

5 Treatment programs

This chapter focuses on main treatment types and programs and examines their relationship to a selection of variables of interest, in particular to the client's 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 only to episodes for clients seeking treatment for their own drug use.

Box 5.1: Key definitions and counts for treatment programs, 2004–05

Closed treatment episode refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2004–05 there were **142,144** closed treatment episodes, of which **135,202** closed treatment episodes were for clients seeking treatment for their own substance use.

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 2004–05, main treatment type was reported for **142,144** treatment episodes.

Caution should be used when comparing the number of closed treatment episodes for main treatment type from the collection periods 2002–03 to 2004–05 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 2004–05, data on the combination of these two data items were reported for **135,202** 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 four other treatment types can be recorded for each client). In 2004–05, there were **18,432** closed treatment episodes which provided a total of **21,434** other treatment types. As in previous collections, in 2004–05 closed treatment episodes from Victoria were excluded from any analysis involving 'other treatment types' as Victoria does 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 2004–05, there were a total of **163,578** 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, counselling (40%) was the most common main treatment type provided within alcohol and other drug treatment services in 2004–05, followed by withdrawal management (detoxification) (18%) and assessment only (12%) (Table 5.1). See Appendix 5 for further details of each treatment type.

With the exception of Queensland, counselling was the most common main treatment type reported in all jurisdictions. Counselling as the main treatment accounted for 63% of all treatment episodes in Tasmania, 55% in Western Australia and 47% in Victoria. South Australia reported the lowest proportion of treatment episodes where counselling was the main treatment (25%).

In Queensland, information and education only was the most common main treatment type (45%), followed by counselling (32%) and assessment only (8%). This pattern of main treatment in Queensland relates largely to the scope of their collection in 2004–05 (namely the inclusion of police diversion and government-provided services but not non-government services; see Section 1.5 for further details).

Nationally, 4,299 closed treatment episodes were provided where the main treatment type was pharmacotherapy. This is a small proportion of pharmacotherapy treatment nationally, as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid 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, 2004–05 (per cent)

Main treatment type	NSW	Vic ^(a)	Qld ^{(b)(c)}	WA	SA	Tas ^(d)	ACT	NT	Australia	Total (no.)
Withdrawal management (detoxification)	22.2	22.5	4.4	9.1	20.8	3.1	26.7	11.8	17.9	25,458
Counselling	34.3	46.9	32.4	54.8	25.2	63.2	27.7	34.5	40.2	57,076
Rehabilitation	10.4	3.7	3.1	12.2	18.8	6.1	5.2	13.1	7.7	10,959
Support and case management only	8.4	12.9	4.5	2.8	1.2	3.0	2.7	1.4	7.9	11,240
Information and education only	2.3	0.7	45.4	7.4	1.3	13.3	11.5	9.0	8.9	12,609
Assessment only	16.0	9.9	8.0	7.4	22.8	8.2	19.4	23.7	12.4	17,663
Other ^(e)	6.4	3.4	2.2	6.8	9.9	3.1	6.9	6.4	5.0	7,139
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	..
Total (number)	43,079	46,369	20,092	16,092	7,952	1,921	4,213	2,426	..	142,144
Per cent of closed treatment episodes	30.3	32.6	14.1	11.3	5.6	1.4	3.0	1.7	100.0	..

(a) The total number of closed treatment episodes for Victoria may be undercounted due to a change in reporting practice introduced in 2004–05.

(b) In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and 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.

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

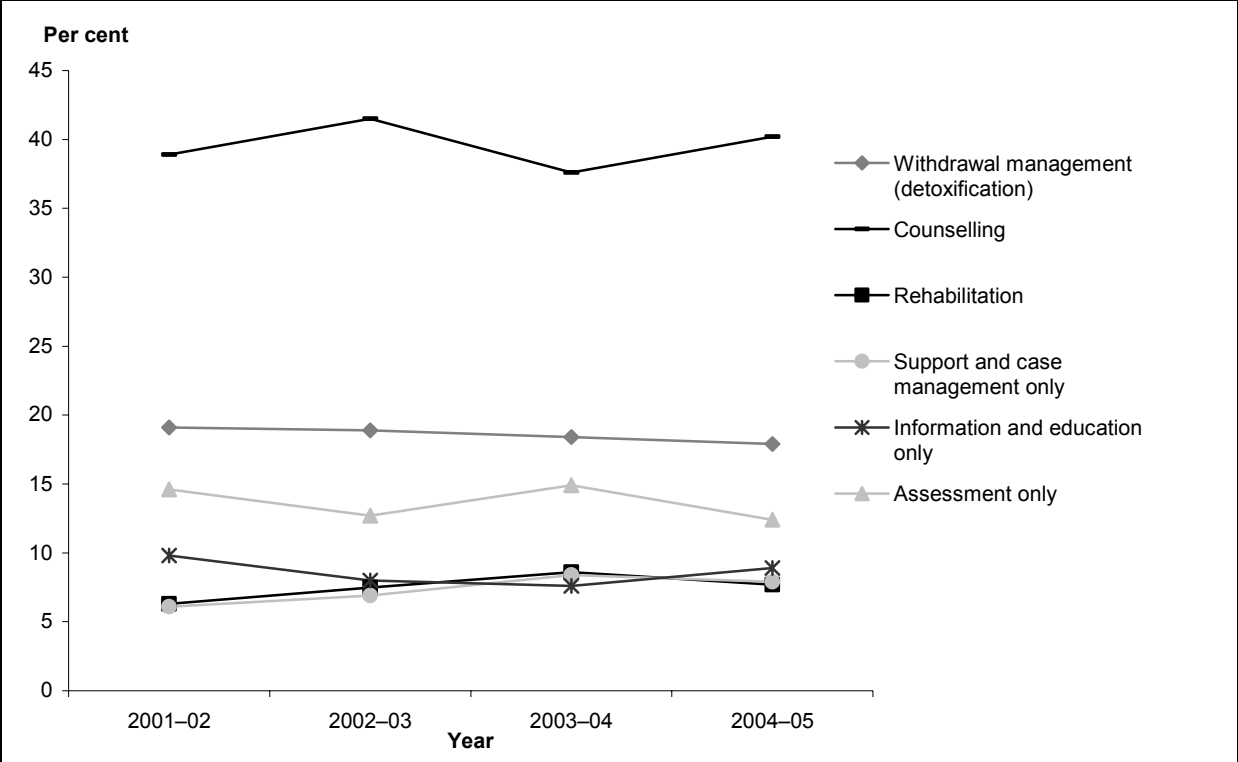
(d) The total number of closed treatment episodes for Tasmania may be undercounted because two agencies only supplied drug diversion data.

(e) 'Other' includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

The proportion of closed treatment episodes where counselling was reported as the main treatment type has fluctuated between 38% and 42% since 2001–02 (Figure 5.1). Assessment only as a main treatment type also fluctuated over the four reporting periods – between 15%

and 13%. In contrast, withdrawal management (detoxification) as a main treatment type remained at a fairly constant proportion – 19% in 2001–02 and 18% in 2004–05.

When comparing data across collection years it is important to consider the caveats of the collection, in particular the coverage of in-scope agencies and data completeness. For instance, in 2001–02 South Australia did not provide data for main treatment type and so were excluded from the national total (see Section 1.5 for further details).



Source: Table A4.16.

Figure 5.1: Closed treatment episodes by main treatment type, Australia, 2001–02 to 2004–05

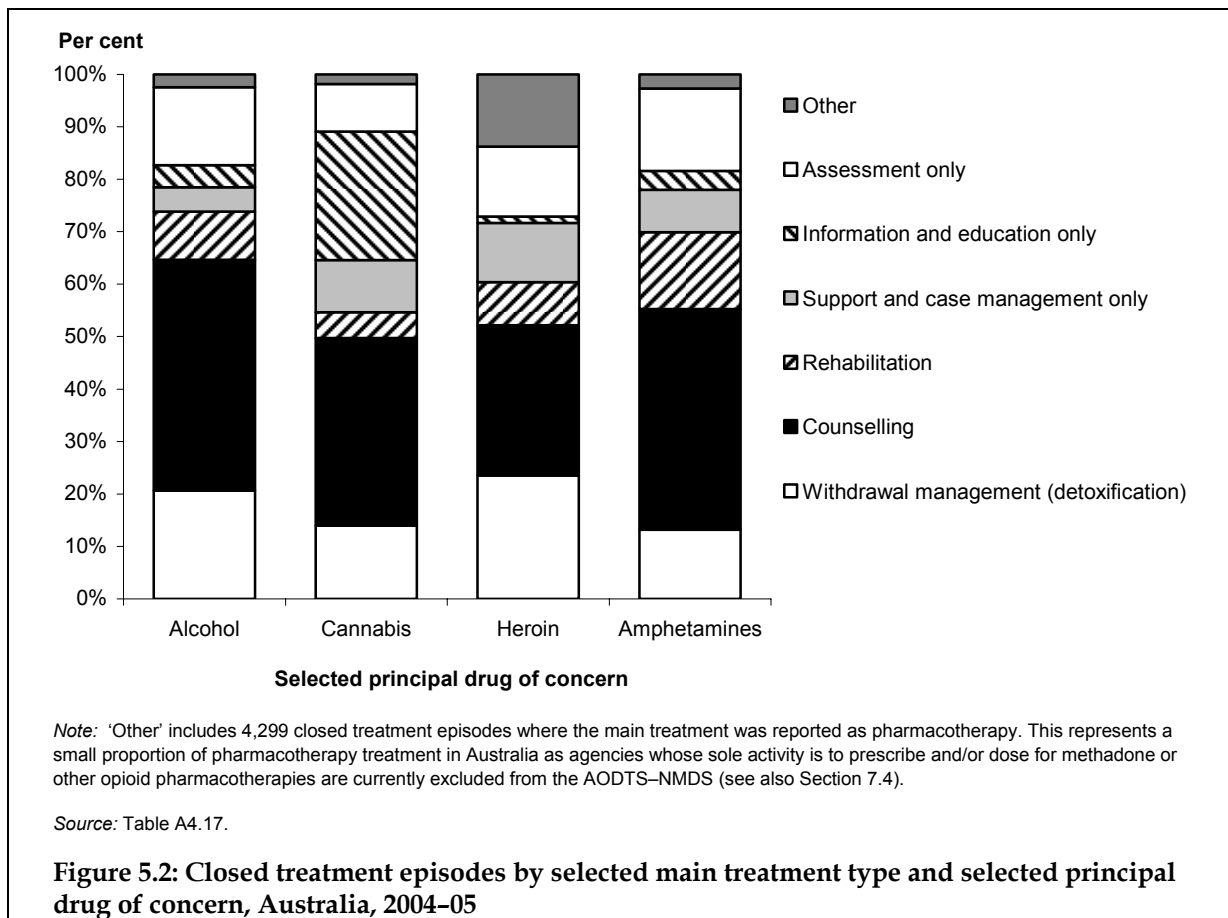
5.2 Main treatment for selected principal drugs

In 2004–05, 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 when alcohol (44%), cannabis (36%), heroin (29%) and amphetamines (42%) were the principal drug of concern (Figure 5.2). Where alcohol was the principal drug, the next most common treatment type was withdrawal management (detoxification) (21%), followed by assessment only (15%) and rehabilitation (9%).

For treatment episodes where cannabis was reported as the principal drug, information and education only was the second most common treatment type (24%), followed by withdrawal management (detoxification) (14%), and assessment only (9%).

Withdrawal management (detoxification) was the second most common treatment type for treatment episodes where heroin was the principal drug of concern (24%), followed by ‘other’ treatment including pharmacotherapy (14%) and assessment only (13%). For treatment episodes where amphetamines were reported as the principal drug, assessment

only was the next most common treatment type (16%), closely followed by rehabilitation (15%) and withdrawal management (detoxification) (13%).



Duration of treatment episode—principal drug of concern

The 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.

Overall in 2004–05, the median number of days for a treatment episode was 18, slightly higher than the figure of 16 days for 2003–04 (Table 5.2). The duration of a treatment episode varied with the principal drug of concern for which treatment was provided and the type of treatment received. When considering principal drug of concern, the highest median number of treatment days within a treatment episode occurred where the principal drug of concern was heroin (27), followed by treatment episodes where the principal drugs of concern were amphetamines (20), alcohol (19) and cannabis (12).

Overall, 'other' treatment, which includes pharmacotherapy, had the highest medium number of treatment days within a treatment episode (61). Support and case management had the second highest median number of treatment days per treatment episode (45), followed closely by counselling (43). These numbers varied somewhat with the principal drug of concern. The median length of time spent on 'other' treatment was longest when the

principal drug of concern was heroin (114). This is probably largely due to the inclusion of treatment episodes where pharmacotherapy was identified as the main treatment type.

For treatment episodes where the client was receiving support and case management, the median number of days per treatment episode was highest where the principal drug of concern was cannabis (52) and shortest where alcohol was the principal drug (33). The median length of time spent on counselling was longest where the principal drug was heroin (56), compared with 43 days when alcohol was the principal drug and 39 days for both cannabis and amphetamines.

