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Alcohol and other drug treatment services in Australia 2008–09

Report on the National Minimum Data Set

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Any enquiries about or comments on this publication should be directed to:

Dr Rob Hayward, Drug Surveys and Services Unit

Australian Institute of Health and Welfare

GPO Box 570

Canberra ACT 2601

Phone: (02) 6249 5143

Email: rob.hayward@aihw.gov.au

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Abbreviations

ABS	Australian Bureau of Statistics
AHS	Area Health Service
AIHW	Australian Institute of Health and Welfare
AOD	Alcohol and other drug
AODTS	Alcohol and other drug treatment services
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
DADC	Drug and Alcohol Data Coordinator
DAO	Drug and Alcohol Office
DASR	Drug and Alcohol Service Report
DASSA	Drug and Alcohol Services South Australia
DoHA	(Australian Government) Department of Health and Ageing
IGCD	Intergovernmental Committee on Drugs
n.e.c.	not elsewhere classified
NDSHS	National Drug Strategy Household Survey
NGO	Non-Government Organisation
NGOTGP	Non-Government Organisation Treatment Grants Program
NHDD	National Health Data Dictionary
NHIA	National Health Information Agreement
NHMRC	National Health and Medical Research Council
NMDS	National minimum data set
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
METeOR	Metadata Online Registry
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OPT	Opioid Pharmacotherapy Treatment
OSR	OATSIH Services Reporting
RRMA	Rural Remote and Metropolitan Areas
SAR	Service Activity Reporting

Symbols

–	nil or rounded to zero
<0.1	non-zero estimate less than 0.1%
. .	not applicable
≈	approximately equal
n.a.	not available
n.p.	not published (data cannot be released because of quality issues, confidentiality, or permission not granted)

Summary

This report presents the findings of the 2008–09 Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). It is the ninth in a series of annual publications focusing on clients of government-funded alcohol and other drug treatment services. In particular, it highlights the drugs that clients are concerned about and the types of treatment they receive. This report also presents contextual information about drug use, drug-related deaths and hospital stays and other treatment provided for alcohol and other drug issues across Australia.

Clients

Around 143,000 treatment episodes were reported during 2008–09, a decrease of about 10,000 episodes compared with 2007–08. A data submission gap from an area of New South Wales due to information systems issues accounts for approximately half of this reported decline. The vast majority of treatment episodes (96%) were for clients seeking treatment for their own drug use. The largest group of clients was males aged 20–29 years. This finding has been consistent over time. Younger clients were more likely to receive treatment for cannabis use and older clients for alcohol use.

Drugs

Alcohol remains the most common principal drug of concern, increasing over time to 46% of all treatment episodes in 2008–09 compared with 38% in 2002–03. Treatment for heroin use has been declining over time to 10% in 2008–09 compared with 18% in 2002–03; also the actual number of episodes for the treatment of heroin use has declined. Treatment for cannabis use has remained stable at about 22% while amphetamine treatment as a proportion of all episodes has declined from 11% in 2007–08 to 9% in 2008–09.

Treatment

Over a third of episodes commenced following self-referral. Counselling remained the most common treatment provided at about 2 in 5 episodes. The proportion of clients in withdrawal management (detoxification) has declined since 2002–03, even though the number of these episodes has increased overall.

Changes over time

In 2008–09, fewer treatment episodes were reported from fewer treatment agencies compared with the previous year. The decline in the number of agencies reporting is mostly due to an information system issue in one New South Wales area, however, a number of other jurisdictions also reported declines in the number of episodes provided to clients in 2008–09. A multitude of factors may potentially contribute to changes in the pattern of drugs for which treatment is sought over time. These factors include but are not limited to changes in the drug market, the perception of use by drug users and the community, the availability of treatment services and willingness to seek treatment.

Summary measures of alcohol and other drug treatment

Table S1: Summary measures of alcohol and other drug treatment, 2008–09

Measure	Description	Value
Client type	Proportion of treatment episodes for clients seeking treatment for their own drug use (per cent)	96.1
Sector	Proportion of agencies—public/government (per cent)	44.6
Geography	Proportion of agencies in *Remote* and *Very remote* Australia (per cent)	4.9
Age	Median age in treatment (years)	32.0
Largest age cohort	Proportion of treatment episodes for those aged 20–29 years of age (per cent)	30.5
Youth	Proportion of treatment episodes for those aged 10–19 years of age (per cent)	12.1
Indigenous	Proportion of episodes for Aboriginal and Torres Strait Islander people (per cent)	11.9
Sex	Proportion of episodes for males (per cent)	66.7
Alcohol	Proportion of episodes for alcohol (per cent)	45.8
Heroin	Proportion of episodes for heroin (per cent)	10.3
Treatment duration	Median duration in days of treatment episode	18.0
Self referral	Proportion of self-referral episodes (per cent)	35.0
Court/police referral	Proportion of court or police referral episodes (per cent)	16.9
Multiple drug use	Proportion of episodes where more than one drug of concern was nominated (per cent)	55.1
Counselling	Proportion of episodes where counselling was the main treatment provided (per cent)	37.4
Withdrawal management	Proportion of episodes where withdrawal management (detoxification) was the main treatment provided (per cent)	16.4
Multiple treatment [(a)]	Proportion of episodes where more than one treatment type was nominated (per cent)	15.0
Indigenous data quality	Proportion of treatment episodes where Aboriginal and Torres Strait Islander status was not stated (per cent)	5.8

(a) Statistic does not include data from Victoria because different counting rules apply—i.e. no episodes may register more than one treatment type.

1 Introduction

This is the ninth report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) since 2002. This report presents data about alcohol and other drug treatment services, their clients, drugs of concern and the types of treatment received. The report also contains relevant information from other collections relating to alcohol and other drug treatment and use.

Responsibility for the collection

The AODTS–NMDS was developed and implemented under the terms of the National Health Information Agreement (NHIA). Under the NHIA, the Australian Government and state and territory government health authorities are committed to working with the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and others to develop, collate and report national health information.

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

Key responsibilities of each authority in regard to the AODTS–NMDS collection are outlined below.

Government health authorities

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

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

The Australian Government and state and territory government departments have custodianship of their own data collections under the NHIA. The AIHW is custodian of the national collection.

Alcohol and other drug treatment agencies

Publicly funded alcohol and other drug treatment agencies collect the agreed data items and forward this information to the appropriate health authority as arranged. Agencies ensure

that the required information is accurately recorded. They are also responsible for ensuring that their clients are generally aware of the purpose for which the information is being collected and that their data collection and storage methods comply with existing privacy principles. In particular, they are responsible for maintaining the confidentiality of their clients' data and/or ensuring that their procedures comply with relevant state, territory and Australian government legislation.

AIHW

Under a memorandum of understanding with the Australian Government Department of Health and Ageing (DoHA), the AIHW is responsible for the management of the AODTS–NMDS. The AIHW maintains a coordinating role in the collection, including providing secretariat duties to the IGCD AODTS–NMDS Working Group, undertaking data development work and highlighting national and jurisdictional implementation and collection issues. The AIHW is also the data custodian of the national collection and is responsible for collating data from jurisdictions into a national data set and analysing and reporting on the data (at national and state/territory levels).

1.1 How are the data collected?

The AODTS–NMDS is a collection of data from publicly funded treatment services in all states and territories (including those directly funded by the DoHA). 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 at that level. Figure 1.1 demonstrates the processes involved in constructing the national data.

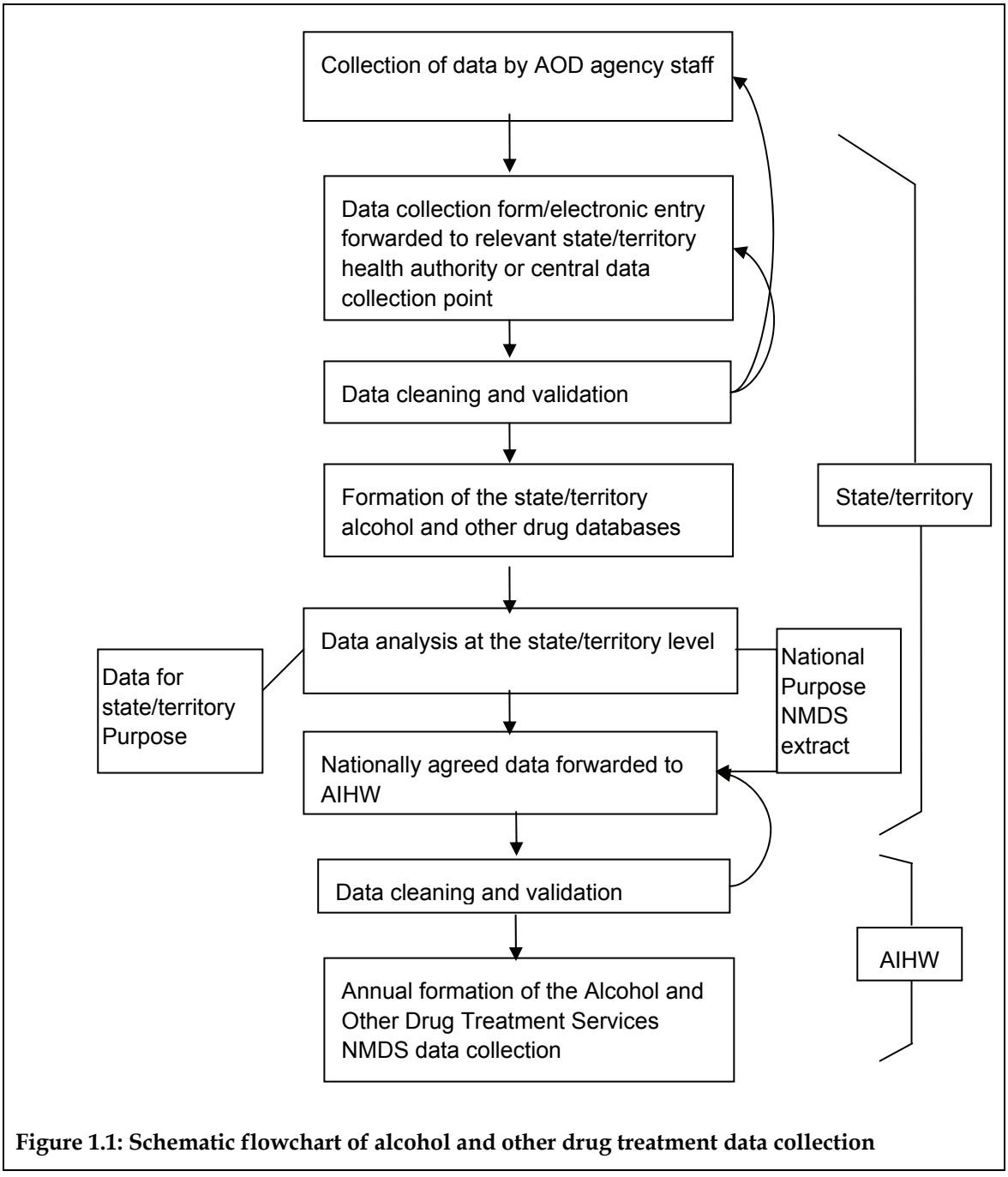


Figure 1.1: Schematic flowchart of alcohol and other drug treatment data collection

1.2 What's included in the AODTS–NMDS?

The NMDS counts 'treatment episodes' defined as a period of contact, with definite dates of commencement and cessation, between a client and a treatment provider. Treatment episodes vary in length from one day to several months or longer depending on the type of treatment provided. Only treatment episodes that are completed during the collection period (between 1 July 2008 and 30 June 2009) are included in the data for 2008–09. (More detail about the circumstances in which episodes are considered to be completed is available in *Alcohol and other drug treatment services NMDS specifications and collection manual 2008–09*.)

The agencies and clients agreed for inclusion—that is, the scope of the collection—has remained the same since 2000–01.

Agencies and clients included

- all publicly funded (at state, territory and/or Australian Government level) government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment service
- all clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during the period 1 July 2008 to 30 June 2009.

Agencies and clients excluded

There is a diverse range of alcohol and other drug treatment services in Australia and not all of these are in the scope of the AODTS–NMDS. Specifically, agencies and clients excluded from the AODTS–NMDS collection are:

- agencies whose sole activity is to prescribe and/or dose for opioid pharmacotherapy treatment
- clients who are on an opioid pharmacotherapy program and who are not receiving any other form of treatment that falls within the scope of the AODTS–NMDS
- agencies for which the main function is to provide accommodation or overnight stays, such as halfway houses and sobering-up shelters
- agencies for which the main function is to provide services concerned with health promotion (for example, needle and syringe exchange programs)
- treatment services based in prisons or other correctional institutions and clients receiving treatment from these services
- clients receiving services that are funded solely by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) as Indigenous Substance Use Services, Aboriginal primary health care services, Aboriginal medical services and community controlled health services
- people who seek advice or information but who are not formally assessed and/or accepted for treatment
- private treatment agencies that do not receive public funding
- clients aged under 10 years, irrespective of whether they are provided with services or received services from agencies included in the collection
- admitted patients in acute care or psychiatric hospitals

1.3 Important issues that explain the data

As a national minimum data set, there are characteristics related to the collection, reporting and analysis practices of the collection that should be considered when reading and interpreting the data. These characteristics limit the application of some analyses and inferences should be drawn with caution.

