



Australian Government

**Australian Institute of
Health and Welfare**

Alcohol and other drug treatment services in Australia 2014–15

DRUG TREATMENT SERIES NO. 27



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Health and Welfare**

*Authoritative information and statistics
to promote better health and wellbeing*

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Number 27

Alcohol and other drug treatment services in Australia

2014–15

Australian Institute of Health and Welfare
Canberra

Cat. no. HSE 173

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This publication is part of the Australian Institute of Health and Welfare's Drug treatment series. A complete list of the Institute's publications is available from the Institute's website <www.aihw.gov.au>.

ISSN 2205-5088 (PDF)

ISSN 1447-6746 (Print)

ISBN 978-1-74249-938-3 (PDF)

ISBN 978-1-74249-939-0 (Print)

Suggested citation

Australian Institute of Health and Welfare 2016. Alcohol and other drug treatment services in Australia 2014–15. Drug treatment series no. 27. Cat. no. HSE 173. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

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Please note that there is the potential for minor revisions of data in this report. Please check the online version at <www.aihw.gov.au> for any amendments.

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Acknowledgments

The authors of this report were Kristina Da Silva, Mark Petricevic and Melinda Petrie from the Tobacco, Alcohol and Other Drugs Unit of the Australian Institute of Health and Welfare. Rachelle Graham assisted with data analysis and Tim Beard, Moira Hewitt and David Whitelaw provided essential advice and guidance. The contributions, comments and advice of the Alcohol and Other Drug Treatment Services National Minimum Data Set Working Group are gratefully acknowledged.

The AIHW thanks the numerous alcohol and other drug treatment service agencies that provided data for this report. Without the cooperation of the staff in these agencies in each state and territory, this data collection and report would not be possible.

The Australian Government Department of Health provided funding for this report.

Thanks are extended to the data managers and staff in the following departments:

- Department of Health, Australian Government
- Ministry of Health, New South Wales
- Department of Health, Victoria
- Department of Health, Queensland
- Mental Health Commission, Western Australia
- Department of Health, South Australia
- Department of Health and Human Services, Tasmania
- Health Directorate, Australian Capital Territory
- Department of Health, Northern Territory.

Abbreviations

AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
ERP	estimated resident population
MDMA	3,4-methylenedioxy-N-methylamphetamine (or ecstasy)
NDSHS	National Drug Strategy Household Survey
NGOTGP	Non-Government Organisation Treatment Grants Program
OSR	Online Services Report
SA2	Statistical Area level 2
SLK	statistical linkage key

Notes

Components of tables may not sum to totals due to rounding.

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia* due to data revisions.

Supplementary tables referred to in this report (tables with the prefix 'S') are available for download from <<https://www.aihw.gov.au/publications/>>.

Summary

Alcohol and other drug (AOD) treatment services across Australia provide a broad range of treatment services and support to people using drugs, and to their families and friends. This report presents the information for 2014–15 about publicly funded AOD treatment service agencies, the people they treat and the treatment provided. Between 2012–13 and 2014–15, the estimated number of clients who received treatment increased by 6%. Of those clients who received treatment in 2014–15, 11% also received treatment in 2013–14.

1 in 200 people in Australia received treatment

An estimated 114,912 clients received treatment in 2014–15. This equates to a rate of 558 clients per 100,000 people, or about 1 in 200 people in the general population. About 2 in 3 clients were male (67%) and 1 in 2 were aged 20–39 (54%). Despite only comprising 2.7% of the population, 1 in 7 (15%) clients were Aboriginal and Torres Strait Islander. This is a rate of 3,140 Indigenous clients per 100,000 Indigenous people, compared with 457 non-Indigenous clients per 100,000 non-Indigenous people.

Treatment agencies provided a total of 170,367 treatment episodes – an average of 1.5 episodes per client – and 4 in 5 (79%) episodes ended within 3 months.

Treatment for alcohol still most common, but increasing for amphetamines

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs of concern for clients since 2005–06. Nationally, alcohol was the most common principal drug of concern in 2014–15, accounting for 38% of episodes. For clients aged 30 and over, alcohol was the most common principal drug of concern, while for clients aged 10–29, cannabis was the most common.

Since 2010–11, the proportion of episodes where alcohol was the most common principal drug of concern has decreased (from 48% to 38%), while the proportion of episodes for amphetamines increased (from 8.7% to 20%). The number of episodes for clients injecting and smoking/inhaling amphetamines has also increased, with more than 6 times as many clients smoking/inhaling in 2014–15 as in 2010–11.

Most clients have more than 1 drug of concern

In more than half (54%) of treatment episodes, the client also reported additional drugs of concern. Just under one-third (28%) had 1 additional drug of concern and 15% had 2 drugs. Nicotine and cannabis were the most common additional drugs of concern.

Counselling continues to be the most common type of treatment

Since 2005–06, the proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management and assessment only being the most common types of treatment. Counselling continues to be the most common main treatment type provided for clients (2 in 5 episodes since 2005–06).

1 Introduction

Alcohol and other drug (AOD) treatment services assist people to address their drug use through a range of treatments. Many types of treatment are available in Australia. Most aim to reduce the harm of drug use, while some use a structured drug-free setting with abstinence-oriented interventions to help prevent relapse and develop skills and attitudes that assist clients to make changes leading to drug-free lifestyles (AIHW 2011).

1.1 Drug use in Australia

Drug use can be either licit or illicit (see Glossary for definitions). Licit and illicit use of drugs is a significant issue in Australia and has a substantial societal cost, estimated at \$56 billion in 2004–05, of which \$8 billion was for illicit drug use (Collins & Lapsley 2008). In 2011, the cost of treatment for illicit drug use – including amphetamines, cannabis, cocaine, ecstasy or opioids – was estimated at \$298 million (Smith et al. 2014).

The 2013 National Drug Strategy Household Survey (NDSHS) found that alcohol and tobacco were the most common drugs used in Australia, with 78% of Australians aged 14 and over drinking alcohol in the previous 12 months and 13% smoking tobacco daily (AIHW 2014). Nearly 1 in 5 (18%) people drank at levels that put them at increased risk of harm over their lifetime (more than 2 standard drinks per day on average), while 26% of people drank at least once a month at levels that put them at risk of accident or injury (more than 4 standard drinks in a session).

Although less prevalent than the use of licit drugs, illicit drug use is still relatively common. In 2013, about 2 in 5 people (42%) aged 14 and over reported using illicit drugs in their lifetime, while 1 in 7 (15%) reported using illicit drugs within the previous 12 months (AIHW 2014). Cannabis was the most commonly used illicit drug – more than 1 in 3 (35%) Australians aged 14 and over had used cannabis in their lifetime, while 1 in 10 (10%) had used it in the previous 12 months. Ecstasy and hallucinogens were the second and third most common (11% and 9.4%, respectively) for lifetime use, while pain-killers (analgesics) for non-medical purposes and ecstasy were the second and third most common for recent use (3.3% and 2.5%, respectively).

1.2 National Drug Strategy

Australia has had a coordinated approach to dealing with alcohol and other drugs since 1985. The National Drug Strategy 2010–2015, is the latest cooperative strategy between the Australian Government, state and territory governments and the non-government sector. It has an overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (MCDS 2011):

- demand reduction to prevent and reduce the use of drugs, support people to recover from dependence and support efforts to promote social inclusion and resilient individuals, families and communities
- supply reduction to reduce the supply of illegal drugs and control and manage the supply of alcohol, tobacco and other legal drugs
- harm reduction to reduce harms to individuals, families and community safety.

Harm reduction actions in the strategy include enhancing treatment ‘across settings to provide help at all stages of drug use, particularly for disadvantaged populations’, preventing drug overdoses through the use of ‘substitution therapies, withdrawal treatment and other pharmacotherapies’ and continuing drug diversion programs (MCDS 2011).

1.3 Alcohol and other drug treatment services

AOD treatment services assist people to address their drug use through a range of treatments. Treatment objectives can include reduction or cessation of drug use, as well as improving social and personal functioning. Assistance may also be provided to support the family and friends of people using drugs. Treatment services include detoxification and rehabilitation, counselling, and pharmacotherapy and are delivered in residential and non-residential settings.

In Australia, publicly funded treatment services for AOD use are available in all states and territories. Most of these services are funded by state and territory governments, while some are funded by the Australian Government. Information on publicly funded AOD treatment services in Australia, and the people and drugs treated, are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). The AODTS NMDS is one of a number of NMDSs mandated for collection under the 2012 National Healthcare Agreement to inform policy and help improve service delivery (COAG 2012).

Other available data sources that support a more complete picture of AOD treatment in Australia include:

- the National Opioid Pharmacotherapy Statistics Annual Data collection <<http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/>>
- the National Hospital Morbidity Database <<http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/drug-related-hospitalisations/>>
- the Online Services Report Database <<http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/treatment-by-indigenous-health-organisations/>>
- the Specialist Homelessness Services collection <<http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/homelessness-services/>>
- the National Prisoner Health Data collection <<http://www.aihw.gov.au/prisoner-health/>>.

1.4 The AODTS NMDS

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government organisations. Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed (see the Glossary for definition). The following types of treatment are examined in this report: assessment only, counselling, information and education only, pharmacotherapy, rehabilitation, support and case management only and withdrawal management (see the Glossary for definitions). The AODTS NMDS collects data about services provided to people who are seeking assistance for their own drug use and those seeking assistance for someone else’s drug use.

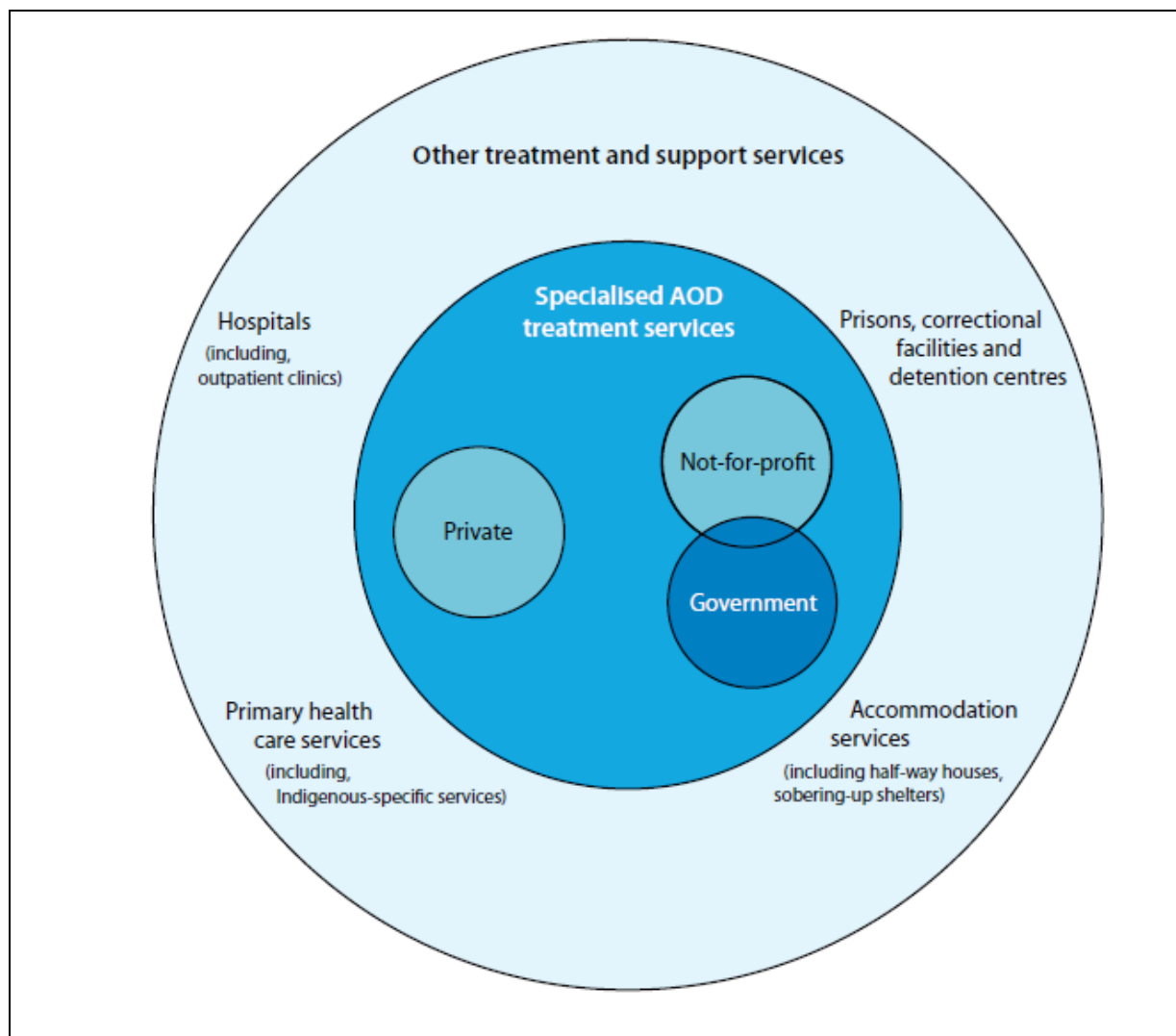
The AODTS NMDS does not contain a unique identifier for clients and information about clients is collected at the episode level. From 2012–13, a statistical linkage key (SLK) was introduced to the collection. Although the SLK is not a unique identifier, it enables the number of clients receiving treatment to be estimated, while continuing to ensure their privacy. In previous reporting years SLK data were not available for all clients and, as such, an imputation strategy was developed to estimate the number of clients and facilitate reporting at the client level. For 2014–15, imputation was not required. Further details on the imputation methodology can be found online <www.aihw.gov.au/publication-detail/?id=60129554768>.

Data are collected by treatment agencies who forward these data to state and territory government health departments who extract required data according to the specifications in the AODTS NMDS. Data are submitted to the AIHW on an annual basis for national collation and reporting.

Coverage and data quality

Although, the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government organisations, it is difficult to fully quantify the scope of AOD services in Australia. There are a variety of settings in which people receive treatment for alcohol and other drug-related issues that are not in scope for the AODTS NMDS. These include: services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding; hospitals, including admitted patient services, outpatient clinics and emergency departments; prisons, correctional facilities and detention centres; primary health-care services, including GP settings, community-based care and Indigenous-specific primary health-care service and dedicated substance use services; health promotion services (for example needle and syringe programs); and accommodation services (for example, half-way houses and sobering-up shelters) (Figure 1.1).

In addition, agencies whose sole function is prescribing or providing dosing services for opioid pharmacotherapy are also excluded from the AODTS NMDS. These agencies are excluded because of the multi-faceted nature of service delivery in this sector; however, these data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection <<http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/>>.



Note: Those in scope for the AODTS NMDS are shaded darker.

Figure 1.1: AOD treatment and support services in Australia

Australian Government-funded primary health-care services and substance-use services specifically aimed at Indigenous Australians are in scope for the AODTS NMDS, but most of these agencies do not contribute to the collection because they currently provide data to the Online Services Report (OSR) collection. To minimise reporting burden, agencies reporting to the OSR do not usually also report to the AODTS NMDS (see online <<http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/treatment-by-indigenous-health-organisations/>> for the latest data).

In 2014–15, over 96% (843) of in-scope agencies submitted data to the AODTS NMDS. Overall, there was a decrease of 3.2 percentage points between 2013–14 and 2014–15 in the proportion of in-scope agencies that reported to the collection. For the 2014–15 reporting period specifically, sector reforms and system issues in some jurisdictions affected the number of in-scope agencies that reported. These have led to an under-count of the number of closed treatment episodes reported for this year and results, especially across reporting years, need to be interpreted with caution.

In addition, several factors can contribute to changes in the number of agencies reporting between years. As well as changes in the number of in-scope agencies, some jurisdictions

may change data collection approaches, such as moving from collecting data at an administrative or management level to a service outlet level.

Data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between jurisdictions. In addition, the AODTS NMDS has been implemented in stages, and comparisons across years, particularly the earlier years of the collection, should be made with caution.

The AODTS NMDS reports on both main and additional treatment types. However, Victoria and Western Australia do not differentiate between main and other treatment types. Caution should be used in comparing episodes from these states with those of other states and territories. Despite variations in reporting practices between jurisdictions, there is very little difference between the proportions for principal drug of concern and all drugs of concern when these 3 jurisdictions are excluded from the analysis. For example, the top 4 drugs of concern remain the same in relative size and order.

Further details on scope, coverage and data quality is available from the Data Quality Statement <<http://meteor.aihw.gov.au/content/index.phtml/itemId/637860>> for the AODTS NMDS and online <<http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/aodts-nmds/>>.

1.5 Report structure

Chapter 1 (this chapter) provides background information about AOD treatment services in Australia, the AODTS NMDS, and the context in which these data are reported.

Chapter 2 provides an overview of findings from the 2014–15 AODTS NMDS.

Chapter 3 presents data on AOD treatment agencies.

Chapter 4 provides information on the drugs of concern for which people receive treatment.

Chapter 5 examines the type of treatment provided, including the characteristics of clients and episodes, and the type and outcome of treatment.

One appendix is included in this report:

- **Appendix A** – Information about the data and methods.
- **Glossary**

The following online information accompanies this report:

- scope, coverage and data quality <<http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/aodts-nmds/>>
- data quality statement <<http://meteor.aihw.gov.au/content/index.phtml/itemId/637860>>
- imputation methodology for AODTS clients <www.aihw.gov.au/publication-detail/?id=60129554768>
- state and territory summaries <www.aihw.gov.au/publication-detail/?id=60129554768>
- supplementary data tables (those with a prefix of 'S' in the report) <www.aihw.gov.au/publication-detail/?id=60129554768>.

2 At a glance

This chapter provides an overview of results from the AODTS NMDS for 2014–15.

2.1 Key facts

In 2014–15:

- A total of 843 publicly funded agencies provided data about services for clients seeking treatment services and support.
- An estimated 114,912 clients aged 10 and over received treatment – about 1 in 20 people in Australia.
- Most clients (85% received treatment at 1 agency; the remainder received treatment from 2 or more.
- About 2 in 3 clients were male (67%) and just over half were aged 20–39 (54%).
- Treatment agencies provided a total of 170,367 closed treatment episodes.
- The main drug that led clients to seek treatment was alcohol, followed by cannabis, amphetamines and heroin (which was consistent for Indigenous and non-Indigenous clients), and for the majority of these, clients received treatment in a non-residential facility.
- Counselling was the most common treatment type (40%).
- About 4 in 5 (79%) closed treatment episodes ended within 3 months.
- The most common age group for clients seeking treatment for pharmaceuticals as a principal drug of concern were aged 30–49 (63%).
- Nationally, over one-quarter (26%) of clients were diverted from the criminal justice system into AOD treatment.

Over the 5-year period to 2014–15:

- The number of publicly funded agencies providing data about services for clients seeking treatment services and support increased by 27%.
- The number of closed treatment episodes increased from 150,488 to 170,367 (a 13% increase).
- Alcohol continued to be the most common drug leading clients to seek treatment.
- Treatment for the use of amphetamines increased (from 8.7% to 20%).

2.2 Agencies

In 2014–15, a total of 843 publicly funded AOD treatment agencies provided data about services for clients seeking treatment services and support, an increase of 27% over the 5-year period from 2010–11. Over half (58%) of treatment agencies were non-government, and these agencies provided almost two-thirds (63%) of closed treatment episodes. Nationally, nearly three-fifths (58%) of treatment agencies were located in *Major cities* and

almost one-quarter (22%) in *Inner regional* areas. Relatively few agencies were in *Remote* or *Very remote* areas (3.8% and 3.2%, respectively) (tables SA.1–SA.3).

2.3 Clients

In 2014–15, 114,912 clients aged 10 and over received treatment from publicly funded AOD treatment agencies across Australia. This equates to a rate of 558 clients per 100,000 people, or about 1 in 200 people in the general population. These clients received over 170,000 treatment episodes (Table 2.1). Between 2012–13 and 2014–15, the number of estimated clients rose from 109,021 to 114,912, a 5% increase overall. Despite only comprising 2.7% of the population, 1 in 7 (15%) clients were Aboriginal and Torres Strait Islander. This is a rate of 3,140 Indigenous clients per 100,000 Indigenous people, compared with 457 non-Indigenous clients per 100,000 non-Indigenous people (Table SC.26).

Clients' own drug use and someone else's drug use

Clients can receive treatment for their own or someone else's drug use (see the Glossary for further details). In 2014–15, around 109,000 clients received treatment for their own drug use, and around 6,069 received treatment in relation to someone else's drug use (Table 2.1). A small proportion (0.6% clients) of clients received both treatment for their own drug use and support for someone else's drug use in 2014–15.

In 2014–15, clients seeking treatment for their own drug use received an average of 1.5 treatment episodes (Table 2.1). This was lower for clients receiving treatment for someone else's drug use (an average of 1.3 episodes).

Table 2.1: Clients^(a), episodes and rates, by client type and state and territory, 2014–15

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Own drug use									
Number of episodes	35,233	42,683	37,943	22,096	12,283	2,972	5,100	3,993	162,303
Number of clients	22,301	23,579	31,353	15,858	8,785	2,414	3,558	2,537	109,623
Episodes per client	1.6	1.8	1.2	1.4	1.4	1.2	1.4	1.6	1.5
Rate of episodes ^(b) (per 100,000 population)	534	829	922	986	824	657	1,516	1,926	788
Rate of clients ^(b) (per 100,000 population)	338	458	762	707	589	534	1,058	1,224	532
Other's drug use									
Number of episodes	1,365	3,172	980	1,446	195	269	122	515	8,064
Number of clients	807	2,485	662	1,316	163	197	113	326	6,069
Episodes per client	1.7	1.3	1.5	1.1	1.2	1.4	1.1	1.6	1.3
Rate of episodes ^(b) (per 100,000 population)	21	62	24	65	13	59	36	248	39
Rate of clients ^(b) (per 100,000 population)	12	48	16	59	11	44	34	157	29
Total									
Number of episodes	36,598	45,855	38,923	23,542	12,478	3,241	5,222	4,508	170,367
Number of clients	23,059	25,484	31,958	17,159	8,939	2,595	3,663	2,822	114,912
Episodes per client	1.6	1.8	1.2	1.4	1.4	1.2	1.4	1.6	1.5
Rate of episodes ^(b) (per 100,000 population)	554	891	946	1050	837	717	1,552	2,175	827
Rate of clients ^(b) (per 100,000 population)	349	495	777	765	600	574	1,089	1,361	558

(a) Client numbers presented were calculated from data with a valid SLK.





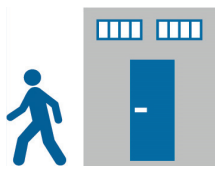



(b) The crude rate is based on the preliminary Australian estimated resident population as at 31 December 2014.

Sources: Tables SC.21 and SC.27.

Client profile

Of all clients receiving treatment, around 2 in 3 (69%) were male and around 1 in 7 (15%) were Indigenous. These proportions were similar for clients receiving treatment for their own drug use, but clients receiving support for someone else's drug use were more likely to be female (63%) and less likely to be Indigenous (10%) (tables SC.1 and SC.3).

In 2014–15, for clients:

<p>2 in 3 were male</p> 	<p>3 in 4 were aged 20–49</p> 	<p>15% were Indigenous Australians</p> 	<p>87% were born in Australia</p> 
<p>1 in 4 were diverted from the justice system</p> 	<p>Most (85%) received assistance from 1 agency</p> 	<p>3 in 4 received 1 treatment episode</p> 	<p>Most (95%) were in treatment for their own drug use</p> 

Age

Clients receiving treatment for their own drug use tended to be younger, on average, than clients receiving support for someone else's drug use. In 2014–15, clients aged 20–39 represented over half (55%) of clients receiving treatment for their own drug use, but only about one-quarter (26%) of clients receiving support for someone else's drug use. Clients aged 40 and over comprised nearly one-third (30%) of clients receiving treatment for their own drug use, compared with over half (55%) of clients receiving support for someone else's drug use (Table SC.2).

Over the 10 years to 2014–15, the proportion of treatment episodes for clients who were aged 20–29 fell from 33% to 27%, while the proportion for those aged 40 and over rose from 26% to 32%. The proportion of episodes for those aged 10–19 and 30–39 has remained stable over time (Table SE.5). Since 2005–06, the median age for all clients increased from 31 years to 33 years. Similarly for clients seeking treatment for their own use, the median age ranged from 31 years in 2005–06 to 32 years in 2014–15. For treatment related to another's drug use, clients tended to be older with the median age decreasing from 44 to 39 over the 10-year period (Table SE.8).

Australia has an ageing population and therefore the absolute numbers of older Australians with AOD issues is expected to increase (Dowling et al. 2008). Further, Gossop (2008) estimates that, internationally, the number of older people needing treatment for AOD issues will double between 2000 and 2020. Although the demographic profile of clients receiving treatment and support from publicly funded AOD services has changed little since 2003–04, in more recent years the age profile of people receiving treatment suggest that there is an ageing cohort of AOD clients.

Indigenous status

Despite only comprising 2.7% of the Australian population, 15% of all clients were Indigenous Australians aged 10 and over in 2014–15 (ABS 2014). This varied by client type – about 1 in 7 (15%) clients receiving treatment for their own drug use were Indigenous, while 10% of clients receiving support for someone else’s drug use were Indigenous (Table SC.3).

The main drugs that led clients to seek treatment were alcohol, cannabis, amphetamines and heroin. This was consistent for both Indigenous and non-Indigenous clients.

Country of birth and preferred language

The majority (87%) of treatment episodes were for clients who were born in Australia. This percentage was higher than that found in the general population (72%) (ABS 2015). Clients born in countries other than Australia represented only a small proportion of all clients, with New Zealand and the United Kingdom being the next most common countries of birth (2.4% and 2.8%, respectively) (Table SE.9). Comparatively, in 2013–14, 5.2% of the Australian population were born in the United Kingdom and 2.6% in New Zealand (ABS 2015). English was the most frequently reported preferred language (96% of treatment episodes for clients) (Table SE.10).

Further information on clients is provided in Chapters 4 and 5.

2.4 Drugs of concern and treatment provided

In 2014–15, AOD treatment services provided a total of 170,367 closed treatment episodes (see Box 2.1), decreasing by 6% from 2013–14 (180,783 episodes), due to sector reforms and system changes in some jurisdictions that led to changes in reporting. The majority (95%) of closed treatment episodes provided in 2014–15 were for clients receiving treatment for their own drug use (Table SE.1).

In 2014–15, the most common principal drugs of concern (the primary drug leading someone to seek treatment, see Box 2.1) were alcohol (38% of episodes), cannabis (24%), amphetamines (20%) and heroin (6.1%). Since 2010–11, the proportion of episodes where alcohol was the principal drug of concern has decreased (from 47% to 38%), while the proportion of episodes for amphetamines increased (from 8.7% to 20%) (Table SE.11). The decrease in alcohol episodes in 2014–15 are likely to have been influenced by the drop in episodes overall in 2014–15, due to sector reforms and system changes in some jurisdictions that led to changes in reporting.

In more than half (53%) of closed treatment episodes, the client also reported additional drugs of concern. Almost one-third (28%) had 1 additional drug of concern, 15% had 2 drugs, and 1.4% had 5. Nicotine and cannabis were the most common additional drugs of concern (Table SD.6).

Since 2005–06, the proportion of closed treatment episodes for each main treatment type (see Box 2.1) remained relatively stable. Counselling continues to be the most common main treatment type provided (comprising about 2 in 5 episodes since 2005–06), but, since 2012–13, assessment only has replaced withdrawal management as the next most common (Table ST.4).

In 2014–15, the majority of treatment episodes for clients receiving treatment for their own drug use were provided by non-residential treatment facilities, such as community health

centres. Episodes provided for the 4 most common principal drugs of concern (alcohol, cannabis, amphetamines and heroin) were most likely to be provided by non-residential treatment facilities (65% of episodes), followed by residential treatment facilities (17%) and outreach settings (13%) (includes any public or private location where services are provided away from the main service location or a mobile service) (Table SD.12).

In 2014–15, nearly 4 in 5 (79%) closed treatment episodes ended within 3 months. Over one-quarter ended within 1 day or within 1 month (28% and 27%, respectively). Only 7.7% of closed treatment episodes lasted 6 months or longer. Nationally, the median duration of closed treatment episodes in 2014–15 was just over 3 weeks (22 days) (tables SE.20 and SE.21).

Box 2.1: Key terminology

Closed treatment episode

A treatment episode is considered closed where any of the following occurs: treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months; or there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they: are not closed in the relevant financial year; are for clients who are receiving pharmacotherapy and not receiving any other form of treatment that falls within the scope of the collection; include only activities relating to needle and syringe exchange; or are for a client aged under 10.

Drugs of concern

Principal drug of concern is the main substance that the client stated led them to seek treatment from the AOD treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses of principal drug of concern. It is assumed that only substance users themselves can accurately report principal drug of concern; therefore these data are not collected from those who seek support for someone else's drug use.

Additional drugs of concern refer to any other drugs the client reports using in addition to the principal drug of concern. Clients can nominate up to 5 additional drugs of concern.

All drugs of concern refer to all drugs reported by clients, including the principal drug of concern and any additional drugs of concern.

