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National opioid pharmacotherapy statistics (NOPSAD) 2017

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Newer release available

On a snapshot day in 2017, almost 50,000 clients received pharmacotherapy treatment for their opioid dependence at 2,732 dosing points around Australia.

As in previous years, methadone was the most common pharmacotherapy drug, with around two-thirds (60%) of clients treated with this drug.

There were 3,074 prescribers of opioid pharmacotherapy drugs, an increase of 3% from 2016.

Cat. no: HSE 199

Findings from this report:

- 49,792 clients received opioid pharmacotherapy treatment nationally
- There were 3,074 authorised opioid pharmacotherapy prescribers
- 89% of opioid pharmacotherapy dosing points were pharmacies
- 1 in 10 opioid pharmacotherapy clients identified as being Aboriginal and/or Torres Strait Islander

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Summary

Dependence on opioid drugs (which include codeine, heroin and oxycodone) is associated with a range of health and social problems that affect individual drug users, their family and friends, and the wider public. Treatment with an opioid pharmacotherapy drug, such as methadone or buprenorphine, can reduce drug cravings [1] and improve physical and mental health and social and economic participation, including a reduction in drug-related crime [2].

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides information on a snapshot days in May and June 2017 on clients receiving opioid pharmacotherapy treatment, the doctors prescribing opioid pharmacotherapy drugs, and the dosing points (such as pharmacies) that clients attend to receive their medication.

Opioid drugs

Opioids are chemical substances that have a morphine-type action in the body. They are most commonly used for pain relief, but they are addictive and can lead to drug dependence. They include:

- opiates—drugs naturally derived from the opium poppy, such as codeine and heroin
- semi-synthetic opiates, such as hydromorphone and oxycodone
- opioids, such as fentanyl and methadone.

Opioid drugs can be:

- illicit opioids, predominantly heroin [3]
- prescription opioids (whether prescribed for the person or obtained illicitly) such as morphine and oxycodone [4]
- over-the-counter opioids in which the opioid drug codeine is combined with a non-opioid analgesic such as paracetamol or ibuprofen [5].

From 1 February 2018, all codeine containing analgesics will require a prescription.

Opioid drug dependence

Dependence on opioid drugs such as heroin or morphine is associated with a range of health and social problems that affect individual drug users, their family and friends, and the wider public. Opioid dependence can lead to many problems such as overdose, medical and psychological complications, social and family disruption, harms to child welfare, violence and drug-related crime, and the spread of bloodborne diseases. It is considered a serious public health issue [3].

Drug dependence is characterised by drug seeking and using, but people experience it in various ways. The *International statistical classification of diseases and related health problems, 10th revision* (ICD-10) [6] defines 'dependence syndrome' due to the use of opioids as:

'A cluster of behavioural, cognitive, and physiological phenomena that develop after repeated substance use and that typically include a strong desire to take the drug, difficulties in controlling its use, persisting in its use despite harmful consequences, a higher priority given to drug use than to other activities and obligations, increased tolerance, and sometimes a physical withdrawal state (Code F11.2).'

Opioid pharmacotherapy treatment

Opioid pharmacotherapy treatment is one of the main treatment types used for opioid drug dependence and involves replacing the opioid drug of dependence with a legally obtained, longer-lasting opioid that is taken orally.

In Australia, 3 medications are registered for long-term maintenance treatment for opioid-dependent people:

- methadone
- buprenorphine
- buprenorphine-naloxone.

These drugs, known as opioid pharmacotherapies, reduce withdrawal symptoms, the desire to take opioids, and the euphoric effect of taking opioids. Treatment with these drugs is administered according to the law of the relevant state or territory, and within a framework that includes medical, social and psychological treatment.

The Australian Government Department of Health, as part of the National Drug Strategy, published the *National guidelines for medication-assisted treatment of opioid dependence* [7] to provide a broad policy context and framework for state and territory policies and guidelines that are concerned with the medication-assisted treatment of opioid dependence.

The NOPSAD collection

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection is a set of jurisdictional data that includes information about:

- clients accessing pharmacotherapy for the treatment of opioid dependence;
- prescribers participating in the delivery of pharmacotherapy treatment; and
- dosing sites providing pharmacotherapy drugs to clients.

References

1. NDARC (National Drug and Alcohol Research Centre) 2004. Treatment options for heroin and other opioid dependence: a guide for frontline workers. Canberra: Commonwealth Department of Health and Ageing for the National Drug Strategy. Viewed 21 March 2018.
2. Ritter A & Chalmers J 2009. Polygon: the many sides to the Australian opioid pharmacotherapy maintenance system. ANCD research paper no. 18. Canberra: Australian National Council on Drugs.
3. WHO 2013. Management of substance abuse: opiates. Geneva: WHO. Viewed 21 March 2018.
4. Roxburgh A, Bruno R, Larance B & Burns L 2011. Prescription of opioid analgesics and related harms in Australia. Medical Journal of Australia 195:280–284.
5. Nielsen S, Cameron J & Pahoki S 2010. Over the counter codeine dependence: final report 2010. Melbourne: Turning Point Alcohol and Drug Centre.
6. WHO (World Health Organization) 2010. Mental and behavioural disorder due to the use of opioids: dependence syndrome. ICD-10: International statistical classification of diseases and related health problems. Viewed 21 March 2018.
7. DoH (Department of Health) 2014. National guidelines for medication-assisted treatment of opioid dependence. Canberra: DoHA for National Drug Strategy. Viewed 21 March 2018.

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Opioid pharmacotherapy clients

On a snapshot day in mid-2017, nearly 50,000 people in Australia were on a course of pharmacotherapy treatment for their opioid dependence.

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides information on clients accessing pharmacotherapy for the treatment of opioid dependence. Data were collected on a snapshot day in June 2017, with the exception of Western Australia where data were collected on a snapshot day in May 2017.

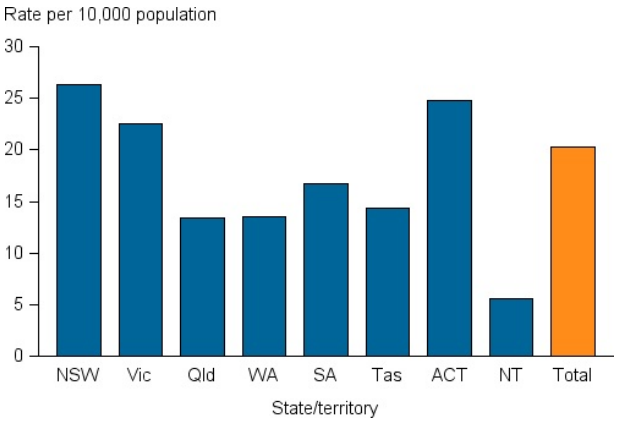
For more details about the collection, refer to the Technical notes.

The number of people receiving pharmacotherapy treatment has remained stable

Both the number of people (49,792) and the rate of people per (20 clients per 10,000 people) receiving pharmacotherapy treatment have remained relatively stable since 2010, with most states recording small increases during this time.