Box 1.1 The AODTS–NMDS does not count clients

The number of closed treatment episodes captured in the AODTS–NMDS does not equate to the total number of people in Australia receiving treatment for alcohol and other drug use. The current collection methodology does not identify when a client receives multiple treatment episodes in the same or different agencies, either concurrently or consecutively.

There is currently no reliable method for estimating the number of individual clients in AOD treatment nationally; however, some states and territories are able to make jurisdictional estimates. The AODTS–NMDS is currently under review, proposed data development may include the functionality to generate a non-duplicated client count.

Funding source cannot be differentiated

Data are reported by each state and territory regardless of funding type. Because all services are publicly funded, they receive at least some of their funding through a state, territory or Australian government program. The actual funding program cannot be differentiated; however, services are categorised according to their sector, with government funded and operated services being reported as public services and those operated by non-government organisations being reported as private services.

Indigenous substance use services

Indigenous substance use-specific services that are funded solely by DoHA generally do not report to the AODTS–NMDS because they have an alternative reporting mechanism. Data from these services are included where possible in this report to provide a more complete picture of AOD treatment in Australia. Interested readers can find more detail about these services in Chapter 3 and Appendix 6.

Implementation makes a difference

National data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between them. Also, the AODTS–NMDS has been implemented in stages, so comparisons across years need to be made with caution. Not all jurisdictions were able to provide data from the beginning of the collection and not all elements have been reported from the same time. Footnotes throughout the report highlight jurisdictional differences. The administrative features of each jurisdiction are outlined in Appendix 2.

1.4 Data issues specific to the 2008–09 year

Each year there are events and issues that have an impact on the collection and these differ between collection periods. These issues are discussed in Chapters 6 and 7 and are summarised below.

- The reporting processes for Indigenous substance use services have been streamlined and are now contained in a single report called the OATSIH Service Report (OSR). These data replace the Drug and Alcohol Services Report (DASR) and Service Activity Report (SAR) that have previously been included in this report.

- There appears to be an increasing disparity for New South Wales and Queensland between the number of agencies believed to be in scope for the AODTS–NMDS and those that actually submit data for the annual collection. Consequently, national data may be an underestimate of the number of treatment episodes provided by in-scope agencies.
- Problems with one particular Area Health Service caused the number of episodes reported by New South Wales to be substantially fewer than anticipated. An estimated 3% of records are missing from the national collection.

More discussion of data quality issues for the collection can be found in Chapter 7.

1.5 Using AODTS–NMDS Data

To complement this national report and provide greater detail, state and territory briefs are also produced annually and are available free of charge on the AIHW website <www.aihw.gov.au>. In addition, public-access data subsets from the AODTS–NMDS are also available on the AIHW website, in the form of interactive data cubes. Cubes are available for the 2001–02 to 2007–08 collections, and cubes for the 2008–09 collection period will be available at <www.aihw.gov.au/drugs/datacubes/index.cfm> from early 2011.

Although every effort has been made to provide comprehensive analysis and tables in this report, there may be times where readers would like specific information, such as cross tabulations or unit record data. The AIHW is happy to support data users with definitions and conditions pertaining to the collection and its analysis. Data may be requested from the AIHW, pending approval from jurisdiction data custodians and ethics approval where necessary. Please contact the AIHW for further information.

2 What sector and where are the treatment agencies?

Treatment agencies collect and supply data on treatment episodes for reporting in the AODTS–NMDS collection annually. The number of treatment agencies reported in this chapter may not necessarily correspond with the total number of service delivery outlets in Australia. There is a variety of service delivery types including outreach locations or in the homes of clients. Some agencies may also have more than one service outlet but only report under the main administrative centre of the service.

- A total of 653 alcohol and other drug treatment agencies provided data for the period 2008–09 (Table 2.1). This represents a decrease of five agencies since 2007–08.
- The movement in the number of agencies reporting has varied between jurisdictions, with an increase of 16 agencies for Queensland offset by a decrease of 18 agencies in New South Wales. South Australia increased by six agencies and other states and territories had minor decreases.
- Several factors contributed to changes in the reported number of agencies between years. These factors may have included changing from collecting data at an administrative or management level to a service outlet level, and changes in the actual number of agencies on the ground. Agencies may also move in or out of scope (see Section 1.2), or may experience issues submitting data appropriately. Changes in the number of agencies do not always reflect overall changes in service delivery capacity.
- In 2008–09, as in previous years, treatment agencies were most likely to be located in the most populous states of New South Wales (38%), followed by Victoria (21%) and Queensland (19%).

2.1 Service sector

In many data collections, including the AODTS–NMDS, a distinction is made between 'government' and 'non-government' agencies. Agencies are asked to identify whether they are managed by the government or non-government sector. In the AODTS–NMDS, the term 'private' (as identified through METeOR, a national metadata repository) refers to the community sector.

An issue was identified in the 2007–08 collection with the interpretation of the government and non-government classification being reported differently between some states and territories. In most previous years, Non-Government Organisation Treatment Grants Program (NGOTGP) agencies had been reported as public agencies (referred to as 'government' agencies). Discussions with the DoHA clarified that the data element had been interpreted in different ways by jurisdictions.

The AODTS–NMDS Working Group examined the issue and clarified the correct approach to coding NGOTGP agencies. It was agreed that NGOTGP agencies are to be referred to as non-government or 'private', because the establishments are not controlled by government and are directed by a group of officers, an executive committee or a similar body. This determination may have contributed to a 5% overall increase in the number of non-government agencies for the 2008–09 collection, with Queensland up 17% and South Australia up 12% since 2007–08.

This change in categorisation means that any time series analysis of this statistic should be interpreted with caution.

- In 2008–09, the number of agencies in the non-government sector and government sector were 362 and 291, respectively (Table 2.1).
- Government sector agencies were more prominent in New South Wales (75%) and South Australia (71%), whereas in Victoria all 136 agencies were in the non-government sector.
- In Western Australia, a reform in the way non-residential treatment services are provided in the metropolitan area has resulted in the co-location and integration of some government and non-government services. Time series data do not adequately illustrate these changes.
- The number of government agencies for 2008–09 increased by 10 percentage points in Tasmania (from 37% to 47%), although the small number of agencies in the state makes this statistic volatile.

Table 2.1: Treatment agencies by sector of service[a] and jurisdiction, 2008–09

Sector of service	NSW[b]	Vic[c]	Qld	WA[d]	SA	Tas	ACT	NT	Australia
					Number				
Government	188	—	47	5	39	7	1	4	291
Non-government[b]	62	136	75	39	16	8	9	17	362
Total	**250**	**136**	**122**	**44**	**55**	**15**	**10**	**21**	**653**
					Per cent				
Government	75.2	—	38.5	11.4	70.9	46.7	10.0	19.0	44.6
Non-government	24.8	100.0	61.5	88.6	29.1	53.3	90.0	81.0	55.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Percentage of total treatment agencies	**38.3**	**20.8**	**18.7**	**6.7**	**8.4**	**2.3**	**1.5**	**3.2**	**100.0**

(a) Sector of service refers to the public (government) and voluntary/private (non-government) sectors. Agencies funded by the DoHA under the Non-Government Organisation Treatment Grants Program are now included in the non-government sector, following clarification by the AODTS–NMDS Working Group. The agency figure quoted in this report may differ with the actual total number of agencies providing AOD treatment within each jurisdiction.

(b) Under-reporting in New South Wales owing to system issues has affected both government and non-government reporting agencies.

(c) Includes only those non-government agencies that receive public funding.

(d) Services in WA are not directly comparable with other states, or previous years, because of the growth of integrated services that include government and non-government service providers.

2.2 Locations

There are treatment agencies in all states and territories of Australia. Factors such as geographical diversity have an impact on service provision in a location.

The Australian Standard Geographical Classification (ASGC) classifies areas into *Major cities*, *Inner regional* areas, *Outer regional* areas, *Remote* and *Very remote* areas.

- In 2008–09, treatment agencies were again mostly located in *Major cities* (57%) and *Inner regional* areas (26%) (Table 2.2). The number of agencies in *Major cities* may be over-represented because of agencies reporting small, non-metropolitan outlets or outreach activities against the central agency location. Thus, services may look less remote than they actually are.
- As expected, because of its geographical profile, most services in the Northern Territory (86%) continued to be located in *Outer regional* or *Remote* areas. Similarly, Tasmania's agencies are all located in *Inner* and *Outer regional* areas reflecting Tasmania's geographic distribution.

Table 2.2: Treatment agencies by geographical location[(a)] and jurisdiction, 2008–09

Location	NSW[(b)]	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Major cities	150	92	50	33	37	—	10	—	372
Inner regional	80	36	29	4	8	11	—	—	168
Outer regional	20	8	29	4	7	4	—	9	81
Remote	—	—	7	3	1	—	—	9	20
Very remote	—	—	7	—	2	—	—	3	12
Total	**250**	**136**	**122**	**44**	**55**	**15**	**10**	**21**	**653**
					Per cent				
Major cities	60.0	67.6	41.0	75.0	67.3	—	100.0	—	57.0
Inner regional	32.0	26.5	23.8	9.1	14.5	73.3	—	—	25.7
Outer regional	8.0	5.9	23.8	9.1	12.7	26.7	—	42.9	12.4
Remote	—	—	5.7	6.8	1.8	—	—	42.9	3.1
Very remote	—	—	5.7	—	3.6	—	—	14.3	1.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The geographical location of treatment agencies in the 2008–09 AODTS–NMDS has been analysed using the Remoteness Areas of the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 4 for information on how these categories are derived).

(b) Under-reporting in New South Wales owing to system issues would increase the proportion of that classification for both the state and Australia.

2.3 Treatment types reporting from different geographical locations

The main treatment types provided by agencies varied somewhat depending on the geographical location of the agency (Table 2.3). The reasons for variations are not clear from the data collected and numerous factors may affect the results.

- Overall, counselling has remained the most common treatment type in all regions across Australia apart from *Very remote* areas, ranging from 36% of episodes in *Major cities* to 43% in *Remote* areas.
- In *Very remote* areas, support and case management had shown the strongest rise to 25% in 2008–09 from 6% in 2007–08, whereas 'other' treatment had fallen to 9% in 2008–09,

but was the most common response (38%) in 2007–08. The decrease in 'other' treatment in *Very remote* areas appears largely because of treatments being categorised and redistributed to support and case management, rehabilitation, or assessment only*:* each of these treatment types rose by more than 5 percentage points in 2008–09.

- There was a decrease of 9 percentage points in *Outer regional* areas for information and education only treatment episodes in 2008–09 and a 5 percentage point rise in assessment only.
- In *Major cities*, 18% of treatment episodes were withdrawal management (detoxification). In *Very remote* areas, this fell to less than 1% in 2008–09 from 3% in 2007–08, with a correspondingly increased proportion in *Outer regional* areas for this treatment type. It is not clear whether this represents changes in reporting or actual changes in service delivery.

Table 2.3: Main treatment type by geographical location[(a)], 2008–09 (per cent)

Main treatment type[(b)]	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Australia
Withdrawal management (detoxification)	18.1	13.3	13.2	11.2	0.9	16.4
Counselling	35.8	42.1	40.0	42.6	14.1	37.4
Rehabilitation	6.8	6.5	6.1	6.6	18.6	6.7
Support and case management only	9.1	9.8	5.4	1.5	25.1	8.9
Information and education only	7.2	11.7	17.4	17.3	10.1	9.2
Assessment only	15.2	12.6	14.5	18.6	22.7	14.7
Other	7.8	4.2	3.5	2.3	8.6	6.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Geographical location reported from the AODTS–NMDS collection is that of the treatment agency (not the residential address of the person receiving treatment).

(b) Additional information about main treatment types, including definitions, is provided in Chapter 5 of this report.

3 Who uses alcohol and other drug treatment services?

This chapter provides a demographic profile of clients who received alcohol and other drug treatment services in 2008–09.

A typical client of an Australian alcohol and other drug treatment service is male, has sought treatment for his own drug use, is 32 years of age, is Australian born and not an Indigenous Australian. He sought treatment for his alcohol consumption and received Counselling in a *Major city*.

This report presents information about the characteristics of people who received treatment (closed treatment episodes) from agencies that report to the AODTS–NMDS (Box 3.1). Section 3.2 about Indigenous status includes some data from another collection.

Box 3.1: Key definition and counts for closed treatment episodes, 2008–09

A **closed treatment episode** refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2008–09 there were 143,672 closed treatment episodes, of which 138,027 were for clients seeking treatment for their own substance use.

It is important to note that the number of closed treatment episodes captured in this collection does not equate to the total number of persons in Australia receiving treatment for alcohol and other drug use. Using the current collection methodology, it is not possible to ascertain how many people received multiple treatment episodes during the year. For this reason, direct comparison of client characteristics from the AODTS–NMDS and population statistics is not appropriate.