Reasons for cessation

The reasons for a client ceasing to receive a treatment episode from an AOD treatment service include:

- *expected cessation*: episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement
- *unexpected cessation*: episodes where the client ceased to participate against advice, without notice or due to non-compliance
- *administrative cessation*: episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

Treatment types

Treatment type refers to the type of activity used to treat the client's alcohol or other drug problem. Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not available for clients seeking support for someone else's drug use.

Main treatment type is the principal activity that is determined at assessment by the treatment provider necessary for the completion of the treatment plan for the client's alcohol or other drug problem for their principal drug of concern. One main treatment type is reported for each treatment episode. Assessment only, support and case management only, and information and education only can only be reported as main treatment types.

Other treatment types refer to other treatment types provided to the client, in addition to their main treatment type. Up to 4 additional treatment types can be reported. Note that Victoria and Western Australia do not supply data on additional treatment types. In these jurisdictions, each type of treatment (main or additional) results in a separate episode.

3 Agencies

The Australian Government and state and territory governments fund both government and non-government organisations to provide a range of AOD treatment services (see Glossary). Services are delivered in residential and non-residential settings and include treatment such as detoxification, rehabilitation, counselling and pharmacotherapy.

The AODTS NMDS contains information on a subset of publicly funded AOD treatment services (see Section 1.4 for details of agencies that are excluded).

3.1 Key facts

In 2014–15:

- A total of 843 publicly funded agencies provided data about services for clients seeking treatment and support.
- Nearly 3 in 5 (58%) agencies were non-government.
- Nearly 3 in 5 (58%) agencies were located in *Major cities*.

Over the 5-year period to 2014–15:

- The number of publicly funded agencies providing data about services for clients seeking treatment and support increased by 27%.

3.2 Number of agencies

In 2014–15, 843 publicly funded AOD treatment agencies reported to the AODTS NMDS, an increase of 5.5 percentage points since 2013–14 in the number of agencies nationally. While the number of agencies increased from 2013–14, the number of closed episodes decreased by 6%, due to sector reforms and system changes in some jurisdictions that led to these changes. The number of agencies per state and territory ranged from 15 in the Australian Capital Territory to 297 in New South Wales (Table SA.1).

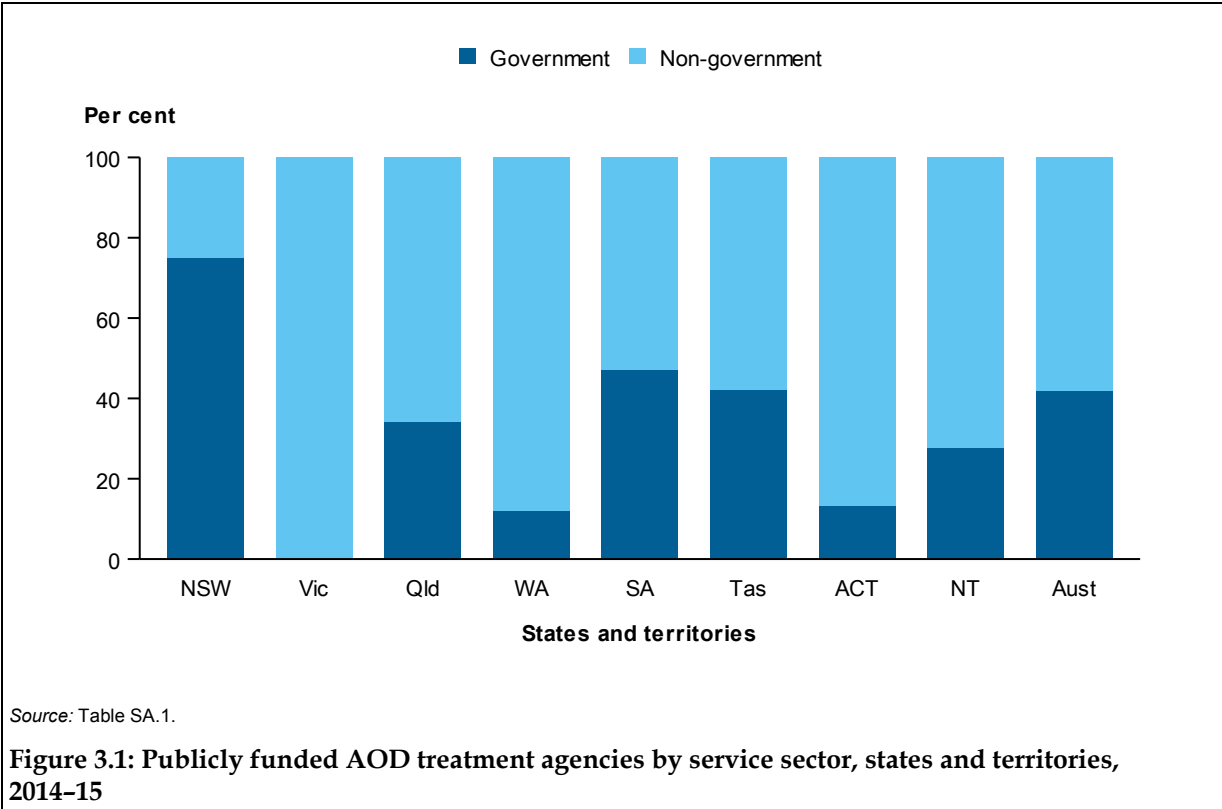
Over the 5-year period to 2014–15, there has been a 27% increase in the number of reporting agencies (from 666 to 843). This increase has largely been driven by increases in reporting agencies in New South Wales (from 262 to 297), Queensland (from 109 to 181), Western Australia (from 56 to 84) and South Australia (from 59 to 89) (Table SA.1).

Several factors can contribute to changes in the number of agencies reporting between years, including changes in the actual numbers of agencies and changes in the mode of data collection. For this reporting year specifically, the increase in agencies and decrease in episodes are likely driven by the data quality issues mentioned previously, in conjunction with sector reforms in some jurisdictions that led to an increase in agencies (see the Data quality statement <<http://meteor.aihw.gov.au/content/index.phtml/itemId/637860>> for further information).

3.3 Service sector

Nationally, almost 3 in 5 (58% or 491) AOD treatment agencies were non-government in 2014–15, and these agencies provided almost two-thirds (63% or 107,721) of closed treatment episodes (Figure 3.1). The proportion of non-government agencies has increased slightly since 2004–05 (from 49% to 58%), while the proportion of government agencies has decreased slightly (from 51% to 42%) (Table SA.2).

In New South Wales, the majority (75%) were government agencies. In the remaining states and territories, most were non-government agencies, ranging from 53% in South Australia to 100% in Victoria (Figure 3.1).



3.4 Remoteness

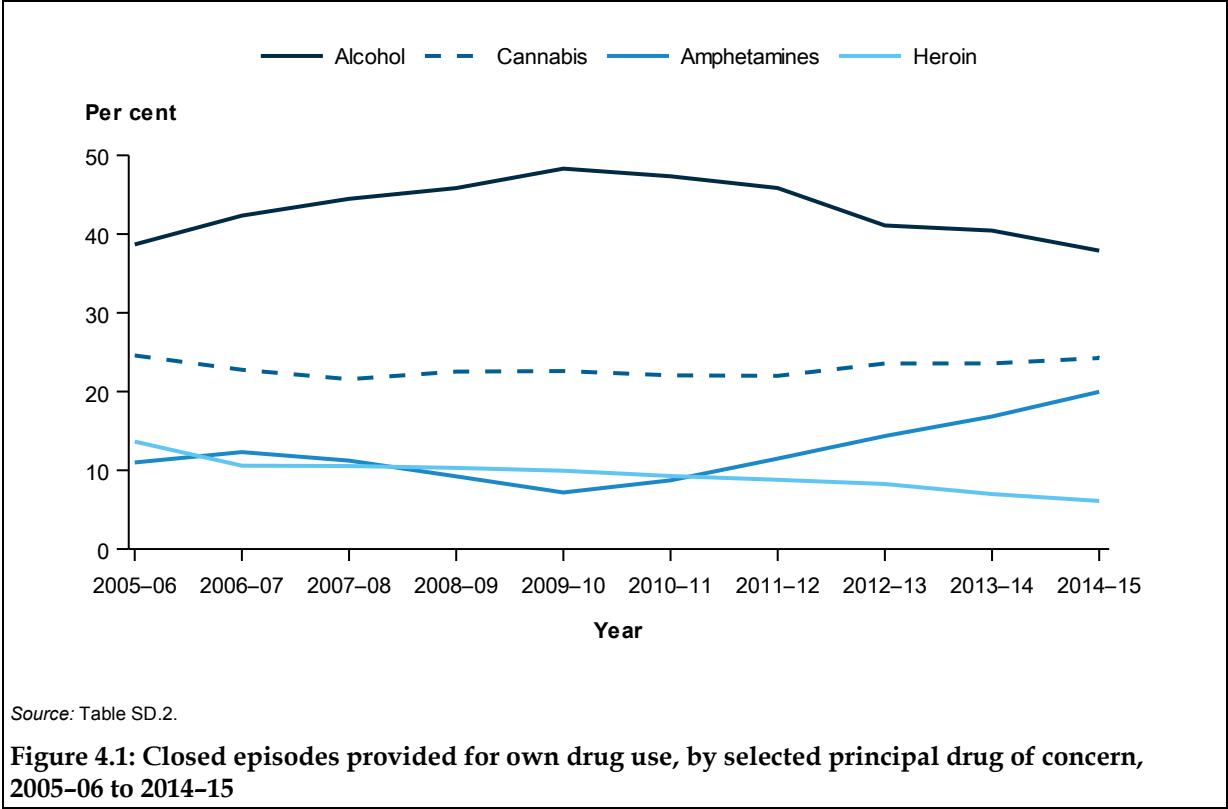
Nationally, in 2014–15, nearly 3 in 5 (58% or 491) treatment agencies were located in *Major cities* and nearly one-quarter (22%) in *Inner regional* areas. Relatively few agencies were in *Remote* or *Very remote* areas (3.8% and 3.2%, respectively). This pattern was similar across most states and territories (Table SA.3).

4 Drugs of concern

People may seek AOD treatment services due to problematic use of 1 or more drugs. For most people, however, there is 1 drug that is of most concern for them, and therefore the focus of the treatment they receive. This is referred to as their principal drug of concern. Clients can also report other drugs of concern (referred to as additional drugs of concern). Information on clients and treatment agencies are included in the AODTS NMDS when a treatment episode provided to a client is closed (see Box 2.1 for more information).

Although there are many different drugs for which people receive treatment, the most common principal drugs of concern – alcohol, cannabis, heroin and amphetamines – have accounted for the large majority of services over time (Figure 4.1). Due to this consistent trend, the focus of this chapter will be on these 4 principal drugs of concern for clients in treatment.

Where a person receives treatment for someone else’s drug use, the principal drug of concern for that person is not collected. Thus, no information is presented in this chapter on support received by people for someone else’s drug use.



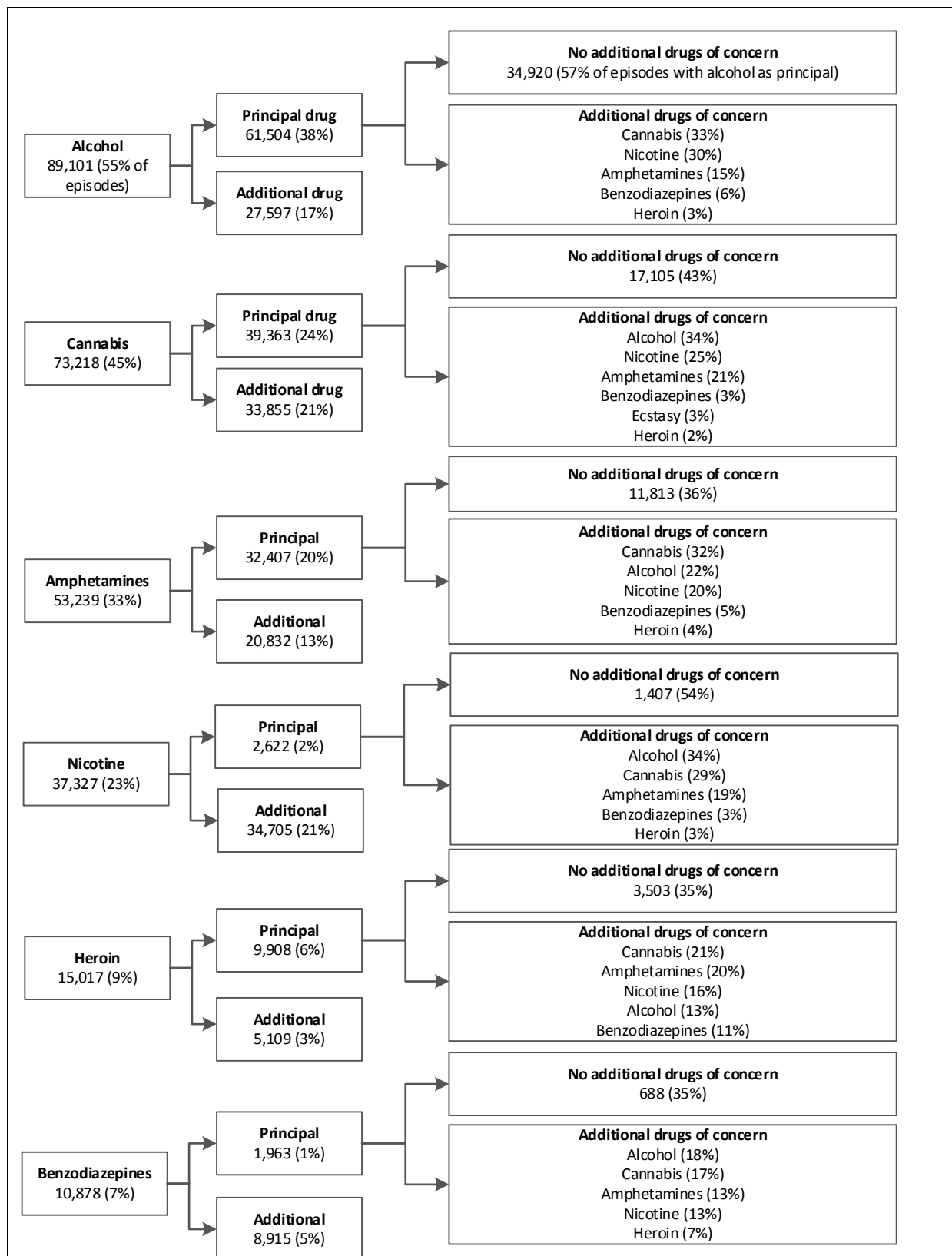
4.1 Key facts

In 2014–15:

- Nationally, alcohol was the most common principal drug of concern, accounting for 38% of episodes (Figure 4.2).
- After alcohol, cannabis (24%), amphetamines (20%) and heroin (6.1%) were the next most common principal drugs of concern (Figure 4.2). Together, these 4 drugs accounted for 88% of all treatment episodes.
- Closed treatment episodes for amphetamines increased in 4 jurisdictions, overtaking cannabis as the second most common principal drug in New South Wales, Western Australia, South Australia and the Australian Capital Territory.
- Alcohol was the most common principal drug of concern in all remoteness areas – with the highest proportion of episodes in *Very remote* areas (72%) and lowest in *Major cities* (35%).
- Cannabis was the most common principal drug of concern for clients aged 10–29, while alcohol was the most common principal drug of concern for clients aged 30 and over.
- For the top 4 principal drugs of concern, most clients received treatment in a non-residential facility – alcohol (62% of episodes for alcohol), cannabis (70%), amphetamines (66%) and heroin (66%).
- Clients whose principal drug of concern was heroin generally spent longer in treatment; the median duration of episodes was 37 days compared with 22 days for all treatment episodes.

Over the 5-year period to 2014–15:

- The top 4 principal drugs of concern have remained consistent. However, from 2010–11, amphetamines replaced heroin as the third most common principal drug of concern.
- The trend in the top 4 principal drugs of concern has been consistent for both Indigenous and non-Indigenous clients.
- The number of episodes for clients injecting and smoking/inhaling amphetamines has increased, with more than 6 times as many clients smoking and inhaling in 2014–15 than in 2010–11.



Note: Totals may not add to 100% due to rounding.

Sources: Tables SD.6, SD.7 and SD.8.

Figure 4.2: Closed episodes for own drug use, by principal drug of concern and additional drugs of concern, 2014–15

Nationally, alcohol was the most common principal drug of concern for more than one-third (37%) of clients, followed by cannabis (27% of clients) and amphetamines (19%) (Table SC.4).

The proportion of clients receiving treatment where alcohol was the principal drug of concern increased substantially with age. Alcohol was the principal drug of concern for 1 in 5 (21%) of clients aged 10–19, but was more common in the older age groups – 64% of those aged 50–59 and 78% of clients aged 60 and over (Figure 4.3). For clients receiving treatment for cannabis the opposite was true, with the proportion of clients decreasing with age. Clients aged 10–29 were most likely to be receiving treatment for cannabis use, with cannabis the principal drug of concern for more than half (59%) of clients aged 10–19, compared with 12% of those aged 50–59 and only 4.4% of clients aged 60 and over.

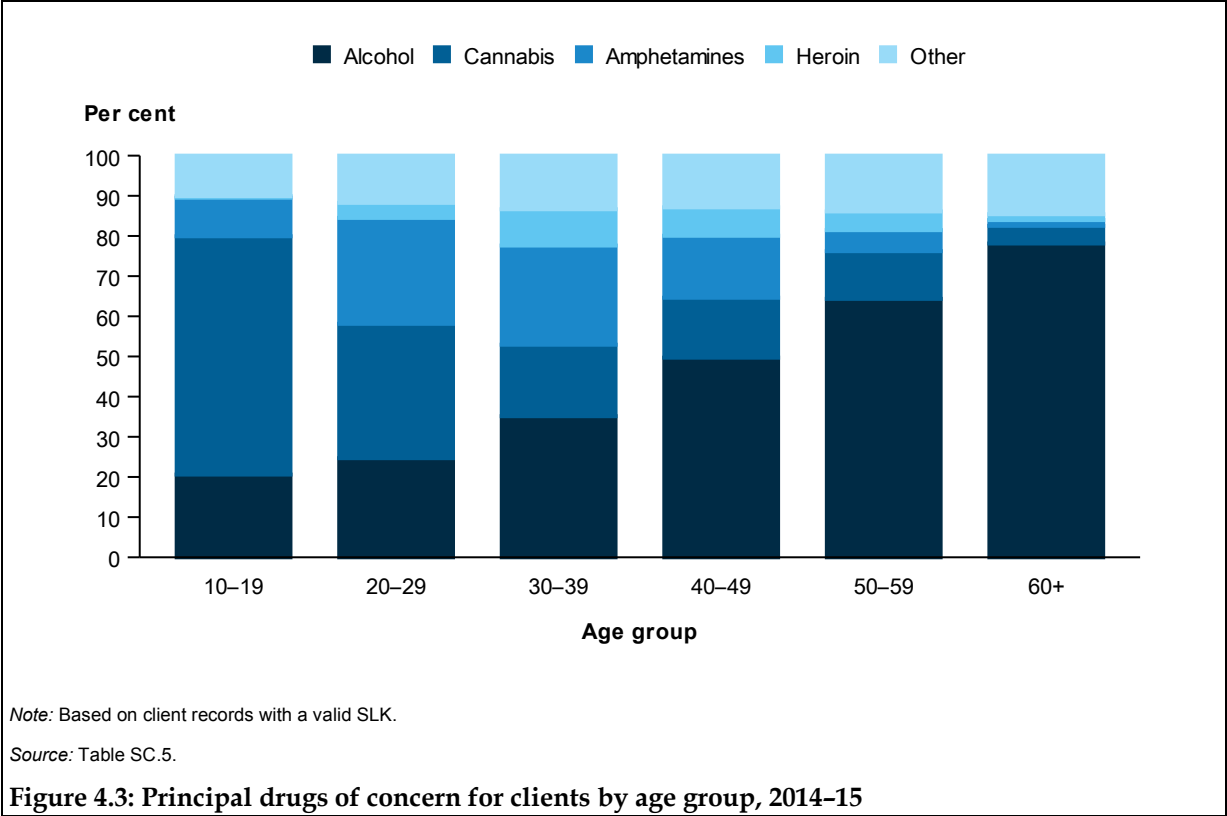


Figure 4.3: Principal drugs of concern for clients by age group, 2014-15

Clients receiving treatment where amphetamines and heroin were the principal drugs of concern were most likely to be aged 20–49. Amphetamines were most likely to be the principal drug of concern for clients aged 20–39 (26% of those aged 20–29 and 25% of those aged 30–39), whereas only 9.6% of those aged 10–19 and 7.2% of clients aged 50+ were receiving treatment for amphetamines. Heroin was most common among clients aged 30–49 (ranging from 7.0% to 9.0%), compared with less than 1% of clients aged 10–19 and 6.1% of clients aged 50+.

4.2 Alcohol

Alcohol is a central nervous system depressant that inhibits brain functions, dampens the motor and sensory centres and makes judgment, coordination and balance more difficult (NDARC 2010). According to the *2009 Australian guidelines to reduce health risks from drinking alcohol* (NHMRC 2009), people who drink more than 2 standard drinks per day on average have an increased lifetime risk of harm from alcohol-related disease or injury, while those who drink more than 4 standard drinks on a single occasion are at risk of harm on that occasion (AIHW 2014).

Results from the 2013 NDSHS (AIHW 2014) showed that:

- About 78% of Australians aged 14 and over drank alcohol in the previous 12 months.
- A significant proportion of the Australian population drank at risky levels – 1 in 5 (17%) aged 14 and over drank at a level that put them at risk of alcohol-related harm over their lifetime, while 1 in 4 (26%) drank at levels that put them at risk of harm from a single drinking occasion at least once in the previous 12 months.
- Males are more likely than females to drink at levels that place them at risk of harm over their lifetime and on a single occasion.

In 2014–15, alcohol was a drug of concern (principal or additional) in 55% of closed episodes, and the most common principal drug of concern in 38% (37% of clients) (Figure 4.2 and Table SC.4). This was consistent for both Indigenous and non-Indigenous clients, but the proportion of episodes where alcohol was the most common principal drug of concern was higher for Indigenous clients – 46% compared with 36% for non-Indigenous clients (Table SC.6). In 43% of episodes where alcohol was the principal drug of concern, the client reported additional drugs of concern. These were most commonly cannabis (33%) or nicotine (30%) (Figure 4.2).

For around 2 in 5 (40%) clients who received treatment during both 2013–14 and 2014–15, alcohol was the main drug that led them to seek treatment (Table SC.34).

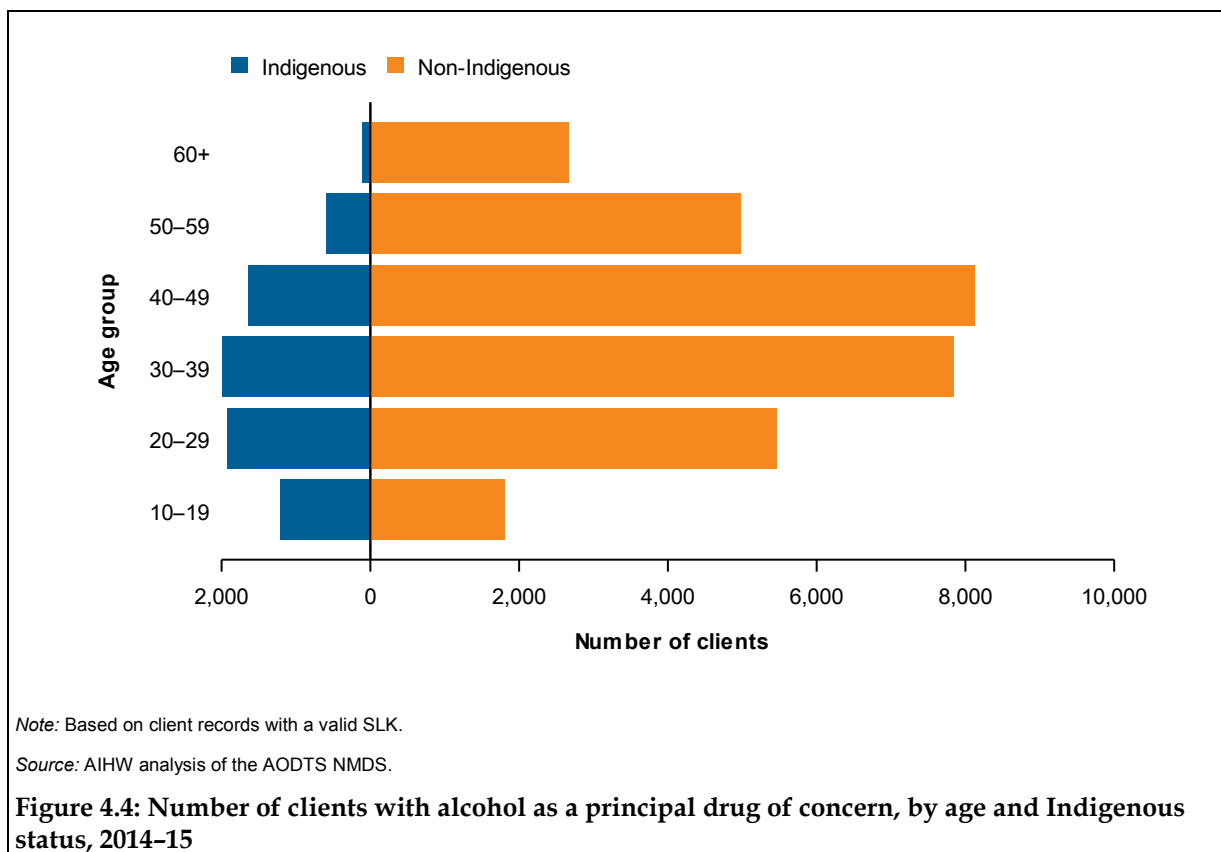
Of the clients receiving treatment across all 3 collection years from 2012–13 to 2014–15, a similar proportion of clients (43%) sought treatment for alcohol as a main drug of concern (Table SC.31).

Over the 5 years to 2014–15, the proportion of closed episodes where alcohol was the principal drug of concern decreased from 47% to 38% (Table SD.2).

Client demographics

In 2014–15, where alcohol was the principal drug of concern, more than two-thirds of clients were male (68%) and 1 in 5 were Indigenous (19%) (Tables SC.4–6). Where alcohol was the principal drug of concern, Indigenous people (1,434 per 100,000 Indigenous Australians) were more likely to have received treatment than the non-Indigenous population (162 per 100,000 non-Indigenous Australians) (Table SC.26).

Clients with alcohol as their principal drug of concern were most likely to be aged 30–39 (26%) or 40–49 (both 25% of clients), followed by 20–29 (19%) and 50–59 (14%). Indigenous clients who had a principal drug of concern of alcohol tended to be younger, with over half (53%) aged 20–39, compared with 43% of non-Indigenous clients in this age group (Figure 4.4).



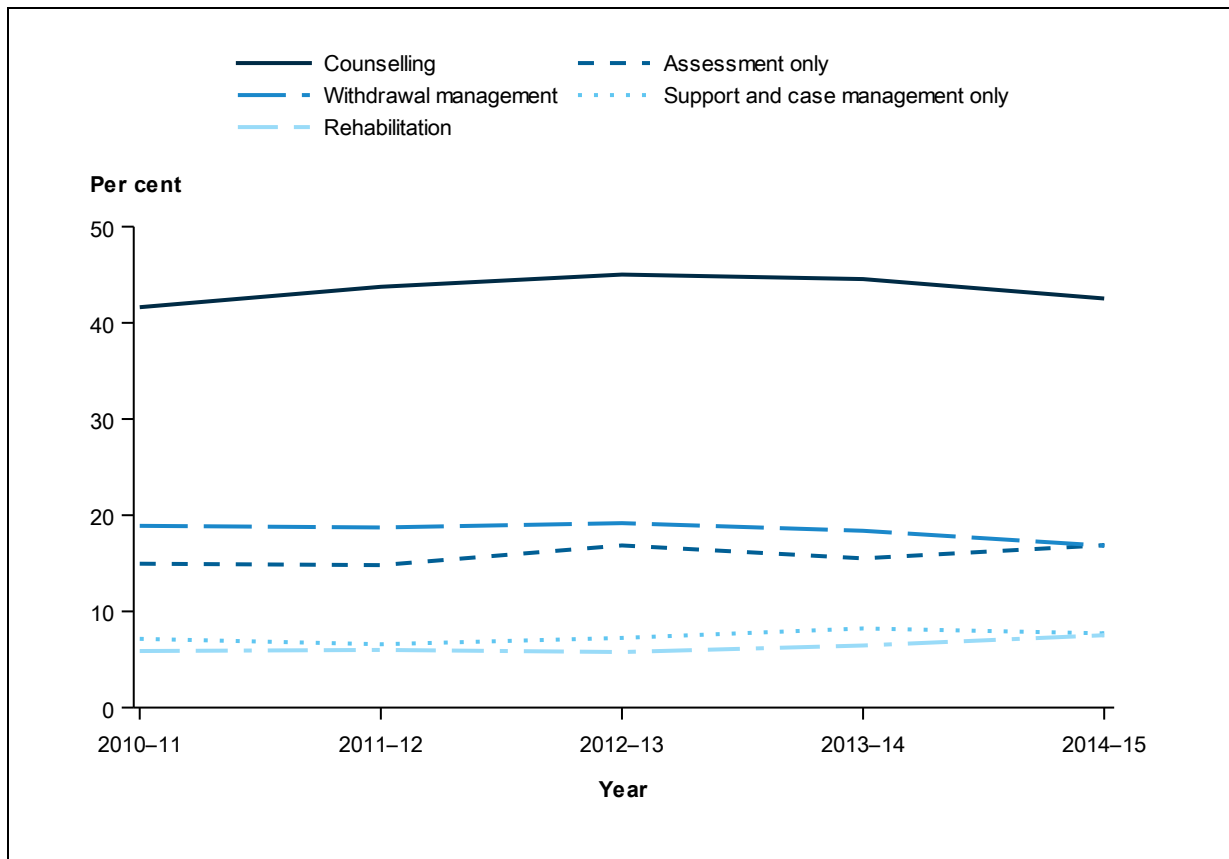
Treatment

In 2014–15, where alcohol was the principal drug of concern, the most common source of referral for treatment episodes was self/family (42%), followed by a health service (32%) (Table SD.21).