Table 5.2: Median duration in days of closed treatment episodes^(a) by main treatment type and selected principal drugs of concern, Australia^(b), 2004–05

Main treatment type	Alcohol	Heroin	Cannabis	Amphetamines	Total ^(c)	Total 2003–04
Withdrawal management (detoxification)	7	7	9	7	8	8
Counselling	43	56	39	39	43	45
Rehabilitation	39	46	32	31	37	30
Support and case management only	33	48	52	50	45	43
Information and education only	1	1	1	1	1	1
Assessment only	1	14	6	1	3	2
Other ^(d)	22	114	31	20	61	47
Total (median number of days)	19	27	12	20	18	16
Total (number of treatment episodes)	49,040	22,287	30,563	14,642	132,292	129,331

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

(b) One large agency has been excluded from this analysis due to poor quality duration data.

(c) Includes 'not stated' for principal drug of concern and balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

(d) 'Other' includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.3 Client type, source of referral and treatment programs

Overall, the most common sources of referral to services in 2004–05 were self-referrals (37% of treatment episodes), followed by referrals from alcohol and other drug treatment services (12%) (Table 5.3). Compared with 2003–04, closed treatment episodes in 2004–05 were slightly less likely to have resulted from self-referral (37%, compared with 41%) and slightly more likely to have resulted from referrals from alcohol and other drug treatment services (12%, compared with 11%) (AIHW 2005a). Section 4.6 contains further information on source of referral, 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 so the pattern of referral for this client group is seen to mirror the overall referral patterns. The referral pattern for clients seeking treatment for others' drug use, however, 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 followed self-referral (49%) or referral from family members or

friends (18%), compared with episodes relating to clients seeking treatment for their own drug use (36% and 5% respectively).

Table 5.3: Closed treatment episodes by client type and source of referral, Australia, 2004–05

Source of referral	Own drug use		Others' drug use		Total	
	No.	%	No.	%	No.	%
Self	48,979	36.2	3,375	48.6	52,354	36.8
Family member/friend	7,324	5.4	1,263	18.2	8,587	6.0
GP/medical specialist	7,808	5.8	344	5.0	8,152	5.7
Hospital	4,616	3.4	95	1.4	4,711	3.3
Community mental health services ^(a)	3,274	2.4	103	1.5	3,377	2.4
Alcohol & other drug treatment services ^(a)	16,001	11.8	523	7.5	16,524	11.6
Other community/health care services ^(b)	5,158	3.8	392	5.6	5,550	3.9
Community-based corrections	13,895	10.3	78	1.1	13,973	9.8
Police diversions	8,188	6.1	37	0.5	8,225	5.8
Court diversions	7,006	5.2	38	0.5	7,044	5.0
Other	12,431	9.2	622	9.0	13,053	9.2
Not stated	522	0.4	72	1.0	594	0.4
Total	135,202	100.0	6,942	100.0	142,144	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 (38%), withdrawal management (detoxification) (19%) and assessment only (13%) (Table 5.4). These proportions are very similar to those for the treatment population overall (see 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 (83%), then support and case management and information and education only (6% each).

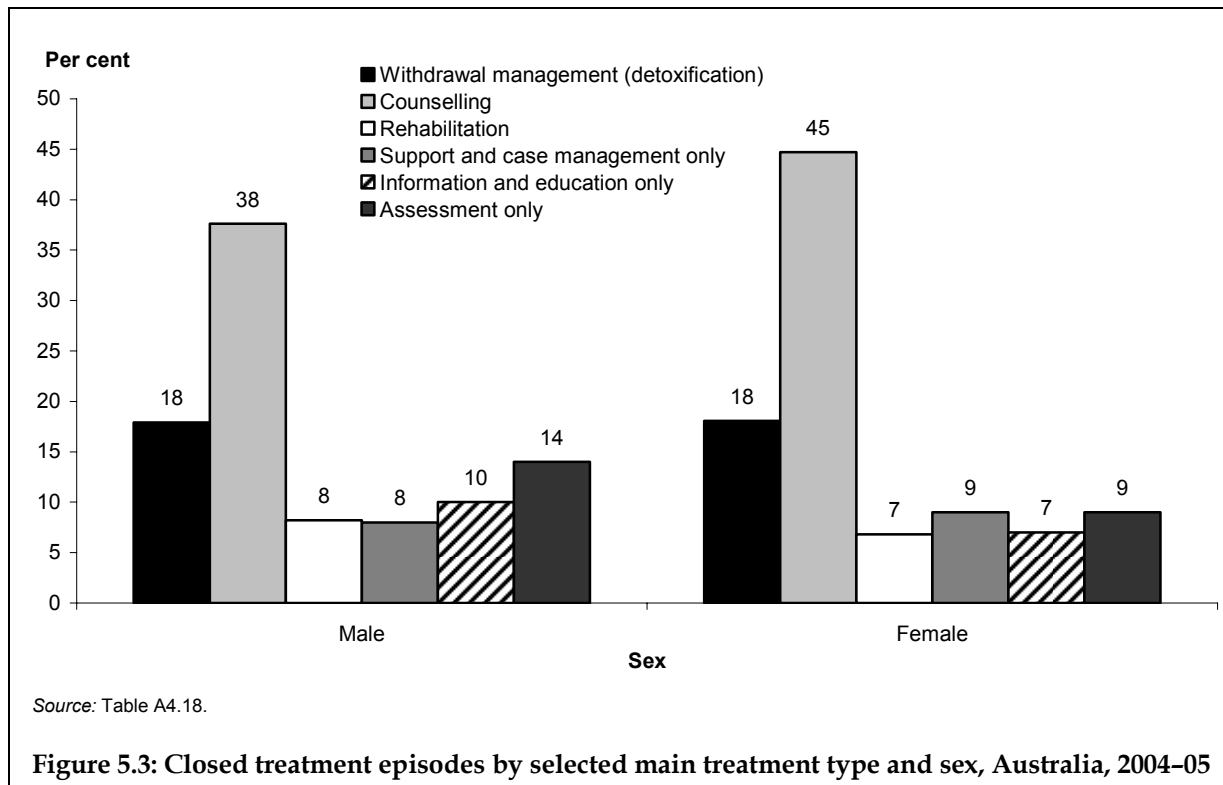
Table 5.4: Closed treatment episodes by client type and main treatment type, Australia, 2004–05

Main treatment type	Own drug use		Others' drug use		Total	
	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	25,457	18.8	1	0.0	25,458	17.9
Counselling	51,308	37.9	5,768	83.1	57,076	40.2
Rehabilitation	10,959	8.1	0	0.0	10,959	7.7
Support and case management only	10,808	8.0	432	6.2	11,240	7.9
Information and education only	12,184	9.0	425	6.1	12,609	8.9
Assessment only	17,474	12.9	189	2.7	17,663	12.4
Other ^(a)	7,012	5.2	127	1.8	7,139	5.0
Total	135,202	100.0	6,942	100.0	142,144	100.0

(a) 'Other' includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.4 Sex, age and treatment program

The main treatment type varied with the sex and age group of the client in 2004–05 (Figures 5.3 and 5.4). Female clients were more likely than male clients to receive counselling as the main treatment (45% of treatment episodes for females compared with 38% for males). In contrast, male clients were more likely than female clients to receive assessment only as their main treatment (14% compared with 9%), and information and education only (10% compared with 7%). Eighteen per cent of treatment episodes for males and females were for clients receiving withdrawal management (detoxification).



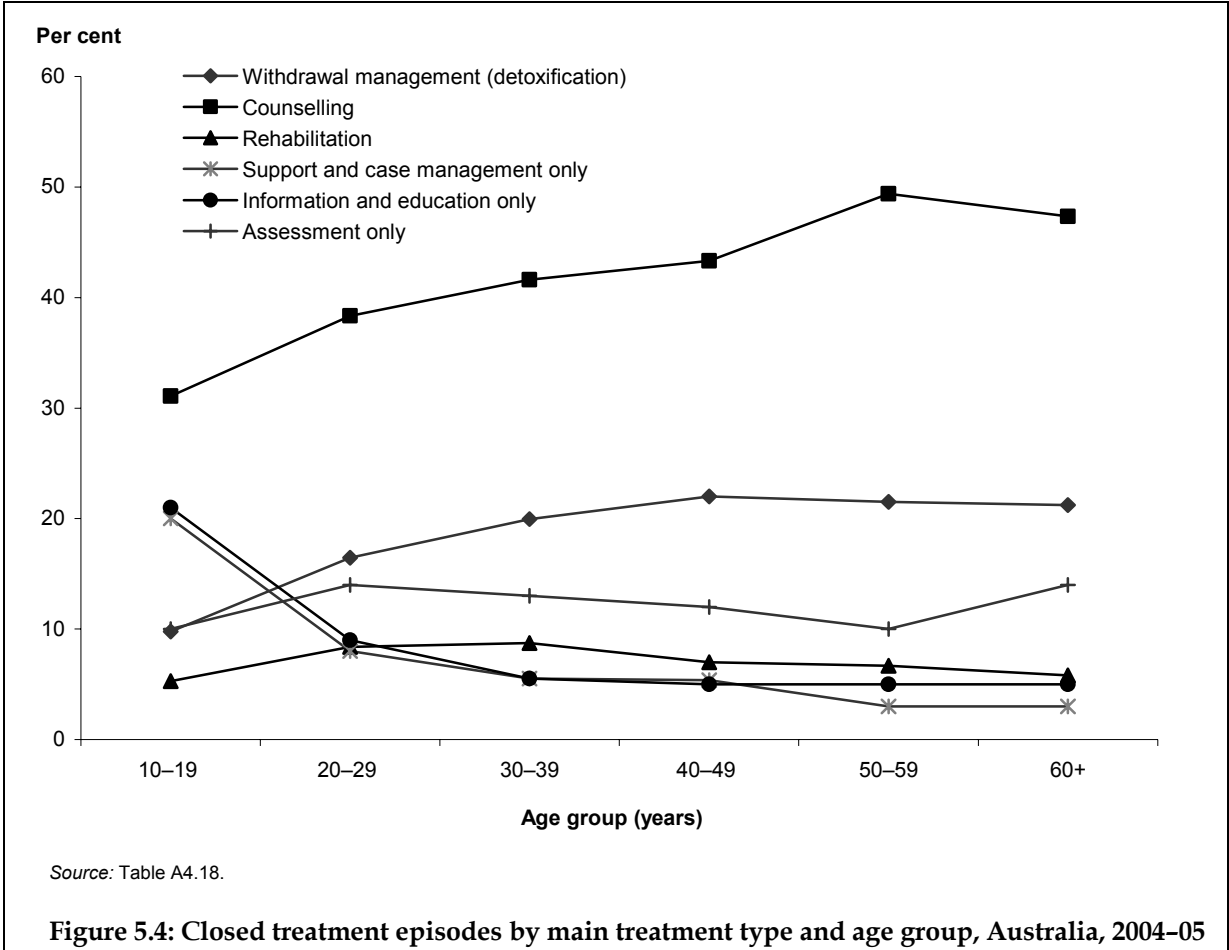
Counselling accounted for 40% of closed treatment episodes nationally in 2004–05; however, the proportion of treatment episodes where counselling was the main treatment increased with the age of the client, from 31% of closed treatment episodes for clients aged 10–19 years to 49% of episodes for clients aged 50–59 years (Figure 5.4).

Withdrawal management (detoxification) was most common in treatment episodes where the clients were in the 40–49 and 50–59 year age groups (22% each). Withdrawal management was least common among the younger age groups – 10% of treatment episodes for clients in the 10–19 year age group and 17% for those in the 20–29 year age group.

Compared with counselling and withdrawal management (detoxification), there was a more even spread of closed treatment episodes across age groups for rehabilitation services. Rehabilitation ranged between 5% and 9% of treatment episodes for all age groups – higher in the 20–29 and 30–39 year age groups (8% and 9% respectively) and lower in clients aged 60 years and over (6%).

As discussed in Section 5.2, different principal drugs of concern are associated with different distributions of main treatment types. Similarly, different age groups are associated with different distributions of main treatment types. The distribution of main treatment types

over age groups may 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 (Figure 5.2), and, in the 10–19 year age group, cannabis was the most common principal drug of concern, more common than in the 20–29 year age group (50% compared with 28%) (Figure 4.2). Figure 5.4 shows that information and education only was correspondingly much more common with younger 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) (12% of treatment episodes for Indigenous clients, compared with 19% of episodes for other Australians) or counselling as the main treatment (38% compared with 41%) (Table 5.5). In contrast, 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 (13% and 14% respectively), compared with episodes for other Australian clients (8% and 12% respectively).

Compared with 2003–04, there has been an increase in the proportion of closed treatment episodes for Indigenous clients receiving counselling (33% in 2003–04 to 38% in 2004–05),

and a decrease in the proportion receiving assessment only (from 20% to 14%) (AIHW 2005a). A similar change can be observed for treatment episodes of other Australians across the collection period – counselling increased from 38% to 41% and assessment only decreased from 14% to 12%.