New South Wales remains the state with the highest rate of people receiving opioid pharmacotherapy treatment (26 clients per 10,000 people). Victoria was the only state to report a rise in the rate of people receiving treatment in 2017 (23 clients per 10,000 people, up from 22 clients per 10,000 in 2016). See Figure C1.

Figure C1: Clients receiving pharmacotherapy treatment on a snapshot day, per 10,000 population, 2017



Notes:

1. The relatively low rate of clients in the Northern Territory may be attributable to the limited availability of heroin [4], the impact of remote locations on treatment delivery, and a highly mobile population.
2. Australian population estimates for June 2017—sourced from *ABS Australian Demographic Statistics, June 2017* (ABS cat. no. 3101.0)—were used to produce this figure.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S2].

The median age of opioid pharmacotherapy clients is increasing

In 2017, clients ranged in age from their late teens to 87 years. The median age across all pharmacotherapy types in 2017 was 42 years, unchanged from 2016. This is an increase from 38 years in 2011, 39 years in 2012 and 40 years in 2013, 2014 and 2015. The first year in which single-year age data were collected was 2011.

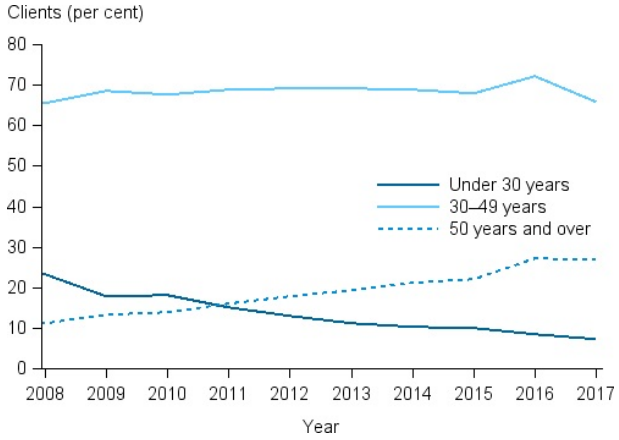
Almost two-thirds (66%) of clients in 2017 were aged 30–49 years. The proportion of clients aged under 30 has declined each year since 2006 (28% of clients in 2006 falling to 7% of clients in 2017).

The number of clients aged 60 years and over continued to increase slowly, from 223 (1% of total clients) in 2008 to 3,192 in 2017 (6% of total clients).

This continues the trend of an ageing cohort in opioid pharmacotherapy treatment and is consistent with the pattern observed in other drug treatment services [1, 2]. This may be due to:

- methadone treatment being available in Australia for more than 40 years
- pharmacotherapy treatment reducing the risk of premature death, resulting in some clients remaining in treatment for decades
- clients seeking treatment for the first time at an older age.

Figure C2: Clients receiving pharmacotherapy treatment on a snapshot day, by age group, 2008 to 2017



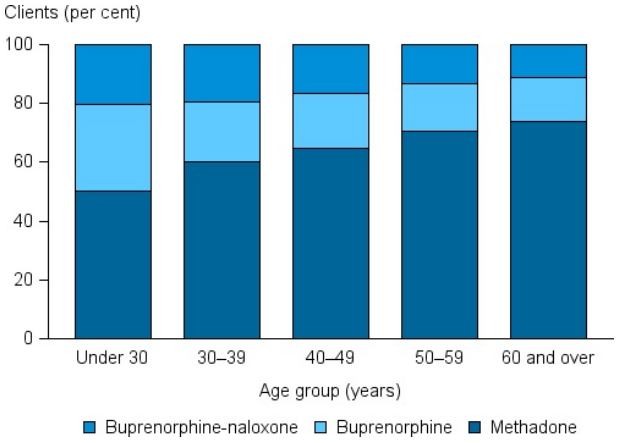
Note: Collection of age groups began in 2006.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S6].

Clients using services in New South Wales and South Australia had the highest median age (44 years) while clients in Victoria, Tasmania and the Australian Capital Territory had the lowest median age (41 years).

Methadone was the most commonly prescribed pharmacotherapy type across all age groups, followed by buprenorphine-naloxone and buprenorphine. This is the first time since 2011 that buprenorphine-naloxone has been prescribed more often than buprenorphine. Older clients were more likely to receive methadone and less likely to receive buprenorphine and buprenorphine-naloxone than younger clients (see Figure C3).

Figure C3: Clients receiving pharmacotherapy on a snapshot day, by age group and pharmacotherapy type, 2017



Note: NSW reports 'buprenorphine-naloxone' as 'buprenorphine'.

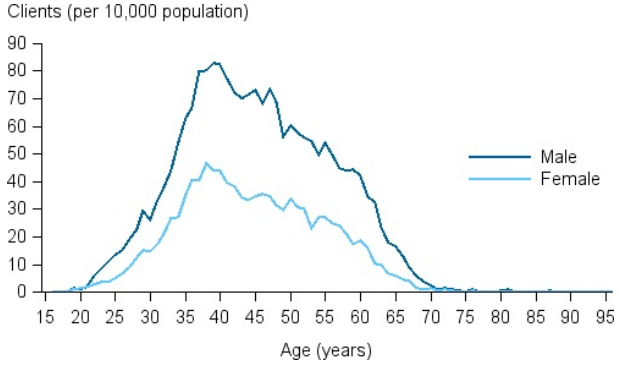
Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S6].

Males were more likely to receive treatment than females

Around two-thirds (66%) of clients receiving pharmacotherapy on the snapshot day in 2017 were male. This proportion was similar for each of the 3 pharmacotherapy types (methadone, buprenorphine and buprenorphine-naloxone), and has remained stable over the 10 years since 2008.

The rate of receiving pharmacotherapy was highest for people in the 40-49 age group for both males and females (see Figure C4). The rate peaked at age 39 for males and 38 for females (87 clients per 10,000 males aged 39 in the population, and 49 clients per 10,000 females aged 38). Males were generally more likely to receive pharmacotherapy than females of the same age—and in some cases about twice as likely.

Figure C4: Clients receiving pharmacotherapy treatment on a snapshot day, by age and sex, 2017



Notes:

1. Unit record data were used to produce this figure. Records were available for 58% of clients receiving pharmacotherapy on a snapshot day in 2017. Unit record data for Victoria and Queensland data were not available.
2. Australian population estimates for June 2017—sourced from *ABS Australian Demographic Statistics, June 2017* (ABS cat. no. 3101.0)—were used to produce this figure.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S24].

Aboriginal and Torres Strait Islander people were over-represented in pharmacotherapy treatment

Where reported, about 1 in 10 (9% in 2017) clients identified as being Aboriginal and/or Torres Strait Islander. Indigenous Australians (70 clients per 10,000 Indigenous Australians) were around 3 times as likely to have received pharmacotherapy treatment as the non-Indigenous population (26 clients per 10,000) (Table S9). Indigenous clients were more likely to be treated with methadone (54%) than non-Indigenous pharmacotherapy clients (41%).

Among the states and territories for which data were available, the Australian Capital Territory and Victoria had the highest rates of Indigenous clients (134 and 125 clients per 10,000 Indigenous Australians respectively). The Northern Territory had the lowest rate of Indigenous clients with 3 clients per 10,000 Indigenous Australians.