The most common main treatment type was counselling (43%), followed by withdrawal management and assessment only (both 17%) – this was consistent across all age groups (Table SD.25).

Over the 5 years from 2010–11, counselling, withdrawal management and assessment only have remained the most common main treatment types for episodes where alcohol was the principal drug of concern (Figure 4.5).

Just over half (52%) of the episodes with alcohol as the principal drug lasted less than 1 month (21% ended within 1 day) (Table SE.25). The median duration of episodes with alcohol as the principal drug of concern was 4 weeks (28 days) (Table SD.33).



Source: Table SD.26.

Figure 4.5: Closed episodes with alcohol as the principal drug of concern by the top 5 treatment types received, 2010-11 to 2014-15

Alcohol-related treatment episodes were most likely to take place in a non-residential treatment facility (62%), with one-fifth (19%) occurring in a residential treatment facility. Most (89%) episodes where counselling was the main treatment type took place in a non-residential treatment facility, while episodes with a main treatment type of withdrawal management were most likely to take place in a residential treatment facility (65%) (Table SD.28).

About three-fifths (62%) of closed episodes where alcohol was the principal drug of concern ended with an expected cessation, while 21% ended due to an unexpected cessation (that is, the client ceased to participate against advice, without notice or due to non-compliance). Expected cessations were most common where the referral source was diversion (10%) (Table SD.29). For more information regarding the groupings for reasons for cessation of treatment, please refer to Appendix A (Table A3).

4.3 Cannabis

Cannabis ('marijuana' or 'gunja') is derived from the cannabis plant (usually *Cannabis sativa*) and is used in whole plant (typically the flowering heads), resin or oil forms. Cannabis has a range of stimulant, depressant and hallucinogenic effects. The risks associated with long-term or regular use of cannabis include addiction, damage to lungs and lung functioning, effects on memory and learning, and psychosis and other mental health conditions. Cannabis withdrawal is now listed as a discrete syndrome in the Diagnostic and Statistical Manual of Mental Disorders (DSM-V) (NCPIC 2011). According to the 2013

NDSHS (AIHW 2014), 1 in 3 Australians aged 14 and over have used cannabis at some point in their lifetime, while 1 in 10 have used it in the previous 12 months.

In 2014–15, cannabis was a drug of concern (principal or additional) in 45% of episodes, and was the second most common principal drug of concern (24% of closed treatment episodes). (Figure 4.2 and Table SD.8). In more than half (57%) of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern. This was most commonly alcohol (34%), nicotine (25%) or amphetamines (21%) (Table SD.7 and Figure 4.2).

For one-fifth of clients (20%) who received treatment during both 2013–14 and 2014–15, cannabis was the main drug that led them to seek treatment (Table SC.34).

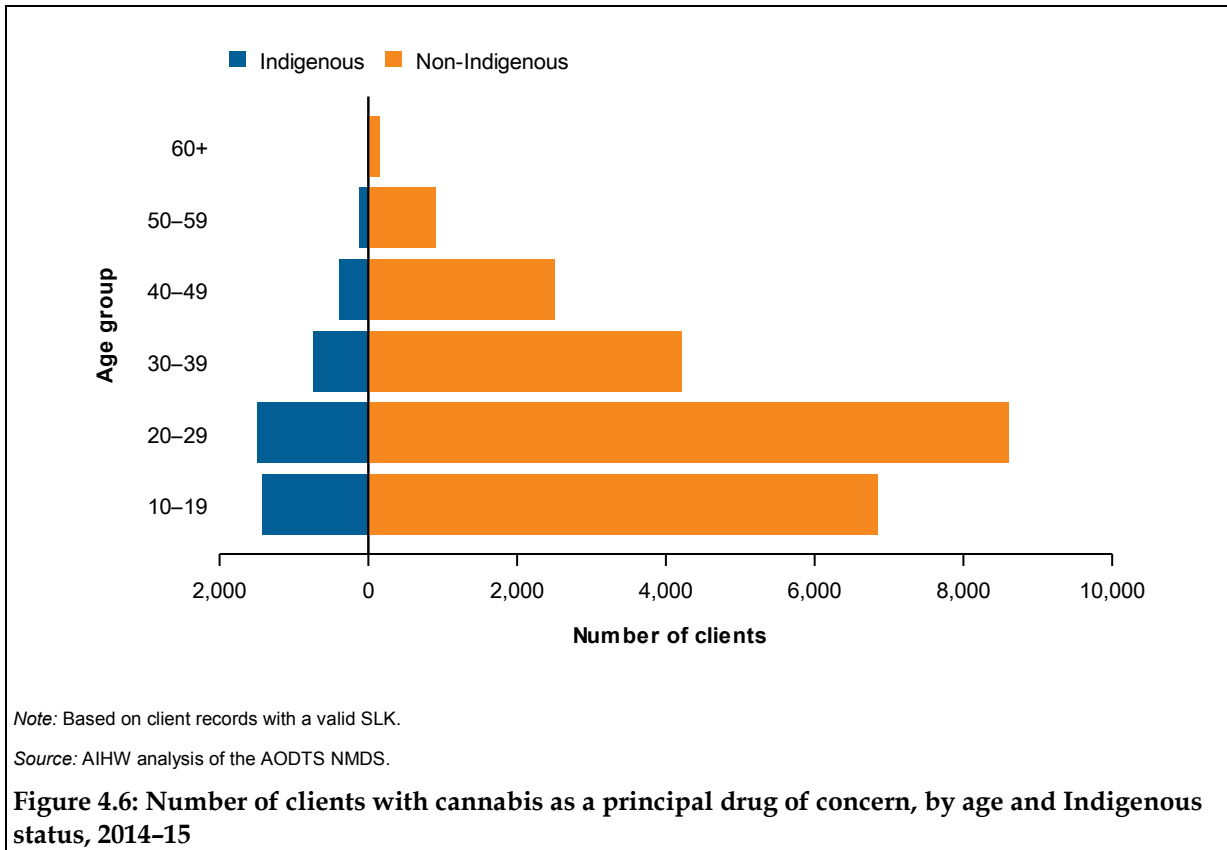
Of the clients receiving treatment across all 3 collection years from 2012–13 to 2014–15, around 1 in 6 clients (17%) sought treatment for cannabis as a main drug concern (Table SC.31).

The proportion of episodes where cannabis was the principal drug of concern has remained relatively stable over the 5 years to 2014–15 (Table SD.2). The small increase seen between 2011–12 and 2012–13 was in part due to the inclusion of new data in 2012–13 from the Drug Diversion Assessment Program in South Australia.

Client demographics

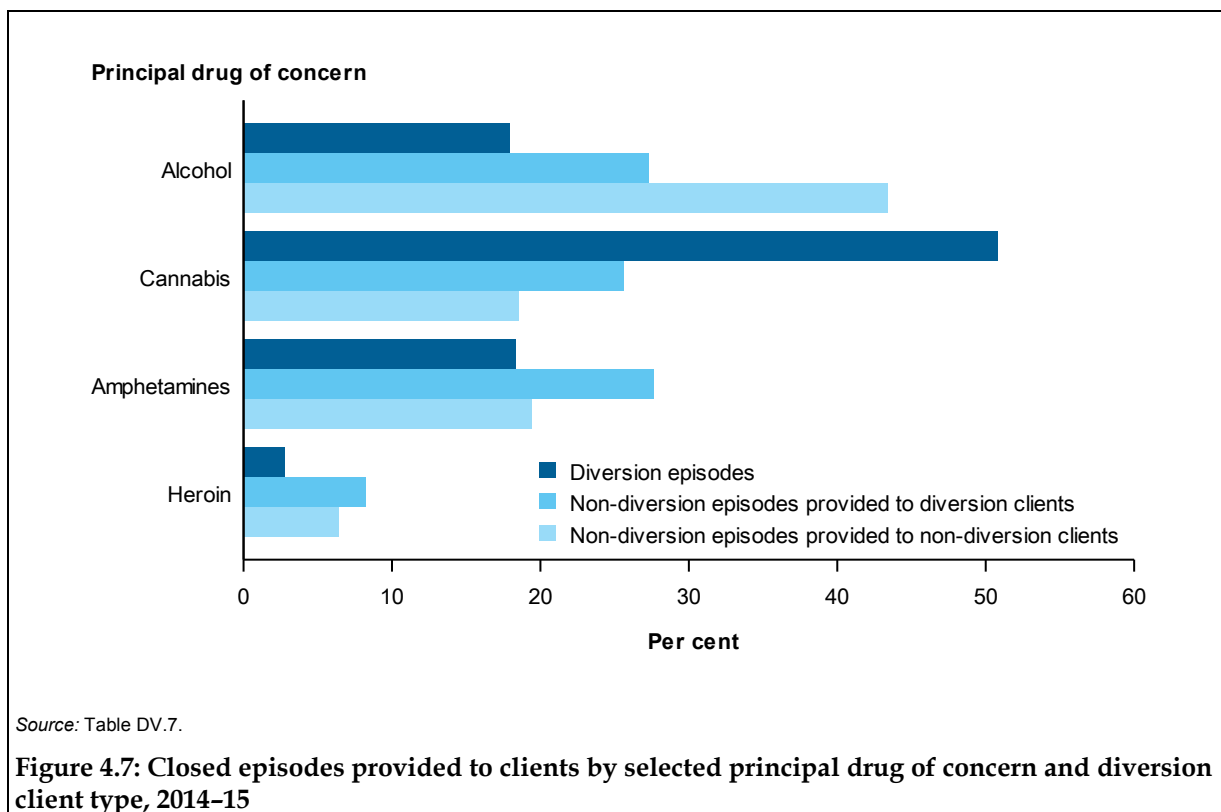
In 2014–15, where cannabis was the principal drug of concern, nearly three-quarters of clients were males (73%), and around 1 in 7 were Indigenous (14%). Where cannabis was the principal drug of concern, Indigenous people (832 per 100,000 Indigenous Australians) were more likely to have received treatment than the non-Indigenous population (123 per 100,000 non-Indigenous Australians) (Table SC.26).

Cannabis was most likely to be the principal drug among younger age groups – just over two-thirds (68%) of clients aged 10–29 had a principal drug of concern of cannabis (tables SC.5–7). This pattern was similar for both Indigenous and non-Indigenous clients (Figure 4.6).



Treatment

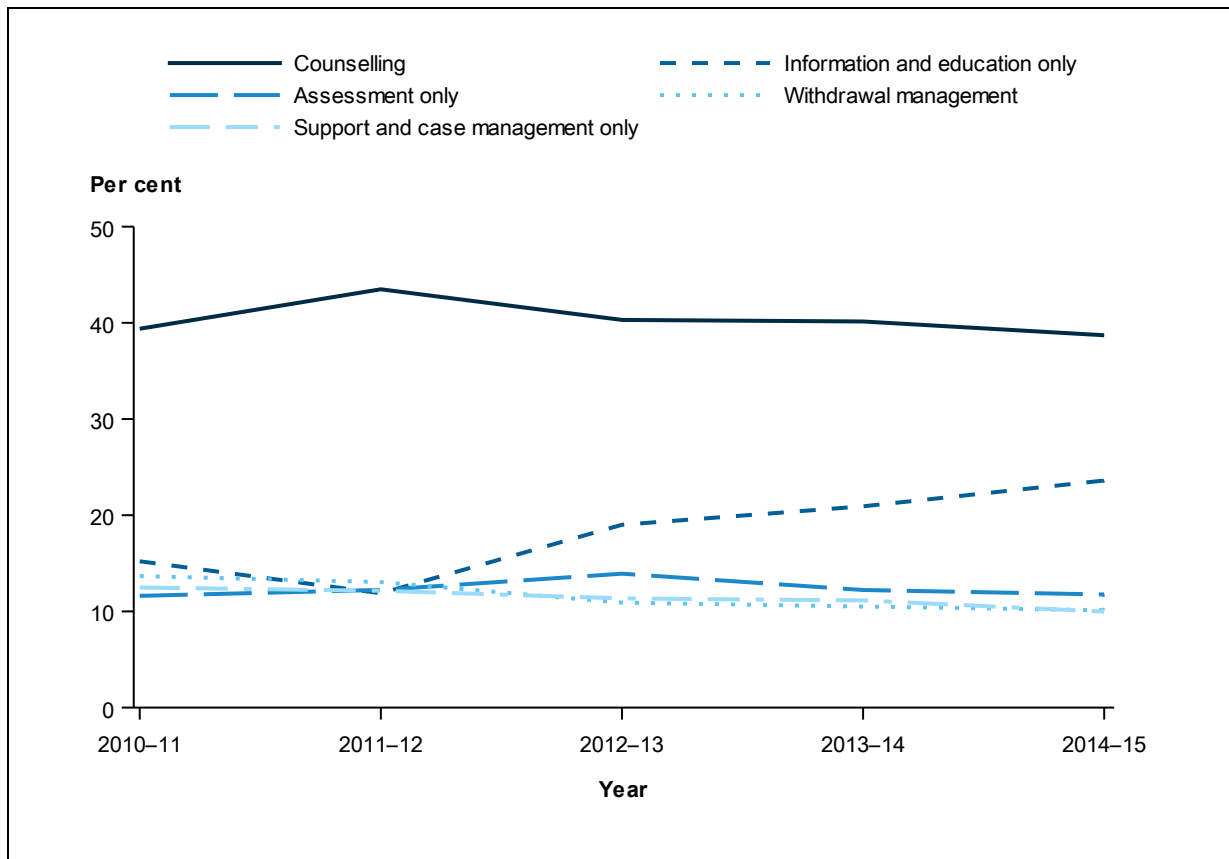
The most common source of referral for treatment episodes where cannabis was the principal drug of concern was diversion (that is, referred from the criminal justice system into AOD treatment for drug or drug-related offences) (38%), followed by self/family (28%) (Table SD.37). Of the top 4 principal drugs of concern, cannabis was the only drug where diversion was the most common source of referral (Figure 4.7).



Counselling was the most common main treatment type (39%) where cannabis was the principal drug of concern, followed by information and education only (24%) (Table SD.41). Treatment episodes where cannabis was the principal drug of concern were most likely to take place in a non-residential treatment facility (70%). Most (88%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table SD.44).

Over the 5 years from 2010-11, in episodes where cannabis was the principal drug, the proportion of episodes with a main treatment type of counselling remained the most common form of treatment, followed by information and education only increasing from 15% to 24%, as a result of diversion programs (Figure 4.8 and Table SD.42).

Nearly two-thirds (62%) of the episodes with cannabis as the principal drug lasted less than 1 month (40% ended within 1 day) (Table SE.25). The median duration of episodes with cannabis as the principal drug of concern was just over 1 week (9 days) (Table SD.47). Episodes with pharmacotherapy as the main treatment type had a median duration of almost 10 weeks (69 days), followed by support and case management only with a median duration of 8 weeks (54 days), compared with 1 week (8 days) for withdrawal management (Table SD.47).



Source: Table SD.42.

Figure 4.8: Closed episodes with cannabis as the principal drug of concern by the top 5 treatment types received, 2010-11 to 2014-15

Around 7 in 10 (71%) closed episodes where cannabis was the principal drug of concern ended with an expected cessation, and expected cessations were most common for episodes where the client was diverted from the criminal justice system (49%). Around 1 in 5 (18%) episodes ended due to an unexpected cessation (Table SD.45).

4.4 Amphetamines

Amphetamines stimulate the central nervous system and can result in euphoria, increased energy, decreased appetite, paranoia and increased blood pressure (ADCA 2013). Long-term effects include: high blood pressure, extreme mood swings, depression, anxiety, psychosis and seizures. There is no approved pharmacotherapy for the management of amphetamine withdrawal or replacement therapy (Lee et al. 2007). According to the 2013 NDSHS (AIHW 2014), 1 in 14 Australians aged 14 and over have used meth/amphetamines for non-medical purposes at some point in their lifetime, while 1 in 50 have used them in the previous 12 months.

In 2014-15, amphetamines were a drug of concern (principal or additional) in 33% of closed treatment episodes, and were the third most common principal drug of concern (20% of all episodes and 19% of clients) (Figure 4.2, tables SD.8 and SC.8). This was consistent for both Indigenous and non-Indigenous clients; however, the proportion of episodes where amphetamines were the most common principal drug of concern was higher for non-Indigenous clients – 19% compared with 16% for Indigenous Australians (Table SC.6).

Where amphetamines were the principal drug of concern, Indigenous people (530 per 100,000 Indigenous Australians) were more likely to have received treatment than the non-Indigenous population (89 per 100,000 non-Indigenous Australians) (Table SC.26). Although a small number of episodes were reported nationally for Indigenous clients for whom amphetamines were a principal drug of concern (about 4,000), this represents a larger proportion of the Indigenous population across Australia compared with the non-Indigenous population.

In just under two-thirds (64%) of episodes with a principal drug of concern of amphetamines, the client reported additional drugs of concern. These were most commonly cannabis (32%), alcohol (22%) and nicotine (20%) (Figure 4.2, tables SD.6 and SD.7).

For one-fifth of clients (20%) who received treatment during both 2013–14 and 2014–15, amphetamines were the main drug that led them to seek treatment (Table SC.34).

Of the clients receiving treatment across all 3 collection years from 2012–13 to 2014–15, over 1 in 6 clients (16%) sought treatment for amphetamines as a main drug concern.

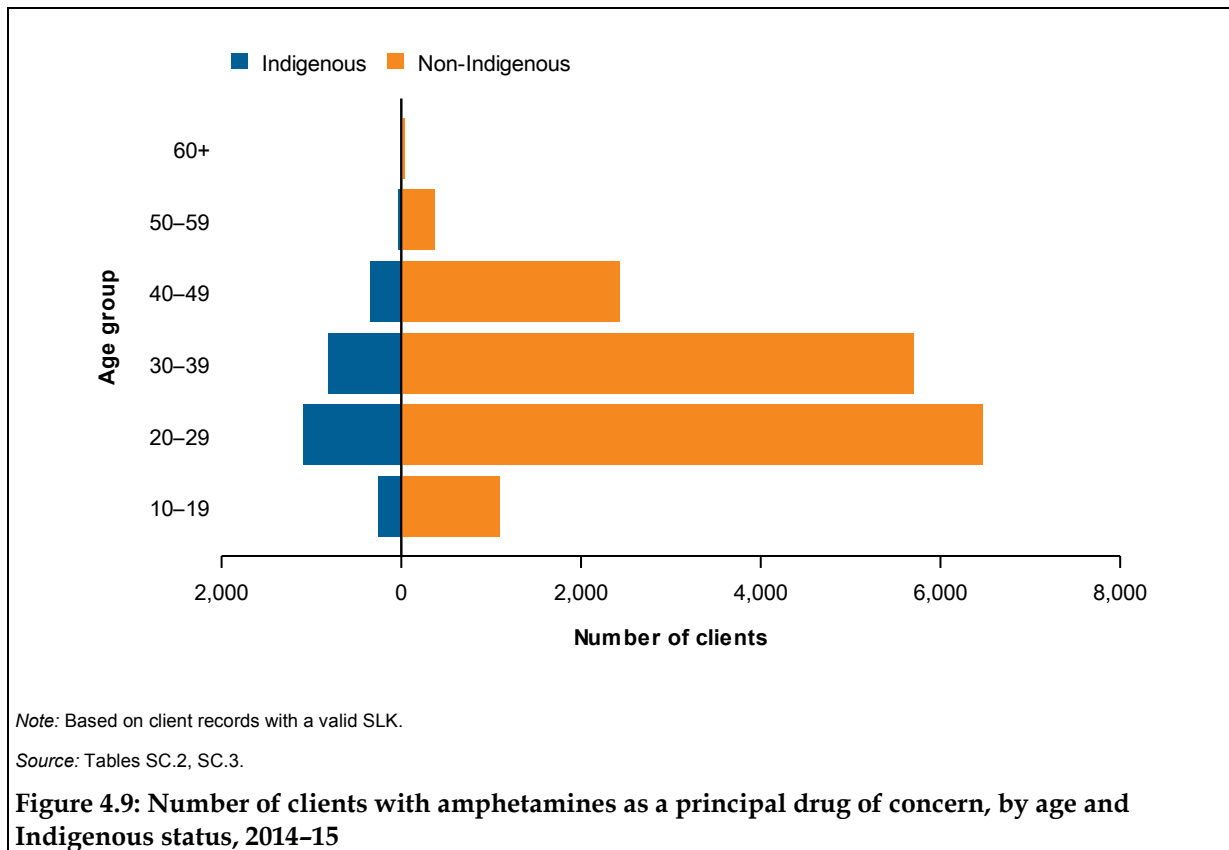
In 2014–15, smoking was the most common usual method of use (44% of episodes), followed by injecting (40%) (Table SD.55).

Over the 5 years to 2014–15, the proportion of episodes where amphetamines were the principal drug of concern has increased (from 8.7% to 20%). AOD treatment services provided a total of 32,407 closed treatment episodes where amphetamines were the principal drug of concern, with an increase of 49% since 2005–06 (15,935 episodes). Over this time, the proportion of amphetamine treatment episodes has increased, despite falling to a low of 7.1% in 2009–10 (Table SD.2).

According to the 2013 NDSHS (AIHW 2014), the proportion of the adult population using methamphetamine in the previous 12 months has remained fairly stable (declining only slightly between 2007 and 2013, from 2.4% to 2.1%). However, among recent methamphetamine users, there has been a change in the main form used – a significant increase in the use of crystal methamphetamine or ‘ice’ (from 27% to 50% over the same time period).

Client demographics

In 2014–15, more than two-thirds of clients receiving treatment for amphetamines as a principal drug of concern were male (69%) and 1 in 8 clients were Indigenous (12%). Clients with a principal drug of concern of amphetamines were most likely to be aged 20–39 (75%), followed by those aged 40–49 (15%) (Table SC.5–7). The age profile was similar for Indigenous clients; however, the proportion of clients was higher for Indigenous clients aged 10–19 (10%) compared with 7% for non-Indigenous clients of the same age (Figure 4.9).

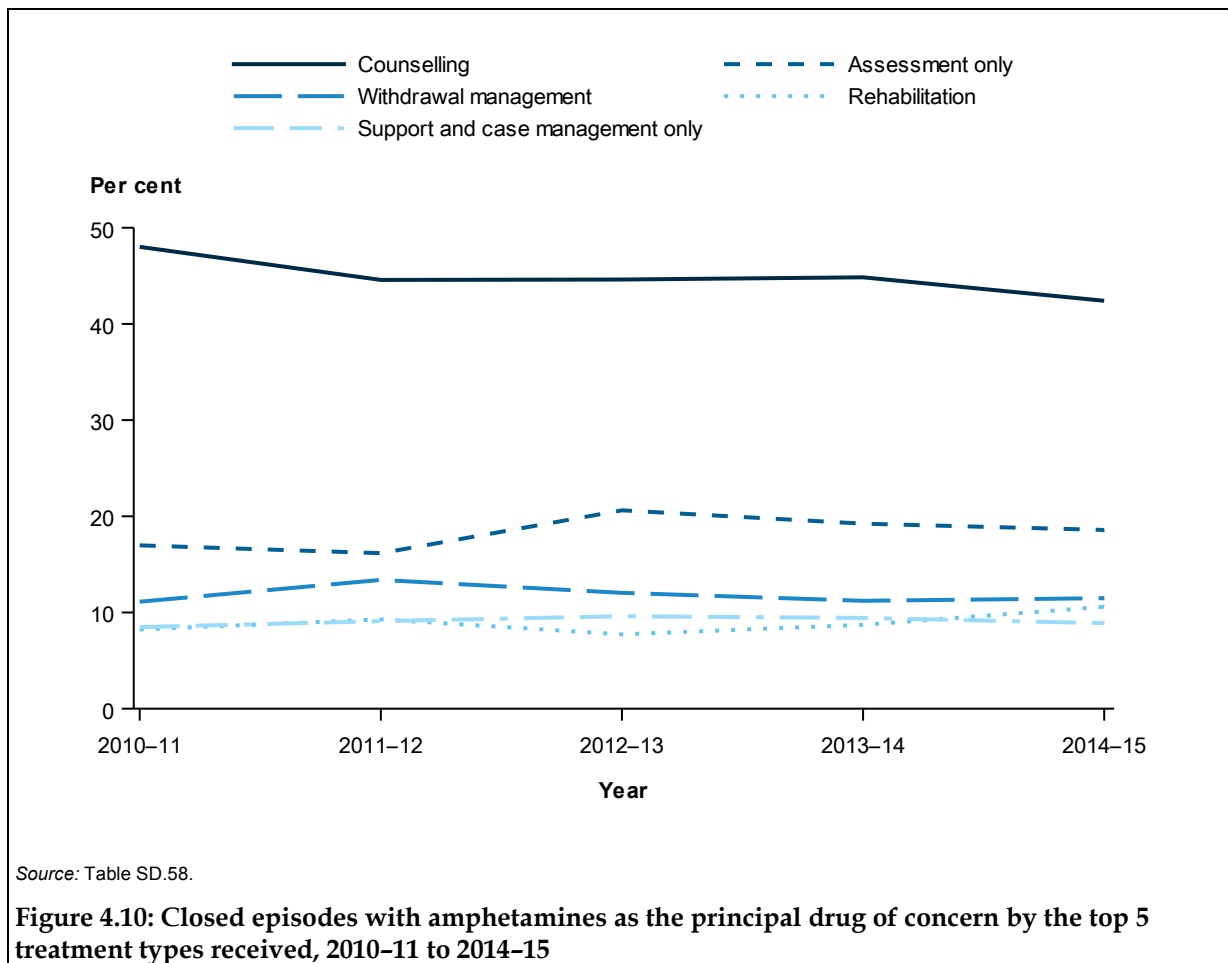


Treatment

The most common source of referral for treatment episodes where amphetamines were the principal drug of concern was self/family (43%), followed by health services (22%) and diversion (20%) (Table SD.61).

In 2014-15, the most common main treatment type for episodes where amphetamines was the principal drug of concern was counselling (42%), followed by assessment only (19%) and withdrawal management (11%). Treatment was most likely to take place in a non-residential treatment facility (66%) (Table SD.60).

Over the 5 years from 2010–11, where amphetamines were the principal drug, the proportion of episodes where counselling was the main treatment type declined (from 48% to 42%) (Figure 4.10, Table SD.58).