Table 5.5: Closed treatment episodes by main treatment type and Indigenous status, Australia, 2004–05

Main treatment type	Indigenous		Non-Indigenous		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	1,691	12.4	22,486	18.6	1,281	17.3	25,458	17.9
Counselling	5,203	38.1	49,157	40.6	2,716	36.7	57,076	40.2
Rehabilitation	1,192	8.7	9,562	7.9	205	2.8	10,959	7.7
Support and case management only	1,171	8.6	9,570	7.9	499	6.7	11,240	7.9
Information and education only	1,814	13.3	9,905	8.2	890	12.0	12,609	8.9
Assessment only	1,895	13.9	14,223	11.7	1,545	20.9	17,663	12.4
Other ^(a)	700	5.1	6,166	5.1	273	3.7	7,139	5.0
Total	13,666	100.0	121,069	100.0	7,409	100.0	142,144	100.0
Per cent of closed treatment episodes	9.6	..	85.2	..	5.2	..	100.0	..

(a) 'Other' includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.6 Geographical location and treatment program

In 2004–05 counselling was the most commonly reported main treatment type across all areas – except for very remote areas – accounting for 38% of treatment episodes in major cities, 46% in inner regional, 43% in outer regional and 52% in remote areas (Table 5.6). In very remote areas, 'other' treatment types accounted for 41% of closed treatment episodes, with rehabilitation being the next most common treatment type in very remote areas (28%).

The spread of other treatment types varied by geographical location of the treatment agency. In major cities and inner regional areas, withdrawal management (detoxification) was the second most common treatment (21% and 14% respectively), followed by assessment only in major cities (14%) and support and case management only in inner regional areas (10%). In outer regional areas, information and education only was the second most common treatment type (27%) and in remote areas assessment only was the second most common treatment (16%). As noted in Section 4.5, caution should be used when interpreting geographical data.

Compared with 2003–04, the largest shift in distribution of main treatment by geographical location is observed in episodes based in very remote areas. In 2003–04, 49% of treatment episodes in very remote areas involved clients receiving rehabilitation; this decreased to 28% in 2004–05. Similarly, the proportion of episodes with information and education only as the main treatment type, in very remote areas, decreased from 23% in 2003–04 to 12% in 2004–05. In contrast, the proportion of episodes where 'other' treatment types were nominated in very

remote areas increased from not being nominated in 2003–04 to accounting for 41% of treatment episodes in 2004–05.

Table 5.6: Closed treatment episodes by main treatment type and geographical location^(a), Australia, 2004–05 (per cent)

Main treatment type	Major cities	Inner regional	Outer regional	Remote	Very remote	Total ^(b)	Total (number) ^(b)
Withdrawal management (detoxification)	20.6	13.6	7.4	9.2	3.2	17.9	25,458
Counselling	37.9	46.3	43.4	52.3	7.1	40.2	57,076
Rehabilitation	8.2	7.0	4.5	12.3	27.8	7.7	10,959
Support and case management only	7.5	10.1	7.0	1.0	4.0	7.9	11,240
Information and education only	6.3	9.8	26.9	7.5	11.9	8.9	12,609
Assessment only	13.9	9.6	6.9	16.0	4.8	12.4	17,663
Other ^(c)	5.6	3.6	3.9	1.7	41.3	5.0	7,139
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	..
Total (number)	99,799	27,834	12,781	1,604	126	..	142,144
Per cent of closed treatment episodes	70.2	19.6	9.0	1.1	0.1	100.0	..

(a) The geographical location of treatment agencies in the 2004–05 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 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

5.7 Additional treatments

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

Of the 95,775 closed treatment episodes where clients were seeking treatment in 2004–05, 18,432 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 'other' treatment type was recorded, 51% of clients reported at least one other treatment type; where withdrawal management (detoxification) was the main treatment type, 41% of clients reported at least one other treatment; and where rehabilitation was the main treatment, 38% of clients reported more than one treatment type. Only 17% of clients reported at least one other treatment type when counselling was the main treatment.

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 recorded only as main treatments.

Between 2003–04 and 2004–05, the total proportion of episodes with other treatment types remained stable (19%). However, the proportion of episodes with an additional treatment type differed for withdrawal management (detoxification), falling from 45% or 6,468 of 14,344 closed treatment episodes to 41% or 6,176 of 15,046 closed treatment episodes between the reporting periods; and ‘other’ treatment type increasing from 44% or 2,045 of 4,645 episodes to 51% or 2,848 of 5,573 episodes.

Table 5.7: Number of closed treatment episodes by main treatment type, with or without other treatment type, Australia^(a), 2004–05

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 2003–04 (%)
Withdrawal management (detoxification)	6,176	8,870	15,046	41.0	45.1
Counselling	5,887	29,440	35,327	16.7	15.0
Rehabilitation	3,521	5,721	9,242	38.1	36.4
Support and case management only	—	5,247	5,427	—	—
Information and education only	—	12,286	12,286	—	—
Assessment only	—	13,054	13,054	—	—
Other ^(b)	2,848	2,725	5,573	51.1	44.0
Total	18,432	77,343	95,775	19.2	18.8

(a) Excludes 46,369 closed treatment episodes from Victoria as this jurisdiction does not provide data for ‘other treatment type’.

(b) ‘Other’ includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

From the 18,432 closed treatment episodes that did report at least one other treatment type, 21,434 other treatment types were reported (clients are able to report up to four other treatment types) (Table A4.15). 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 in 2004–05 was because the treatment was completed (53%), followed by the client ceasing to participate without notice to the treatment agency (17%)⁵ (Table 5.8).

The reason for cessation of a treatment episode varied by main treatment type. Treatment was relatively more likely to be completed where the main treatment type was assessment only (74% of episodes with this treatment type) and withdrawal management

5 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).

(detoxification) (63%), and less likely where the main treatment type was information and education only (23%) (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 (61%). This finding may be expected, since expiation, as defined in the AODTS–NMDS, refers to when a client has completed the required education or information program. This relates closely to the use of expiation for cannabis use – 70% of all treatment episodes where information and education was the main treatment type involved cannabis as the principal drug of concern⁶ (Table A4.17).

A relatively high proportion of treatment episodes for counselling were recorded as ending because the client ceased to participate without notice (26% 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 10% of treatment episodes respectively).

Table 5.8: Closed treatment episodes by main treatment type and selected reason for cessation, Australia, 2004–05 (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)	63.4	5.2	10.5	10.4	0.8	9.0	100.0	25,458
Counselling	52.3	4.5	26.1	1.8	2.0	11.9	100.0	57,076
Rehabilitation	37.9	6.4	15.5	15.2	1.1	23.4	100.0	10,959
Support & case management only	56.3	10.2	15.2	1.6	0.7	14.6	100.0	11,240
Information and education only	23.4	1.8	5.6	0.3	60.7	6.5	100.0	12,609
Assessment only	73.9	8.6	6.3	0.7	0.4	7.5	100.0	17,663
Other ^(c)	44.5	14.4	20.5	1.9	0.6	15.5	100.0	7,139
Total (per cent)	53.2	6.0	17.1	4.1	6.5	11.6	100.0	..
Total (number)	75,680	8,501	24,275	5,827	9,280	16,527	..	142,144

(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 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

6 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. In 2004–05, 70% of treatment episodes occurred at a non-residential facility⁷ (Table 5.9). Almost one-fifth (18%) of treatment episodes occurred in residential facilities and 7% in an outreach setting such as a mobile van service.

Treatment episodes were most likely to occur at a non-residential treatment facility where the main treatment was counselling (93% of episodes with this treatment type), assessment only (80%) and information and education only (70%), and less likely where the main treatment was rehabilitation (28%). Where rehabilitation was the main treatment, treatment episodes were most likely to occur at a residential treatment facility (68%). The majority of closed treatment episodes where withdrawal management (detoxification) was the main treatment also occurred at a residential treatment facility (58%).

For those treatment episodes where the main treatment was support and case management only, treatment was most likely to occur at a non-residential treatment facility (48%) or at an outreach setting (47%).

Table 5.9: Closed treatment episodes by main treatment type and treatment delivery setting, Australia, 2004–05 (per cent)

Main treatment type	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total	Total (no.)
Withdrawal management (detoxification)	32.4	57.6	9.2	0.6	0.1	100.0	25,458
Counselling	93.4	0.9	0.9	3.0	1.8	100.0	57,076
Rehabilitation	27.6	67.8	0.1	1.5	2.9	100.0	10,959
Support and case management only	48.0	0.9	0.8	47.2	3.1	100.0	11,240
Information and education only	69.5	5.4	0.2	14.8	10.0	100.0	12,609
Assessment only	80.1	11.4	0.4	5.9	2.2	100.0	17,663
Other ^(a)	90.0	0.5	0.6	4.6	4.3	100.0	7,139
Total (per cent)	69.9	17.9	2.2	7.4	2.6	100.0	..
Total (number)	99,318	25,471	3,132	10,566	3,657	..	142,144

(a) 'Other' includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

⁷ Some of these non-residential facilities may also have a component of residential care available.

Duration of treatment episode—treatment delivery setting

When all closed treatment episodes are considered, the overall median number of treatment days⁸ for a treatment episode was 19 (Table 5.10). The highest median number of days within a treatment episode occurred where the treatment delivery was either in a non-residential treatment facility or in an outreach setting (26 and 23 respectively). Treatment episodes where the treatment delivery setting was a client's home had a median length of treatment of 17 days, while clients receiving treatment in residential treatment facilities had a median length of 8 treatment days.

Overall, the median length of time spent on support and case management was 44 days. This varied by treatment delivery setting—79 days for those receiving treatment at home, 50 days for non-residential treatment facilities, 43 days in an outreach setting, and 32 days for residential treatment facilities.

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 (17 and 16 days respectively). The shortest median duration for this treatment type was for clients receiving treatment through an outreach setting (4 days).

Table 5.10: Median duration^(a) in days of closed treatment episodes by main treatment type and treatment delivery setting, Australia^(b), 2004–05

Main treatment type	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Withdrawal management (detoxification)	16	6	17	4	8	8
Counselling	44	14	15	25	25	43
Rehabilitation	33	38	19	29	64	37
Support and case management only	50	32	79	43	22	44
Information and education only	1	1	2	1	1	1
Assessment only	6	1	2	1	1	2
Other ^(c)	71	39	2	8	14	61
Total	26	8	17	23	4	19
Total (number of treatment episodes)	97,958	23,933	3,129	10,555	3,657	139,232

(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) One large agency has been excluded from this analysis due to poor quality duration data.

(c) 'Other' includes 4,299 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 pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

8 The median number of treatment days for a treatment episode 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 2004–05, 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 (37%, 42%, 38% and 30% respectively) (Table 5.11). This was similar in 2003–04 (38%, 39%, 39% and 31% respectively) (AIHW 2005a). Cannabis was the next most common principal drug for clients in non-residential facilities (24%), at home (25%) and in outreach settings (30%), followed by heroin for these three treatment delivery settings (16%, 12% and 13% respectively). This pattern was reversed for residential treatment facilities, where heroin was the second most common principal drug of concern (22%), and the third was cannabis (15%).

For treatment episodes where the delivery setting was an 'other' delivery setting, the most common principal drug was cannabis (32%), followed by alcohol (22%), heroin (19%), and amphetamines (17%).

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 2004–05.

Table 5.11: Closed treatment episodes by principal drug of concern and treatment delivery setting, Australia, 2004–05^(a) (per cent)

Principal drug of concern	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Alcohol	37.3	41.7	38.3	29.9	22.1	37.2
Amphetamines	10.7	12.3	9.5	8.2	17.4	10.9
Benzodiazepines	1.8	2.4	5.0	0.9	0.7	1.9
Cannabis	24.1	14.7	24.5	29.4	31.9	23.0
Cocaine	0.3	0.4	0.0	0.2	0.1	0.3
Ecstasy	0.5	0.1	0.3	0.6	0.1	0.4
Heroin	16.4	21.9	12.1	13.3	19.0	17.2
Methadone	1.8	1.9	2.2	1.5	0.6	1.8
Nicotine	1.6	0.3	0.7	7.1	4.8	1.8
Other drugs ^(b)	5.5	4.2	7.4	8.9	3.4	5.5
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	93,101	25,413	3,069	10,000	3,619	135,202
Per cent of closed treatment episodes	68.9	18.8	2.3	7.4	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: cannabis

This special theme chapter focuses on closed treatment episodes where cannabis was the principal drug of concern for a client in 2004–05. This theme was selected on the basis of feedback received from agencies via the 2005 Survey of Treatment Agencies. Themes from previous years have focused on amphetamines, clients aged 10–19 years and alcohol.