- Western Australia did not report the Indigenous status of their clients.
- Victoria did not provide a breakdown by pharmacotherapy type for Indigenous clients.

See the National Opioid Pharmacotherapy Statistics Annual Data collection data quality statement for more information.

Heroin was by far the most common opioid drug of dependence for clients

Clients receive pharmacotherapy treatment for a range of opioid drugs. These include illicit opioids (such as heroin), and pharmaceutical opioids available by prescription (such as oxycodone), over-the-counter (such as codeine-paracetamol combinations) or through illicit means. Opioids in the form of codeine and codeine combinations were still available over the counter on the snapshot day. Data for opioid drug of dependence should be used with caution due to the high proportion of clients with 'Not stated/not reported' as their opioid drug of dependence (38% of clients in 2017).

Nationally in 2017, 38% of clients reported heroin as their opioid drug of dependence. Oxycodone (5%) was the next most commonly reported drug of dependence followed by morphine, codeine and methadone (all 4%).

Heroin was the most common drug of dependence in all states and territories, except Tasmania and the Northern Territory, where morphine was the most common.

Pharmacotherapy drugs may be subject to misreporting if a client's treatment drug is reported instead of the opioid drug of dependence which led to the client seeking treatment.

Methadone continued to be the most commonly prescribed drug

Almost two-thirds (60%) of clients were treated with methadone in 2017 and the remaining 40% were treated with buprenorphine, either alone or in combination with naloxone, which is added to deter administration by injection (see the buprenorphine-naloxone entry in the Glossary for further details).

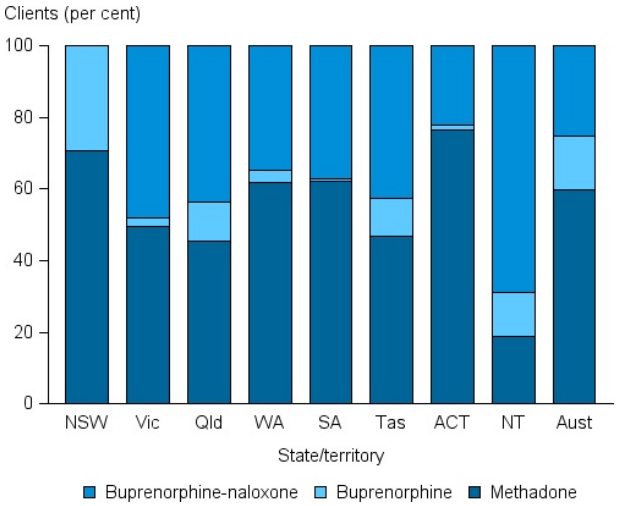
From 2008 to 2017, treatment with:

- methadone fell (from 70% of clients to 60%)
- buprenorphine remained stable (15%), and
- buprenorphine-naloxone increased (from 16% of clients to 25%).

Previous trend data has shown that buprenorphine-naloxone prescription is replacing buprenorphine prescription. This is in keeping with the national guidelines [3] which recommend that buprenorphine-naloxone should be preferred over buprenorphine for most clients as it is expected to have a lower risk of diversion (that is, injected by the client or sold to others to inject).

In 2017, methadone was the most common pharmacotherapy drug in all jurisdictions except for the Northern Territory (where 69% of clients received buprenorphine-naloxone). Buprenorphine-naloxone is the default treatment drug for the main pharmacotherapy program in the Northern Territory. Treatment with methadone ranged from 19% of clients in the Northern Territory to 76% of clients in the Australian Capital Territory (see Figure C5).

Figure C5: Clients receiving pharmacotherapy on a snapshot day, by pharmacotherapy type, states and territories, 2017



Note:

NSW reports 'buprenorphine-naloxone' as 'buprenorphine'. When New South Wales data are excluded, in the rest of Australia 52% of clients received methadone, 5% received buprenorphine, and 43% received buprenorphine naloxone.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S4].

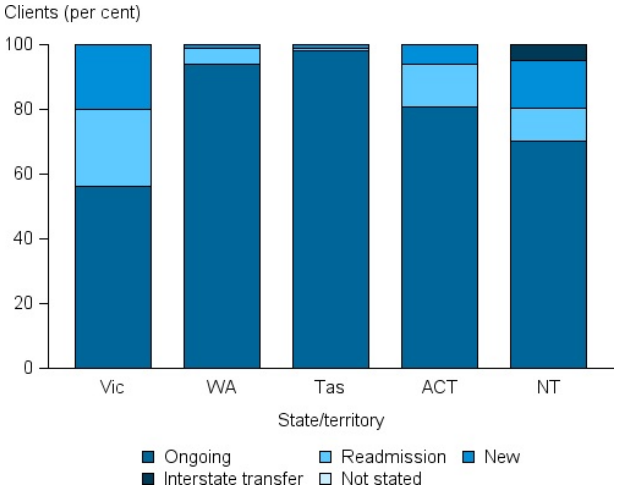
Most clients are continuing treatment

Clients interact with the pharmacotherapy treatment system in a number of ways. A client's status may differ according to whether they are:

- receiving treatment for the first time (new);
- re-entering treatment after a lapse (re-admission);
- continuing treatment (ongoing); or
- transferring from another state/territory (interstate transfer).

Client status data were available for Victoria, Western Australia, Tasmania, the Australian Capital Territory and the Northern Territory. In these jurisdictions, the majority of clients (58%) were classed as ongoing (see Figure C6).

Figure C6: Clients receiving pharmacotherapy on a snapshot day, by client status, states and territories, 2017



Note: NSW, Qld and SA do not report client status.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S11].

References

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2. AIHW (Australian Institute of Health and Welfare) 2016. National Drug Strategy Household Survey 2016: detailed findings. Drug statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.
3. DoH (Department of Health) 2014. National guidelines for medication-assisted treatment of opioid dependence. Canberra: DoH. Viewed 24 January 2018.
4. Moon, C 2014. Northern Territory drug trends 2013: Findings from the Illicit Drug Reporting System (IDRS). Australian Drug Trends Series No. 116. Sydney: National Drug and Alcohol Research Centre.

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Opioid pharmacotherapy prescribers

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides information on prescribers delivering pharmacotherapy treatment on a snapshot day in mid-2017.

For more details about the collection, refer to the Technical notes.

***Note*:** Data on all registered or authorised prescribers are included in this report, except for New South Wales, Western Australia and South Australia, where prescribers are included only if they are actively prescribing to at least 1 client on the snapshot day (see Table T2 of the Technical notes for further details). New South Wales, Western Australia and South Australia have prescribers who prescribe in more than 1 location, and as such are counted twice. This will lead to slightly deflated client to prescriber ratios.

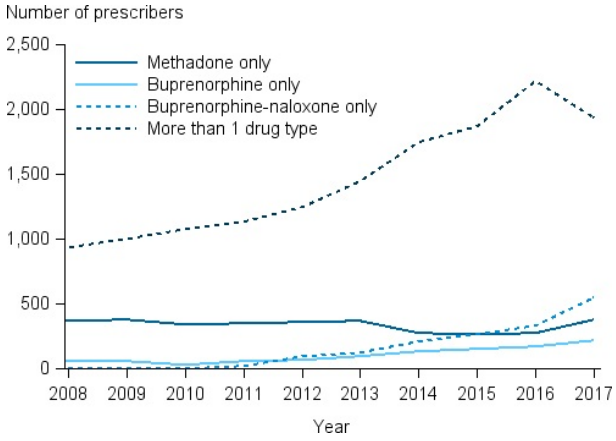
Number and type of prescribers

On the snapshot day in 2017, there were 3,074 authorised prescribers of opioid pharmacotherapy drugs (Table S15).