Those people who sought treatment in relation to someone else's drug use may include people looking for ideas to help someone with their drug use and people seeking assistance because of the personal impact on them of someone else's drug use. It is important to note that not all treatments related to someone else's drug use would be reported through the NMDS. It is likely that many people would approach other services for assistance, such as relationship counsellors.

3.1 Own or other's drug use

Clients in the collection are categorised as those seeking treatment for their own drug use and those seeking treatment because of the drug use of another person. As in previous reporting periods, clients in 2008–09 most often sought treatment for their own drug use. A small proportion (4%) of episodes pertained to clients receiving treatment related to someone else's drug use.

- There were 138,027 episodes reported in 2008–09 for clients seeking treatment for their own drug use (Table 3.1); 5,645 treatment episodes were provided to people seeking assistance related to another person's drug use.

- Of the episodes for people seeking assistance related to someone else's drug use, 77% received counselling, 10% received support and case management only and 5% received information and education only.
- The states and territories varied in the proportion of treatments they provided to people seeking assistance for their own drug use and those they provided to people seeking assistance related to another person's drug use. All states and territories provided less than 10% of treatment to the latter group. Appendix tables A3.2 and A3.5 provide additional data on the geographic profile of agencies and treatment episodes.

Table 3.1: Client type by jurisdiction, 2008–09 (per cent)

Client type	NSW[(a)]	Vic[(b)]	Qld[(c)]	WA	SA	Tas[(d)]	ACT	NT	Australia	Total (no.)
Own drug use	98.2	94.9	97.9	92.0	97.3	95.3	96.8	93.7	96.1	138,027
Other's drug use	1.8	5.1	2.1	8.0	2.7	4.7	3.2	6.3	3.9	5,645
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**34,893**	**47,089**	**25,523**	**16,915**	**9,664**	**2,081**	**3,750**	**3,757**	**. .**	**143,672**
State/territory (per cent)	24.3	32.8	17.8	11.8	6.7	1.4	2.6	2.6	100.0	. .

(a) The total number of episodes for New South Wales has been under-reported because of system issues for the reporting period of 2008–09.

(b) Victoria does not report data for 'Other treatment type'. All treatment provided is recorded as 'Main treatment'. Additional information regarding Victoria's approach to alcohol and other drug treatment data can be found in Box 5.1.

(c) The total number of episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(d) The total number of episodes for Tasmania may be under-counted because two agencies supplied drug diversion data only.

3.2 Age and Sex

The median age of all clients was 32 years and a large majority of clients were male (Table 3.2).

Table 3.2: Sex by age group, 2008–09 (per cent)

	Age group (years)							Total	Median age
	10–19	20–29	30–39	40–49	50–59	60+	Total[(a)]	(no.)	
Males									
Own drug use	11.6	32.2	28.4	17.6	7.4	2.7	100.0	93,837	32
Other's drug use	25.0	14.4	17.3	14.4	17.1	10.3	100.0	2,015	35
Total males	11.9	31.8	28.1	17.6	7.6	2.8	100.0	. .	32
Total males (number)	*11,395*	*30,486*	*26,966*	*16,829*	*7,331*	*2,694*	. .	*95,852*	. .
Females									
Own drug use	12.4	29.1	28.9	19.3	7.3	2.7	100.0	44,108	32
Other's drug use	12.0	12.6	15.1	23.8	23.2	12.2	100.0	3,625	44
Total females	12.4	27.9	27.8	19.6	8.5	3.4	100.0	. .	33
Total females (number)	*5,911*	*13,311*	*13,288*	*9,354*	*4,076*	*1,645*	. .	*47,733*	. .
Persons[(b)]									
Own drug use	11.9	31.2	28.5	18.2	7.4	2.7	100.0	138,027	32
Other's drug use	16.6	13.2	15.9	20.4	21.0	11.5	100.0	5,645	41
Total persons	**12.1**	**30.5**	**28.0**	**18.2**	**7.9**	**3.0**	**100.0**	**. .**	**32**
Total (number)	**17,316**	**43,823**	**40,274**	**26,205**	**11,412**	**4,339**	**. .**	**143,672**	**. .**

(a) Includes 'not stated' for age.

(b) Includes 'not stated' for sex.

- More episodes were provided to male clients (67%). Males have accounted for the majority of episodes since 2001–02.
- Where related to treatment for another's drug use, clients tended to be older, with more episodes provided to female clients (64%).
- People in their twenties and thirties again dominated the age distribution of all treatment clients.

3.3 Indigenous status

In 2008–09, 12% of episodes involved clients that identified as being of Aboriginal and Torres Strait Islander origin (Table 3.3). When compared with a general population prevalence of 2.5%, Aboriginal and Torres Strait Islander people were possibly over-represented in this treatment collection.

Table 3.3: Age group by Indigenous[a] status and sex, 2008–09

Age group (years)	Indigenous			Non-Indigenous			Not stated			Total persons[c]
	Males	Females	Total[b]	Males	Females	Total[b]	Males	Females	Total[b]	
					(number)					
10–19	2,055	1,248	3,303	8,595	4,242	12,840	745	421	1,173	17,316
20–29	3,730	1,928	5,661	24,910	10,654	35,581	1,846	729	2,581	43,823
30–39	2,983	1,756	4,741	22,368	10,816	33,200	1,615	716	2,333	40,274
40–49	1,696	853	2,549	14,241	8,028	22,284	892	473	1,372	26,205
50–59	409	201	610	6,486	3,679	10,168	436	196	634	11,412
60+	95	52	147	2,463	1,514	3,977	136	79	215	4,339
Not stated	18	14	32	124	114	239	9	20	32	303
Total	**10,986**	**6,052**	**17,043**	**79,187**	**39,047**	**118,289**	**5,679**	**2,634**	**8,340**	**143,672**
					(per cent)					
10–19	18.7	20.6	19.4	10.9	10.9	10.9	13.1	16.0	14.1	12.1
20–29	34.0	31.9	33.2	31.5	27.3	30.1	32.5	27.7	30.9	30.5
30–39	27.2	29.0	27.8	28.2	27.7	28.1	28.4	27.2	28.0	28.0
40–49	15.4	14.1	15.0	18.0	20.6	18.8	15.7	18.0	16.5	18.2
50–59	3.7	3.3	3.6	8.2	9.4	8.6	7.7	7.4	7.6	7.9
60+	0.9	0.9	0.9	3.1	3.9	3.4	2.4	3.0	2.6	3.0
Not stated	0.2	0.2	0.2	0.2	0.3	0.2	0.2	0.8	0.4	0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Proportion of treatment episodes	**7.6**	**4.2**	**11.9**	**55.1**	**27.2**	**82.3**	**4.0**	**1.8**	**5.8**	**100.0**

(a) The term 'Indigenous' refers to clients who identified as being Aboriginal and Torres Strait Islander people; 'non-Indigenous' refers to clients who said they were not Aboriginal and Torres Strait Islander people.

(b) There were 5 episodes for Indigenous Australians where sex was not stated, 55 episodes for non-Indigenous people where sex was not stated and 27 episodes where Indigenous status and sex were not stated.

(c) Includes 'not stated' for sex.

- Episodes were most common among those aged 20–29 years for both Indigenous and non-Indigenous clients.
- As with all episodes reported in the collection, some pertaining to Indigenous clients may have been provided to the same individuals. The current collection methodology does not allow analysis of this issue. Therefore, direct comparisons with the overall Indigenous/non-Indigenous composition of the Australian population are not advised.
- Indigenous status was 'not stated' for 6% of episodes nationally: a slight rise from previous collection years.

- Episodes were relatively more common among Indigenous clients aged 10–19 years (19%) than among non-Indigenous clients aged 10–19 years (11%). These differences may reflect the age structures of the two populations, because Indigenous Australians have a younger age profile than non-Indigenous Australians.

Most Australian Government-funded alcohol and other drug services for Indigenous Australians are out of scope for the AODTS–NMDS. The OATSIH Service Report (OSR) details the activity of Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services. Additional information on the definitions used in the OSR report including the definition of 'episodes of care' is available in Appendix 6.

Care provided by Office for Aboriginal and Torres Strait Islander-funded substance use-specific services

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2008–09, an estimated 3,633 episodes of care were provided to clients in residential treatment/rehabilitation services (Table 3.4). Of these episodes of care, 68% were for male clients.

In 2008–09, an estimated 14,289 episodes of care were provided to clients accessing sobering-up or residential respite services. Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation, whereas residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. Approximately three in five (59%) episodes of care were for male clients.

'Other care' refers to a diverse range of non-residential programs, including preventative care, after-care follow-up and mobile assistance/night patrol. In 2008–09, there were an estimated 50,000 episodes for 'Other care', down from 72,000 episodes in 2007–08. The high number of episodes of 'Other care', compared with residential or sobering-up episodes of care, is due to the short-term nature of 'Other care', with some clients receiving multiple episodes of care over the course of the year (see Appendix 6). Three in five (57%) episodes for 'Other care' were for male clients.

Table 3.4: Estimated number of episodes of care[(a)] provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services, by sex and treatment type, 2008–09

	Male		Female		Unknown		Total	
Treatment type	**No.**	**%**	**No.**	**%**	**No.**	**%**	**No.**	**%**
Residential treatment/rehabilitation[(b)]	2,456	68	696	19	481	13	3,633	100
Sobering-up/residential respite[(c)]	8,441	59	5,837	41	11	—	14,289	100
Other care[(d)]	28,606	57	19,795	39	1,777	4	50,178	100

(a) Estimated 'episodes of care' refers to the number of episodes of the service. It does not always equate to the total number of clients in all programs because some clients may be in multiple programs.

(b) Includes people who were officially clients of the service; that is, people who received treatment/rehabilitation in a residential setting and had their own file/record.

(c) Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation. Respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation.

(d) Clients receiving 'other care' receive non-residential care (e.g. counselling, assessment, treatment, education, support, home visits and/or mobile assistance patrol/night patrol) or follow-up from residential services after discharge.

Source: OATSIH Services Reporting data base 2008–09.

3.4 Country of birth and preferred language

Country of birth

- The majority (87%) of AODTS–NMDS episodes in 2008–09 involved clients born in Australia (Table A3.1).
- Clients born in other countries were represented in only a small proportion of episodes, with England (2%) and New Zealand (2%) being the next most common countries of birth. Similar to the issues outlined above for Indigenous Australians, treatment episodes for people born outside Australia are not directly comparable to general population proportions.

Preferred language

- As in previous reporting periods, English was the most frequently reported preferred language in 2008–09 (95% of episodes). Less than 1% of episodes were for clients who reported preferring to speak any other language, including Indigenous Australian languages.

4 What drugs do people seek treatment for?

This chapter presents contextual information on mortality, morbidity and behaviours associated with licit and illicit drug use in Australia. It also focuses on the drugs of concern reported by clients of alcohol and other drug treatment services, including the main drug that led them to seek treatment, called the principal drug of concern (Section 4.2), and all drugs reported to be of concern (Section 4.3). The chapter also briefly examines peculiarities of most common drugs of concern in relation to client, drug and treatment profiles (sections 4.4 and 4.5).

4.1 Context

Alcohol, tobacco and illicit drug use are responsible, directly and indirectly, for a considerable number of accidents, injuries, illnesses and deaths in Australia.

Mortality

In the most recent Burden of Disease and Injury in Australia study (Begg et al. 2007), it was estimated that 20,600 deaths were attributable to the use of tobacco, alcohol or illicit drugs in 2003.

Hospital treatment (morbidity)

There were 89,222 hospital 'separations' reported with a drug-related principal diagnosis in 2008–09 (Table 4.1). 'Separations' refer to completed episodes of hospital care ending with discharge, death, transfer or a change to another type of care. 'Drug-related' separations refer to hospital care with selected diagnoses of substance use disorder or harm (accidental, intended or self-inflicted) due to selected substances (See Appendix 7 for technical details). As well as alcohol and tobacco, some of the drugs of concern discussed here are available by prescription or can be legally purchased over the counter. Therefore, a proportion of the separations reported here may result from harm arising from the therapeutic use of drugs. The inclusion of therapeutic use may mean the burden of drugs and alcohol on the hospital system appears larger than expected. The 89,222 separations with a drug-related principal diagnosis in 2008–09 represented 1.1% of all hospital separations, the same proportion as the previous 2 years (AIHW 2010a).

In 2008–09, sedatives and hypnotics continued to account for the highest number of drug-related hospital separations (65% of all drug-related separations), with alcohol making up 82% of separations for sedatives and hypnotics. On its own, alcohol accounted for 53% of drug-related hospital separations (Table 4.1). Of all drug-related separations reported, 14% were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for more than half of this group (8% of all drug-related separations). Stimulants and hallucinogens, including cannabis and cocaine, accounted for 8% of all drug-related separations. All of these proportions are similar to 2007–08.