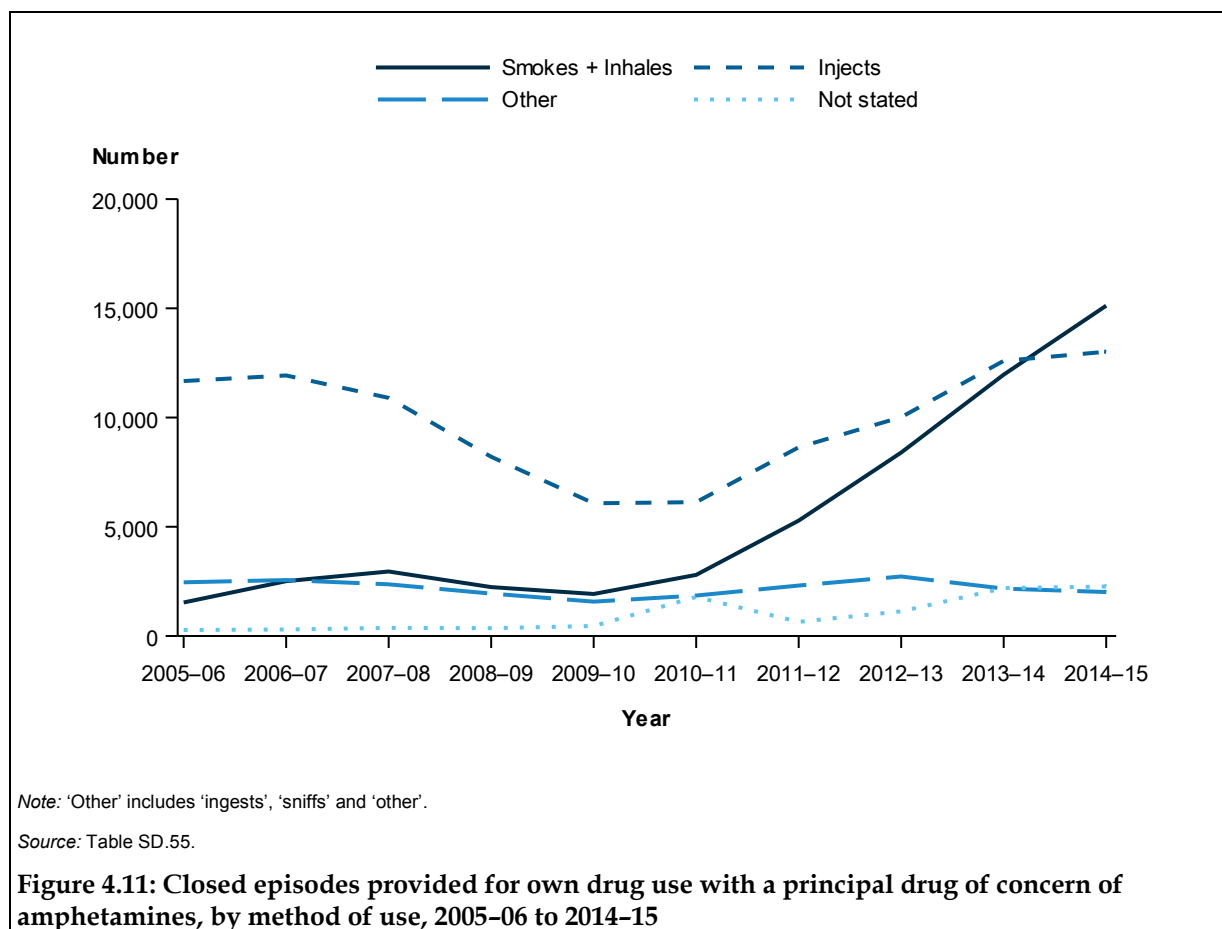


Just over half (53%) of episodes where amphetamines were the principal drug of concern lasted less than 1 month (24% ended within 1 day and were mostly for the main treatment type of Assessment only) (Table SE.25). The median duration of episodes was just under 4 weeks (26 days) (Table SE.23). Episode duration varied widely depending on the main treatment type – episodes with a main treatment type of counselling had a median duration of just over 7 weeks (53 days), while episodes with withdrawal management ended within 1 week (7 days) and information and education only lasted a median duration of 1 day (Table SD.64).

Almost three-fifths (59%) of closed episodes where amphetamines were the principal drug of concern ended with an expected cessation, with expected cessations most common for episodes where self/family was the referral source (40%). Over one-quarter (26%) of episodes ended with an unexpected cessation (Table SD.61).

Over the 5 years to 2014–15, the number of episodes for clients smoking/inhaling amphetamines increased. In 2014–15, clients were 6 times as likely to smoke/inhale amphetamines as they were in 2010–11 (Figure 4.11). Around 2010–11 there was an increase in injecting as a method of use for amphetamines, which may be attributed to a few interesting patterns arising from: an increase in availability of crystal methamphetamines; and an increase in treatment episodes and for injecting clients who may have been using

amphetamines and heroin interchangeably (for further information refer to; Trends in methylamphetamine availability, use and treatment 2003-04 to 2013-14, AIHW <<http://www.aihw.gov.au/publication-detail/?id=60129552818>>).



4.5 Heroin

Heroin is one of the opioid drugs, which are strong pain-killers with addictive properties. Short-term side effects of use include pain relief and feelings of euphoria and wellbeing, while long-term effects can include lowered sex drive and infertility (for women), along with risk of overdose, coma and death (ADCA 2013). Heroin users seeking treatment can undertake a withdrawal program (also called detoxification), an abstinence-based treatment (for example, residential rehabilitation in a therapeutic community), or attend an opioid maintenance substitution program (O'Brien 2004). Results from the 2013 NDSHS showed that:

- 1.2% of people in Australia aged 14 and over had used heroin in their lifetime and 0.1% had used it in the previous 12 months
- there was a significant decline in the proportion of people using heroin between 2010 and 2013 (AIHW 2014).

In 2014-15, heroin was a drug of concern (principal or additional) in 9.2% of closed treatment episodes, and was the fourth most common principal drug of concern – being reported in 6.1% of episodes (5.3% of clients) (Figure 4.2, tables SC.5 and SD.82). This was consistent for both Indigenous and non-Indigenous clients; however, the proportion of episodes where

heroin was the most common principal drug of concern was higher for non-Indigenous clients – 5.8% compared with 3.8% for Indigenous Australians (Table SC.6). In just under two-thirds (65%) of episodes with heroin as the principal drug of concern, the client reported additional drugs of concern. These were most commonly cannabis (21%) and amphetamines (20%) (Table SD.7).

Injecting was the most common method of use in most episodes where the principal drug of concern was heroin (81% of episodes) (Table SD.87). In almost 3 in 5 (58%) episodes, the client reported they had injected drugs in the previous 3 months, while 14% reported they last injected 3–12 months ago (injecting status was not reported for 8% of episodes) (Table SD.88).

For almost 1 in 10 clients (9%) who received treatment during both 2013–14 and 2014–15, heroin was the principal drug of concern (Table SC.34).

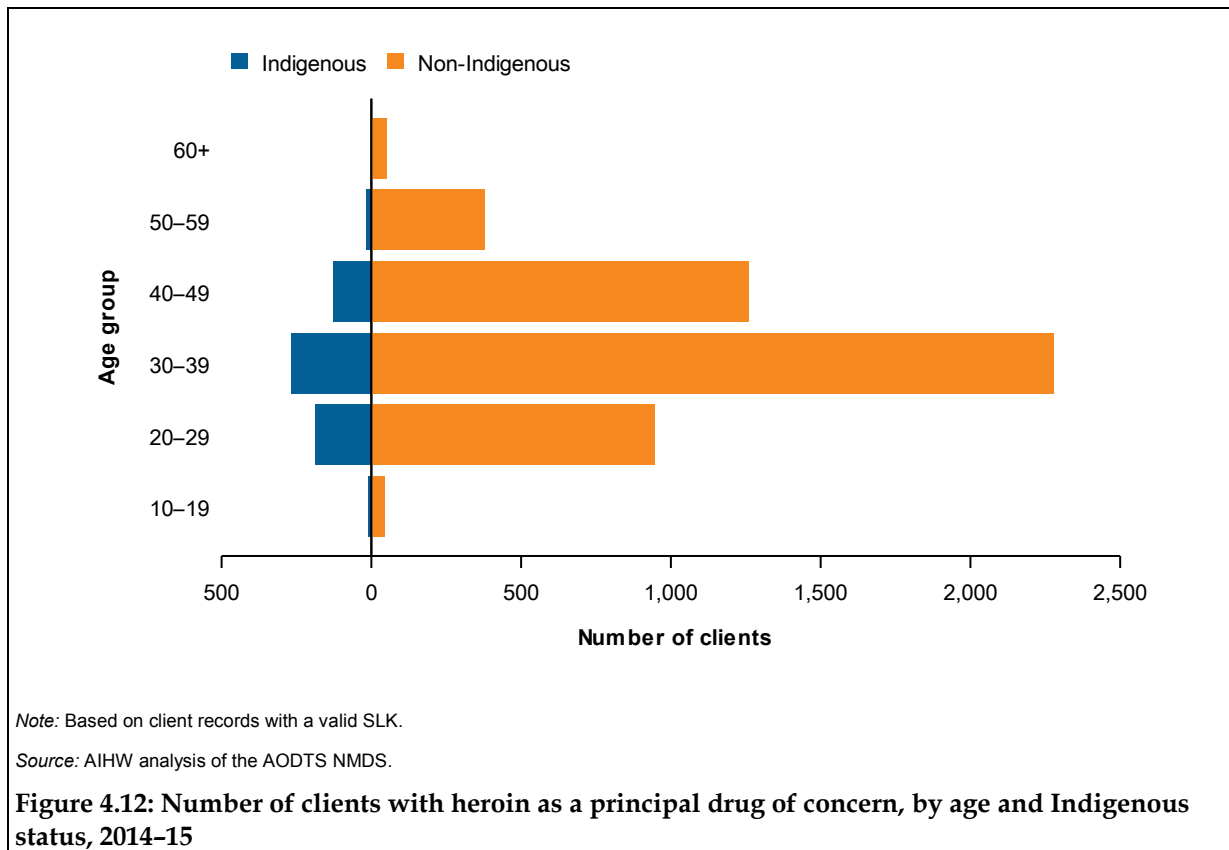
Of the clients receiving treatment across all 3 collection years from 2012–13 to 2014–15, a similar proportion of clients (11%) sought treatment for heroin as a main drug concern (Table SC.31).

Over the 5 years from 2010–11, the proportion of episodes where heroin was the principal drug of concern decreased steadily (from 9.9% to 6.1%) (Table SD.2).

Client demographics

Where heroin was the principal drug of concern, 69% of clients were male and 11% were Indigenous. Where heroin was the principal drug of concern, Indigenous people (133 per 100,000 Indigenous Australians) were more likely to have received treatment than the non-Indigenous population (28 per 100,000 non-Indigenous Australians) (Table SC.26).

Clients with heroin as their principal drug of concern were most likely to be aged 30–39 (45%), followed by those aged 40–49 (25%) and 20–29 (20%) (Tables SC.4–6). Indigenous clients who had a principal drug of concern of heroin tended to be younger: almost three-quarters (74%) were aged 20–39 (44% aged 30–39 and 30% aged 20–29) (Figure 4.12).

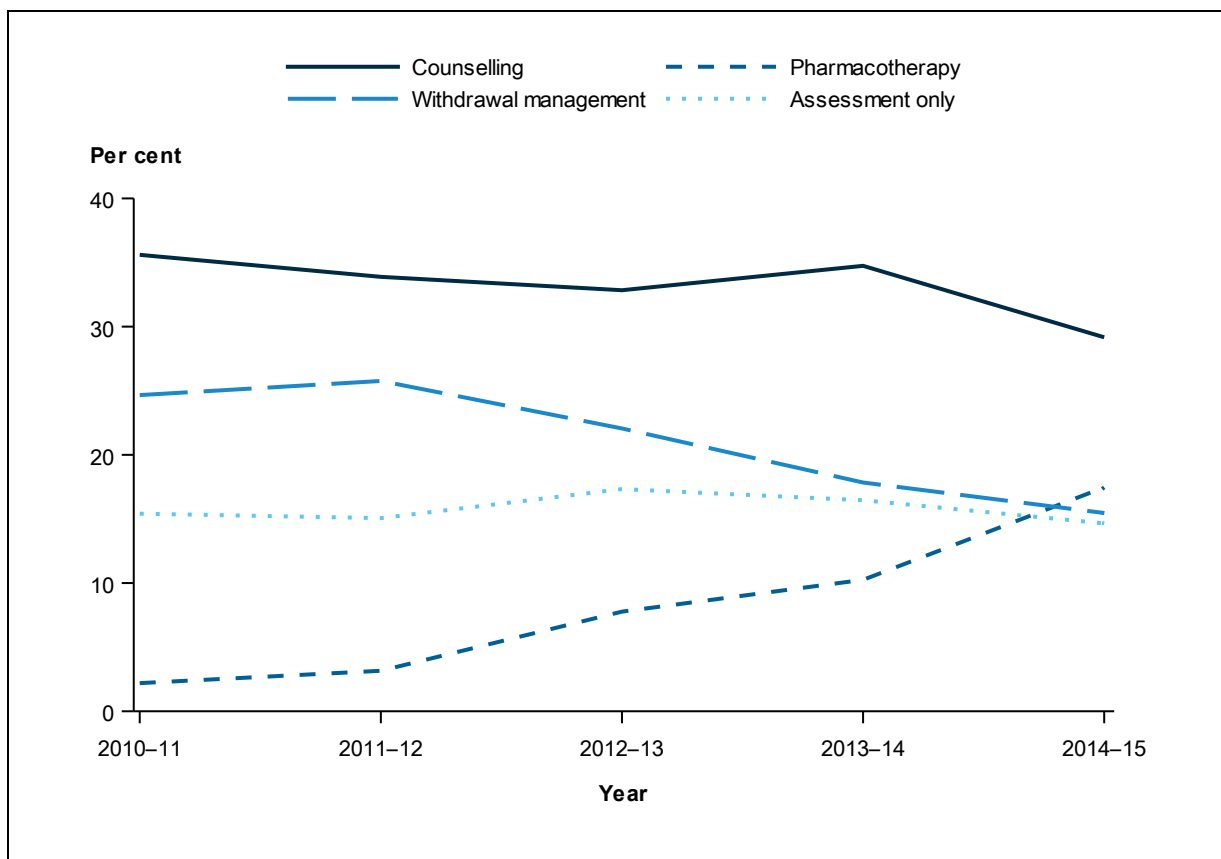


Treatment

The most common source of referral for treatment episodes where heroin was the principal drug of concern was self/family (47%), followed by a health service (23%) and diversion programs (12%) (Table SD.85).

The most common main treatment types were counselling (29%), pharmacotherapy and withdrawal management (both 15%) (Table SD.90). Note this collection does not systematically cover replacement therapies. Treatment episodes with heroin as the principal drug of concern were most likely to take place in a non-residential treatment facility (66%) (Table SD.92).

Over the 5 years to 2014-15, the proportion of episodes with withdrawal management as the main treatment type for the principal drug of concern of heroin decreased (from 25% to 15%) (Figure 4.13). The increase in the proportions for pharmacotherapy are mostly due to changes in the AODTS reporting specifications, allowing pharmacotherapy to be reported as a primary treatment, in combination with some other form of treatment, for the first time in 2011-12.



Source: Table SD.90.

Figure 4.13: Closed episodes with heroin as the principal drug of concern by the top 4 treatment types received, 2010-11 to 2014-15

Almost half (46%) of the episodes where heroin was the principal drug of concern lasted less than 1 month (19% ended within 1 day and were mostly for the main treatment types of assessment only, counselling and withdrawal management) (Table SE.25). The median duration of episodes with heroin as the principal drug of concern was just over 5 weeks (37 days). Episodes with counselling as the main treatment type had a median duration of about 9 weeks (64 days) and support and case management only had a median duration of more than 12 weeks (87 days). Episodes with a main treatment type of withdrawal management had a median duration of around 1 week (6 days) (Table SD.96).

More than half (56%) of closed episodes with heroin as the principal drug of concern ended with an expected cessation, and expected cessations were most common where the main treatment type was information and education only (91%) because this treatment type is usually completed within a day (Table SD.93).

4.6 Selected other drugs

A number of other drugs make up a smaller proportion of overall treatment services. These drugs may be less prominent in treatment services because they are less common or users are less likely to seek treatment. Information on nicotine, ecstasy, benzodiazepines and pharmaceuticals is presented in this section due to the size of the population using the drug and/or harms associated with use of that drug (see Box 4.1).

Results from the NDSHS showed that in 2013:

- Almost 1 in 6 Australians were current smokers and 1 in 8 were daily smokers.
- Among people aged 14 and older, daily smoking declined significantly between 2010 and 2013 (from 15% to 13%).
- Two per cent of Australians aged 14 and over used ecstasy in the previous 12 months.
- Ecstasy use declined from 3% in 2010 to 2.5% in 2013.
- An increase in pharmaceutical misuse in 2013 was mainly due to significant increases in recent use by men aged 30–39 (from 4.5% to 6.9%) and women aged 40–49 (from 3.1% to 4.5%).
- In 2013, 4.7% of people aged 14 or older used a pharmaceutical drug for non-medical purposes in the previous 12 months. This has increased since 2007 (3.7%) and was at the highest level of use seen since 2001 (3.9%) (AIHW 2014).

Box 4.1: Drug descriptions

Nicotine

Nicotine is the stimulant drug in tobacco smoke. It is highly addictive and causes dependency (ADCA 2013). Almost 8% of Australia's burden of disease was attributable to tobacco smoking in 2003 (Vos et al. 2007). The health effects of smoking include premature death and tobacco-related illnesses such as cancer, chronic obstructive pulmonary disease and heart disease.

Ecstasy

Ecstasy is the popular street name for a range of drugs said to contain the substance 3, 4 methylenedioxymethamphetamine (MDMA) – an entactogenic stimulant with hallucinogenic properties. Ecstasy is usually sold in tablet or pill form, but is sometimes found in capsule or powder form. The short-term effects of ecstasy include euphoria, feelings of wellbeing and closeness to others and increased energy. Harms include psychosis, heart attack and stroke. Little is known about the long-term effects of ecstasy use, but there is some research linking regular and heavy use of ecstasy to memory problems and depression (ADCA 2013).

Benzodiazepines

Benzodiazepines are depressant drugs – they slow down the activity of the central nervous system and the speed of messages going between the brain and the body. Formerly known as 'minor tranquillisers', benzodiazepines are most commonly prescribed by doctors to relieve stress and anxiety and to aid sleep. They are a drug of dependence and are associated with fatal and non-fatal overdose among opioid users. Some people use benzodiazepines illegally to become intoxicated or to 'come down' from the effects of stimulants such as amphetamines or cocaine (ADF 2013).

Pharmaceuticals

A pharmaceutical is a drug that is available from a pharmacy, over the counter or by prescription, which may be subject to misuse (MCDS 2011). In the 2014–15 AODTS NMDS report, 10 different drug types were identified as making up the group 'pharmaceuticals' for the purposes of this analysis: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics. Further information corresponding to the ASCDC codes and classifications are detailed in Appendix A.

The following selected drugs of concern were more likely to be reported as an additional drug of concern rather than a principal drug of concern (Table 4.1). Nicotine as a principal drug of concern was reported in only 1.6% of treatment episodes, but in 21% of episodes as an additional drug of concern. Clients seeking treatment for ecstasy tended to be younger, aged 10–29 (94%), and were more likely to be male (83%). Eight in 10 (80%) clients seeking treatment for benzodiazepines were aged over 30. Where pharmaceuticals were the principal drug of concern, there was a high rate of unexpected cessation for treatment (20%). (Table 4.1).

Table 4.1: Summary characteristics of other selected drugs, 2014–15 (%)

	Nicotine	Ecstasy	Benzodiazepines	Pharmaceuticals ^(a)
Sex^(b)				
Male	56.7	82.9	51.4	57.6
Female	43.3	17.1	48.6	42.4
Indigenous status^{(b)(c)}				
Indigenous	12.7	2.9	8.0	10.9
Non-Indigenous	64.1	73.3	89.2	84.6
Age^(b)				
10–19	16.9	33.6	1.9	1.9
20–29	22.5	57.1	18.0	19.2
30–39	19.4	7.9	34.3	37.2
40–49	17.7	0.1	25.7	25.7
50+	23.6	0	20.1	15.9
Drugs of concern				
Principal drug of concern	1.6	0.6	1.2	5.9
Additional drug of concern	21.3	2.0	5.5	11.1
Referral to treatment				
Self/family	26.6	12.9	46.7	48.8
Health service	32.8	5.3	35.1	35.3
Corrections	1.9	6.7	3.5	4.9
Diversion	30.1	72.4	6.9	4.4
Other	8.6	2.7	7.7	6.6
Main treatment type				
Counselling	34.2	25.0	34.6	26.0
Information and education only	11.2	35.4	4.4	3.4
Assessment only	25.1	25.7	19.8	20.7
Withdrawal management	9.8	2.0	20.3	17.5
Other ^(d)	19.6	11.8	20.9	32.4

(continued)

Table 4.1 (continued): Summary characteristics of other selected drugs, 2014–15 (%)

	Nicotine	Ecstasy	Benzodiazepines	Pharmaceuticals ^(a)
Treatment setting				
Non-residential treatment facility	66.7	84.2	61.4	67.6
Residential treatment facility	3.1	2.0	20.3	15.4
Other ^(e)	28.8	13.7	18.3	16.9
Treatment completion				
Expected cessation	79.4	87.6	56.3	53.6
Unexpected cessation	11.3	5.2	17.8	20.2
Other ^(f)	9.2	7.1	25.8	26.3
Median duration	3 days	1 day	21 days	22 days

(a) Includes codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

(b) Based on valid SLK client data

(c) The proportion of clients for Indigenous status may not sum to the total due to missing or not reported data.

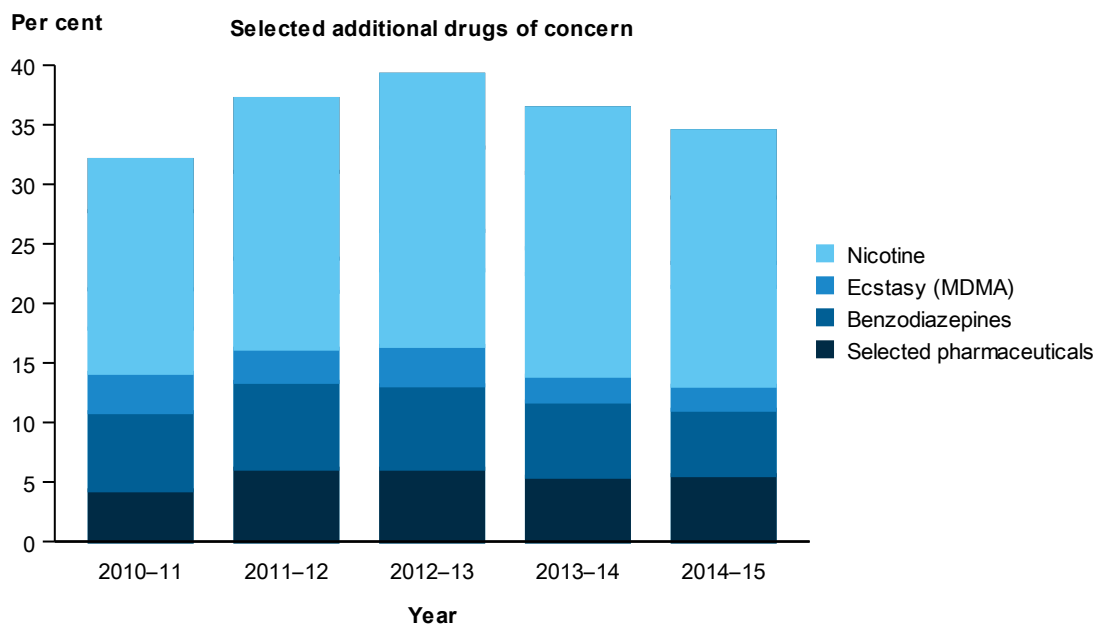
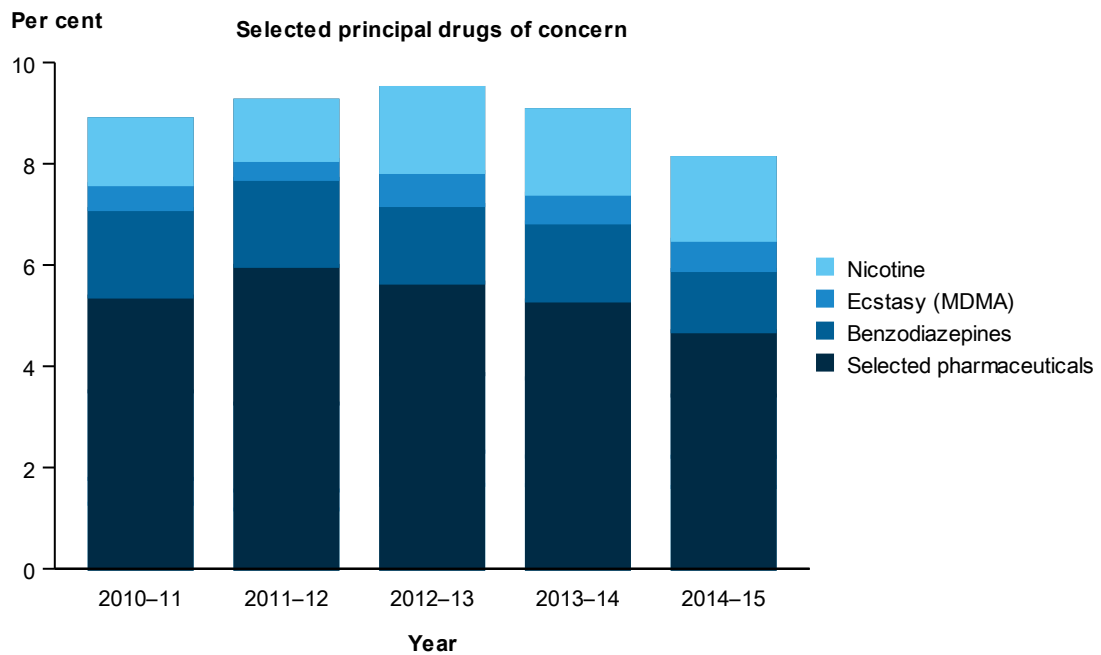
(d) Includes support and case management only, pharmacotherapy, other and rehabilitation.

(e) Includes where treatment is delivered in the client's own home or usual place of residence or in an outreach setting.

(f) Includes administrative cessation.

Sources: Figure 4.2, tables SC.4–6, SD.66, SD.69, SD.73, SD.78–79, SD.98, SD.106, SD.108–110, SD.114, SD.122, SD.124–126.

The proportion of episodes with nicotine, ecstasy and benzodiazepines as the principal drug of concern remained stable at 1–2% per year since 2010–11, whereas pharmaceutical drugs as a group increased from 7.1% of episodes in the same period peaking at 7.7% in 2011–12, decreasing in 2014–15 (5.9%) (Figure 4.14, table SD.2). Over the 5 years to 2014–15, results for additional drugs of concern varied, with decreases in ecstasy (from 4% to 2% of treatment episodes) and benzodiazepines (from 8% to 6%), increases in episodes for nicotine (21% to 23%) and fluctuations for pharmaceutical drugs—increasing from 11% to 13% in 2011–12, then decreasing to 11% in 2014–15 (tables SD.9 and SD.146).



Notes

1. Selected pharmaceuticals include: analgesics (excluding heroin), sedatives and hypnotics (excluding alcohol and benzodiazepines) and steroids.
2. The stacked bars represent the proportion of selected drugs reported as either a principal drug of concern or an additional drug of concern. Up to 5 'Other' drugs of concern can be reported in addition to the principal drug of concern but clients do not receive treatment for these.

Source: AIHW analysis of the AODTS NMDS.

Figure 4.14: Closed episodes for selected drugs of concern, 2010-11 to 2014-15

Nicotine

In 2014–15, nicotine was a principal drug of concern in just 1.6% of episodes. However, it was an additional drug of concern in 21% of episodes (Figure 4.2). Since 2005–06, the proportion of episodes with nicotine as the principal drug has remained stable at 1–2% (Table SD.2). Possible reasons for the low proportion of episodes in which nicotine was the principal drug include the wide availability of support and treatment for nicotine use in the community, such as through general practitioners, pharmacies, helplines or web services. People may also view AOD treatment services as most appropriate for drug use that is beyond the expertise of general practitioners.

Client demographics

Where nicotine was a principal drug of concern, 57% of clients were male and 13% were Indigenous. Over one-third of clients with nicotine as a principal drug of concern were aged 10–29 (39%) and a further 24% were aged over 50 (Table 4.1). Nicotine was more likely to be an additional drug of concern rather than the principal drug for all age groups – nicotine was the most commonly reported drug as an additional drug of concern in all episodes (Table SD.8).

Nicotine was more commonly reported as an additional drug of concern – the most commonly reported principal drugs of concern in combination with nicotine as an additional drug of concern were alcohol (34%) and cannabis (29%) (Figure 4.2).

Treatment

The most common source of referral for treatment episodes where nicotine was the principal drug of concern was a health service (33%), followed by police or court diversion program (30%) (Table 4.1).

Counselling (34%), assessment only (25%) and information and education only (11%) were the most common main treatment types (Tables 4.1 and SD.74). Treatment episodes where nicotine was the principal drug of concern were most likely to take place in a non-residential treatment facility (67%) (Table SD.76).

Two-thirds (66%) of episodes with nicotine as the principal drug lasted less than 1 month (48% ended within 1 day and were mostly for the main treatment type of assessment only) (Table SE.25). The median duration of episodes with nicotine as the principal drug of concern was 3 days (Table SD.79).

More than three-quarters (79%) of episodes with nicotine as the principal drug of concern ended with an expected cessation, while 1 in 10 (11%) ended due to an unexpected cessation. Expected cessations were most common where the main treatment type was assessment only (30%) (Table SD.78).

Ecstasy

Ecstasy was a principal drug in less than 1% of episodes and an additional drug of concern in 2.0% of closed episodes in 2014–15 (tables SD.114 and SE.9). The proportion of episodes with ecstasy as a principal drug has remained stable up to 1% of all episodes since 2005–06. However, as an additional drug of concern, it decreased from 5.8% of episodes in 2008–09 to 2.1% in 2014–15 (tables 4.1 and SD.2).

Client demographics

Where ecstasy was the principal drug of concern, over 8 in 10 (83%) clients were male and 3% were Indigenous. Over half of the clients (57%) with ecstasy as a principal drug of concern were aged 20–29, and almost 2 in 5 were aged 10–19 (34%) (Table 4.1).

As for nicotine, ecstasy was more likely to be reported by clients as an additional drug of concern – the most common principal drugs of concern that were reported in combination with ecstasy as an additional drug of concern were alcohol (34%) and cannabis (27%) (Figure 4.2).

Treatment

In almost 3 in 4 treatment episodes where ecstasy was the principal drug of concern, the client's source of referral was from police and court diversion (72%) (Table 4.1).