Almost two-thirds (63%) of prescribers were authorised to prescribe more than one type of drug. A further 18% were authorised to prescribe buprenorphine-naloxone only, and 12% were authorised to prescribe methadone only. The remaining 7% were located in New South Wales and Victoria and were authorised to prescribe buprenorphine; however, NSW reported both buprenorphine and buprenorphine-naloxone as 'buprenorphine only' (see Figure P1).

All prescribers in Queensland, the Australian Capital Territory and the Northern Territory were registered to prescribe more than one type of drug in 2017 (Table S16).

Figure P1: Prescribers, by pharmacotherapy type, 2008 to 2017



Note: NSW counts 'buprenorphine-naloxone' as 'buprenorphine'. See the Technical notes for further details.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S16].

Most prescribers worked in the private sector

The majority of prescribers worked in the private sector (83%) with the remainder working in the public sector (13%), correctional facilities (3%), or a combination of sectors (less than 1%) (see Table P1).

Table P1: Prescriber types, states and territories, 2017

Prescriber type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total
Public prescriber	212	–	91	24	29	13	6	14	389
Private prescriber	608	1,454	124	83	203	22	66	–	2,560
Public/private prescriber	–	–	–	–	–	2	1	–	3
Correctional facility	38	20	7	18	6	1	1	–	91
Total	**858**	**1,474**	**253**	**125**	**238**	**38**	**74**	**14**	**3,074**

Notes:

— Nil or rounded to zero.

The states and territories have different guidelines and policies regarding training and registration to prescribe opioid pharmacotherapy types. See the Technical notes for more information.

The Qld total includes 31 prescribers who have a prescriber type of 'Not stated'.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S15].

Victoria had the highest proportion of private prescribers (99%), followed by the Australian Capital Territory with 89%. The Northern Territory had the highest proportion of public prescribers (100%), followed by Queensland with 36%.

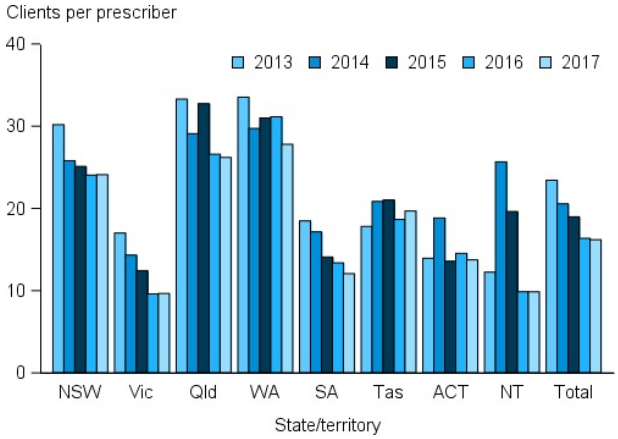
Of the 49,792 clients receiving pharmacotherapy treatment in Australia on a snapshot day in 2017, 67% received treatment from a private prescriber, 26% received treatment from a public prescriber, and 7% from a correctional facility prescriber (Table S12).

Private prescribers treated the majority of clients in New South Wales, Victoria, Western Australia, South Australia and Tasmania. Public prescribers treated the majority of clients in Queensland, the Australian Capital Territory and the Northern Territory (Table S3).

Prescribers treated an average of 16 clients on a snapshot day

Between 2016 and 2017, the number of clients per prescriber remained steady in most jurisdictions. In relative terms, Western Australia had the largest decrease (from 31 to 28 clients per prescriber), followed by South Australia (from 13 to 12 clients per prescriber) (see Figure P2).

Figure P2: Clients per prescriber, states and territories, 2013 to 2017



Note:

In South Australia, the decline in clients per prescriber is attributed to the introduction of the Medication Assisted Treatment for Opioid Dependence—Suboxone Opioid Substitution Program (MATOD-SOSP). This resulted in an increase in the number of prescribers treating relatively few clients. On a snapshot day in 2017, 137 prescribers registered under the MATOD-SOSP treated a total of 205 clients, while the remaining 101 prescribers treated a total of 2,667 clients.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S21].

Prescribers working in the public sector had, on average, about two and a half times as many clients as prescribers in the private sector (34 clients per prescriber compared with 13). In 2017, Western Australia had the highest number of clients per prescriber (28), while Victoria and the Northern Territory had the lowest (10).

The private sector saw a decrease in client ratios between 2016 and 2017 with ratios for private prescribers falling from 14 in 2016 to 13 in 2017. The ratio of clients to public prescribers decreased to 34 in 2017 from a ratio of 35 clients per prescriber in 2016.

The Australian Capital Territory had the highest ratio of clients to public prescribers (82) followed by Western Australia (59). Queensland had the highest ratio of private prescribers (26). Private prescribers had a lower average number of clients than public prescribers in all jurisdictions except Victoria (who had no public prescribers) and Tasmania.

Nationally, prescribers working in correctional facilities had an average of 36 clients, but at a state and territory level this varied widely, from 3 clients per prescriber in Tasmania to 126 in the Australian Capital Territory (Table S22).

The majority (43%) of prescribers treated between 1 and 5 clients, with only 10% treating more than 50 clients. Across states and territories, the proportion of pharmacotherapy prescribers treating between 1 and 5 clients ranged between 73% in South Australia and 15% in Queensland. Twenty-nine per cent of prescribers were not treating any clients on the snapshot day (Table S19).

Treatment varies between sectors

In 2017, methadone was the most commonly prescribed drug across all sectors (Table S12). However, prescribers in correctional facilities were far more likely to prescribe methadone (89% of clients) when compared with private (64%) and public prescribers (58%). Private prescribers were the most likely to prescribe buprenorphine-naloxone (23%) compared with public (21%) and correctional facility (3%) prescribers. Given that clients prescribed buprenorphine-naloxone in New South Wales are reported as receiving buprenorphine, the proportion of clients actually receiving buprenorphine-naloxone nationally is likely to be an underestimate.

Based on 2017 unit record data from 6 states and territories (excludes data from Victoria and Queensland) on a snapshot day, prescribers in correctional facilities were more likely to treat:

- Younger clients (Table S27)—correctional facilities treated clients aged between 30 and 39 years at almost twice the rate than that of public or private prescribers. Public and private prescribers treated similar client groups.
- Males (Table S28)—correctional facilities treated about 9 males for every female. Public and private prescriber types were generally similar in terms of the proportion of male and female clients treated, each treating about one-third as many males as females.

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Opioid pharmacotherapy dosing points

Clients attend a clinic or pharmacy (dosing point sites) regularly to take the dose of their prescribed medication under the supervision of a pharmacist or other health professional.

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection provides information on dosing sites providing pharmacotherapy drugs to clients on a snapshot day in June 2017. WA used a snapshot day in May 2017.