Table 4.1: Same-day and overnight separations[a][b] with a principal diagnosis of drug-related harm or disorder, by drug of concern, Australia, 2008–09

Drug of concern[c]	Same-day separations	Overnight separations	Total separations[d]
Analgesics			
Opioids (includes heroin, opium, morphine and methadone)	2,329	4,839	7,168
Non-opioid analgesics (includes paracetamol)	1,473	4,231	5,704
Total analgesics	*3,802*	*9,071*	*12,873*
Sedatives and hypnotics			
Alcohol	23,823	23,332	47,155
Other sedatives and hypnotics (includes barbiturates and benzodiazepines; excludes alcohol)	3,361	7,143	10,504
Total sedatives and hypnotics	*27,184*	*30,475*	*57,659*
Stimulants and hallucinogens			
Cannabinoids (includes cannabis)	1,016	2,254	3,270
Hallucinogens (includes LSD and ecstasy)	80	107	187
Cocaine	104	126	230
Tobacco and nicotine	15	34	49
Other stimulants (includes amphetamines, volatile nitrates and caffeine)	1,260	2,065	3,325
Total stimulants and hallucinogens	*2,475*	*4,586*	*7,061*
Antidepressants and antipsychotics	1,984	5,672	7,656
Volatile solvents	333	462	795
Other and unspecified drugs of concern			
Multiple drug use	1,059	1,980	3,039
Unspecified drug use and other drugs not elsewhere classified[b]	47	93	140
Total other and unspecified drugs of concern	*1,106*	*2,073*	*3,179*
Total	**36,884**	**52,338**	**89,222**

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

(b) See Appendix 7 for technical details. Please note that some codes included in these reports previously are now excluded.

(c) Drug of concern codes based on Australian Standard Classification of Drugs of Concern (ASCDC) which are mapped to ICD-10-AM 6th edition codes.

(d) Refers to total drug-related separations, including substance use disorders and instances of harm for selected substances.

Source: AIHW analysis of the National Hospitals Morbidity Database 2008–09.

Separations can be either same-day (where the patient is admitted and separated on the same day) or overnight (where the patient is admitted to hospital and separates on different dates). In 2008–09, overnight separations continued to be more common for drug-related treatment than same-day separations, accounting for 59% of all drug-related separations. Separations were most likely to be overnight for non-opioid analgesics (74%) out of all the drugs reported. This group has overtaken cannabis as the drug most likely to result in an overnight stay. For alcohol, there were similar numbers of same-day and overnight separations.

Table 4.2 reports separations with additional diagnoses where these drugs of concern were implicated. Separations with a principal diagnosis as already presented in Table 4.1 are excluded from data presented in Table 4.2.

Table 4.2: Same-day and overnight separations[a][b] with an additional (but not principal) diagnosis of drug-related harm or disorder, by drug of concern, Australia, 2008–09

Drug of concern[c]	Same-day separations	Overnight separations	Total separations[d]
Analgesics			
Opioids (includes heroin, opium, morphine and methadone)	1,542	8,895	10,437
Non-opioid analgesics (includes paracetamol)	250	1,097	1,347
Sedatives and hypnotics			
Alcohol	19,802	59,455	79,257
Other sedatives and hypnotics (includes barbiturates and benzodiazepines; excludes alcohol)	871	4,301	5,172
Stimulants and hallucinogens			
Cannabinoids (includes cannabis)	2,241	13,148	15,389
Hallucinogens (includes LSD and ecstasy)	109	171	280
Cocaine	143	345	488
Tobacco and nicotine	121	1,648	1,769
Other stimulants (includes amphetamines, volatile nitrates and caffeine)	746	4,553	5,299
Antidepressants and antipsychotics	236	1,409	1,645
Volatile solvents	86	363	449
Other and unspecified drugs of concern			
Multiple drug use	1,187	4,992	6,179
Unspecified drug use and other drugs not elsewhere classified[b]	77	208	285

(a) Separations in this table are not unique: they may be double-counted between rows. Diagnoses relating to a separation for which the care type was reported as 'Newborn with no qualified days', and records for 'Hospital boarders' and 'Posthumous organ procurement' have been excluded.

(b) See Appendix 7 for technical details. Please note that some codes included in these reports previously are now excluded.

(c) Drug of concern codes based on Australian Standard Classification of Drugs of Concern (ASCDC), which are mapped to ICD-10-AM 6th edition codes.

(d) Refers to total drug-related separations, including substance use disorders and instances of harm for selected substances.

Source: AIHW analysis of the National Hospitals Morbidity Database 2008–09.

In 2008–09, there were 127,996 occasions where a drug of concern was identified as an additional diagnosis during hospital treatment. This excludes those episodes where a drug of concern was identified in the principal diagnosis. However, separations can include more than one (and sometimes many) additional diagnoses. This figure of 127,996 counts some separations more than once.

Again, excluding separations where the principal diagnosis was drug-related, in 2008–09:

- the number of *unique* separations with drug-related additional diagnoses was 124,819. (This figure is lower than the figure above, because that included some double-counting between drug classes).

- the majority of separations with a drug-related additional diagnosis (63%) included alcohol.
- following alcohol, the next most prevalent additional diagnosis was for a cannabis-related disorder or harm (12%).

As mentioned previously, 1.1% of all hospital separations were for a drug-related principal diagnosis. When additional diagnosis is also considered, a drug-related harm or disorder was indicated in around 2.7% of all hospital separations.

4.2 Key definitions

The following data relates to those 138,027 episodes where clients were seeking treatment for their own drug use. There is more information about treatment episodes where clients were seeking treatment for someone else's substance use in Chapter 5.

Box 4.1: Key definitions and counts for closed treatment episodes and drugs, 2008–09

Principal drug of concern refers to the main substance that the client stated led them to seek treatment from the alcohol and other drug treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses involving principal drug of concern because it is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2008–09, the principal drug of concern was reported for all 138,027 closed treatment episodes.

Other drugs of concern refers to any other drugs reported by the client, in addition to the principal drug of concern. Clients can nominate up to five other drugs of concern. In 2007–08, over half of the closed treatment episodes included at least one other drug of concern (55% or 76,019), in which 136,038 instances of other drugs of concern were reported (apart from principal drug of concern). This is an average of 1.0 'Other drugs of concern' per treatment episode.

All drugs of concern refers to all drugs reported by clients, including the principal drug of concern and all other drugs of concern. In 2008–09, there were a total of 274,065 drugs of concern reported, either as a principal or other drug of concern.

4.3 Principal drug of concern

Principal drug of concern across Australia

In 2008–09, alcohol and cannabis were again the most common principal drugs of concern in episodes nationally (46% and 23%, respectively). These were followed by opioids (15%, with heroin accounting for 10%)[1] and amphetamines (9%). Benzodiazepines, methadone and nicotine each accounted for approximately 2% of episodes. Ecstasy treatment represented 1% of episodes and cocaine was substantially less. (Table 4.3).

Jurisdictions varied in terms of changes to proportions of treatment episodes for alcohol use, although all states and territories increased, except Victoria (whose proportion slightly

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

decreased) and South Australia (which remained stable). The largest increases were in Tasmania (about 6%), Australian Capital Territory and Western Australia (both around 5%). These variations may be attributed to changes in attention to problematic alcohol consumption, service availability, alcohol availability or improvements to data collection.

The large populations in New South Wales and Victoria heavily influenced national results and this should be considered when interpreting the data below.

- The Australian Capital Territory and Victoria had the largest proportion of treatment episodes where heroin was the principal drug of concern (15%), and New South Wales reported 11%.
- The proportion of episodes where heroin was the principal drug of concern increased in South Australia (from 9% in 2007–08 to 11% in 2008–09).
- The Northern Territory continued to report the highest proportion of episodes where morphine was the principal drug of concern (7% compared with the national proportion of 1%).
- Alcohol-related treatment continued to dominate service delivery in *Very remote* areas (81% of episodes, down from with 87% in 2007–08). Episodes where heroin was the principal drug of concern were more common in *Major cities,* and episodes for cannabis use (secondary to alcohol) dominated service delivery in *Inner regional* and *Outer regional* areas.

Table 4.3: Principal drug of concern[a] by jurisdiction, 2008–09 (per cent)

Principal drug	NSW[b]	Vic	Qld[c]	WA	SA	Tas[d]	ACT	NT	Australia	Total (no.)
Alcohol	51.0	43.8	35.8	45.5	53.0	37.7	54.1	70.7	45.8	63,272
Amphetamines[e]	8.5	6.6	7.7	19.8	13.2	8.5	9.5	2.4	9.2	12,739
Benzodiazepines	2.0	1.8	1.0	0.8	1.9	1.4	0.7	0.4	1.5	2,080
Cannabis	18.4	23.6	36.4	15.9	10.1	38.7	15.7	10.5	22.5	31,100
Cocaine	0.8	0.2	0.2	0.2	0.3	n.p.	0.3	n.p.	0.3	479
Ecstasy	0.4	0.8	2.3	0.7	1.5	1.3	0.6	0.2	1.0	1,397
Nicotine	1.1	0.8	6.1	0.7	0.7	1.1	n.p	n.p	1.8	2,461
Opioids										
Heroin	10.8	14.9	3.8	8.5	10.5	0.5	15.0	0.8	10.3	14,222
Methadone	2.4	1.1	0.7	2.1	2.4	1.3	1.1	0.5	1.5	2,136
Morphine	0.9	1.1	1.7	0.2	2.6	6.4	0.2	7.1	1.4	1,877
Total opioids[f]	*16.5*	*19.1*	*8.0*	*11.4*	*18.5*	*10.1*	*18.1*	*9.2*	*15.1*	*20,890*
All other drugs[g]	1.3	3.2	2.5	5.1	0.8	n.p	n.p	5.9	2.6	3,609
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**34,250**	**44,691**	**24,984**	**15,570**	**9,399**	**1,983**	**3,629**	**3,521**	**. .**	**138,027**

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

(b) The total number of episodes for New South Wales has been under-reported because of system issues for the reporting period of 2008–09

(c) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

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

(e) Amphetamines proportion in New South Wales will be under-reported because other sources indicate a relatively high incidence of methamphetamine clients in the agencies affected by under-reporting because of system issues.

(f) 'Total opioids' includes the balance of opioid drugs coded according to ASCDC. See Appendix 5 and Table A3.3.

(g) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5 and Table A3.3.

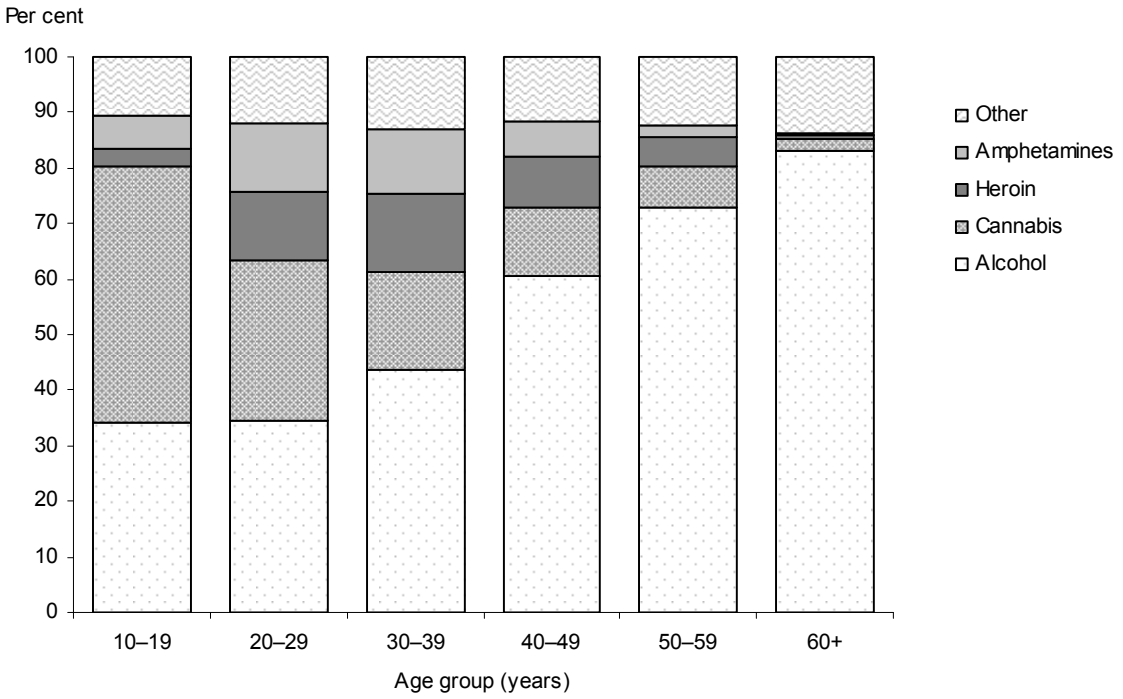
Appendix tables A3.3 to A3.16 provide additional data on drug-related items.

Age and principal drug of concern

Consistent with previous collections, there was considerable variation in the principal drugs of concern reported by age groups. Figure 4.1 shows the increasing proportion of treatment episodes for alcohol use and the decreasing proportion of episodes for cannabis use, as well as stable proportions for the treatment of 'other drug' use, across age groups.

- Alcohol was the most frequently reported principal drug of concern for all age groups except 10–19 year olds.
- Clients aged 10–19 years most frequently reported cannabis as their principal drug of concern (46%). Alcohol was the second most frequently reported principal drug of concern for this age group (34%).
- 20–29 year olds continued to report alcohol most frequently as their principal drug of concern, and as frequently as 10–19 year olds (up 2 percentage points from 2007–08). Alcohol was followed by cannabis (28%) and amphetamines (16%).