Section 6.1 provides background information on cannabis, including the effects of cannabis and the use and availability of cannabis in Australia. An overview of clients receiving alcohol and other drug treatment services in 2004–05 who nominated cannabis as their principal drug of concern, and the treatment types and programs received, are provided in Sections 6.2 and 6.3. The analysis presented in Sections 6.2 and 6.3 is based on 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, 2004–05

Principal drug of concern refers to the main substance that the client states 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 2004–05 there were:

- **31,044** closed treatment episodes for clients who nominated cannabis as their principal drug of concern
- **104,158** closed treatment episodes for clients who nominated a principal drug of concern other than cannabis.

Other drugs of concern refers to any other drugs apart from the principal drug of concern which clients perceive as being a health concern. Clients can nominate up to five other drugs of concern. In 2004–05:

- **25,267** other drugs of concern were recorded where cannabis was nominated as the principal drug of concern
- **89,235** other drugs of concern were recorded where principal drugs of concern, other than cannabis, were nominated.

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

6.1 Introduction

What is cannabis and what are its effects?

Cannabis is the generic term used for the products made from the *cannabis sativa* plant. The cannabis plant contains more than 60 cannabinoids, which are the psychoactive chemical components of the drug. The cannabinoid with the strongest psychoactive effect is delta-9-tetrahydrocannabinol, more commonly known as THC (NDARC forthcoming).

The concentration of THC varies between the three main forms of cannabis: marijuana, hashish and hash oil. Marijuana, which is prepared from the dried flowering heads and leaves of the plant, is the least potent form of cannabis with concentrations of THC ranging from 0.5% to 20%. Hashish (or hash), which consists of dried cannabis resin, has the next highest level of THC which typically ranges from 10% to 20%. Hash oil is the most potent form of cannabis obtained by extracting THC from hashish. Concentrations of THC in hash oil range from 15% to 30% (NDARC forthcoming). According to the 2004 National Drug Strategy Household Survey (NDSHS), more than three-quarters (76%) of people who had used cannabis in the 12 months preceding the survey stated they used cannabis heads, 44% cannabis leaf, 19% skunk (a particularly potent form of cannabis heads), 13% resin (including hash) and 4% oil (including hash oil) (AIHW 2005c).

Common names for cannabis include pot, grass, weed, dope, spliff, joint, reefer, cone, hash, mull, and skunk. Cannabis is commonly smoked but can also be mixed with food or drink and ingested orally, or inhalers can be used to deliver oral doses of THC (Copeland et al. 2006). Cannabis cannot be injected.

The effects of cannabis depend on how much and how frequently it is used, the mode of administration (i.e. smoked or eaten), any concurrent drug use, the environment in which the drug is used, and characteristics of the individual using the drug such as their health and mood state (ADF 2003a). Cannabis use produces a period of acute intoxication which includes a range of psychological and physiological changes in the body which generally lasts from four to six hours after use (Copeland et al. 2006). Common immediate effects of using cannabis include increased heart rate, low blood pressure and reddened eyes. Other short term effects of using cannabis may include:

- sleepiness
- feeling of wellbeing
- talkativeness
- reduced coordination and concentration
- loss of inhibitions
- anxiety and paranoia
- increased appetite
- dryness of the mouth and throat.

There are a number of probable harms associated with regular long-term use of cannabis, these being:

- increased risk of respiratory diseases associated with smoking, including cancer
- decreased memory and learning abilities
- decreased motivation or concentration

- impaired immune function
- impaired reproductive function
- dependence.

Withdrawal is the most commonly reported symptom reported by adults who are dependent upon cannabis, which may include experiences such as sleep disturbance, irritability, loss of appetite and consequently weight loss, anxiety, and stomach cramps (ADF 2003a).

There is also concern that cannabis use may trigger psychosis. The issue is still debatable; however, there is a growing body of evidence that indicates cannabis use may precipitate a psychotic episode and make the course of the episode prolonged among those who are vulnerable due to a personal or family history of psychotic illness (NDARC forthcoming).

Cannabis use and dependence is second only to heroin use and dependence in terms of healthy years of life lost due to illicit drug-related conditions (NDARC forthcoming). In 1996, an estimated 4,416 disability-adjusted healthy years of life was lost due to cannabis use and dependence (AIHW: Mathers et al. 1999). Although cannabis has not been identified as a cause of death in Australia, it is estimated that the burden of disease caused by dependence and the extent of use in Australia is greater than, for example, HIV, hepatitis B and hepatitis C combined (NDARC forthcoming).

Cannabis and the law

It is illegal to possess, use and supply cannabis in Australia, however, there is no uniform set of laws dealing with cannabis related offences at the national level. Penalties for cannabis-related offences differ for each state and territory. In some jurisdictions (South Australia, Western Australia, the Australian Capital Territory and the Northern Territory) minor cannabis offences are dealt with by a civil penalty such as a fine rather than receiving a criminal conviction. In other jurisdictions (New South Wales, Victoria, Queensland and Tasmania), any cannabis offence is a criminal offence that attracts a criminal record and may be punishable by penalties such as fines and incarceration.

Despite these differences, all Australian states and territories have implemented diversion programs which aim to divert non-violent, minor and early cannabis offenders away from the legal system and into treatment and/or education programs. Thus even in those states and territories where all cannabis offences are in the criminal code, it is rare for early offenders possessing small amounts of cannabis to receive a criminal conviction. Through the Council of Australian Governments Illicit Drug Diversion Initiative, the Australian Government is working together with all jurisdictions to establish a nationally consistent approach to drug diversion (DoHA 2004). There are a number of different drug diversion programs currently operating in each state and territory – not all of which are funded by the initiative. The effectiveness of drug diversion programs funded under the initiative are to be evaluated in the near future.

According to the Australian Crime Commission's Illicit Drug Report (ACC 2006), there were 54,936 cannabis-related arrests nationally in 2004–05, which accounted for 71% of all drug-related arrests. In recent years, the number of cannabis-related arrests has remained fairly stable.

Cannabis use in Australia

Cannabis is the most widely used illicit drug in Australia. According to the 2004 National Drug Strategy Household Survey (AIHW 2005b), of Australians aged 14 years and over:

- Just over one in three (34%) had used cannabis⁹ at some stage in their lifetime, and one in nine (11%) had used it at least once in the last 12 months (Table 6.1).
- The 20–29 and 30–39 year age groups were more likely to have ever used cannabis (55% each) than any other age group, while the 20–29 year age group was most likely to have used cannabis in the last 12 months (26%). Males aged 30–39 years were most likely to have ever used cannabis (59%) and males aged 20–29 were most likely to have recently used cannabis (32%).
- Males were more likely than females to have used cannabis in the last 12 months (14% and 8% respectively). This was also true for lifetime use (37% compared with 30% respectively); however, females aged between 14 and 19 years were slightly more likely to have ever used cannabis than males in the same age group (26% and 25% respectively).
- Of those who have ever used cannabis, the average age of initiation was 18.7 years.

According to the 2004 NDSHS, almost half of recent users (49%) used cannabis less than once a month. Nevertheless, 16% of recent cannabis users do so daily, and 23% used it at least once per week (AIHW 2005c).

Table 6.1: Use of cannabis: 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	24.9	26.2	25.5	18.4	17.4	17.9
20–29	57.4	51.6	54.5	32.4	19.5	26.0
30–39	59.1	50.0	54.5	21.4	10.6	15.9
40–49	47.0	36.2	41.6	11.9	5.7	8.7
50–59	27.6	16.5	22.1	4.3	2.1	3.2
60+	5.7	3.3	4.4	0.4	0.2	0.3
Aged 14+	37.4	29.9	33.6	14.4	8.3	11.3

(a) Used at least once in lifetime.

(b) Used in the last 12 months.

Source: AIHW 2005b.

9 The 2004 National Drug Strategy Household Survey refers to this group as marijuana/cannabis. Similarly, within this report, the term ‘cannabis’ includes those drugs that are classified as marijuana.

Between 1993 and 2004, the proportion of the population aged 14 years and over who had used cannabis in the last 12 months rose and fell – peaking at 18% in 1998 and dropping significantly from 13% to 11% between 2001 and 2004, the lowest proportion observed over the 11 year period (see Table 7.1). This trend was similar for males and females (falling from 16% to 14% for males and from 10% to 8% for females, between 2001 and 2004) (Table 6.2). This trend was also apparent among the younger age groups, particularly the 14–19 year age group which, between 2001 and 2004, saw a significant drop in the proportion who had used cannabis in the previous 12 months from 27% to 18% among males and 23% to 17% among females.

Table 6.2: Recent use of cannabis^(a): proportion of the population aged 14 years and over, by age group and sex, Australia, 1995 to 2004 (per cent)

Age group	Males				Females			
	1995	1998	2001	2004	1995	1998	2001	2004
14–19	35.9	35.0	26.6	18.4 #	20.1	34.2	22.6	17.4 #
20–29	43.7	43.7	35.1	32.4 #	23.4	29.3	23.2	19.5 #
30–39	19.0	24.1	20.8	21.4	8.2	16.3	11.7	10.6 #
40–49	8.0	16.6	10.7	11.9 #	2.2	6.3	6.6	5.7 #
50–59	1.9	5.6	4.5	4.3	1.2	7.6	2.0	2.1
60+	—	1.1	0.7	0.4 #	0.5	1.2	0.3	0.2
Aged 14+	18.0	21.3	15.8	14.4 #	8.6	14.7	10.0	8.3 #

(a) Used in the last 12 months.

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

Source: AIHW 2005b.

Cannabis and other drug use

In common with all illicit drug users, many users of cannabis are poly-drug users (NDARC forthcoming). According to the 2004 NDSHS, 86% of recent cannabis users had used alcohol at the same time as cannabis, 28% had used meth/amphetamines at the same time and 24% had used ecstasy at the same time (Table 6.3). Only 11% of recent cannabis users had not used another drug with cannabis. Cannabis users are also more likely to be tobacco smokers than non-users (Copeland et al. 2006).

Table 6.3: Other drugs used with cannabis, recent users aged 14 years and older, by sex, Australia, 2004

Drug	Males	Females	Totals
Alcohol	88.8	82.0	86.2
Heroin	2.4	2.6	2.5
Cocaine	9.6	5.8	8.2
Tranquillisers/sleeping pills	4.6	4.0	4.4
Antidepressants	4.3	8.0	5.7
Pain-killers/analgesics	6.0	7.7	6.6
Barbiturates	0.9	0.4	0.7
Meth/amphetamines (speed)	29.8	24.6	27.9
Ecstasy/designer drugs	26.3	20.6	24.2
Other	3.5	2.5	3.2
None	8.6	14.6	10.8

Notes

1. Base is recent users.
2. Respondents could select more than one response.

Source: AIHW 2005c.

Availability of cannabis

In 2004, more than one-fifth of Australians aged 14 years and over (21%) were offered or had the opportunity to use cannabis in the preceding 12 months. This proportion was slightly lower than 2001 where 24% of the population reported the availability of this drug (AIHW 2005b). In 2004, males were more likely than females to have been offered or had the opportunity to use cannabis (24%, compared with 17%), as was the case in 2001 (28% and 20%).

Data from the Illicit Drug Reporting System (IDRS) are compiled through interviews with injecting drug users and key experts who have regular contact with illicit drug users through their work (NDARC 2006; see also Section 7.2 for further details). 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 2005 IDRS (NDARC 2006) indicated that:

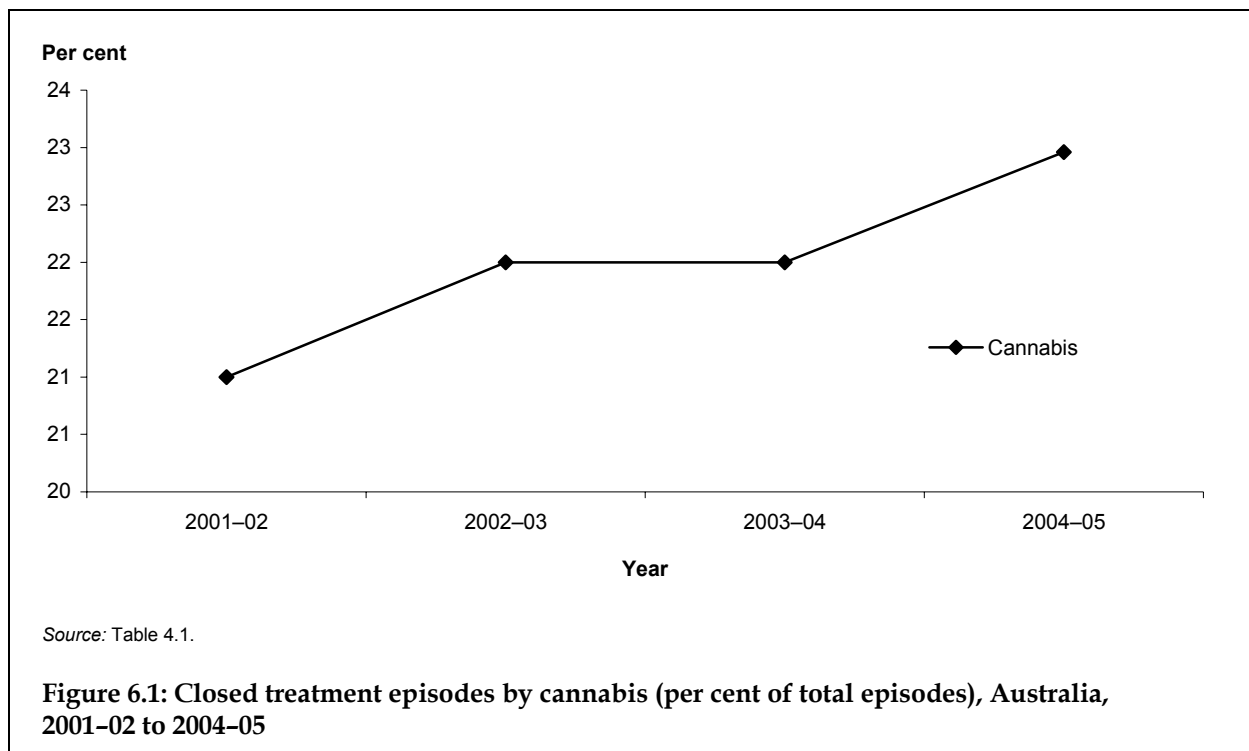
- the majority of interviewees across Australia reported it was 'easy' or 'very easy' to obtain hydroponic cannabis and outdoor cultivated (bush) cannabis (89% and 56% respectively)
- most injecting drug users purchased hydroponic and bush cannabis from a friend or at a dealer's home (75% and 74% respectively)
- the median price of cannabis (based on the participant's last purchase) varied according to the form of cannabis purchased and by jurisdiction. For example, in 2005 the median price *per ounce* of hydroponic cannabis ranged from \$200 in South Australia to \$300 in New South Wales, Western Australia, Queensland and the Northern Territory; for bush cannabis from \$200 in New South Wales, Victoria, Tasmania, South Australia and the Northern Territory to \$250 in the Australian Capital Territory

- the potency of hydroponic cannabis was considered by most as 'high' (57%) and bush cannabis 'medium' (37%).