For more details about the collection, refer to the Technical notes.

Most dosing points are located in pharmacies

Nationally there were 2,732 dosing points in 2016–17 (see Table D1), a steady increase over the 10 years since 2007–08. Nearly 9 in 10 (89%) were located in pharmacies, which were the most common dosing point sites in all states and territories. These proportions are similar to previous years (see Table S17).

Table D1: Dosing point sites, states and territories, 2016–17

Dosing point sites	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Total	Total (%)
Public clinic	35	—	12	1	3	2	1	2	56	2.0
Private clinic	12	—	8	—	—	—	—	—	20	0.7
Pharmacy	773	594	493	256	198	61	32	17	2,424	88.7
Correctional facility	2	13	4	2	8	1	1	2	33	1.2
Other	78	33	83	2	—	1	2	—	199	7.3
Total	**900**	**640**	**600**	**261**	**209**	**65**	**36**	**21**	**2,732**	**100.0**
Total (%)	**32.9**	**23.4**	**22.0**	**9.6**	**7.7**	**2.4**	**1.3**	**0.8**	**100.0**	**. .**

Note:

— Nil or rounded to zero.

See the Technical notes for more information about NSW. NSW and WA correctional dosing points are reported as two sites.

The category 'other' includes hospitals, mobile dosing sites, community health clinics, non-government organisations, doctors' surgeries and dosing points 'not stated'.

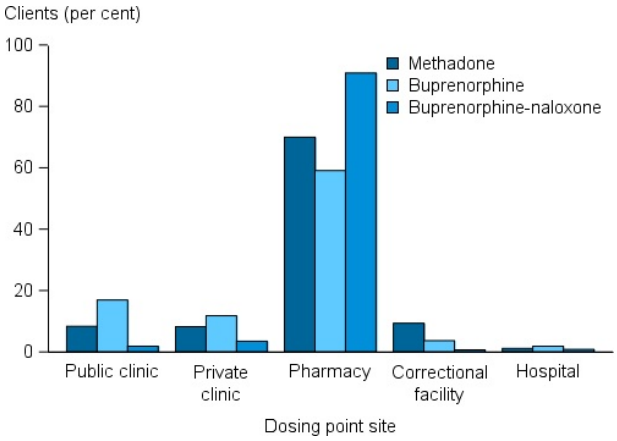
Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S17].

The proportion of clients taking each drug type varied between dosing points

Clients taking buprenorphine-naloxone were more likely to receive their dose at a pharmacy (91%) than clients taking methadone (70%) or buprenorphine only (59%). Clients who received their pharmacotherapy dose in correctional facilities were more likely to receive methadone (9% of total methadone dosed) than clients taking buprenorphine only (4% of total buprenorphine dosed) or buprenorphine-naloxone only (1% of total buprenorphine-naloxone dosed) (see Figure D1). These proportions have remained similar for about the last 5 years (Table S13).

The proportion of clients dosed with buprenorphine-naloxone may be higher than reported, as clients receiving this treatment in New South Wales are reported as receiving buprenorphine. (Refer to Table S14 for a further breakdown of clients by pharmacotherapy type, dosing points, and state and territory.)

Figure D1: Clients receiving pharmacotherapy on a snapshot day, by pharmacotherapy type and dosing point site, 2017



Note:

NSW reports 'buprenorphine-naloxone' as 'buprenorphine'.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S13].

As with prescriber types, the characteristics of the clients treated at particular dosing point sites are not uniform. Dosing points located in pharmacies treated an older client group (those aged 50 and over) in 2017 than other dosing point sites. The client groups dosed at public clinics and private clinics were similar (Table S29).

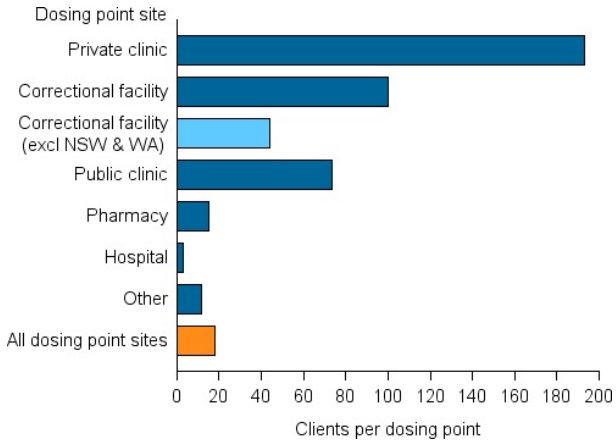
All dosing point sites (with the exception of 'other' which had an even split) treated more males than females, reflecting the overall proportion of males and females receiving pharmacotherapy treatment. The proportion of male clients ranged from 62% for pharmacy dosing points to 89% for correctional facility dosing points. The proportion of female clients ranged from 11% for correctional facility dosing points to 50% in other dosing points and 38% in pharmacy dosing points. Correctional facility dosing points dosed around 9 male clients for every female client (Table S30).

On a snapshot day in 2017, the large majority of clients dosed at public clinics were prescribed by public prescribers (8 in 10 clients). Likewise, almost all clients dosed at private clinics were dosed by private prescribers (9 in 10). For clients treated at pharmacies, about 3 in 10 were prescribed by public prescribers and about 7 in 10 by private prescribers (Table S31).

Dosing points dosed an average of 17 clients

Private clinics dosed, on average, almost 13 times as many clients as each pharmacy (193 clients per dosing point compared to 15) (see Figure D2). Correctional facilities dosed an average of 100 clients, but this number is inflated as New South Wales and Western Australia report all correctional dosing points as being under 2 sites each, rather than counting individual correctional dosing points. When New South Wales and Western Australian data are excluded, correctional facilities dosed an average of 42 clients across the jurisdictions that supplied data (Table S23).

Figure D2: Clients per dosing point site, on a snapshot day, 2017



Note:

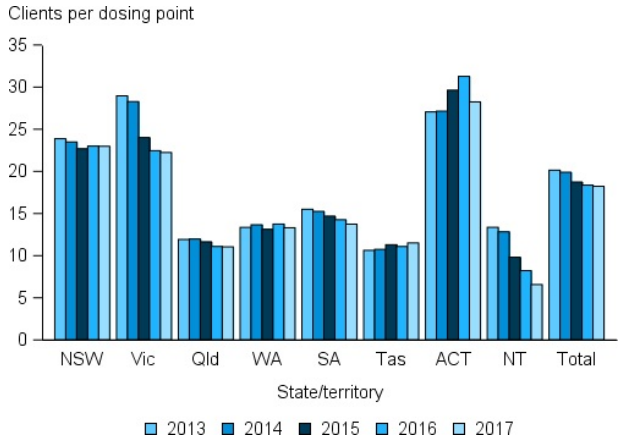
NSW and WA correctional dosing points are reported as two sites.

Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S23].

On a snapshot day in 2017, most (70%) dosing points treated between 1 and 20 clients with only 7% treating more than 50 clients. Thirty-five per cent of dosing points treated 1–5 clients, 18% treated 11–20 clients, and 17% treated 6–10 clients. The pattern of client numbers per dosing point varied greatly across the states and territories (Table S20).