- After alcohol, cannabis and heroin were the most frequently reported principal drugs of concern for those aged 40–49 and 50–59 years.
- After alcohol, those aged 60+ years most frequently reported benzodiazepines or cannabis as their principal drug of concern, at around 2% of episodes. These proportions for benzodiazepines were evident in clients from ages 30 years and up. Clients aged 60+ were also more likely than other ages to present nicotine as a principal drug of concern.



Source: Table A3.6.

Figure 4.1: Selected principal drug of concern by age group, 2008–09

Indigenous status and principal drug of concern

- Aboriginal and Torres Strait Islander people were most likely to report the same four principal drugs of concern as the population overall—alcohol (54% of episodes), cannabis (23%), opioids (10%, with heroin accounting for 6%) and amphetamines (8%) (Table 4.4).
- Alcohol was more likely to be nominated by Indigenous clients (54% of episodes, compared with 45% for non-Indigenous Australians) and opioids less so (10%, compared with 16%). Ecstasy and cocaine treatment was delivered very infrequently to Indigenous Australians (0.3% and 0.2%, respectively).

As previously noted, these data relating to Indigenous status do not present all the information about substance use services provided to Aboriginal and Torres Strait Islander people in Australia. A substantial number of agencies providing treatment to Indigenous Australians for substance use report to different data collections (see Section 1.5 for further details, and Chapter 3 and Appendix 6 for data on these services).

Table 4.4: Principal drug of concern[a] by Indigenous status, 2008–09

Principal drug of concern	Indigenous		Non-Indigenous		Not stated		Total	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Alcohol	8,937	53.7	50,805	44.8	3,530	44.1	63,272	45.8
Amphetamines	1,253	7.5	10,829	9.6	657	8.2	12,739	9.2
Benzodiazepines	100	0.6	1,867	1.6	113	1.4	2,080	1.5
Cannabis	3,887	23.4	25,236	22.3	1,977	24.7	31,100	22.5
Cocaine	27	0.2	435	0.4	17	0.2	479	0.3
Ecstasy	42	0.3	1,286	1.1	69	0.9	1,397	1.0
Nicotine	272	1.6	2,096	1.8	93	1.2	2,461	1.8
Opioids								
Heroin	1,019	6.1	12,398	10.9	805	10.1	14,222	10.3
Methadone	217	1.3	1,821	1.6	98	1.2	2,136	1.5
Morphine	191	1.1	1,576	1.4	110	1.4	1,877	1.4
Total opioids[b]	1,576	*9.5*	18,119	*16.0*	1,195	*14.9*	20,890	*15.1*
All other drugs[c]	539	3.2	2,715	2.4	355	4.4	3,609	2.6
Total	**16,633**	**100.0**	**113,388**	**100.0**	**8,006**	**100.0**	**138,027**	**100.0**
Percentage of Indigenous status	**12.1**	**. .**	**82.1**	**. .**	**5.8**	**. .**	**100.0**	**. .**

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

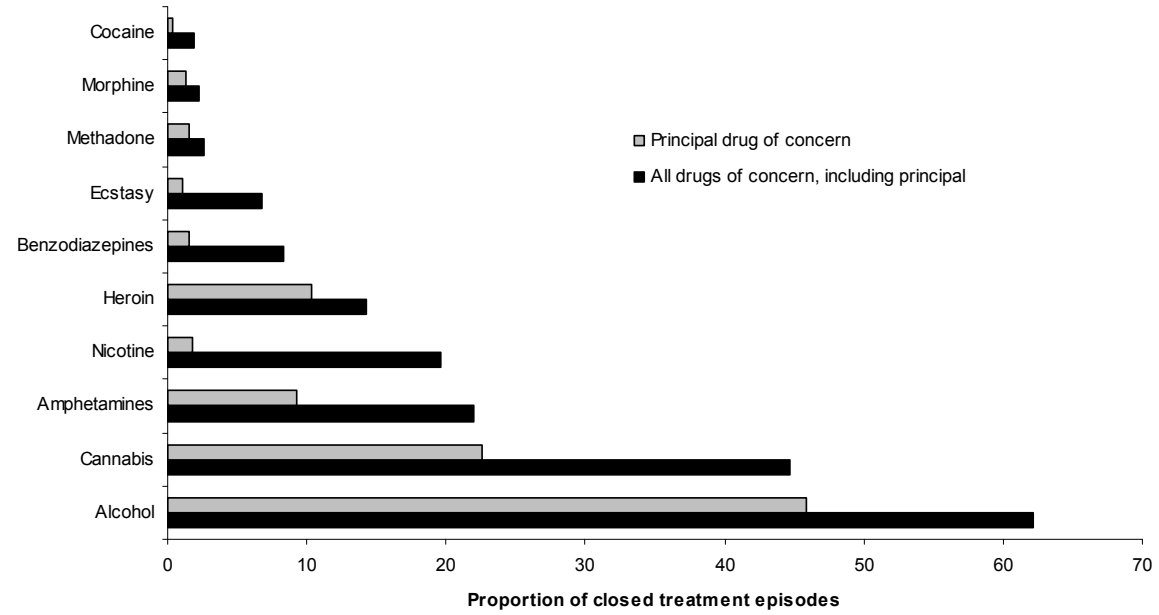
(b) 'Total opioids' includes the balance of opioid drugs coded according to ASCDC. See Appendix 5.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

4.4 All drugs of concern

When all drugs of concern are considered (that is, the principal and all other drugs of concern nominated by the client):

- Alcohol and cannabis remained the two most commonly reported drugs of concern in 2008–09 (62% and 45% of all drugs of concern, respectively—see Figure 4.2).
- The number of treatment episodes where benzodiazepines were reported as a drug of concern was stable at 8%.
- Despite being reported as a principal drug of concern in only 2% of treatment episodes, nicotine was the fourth most common drug of concern reported overall, reported in 20% of all episodes.



Source: Table A3.7.

Figure 4.2: Principal drug of concern and all drugs of concern, 2008–09

4.5 Individual principal drug of concern profiles

4.5.1 Overview

The following section provides more detailed information on each of the key substances profiled in the AODTS–NMDS. Previous editions of this report set out all the relevant information in text, whereas this report has summarised much of the common drug, client and treatment profile information into a new table. Tables 4.3 and 4.6 provide key information on selected important drugs, and further detailed information can be found within each section on the specific drug types.

The overview of selected principal drugs of concern provided in Table 4.6 shows that alcohol, cannabis and heroin are principal drugs that dominate treatment delivery in Australia. Alcohol was the single principal drug of concern where the majority of episodes did not have an additional drug of concern. Cannabis was the drug most likely to be identified as an additional drug of concern. Current injectors were in treatment for amphetamine, heroin or morphine use. Alcohol clients tended to be the oldest in treatment (median age 36 years) while ecstasy clients were the youngest (median age 22 years). Cocaine and ecstasy treatment was very male dominated, while episodes for methadone and benzodiazepines were more evenly split between the sexes. Aboriginal and Torres Strait Islander people were over-represented in treatment generally (based on a general population prevalence of 2.5%, contrasted with 12% of AODTS–NMDS episodes pertaining to clients identified as Indigenous Australians), and their principal drugs of concern were most frequently alcohol and cannabis. Indigenous Australians rarely received treatment for ecstasy, benzodiazepine or cocaine use.

Self-referral was the most common source of treatment access, with heroin and benzodiazepines treatment episodes particularly prevalent with self-referral. Criminal justice diversion policies for ecstasy, particularly in Queensland, dominated source of referral for that drug. Counselling was the most prevalent treatment type for all principal drugs of concern with the exception of methadone, which was mostly associated with 'other' treatment types, fundamentally because opioid pharmacotherapy was included in this category. The predominant setting for treatment for all drugs of concern was non-residential facility, although this was less dominant for alcohol, benzodiazepines and heroin.

Box 4.2: Reasons for leaving treatment

Since the start of the collection in 2001–02, the reasons for treatment episodes ending have remained consistent. That is, the same five reasons for cessation have been the most commonly reported in each year. 'Treatment completed' has always been the most common cessation reason reported, accounting for over 50% of closed treatment episodes in each year, and 56% in 2008–09. The next most common cessation reason has consistently been 'ceased to participate without notice'. 'Transferred to another service provider', 'ceased to participate against advice' and 'ceased to participate at expiation' each accounted for between 4% and 8% during 2008–09 (see Table A3.20). Many of the remaining cessation reasons, such as 'change in main treatment type', were infrequently reported in all years of the collection.

'Ceased to participate at expiation' has grown as a proportion of all cessation reasons, possibly because of the growth in treatment episodes provided and reported by police and court drug diversion schemes. These schemes direct drug-related offenders to participate in certain treatments which, when minimum requirements are met, lead to the expiation of the offence.

The AODTS–NMDS does not contain an indicator of treatment outcomes. However, it is possible to group cessation reasons into categories that can be defined as 'expected/compliant completions, unexpected/non-compliant cessations', and 'changes to treatment mode' (or administrative cessations), as shown in Table 4.5. This method has been previously used to configure and present AODTS–NMDS data (AIHW 2009a).

Table 4.5: Cessation reasons grouped by indicative outcome type[(a)]

Expected/compliant completions	Unexpected/non-compliant cessations	Changes to treatment mode
Treatment completed[(b)]	Ceased to participate against advice	Change in treatment type
Ceased to participate at expiation[(c)]	Ceased to participate without notice	Change in delivery setting
Ceased to participate by mutual agreement	Ceased to participate involuntary (non-compliance)	Change in principal drug of concern
	Drug court/and or sanctioned by court diversion service	Transferred to another service provider
	Imprisoned, other than drug court sanctioned	
	Died	

(a) 'Other' and 'not stated' cessation reasons not included.

(b) 'Treatment completed' can be reported in a range of circumstances (see box opposite).

(c) 'Ceased to participate at expiation' is an expected/compliant completion in the sense that legally mandated treatment is completed. It is not possible to exclude episodes reported as 'ceased to participate at expiation' where clients finished enough treatment to expiate their offence but did not return for further treatment as expected.

Although 'treatment completed' has consistently been the most common reason for clients to cease alcohol and other drug treatment, many situations may be reported as treatment completed. It is unclear how many 'treatment completed' episodes are reported when, for example, all immediate treatment goals are met, a client has only completed part of anticipated treatment or the term of treatment is not fixed.

Treatment cessation was generally associated with expected/compliant reasons (this defined as when reason for cessation was either 'treatment completed', 'ceased to participate at expiation', or 'ceased to participate by mutual agreement'), particularly for ecstasy and cannabis. Methadone and heroin had relatively fewer expected/compliant completions.

Table 4.6: Selected principal drug of concern profiles in 2008–09

Drug of concern	Principal drug of concern	Change in principal drug of concern[a]	All drugs of concern[b]	Change in all drugs of concern[a][b]	One or more other drug of concern[c]	Typical additional drug of concern	Predominant method of use	Predominant client injecting status	Median age (years)	Proportion of males	Proportion of Indigenous Australians
	Per cent									Per cent	
All drugs	. .	—	—	—	—	**Cannabis**	**Ingests**	**Never**	**32**	**68**	**12.1**
Alcohol	45.8	Up 1.4	62.2	Up 2.1	46.2	Cannabis	Ingests	Never	36	**70**	14.1
Amphetamines	9.2	Down 2.0	22.0	Down 2.1	67.1	Cannabis	Injects	Current	30	**68**	9.8
Benzodiazepines	1.5	Down 0.2	8.3	Up 0.1	67.4	Cannabis	Ingests	Never	35	**50**	4.8
Cannabis	22.5	Up 1.0	44.6	Up 1.1	62.5	Alcohol	Smokes	Never	25	**70**	12.5
Cocaine	0.3	≈	1.9	≈	68.9	Other	Sniffs	Never	30	**76**	5.6
Ecstasy	1.0	Up 0.1	6.8	Up 1.1	63.4	Alcohol	Ingests	Never	22	**80**	3.0
Heroin	10.3	Down 0.2	14.3	Up 0.1	67.0	Cannabis	Injects	Current	31	**67**	7.2
Methadone	1.5	≈	2.6	Down 0.1	59.1	Cannabis	Ingests	Previous	34	**53**	10.2

(continued)

Table 4.6 (continued): Selected principal drug of concern profiles in 2008–09

Drug of concern	Most common source of referral (Referral source, per cent)	Predominant type of treatment (Main treatment type, per cent)	Median duration of predominant type of treatment (days)	Predominant treatment setting (per cent)	Expected/ compliant completions[f] (per cent)
All drugs	**Self (34.6)**	**Counselling (35.8)**	**44.0**	**Non-residential treatment facility (63.8)**	**65.9**
Alcohol	Self (36.3)	Counselling (39.0)	45.0	Non-residential treatment facility (61.5)	66.3
Amphetamines	Self (34.4)	Counselling (41.8)	48.0	Non-residential treatment facility (65.7)	59.5
Benzodiazepines	Self (40.8)	Counselling (31.3)	57.0	Non-residential treatment facility (60.5)	61.4
Cannabis	Self (26.5)	Counselling (33.6)	46.0	Non-residential treatment facility (67.2)	72.9
Cocaine	Self (37.0)	Counselling (39.5)	24.0	Non-residential treatment facility (71.2)	64.5
Ecstasy	Court Diversion[d] (42.3)	Counselling (37.8)	23.0	Non-residential treatment facility (79.7)	82.4
Heroin	Self (43.7)	Counselling (30.4)	49.0	Non-residential treatment facility (62.2)	57.3
Methadone	Self (35.8)	Other[e] (37.9)	61.5	Non-residential treatment facility (65.3)	55.2

(a) Percentage-point change from 2007–08 to 2008–09.