Information and education only (35%) was the most common main treatment type for episodes where ecstasy was the principal drug, followed by assessment only (26%) and counselling (25%) (Table SD.121). Treatment episodes where ecstasy was the principal drug of concern were most likely to take place in a non-residential treatment facility (84%) (Table SD.124).

Just over 4 in 5 (81%) episodes with ecstasy as the principal drug lasted less than 1 month (64% ended within 1 day and were mostly for the main treatment type of assessment only) (Table SE.25). The median duration of episodes with ecstasy as the principal drug of concern was 1 day (Table SD.127).

Almost 9 in 10 (88%) episodes with ecstasy as the principal drug of concern ended with an expected cessation, while 5% ended due to an unexpected cessation. Expected cessations were most common where the main treatment type was information and education only (39%) (Table SD.125).

Benzodiazepines

In 2014–15, benzodiazepines were a drug of concern (principal or other) in 7% of closed episodes and the principal drug in 1% of episodes (Table 4.1). There was only 1 percentage point change in the proportion of episodes with benzodiazepines as the principal drug in the 10 years from 2005–06 (Table SD.2).

Client demographics

Where benzodiazepines were the principal drug of concern, around half (51%) of the clients were male and 8% were Indigenous. Around 3 in 5 clients (60%) with benzodiazepines as a principal drug of concern were aged 30–49, and one-fifth (20%) were aged 50 and over (Table 4.1).

Benzodiazepines were more likely to be an additional drug of concern for clients – the most common principal drugs of concern in combination with benzodiazepines as an additional drug of concern were alcohol (18%), cannabis (17%) and nicotine (13%) (Figure 4.2).

Treatment

The most common source of referral for treatment episodes where benzodiazepines were the principal drug of concern was self/family (47%), followed by a health service (35%) (Table 4.1).

The most common main treatment type for episodes where benzodiazepines were the principal drug of concern was counselling (35%), followed by withdrawal management and assessment only (both 20%) (Table SD.106). Treatment episodes were most likely to take place in a non-residential treatment facility (61%) or a residential treatment facility (20%). Almost all (95%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table SD.108).

More than half (56%) of the episodes with benzodiazepines as the principal drug of concern lasted less than 1 month, with another 24% of episodes lasting up to 3 months, with a main treatment of counselling (57%) (Table SE.25). The median duration of episodes with benzodiazepines as the principal drug of concern was 3 weeks (21 days) (Table SD.111).

Over half (56%) of episodes with benzodiazepines as the principal drug of concern ended with an expected cessation, while 1 in 5 (18%) ended due to an unexpected cessation. Expected cessations were more common for episodes where the main treatment type was counselling (29%) or withdrawal management (23%) (Table SD.109).

Pharmaceuticals

As a group, pharmaceuticals are not listed as a broad drug group in the Australian Standard Classification of Drugs of Concern (ASCDC) classification. Ten different drug types were identified as making up the group pharmaceuticals for the purposes of this report: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics. In 2014–15, pharmaceuticals were the principal drug of concern in 5.9% of episodes (Table 4.1).

Over the 10-year period from 2005–06, the proportion of treatment episodes with a pharmaceutical drug as the principal drug of concern generally increased from 6.0% in 2005–06 to 7.7% in 2011–12, and again decreased in 2014–15 (5.9%). The proportion of treatment episodes for methadone, morphine and benzodiazepines have been decreasing over the 10-year period, while they have been increasing for codeine, oxycodone and buprenorphine (Table SD.146).

Despite this, in 2014–15, benzodiazepines still represent the largest single drug type within the pharmaceutical group, at 21% of the proportion of closed episodes. This was followed by methadone (17%), morphine (15%), codeine (13%) and oxycodone (11%) (Table SD.146).

Client demographics

Where pharmaceuticals were the principal drug of concern, over half (58%) the clients were male and around 1 in 10 were Indigenous (11%). Female clients are more likely to report certain individual pharmaceutical drug types. For example, in 2014–15, a higher proportion of female clients (53%) reported codeine as their principal drug of concern, where historically higher proportions of female clients have reported benzodiazepines as their principal drug of concern (Table 4.1).

The most common age group for clients seeking treatment for pharmaceuticals as a principal drug of concern were aged 30–39 (37%), followed by clients aged 40–49 (26%) and 20–29 (19%) (Table 4.1).

Pharmaceuticals were more likely to be reported as an additional drug of concern in closed treatment episodes – the most common principal drugs of concern reported in combination

with pharmaceuticals as an additional drug of concern were alcohol (24%), amphetamines (22%) and heroin (18%) (tables 4.1 and SD.147).

Treatment

Almost half of the referrals for treatment episodes where pharmaceuticals were the principal drug of concern were for self/family (49%), followed by a health service (35%) (Table 4.1).

The most common main treatment type for episodes where pharmaceuticals were the principal drug of concern was counselling (26%), followed by assessment only (21%) and withdrawal management (17%) (Table 4.1). In 2014–15, clients with pharmaceuticals as a principal drug of concern were more likely than other clients to have ever injected a drug. In around one-third of episodes (31%), clients reported they last injected within the last 3 months, whereas for all other drugs, clients were more likely to report having never injected (57% of treatment episodes) (Table SD.153).

Over half (54%) of episodes ended with an expected cessation for clients receiving treatment for pharmaceuticals as the principal drug of concern, while 1 in 5 (20%) ended due to an unexpected cessation. In 2014–15, expected cessations were more common within the pharmaceutical group for episodes where the treatment was for benzodiazepines (22%), while the highest proportion for unexpected cessation was for morphine (17%) (tables 4.1 and SD.150).

5 Treatment provided

There are a number of treatment types available to assist people with problematic drug use in Australia. Most aim to reduce the harm of drug use, while others use a structured drug-free setting with abstinence-oriented interventions. This chapter provides information on the treatment types provided by publicly funded AOD treatment agencies in Australia. Information on clients and treatment agencies is included in the AODTS NMDS when a treatment episode provided to a client is closed (see Box 2.1). Treatment is available to assist people to address their own drug use, and to support the family and friends of people using drugs.

5.1 Key facts

In 2014–15:

- Counselling was the most common treatment type (40%).
- The most common source of referral for treatment episodes was self/family (39%).
- Around 4 in 5 (79%) closed treatment episodes ended within 3 months.
- The median duration of closed treatment episodes was about 3 weeks (22 days).
- Around 2 in 3 (63%) closed treatment episodes had an expected cessation.
- Most of the treatment episodes provided to clients for their own drug use were for male clients (66%), whereas most clients seeking support for someone else's drug use were female (63%).
- Clients seeking support for someone else's drug use tended to be older – over half (55%) of the clients were aged over 40, compared with over two-thirds (70%) of clients seeking treatment for their own drug use aged 10-39.

Over the 5-year period to 2014–15:

- The proportion of episodes for each main treatment type has remained fairly stable, with counselling, withdrawal management and assessment only being the most common types of treatment.
- The median duration of closed episodes for the client's own drug use decreased from 23 days to 22 days, peaking at 25 days in 2011–12.
- The proportion of episodes with an expected cessation has decreased from 68% to 63%.

5.2 Characteristics of clients and episodes

In 2014–15, 114,912 clients (client records with a valid SLK) received 170,367 treatment episodes from AOD treatment agencies. Most (95%) of the clients were seeking treatment for their own drug use – a total of 109,284 clients (or 95% of episodes) – and most of these were male (69% of clients). Conversely, clients seeking support for someone else’s drug use were more likely to be female (63%) (tables SC.1, SC.14 and SE.2).

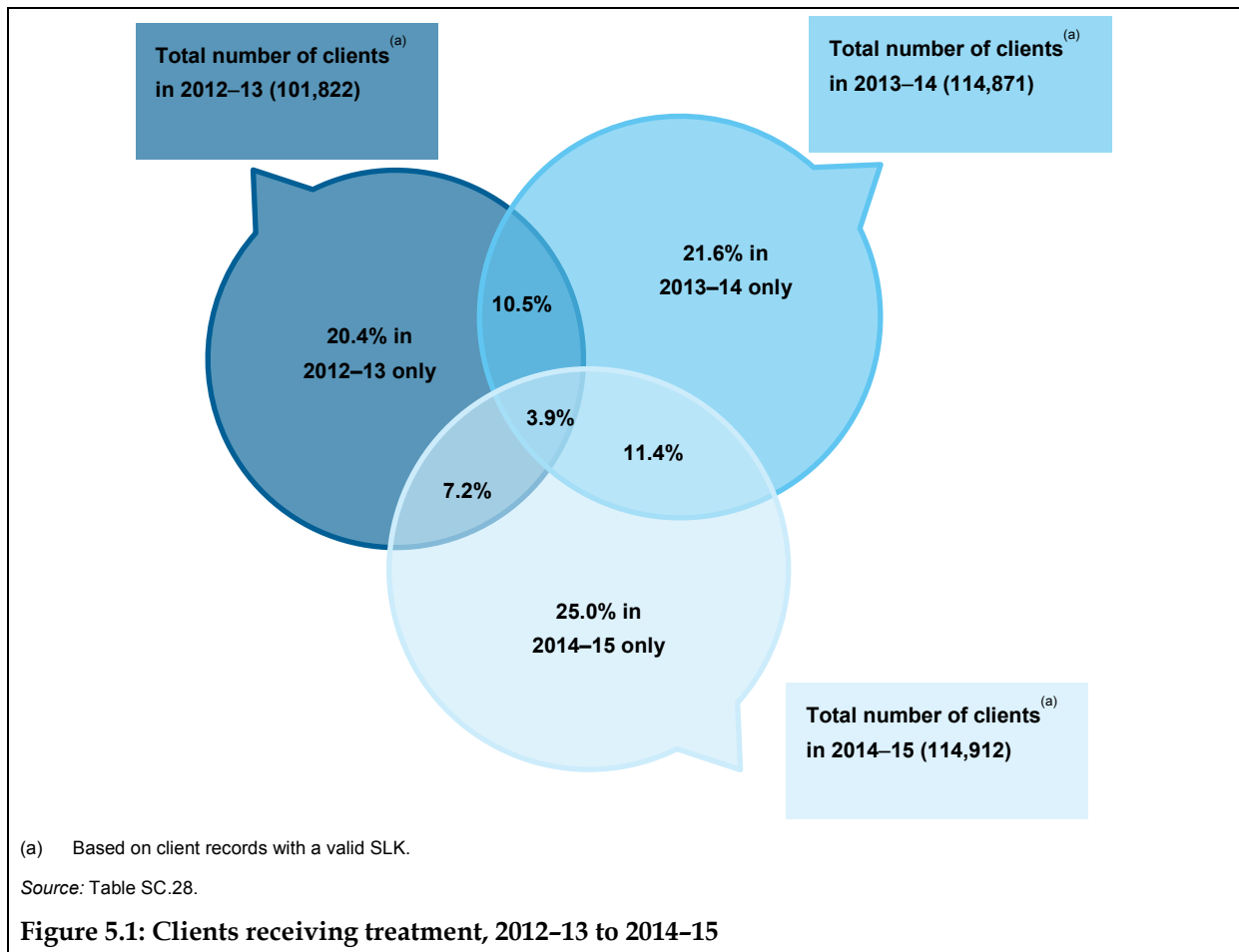
Treatment was provided to around 1 in 7 (15%), Indigenous clients in 2014–15. This proportion was consistent for clients receiving treatment for their own drug use (15%), while 10% of Indigenous clients were receiving support for someone else’s drug use (Table SC.4).

In 2014–15, more than half (55%) of clients seeking treatment were aged 20–39. Clients seeking support for someone else’s drug use tended to be older – over half (55%) of the clients were aged 40 and over, compared with just under one-third (30%) of episodes for those in that age group receiving treatment for their own drug use (Table SC.3).

Nationally, in 2014–15, just over two-thirds (70%) of closed treatment episodes were provided in *Major cities*, 16% in *Inner regional* areas and 11% in *Outer regional* areas. Relatively few treatment episodes were provided in *Remote* or *Very remote* areas (3% and 1%, respectively).

In 2014–15, most (85%) clients received treatment at 1 agency, 11% at 2, and 2% of clients received treatment at 3 or more agencies (Table SC.23). Nationally, the number of clients presenting to publicly funded AOD services slightly increased between 2013–14 and 2014–15.

A total of 242,279 clients received treatment over these 3 years. Of these, 25% (60,507 clients) presented in 2014–15 only, and 11% (27,595) received treatment in both 2013–14 and 2014–15 (Figure 5.1).



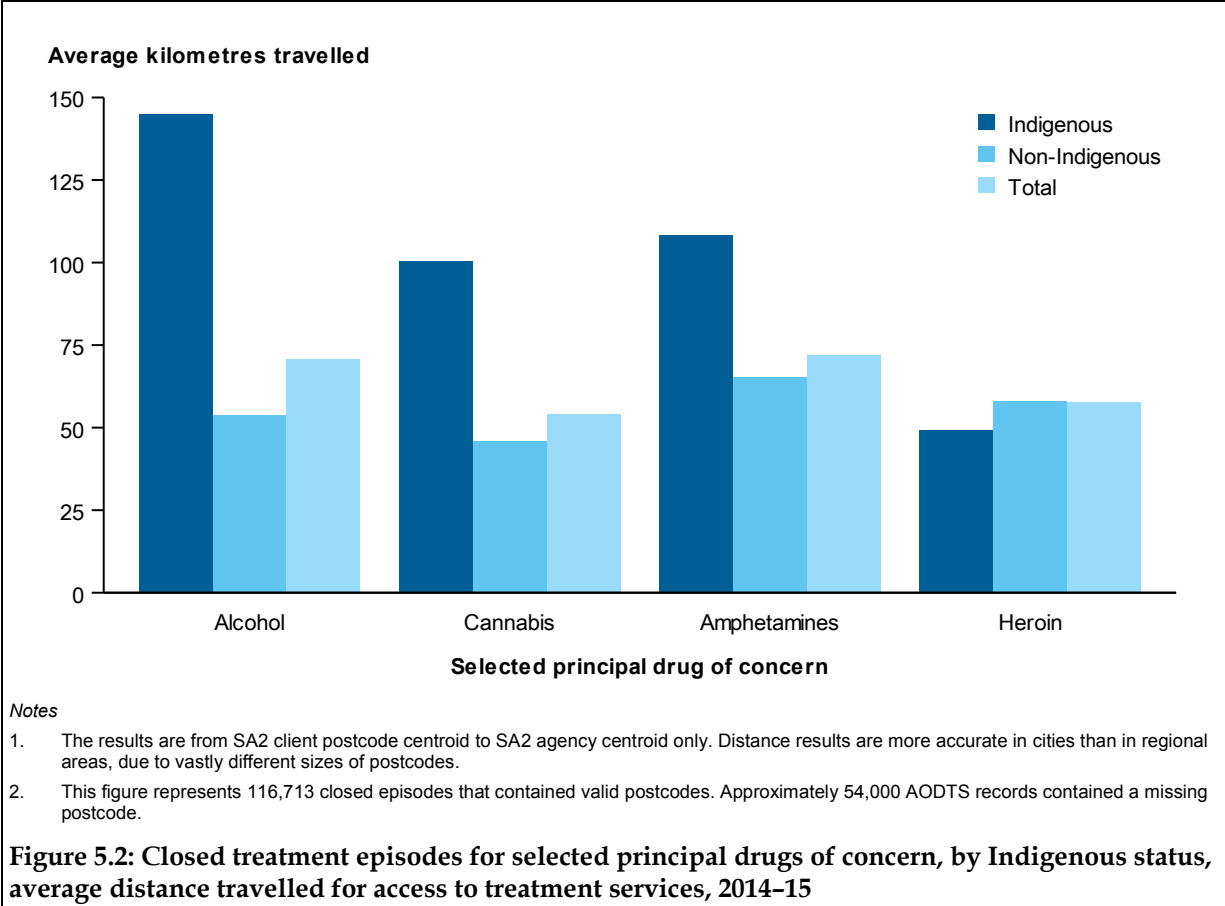
5.3 Location of treatment

This section focuses on the average distance clients travel to receive treatment. It also describes the coverage of treatment services across Australia (using population rates) and how this correlates to selected principal drugs of concern.

The proportion of AOD treatment services catering for specific drugs of concern varies with the geographic distribution of the client population, and specific services. This means that access to treatment will vary depending on the drug of concern, treatment type and specific population group seeking treatment. For example, the proportion of the Indigenous population living in remote areas is greater than the non-Indigenous population, so the average distance travelled to services for Indigenous people is likely to be greater. Overall travel to residential treatment services (including, rehabilitation and withdrawal management) are greater because the proportion of these services are much lower compared with non-residential services, whereas counselling services are more widely available so less travel is required, on average. A large number of Information and education only services relate to specific programs that are delivered to people who are diverted from the criminal drug system; access to these services may require greater travel because they may only be located in highly populated areas.

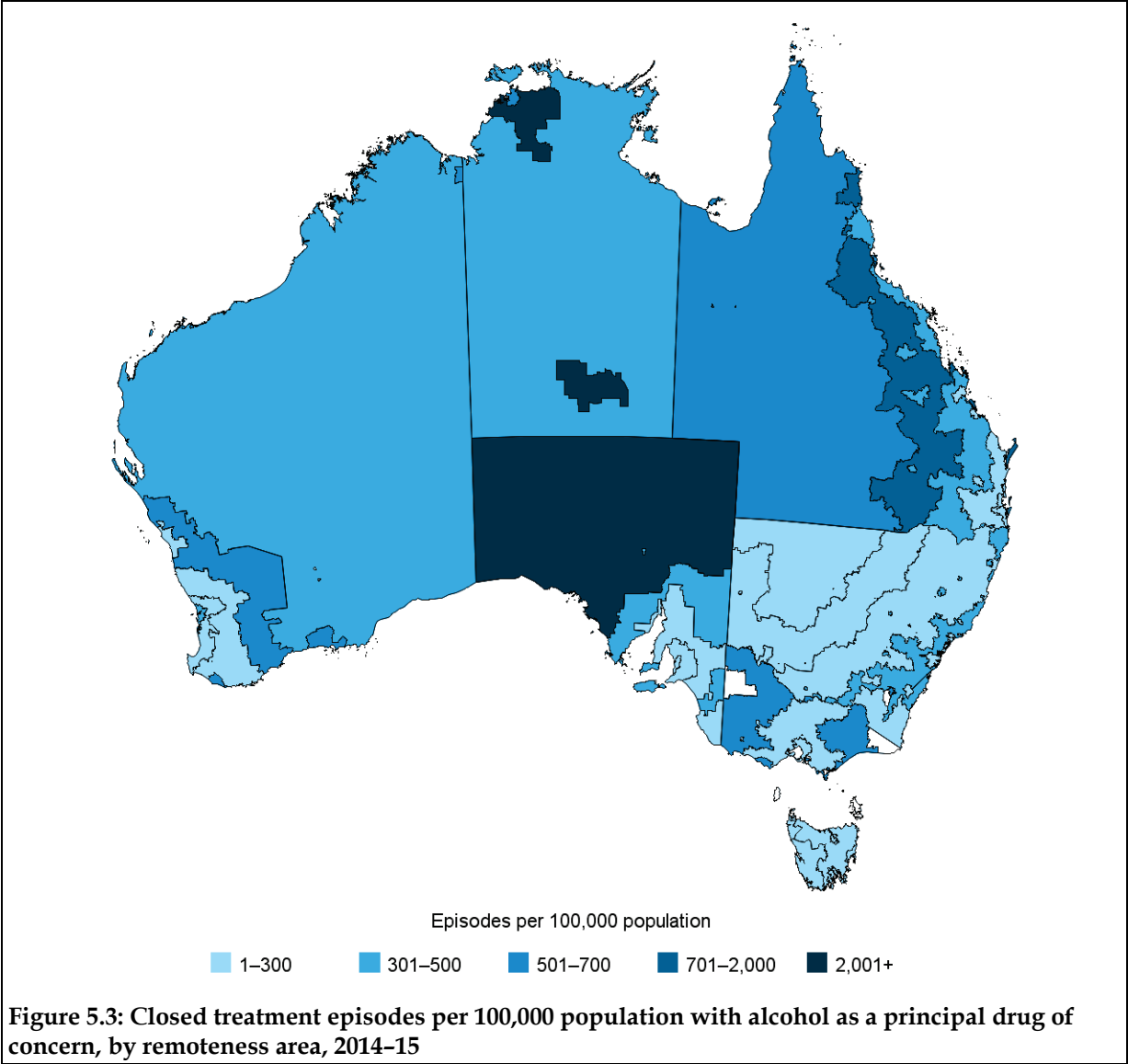
Distance travelled is measured by calculating the distance between the postcode of the client’s usual address and the Statistical Area level 2 (SA2) of the agency where treatment was provided. See Appendix A for more detail.

For the top 4 principal drugs of concern, the average distance travelled to access AOD treatment services in 2014–15, was similar for amphetamines (72 km) and alcohol (71 km), followed by heroin (58 km) and cannabis (54 km). Where alcohol was the principal drug of concern, the average distance travelled by Indigenous clients seeking treatment services (145 km) was 3 times the average distance travelled by non-Indigenous clients (54 km). Where cannabis was the principal drug of concern, Indigenous clients seeking treatment travelled more than twice the average distance than non-Indigenous clients – 101 km compared with 46 km. The average distance travelled overall for AOD treatment services was greater for Indigenous clients (123 km) than non-Indigenous clients (53 km) (Figure 5.2).

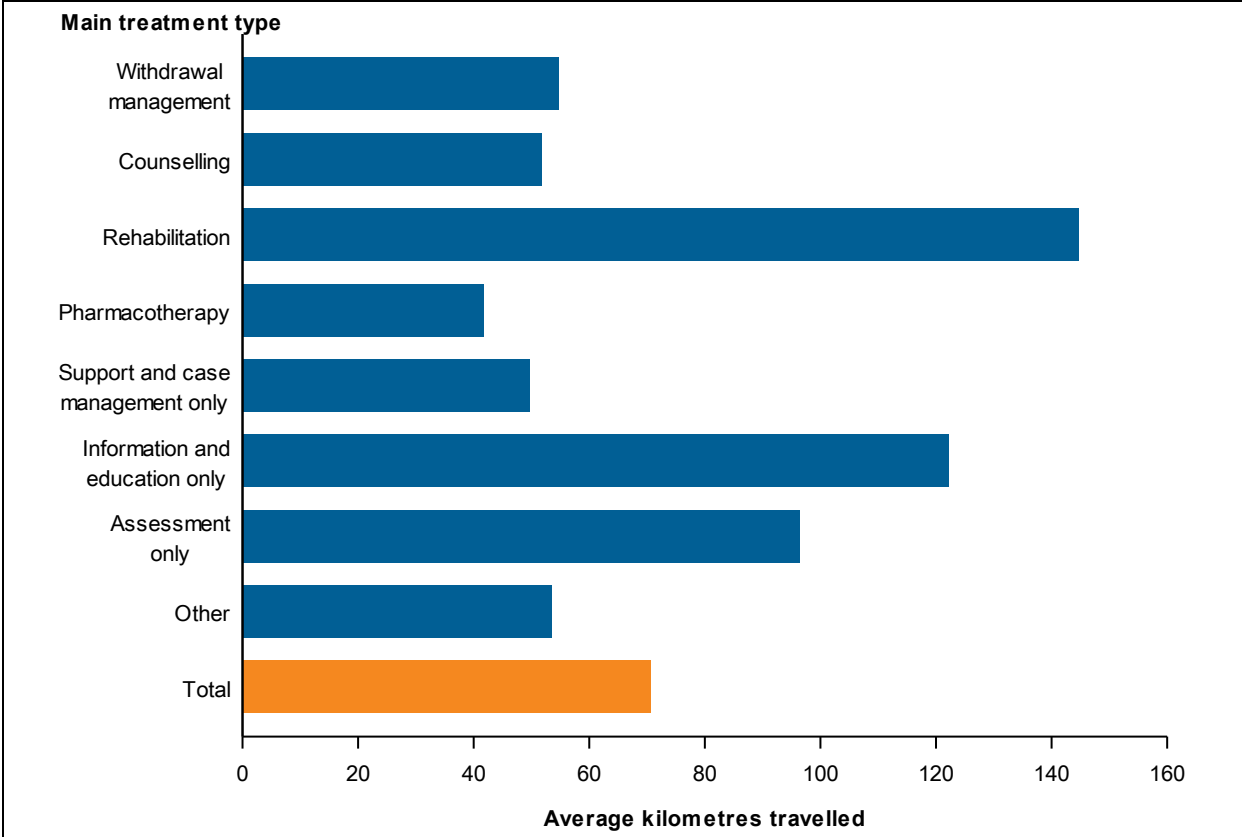


Alcohol

Closed treatment episodes in 2014–15 where alcohol was the principal drug of concern were more likely to be provided in a major city (65%) (Table SA.8). However, when population rates were applied, the proportion of treatment services was highest overall in remote areas across Australia (Table SG.5). The highest rates for treatment related to alcohol were spread across *Very remote* areas in South Australia, following *Remote* and *Very remote* parts of the Northern Territory, and *Remote* regions in Queensland and Western Australia. Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map (Figure 5.3).



In 2014–15, the average distance travelled to access treatment services provided for alcohol was approximately 71 km. Access to different forms of treatment provided for alcohol varied, with rehabilitation services reporting the longest average distance travelled (145 km), followed by information and education only (122 km), with the shortest average distance travelled for pharmacotherapy services (42 km) (Figure 5.4, Table SG.3).

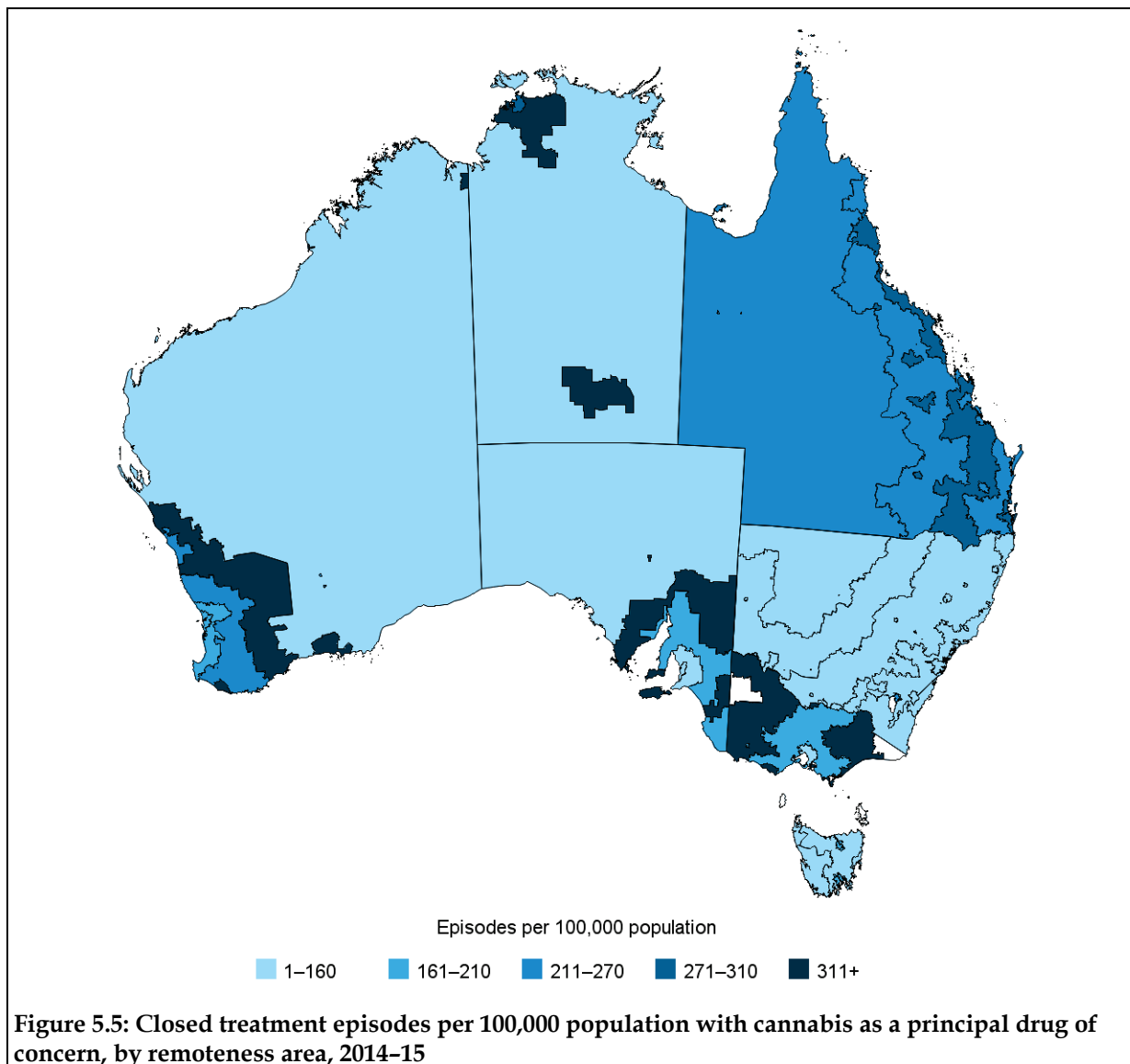


- Notes*
1. The results are from client postcode centroid to SA2 agency centroid only. Distance results are more accurate in cities than in regional areas, due to discrepancies in sizes between different postcodes.
 2. This figure represents 116,713 closed episodes that contained valid postcodes. Approximately 54,000 AODTS records contained a missing postcode.

