.3 | 0.1 | 0.8 |
| Indigenous status | 4.5 | 8.1 | 6.3 | 1.4 | 8.7 | 17.8 | 3.7 | 1.7 | 6.1 |
| Preferred language | 0.8 | 3.7 | 2.1 | 0.3 | 4.2 | 0.0 | 0.8 | 4.9 | 2.2 |
| Sex | 0.1 | 0.1 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.0 | 0.1 |
| Source of referral | 0.0 | 0.4 | 0.4 | 1.3 | 1.2 | 0.0 | 0.9 | 4.5 | 0.5 |
| Drug data items^(c) | | | | | | | | | |
| Principal drug of concern | 1.4 | 0.0 | 0.0 | 0.4 | 0.0 | 0.5 | 0.0 | 0.0 | 0.5 |
| Method of use | 2.2 | 2.2 | 1.2 | 0.3 | 2.0 | 1.2 | 0.3 | 1.3 | 1.8 |
| Injecting drug use | 10.1 | 15.6 | 15.8 | 2.4 | 15.1 | 28.5 | 7.5 | 41.2 | 13.1 |
| Treatment data items | | | | | | | | | |
| Main treatment type | — | — | — | — | — | — | — | — | — |
| Reason for cessation | 0.0 | 0.3 | 1.5 | 0.5 | 0.4 | 1.7 | 1.2 | 9.0 | 0.6 |
| Treatment delivery setting | — | — | — | — | — | — | — | — | — |
| 2002–03 | | | | | | | | | |
| 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^(c) | | | | | | | | | |
| 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) 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.

(c) 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.