(b) All drugs of concern refers to episode data where the drug is identified as either 'principal drug of concern' or 'other drug of concern'.

(c) Percentage of episodes including at least one 'other drug of concern' in addition to 'principal drug of concern'

(d) Queensland provided 412 episodes where 'court diversion' was the source of referral.

(e) Inclusion of pharmacotherapy in 'other' clarifies this difference.

(f) Proportion of all reason for cessation data where 'treatment completed', 'ceased to participate at expiation' or 'ceased to participate by mutual agreement'.

4.5.2 Alcohol

Alcohol consumption guidelines

The National Health and Medical Research Council (NHMRC) released the *Australian guidelines to reduce health risks from drinking alcohol* in February 2009. These guidelines take a very different approach from the previous *Australian alcohol guidelines* (NHMRC 2001) in that they identify a progressively increasing risk of harm with increasing amounts of alcohol consumed rather than specifying 'risky' or 'high risk' levels of consumption. The guidelines suggest that Australians drink no more than two standard drinks on any day (Guideline 1) (NHMRC 2009). Analysis of risk in this report is based on the definitions from the 2001 guidelines, which pertains to statistics from 2007 National Drug Strategy Household Survey (NDSHS) (AIHW 2008b, 2008c).

Patterns of use in Australia

Alcohol is the most widely used drug in the Australian community. Analysis from research into drug and alcohol behaviours and attitudes of Australians aged 14 years and over, (AIHW 2008b, 2008c) describes various characteristics of alcohol use. Most Australians drink alcohol, and in the 12 months before the survey 49% of respondents drank alcohol on a daily or weekly basis, and 34% drank less than once a week. Older people were more likely to be daily drinkers than younger people, and males were more likely to be regular drinkers than females.

According to the 2001 NHMRC Australian alcohol guidelines[2] (NHMRC 2001), in the 12 months before the survey:

- One in ten Australians aged 14 years and older consumed alcohol at levels that are considered risky or high risk to health in the long term, with persons in the 20–29 years age group most likely to consume alcohol in a way that put them at risk of long-term alcohol-related harm.
- Almost one quarter of recent drinkers[3] reported being 'unable to remember afterwards what happened' while they were drinking (24%) or reported having 'a feeling of guilt or remorse after drinking' (23%) at least once in the previous 12 months.
- Almost one in five people who reported drinking in the previous 12 months also reported that they 'were not able to stop drinking' once they had started (19%) or 'failed to do what was normally expected' of them because of drinking (18%) at least once in the previous year.

Alcohol as a principal drug of concern (tables A3.10 and A3.12)

Alcohol was the most common principal drug of concern for which treatment was sought in 2008–09, accounting for 46% of episodes: an increase since 2007–08. When other drugs of concern are also considered, 62% of treatment episodes included alcohol in 2008–09, which is

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2 According to the NHMRC 2001 guidelines, the consumption of 29 or more (if male) or 15 or more (if female) standard drinks per week is considered risky or high risk to health in the long term. The consumption of 7 or more (if male) or 5 or more (if female) standard drinks on any one day is considered risky or high risk to health in the short term.

3 A recent drinker is defined as a person who consumed a full serve of alcohol in the last 12 months.

also higher than 2007–08. Alcohol has been the most common principal drug of concern reported since the inception of collection in 2001–02 (see Chapter 6).

Of the 63,272 episodes where alcohol was nominated as the principal drug of concern:

- Reports of other drugs of concern (46%) were substantially less likely compared with the national proportion (55%). Alcohol and cannabis were frequently reported as drugs of concern in the same episode.
- The proportion of episodes for males (70%) was higher than the national proportion (68%). The median age was 36 years, higher than national median of 32 years. This is not surprising because older clients were more likely to receive treatment for alcohol than younger clients (Figure 4.1). 14% per cent of episodes were for Indigenous Australians, which is 2% higher than across all principal drugs of concern.
- Counselling was the most common main treatment type (39%). This proportion was higher than the national proportion for all drugs (36%).
- Most episodes were completed as expected (66%). The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (16%). For a full list of cessation reasons see Table A3.12.

4.5.3 Cannabis

Patterns of use in Australia

Cannabis is the most widely used illicit drug in Australia. According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over, almost one in ten respondents had used cannabis at least once in the last 12 months and one in three had used cannabis at some stage in their lifetime. The 20–29 years age group was most likely to have used cannabis recently (21%) and 30–39 year olds were more likely to have ever used cannabis (55%). Males were more likely to have ever used, or recently used, cannabis. Of those who have ever used cannabis, the average age at which Australians first used cannabis was 19 years. Approximately 12% of recent cannabis users reported attempting to stop or cut down their use in the previous 12 months.

Cannabis as a principal drug of concern (tables A3.8 and A3.12)

Cannabis was the second most common principal drug of concern for which treatment was sought in 2008–09, accounting for 23% of closed treatment episodes: a rise from 2007–08. As usual in the AODTS–NMDS, cannabis was the illicit principal drug commanding the greatest number of treatment episodes. When other drugs of concern are also considered, 45% of episodes included cannabis as a drug of concern (Figure 4.2).

Of the 31,100 closed treatment episodes where cannabis was nominated as the principal drug of concern:

- Smoking was the most common method of use.
- 63% of episodes included at least one other drug of concern in addition to cannabis, and this was most likely to be alcohol (34% of relevant episodes).

- The majority (70%) of episodes were for male clients. This was the same as for the last two collection periods. The median age of those in treatment for cannabis use was 25 years.
- Self-referral was the most common source of referral (27% of episodes); referrals from police diversion and court diversion were 18% and 16%, respectively.
- Counselling was the most common main treatment type received (34% of episodes), albeit lower than the national proportion, and most likely to take place in a non-residential treatment facility (67% of episodes).
- Most episodes were completed as expected (73%). The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (13%).

4.5.4 Heroin

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over, fewer than 2% (0.3 million people) had used heroin in their lifetime and fewer than 1% had used heroin in the 12 months before the survey. Persons in the 30–39 years age group were most likely to have used heroin in their lifetime and males were twice as likely as females to have used heroin. Persons in the 20–29 years age group were most likely to have used heroin recently. The average age at which Australians first used heroin was 22 years. Sixty-one per cent of recent heroin users reported attempting to stop or cut down their use in the previous 12 months.

Heroin as a principal drug of concern (tables A3.8, A3.9 and A3.12)

Although the proportion of heroin episodes fell from 11% in 2007–08 to 10% in 2008–09, heroin was the third most common principal drug of concern for which treatment was sought in 2008–09. When other drugs of concern are also considered, 14% of episodes included heroin as a drug of concern (Figure 4.2), which is consistent with the previous year.

Of the 14,222 closed treatment episodes where heroin was nominated as the principal drug of concern:

- Injecting was the most common method of use (89% of episodes). In 6% of episodes, people reported that they most often smoked their heroin. Consistent with 2007–08, the majority (62%) of episodes involved clients who reported being current injectors. 5%of episodes involved clients who reported never having injected drugs: a 1% increase on the proportion in 2007–08.
- 67% of episodes included at least one other drug of concern in addition to heroin, and this was most likely to be cannabis (25% of relevant episodes).
- The majority (67%) of episodes were for male clients; however, this was slightly below the collection's national proportion (68%). The median age of persons receiving treatment was 31 years (males 32 years; females 30 years). Clients aged 30–39 years accounted for the greatest proportion of episodes (38%), followed by those aged 20–29 years (39%): a switch from previous years. Seven per cent of episodes involved clients who identified as Indigenous Australians, which is consistent with 2007–08. Self referral

was the most common source of referral, as it was for most drug types, but at 44% of episodes this was higher than the national proportion.

- Counselling was the most common main treatment type received (30% of episodes). Following this, 22% of episodes were withdrawal management (detoxification).
- Most episodes were completed as expected (57%); however, this was the lowest rate of all the principal drugs of concern. The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (16%).

4.5.5 Amphetamines

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over, 6% of Australians had used amphetamines[4] for non-medical purposes at some stage in their lifetime, and fewer than 3% had used them in the previous 12 months. The age group most likely to have ever used or recently used amphetamines was 20–29 years. Males were more likely than females to have used amphetamines in the 12 months before the survey. Of those who had ever used amphetamines, the average age of first use was 21 years. 13% of recent amphetamine users reported attempting to stop or cut down their use in the previous year.

Amphetamines as the principal drug of concern (tables A3.8, A3.9 and A3.12)

Amphetamines were the fourth most common principal drug of concern for which treatment was sought in 2008–09, accounting for 9% of episodes, and representing a notable drop in proportion of episodes from 2007–08 (11%). There was a higher proportion of episodes for heroin than amphetamines in 2008–09. When other drugs of concern were also considered, 22% of treatment episodes included amphetamines in 2008–09: also a decrease on 2007–08 (Figure 4.2).

In 2008–09, of the 12,739 closed treatment episodes where amphetamines were nominated as the principal drug of concern:

- Though injecting was the most commonly reported method of use, this behaviour fell two percentage points from the previous collection year to 64% of episodes. Most episodes involved clients who reported being current injectors (49%).
- 67% per cent of episodes included at least one other drug of concern in addition to amphetamines, most commonly cannabis (33%).
- The median age of persons receiving treatment was 30 years: a rise from 29 in 2007–08. Persons aged 20–40 years accounted for 78% of treatment episodes. 10% of episodes involved clients who identified as being Aboriginal and Torres Strait Islander people: an increase on the 9% reported in 2007–08 but lower than the current collection's national proportion (12%). Most people referred themselves to treatment (34%), which was less than the national proportion, with court diversion providing a further 15% of referrals.

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[4] The 2007 NDSHS refers to this group of drugs as meth/amphetamines. Similarly, within this report, the term 'amphetamines' includes those drugs that are referred to as methamphetamines.

- Similar to the previous year, counselling was the most common main treatment type received (42% of episodes), which was higher than the national proportion for all principal drugs of concern.
- Most episodes were completed as expected (60%), although this figure is lower than for other principal drugs other than heroin. The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (20%). Proportionately more treatment episodes for amphetamines than for any other principal drug of concern ended this way.

4.5.6 Benzodiazepines

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over, fewer than 2% of respondents reported using benzodiazepines (identified as tranquillisers or sleeping pills) in the previous 12 months for non-medical purposes. People aged 20–29 years were most likely to use benzodiazepines (3%) compared with other age groups. There was very little overall difference in the prevalence of recent use of tranquillisers or sleeping pills between males and females.

Benzodiazepines as a principal drug of concern (tables A3.8, A3.9 and A3.12)

Benzodiazepines as a principal drug of concern accounted for fewer than 2% of closed treatment episodes in 2008–09. When other drugs of concern are also considered, 8% of treatment episodes included benzodiazepines in 2008–09 (Figure 4.2).The proportion of treatment episodes where benzodiazepines were reported as the principal drug of concern has remained stable since 2001–02 at approximately 2% (see Chapter 6).

Of the 2,080 closed treatment episodes where benzodiazepines where nominated as the principal drug of concern:

- Most clients (93%) reported ingesting benzodiazepines; however, 4% said they injected them.
- 67% of episodes included at least one other drug of concern in addition to benzodiazepines, most commonly (19%) cannabis.
- Proportionately more females received treatment for benzodiazepines compared with other drugs. The median age of persons receiving treatment was 35 years, which is older than the collection average of 32 (see Section 4.2 for a more detailed discussion regarding age and drug of concern). 5%of episodes were for clients who identified as being Aboriginal and Torres Strait Islander people, which was lower than the collection's national proportion. Self-referral was the most common source of referral (41% of episodes), which was greater than the collection's national proportion. Medical practitioners were the referral source for a greater proportion of benzodiazepine episodes than other drug types (with the exception of 'other' opioids and methadone).
- Counselling and withdrawal management (detoxification) were the most common main treatment types received (31% of episodes for each type). Benzodiazepines featured a higher proportion of withdrawal management (detoxification) than any other principal drug.

- Most episodes were completed as expected (61%). The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (13%).

4.5.7 Ecstasy

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over, 9% of respondents had used ecstasy at some stage in their lifetime, and fewer than 4% had used it in the previous 12 months. The 20–29 year age group was more likely than others to have used ecstasy either recently or ever. Overall, males were more likely than females to have recently used ecstasy. Of those who had ever used ecstasy, the average age of first use was 23 years. Fewer than 1% of recent ecstasy users reported attempting to stop or cut down their use in the previous 12 months.