Much of the cannabis consumed in Australia is locally produced rather than imported; however, there are a number of cannabis detections by Australian Customs each year, the majority of which are small amounts sent in parcels or found on passengers (ACC 2006). In 2004–05 there were 469 cannabis detections at the Australian border, down from 659 in 2003–04, with a total weight of less than 5 kg. The total yearly weight of cannabis detections has been less than 75 kg over the last decade, with the exception of 1996–07, 2001–02 and 2003–04 when 24,522 kg, 2,944 kg and 709 kg were seized respectively (NDARC 2006).

Cannabis as a principal drug of concern

As discussed in Chapter 4, cannabis was the second most common principal drug of concern after alcohol for which treatment was sought in 2004–05, accounting for 23% of all closed treatment episodes in the AODTS-NMDS. Since 2001–02, the proportion of closed treatment episodes where cannabis was reported as the principal drug of concern has slightly increased from 21% (or 23,826 of 113,231 episodes) to 23% (or 31,044 of 135,202 episodes) in 2004–05 (Figure 6.1).



Multivariate analysis of the 2003–04 AODTS-NMDS data looked at the group of closed treatment episodes where cannabis was selected as the principal drug of concern, together with the group of closed treatment episodes for all other principal drugs of concern (that is, excluding episodes where cannabis was the principal drug as well as episodes whose principal drug of concern was missing). The analysis involved a step-wise logistic regression to determine the likelihood of use of AODT services for the principal drug cannabis, over any other principal drug (Bartu et al. 2005).

Results of this analysis showed that:

- cannabis users were 8.3 times more likely to receive information and education as the main treatment type (compared to counselling)
- cannabis users were 1.6 times more likely to receive treatment in inner regional locations (compared to major cities)
- cannabis users were 1.4 times more likely to receive treatment in a non-residential setting (compared to a residential setting)
- cannabis users were marginally more likely to be male and younger in age.

6.2 Client profile

This section provides an overview of clients receiving alcohol and other drug treatment services in 2004–05 who nominated cannabis as their principal drug of concern. This section reports only on those episodes where clients were seeking treatment for their own substance use.

Age and sex

Cannabis was more likely to be reported as the principal drug of concern for younger age groups. Of those closed treatment episodes where cannabis was the principal drug of concern, a higher proportion of episodes involved people in the 10–19 and 20–29 year age groups (26% and 41% respectively) compared with episodes for all other principal drugs of concern (8% and 31% respectively) (Table 6.4).

Overall, treatment episodes were more likely to involve males (67%) than females (32%) (Table 6.4). This pattern was similar for episodes where cannabis was nominated as the principal drug of concern (71% involving males and 29% females).

Table 6.4: Closed treatment episodes^(a) by principal drug of concern, age group and sex, Australia, 2004–05 (per cent)

Age group	Cannabis			All other principal drugs of concern ^(b)			Total		
	Males	Females	Persons ^(c)	Males	Females	Persons ^(c)	Males	Females	Persons ^(c)
10–19	26.9	25.2	26.4	7.5	8.8	7.9	12.2	12.2	12.2
20–29	41.6	39.2	40.9	31.9	30.4	31.4	34.3	32.2	33.6
30–39	21.8	23.5	22.3	31.1	30.1	30.8	28.9	28.7	28.8
40–49	7.3	8.9	7.7	18.8	19.5	19.1	16.0	17.3	16.5
50–59	1.4	1.8	1.5	7.1	7.6	7.3	5.7	6.4	6.0
60+	0.2	0.1	0.2	2.5	2.6	2.6	2.0	2.1	2.0
Not stated	0.9	1.3	1.0	0.9	1.0	1.0	0.9	1.0	1.0
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (no.)	21,941	8,997	31,044	69,276	34,523	104,158	91,217	43,520	135,202

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

(b) Includes all principal drugs of concern other than cannabis.

(c) Includes 'not stated' for sex.

Method of use

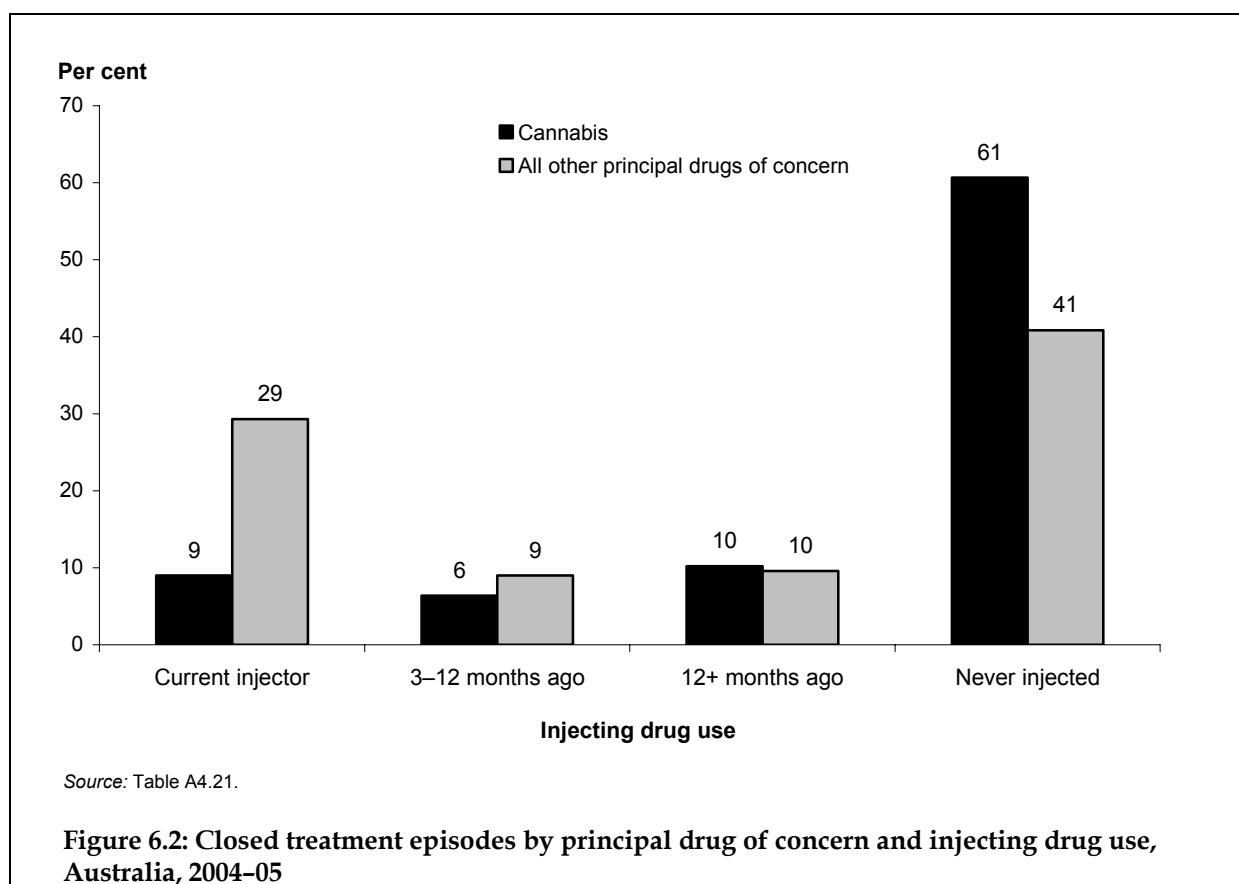
As part of the AODTS–NMDS, clients are asked to nominate the usual method of administering their principal drug of concern, that is, their ‘method of use’. As mentioned in Section 4.9 for all closed treatment episodes in 2004–05 the most likely methods of use were ingestion (45%), followed by injection (26%) and smoking (25%) (Table 4.8).

Where cannabis was nominated as the principal drug of concern, smoking accounted for 91% of closed treatment episodes within this group, compared with all other principal drugs of concern, where smoking accounted for 5% (Tables A4.19 and A4.20).

Across all age groups, smoking was the most common method of use for closed treatment episodes where cannabis was the principal drug of concern (Table A4.19). Similar proportions were recorded for all age groups with the exception of the 60 years and over age group, where 82% reported smoking as their usual method of administering cannabis.

Injecting drug use

Overall in 2004–05, 25% of clients identified themselves as current injectors, a further 18% reported having injected in the past (8% between 3 and 12 months ago and 10% 12 or more months ago) and 45% reported they had never injected (Table A4.21). Clients nominating cannabis as the principal drug of concern were less likely than those nominating all other principal drugs of concern to be current injectors (9% and 29% respectively) and more likely to have never injected (61% and 41% respectively) (Figure 6.2). The proportion of clients ever having injected in the past was similar for each group: 16% of episodes where cannabis was the principal drug of concern compared with 19% of episodes where a principal drug other than cannabis was selected. Caution should be used, however, when interpreting data for ‘injecting drug use’ due to the high ‘not stated’ response for this item (12% of closed treatment episodes).



Other drugs of concern

As stated in Section 4.7, of closed treatment episodes where cannabis was nominated as the principal drug of concern, 16,148 episodes (or 52%) had at least one other drug of concern reported (Table 4.6). From these episodes, 25,267 other drugs of concern were recorded (clients are able to report up to five other drugs of concern), equating to 1.6 other drugs of concern per treatment episode.

For closed treatment episodes where a drug other than cannabis was nominated as the principal drug of concern, 53,920 episodes (or 52%) had at least one other drug of concern reported. From these episodes, 89,235 other drugs of concern were recorded, equating to 1.7 other drugs of concern per treatment episode.

Of the 25,267 other drugs of concern recorded for clients who nominated cannabis as their principal drug of concern, 36% of these were alcohol, 21% nicotine, 20% amphetamines and 6% ecstasy (Table 6.5). Of the other drugs of concern recorded for clients who nominated a principal drug of concern other than cannabis, 33% of other drugs were cannabis, 18% nicotine, 12% amphetamines, 11% alcohol and 9% benzodiazepines.

Table 6.5: Other drugs of concern where the principal drug of concern is cannabis and where the principal drug of concern is not cannabis, Australia, 2004–05^(a)

Other drugs of concern	Cannabis		All other principal drugs of concern ^(b)		All principal drugs of concern	
	No.	%	No.	%	No.	%
Alcohol	9,041	35.8	9,377	10.5	18,418	16.1
Amphetamines	4,998	19.8	10,336	11.6	15,334	13.4
Benzodiazepines	1,020	4.0	8,102	9.1	9,122	8.0
Cannabis	—	—	29,621	33.2	29,621	25.9
Cocaine	254	1.0	1,483	1.7	1,737	1.5
Ecstasy	1,498	5.9	2,621	2.9	4,119	3.6
Heroin	1,311	5.2	4,163	4.7	5,474	4.8
Methadone	198	0.8	1,639	1.8	1,837	1.6
Nicotine	5,390	21.3	15,345	17.2	20,735	18.1
Other drugs ^(c)	1,557	6.2	6,548	7.3	8,105	7.1
Total	25,267	100.0	89,235	100.0	114,502	100.0

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

(b) Includes all principal drugs of concern other than cannabis.