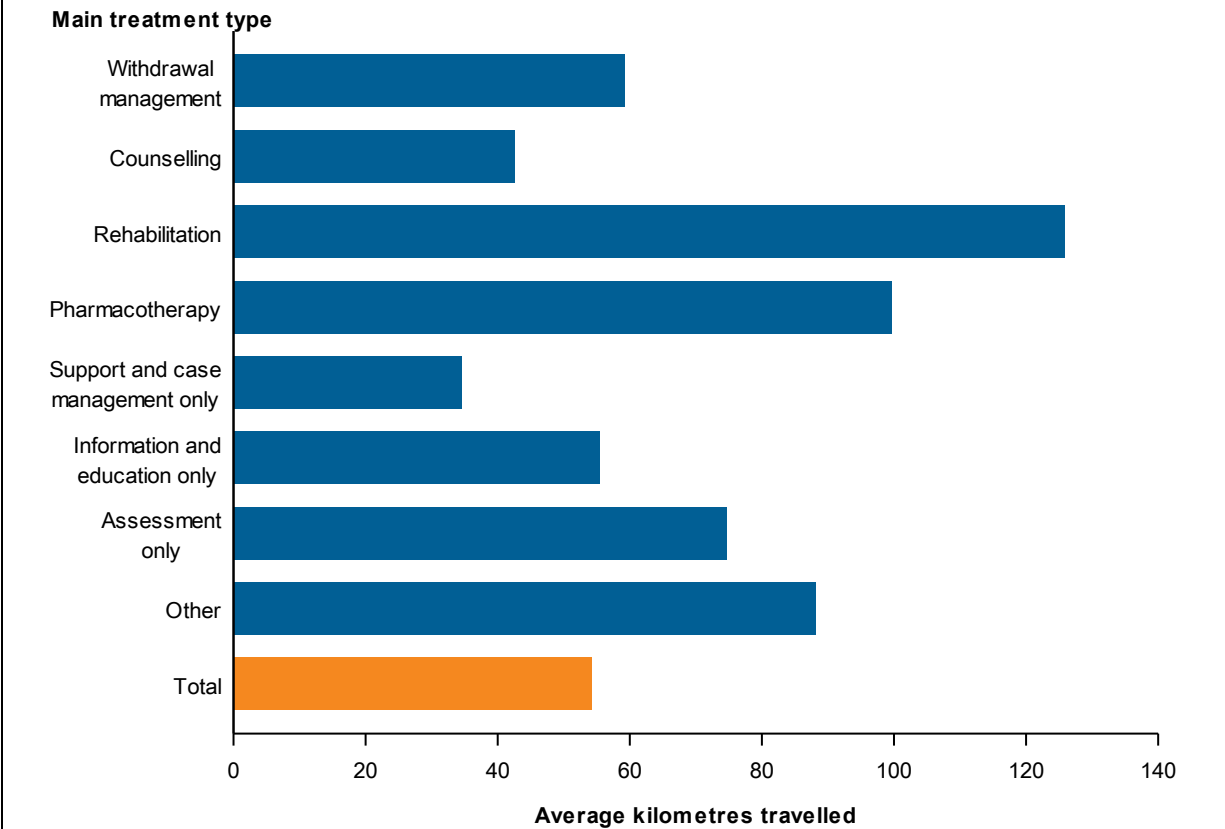
Figure 5.4: Closed treatment episodes provided for own drug use with alcohol as a principal drug of concern, by average distance travelled by clients to main treatment services, 2014–15

Cannabis

Closed treatment episodes in 2014–15 where cannabis was the principal drug of concern were more likely to be provided in *Major cities* (67%) (Table SA.8). However, when population rates were applied, the proportion of treatment services was highest overall in *Outer regional* areas across Australia (Table SG.6). The highest rates for treatment related to cannabis were spread across *Outer regional* and *Remote* areas in Queensland, followed by *Remote* areas of Western Australia, and *Remote* parts bordering Victoria and South Australia. The Northern Territory displays a concentration of cannabis treatment in *Outer regional* areas as well as the *Remote* central desert region. Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map (Figure 5.5).



In 2014–15, the average distance travelled to access treatment services provided for cannabis was approximately 54 km. Access to different forms of treatment provided for cannabis varied, with rehabilitation services reporting the longest average distance travelled (126 km), followed by pharmacotherapy (100 km), with the shortest average distance travelled for support and case management services (35 km) (Figure 5.6, Table SG.3).

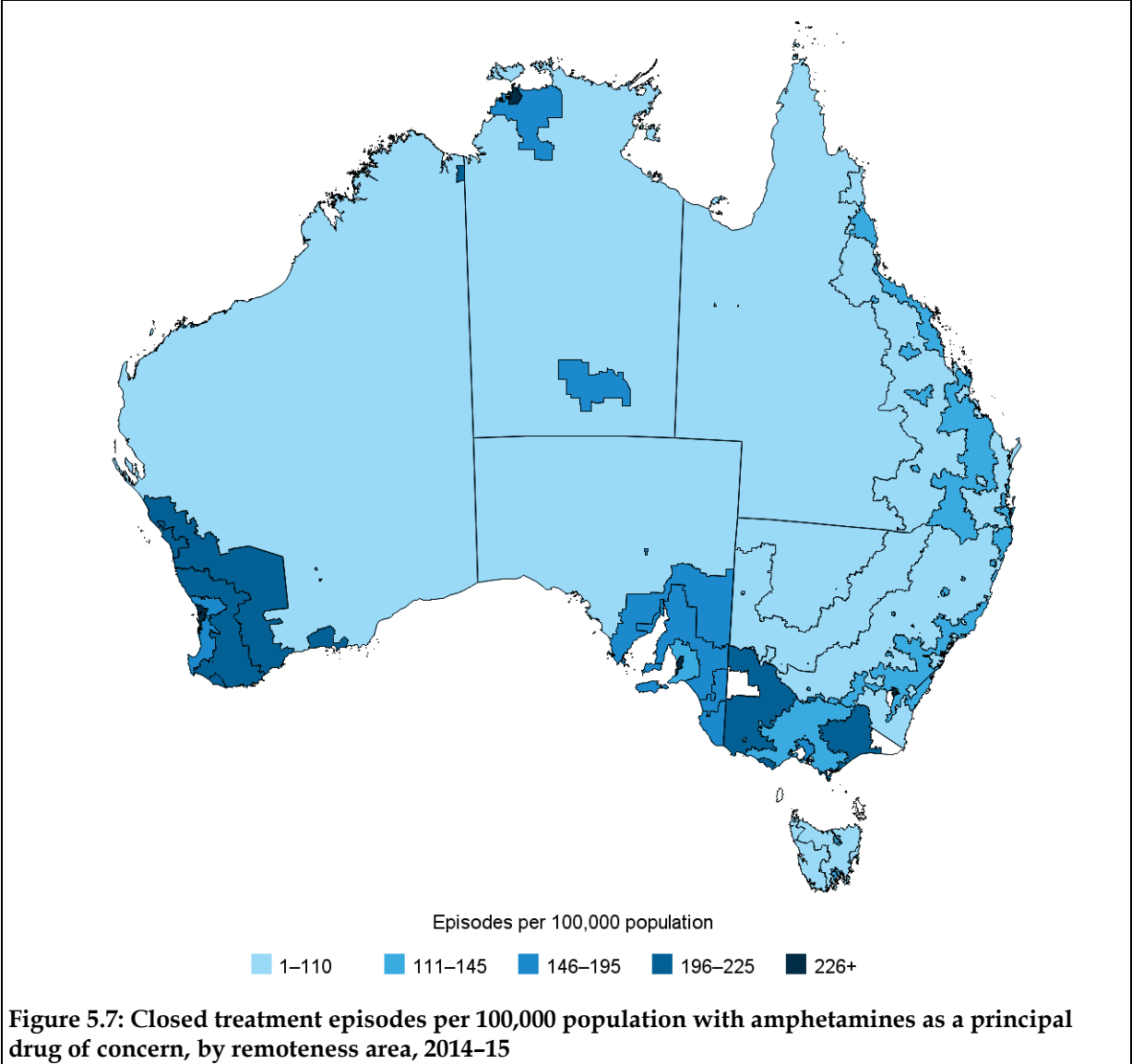


- Notes
1. The results are from client postcode centroid to SA2 agency centroid only. Distance results are more accurate in cities than in regional areas, due to discrepancies in sizes between different postcodes.
 2. This figure represents 116,713 closed episodes that contained valid postcodes. Approximately 54,000 AODTS records contained a missing postcode.

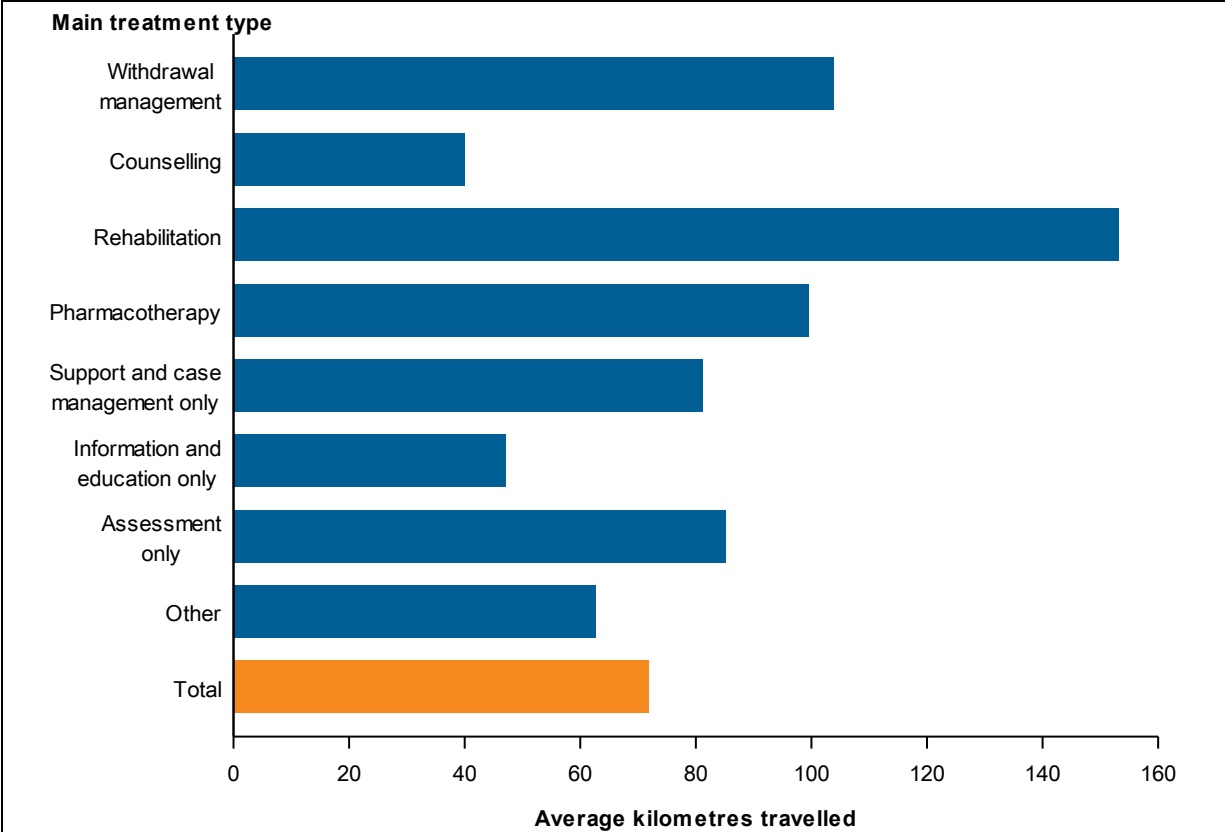
Figure 5.6: Closed treatment episodes provided for own drug use with cannabis as a principal drug of concern, by average distance travelled by clients to main treatment services, 2014–15

Amphetamines

Closed treatment episodes in 2014–15 where amphetamines was the principal drug of concern were very likely to be provided in *Major cities* (74%) (Table SA.8). However, when population rates were applied, the proportion of treatment services was highest overall in *Outer regional* areas across Australia (Table SG.7). The highest rates for treatment related to amphetamines were spread across *Outer regional* and *Remote* areas of Western Australia, also bordering *Outer regional* parts of Victoria and South Australia. The Northern Territory displays a concentration of amphetamine treatment in *Outer regional* areas as well as the *Remote* central desert region. Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map (Figure 5.7).



In 2014–15, the average distance travelled to access treatment services provided for amphetamines was approximately 72 km. Access to different forms of treatment provided for amphetamines varied, with rehabilitation services reporting the longest average distance travelled (153 km), followed by pharmacotherapy (100 km), with the shortest average distance travelled for counselling services (40 km) (Figure 5.8, Table SG.3).



- Notes
1. The results are from client postcode centroid to SA2 agency centroid only. Distance results are more accurate in cities than in regional areas, due to discrepancies in sizes between different postcodes.
 2. This figure represents 116,713 closed episodes that contained valid postcodes. Approximately 54,000 AODTS records contained a missing postcode.

Figure 5.8: Closed treatment episodes provided for own drug use with amphetamines as a principal drug of concern, by average distance travelled by clients to main treatment services, 2014–15

Heroin

Closed treatment episodes in 2014–15 where heroin was the principal drug of concern were very likely to be provided in a *Major city* (89%) (Table SA.8). Similar results were found when population rates were applied, with the proportion of heroin treatment services highest overall in *Major cities* across Australia (Table SG.8). The Australian Capital Territory had the highest rates for heroin treatment in a *Major city*. For *Inner regional* areas the highest rates for treatment services were in New South Wales, followed by Victoria which also had high rates in *Outer regional* areas. Due to the size of the remoteness areas, the concentration of treatment provided in *Major cities* is not visible on the map (Figure 5.9).

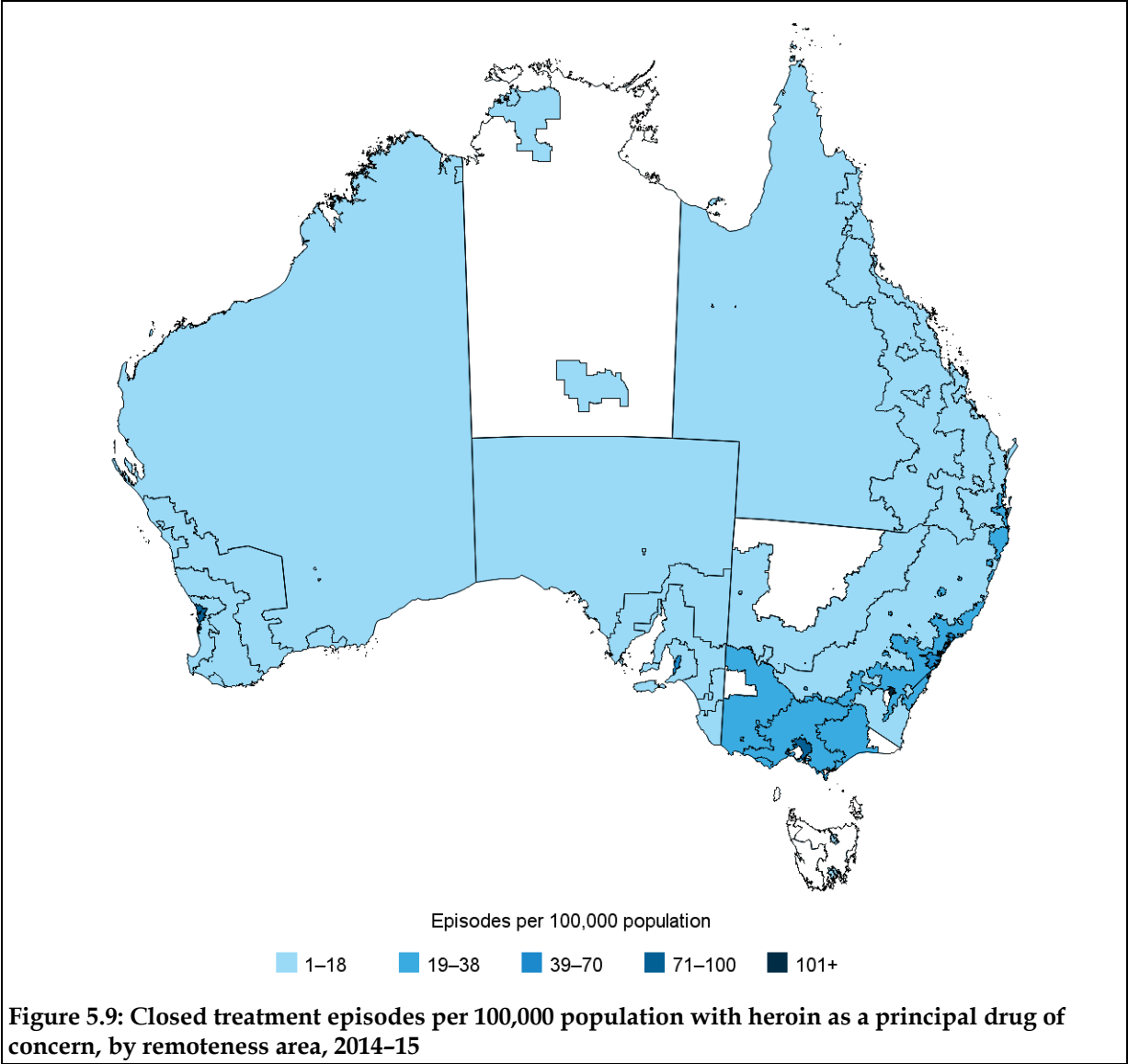
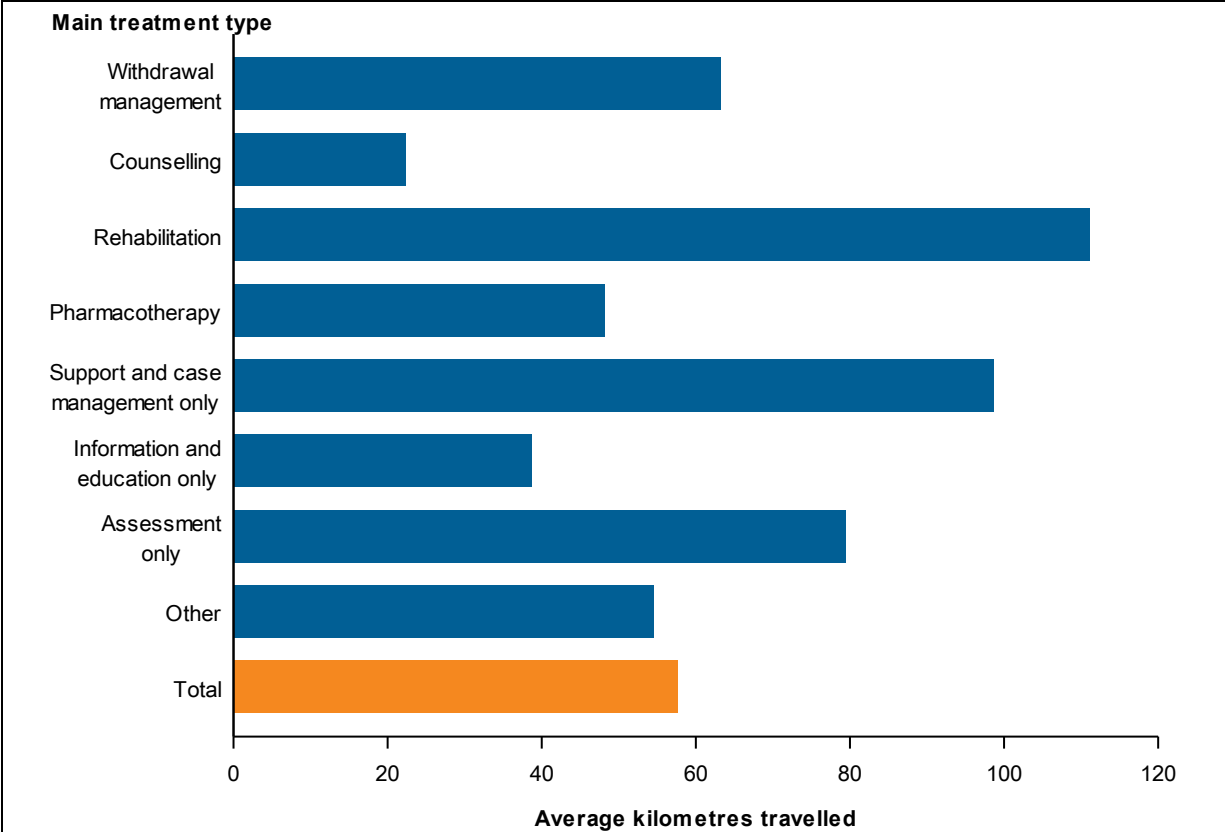


Figure 5.9: Closed treatment episodes per 100,000 population with heroin as a principal drug of concern, by remoteness area, 2014–15

In 2014–15, the average distance travelled to access treatment services provided for heroin was approximately 58 km. Access to different forms of treatment provided for heroin varied, with rehabilitation services reporting the longest average distance travelled (111 km), followed by support and case management only (99 km), with the shortest average distance travelled for counselling services (22 km) (Figure 5.10, Table SG.3).



- Notes
1. The results are from client postcode centroid to SA2 agency centroid only. Distance results are more accurate in cities than in regional areas, due to discrepancies in sizes between different postcodes.
 2. This figure represents 116,713 closed episodes that contained valid postcodes. Approximately 54,000 AODTS records contained a missing postcode.

Figure 5.10: Closed treatment episodes provided for own drug use with heroin as a principal drug of concern, by average distance travelled by clients to main treatment services, 2014–15

5.4 Referral to treatment

Nationally, in 2014–15, the most common treatment episodes for source of referral for both clients receiving treatment for their own drug use and those receiving support for someone else’s drug use was self/family (38% and 64%, respectively). Referral episodes from a health service were also common for both groups (26% and 17%, respectively). Referral episodes from police or court diversion programs accounted for 20% of episodes for clients receiving treatment for their own drug use (tables ST.13 and ST.14). Clients referred by diversion programs tended to be younger: 26% of these episodes were for clients aged 10–19 and 35% were for clients aged 20–29 (Table SE.16).

Over the 5 years from 2010–11, the proportion of episodes provided to clients for their own drug use where the client was referred by self/family increased from 40% in 2005–06 to 42% in 2013–14 then decreased to 38% in 2014–15. Over the same 5-year period, for clients receiving support for someone else’s drug use, there was a rise in the proportion of referrals by self/family (from 61% to 64%) (Table SE.15).

Table 5.1: Closed episodes by principal drug of concern and source of referral, 2014–15 (%)

Principal drug of concern	Self/family	Health service	Corrections	Diversion	Other	Total
Analgesics						
Codeine	50	39	2	1	8	100
Morphine	54	31	6	5	4	100
Buprenorphine	46	32	13	3	6	100
Heroin	47	23	11	12	6	100
Methadone	44	37	7	4	8	100
<i>Total analgesics</i>	52	36	3	3	6	100
Sedatives and hypnotics						
Alcohol	42	32	8	10	9	100
Benzodiazepines	47	35	4	7	8	100
<i>Total sedatives and hypnotics</i>	44	32	3	14	7	100
Stimulants and hallucinogens						
Amphetamines	43	22	9	20	6	100
Ecstasy	13	5	7	72	3	100
Cocaine	37	18	12	28	4	100
Nicotine	27	33	2	30	9	100
<i>Total stimulants and hallucinogens</i>	28	26	4	36	7	100
Cannabis	28	20	8	38	7	100
Volatile solvents	16	31	4	20	28	100

Source: AIHW analysis of the AODTS NMDS.

In 2014–15, the source of referral varied according to clients’ principal drugs of concern. Self/family were the most common source of referral episodes for clients receiving treatment for the principal drug of heroin (47%), alcohol (42%) and amphetamines (43%) (Table 5.1). Where cannabis was the principal drug of concern, diversion (38% of episodes) was the most common source of referral, followed by self/family (28% of episodes). Clients receiving treatment for alcohol as their principal drug of concern were less likely to be referred through diversion (10% of episodes) and more likely to be referred from a health service (32% of episodes), when compared with clients receiving treatment episodes for heroin (23%), amphetamines (22%) or cannabis (20%). Around 7 in 10 (72%) treatment episodes for clients whose principal drug of concern was ecstasy were referred to treatment through police or court diversion programs (see Chapter 4 for further information).

Over the 5 years to 2014–15, the proportion of episodes where the client was referred by self/family increased from 39% in 2011–12 to 42% in 2013–14, but decreased to 38% in 2014–15. Episodes where alcohol was the principal drug of concern also had a decrease in

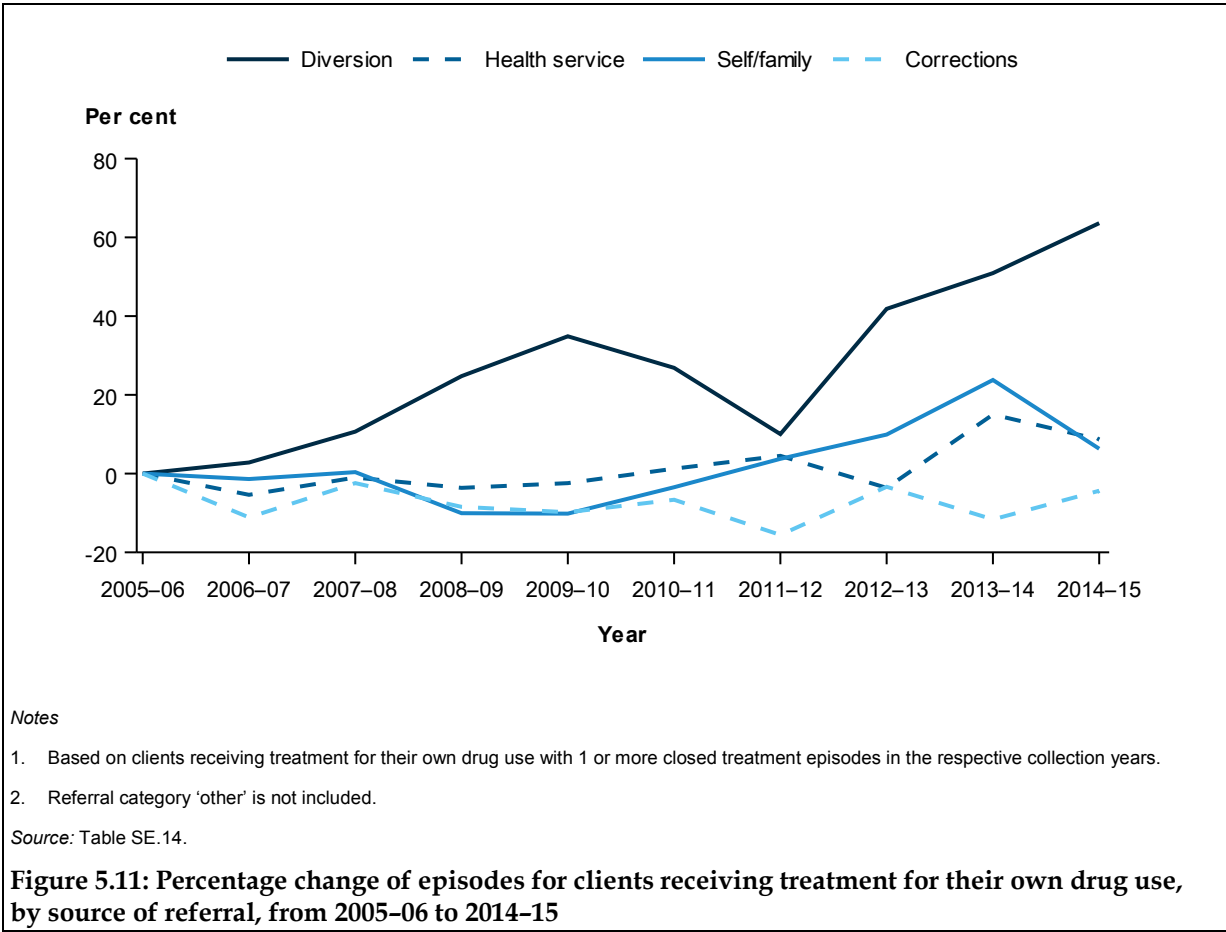
self/family as the source of referral, from 47% to 42% since 2013–14. The proportion of episodes where the client was referred by diversion increased from 14% in 2010–11 to 19% in 2014–15, with high proportions of diversion episodes for cannabis over this period (28% to 38%). Over the same period, the proportion for referral episodes from health services decreased (from 27% to 26%) (Table SD.17).

5.5 Clients diverted from the justice system

This section presents a snapshot of episodes and client information on people accessing AOD treatment who have been diverted from the justice system (for example, the police, or court system).

In the 10 years to 2014–15, the number of treatment episodes provided to clients for their own drug use who were diverted from the criminal justice system into alcohol and other drug (AOD) treatment for drug or drug-related offences more than doubled, while treatment episodes for other clients increased only marginally.

Importantly, people diverted from the criminal justice system represent a substantial share of clients treated by AOD agencies. Data from the AODTS NMDS show that clients referred from police or court diversion programs for their own drug use, received 31,875 treatment episodes in 2014–15, accounting for 19% of all treatment episodes provided by AOD treatment agencies (Figure 5.11, table SE.14).