Ecstasy as a principal drug of concern (tables A3.8 and A3.12)

Ecstasy as a principal drug of concern accounted for 1% of closed treatment episodes in 2008–09. When all drugs of concern are considered, 7% of treatment episodes included ecstasy as a drug of concern (Figure 4.2). The proportion of episodes where ecstasy was reported as the principal drug of concern have consistently increased in number since 2001–02, but remained relatively minor at less than 1% of treatment episodes (see Chapter 6).

Of the 1,397 closed treatment episodes where ecstasy was nominated as the principal drug of concern:

- Ingestion was the most common method of use (89% of episodes).
- 63% of episodes included at least one other drug of concern in addition to ecstasy, most commonly (33%) alcohol. When other drugs of concern are also considered, 7% of treatment episodes included ecstasy in 2008–09, (Figure 4.2).
- The majority (80%) of episodes were for male clients. People seeking treatment for ecstasy tended to be younger than those seeking treatment for other drugs, with the median age for ecstasy-related episodes at 22 years. Almost 90% of clients receiving episodes of treatment for ecstasy use were under 30 years old. Only 3% of episodes involved clients who identified as being Aboriginal and Torres Strait Islander people. Ecstasy-related episodes had a relatively low rate of self-referrals (18%) compared with other drug types. More episodes were initiated by a referral from a diversion program (59%), including police (16%) and court-based (42%) diversion.
- Counselling was the most common main treatment type received (38% of episodes). Information and education only at 34% was higher for ecstasy than for any other principal drug of concern.
- Most episodes were completed as expected (82%), mainly because of the high rate of 'ceased to participate at expiation' (34%) in addition to the general high rate of 'treatment complete'. The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (10%).

4.5.8 Cocaine

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over, 6% of respondents had used cocaine at some stage in their lifetime, and less than 2% reported using cocaine in the previous 12 months. The 20–29 years age group had the highest proportion (12%) of persons ever using cocaine compared with all other age groups. Similarly, the 20–29 years age group had the highest proportion (5%) of persons who had recently used cocaine. Overall, males were more likely than females to have recently used cocaine. The average age at which Australians used cocaine for the first time was 23 years. Few cocaine users (3%) reported attempting to stop or cut down their use in the previous 12 months.

Cocaine as a principal drug of concern (tables A3.8, A3.9 and A3.12)

Consistent with previous collections, cocaine as a principal drug of concern accounted for a very small proportion of episodes in 2008–09 (less than 1% or 479 episodes).

Of the 479 episodes where cocaine was nominated as the principal drug of concern:

- Sniffing cocaine as a powder was the most common method of use (47% of episodes).
- 69% of episodes included at least one other drug of concern in addition to cocaine. When other drugs of concern are also considered, 2% of treatment episodes included cocaine in 2008–09 (Figure 4.2).
- The majority (76%) of episodes were for male clients. The median age of persons receiving treatment was 30 years. 6% of episodes involved clients who identified as Indigenous Australians. Self-referral was the most common source of referral (37% of episodes).
- Counselling was the most common main treatment received (40% of episodes), and treatment was most likely to take place in a non-residential treatment facility (71% of episodes), or a residential treatment facility (21%).
- Most episodes were completed as expected (65%). The most common unexpected or administrative reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (18%).

5 What treatments do people receive?

Treatment programs consist of the main treatment types received by a client together with any additional treatments received from the same service.

Data presented in this chapter generally relate to all episodes, including those for people seeking treatment in relation to someone else's drug use. The one exception is in relation to data about principal drug of concern. As people seeking treatment in relation to someone else's drug use are not asked to identify the other person's drug of concern, these clients are not included in those data relating to drugs of concern.

Box 5.1: Key definitions and counts for treatment programs, 2008–09

Main treatment type refers to the principal activity, as judged by the provider, that is necessary for the completion of the treatment plan for the principal drug of concern. In practice, however, the main treatment type may be the actual treatment provided, rather than that considered necessary at the start of the episode. Agencies are asked to provide the main treatment for each episode. In 2008–09, the main treatment type was reported for all 143,672 episodes.

Some caution should be used when comparing main treatment types over time and between jurisdictions. For example, caution is required when comparing the number of closed treatment episodes for main treatment type from the collection periods 2002–03 to 2008–09 with those of 2001–02. In 2001–02, records from South Australia were excluded from tables using main treatment type because South Australia did not provide this data item. In 2008–09, as in previous years, Victoria did not differentiate between main and other treatment types. Victoria is not directly comparable with other jurisdictions because every treatment type provided to a client is reported as a separate episode.

Other treatment type refers to two separate concepts in the technical specifications for the AODTS–NMDS collection. First, it refers to main treatment types that do not fit into the categories of withdrawal management (detoxification), counselling, rehabilitation, support and case management only, information and education only or assessment only. In this context, 'other treatment types' might include living skills classes or relapse prevention. In 2008–09 there were 9,424 treatment episodes featuring 'other treatment types' as the main treatment provided. Second, 'other treatment type' refers to *additional* treatments provided to clients as well as the main treatment type. These are referred to as *additional treatment types* in this report. Additional treatment types most often include treatments from the categories used for main treatment type. For example, a client may receive withdrawal management (detoxification) as their main treatment and Counselling as an additional treatment. Up to four additional treatment types can be recorded for each client. In 2008–09, there were 14,663 closed treatment episodes that included at least one additional treatment type. (Note that Victoria is excluded from analyses of additional treatment types.)

All treatment types refers to all treatments reported by agencies as taking place during the collection period, including the main and additional treatments. In 2008–09, there were a total of 162,199 treatments reported (tables A3.17 and A3.18).

5.1 Main treatment

The treatment types reported to the AODTS–NMDS are broad categories. They are intended to group similar treatments rather than represent in detail the large variety of treatment programs around Australia. It is useful to keep in mind that several jurisdictions 'map' their treatment data into the treatment types presented here. For example, a state's treatment agencies may report specific types of counselling to the state's health authority but these are then amalgamated into 'counselling' for reporting to the AIHW. It is also important to note that there is no consensus about the 'right' mix of treatments or the volume of treatment services needed to meet the needs of people with drug use issues in Australia.

Main treatment types across Australia

Although there has not been much variation in the main treatment types provided at the national level over time (see Chapter 6), there was some variation in the proportions of types of treatment provided in states and territories relating to 2008–09 as shown in Table 5.1.

Table 5.1: Main treatment type by jurisdiction, 2008–09

Main treatment type	NSW[(a)]	Vic[(b)]	Qld[(c)]	WA	SA	Tas[(d)]	ACT	NT	Australia	Total (no.)
Withdrawal management (detoxification)	20.4	21.1	6.4	10.2	17.4	6.4	21.3	15.3	16.4	23,599
Counselling	30.0	46.7	25.0	56.4	25.7	57.2	29.7	16.9	37.4	53,787
Rehabilitation	7.2	3.9	2.6	13.8	14.4	8.5	6.3	13.8	6.7	9,667
Support and case management only	9.7	13.7	5.7	3.1	1.2	2.6	13.5	6.6	8.9	12,740
Information and education only	1.3	0.8	40.3	3.6	5.8	16.5	8.9	8.5	9.2	13,283
Assessment only	16.3	10.6	18.0	7.6	26.9	7.5	16.5	33.2	14.7	21,172
Other[(e)]	15.2	3.2	1.9	5.3	8.6	1.2	3.9	5.7	6.6	9,424
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**..**
Total (number)	**34,893**	**47,089**	**25,523**	**16,915**	**9,664**	**2,081**	**3,750**	**3,757**	**..**	**143,672**

(a) In New South Wales, the 'Other' category includes outreach services provided to hospital patients by community-based alcohol and other drug treatment agencies. These 'consultation liaison' activities were excluded from the data in 2006–07. Consultation liaison was included in earlier years of the collection but increased substantially in 2007–08. The number of these episodes dropped in 2008–09 in proportion with all New South Wales main treatment types, owing to the under-reporting caused by system issues.

(b) The number of closed treatment episodes for Victoria may not be directly comparable to other jurisdictions because Victoria does not differentiate between main and other treatment types. All treatment provided is reported as a unique episode against main treatment type, regardless of whether it was judged to be the principal activity necessary for completion of a treatment plan.

(c) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

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

(e) 'Other' includes 37% closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

- Over half of treatment episodes in Western Australia and Tasmania were for counselling.
- There was substantial variation in the proportion of information and education only episodes provided, from less than 1% in Victoria to 40% in Queensland.
- Most states and territories reported that 90% of their episodes met one of the defined treatment types in the NMDS. The Northern Territory, South Australia and New South Wales had higher proportions of 'other' main treatments. In New South Wales, this was related to a growing number of outreach services to hospital in-patients. In the Northern Territory, this may relate to bush adventure therapy programs, outstation services and day programs.

Aboriginal and Torres Strait Islander people and treatment programs

- Episodes for Indigenous Australians were most likely to be for counselling (37%), followed by assessment only (18%), withdrawal management (detoxification) (12%) and information and education only (11%) (Table 5.2).
- Similar to 2007–08, Indigenous Australian clients received counselling in similar proportions to non-Indigenous clients, but were less likely to access withdrawal management (detoxification) as a main treatment (12%) compared with non-Indigenous people (17%).
- Treatment episodes for Indigenous Australians were more likely to be assessment only (18%) as the main treatment type, compared with 14% of episodes for non-Indigenous clients.
- Overall, the differences in service patterns between Indigenous and non-Indigenous Australian clients are similar to those found in the 2007–08 collection.

Table 5.2: Main treatment type by Indigenous status, 2008–09

	Indigenous		Non-Indigenous		Not stated		Total	
Main treatment type	**No.**	**Per cent**	**No.**	**Per cent**	**No.**	**Per cent**	**No.**	**Per cent**
Withdrawal management (detoxification)	2,041	12.0	20,163	17.0	1,395	16.7	23,599	16.4
Counselling	6,333	37.2	43,872	37.1	3,582	42.9	53,787	37.4
Rehabilitation	1,336	7.8	8,055	6.8	276	3.3	9,667	6.7
Support and case management only	1,564	9.2	10,526	8.9	650	7.8	12,740	8.9
Information and education only	1,827	10.7	10,717	9.1	739	8.9	13,283	9.2
Assessment only	3,113	18.3	16,721	14.1	1,338	16.0	21,172	14.7
Other[(a)]	829	4.9	8,235	7.0	360	4.3	9,424	6.6
Total	**17,043**	**100.0**	**118,289**	**100.0**	**8,340**	**100.0**	**143,672**	**100.0**
Percentage of closed treatment episodes	**11.9**	**. .**	**82.3**	**. .**	**5.8**	**. .**	**100.0**	**. .**

(a) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

For more information about alcohol and other drug treatment provided to Aboriginal and Torres Strait Island people in services not included in the AODTS–NMDS see Appendix 6.

5.2 Additional treatments

This section looks at the provision of multiple treatment types, in the same episode, by the same agency. As in previous years, Victorian data have been excluded from these analyses because Victoria counts each treatment as a distinct episode.

The provision of more than one type of treatment during an episode may occur because treatment agencies provide multiple treatments that can be (but are not required to be) part of a single treatment plan. Other treatment agencies provide only one type of treatment and, therefore, do not report other treatment types. Other treatment type is not reported where it may be regarded as a core component of the main treatment type, such as counselling that is required as part of a rehabilitation episode is not reported in addition to rehabilitation as the main treatment type.

- Of the 96,582 episodes in 2008–09 (excluding Victoria), 14,663 episodes (15%) reported at least one 'other' treatment type (see Table 5.3).
- 38% of withdrawal management (detoxification) episodes included at least one additional treatment type; therefore it was the most likely treatment type to be provided in combination with another treatment.
- 35% of rehabilitation episodes included at least one additional treatment type.
- Counselling was most often a stand-alone treatment, with only 10% of episodes including an additional treatment.

Table 5.3: Main treatment type, with or without additional treatment types, Australia[(a)], 2008–09

Main treatment	With additional treatment	With no additional treatment	Total episodes	Proportion of episodes with additional treatment
	Number			Per cent
Withdrawal management (detoxification)	5,221	8,463	13,684	38.2
Counselling	3,345	28,448	31,793	10.5
Rehabilitation	2,705	5,137	7,842	34.5
Support and case management only	—	6,286	6,286	—
Information and education only	—	12,907	12,907	—
Assessment only	—	16,164	16,164	—
Other[(b)]	3,392	4,514	7,906	42.9
Total	**14,663**	**81,919**	**96,582**	**15.2**

(a) Excludes 47,089 closed treatment episodes from Victoria because this jurisdiction does not provide data for 'other treatment types' separately, but instead reports each treatment provided as a main treatment type in unique episodes.

(b) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

5.3 Counselling

What is Counselling?

In the context of the AODTS–NMDS, Counselling is defined as any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency (AIHW 2009b). 'Counselling is a joint approach between the counsellor and the client with treatment plans negotiated and agreed upon by both parties' (NCETA 2004).