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

Source of referral

People seeking treatment for cannabis as the principal drug of concern were more likely than those nominating other drugs of concern to be referred to treatment by police diversion (21%, compared with 2%)¹⁰, and less likely to be referred to treatment by a hospital (1%, compared with 4%) or by a general practitioner or medical specialist (3%, compared with 7%).

For both groups, self-referring to treatment was the most common source of referral (28% of episodes where cannabis was the principal drug of concern and 39% of episodes for all other principal drugs of concern) (Table 6.6).

10 In Queensland, clients undergoing police diversion automatically have their principal drug of concern recorded as 'cannabis'. Of clients seeking treatment for cannabis as the principal drug of concern, who were referred to treatment by police diversion in 2004–05, 86% (or 5,634 of 6,541 closed treatment episodes) were from Queensland.

Table 6.6: Closed treatment episodes by principal drug of concern and source of referral, Australia, 2004–05^(a)

Source of referral	Cannabis		All other principal drugs of concern ^(b)		Total	
	No.	%	No.	%	No.	%
Self	8,556	27.6	40,423	38.8	48,979	8,556
Family member/friend	1,857	6.0	5,467	5.2	7,324	1,857
General practitioner/medical specialist	1,004	3.2	6,804	6.5	7,808	1,004
Hospital	394	1.3	4,222	4.1	4,616	394
Community health care centre	917	3.0	2,357	2.3	3,274	917
Alcohol and other drug treatment service	2,990	9.6	13,011	12.5	16,001	2,990
Other community/health care service	1,238	4.0	3,920	3.8	5,158	1,238
Correctional service	3,035	9.8	10,860	10.4	13,895	3,035
Police diversion	6,541	21.1	1,647	1.6	8,188	6,541
Court diversion	1,900	6.1	5,106	4.9	7,006	1,900
Other	2,513	8.1	9,918	9.5	12,431	2,513
Not stated	99	0.3	423	0.4	522	99
Total	31,044	100.0	104,158	100.0	135,202	31,044

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

(b) Includes all principal drugs of concern other than cannabis.

6.3 Treatment programs

This section provides an overview of the treatment types and programs for clients who nominated cannabis as their principal drug of concern in 2004–05. This section reports only on those episodes where clients were seeking treatment for their own substance use.

Main treatment type

Counselling was the most common treatment type for clients who nominated cannabis as their principal drug of concern, as well as for clients who nominated a principal drug of concern other than cannabis (36% and 39% respectively) (Table 6.7).

Clients who nominated cannabis as their principal drug of concern were more likely to receive information and education only (24%) and support and case management only (10%), compared with clients who nominated a principal drug other than cannabis (4% and 7% respectively) (Table 6.7). It is important to note that, in Queensland, clients undergoing police diversion automatically have their principal drug of concern recorded as cannabis and their main treatment type as information and education only.

Conversely, clients with a principal drug other than cannabis were more likely than those who nominated cannabis as their principal drug to receive withdrawal management (detoxification), rehabilitation and assessment only (20%, 9% and 14%, compared with 14%, 5% and 9% respectively).

Table 6.7: Closed treatment episodes by principal drug of concern and main treatment type, Australia, 2004–05^(a)

Main treatment type	Cannabis		All other principal drugs of concern ^(b)		Total	
	No.	%	No.	%	No.	%
Withdrawal management (detoxification)	4,335	14.0	21,122	20.3	25,457	18.8
Counselling	11,101	35.8	40,207	38.6	51,308	37.9
Rehabilitation	1,535	4.9	9,424	9.0	10,959	8.1
Support and case management	3,090	10.0	7,718	7.4	10,808	8.0
Information and education only	7,590	24.4	4,594	4.4	12,184	9.0
Assessment only	2,823	9.1	14,651	14.1	17,474	12.9
Other ^(c)	570	1.8	6,442	6.2	7,012	5.2
Total	31,044	100.0	104,158	100.0	135,202	100.0

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

(b) Includes all principal drugs of concern other than cannabis.

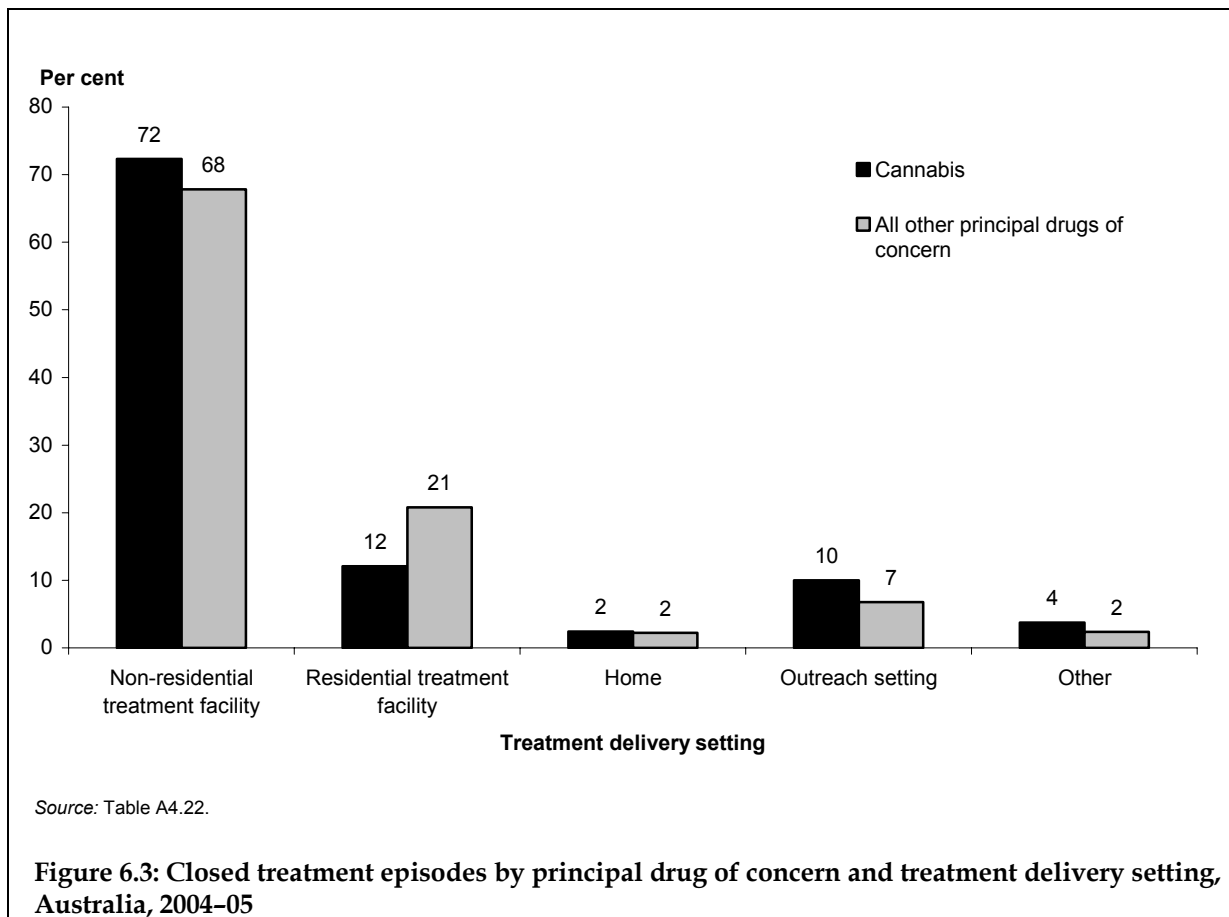
(c) 'Other' includes 4,299 closed treatment episodes (33 episodes for the cannabis group and 4,266 episodes for all other drugs of concern group) where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 7.4).

Treatment delivery setting

In 2004–05, just over two-thirds of all closed treatment episodes were conducted in non-residential treatment facilities (69%), almost one-fifth in residential treatment facilities (19%) and 7% in outreach settings¹¹ (Table A4.22).

Closed treatment episodes where cannabis was the principal drug of concern were less likely to involve treatment in a residential facility (12%) than closed treatment episodes for all other principal drugs of concern (21%) (Figure 6.3). Correspondingly, closed treatment episodes where cannabis was the principal drug of concern were more likely to involve treatment in a non-residential treatment facility (72%) or in an outreach setting (10%), compared with treatment episodes for all other principal drugs of concern (68% and 7% respectively). The same proportion of closed treatment episodes in both groups had treatment delivered at home (2% each).

11 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 2004-05, where cannabis was the principal drug of concern, 46% of episodes ceased because the treatment was completed, compared with 55%¹² for other principal drugs of concern (Table 6.8). The next most common reason for ceasing treatment among clients who nominated cannabis as their principal drug of concern was expiation (22%) – that is, where the client had completed the required education or information program. It is important to note that in Queensland, clients undergoing police diversion automatically have their principal drug of concern recorded as cannabis and the reason for cessation as ceased to participate at expiation.

12 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 6.8: Closed treatment episodes by principal drug of concern and selected reason for cessation, Australia, 2004–05^(a)

Reason for cessation	Cannabis		All other principal drugs of concern ^(b)		Total	
	No.	%	No.	%	No.	%
Treatment completed	14,241	45.9	56,912	54.6	71,153	52.6
Change in main treatment type	283	0.9	1,435	1.4	1,718	1.3
Change in delivery setting	169	0.5	1,135	1.1	1,304	1.0
Change in principal drug of concern	14	0.0	151	0.1	165	0.1
Transferred to another service provider	1,268	4.1	6,992	6.7	8,260	6.1
Ceased to participate against advice	819	2.6	4,944	4.7	5,763	4.3
Ceased to participate without notice	4,838	15.6	18,342	17.6	23,180	17.1
Ceased to participate involuntary (non-compliance)	522	1.7	2,387	2.3	2,909	2.2
Ceased to participate at expiation	6,794	21.9	2,441	2.3	9,235	6.8
Ceased to participate by mutual agreement	687	2.2	2,665	2.6	3,352	2.5
Drug court and/or sanctioned by court diversion service	79	0.3	241	0.2	320	0.2
Imprisoned, other than drug court sanctioned	123	0.4	948	0.9	1,071	0.8
Died	12	0.0	178	0.2	190	0.1
Other	913	2.9	3,701	3.6	4,614	3.4
Not stated	282	0.9	1,686	1.6	1,968	1.5
Total	31,044	100.0	104,158	100.0	135,202	100.0

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

(b) Includes all principal drugs of concern other than cannabis.

7 Other data collections

This chapter briefly describes a range of relevant data collections that relate to alcohol and other drug treatment services and drug use in Australia, and provides context to the information presented in the remainder of this report.

7.1 Background

Drug use – both licit and illicit – impacts on Australian society through its associations with premature death, injury and illness, accidents, crime, violence, and social and family disruption. In 1998, it was estimated that 17,671 deaths and 185,558 hospital separations were related to drug use (AIHW: Ridolfo & Stevenson 2001).

The National Drug Strategy, formerly the National Campaign Against Drug Abuse, has been operating since 1985 to confront the impact licit and illicit drugs have on Australian society. The aims of the National Drug Strategy are to improve health, social and economic outcomes by preventing and reducing the uptake of harmful drug use and minimising the harmful effects of licit and illicit drugs in Australia (Commonwealth of Australia 2004a).

In recent times there has been an increased recognition of the importance of drug information systems and great interest in attaining a coordinated approach to data collection. 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): 2003–2004 key results (DoHA 2005a) (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 and the National Aboriginal Community Controlled Health Organisations. See, for example, *A national profile of Australian government funded Aboriginal and Torres Strait Islander primary health care services, service activity reporting: 2003–2004 key results* (DoHA 2005b).
- National Opioid Pharmacotherapy Statistics Annual Data Collection (held by AIHW) 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 (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 by the Cancer Council Victoria (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: a one-day snapshot census of all clients using drug and alcohol treatment services across Australia, conducted in 1990, 1992, 1995 and 2001 (e.g. Shand & Mattick 2002). This census has effectively been superseded by the AODTS-NMDS.
- The Council of Australian Governments Illicit Drug Diversion Initiative: 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, and available data are held centrally by the Australian Government Department of Health and Ageing (ongoing).
- Drug Use Monitoring in Australia: 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: 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: 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 system 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 2006). The Ecstasy and Related Drugs Reporting System (previously known as the Party Drug Initiative) uses a similar methodology – for example, 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. This collection was conducted nationally for the first time in 2003 (see, for example, Breen et al. 2004) (annual).
- Bettering the Evaluation and Care of Health 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. 2005) (annual).
- National Survey of Mental Health and Wellbeing of Adults (ABS 1998): provided 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: a national Internet-based data storage and retrieval system for coronial cases in Australia. The system 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 2005d) (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 and hepatitis (B and C) among injecting drug users and examines injecting and sexual behaviours associated with these infections (NCHECR 2005).