Box 5.1: Key concepts

A number of concepts used in this report have a specific meaning, including:

Source of referral – the source from which a person was referred to an AOD treatment agency. Referral sources include self/family, medical practitioner, correctional service, police diversion and court diversion, among others.

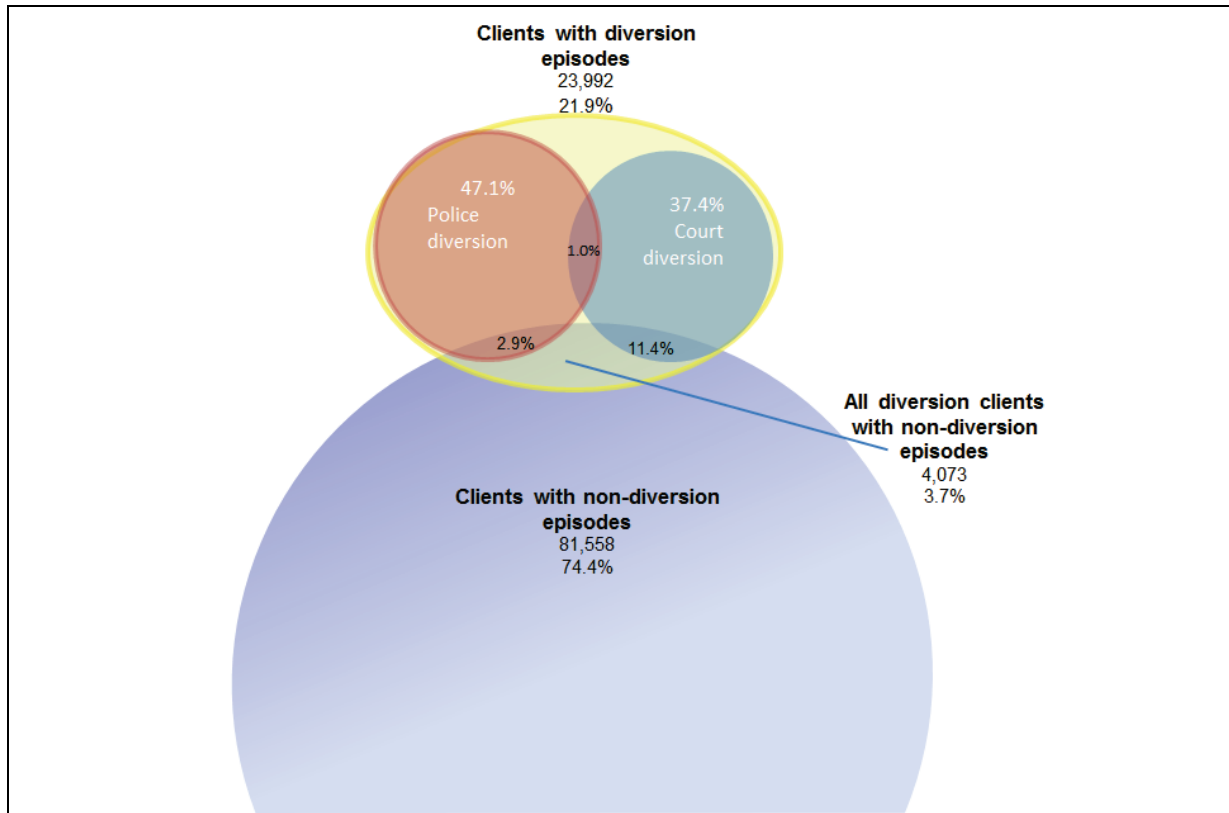
Diversion client type – there are 2 main diversion client types:

- **Diversion clients** are clients who received at least 1 AOD treatment episode during a collection year resulting from a referral by a police or court diversion program (a diversion episode). Within this group, there are 2 subtypes. **Diversion only clients** received treatment as a result of diversion referrals only. **Diversion clients with non-diversion episodes** received at least 1 episode of treatment resulting from a diversion referral but also received at least 1 treatment episode resulting from a non-diversion referral in a collection year.
- **Non-diversion clients** are clients who received at least 1 AOD treatment episode during a collection year, but were not referred by a diversion program (that is, they received only non-diversion episodes).

Diversion referral type – describes clients and treatment episodes with a diversion-based source of referral into AOD treatment. The 2 diversion types included in the AODTS NMDS are **police diversion** and **court diversion**.

Nationally, there were 28,065 clients who were diverted from the criminal justice system into AOD treatment in 2014–15, which is about one-quarter (26%) of all clients (Figure 5.12). Clients who received diversion episodes only accounted for 22% (23,992 clients), while clients who received diversion and non-diversion episodes accounted for 4% (4,073 clients) (Table DV.2). Among diversion clients, about 1 in 7 (15%) also received AOD treatment outside of their diversion program commitments in 2014–15. This suggests that diversion clients are fairly distinct from the non-diversion client group over the short term (within a single year) (Table DV.2).

Although some clients receive police diversion or court diversion episodes only, clients may receive a combination of police and court diversion episodes, as well as non-diversion episodes. This means that police diversion, court diversion and non-diversion client groups can overlap in a number of ways (Figure 5.12). In 2014–15, half of diversion clients (50%) had at least 1 court diversion episode and 51% had at least 1 police diversion episode, with 1% of diversion clients receiving both police and court diversion episodes. In 2014–15, clients with court diversion episodes were more likely to receive treatment not related to diversion than clients with police diversion episodes (11% compared with 2.9%). Police diversion episodes had less intensive treatment types compared with court diversion episodes (Table DV.1).



Note: Data are based on the number of distinct clients (from valid SLK information) in the AODTS NMDS 2014–15 collection. Only clients receiving treatment for their own drug use with 1 or more closed treatment episodes in 2014–15 are included.

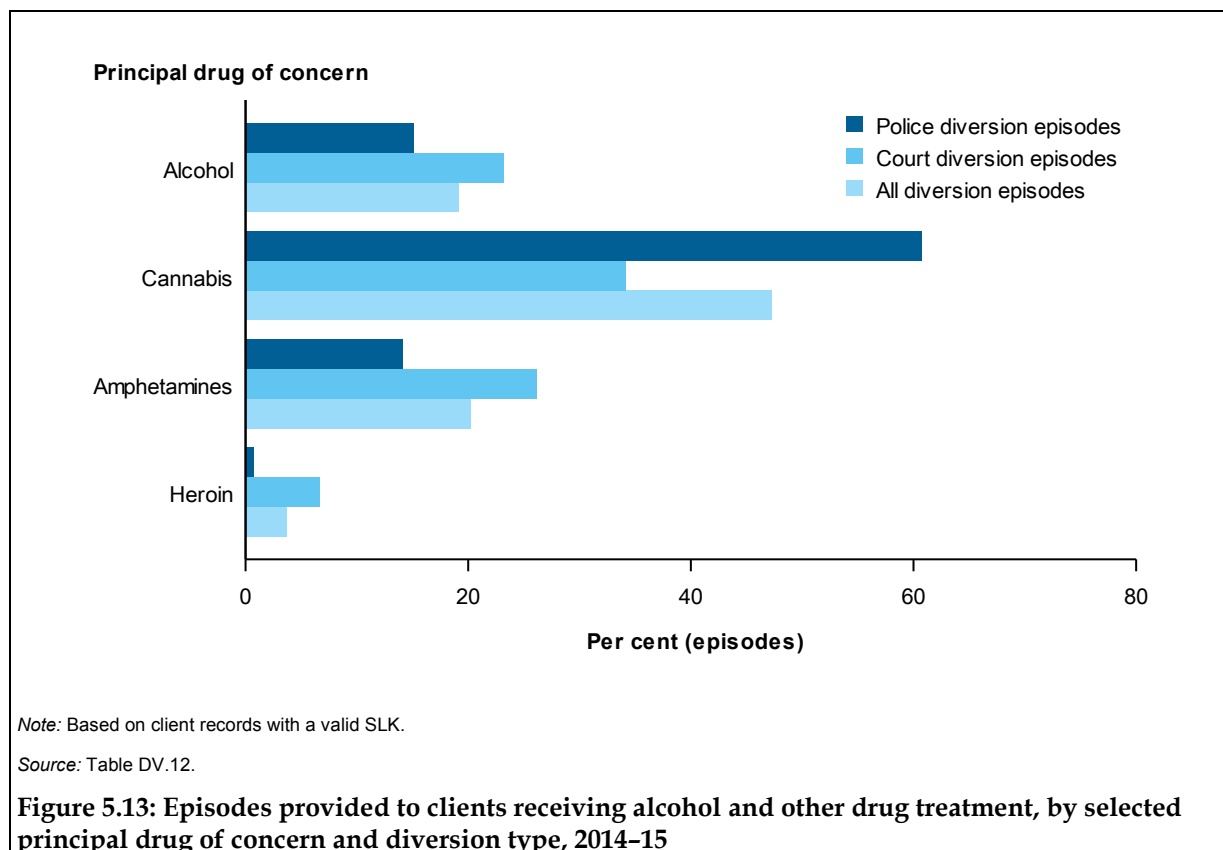
Source: Tables, DV.1 and DV.2.

Figure 5.12: Clients receiving alcohol and other drug treatment, by diversion client status, including police and court diversion 2014–15

In 2014–15 diversion clients were younger and more likely to be male than non-diversion clients, and less likely to be Indigenous. Just over one-quarter (26%) of clients were aged 10–19 compared with 10% for non-diversion clients. Over three-quarters of diversion clients (80%) were male compared with 66% of non-diversion clients, and 12% of diversion clients were Indigenous compared with 16% for non-diversion clients. (tables DV.3–5).

Among diversion clients, about 1 in 7 also received non-diversion treatment during 2014–15. Treatment episodes for diversion clients were about twice as likely to involve cannabis as the principal drug of concern compared with episodes for non-diversion clients.

Cannabis was more likely to be reported as a principal drug by police diversion clients than by court diversion clients (61% of treatment episodes compared with 34%). Court diversion clients were more likely than police diversion clients to report amphetamines (26% of treatment episodes compared with 14%) and alcohol (23% compared with 15%) (Figure 5.13, Table DV.12).



In 2014–15, the majority (71%) of police diversion clients were aged under 30, with 39% aged 10–19 and 31% aged 20–29, which is younger than court diversion clients (54% aged under 30). Court diversion clients were marginally more likely to be male (79%) than police diversion clients (74%), while the proportion of Indigenous Australians diverted by the police and courts was similar (13% and 12%) (tables DV.8–10).

In general, episodes for police diversion clients tended to involve shorter, less intensive treatment types and episodes for court diversion clients were generally longer, more intensive treatment types. More specifically, police diversion clients were far less likely than court diversion clients to involve counselling as the main treatment type (23% of treatment episodes compared with 48%), but much more likely to involve information and education only (43% compared with 24%) and assessment only (31% compared with 6%) (Table DV.11).

5.6 Length of treatment

In 2014–15, around 4 in 5 (79%) closed episodes ended within 3 months (79% for clients receiving treatment for their own drug use and 79% for someone else’s drug use; see sections 5.5 to 5.6 for further information). Over the 5 years to 2014–15, the proportion of episodes for the client’s own drug use that ended within 3 months remained fairly stable (around 79%) (Table SE.21).

Nationally, the median duration of closed episodes for the client’s own drug use was just over 3 weeks (22 days), and just under 4 weeks (27 days) for clients receiving support for someone else’s drug use. The median duration of closed episodes for the client’s own drug use decreased slightly over the 5 years from 2010–11 from 23 days to 22 days in 2014–15, peaking at 25 days in 2011–12. This increase over time is largely due to increases in the median duration of episodes with a main treatment type of counselling, rehabilitation or other (Table SE.20).

5.7 Treatment completion

Reasons for clients no longer receiving treatment from an AOD treatment service include expected cessations (for example, treatment was completed), unexpected cessations (for example, non-compliance) and administrative cessation (for example, client transferred to another service provider) (see the Glossary and Box 2.1 for further details). In 2014–15, around 3 in 5 (62%) episode completions for the client’s own drug use were expected cessations. Unexpected episode cessations accounted for one-fifth (20%), other reasons (9.8%) and episodes with administrative cessations 7.3%. This pattern was broadly similar for completions for clients who received support for someone else’s drug use, with the exception of unexpected episode completions, which were lower at 12% (Table 5.2).

In 2014–15, treatment episodes with an expected cessation were highest where ecstasy was the principal drug of concern (88%), followed by nicotine (79%) and cannabis (71%). The lowest proportion of expected cessations was for episodes with morphine as the principal drug of concern (42%). As a group, analgesics tended to have the lowest proportion of closed episodes with an expected cessation (55%) (Table 5.3).

Table 5.2: Closed episodes by reason for cessation and client type, 2014–15 (%)

Reason for cessation	Own drug use	Other’s drug use
Expected cessation	62.5	65.1
Unexpected cessation	20.4	12.3
Administrative cessation	7.3	5.9
Other	9.8	16.8
Total	100.0	100.0

Source: Table SE.17.

About one-quarter (26%) of treatment episodes where amphetamines were the principal drug of concern had an unexpected cessation, followed by morphine (24%) and codeine (23%), while ecstasy had the lowest proportion (5.1%) (Table 5.3).

Table 5.3: Closed episodes by principal drug of concern and reason for cessation, 2014–15 (%)

Principal drug of concern	Expected cessation	Unexpected cessation	Administrative cessation	Other	Total
Analgesics					
Codeine	55	23	15	7	100
Morphine	42	24	22	12	100
Buprenorphine	48	19	21	12	100
Heroin	56	20	9	15	100
Methadone	58	15	16	11	100
<i>Total analgesics</i>	55	22	14	8	100
Sedatives and hypnotics					
Alcohol	62	21	8	9	100
Benzodiazepines	56	18	11	15	100
<i>Total sedatives and hypnotics</i>	62	22	9	7	100
Stimulants and hallucinogens					
Amphetamines	59	26	7	8	100
Ecstasy	88	5	2	5	100
Cocaine	64	22	6	9	100
Nicotine	79	11	3	6	100
<i>Total stimulants and hallucinogens</i>	69	18	6	7	100
Cannabis	71	18	4	7	100
Volatile solvents	65	16	5	14	100

Source: Table SE.12.

Over the 5 years to 2014–15, treatment episodes that ended in an expected cessation have decreased overall (by 6 percentage points) (Table SD.16). The decrease in expected cessation was greatest for episodes where alcohol was the principal drug of concern (7 percentage points), followed by heroin (6 percentage points) and amphetamines (5 Percentage points). Over the same time period, unexpected cessation increased by 1 percentage point for episodes with alcohol and amphetamines as the principal drug of concern, and decreased by 2 percentage points for both heroin and cannabis episodes (Table SD.16).

5.8 Treatment types

Counselling was the most common treatment type provided to all clients in 2014–15 (43%), followed by assessment only (18%), and information and education only (13%). This pattern was consistent for both client groups (that is, clients receiving treatment for their own drug use and clients receiving support for someone else’s drug use) (Table SC.14).

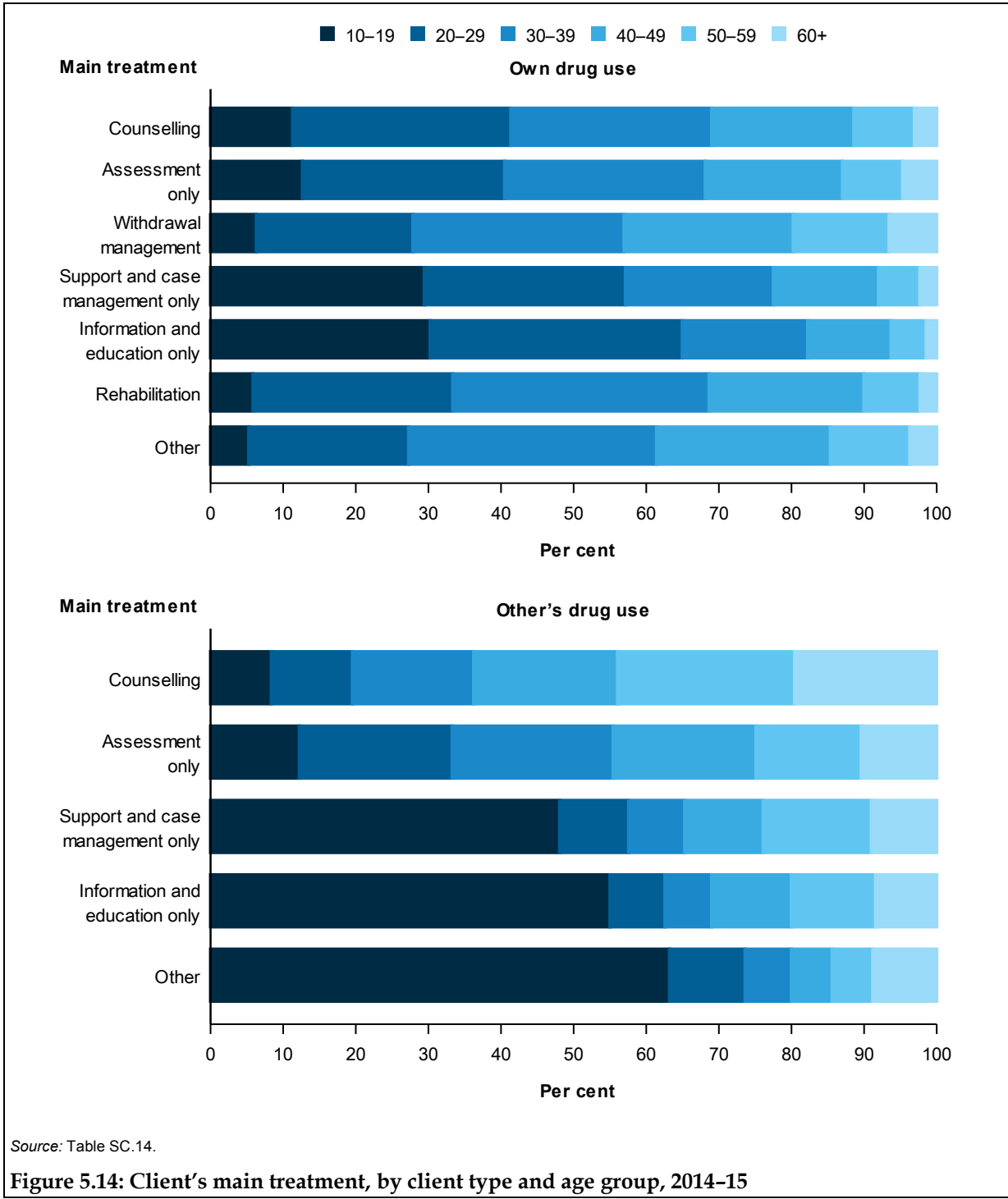
In 2014–15, clients seeking treatment for their own drug use were more likely to be aged between 20 and 49 for all treatment types (ranging between 73 and 86%), with the exception of support and case management only and information and education only, where clients were more likely to be aged between 10 and 39 (78% and 82%, respectively) (Figure 5.14). The age of clients was more varied for those seeking support for someone else’s drug use.

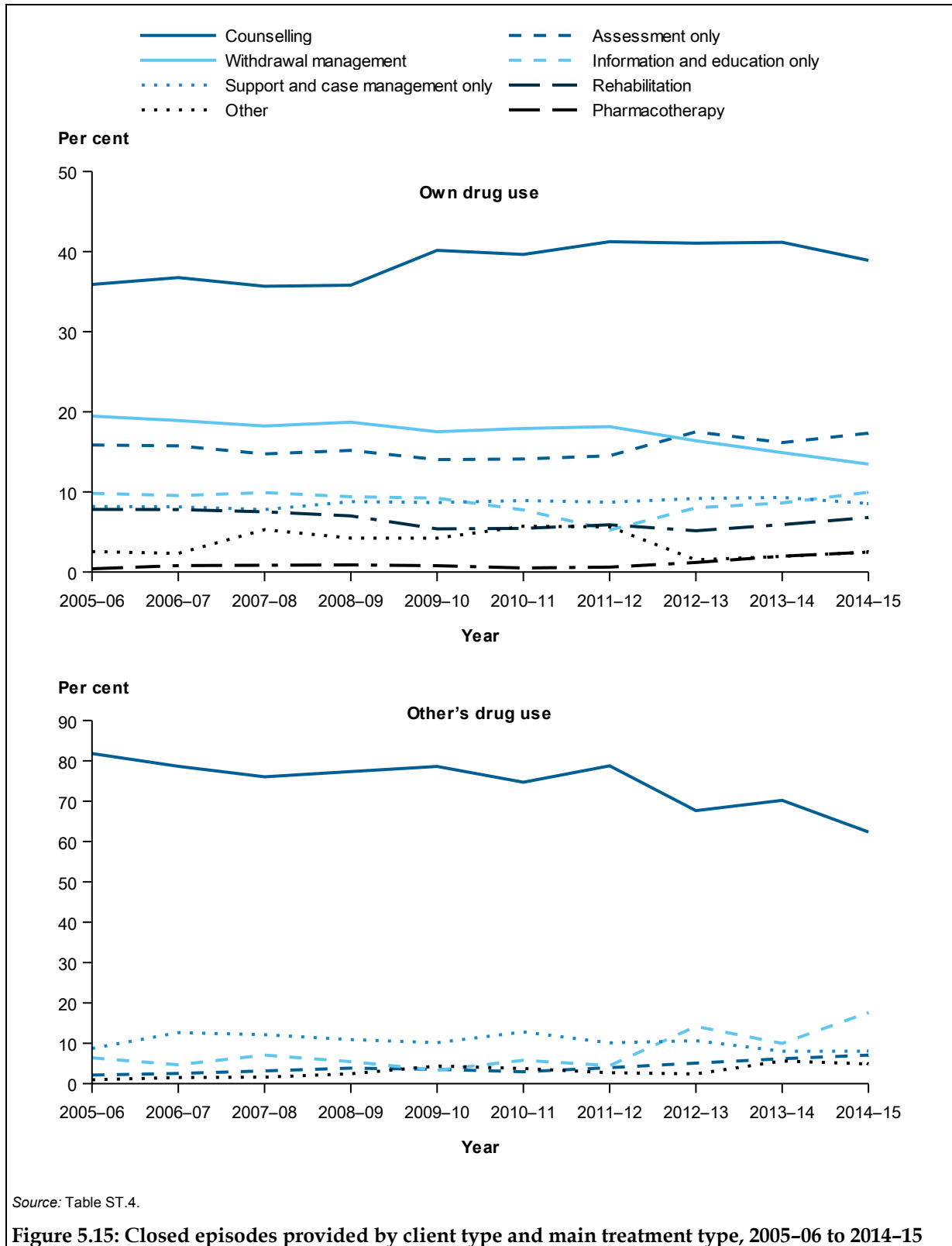
Clients receiving counselling were most likely to be aged 40 or older (64%), while clients receiving information and education only, and support and case management only were most likely to be aged 10–19 (55% and 48%, respectively) (Figure 5.14, table SC.14).

In 2014–15, the most common source of referral for clients was self/family (36%). This was consistent for all treatment types, with the exception of information and education only, where diversion was the most common source of referral (69%) (Table SC.17).

Nearly two-thirds (63%) of clients had an expected cessation (for example, their treatment was completed). This varied by treatment type – from 43% of clients receiving pharmacotherapy to 91% of those clients receiving information and education only (Table SC.18).

Overall since 2005–06, the proportion of episodes for each main treatment type for clients seeking treatment for their own drug use has remained fairly stable, with counselling, withdrawal management and assessment only being the most common types of treatment. Counselling continues to be the most common main treatment type provided (comprising about 2 in 5 episodes since 2005–06). In 2012–13, assessment only replaced withdrawal as the second most common main treatment type. Although this pattern of main treatment type was consistent for clients seeking treatment for their own drug use, for those seeking support for someone else’s drug use, counselling, information and education only, and support and case management only have remained the most common main treatment types over the same period (Figure 5.15).



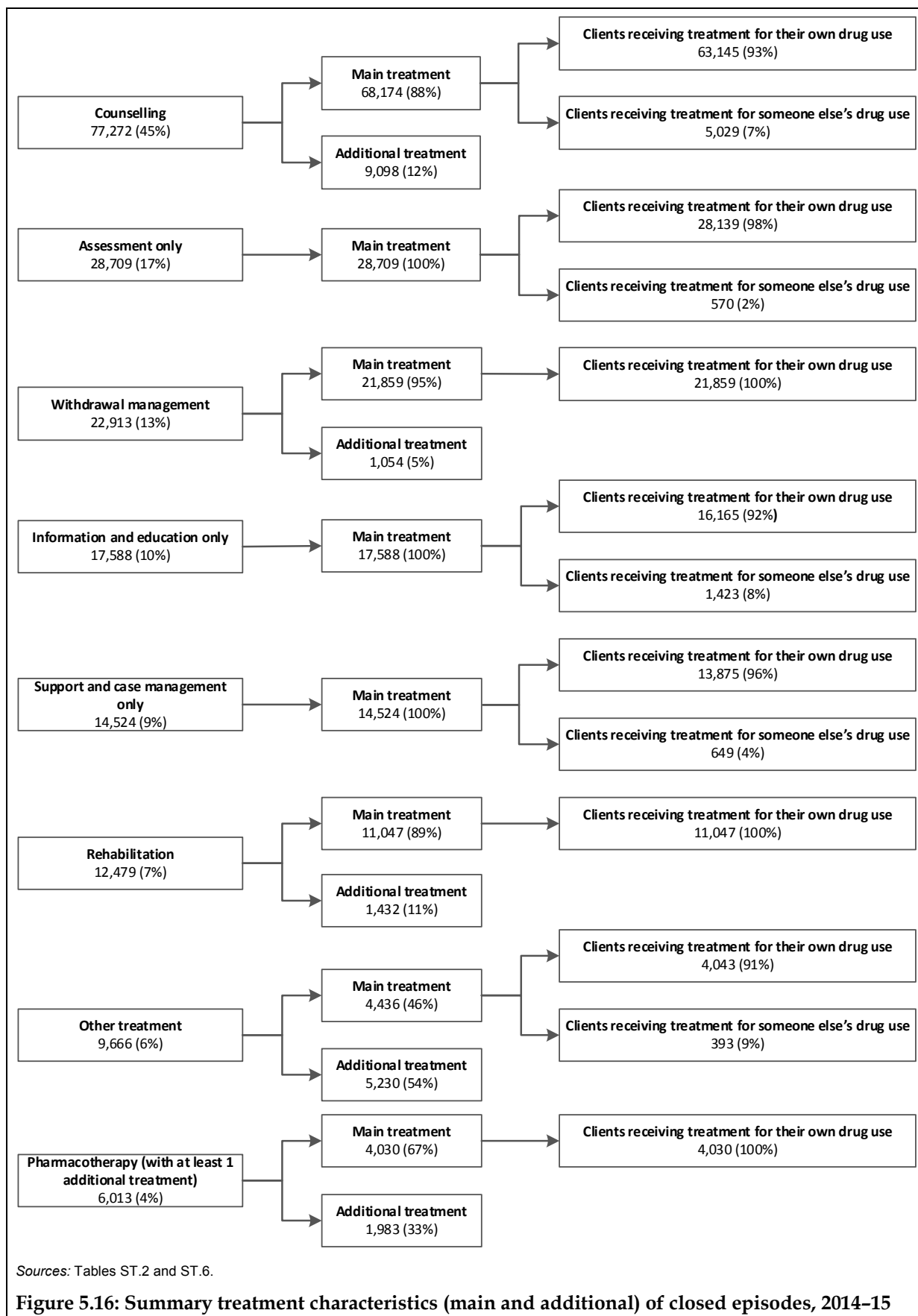


Since 2005-06, for clients seeking treatment for their own drug use, there has been an overall increase in the proportion of episodes with counselling as the main treatment type (from 36% to 39%), and a decrease in those episodes with withdrawal management as the main treatment type (from 19% to 13%). For clients seeking support for someone else's drug use there has been a significant decrease over the same time period in the proportion of episodes

with counselling as the main treatment type (from 82% to 62%), and an increase in those episodes with information and education only as the main treatment type (from 5.8% to 18%) (Table ST.4).

Counselling was the most common treatment type in all regions. Withdrawal management (detoxification) was more common in *Major cities* than in other areas. The lowest number of treatment episodes for withdrawal management and rehabilitation were in *Very remote* areas (Table SA.9).

Of the main and additional treatment types that were available to both clients receiving treatment for their own drug use and to those receiving support for someone else's drug use, most episodes were for clients receiving treatment for their own drug use – ranging from 91% for other treatment to 98% for assessment only (Figure 5.16).



Counselling

Counselling is the most common treatment type for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013). In 2014–15, nearly 2 in 5 (39%) episodes provided to clients for their own drug use, and over 6 in 10 (62%) episodes provided to clients for someone else's drug use, had a main treatment type of counselling (Table ST.4). Younger males were more likely to receive counselling for their own drug use – 66% of closed treatment episodes were for males, and 42% of these episodes were provided to those aged 10–29. Clients receiving counselling for someone else's drug use were more likely to be female (66% of episodes) and aged over 40 (66%) (Table ST.19).