In 2017, the average number of clients per dosing point was 18 (see Figure D3). The average has slowly declined each year since 2011 when it peaked at 21 (Table S21). The Australian Capital Territory had the highest ratio of clients per dosing point (28), while the Northern Territory had the lowest number of clients per dosing point (7) (see Figure D3).

Figure D3: Clients per dosing point site, states and territories, 2013 to 2017

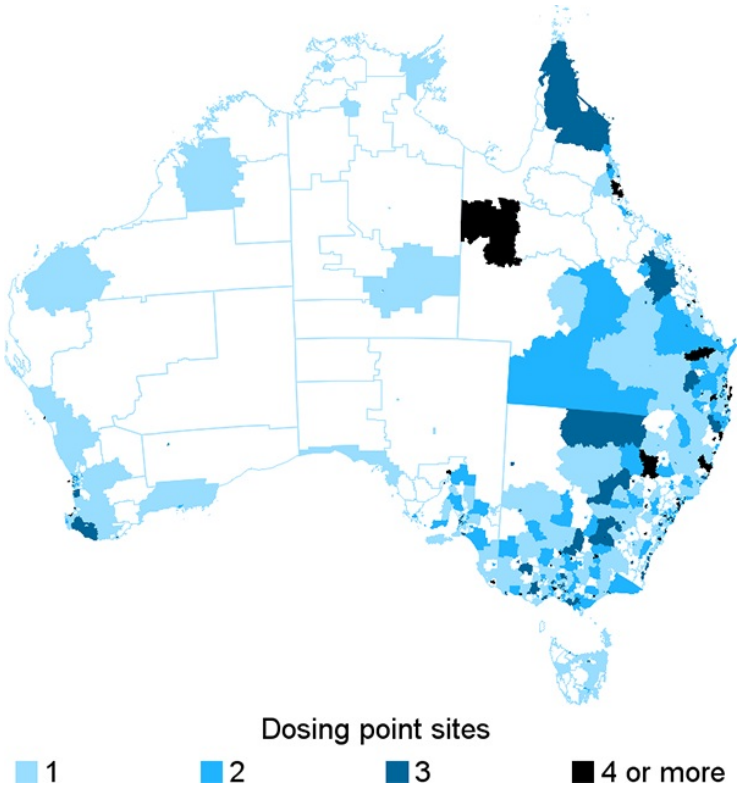


Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection. Data table [Table S21].

Dosing points were located mainly in *Major cities*

Figure D4 shows the distribution of dosing point sites across the states and territories in 2017. The majority of dosing points were located in *Major cities*. However, when taking the population into account, there were 12 dosing points per 100,000 population in *Very remote* areas, compared to 10 dosing points per 100,000 population in *Major cities*. The rate of dosing points per 100,000 population increased with increasing remoteness in New South Wales and Victoria (Table S18).

Figure D4: Dosing point sites, by Statistical Areas Level 2, 2017



Source: National opioid pharmacotherapy statistics annual data (NOPSAD) 2017 collection.

Last updated 7/03/2018 v11.0

Notes

Technical notes | 09 Apr 2018

Age

Age is calculated as at 30 June of the collection year.

Agency remoteness area

Dosing points have been classified according to their remoteness area (RA) as defined by the Australian Statistical Geography Standard (ASGS) Remoteness Structure [1]. This structure allows areas that share common characteristics of remoteness to be classified into broad geographic regions of Australia. These areas are:

- *Major cities*
- *Inner regional*
- *Outer regional*
- *Remote*
- *Very remote*.

The Remoteness Structure divides each state and territory into several regions on the basis of their relative access to services.

Examples of places that are considered *Major cities* in the ASGS classification include Sydney, Canberra and Newcastle. Hobart and Bendigo are *Inner regional* areas and Cairns and Darwin are *Outer regional* areas. Katherine and Mount Isa are *Remote areas* and Tennant Creek and Meekatharra are *Very remote*.

Using this classification, dosing points were assigned to an RA based on their recorded Statistical Areas Level 2 (SA2) code.

Some SAs are split between multiple remoteness areas. Where this was the case, the data were weighted according to the proportion of the population of the SA2 in each remoteness area.

Average annual rates of change

The average annual rates of change or growth rates have been calculated as geometric rates:

Average rate of change = ((Pn/Po)^(1/n) -1) x 100

where:

Pn= value in the later time period

Po= value in the earlier time period

n = number of years between the 2 time periods.

Confidentiality

The Australian Institute of Health and Welfare (AIHW) has strict confidentiality policies which have their basis in section 29 of the *Australian Institute of Health and Welfare Act 1987* (the AIHW Act) and the *Privacy Act 1988* (the Privacy Act). Cells in supplementary tables may be suppressed for either confidentiality reasons or where estimates are based on small numbers, resulting in low reliability. Information that results in attribute disclosure will be suppressed unless agreement from the particular data provider to publish the data has been reached. Information on the AIHW's Privacy policy is available on the privacy page.

Population estimates used for rates calculations

All rates in this report, including historical rates, have been calculated using population estimates based on the 2011 Census. All Indigenous rates in this report are calculated using the Indigenous population estimates and projections, based on the 2011 Census.

Population rates

Crude rates are calculated using the Australian Bureau of Statistics estimated resident population (ERP) as at 30 June of each collection year. Rates for 2017 data were calculated using the preliminary ERP at 30 June 2017, with the exception of remoteness rates which were calculated using the preliminary ERP at 30 June 2016.

Trends

Trend data may differ from data published in previous versions of *National opioid statistics in Australia* due to data revisions.

Data collection by states and territories | 09 Apr 2018

State and territory governments use different methods to collect data about the clients, prescribers and dosing points associated with the opioid pharmacotherapy system. These methods are driven by differences between the states and territories in relation to legislation, information technology systems and resources. Caution should be taken when comparing one state or territory with another. Information on these differences is detailed in the following tables:

- Table T1—Administrative features of the NOPSAD collection in each state and territory
- Table T2—Methodological differences for the NOPSAD collection in each state and territory
- Table T3—Policies and guidelines for opioid pharmacotherapy
- Table T4—History of data reported for the NOPSAD collection, 2005 to 2016.