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* (2005e). Also, information on a range of national data sources relating to drug use among Aboriginal and Torres Strait Islander peoples is due for release in 2006 (AIHW forthcoming). A report detailing a range of data sources relating to alcohol is available from the AIHW publication *A guide to Australian alcohol data* (AIHW 2004b), 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* (ABS 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 conducted 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 which is consistent with previous years. Participants in the 2004 survey were asked about their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours (AIHW 2005b, 2005c).

In 2004, more than four-fifths (84%) of Australians aged 14 years and over had recently consumed alcohol and more than one-fifth (21%) smoked tobacco (Table 7.1). Illicit drugs were used by fewer than one in six Australians (15%) in the last 12 months.

Marijuana/cannabis 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%, with a significant increase occurring between 2001 (82%) and 2004 (84%) (Table 7.1). Comparisons between recent tobacco use are only possible between 1998 and 2004 due to a change in definition (see AIHW 2005c for further details).

Over this period, the proportion of persons who had recently smoked tobacco declined from 25% in 1998 to 21% in 2004.

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 from 13% in 1993 to 11% in 2004 (see Chapter 6 for further details on cannabis). Overall, the use of any illicit drugs in the last 12 months prior to the NDSHS being conducted dropped significantly 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 and alcohol, 'recent use' means daily, weekly and less than weekly smokers and drinkers.

(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 gamma-hydroxybutyrate (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.

Overall in 2004, males were more likely than females to have recently used an illicit drug (18% compared with 13%). This was apparent across all age groups with the exception of those aged 14–19 years, where females (22%) were more likely than males (21%) to have used an illicit drug in the 12 months prior to the survey (AIHW 2005b).

People aged 20–29 years were more likely to have used an illicit drug in the 12 months prior to the 2004 NDSHS – 32% of 20–29-year-olds compared with 21% of 14–19-year-olds, 20% of 30–39-year-olds, and 7% 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 previous 12 months compared with people in older age groups. Cocaine is the only illicit drug that was more likely to have been used by people in the 30–39 year age group than people in the 14–19 year age group.

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
Any illicit drug^(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, gamma-hydroxybutyrate (GHB) and ketamine.

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

Alcohol and other drug treatment reported by the population

The NDSHS provides 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).

Morbidity

There were 74,917 hospital separations reported in 2004–05 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 2006a). 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 (45,449 or 61% of all separations), with alcohol the main contributor in this category (35,864 or 48% of all separations) (Table 7.4). Fifteen per cent (or 11,238) of all separations reported were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for more than half of this group (52%) and 8% of all separations. Stimulants and hallucinogens accounted for 10% (or 7,518) of all separations.

Table 7.4: Same-day and overnight separations^(a) with a principal diagnosis related to substance use disorders, by drug of concern, Australia, 2004–05

Drug of concern identified in principal diagnosis ^(b)	Same-day separations	Overnight separations	Total separations ^(c)
Analgesics			
Opioids (includes heroin, opium, morphine & methadone)	1,640	4,209	5,849
Non-opioid analgesics (includes paracetamol)	1,564	3,825	5,389
<i>Total</i>	<i>3,204</i>	<i>8,034</i>	<i>11,238</i>
Sedatives & hypnotics			
Alcohol	17,691	18,173	35,864
Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes alcohol)	3,114	6,471	9,585
<i>Total</i>	<i>20,805</i>	<i>24,644</i>	<i>45,449</i>
Stimulants & hallucinogens			
Cannabinoids (includes cannabis)	664	2,217	2,881
Hallucinogens (includes LSD & ecstasy)	229	187	416
Cocaine	195	110	305
Tobacco & nicotine	14	37	51
Other stimulants (includes amphetamines, volatile nitrates & caffeine)	982	2,883	3,865
<i>Total</i>	<i>2,084</i>	<i>5,434</i>	<i>7,518</i>
Antidepressants & antipsychotics	1,908	4,845	6,753
Volatile solvents	467	464	931
Other & unspecified drugs of concern			
Multiple drug use	648	2,175	2,823
Unspecified drug use & other drugs not elsewhere classified	85	120	205
<i>Total</i>	<i>733</i>	<i>2,295</i>	<i>3,028</i>
Total	29,201	45,716	74,917

(a) Separations for which the care type was reported as Newborn with no qualified days, and records for Hospital boarders and Posthumous organ procurement have been excluded.

(b) Drug of concern codes based on ASCDC which are mapped to ICD-10-AM 4th edition codes.

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

Source: AIHW National Hospital Morbidity Database 2004–05.

Same-day versus overnight separations

Overnight separations were more common than same-day separations, accounting for 61% of all separations (Table 7.4). Separations were relatively more likely to be overnight for multiple drug use or when the principal drug identified was cannabis (77% of both such separations were overnight). The highest proportion of same-day and overnight separations was for separations where the principal diagnosis was alcohol (61% of same-day separations and 40% 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 pharmacotherapies, collected as part of the AODTS-NMDS.

National Opioid Pharmacotherapy Statistics Annual Data collection 2005

Methadone maintenance was endorsed as an effective treatment for opioid dependence in 1985. The National Pharmacotherapy Policy for People Dependent on Opioids acknowledges that methadone is an internationally recognised effective method for treating opioid dependence, and is currently the most common pharmacotherapy used in Australia. Buprenorphine has also been used as a maintenance treatment for opioid dependence in Australia since 2000 (Commonwealth of Australia 2004b).

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 (IGCD MOTS 2004).

Data on the clients participating in opioid pharmacotherapy programs are collected through the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection. These data are routinely collected as at 30 June of the financial year by the state and territory health departments and, since the 2004 collection, provided annually to the AIHW for collation (prior to 2004, data were provided directly to the Australian Government Department of Health and Ageing). Data items collected for the NOSPAD collection include:

- number of clients by prescriber type
- number of clients by dosing point
- number of pharmacotherapy prescribers.

Numbers of pharmacotherapy clients have been collected since 1986, with the most recent data being from 2005. The type of data collected has varied in terms of detail over this period of time, and there is still inconsistency in the way data items are defined and collected across jurisdictions, which impacts on the reliability and interoperability of national pharmacotherapy data.

Table 7.5: Number of pharmacotherapy clients by state and territory, Australia, 1998–2005^(a)

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1998	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
2005	16,469	10,753	4,440	2,883	2,857	588	764	183	38,937

(a) Number of clients on the program at 30 June each year, except for Western Australia, where the number of clients treated through the month of June 2005 is reported. The 2005 figures reported for Western Australia are substantially lower than previous years which included the number of clients through the year.

Source: Unpublished data from the NOPSAD collection held at the AIHW, 2006.

Number of clients by prescriber type

Nationally, an estimated 38,937 clients were receiving pharmacotherapy treatment as at 30 June 2005 (Tables 7.5 and 7.6). Of these, the majority of clients received treatment in New South Wales (42%), followed by Victoria (28%), Queensland (11%), and Western Australia¹³ and South Australia (7% each). The Australian Capital Territory and Tasmania accounted for 2% each, while the Northern Territory accounted for less than 1% of all the clients receiving pharmacotherapy treatment.

Of the overall 38,937 clients receiving pharmacotherapy treatment, 70% received the treatment from a private prescriber, 24% from a public prescriber and 7% from a correctional facility.

Victoria accounted for the highest proportion of clients prescribed by private prescribers (97% or 10,412 of 10,753), followed by Tasmania (75%), New South Wales (71%), Western Australia (62%) and South Australia (57%). In contrast, clients scripted by public prescribers were most common in the Northern Territory (82%), the Australian Capital Territory (79%) and Queensland (76%).

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 can not be segregated into either section. Clients scripted by 'public/private prescribers' accounted for less than 0.5% of all clients in New South Wales.

Clients being prescribed at correctional facilities was most common in New South Wales (10% or 1,678 of 16,469), followed by Western Australia (9%) and South Australia (8%).

13 The 2005 figures reported for Western Australia refer to the number of clients treated through the month of June 2005, and are substantially lower than the ones reported in 2004, which included the number of clients through the year.

Table 7.6: Proportion of pharmacotherapy clients by prescriber, states and territories, Australia, 2005^(a) (per cent)

Prescriber	NSW	Vic	Qld ^(b)	WA	SA	Tas	ACT	NT	Australia
Public prescriber	18.3	—	76.4	29.3	34.7	24.0	78.9	82.0	23.5
Private prescriber	71.2	96.8	22.8	62.2	57.2	74.7	19.5	14.8	69.8
Public/private prescriber ^(c)	0.4	—	—	—	—	—	—	—	0.1
Correctional facilities	10.2	3.2	0.8	8.5	8.1	1.4	1.6	3.3	6.6
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	16,469	10,753	4,440	2,883	2,857	588	764	183	38,937

(a) Number of clients on the program at 30 June 2005, except for Western Australia, where the number of clients treated through the month of June 2005 is reported. The 2005 figures reported for Western Australia are substantially lower than the ones reported in 2004, which included the number of clients through the year.

(b) In Queensland, the total number of clients 'registered' (Table 7.6) and 'dosed' (Table 7.7) varies due to outstanding paperwork in the jurisdiction.

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

Source: Unpublished data from the 2005 NOPSAD collection held at the AIHW, 2006.

Number of clients by dosing point

Nationally, an estimated 38,797 clients were being dosed as at 30 June 2005 (Table 7.7). This total is different from that in Table 7.6 because of counting methods in Queensland, where dosing figures are based on the number of clients registered on 30 June 2005 who had picked up a dose at anytime during June 2005.

Overall, New South Wales accounted for most clients being dosed for pharmacotherapies (42%), followed by Victoria (28%), Queensland (11%), and Western Australia and South Australia (7% each) (Table 7.7). The Australian Capital Territory and Tasmania accounted for 2% each, while the Northern Territory accounted for less than 1%.

Of the 38,797 clients, the majority were dosed at pharmacies (69%, or 26,615), followed by public clinics (11%), private clinics (8%) correctional facilities (7%) 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, at a community health centre or at a doctor's surgery. In New South Wales, this category included clients where their dosing point was not stated. In the Northern Territory, clients dosing at public clinics or pharmacies can not be distinguished and are in turn reported as 'other'.

Table 7.7: Proportion of pharmacotherapy clients by dosing site, states and territories, Australia, 2005^(a) (per cent)

Dosing site	NSW ^(b)	Vic ^(c)	Qld ^{(d)(e)}	WA	SA ^(f)	Tas	ACT	NT ^(g)	Australia
Pharmacies	40.2	94.6	86.1	87.5	88.3	96.3	65.6	—	68.6
Public clinics	22.1	—	7.8	4.1	3.2	2.4	32.9	—	11.4
Private clinics	18.6	1.5	—	—	—	—	—	—	8.3
Correctional facilities	10.2	3.2	0.4	8.5	8.1	1.4	1.6	3.3	6.6
Public/private prescriber ^(h)	3.0	—	—	—	—	—	—	—	1.3
Other	5.9	0.7	5.7	—	0.4	—	—	96.7	3.8
Total (per cent)	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0
Total (number)	16,469	10,753	4,300	2,883	2,857	588	764	183	38,797

- (a) Number of clients on the program at 30 June 2005, except for Western Australia and Queensland, where the number of clients that had picked up a dose at anytime during the month of June 2005 is reported. The 2005 figures reported for Western Australia are substantially lower than the ones reported in 2004, which included the number of clients through the year.
- (b) In New South Wales, the total of 'other' includes 651 clients where dosing point was not stated.
- (c) In Victoria, specialist methadone services are considered 'private clinics', although they are agencies receiving State Government funding. The total for 'other' includes dosing to out-patients, as well as clients being dosed in public hospitals while in treatment for unrelated conditions.
- (d) In Queensland, the total for 'other' comprises 220 clients receiving doses at public and private hospitals, 23 clients receiving doses from doctors and 4 clients receiving doses from a Government Department.
- (e) In Queensland, dosing figures are based on the number of clients registered on 30 June 2005 and that had picked up a dose at any time during June 2005. In Queensland, the total number of clients 'registered' (Table 7.6) and 'dosed' (Table 7.7) varies due to outstanding paper work in the jurisdiction.
- (f) In South Australia, the total for 'other' refers to a pharmacy department within a state government hospital in a regional area, which dispenses for clients prescribed by local private prescribers.
- (g) In the Northern Territory the number of clients dosing at public clinics or pharmacies can not be distinguished. 'Other' comprises 177 clients receiving doses from either a public clinic or a pharmacy.
- (h) 'Public/private prescribers' refers to prescribers in dual clinics in NSW, which are private clinics receiving some public funding, where clients can not be segregated into public or private.

Source: Unpublished data from the 2005 NOPSAD collection held at the AIHW, 2006.

Number of pharmacotherapy prescribers

Every jurisdiction has a registration process through which a general practitioner becomes 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 prescribe for this drug only. With the introduction of buprenorphine as an opioid pharmacotherapy drug, the registration process in most jurisdictions changed to allow practitioners to prescribe for both drug types. Some prescribers – for various reasons – are only authorised to prescribe buprenorphine. Table 7.8 footnotes detail the jurisdiction authorisation differences further.

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, practitioners who are prescribing at least one client as at 30 June 2005.