For those clients seeking treatment for their own drug use, around 1 in 6 (16%) closed treatment episodes with a main treatment type of counselling were for Indigenous clients. For episodes where clients received support due to someone else's drug use, 8.1% of clients identified as Indigenous (Table ST.21).

For both client types, more than one-third of episodes with a main treatment type of counselling lasted 1–3 months (34% for own drug use and 32% for someone else's use), while nearly one-quarter (20% and 23%, respectively) lasted 2–29 days (Table ST.26).

Over the 5 years from 2010–11, for clients receiving treatment for their own drug use, the proportion of episodes ending within 1 month increased slightly (from 33% to 35%), while the proportion of episodes lasting more than 1 month decreased (from 67% to 65%) (Table ST.27). Over the same period, for clients receiving support for someone else's drug use, the proportion of closed episodes lasting 1 day increased slightly (from 16% to 17%), while the proportion lasting 6 months or more decreased (from 12% to 11%) (Table ST.27).

Assessment only

Although all service providers would normally include an assessment component in all treatment types, assessment only episodes are treatment episodes for which only an assessment is provided to the client. In 2014–15, 17% of treatment episodes provided to clients for their own drug use, and 7.1% of episodes provided to clients for someone else's drug use, had a main treatment type of assessment only (Table ST.4).

Younger males aged 10–39 were more likely to receive assessment only for their own drug use – 69% of closed treatment episodes, with 58% of these episodes provided to those aged 20–39. Clients receiving assessment only for someone else's drug use were also more likely to be male (55%), with 64% of these clients aged under 40 (Table ST.41).

Over the 5 years from 2010–11, for clients seeking treatment for their own drug use, the proportion of treatment episodes for clients aged 10–19 increased from 7.9% to 13%, while the proportion for those aged 20–29 decreased from 33% to 28%. For those clients seeking support for someone else's drug use, there was a decrease in the proportion of episodes provided to older clients. Nearly two-thirds (60%) of episodes were provided to clients aged 40 and over in 2012–13, compared with 41% in 2014–15 (Table ST.42).

Where the main treatment type was assessment only, 15% of closed treatment episodes for clients' own drug use were for Indigenous clients, and 12% of clients seeking support for some else's drug use identified as Indigenous (Table ST.43).

The majority of treatment episodes for clients lasted just 1 day – 65% of episodes for clients seeking treatment for their own drug use, and 80% of episodes those seeking support for someone else’s drug use (Table ST.45).

Over the 5 years from 2010–11, for clients seeking treatment for their own drug use, the proportion of closed episodes ending within 1 day increased from 49% to 65% while the proportion of episodes lasting 2–29 days decreased from 29% to 20%. For those clients seeking support for someone else’s drug use, the proportion of closed episodes ending within 1 day decreased from 87% to 80% and episodes lasting 3–6 months increased from 1.1% to 5.1%. The proportion of episodes overall for all duration groups decreased over the same time period, with the exception of closed episodes ending within 1 day, where the proportion increased (Table ST.46). It is important to note that these trends are influenced by differences in jurisdictional service delivery practices and data quality improvement over time.

Withdrawal management

Withdrawal management (detoxification) includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern. In 2014–15, 13% of closed treatment episodes provided to clients for their own drug use had a main treatment type of withdrawal management (Table ST.4). (Note that this type of treatment is not available for clients seeking support for someone else’s drug use.) Almost two-thirds (63%) of these episodes were provided to male clients, and 1 in 11 (9.4%) were for Indigenous clients (tables ST.30 and ST.32).

Over half (53%) of the treatment episodes provided for withdrawal management were for those aged 30–39 (29%) or 40–49 (24%) (Table ST.31). The majority of withdrawal management treatment episodes (83%) lasted less than 1 month (Table ST.38).

Over the 5 years from 2010–11, the proportion of closed withdrawal management episodes ending within 1 month increased from 76% to 83%, while the proportion of episodes lasting longer than 1 month decreased from 24% to 17% (Table ST.38).

Support and case management only

Support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than ‘support’. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007). In 2014–15, 8.6% of episodes provided to clients for their own drug use, and 8.1% of episodes provided to clients for someone else’s drug use, had a main treatment type of support and case management only (Table ST.4).

Almost two-thirds (64%) of the closed treatment episodes provided to clients for their own drug use were for male clients, 3 in 5 (60%) were aged 10–29, and 15% of episodes were for Indigenous clients. Female clients were more likely to be Indigenous than male clients (18% compared with 14%) (tables ST.49–51).

For those clients seeking support for someone else’s drug use, 63% of treatment episodes were for female clients, almost half (45%) were aged 10–19, and 1 in 11 (9.1%) were for Indigenous clients. Female clients were more likely to be Indigenous than male clients (11% compared with 6.3%) (tables ST.49–51).

Over the 5 years from 2010–11, there has been an increase in the proportion of episodes provided to older clients. For both client groups, those aged 40 and over increased (from 19% to 21% of episodes for clients receiving treatment for their own drug use, and 24% to 28% for clients seeking support for someone else’s drug use) (Table ST.50).

Three in 5 (60%) of the treatment episodes provided to clients for their own drug use with a main treatment type of support and case management only were provided to those in 10–19 (30%) or 20–29 (29%) age groups.

For both client types, the proportion of episodes lasting between 1 and 3 months were similar (37% for own drug use and 40% for someone else’s use), while the proportion of episodes lasting 3–6 months tended to be higher for clients receiving treatment for their own drug use (24% compared with 10% for someone else’s use) (tables ST.50 and ST.54).

Over the 5 years since 2010–11, the duration of treatment episodes for clients seeking treatment for their own drug use remained relatively stable. Conversely, for clients seeking support for someone else’s drug use, the proportion of closed episodes lasting 1 day and 1–3 months have changed substantially. The proportion of episodes lasting 1 day decreased from 39% to 13% and those lasting 1–3 months increased from 24% to 40% (Table ST.54).

Information and education only

In 2014–15, around 1 in 10 episodes provided to clients had a main treatment type of information and education only (10% of episodes for client’s own drug use and 18% of episodes for someone else’s) (Table ST.4).

Clients receiving information and education only for their own drug use were most likely to be male (72%) and younger (30% of episodes were for clients aged 10–19 and 34% for clients aged 20–29). Clients receiving information and education only for someone else’s drug use were more likely to be female (64%) and younger (52% of episodes were provided to clients aged 10–19). Over the 5 years from 2010–11, the age of all clients seeking treatment for their own use remained relatively stable, but for clients seeking support for someone else’s drug use, there was a significant increase in clients aged 10–19, from 17% to 57% in 2014–15 (tables ST.57–58).

Similar rates of closed treatment episodes were provided to clients who identified as Indigenous – 15% of closed treatment episodes for those clients seeking treatment for their own drug use, and 17% of clients seeking support for some else’s drug use (Table ST.59).

As expected for this type of treatment, the majority of episodes for clients lasted just 1 day – 78% of episodes for clients seeking treatment for their own drug use, and 62% of episodes for those seeking support for someone else’s drug use (Table ST.62).

Over the 5 years since 2010–11, for clients seeking treatment for their own drug use, the proportion of closed episodes ending within 1 day decreased from 87% to 78%, while the proportion of episodes lasting 2–29 days increased from 4.8% to 11%. For those clients seeking support for someone else’s drug use, the proportion of closed episodes ending within 1 day decreased from 85% to 62% and episodes lasting 3–6 months increased from 1.8% to 3.6% (Table ST.62). It is important to note that these trends were influenced by differences in jurisdictional program practices over time.

Rehabilitation

Rehabilitation focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011). In 2014–15, 6.8% of closed treatment episodes provided to clients for their own drug use had a main treatment type of rehabilitation. (Note that this type of treatment is not available for clients seeking support for someone else's drug use.) Two-thirds (66%) of these episodes were provided to male clients, and almost one-fifth (19%) were for Indigenous clients (tables ST.4, ST.65 and ST.67).

Over 3 in 5 (63%) of the treatment episodes provided for rehabilitation were for those aged 20–29 (28%) or 30–39 (35%). More than one-third (37%) of the episodes lasted from 1–3 months, while a further 30% lasted 2–29 days (tables ST.66 and ST.73).

Over the 5 years from 2010–11, the duration of closed episodes for those clients seeking treatment for their own drug use remained relatively stable. (Table ST.73).

Pharmacotherapy

Pharmacotherapy is the replacement of a person's drug of choice with a legally prescribed and dispensed substitute. Pharmacotherapy programs are available for a range of drugs, including alcohol and opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy. Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment and an additional treatment was provided, are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded. Pharmacotherapy is only available to clients receiving treatment for their own drug use. Because most pharmacotherapy services are outside the scope of the AODTS NMDS, the data presented on pharmacotherapy episodes are a significant underrepresentation. More comprehensive information on opioid pharmacotherapy treatment provided in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics <<http://www.aihw.gov.au/alcohol-and-other-drugs/nopsad/>> Annual Data (NOSPAD) collection.

For those services that were within scope of the AODTS NMDS in 2014–15, 3.7% of treatment episodes were provided with a treatment type of pharmacotherapy (main or additional). In just over one-third (33%) of these episodes, pharmacotherapy was an additional treatment (tables ST.4 and ST.75).

Over three-fifths (63%) of treatment episodes with a main treatment type of pharmacotherapy were provided to male clients, and 9.9% were for Indigenous clients. Over two-thirds (68%) of these episodes were for those aged 30–39 (42%) or 40–49 (26%) and. A further 20% were for clients aged 20–29; just 1.9% were for clients aged 60 and over (tables ST.76–78).

Of the closed episodes where pharmacotherapy was the main treatment type, almost 3 in 10 (28%) lasted over 12 months, while a further 32% lasted 3–12 months (Table ST.84).

Of the treatment episodes provided to clients with a main treatment type of pharmacotherapy, more than two-fifths (43%) had heroin as a principal drug of concern,

while almost 1 in 10 (10%) had a principal drug of methadone. Pharmacotherapy is commonly reported as an additional treatment in the AODTS NMDS. The most common principal drugs of concern with additional treatment episodes of pharmacotherapy include alcohol (43%) followed by amphetamines (17%), heroin (12%) and cannabis (11%) (Table ST.80).

Appendix A: Data and methods

Age

Age is calculated as at the start of the episode.

Data collection process

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning and policy. Figure A1 demonstrates the processes involved in constructing the national data.

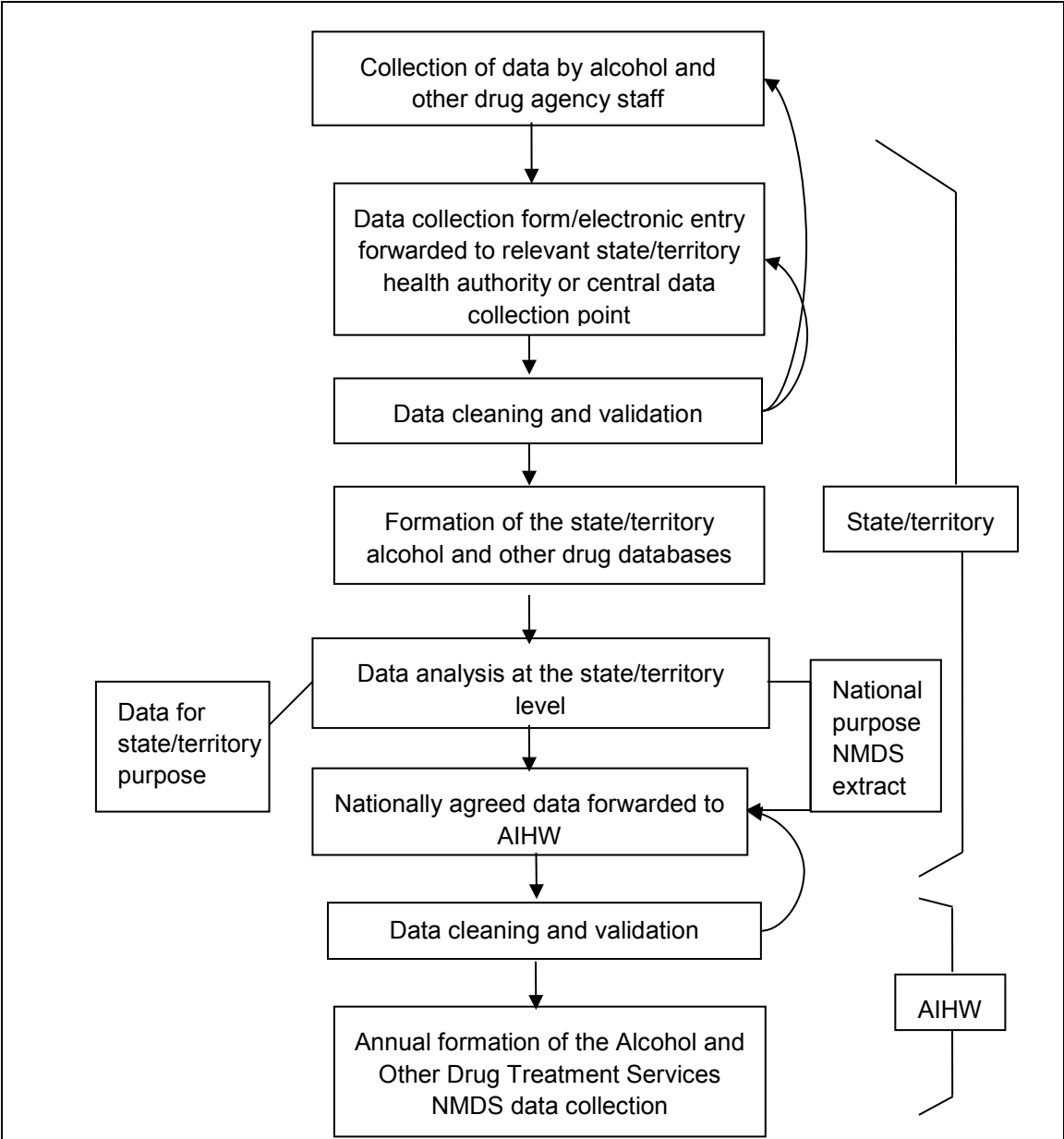


Figure A1: Alcohol and other drug treatment data collection flow chart

Distance travelled

Distance travelled is calculated using postcode of client's usual address to the SA2 of the agency where treatment was provided. The travel distance results for 2014–15 are from postcode centroid location to SA2 centroid only. Distance results are more accurate in cities than in regional areas, due to vastly different sizes of postcodes. Centroid locations were used for analysis, because some results were manually adjusted to the nearest available road for the application to work. Approximately 116,713 closed treatment episodes contained valid postcodes for mapping purposes. The proportion of non-disclosed postcodes or missing postcode data represented around 50,000 episodes.

Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's *Australian standard classification of drugs of concern 2011* (ASCDC) (ABS 2011a). In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	ASCDC codes	Category	Includes
Analgesics	1000–1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other opioids	Oxycodone, fentanyl, pethidine
		Other analgesics	Paracetamol
Sedatives and hypnotics	2000–2999	Alcohol	Ethanol, methanol and other alcohols
		Benzodiazepines	Clonazepam, diazepam and temazepam
		Other sedatives and hypnotics	Ketamine, nitrous oxide, barbiturates and kava
Stimulants and hallucinogens	3000–3999	Amphetamines	Amphetamine, dexamphetamine and methamphetamine
		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	Volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Cannabinoids	7000–7199	Cannabis	
Other	4000–6999	Other	Anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
	9000–9999		
Not stated	0000–0002	Not stated	

In this report, pharmaceutical drugs were grouped using 10 different drug types, making up the group 'pharmaceuticals' for the purposes of the analysis. These drugs correspond to the ASCDC codes and classifications (Table A2).

Table A2: Pharmaceutical drugs of concern; ASCDC codes and classifications

Drug category	ASCDC code	ASCDC classification (Broad group and narrow group/s)	Drug description (ASCDC base level unit/s)
Codeine	1101	Analgesics Organic opiate analgesics	Codeine
Morphine	1102	Analgesics Organic opiate analgesics	Morphine
Buprenorphine	1201	Analgesics Semisynthetic opioid analgesics	Buprenorphine
Oxycodone	1203	Analgesics Semisynthetic opioid analgesics	Oxycodone
Methadone	1305	Analgesics Synthetic opioid analgesics	Methadone
Benzodiazepines	2400–2499	Sedatives and hypnotics Benzodiazepines	Benzodiazepines nfd, alprazolam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam, benzodiazepines nec
Steroids	4000–4999	Anabolic agents and selected hormones Anabolic androgenic steroids Beta2 agonists Peptide hormones, mimetics and analogues Other anabolic agents and selected hormones Not further defined	Anabolic agents and selected steroids nfd, anabolic androgenic steroids nfd, boldene, dehydroepiandrosterone, fluoxymesterone, mesterolone, methandriol, methenolone, nandrolone, oxandrolone, stanozolol, testosterone, anabolic androgenic steroids nec, beta2 agonists nfd, eformoterol, fenoterol, salbutamol, beta2 agonists nec, peptide hormones, mimetics and analogues nfd, chorionic gonadotrophin, corticotrophin, erythropoietin, growth hormone, insulin, peptide hormones, mimetics and analogues nec, other anabolic agents and selected hormones nfd, sulfonyleurea hypoglycaemic agents, tamoxifen, thyroxine, other anabolic agents and selected hormones nec
Other opioids	1100, 1199, 1200, 1298–1299, 1300–1304, 1306–1399	Analgesics Organic opiate analgesics Semisynthetic opioid analgesics Synthetic opioid analgesics Not further defined	Organic opiate analgesics nfd, organic opiate analgesics nec, semisynthetic opioid analgesics nfd, semisynthetic opioid analgesics nec, synthetic opioid analgesics nfd, fentanyl, fentanyl analogues, levomethadyl acetate hydrochloride, meperidine analogues, pethidine, tramadol, synthetic opioid analgesics nec
Other analgesics	0005, 1000, 1400–1499	Analgesics Non opioid analgesics Not further defined	Analgesics nfd, non-opioid analgesics nfd, acetylsalicylic acid, paracetamol, ibuprofen, non-opioid analgesics nec
Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999	Sedatives and hypnotics Anaesthetics Barbiturates GHB type drugs and analogues Other sedatives and hypnotics	Sedatives and hypnotics nfd, anaesthetics nfd, ketamine, nitrous oxide, phencyclidine, propofol, anaesthetics nec, barbiturates nfd, amylobarbitone, methylphenobarbitone, phenobarbitone, barbiturates nec, GHB type drugs and analogues nfd, gamma-hydroxybutyrate, gamma-butyrolactone, 1,4-butanediol, GHB type drugs and analogues nec, other sedatives and hypnotics nfd, chlormethiazole, kava lactones, zopclon, doxylamine, promethazine, zolpidem, other sedatives and hypnotics nec.

Duration

Duration is calculated in whole days and calculated only for closed episodes.

Imputation methodology for AODTS clients

From the inception of the AODTS NMDS, data have been collected only about treatment episodes provided by AOD treatment services. Data about the clients those episodes relate to have not been available at a national level. An SLK was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continuing to ensure the privacy of these individuals receiving treatment.

An imputation strategy for the collection was developed to correct for the impact of invalid or missing SLKs on the total number of clients. This strategy takes into account a number of factors relating to the number of episodes per client and makes assumptions relating to spread across agencies. It also takes into consideration the likelihood that an episode with a missing SLK relates to a client that has already been counted through other episodes with a valid SLK. Further details on the imputation strategy are provided in the following link <www.aihw.gov.au/publication-detail/?id=60129554768>.

To ensure an accurate representation was made of the AODTS client population, imputation was applied to the 2012–13 and 2013–14 AODTS NMDS to account for the proportion of valid SLKs being below 95% for these years. The national rate of valid SLKs for these years was largely affected by low proportions of valid SLKs in New South Wales.

Improvements in the rate of valid SLKs for 2014–15 meant that imputation was not required for this reporting period.

For the 2014–15 reporting period specifically, sector reforms and system issues in some jurisdictions have resulted in an under-count of closed treatment episodes and clients. However, due to the improvements in the rate of valid SLKs, there was a slight increase in the number of un-imputed clients from 2013–14 to 2014–15 (114,871 to 114,912). But, when using imputed client numbers, the number of clients decreased from 2013–14 to 2014–15 (118,760 to 114,912). The imputed number is larger in 2013–14, because it accounts for those records with an invalid SLK and could not be used to create a client record.

Population rates

In this publication, crude rates were calculated using the ABS estimated resident population (ERP) at the midpoint of the data range; that is, rates for 2014–15 data were calculated using the ERP at 31 December 2014.

Reason for cessation

The AODTS NMDS contains data on the episode end reason (reason for cessation). In this report, these end reasons are grouped (Table A3). Data for the individual end reasons are available in the online supplementary tables.

A different method was used for grouping end reasons in reports released before 2014 and therefore trend comparisons across reports should be made with caution. It is possible to compare data at the individual end reasons using the supplementary tables.

Table A3: Grouping of cessation reasons by indicative outcome type

Outcome type	Reason for cessation
Expected cessation	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Unexpected cessation	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Administrative cessation	Change in main treatment type
	Change in delivery setting
	Change in principal drug of concern
	Transferred to another service provider
Other	Drug court or sanctioned by court diversion service
	Imprisoned (other than drug court sanctioned)
	Died
	Other
	Not stated

Remoteness

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure 2011 (ABS 2011b) to analyse the remoteness of AOD treatment agencies. 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 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.*

For this report, the remoteness of the agency was determined using the Statistical Area level 2 (SA2) of the agency. 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 SA in each remoteness area.

The ASGS has replaced the Australian Standard Geographical Classification (ASGC) 2006 (ABS 2006). Remoteness areas for previous reports were calculated under the ASGC. Therefore remoteness data for 2011–12 and previous years are not comparable with remoteness data for 2012–13 and subsequent years.

Service sectors

From 2008–09, agencies funded by the Australian Government Department of Health under the Non-Government Organisation Treatment Grants Program (NGOTGP) were classified as 'non-government' agencies. Before this, many of these agencies were classified as 'government' agencies. Trends in service sectors of agencies should be interpreted with caution.

Trends

Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia*, due to data revisions.

Glossary

additional drugs: clients receiving treatment for their own drug use nominate a principal drug of concern that has led them to seek treatment and additional drugs of concern, of which up to 5 are recorded in the AODTS NMDS. Clients receiving treatment for someone else's drug use do not nominate drugs of concern.

additional treatment type: clients receive 1 main treatment type in each episode and additional treatment types as appropriate, of which up to 4 are recorded in the AODTS NMDS.

administrative cessation: includes episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

alcohol: a central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgement, coordination and balance more difficult.

amphetamines: stimulants that include methamphetamine, also known as methylamphetamine. Amphetamines speed up the messages going between the brain and the body. Common names are speed, fast, up, uppers, louee, goey and whiz. Crystal methamphetamine is also known as ice, shabu, crystal meth, base, whiz, goey or glass.

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGS replaced the Australian Standard Geographical Classification (ASGC) in July 2011.

benzodiazepines: also known as 'minor tranquillisers', are most commonly prescribed by doctors to relieve stress and anxiety and to help people sleep. Common names include Benzos, tranx, sleepers, downers, pills, serras (Serepax®), moggies (Mogadon®) and normies (Normison®).

client type: the status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use or that of another person. Clients may seek treatment or assistance concerning their own alcohol and/or other drug use, or support and/or assistance in relation to the alcohol and/or other drug use of another person.

closed treatment episode: a period of contact between a client and a treatment provider or team of providers. An episode is closed when treatment is completed, there has been no further contact between the client and the treatment provider for 3 months or when treatment is ceased (see **reason for cessation**).

cocaine: a drug that belongs to a group of drugs known as stimulants. Cocaine is extracted from leaves of the coca bush (*Erythroxylum coca*). Some of the common names for cocaine include C, coke, nose candy, snow, white lady, toot, Charlie, blow, white dust and stardust.

ecstasy: the popular street name for a range of drugs containing the substance 3, 4-methylenedioxymethamphetamine (MDMA) – a stimulant with hallucinogenic properties. Common names for ecstasy include Adam, Eve, MDMA, X, E, the X, XTC and the love drug.

expected cessation: includes episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement.

government agency: an agency that operates from the public accounts of the Australian Government or a state or territory government, is part of the general government sector, and is financed mainly from taxation.

heroin: one of a group of drugs known as opioids, which are strong pain-killers with addictive properties. Heroin and other opioids are classified as depressant drugs. It is also known as smack, skag, dope, H, junk, hammer, slow, gear, harry, big harry, horse, black tar, China white, Chinese H, white dynamite, dragon, elephant, boy, home-bake or poison.

illicit drug use: includes:

- the use of illegal drugs – a drug that is prohibited from manufacture, sale or possession in Australia, such as cannabis, cocaine, heroin and ecstasy
- misuse, non-medical or extra-medical use of pharmaceuticals – drugs that are available from a pharmacy, over-the-counter or by prescription, which may be subject to misuse, such as opioid-based pain relief medications, opioid substitution therapies, benzodiazepines, over-the-counter codeine and steroids
- use of other psychoactive substances – legal or illegal, potentially used in a harmful way, such as kava or inhalants such as petrol, paint or glue (but not including tobacco or alcohol).

licit drug use: the use of legal drugs in a legal manner, and includes tobacco smoking and alcohol consumption.

main treatment type: the principal activity that is determined at assessment by the treatment provider to treat the client's alcohol or other drug problem for the principal drug of concern.

median: the midpoint of a list of observations ranked from the smallest to the largest.

nicotine: the highly addictive stimulant drug in tobacco.

non-government agency: an agency that receives some government funding but is not controlled by the government, is directed by a group of officers or an executive committee, and may be an income tax-exempt charity

principal drug of concern: the main substance that the client stated led them to seek treatment from an alcohol and drug treatment agency.

reason for cessation: the reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service:

- **ceased to participate against advice:** where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- **ceased to participate at expiation:** where the client has fulfilled their obligation to satisfy expiation requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment

- **ceased to participate by mutual agreement:** where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area
- **ceased to participate involuntarily:** where the service provider stops the treatment due to non-compliance with the rules or conditions of the program
- **ceased to participate without notice**
- **change in the delivery setting**
- **change in the principal drug of concern**
- **change in the main treatment type**
- **death**
- **drug court or sanctioned by court diversion service:** where the client is returned to court or jail due to non-compliance with the program
- **imprisoned (other than sanctioned by a drug court or diversion service)**
- **treatment completed:** where the treatment was completed as planned
- **transferred to another service provider:** this includes situations where the service provider is no longer the most appropriate and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. This excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment.

referral source: the source from which the client was transferred or referred to the alcohol and other drug treatment service.

standard drink: contains 10 g of alcohol (equivalent to 12.5 mL of alcohol). Also referred to as a full serve.

tobacco: see **nicotine**.

treatment type: the type of activity that is used to treat the client's alcohol or other drug problem:

- **assessment only:** where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types
- **counselling:** is the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
- **information and education only**
- **pharmacotherapy, where the client receives another type of treatment in the same treatment episode:** includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy
- **rehabilitation:** focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways, including residential

treatment services, therapeutic communities and community-based rehabilitation services

- **support and case management only:** support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy
- **withdrawal management (detoxification):** includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

treatment episode: the period of contact between a client and a treatment provider or a team of providers. Each treatment episode has 1 principal drug of concern and 1 main treatment type. If the principal drug or main treatment changes, then a new episode is recorded.

unexpected cessation: includes episodes where the client ceased to participate against advice, without notice or due to non-compliance.

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Related publications

This report, *Alcohol and other drug treatment services in Australia 2013–14*, is part of an annual series. This publication, as well as past reports in this series, can be downloaded free from the AIHW website, <www.aihw.gov.au/alcohol-and-other-drugs-publications/>. The website also includes information on ordering printed copies.

The following AIHW publications relating to alcohol and other drug use might also be of interest:

- AIHW (Australian Institute of Health and Welfare) 2014. Alcohol and other drug treatment and diversion from the Australian criminal justice system 2012–13. Bulletin no. 125. Cat. no. AUS 186. Canberra: AIHW.
- AIHW 2014. National Drug Strategy Household Survey detailed report 2013. Drug statistics series no. 28. Cat. no. PHE 183. Canberra: AIHW.
- AIHW 2014. National Key Performance Indicators for Aboriginal and Torres Strait Islander primary health care: results from December 2013. National key performance indicators for Aboriginal and Torres Strait Islander primary health care series. Cat. no. IHW 146. Canberra: AIHW.
- AIHW 2015. Aboriginal and Torres Strait Islander health organisations: Online Services Report – key results 2013–14. Aboriginal and Torres Strait Islander health services report No. 6. Cat. no. IHW 152. Canberra: AIHW.
- AIHW 2015. National opioid pharmacotherapy statistics 2014. Bulletin no. 128. Cat. no. AUS 190. Canberra: AIHW.

In 2014–15, around 850 alcohol and other drug treatment services provided just over 170,000 treatment episodes to around 115,000 clients.

The top 4 drugs that led clients to seek treatment were alcohol (38% of treatment episodes), cannabis (24%), amphetamines (20%) and heroin (6%). The proportion of episodes where clients were receiving treatment for amphetamines has continued to increase over the last 10 years, from 11% of treatment episodes in 2005–06 to 20% in 2014–15. The median age of clients in AOD treatment services is increasing, 33 years in 2014–15, up from 31 in 2005–06.