Table T1: Administrative features of the NOPSAD collection in each state and territory

State/territory	Administrative features
New South Wales	Treatment for a client under the NSW Opioid Treatment Program (OTP) must be initiated by an accredited OTP prescriber. A NSW medical practitioner who has not received accreditation as a NSW OTP prescriber may be authorised by the Ministry of Health to prescribe methadone or buprenorphine for up to 5 'stable' clients; that is, a client may be transferred to them, but they cannot induct a person onto treatment. To participate in the NSW OTP, community pharmacies must register with the Ministry of Health and comply with the protocol for community pharmacy dosing points issued by the Ministry.
Victoria	The Victorian pharmacotherapy system is essentially community-based, other than inpatients in hospitals and in prisons. Although a small number of services receive government funding, services are independent bodies and the government does not manage them directly. Since the release of the 2013 policy, general practitioners have been able to prescribe buprenorphine-naloxone for up to 5 patients without the need to attend specific training (Vic Health 2013). Victoria's *Policy for maintenance pharmacotherapy for opioid dependence* was revised in 2016.
Queensland	The Queensland Opioid Treatment Program is essentially community based, other than inpatients in hospitals and correctional facilities. Prescribers attend training provided by Medicines Regulation and Quality Unit (Queensland Department of Health) and the Chief Executive Officer provides authorisation to commence prescribing on successful completion of the training program. Prescriber training is provided for all pharmacotherapies currently available.
Western Australia	The Western Australian pharmacotherapy program is community-based, other than inpatients in hospitals, prisons and the public clinic. Prescribers attend training provided by the Mental Health Commission (MHC) and the Chief Executive Officer of Health provides authorisation under the *Medicines and Poisons Regulations 2016*, the legislative instrument. Prescriber training is provided for all pharmacotherapies currently available and now includes prescriber training for practitioners wishing to prescribe Suboxone® to up to 5 patients. Community pharmacies are authorised to participate in the Community Program for Opioid Pharmacotherapy (CPOP). The Pharmacist with overall responsibility is required to ensure that all pharmacists dosing clients have completed the pharmacist online training module on the MHC website.
South Australia	In 2011 a program to allow any medical practitioner to prescribe buprenorphine-naloxone film for up to 5 patients for the treatment of opioid drug dependence was introduced. This program is known as the Suboxone® Opioid Substitution Program (SOSP). Authorities granted by the Drugs of Dependence Unit are still required to be held before starting treatment with buprenorphine-naloxone, and the usual program rules for all pharmacotherapy programs remain in force. Buprenorphine-naloxone film is the only drug option authorised for this program. A prescriber can treat up to 5 patients with buprenorphine-naloxone film before having to undertake accreditation by Drug and Alcohol Services South Australia and formal approval by the Drugs of Dependence Unit to be an accredited prescriber via the Opioid Dependence Substitution Program (ODSP). A prescriber cannot provide treatment with buprenorphine alone or methadone liquid without first being accredited.
Tasmania	In Tasmania, pharmacotherapy training is provided separately for each pharmacotherapy drug.
Australian Capital Territory	All pharmacists are required to attend training in 'Risk Management of the Process of Dosing Opioid Dependent Consumers' before they start dosing clients. The Canberra Hospital Pharmacy Services conducts this training.
Northern Territory	Accredited prescribers complete an 'Application for authority to prescribe a restricted Schedule 8 substance for the treatment of addiction' and submit the form with a photograph of the client to the Department of Health, Medicines and Poisons Control. A contract between the client, prescriber and supplying pharmacy is also required for all applications for maintenance treatments. The application information is recorded in the Drug Monitoring System database. The prescriber is not permitted to prescribe until they receive a signed authorisation document. The prescriber must notify Medicines and Poisons Control within 14 days of cessation of treatment.

Table T2: Methodological issues of note for the NOPSAD collection in each state and territory

State/territory	Methodological issues
National	While the standard snapshot day is set in June of any given year, it varies between states and territories. Despite this variance, it allows the number of clients to be estimated at a single point in time. Data collected for a snapshot day are likely to result in an underestimate of total clients receiving pharmacotherapy within a year. In general, all clients receiving their pharmacotherapy dose in person on the snapshot day are counted.
New South Wales	The NSW Electronic Recording and Reporting of Controlled Drugs (ERRCD) system is used in the administration of the New South Wales Opioid Treatment Program. It replaced the legacy Pharmaceutical Drugs of Addiction System (PHDAS) in September 2016. The ERRCD system is used to record authorisations to prescribe as part of the New South Wales Opioid Treatment Program. It also records client admissions to, and exits from, treatment, as well as details of prescribers and dosing points. For these reasons, the ERRCD system is characterised by continual fluctuations and data extracted at different times for the same period may not be the same. However, while delays in reporting entries to the program, exits from the program and changes in the status of dosing points cause short-term fluctuations in the database, these flatten out over time. Clients prescribed buprenorphine-naloxone are counted under 'buprenorphine'. Similarly, New South Wales data collection does not differentiate between prescribers who are authorised to prescribe buprenorphine and those authorised to prescribe buprenorphine-naloxone. Data on prescribers refer to prescribers who were treating at least 1 client on the snapshot day. Data on dosing point sites relate to sites that had at least 1 client receiving treatment on the snapshot day. Client data are reported in New South Wales as at 30 June.
Victoria	Data are collected from 2 sources: a yearly census of pharmacists who are requested to report the actual number of clients being dosed on a snapshot day, and the permit database, which records information about prescribers authorised to prescribe pharmacotherapy drugs, as well as demographic information about clients accessing pharmacotherapy treatment. These 2 data sources cannot be linked. The number of clients receiving pharmacotherapy treatment is reported on a snapshot day in June. The number of prescribers in Victoria is determined by adding the number of prescribers registered for that year to the number of existing prescribers. Victoria does not provide data for age and sex by individual pharmacotherapy drug type. Age and sex data for all pharmacotherapy drugs (combined) were are provided. Prior to 2013, Victoria estimated these data. Victoria has commenced collecting the Indigenous status of clients. Data for 2016 and 2017 included Indigenous status for totals. Client data are reported in Victoria on a snapshot day in June.
Queensland	Data are collected monthly from pharmacists and entered into a central database that Medicines Regulation and Quality manages. Data are also collected from administrative 'Admission' and 'Discharge' forms. Queensland totals may vary slightly due to these data source differences. For example, a client may be counted as registered and having received a dose on the snapshot day, but a dosing point cannot be assigned because the dose consumed on that day was a takeaway dose. The total number of prescribers for Queensland includes those from private practice, public clinics, correctional facilities and government medical offices. Client data are reported in Queensland on a snapshot day in June.
Western Australia	Data are collected from the monthly reports received from pharmacies and other dosing sites authorised to participate in the Community Program for Opioid Pharmacotherapy (CPOP). The dosing data are entered into the Medicines and Poisons Regulation Branch's Monitoring of Drugs of Dependence System (MODDS) database. Data are also collected from the 'Application for authority', 'Authority to prescribe' and 'Termination of treatment' forms. The number of clients receiving pharmacotherapy treatment is reported through the month of June. The total number of prescribers usually includes those treating at least 1 client as at 30 June 2017 in private practice, public clinics and correctional facilities. In Western Australia, data relating to the Indigenous status of clients is now being collected from new 'Application to prescribe opioid substitution treatment' forms but not at the time of renewal for patients continuing in treatment. Client data are usually reported in Western Australia for the entire month of June. Specifically, pharmacies supply information at the end of June relating to the last dose supplied to the patient for the month of June. If a patient changes pharmacies mid-month, it is possible that they appear on more than 1 pharmacy's monthly transaction reports and are counted more than once. In 2017 data for WA were reported for the month of May. Before 2005, Western Australia reported clients over a year.