Nationally, 1,234 practitioners were authorised to prescribe at 30 June 2005 (Table 7.8). Those registered to prescribe both methadone and buprenorphine accounted for 74% of the total pharmacotherapy prescribers; 26% (or 315) were registered to prescribe methadone only, while only 0.2% (or 2) were registered to prescribe buprenorphine only. 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 (35% or 428), followed by New South Wales (34%), Queensland (10%), Tasmania (7%) and Western Australia and South Australia (6% each). The Australian Capital Territory and the Northern Territory had the lowest percentages of prescribers (2% and 1% respectively).

Table 7.8: Estimated number of prescribers registered^(a) to prescribe pharmacotherapy drugs by drug type and jurisdiction, Australia (as at 30 June 2005)

	NSW ^(b)	Vic ^(c)	Qld ^(d)	WA	SA ^(e)	Tas ^(f)	ACT	NT	Total	Total (%)
Methadone only	123	112	10	15	—	42	13	—	315	25.5
Buprenorphine only	—	—	1	1	—	—	—	—	2	0.2
Methadone and buprenorphine	293	316	114	56	73	39	15	11	917	74.3
Total (number)	416	428	125	72	73	81	28	11	1,234	100.0
Total (per cent)	33.7	34.7	10.1	5.8	5.9	6.6	2.3	0.9	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 were scripting at least one client at 30 June 2005.

(b) In New South Wales, prescribers authorised to prescribe methadone can also have accreditation to prescribe buprenorphine, but not vice versa. However, a small number of medical practitioners have not completed any pharmacotherapy training, and are, therefore, not approved under Section 28A of the 1966 NSW Poisons and Therapeutics Goods Act. Currently, these prescribers may continue management of up to five stable patients. At 30 of June 2005, 42 prescribers (out of the 416 reported for New South Wales) who had not completed any pharmacotherapy training were treating a total of 72 clients.

(c) 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 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. However, a small number of practitioners in Victoria (about 3) are authorised to prescribe pharmacotherapy drugs, although they have not undergone the training course for prescribing pharmacotherapy drugs.

(d) The total for Queensland includes those prescribers from private practice, public clinics, correctional centres and government medical officers.

(e) In South Australia, prescribers are authorised to prescribe both methadone and buprenorphine. The number of prescribers reported in Table 7.8 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.

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

Source: Unpublished data from the 2005 NOPSAD collection held at the AIHW, 2006.

Data on opioid pharmacotherapies from the AODTS–NMDS

As outlined in Section 1.3, agencies whose sole activity is to prescribe and/or dose for opioid pharmacotherapy treatment (and their clients) are excluded from the AODTS–NMDS. In 2004–05 there were, however, 4,299 or 3.0% of closed treatment episodes where pharmacotherapy was the main treatment type provided (and where clients were seeking treatment for their own drug use). Throughout this report these treatment episodes have been included in the ‘other’ treatment type category.

Of the 4,299 AODTS–NMDS treatment episodes with pharmacotherapy as the main treatment type, most were provided in New South Wales (1,372 treatment episodes) and Victoria (909), followed by Western Australia (766), South Australia (632), the Australian Capital Territory (289), Queensland (246), the Northern Territory (69) and Tasmania (16).

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

Reported numbers in the 2004–05 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 for 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 2004–05, 41 services (100% of funded services) provided DASR data. Of these, 28 were classified as residential substance use services and 13 were classified as non-residential.
- Service Activity Reporting (SAR), a joint collection by the National Aboriginal Community Controlled Health Organisation and OATSIH. The SAR collects information from Aboriginal and Torres Strait Islander primary health care services that receive Australian Government funding. In 2003–04, 138 services (99% of funded services required to report against the SAR) provided SAR data.

This section presents a selection of data from these collections to provide a broader picture of the types of treatment services being accessed by the Australian population for drug and alcohol problems. 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 2004–05, 6 out of 41 Australian Government-funded services reporting in the DASR also reported under the AODTS–NMDS and 9 out of 143 Aboriginal and Torres Strait Islander primary health care services, reporting in the SAR, also reported under the AODTS–NMDS. From these 15 agencies, approximately 1,300 closed treatment episodes were reported in the 2004–05 AODTS–NMDS, with 92% of these closed treatment episodes relating to clients who identified as being of Aboriginal and/or Torres Strait Islander origin.

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/respice). 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 this 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 this 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’, this 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 this 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 (Drug and Alcohol Service Report)

In 2004–05, an estimated 27,600 clients were seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services (Table 7.9). Of these clients, 78% identified as being of Aboriginal and/or Torres Strait Islander origin. The majority of clients accessed services in South Australia (41%) and Queensland (37%).

Table 7.9: Estimated number of clients seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services by jurisdiction and Indigenous status, 2004–05

	Estimated number of clients					
	NSW & Vic	Qld	WA	SA	NT	Australia
Indigenous	1,100	6,300	2,500	9,400	2,200	21,600
Non-Indigenous	200	3,900	100	1,800	<100	6,000
Total (numbers)	1,400	10,200	2,700	11,200	2,200	27,600
Total (per cent)	5	37	10	41	8	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 2004–05 Drug and Alcohol Service Reporting collection.

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2004–05, an estimated 3,000 episodes of care were provided to clients in residential treatment/rehabilitation services (Table 7.10). Of these episodes of care, 71% were for male clients.

In 2004–05, an estimated 4,300 episodes of care were provided 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. More than three-fifths (62%) 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 2004–05, there were an estimated 49,600 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). Just over half (51%) of episodes for other care were for male 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 by sex and treatment type, 2004–05

	Estimated number of ‘episodes of care’					
	Male		Female		Total	
	No.	%	No.	%	No.	%
Residential treatment/rehabilitation ^(b)	2,100	71	900	29	3,000	100
Sobering-up/residential respite ^(c)	2,700	62	1,600	38	4,300	100
Other care ^(d)	25,200	51	24,500	49	49,600	100

- (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 2004–05 Drug and Alcohol Service Reporting.

During 2004–05, 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 (95%), multiple drug use (78%), amphetamines and tobacco/nicotine (61% each).

Table 7.11: Substances/drugs for which treatment/assistance was provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services, 2004–05

Substance/drug	Percentage of services that provided treatment/assistance for this substance/drug
Alcohol	100
Cannabis (marijuana, gunja, yamdi)	95
Multiple drug use (two or more drugs/substances)	78
Amphetamines (speed, uppers)	61
Tobacco/nicotine	61
Petrol	54
Other solvents/inhalants (chroming, paint, glue, aerosol cans)	51
Benzodiazepines (sleeping pills, Valium, Rohypnol)	49
Heroin	44
Cocaine (coke, crack)	37
Barbiturates (downers, Phenobarbital, Amytal)	34
Methadone	34
Ecstasy/MDMA	34
Morphine	29
LSD (acid, trips)	17
Steroids/anabolic agents	10
Kava	7
Other	0

Source: Australian Government Department of Health and Ageing analysis of the 2004–05 Drug and Alcohol Service Reporting.

Australian Government-funded Aboriginal and Torres Strait Islander primary health care services (Service Activity Report)

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. The number of clients who attended Aboriginal and Torres Strait Islander primary health care services and received alcohol or other drug treatment is not collected in the SAR. Similarly, the number of reported episodes of care that related solely or partially to alcohol or other drug treatment is not collected.

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 (89%), tobacco/nicotine (84%) or cannabis (82%) on an individual basis as they arose. Around half of all primary health care services had

clients raise issues for substances such as multiple drug use (53%), benzodiazepines (52%), solvents and inhalants (49%) and petrol (47%).

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, 2003–04

Substance/drug	Percentage of services that cover substance use issues on an individual basis as they arise
Alcohol	89
Tobacco/nicotine	84
Cannabis (marijuana, gunja, yamdi)	82
Multiple drug use (two or more drugs/substances)	53
Benzodiazepines (sleeping pills, Valium, Rohypnol)	52
Other solvents/inhalants (chroming, paint, glue, aerosol cans)	49
Petrol	47
Heroin	45
Methadone	44
Amphetamines (speed, uppers)	42
Barbiturates (downers, Phenobarbital, Amytal)	33
Morphine	28
Cocaine (coke, crack)	27
Ecstasy/MDMA	21
LSD (acid, trips)	17
Steroids/anabolic agents	13
Kava	10
Other (Panadeine Forte, analgesics, designer drugs, antidepressants)	7

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

8 Data quality of the AODTS–NMDS in 2004–05

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 2004c)
- jurisdictions improving their own data quality and checking mechanisms, and providing training to 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.

To further maximise the quality of the data collected, a user-friendly Data Guide to the AODTS–NMDS is currently being developed for service agencies participating in the collection. The data guide will present background information on the AODTS–NMDS, the scope of the collection and detailed information about AODTS–NMDS data items. This will supplement the more formal specification of data items in the *National health data dictionary* and AIHW's Metadata Online Registry (METeOR) (NHDC 2003; AIHW 2006b).

Comprehensiveness of the data

In 2004–05, data were provided from 565 (96%) of the 586 agencies that were in scope for this collection. This calculation excludes Queensland agencies as the number of missing non-government 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 2004–05 include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). Since the 2002–03 annual report, Australian Government data are not analysed separately under the heading 'other'; rather, they have been analysed as part of the jurisdiction in which the agency was located.

8.2 Data quality

Overall, the quality of the 2004–05 AODTS–NMDS data has continued the trend of improvements across collection periods. The proportions of those responses that were ‘not stated’, ‘missing’ or ‘unknown’ in 2004–05 and 2003–04 are given in Table 8.1 for each state and territory and nationally, as a proportion of total responses for each data item. There are some items of concern.

For the client data items:

- ‘Indigenous status’ was ‘not stated’ for 5% of responses – with the highest rates in Tasmania (18%), the Australian Capital Territory (17%) and Victoria (8%).
- Overall, 2% of responses were ‘not stated’ for ‘preferred language’ – this proportion was higher in the Northern Territory (6%) and Victoria (4%).

For drug data items:

- ‘Injecting drug use’ was ‘not stated’ for 12% of responses – higher in Tasmania (39%), Queensland (18%), the Australian Capital Territory (17%) and Victoria (15%).
- ‘Method of use’ was ‘not stated’ for 2% of responses – with the highest rates in Tasmania (4%) and Queensland (3%).

For treatment data items:

- ‘Reason for cessation’ was ‘not stated’ for 1% of responses – higher in the Northern Territory (6%), Queensland (5%) and Tasmania (3%).

Compared with 2003–04, the national proportion of responses that were ‘not stated’, ‘missing’ or ‘unknown’ has dropped slightly for a few variables – these being ‘Indigenous status’, ‘source of referral’, ‘principal drug of concern’ and ‘injecting drug use’ (6.1% to 5.2%, 0.5% to 0.4%, 0.5% to 0.0%, and 13.1% to 11.9% respectively).

The Australian Capital Territory saw the greatest increases in ‘not stated’ responses for ‘Indigenous status’ and ‘injecting drug use’ (4% to 17% and 8% to 17% respectively), possibly related to the exclusion of data from one large service provider in 2003–04. New South Wales and South Australia had the largest reductions in ‘not stated’ responses for ‘Indigenous status’ (4.5% to 1.9% and 8.7% to 5.3%); while the Northern Territory and South Australia had the largest reductions in ‘not stated’ responses for ‘injecting drug use’ (41.2% to 9.6% and 15.1% to 6.1% respectively).

8.3 Data transmission

The data transmission process for the 2004–05 AODTS–NMDS collection represented an improvement on that of previous years. Most jurisdictions were able to transmit their data to the AIHW earlier than in previous years, with a one month improvement in most cases. This has contributed to the more timely release of this annual report and associated data products for the 2004–05 collection.

Table 8.1: Not stated/missing/unknown responses for data items by jurisdiction, Australia, 2004–05 and 2003–04^(a) (per cent)

Data item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
2004–05									
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	2.4	3.7	3.9	0.2	2.5	0.1	0.0	0.8	2.7
Date of birth/age	0.1	1.5	2.5	1.5	0.0	0.1	0.4	0.2	1.1
Indigenous status	1.9	7.7	6.3	1.4	5.3	18.2	17.3	1.1	5.2
Preferred language	1.8	3.6	2.8	0.3	2.4	0.0	0.1	5.7	2.4
Sex	0.0	0.1	2.1	0.0	0.1	0.0	0.0	0.0	0.3
Source of referral	0.2	0.6	0.4	0.1	1.3	0.3	0.5	0.7	0.4
Drug data items^(b)									
Principal drug of concern	—	—	—	—	—	—	—	—	—
Method of use	1.7	2.2	3.1	0.3	1.5	4.4	0.1	2.0	1.9
Injecting drug use	8.0	15.2	17.7	4.1	6.1	38.7	16.8	9.6	11.9
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation	1.2	0.3	5.4	0.5	0.6	2.6	0.6	5.7	1.4
Treatment delivery setting	—	—	—	—	—	—	—	—	—
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^(b)									
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	—	—	—	—	—	—	—	—	—

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

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

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