South Australia	Data are collected from the forms 'Application for authority', 'Termination of treatment' and 'Request for additional methadone/buprenorphine takeaway', which are entered into a central database system at the Drugs of Dependence Unit, SA Health. Information from dispensed prescriptions is also collected electronically from the majority of pharmacies on a monthly basis by the Drugs of Dependence Unit. From 2011, data have been collected via a half-yearly survey that pharmacists completed and reported on a snapshot day in June. From 2014, this survey has been conducted annually. Other data are drawn from the Drugs of Dependence Unit's Drugs of Misuse Surveillance System and are about those clients registered for treatment on the snapshot day (but who may not actually receive treatment on that day). Clients who did not enter a dosing point on the snapshot day are reported as 'other' when describing clients by dosing point site. All tables include Opioid Dependence Substitution Program (ODSP) and Suboxone® Opioid Substitution Program (SOSP) clients and prescribers. In South Australia, data relating to prescribers refer to prescribers who were treating at least 1 client on the snapshot day.
Tasmania	Data are collected monthly from all pharmacies participating in the Tasmanian Opioid Pharmacotherapy Program (TOPP), and entered into the Drugs and Poisons Information System (DAPIS). This system is administered by the Pharmaceutical Services Branch (PSB) and manages client registration, dosing activity, dosing sites, authority to prescribe and dispensing information relating to drugs of high abuse potential. The system also makes available limited information to relevant medical practitioners and pharmacists, both within and external to the Department to assist safe treatment of patients requiring drugs of a high abuse potential. Data from DAPIS are made available for management style reporting from a Qlikview-based intranet dashboard. Client data in Tasmania are reported from a snapshot for the month of June. However, clients are counted only once—if they change dosing point site during the month, the dosing point site that administered the greater number of doses is attributed the activity. Data on prescribers refer to prescribers who were treating at least 1 client during the month of June. Data on dosing points refer to dosing points that had a client receiving treatment during the month of June.
Australian Capital Territory	Client participation data are collected manually from the Health Directorate's Alcohol and Drug Services spreadsheets and from Medication Administration Chart (MAC) Sheets which the community pharmacies provide every month. Client participation data are also collected via iDose which is an in-house database that contains client dosing information in real time. General practitioner and pharmacy participation data are also collated from the MAC Sheets. Client data are reported on clients receiving treatment in the Australian Capital Territory on a snapshot day in June.
Northern Territory	Data are generated from the current active authorisations in the Drug Monitoring System database on the snapshot day in June. The data are audited against current Schedule 8 prescription data also within the database.

Table T3: Policies and guidelines for opioid pharmacotherapy

State/territory	Policies and guidelines
National	◦ National pharmacotherapy policy for people dependent on opioids 2007
New South Wales	◦ Opioid Treatment Program: Clinical guidelines for methadone and buprenorphine treatment of opioid dependence 2006
Victoria	◦ Policy for maintenance pharmacotherapy for opioid dependence
Queensland	◦ Queensland Opioid Treatment Program: clinical guidelines 2012
Western Australia	◦ Western Australian Community Program for Opioid Pharmacotherapy (CPOP): clinical policies and procedures for the use of methadone and buprenorphine in the treatment of opioid dependence—3rd Edition ◦ Operational Directive 0598/15 Management of Community Program for Opioid Pharmacotherapy (CPOP) patients in a hospital setting
South Australia	The following documents are available via the SA Opioid Dependence Substitution Program:
Tasmania	◦ Tasmanian Opioid Pharmacotherapy Policy and Clinical Practice Standards
Australian Capital Territory	◦ The ACT Opioid Maintenance Treatment Guidelines
Northern Territory	◦ Code of Practice: Schedule 8 Substances

Table T4: History of data reported for the NOPSAD collection, 2005 to 2017

Table T4 (45KB XLS)

Glossary | 09 Apr 2018

Concept	Definition
Buprenorphine (Subutex®)	Buprenorphine acts in a similar way to methadone, but is longer lasting and may be taken daily or every second or third day. Two buprenorphine preparations are registered in Australia for the treatment of opioid dependence: a product containing buprenorphine only, and a combined product containing buprenorphine and naloxone. The buprenorphine only product is available as a tablet containing buprenorphine hydrochloride that is administered sublingually (by dissolving under the tongue) [3].
Buprenorphine-naloxone (Suboxone®)	The combination buprenorphine-naloxone product is a sublingual tablet or film containing buprenorphine hydrochloride and naloxone hydrochloride [1]. It is recommended that buprenorphine-naloxone should be prescribed in preference to buprenorphine for most clients [3]. This is because, when taken as intended by dissolving the tablet or film under the tongue, the combined product acts as if it was buprenorphine alone. However, if the combined product is injected, naloxone can block the effects of buprenorphine and increases opioid withdrawal symptoms. This reduces the risk that those receiving buprenorphine naloxone as a takeaway dose will inject it or sell it to others to inject [2, 3, 4].
client	A person registered as receiving opioid pharmacotherapy treatment on the snapshot day.
correctional facility prescribers	Prescribers who work in prisons or other correctional services.
dosing point site	A place at which a client is provided a pharmacotherapy drug. Sites include public and private clinics (such as methadone clinics), pharmacies, correctional facilities, hospitals (admitted patients and outpatients) and other locations such as community health centres and doctors' surgeries.
Methadone (Methadone Syrup®, Biodone Forte®)	A synthetic opioid used to treat heroin and other opioid dependence. It reduces opioid withdrawal symptoms, the desire to take opioids and the euphoric effect when opioids are used. It is taken orally on a daily basis [3].
prescriber	A prescriber who held an authority to prescribe a pharmacotherapy drug and who has not been recorded as ceasing this authority before the snapshot day. See the Technical notes for information about the counting of prescribers for each state and territory.
prescriber type	The sector (public or private) in which the prescriber is practising when prescribing pharmacotherapy drugs.
private prescribers	Prescribers who work in organisations that are not controlled by government, such as private general practice clinics.
public prescribers	Prescribers who work in organisations that are part of government or are government controlled, such as public drug and alcohol clinics and public hospitals.
Schedule 4 drug	**Prescription only medicine**—substances, the use or supply of which, should be by, or on the order of, persons permitted by State or Territory legislation to prescribe and should be available from a pharmacist on prescription.
Schedule 8 drug	A **controlled drug**—substances which should be available for use but require restriction of manufacture, supply, distribution, possession and use to reduce abuse, misuse and physical or psychological dependence. Methadone and buprenorphine are examples of Schedule 8 drugs.
specified or snapshot day	A particular day, usually in June each year, on which clients are counted for the NOPSAD collection. The snapshot day varies between states and territories, but allows the number of clients to be estimated at a single point in time. See the Technical notes for information about the use of the snapshot day for each state and territory.

References

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- Department for Health and Ageing, South Australia
- Department of Health and Human Services, Tasmania
- Health Directorate, Australian Capital Territory
- Department of Health, Northern Territory.

Data quality statement

National Opioid Pharmacotherapy Statistics Annual Data collection, 2017

Last updated 15/03/2018 v5.0

Data

Index of supplementary data tables

The following table provides a guide to the range and location of information available in the supplementary tables.

Grouping	Characteristic
Clients	Pharmacotherapy type Prescriber type Dosing point type Age Sex Indigenous status Opioid drug of dependence Client status Population rates
Prescribers	Prescriber type Pharmacotherapy type
Dosing points	Dosing point type Remoteness area

Data tables: Tables S1–S31 NOPSAD 2017

Data tables: Tables S1–S31 NOPSAD 2017
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