Though there is no agreed approach, style or type of counselling that is provided in the AOD sector, the Best Practice in Alcohol and Other Drug Interventions Working Group (2000) recommended that general counselling should include:

- linking patients with the appropriate services while the patient is still engaged
- anticipating and developing strategies with the patient to cope with difficulties before they arise
- specific evidence-based interventions where appropriate (e.g. goal setting, cognitive behavioural therapy, motivational enhancement therapy and problem solving) focusing on positive internal and external resources and successes, as well as problems and disabilities
- consideration of the wider picture and helping the patient on a practical level (e.g. with food, finances and housing) where appropriate, involving key supportive others to improve the possibility of behavioural change outside the therapeutic environment.

Counselling as a main treatment

Counselling was the most common main treatment provided in 2008–09, accounting for 53,787 closed treatment episodes (37%) (Table 5.1). Of these episodes in 2008–09:

Client profile (Table A3.19)

- 92% of episodes were for clients seeking treatment for their own drug use. Counselling was also the treatment most likely to be provided to people seeking treatment related to someone else's drug use.
- The majority (64%) of episodes were for male clients.
- The median age of persons receiving treatment was 33 years (males 32 years; females 34 years).
- People in their 20s and 30s accounted for the largest proportion of episodes (both 29%), followed by people aged 40–49 years (19%).
- 12% of episodes involved clients who identified as Aboriginal and Torres Strait Islander people.
- Self-referral was the most common source of referral (40%), followed by court diversion (13%) and referrals from alcohol and other drug treatment services (9%).

Treatment profile (tables A3.20 and A3.24)

- Counselling was most likely to occur in a non-residential treatment facility (92%), rather than at the client's home (2%), an outreach setting (4%) or a residential treatment facility (less than 1%).

- The majority (52%) of episodes were reported to have ended because the treatment was completed. The next most common reason for ending a treatment episode (24%) was that the client ceased to participate without notifying the service provider.
- Counselling episodes were longer than most other treatment types, with a median length of 44 days. Support and case management only was the only other treatment type that took place over a longer period (47 days).

Principal drug profile (Table A3.27)

Of the 49,421 episodes in 2008–09 where counselling was nominated as the main treatment and the client was seeking treatment for their own drug use, alcohol was the most common principal drug of concern reported (50% of episodes), followed by cannabis (21%), amphetamines (11%) and heroin (9%).

5.4 Withdrawal management (detoxification)

What is withdrawal management?

Withdrawal management supports people through the process of detoxification, where alcohol and/or other drugs are removed from the body. Withdrawal management assists clients by monitoring the withdrawal process and may include medical intervention as appropriate (Shand et al. 2003). Detoxification may be medicated or not, depending on the drugs the client is receiving treatment for and the severity of dependency. Withdrawal management can take place in an inpatient or outpatient clinic or a home-based setting.

Box 5.2: Withdrawal management treatment case study from Western Australia

'Cheryl was a young lady in her mid-20's who attended the Next Step inpatient withdrawal unit to help with her problematic alcohol use. Cheryl has a longstanding history of epilepsy, although her regular use of alcohol lessened the effectiveness of anti-epileptic medication. Her living situation had been unstable in the months before admission and has included living on the streets and staying in short-term lodges. While in the unit, staff identified concerns with her memory and seemed to feel that she was often confused and was not understanding many verbal instructions or following conversations. To formally examine these concerns, she was referred for a neuropsychological assessment. The results of that assessment identified marked deficits in Cheryl's verbal abilities, relative to her non-verbal skills, and also in her academic and adaptive functioning. This meant that she was likely to struggle to understand complex verbal instructions and also to remember verbal information provided to her. This has contributed to feelings of confusion and frustration when dealing with complex problems, and even when following a group conversation.

Rather than being sent home following her discharge from the unit, Cheryl was subsequently placed in a structured accommodation setting and put in touch with community services that can assist with her daily functioning when required. She has also been provided with Clinical Psychology services, modified to accommodate her reduced verbal abilities, to assist with strategies to further reduce her drinking. With the additional assistance Cheryl has been able to cut down on her drinking. This has significantly improved the effectiveness of her anti-epileptic medication. Furthermore, staff working with her are now aware of her reduced verbal abilities and have been able to modify their interaction with her to accommodate these weaknesses.'

Withdrawal management as a main treatment

Withdrawal management was the second most common main treatment type provided in 2008–09, accounting for 23,599 episodes (16%) (Table 5.1). Of these episodes in 2008–09:

Client profile (Table A3.19)

- Only clients seeking treatment for their own drug use received this main treatment type.
- The majority (65%) of episodes were for male clients.
- The median age of clients receiving treatment was 36 years (males 36 years; females 35 years).
- People accessing withdrawal management were most likely to be aged 30–39 years (31%), followed by people aged 20–29 years (24%).
- 9% of episodes were for clients who identified as being Aboriginal and Torres Strait Islander people.
- Self-referral was the most common source of referral (53% of episodes); 16% of withdrawal management referrals came from alcohol and other drug treatment services.

Treatment profile (tables A3.20 and A3.24)

- Treatment was most likely to occur in a residential treatment facility (59%). 29% of episodes were also provided via a non-residential setting, and 9% at the home of the client.
- The majority (64%) of episodes were reported to have ended because the treatment was completed. The next most common reasons for ending a treatment episode were that the client ceased to participate against advice or without notice (around 10% each).
- The median duration of a treatment episode was unchanged from 2007–08 at 8 days.

Principal drug profile (Table A3.27)

Of the 23,599 closed treatment episodes in 2008–09 where withdrawal management (detoxification) was nominated as the main treatment type, alcohol was the most common principal drug of concern reported (51% of episodes), followed by cannabis (16%) and heroin (13%).

5.5 Assessment only

What is assessment only?

To be included in the AODTS–NMDS, clients of specialist AOD agencies are assessed and/or accepted for one or more types of treatment for their own, or another person's, alcohol and other drug problem (AIHW 2009b). For some clients, a treatment episode consists simply of an assessment and no other treatment is received. These episodes are reported as assessment only.

The process of assessment identifies the nature of the drug issue, including the extent and associated health implications, the client's needs (which form the basis of the treatment plan) and which treatment would be most appropriate for the client (NCETA 2004). Assessment may be done by a central agency whose sole purpose is to make assessments and refer to

appropriate treatment agencies, or completed in-house at an alcohol and other drug treatment agency as the first part or session in a course of treatment.

There is no brief intervention category in the AODTS–NMDS. As a result, some interventions of this nature are likely to be reported as assessment only. Sometimes assessment itself may be regarded as a brief intervention because it can have the effect of increasing the client's motivation (Flannery & Farrell 2007).

Information from states and territories indicates that some episodes reported as 'assessment only' are those where clients did not return for further treatment. The AODTS–NMDS does not collect information about clients' reasons for not returning to treatment as expected. There are a variety of reasons that clients may not return after undergoing assessment. For example, a client may have felt that they received enough assistance, may not have found the contact useful or may not have been motivated to continue.

Sometimes, the coding practices of treatment agencies can affect the number of Assessment only episodes that are recorded. Coding practices are influenced by the service delivery processes within the agency. Therefore the method of counting Assessment only episodes may differ between states and territories, and comparison of data nationally and across jurisdictions should be made with caution.

Assessment only as a main treatment type

Assessment only was the third most common main treatment provided in 2008–09, accounting for 15% of closed treatment episodes (Table 5.1). In 2008–09, of the 21,172 episodes where assessment only was nominated as the main treatment received:

Client profile (Table A3.19)

- Almost all (99%) episodes were for clients seeking treatment for their own drug use.
- The majority (75%) of episodes were for male clients.
- The median age of persons receiving treatment was 32 years (males 31 years; females 33 years).
- Persons aged 20–29 years accounted for the greatest proportion of episodes (35%), followed by persons aged 30–39 years (30%).
- 15% of episodes involved clients who identified as Aboriginal and Torres Strait Islander people.
- People most often were referred by a correctional service (35%) or referred themselves (24%).

Treatment profile (tables A3.20 and A3.24)

- Treatment was most likely to occur in a non-residential treatment facility (61%) followed by 'other' treatment settings (27%).
- The majority (79%) of episodes were reported to have ended because the treatment was completed. The next most common reason reported for ending an episode (8%) was that the client ceased to participate without notifying the service provider.

Principal drug profile (Table 3.27)

Of the episodes in 2008–09 where assessment only was nominated as the main treatment and the client was seeking treatment for their own drug use, alcohol was the most common principal drug of concern reported (52%), followed by cannabis (16%) and amphetamines (11%).

5.6 Information and education only

What is information and education only?

These episodes in the AODTS–NMDS comprise those where no treatment was provided to the client beyond information and education. They may be delivered to an individual or group. Group information and education is included in the AODTS–NMDS data only if the individuals involved are registered clients of a treatment agency. Open information sessions for the general public or where clients are not registered, are not included.

Information and education only as a main treatment

Information and education only was the fourth most common main treatment provided in 2008–09, accounting for 9% of episodes (Table 5.1). In 2008–09, of the 13,283 episodes where Information and education only was nominated as the main treatment received:

Client profile (Table A3.19)

- 98% were for clients seeking treatment for their own drug use.
- The majority (72%) of episodes were for male clients.
- The median age of persons who received treatment was younger than the median age for all treatment types (25 years compared with 32 years). Males receiving information and education only had a median age of 24 years; females 26 years.
- Persons aged 20–29 years accounted for the largest proportion of episodes (39%), followed by persons aged 10–19 years (25%).
- 14% of episodes involved clients who identified as Aboriginal and Torres Strait Islander people.
- Police and court diversion programs were the most common sources of referral (47% and 29% of episodes, respectively). Information and education only had the lowest rate of self-referral (11%).

Treatment profile (tables A3.20 and A3.24)

- Treatment was most likely to occur in a non-residential treatment facility (70%), followed by an outreach setting (19%).
- More than 70% of episodes were reported to have ended because the client expiated their offence—that is, the client had completed an education or information program as a requirement of a diversion program. The next most common reason for episodes to end (21%) was because the treatment was completed.
- Information and education only tended to be delivered on a single day, rather than over a number of sessions (the median number of days for a treatment episode was 1).

Principal drug profile (Table A3.27)

For clients who received information or education only about their own drug use, cannabis was the most common principal drug of concern reported (57%), followed by alcohol (21%).

5.7 Support and case management only

What is Support and case management only?

Support and case management only in alcohol and other drug treatment services takes a variety of forms. 'Support' tends to encompass activities that do not fall into other treatment types (AIHW 2009a). For example, supportive contact with a client that does not meet the definition of Information and education only could be reported as support and case management only. Occasional contact with a client who calls into an agency for emotional support is an example of this type of intervention.

'Case management' is generally more structured than 'support'. The functions of case management have been described as assessment, planning, linking, monitoring and advocacy (Vanderplasschen et al. 2007). Generally, case management takes a holistic approach, looking at general welfare needs, such as housing, together with drug-related issues.

Case management can be delivered in numerous ways. Case management models include the 'brokerage' approach where the case manager is responsible for coordinating other services to meet the client's needs. Other models may provide more services directly to clients. For example, some models include the provision of some counselling by the case manager (Vanderplasschen et al. 2007).

Support and case management only as a main treatment type

Support and case management only as the main treatment accounted for 9% of closed treatment episodes in 2008–09 (Table 5.1). In 2008–09, of the 12,740 episodes where support and case management only was nominated as the main treatment provided:

Client profile (Table A3.19)

- 95% were for clients seeking treatment for their own drug use.
- The majority (64%) of episodes were for male clients.
- The median age of persons receiving Support and case management only was 25 years (males 25 years; females 24 years).
- Clients aged 20–29 years accounted for the greatest proportion of episodes (34%), followed by those aged 10–19 years (28%).
- 12% of episodes involved clients who identified as Aboriginal and Torres Strait Islander people.
- One third of referrals were self-referrals (34%), with court diversion (18%) being the next most common source of referral.

Treatment profile (tables A3.20 and A3.24)

- Treatment was most likely to occur in an outreach setting (49% of episodes). This is a very large proportion compared with other treatment types (the proportion across all treatment types was 10%). Non-residential treatment facilities provided 48% of support and case management only.
- Around two-thirds (62%) of episodes were reported to have ended because the treatment was completed. The next most common reason reported for ending an episode (15%) was that the client ceased to participate without notifying the service provider.
- Support and case management only episodes remained the longest, with a median number of treatment days of 47 (down from 52 in 2007–08).

Principal drug profile (Table A3.27)

Where Support and case management only was the main treatment and the client was seeking treatment for their own drug use, alcohol was the most common principal drug of concern reported (35% of episodes), followed by cannabis (31%) and heroin (13%).

5.8 Rehabilitation

What is Rehabilitation?

In the AODTS–NMDS, rehabilitation refers to an intensive treatment program that integrates a range of services and therapeutic activities that may include counselling, behavioural treatment approaches, recreational activities, social and community living skills, group work and relapse prevention. Rehabilitation treatment can provide a high level of support (i.e. up to 24 hours a day) and tends towards a medium to longer term duration. Rehabilitation activities can occur in residential or non-residential settings (AIHW 2009a).

Rehabilitation includes residential treatment services, therapeutic communities and community-based rehabilitation services. Residential rehabilitation provides an appropriate, often drug-free environment in which structured interventions can be delivered to people who are drug dependent (New South Wales Department of Health 2007). Rehabilitation programs offered in therapeutic communities are multidimensional (often including psychological therapies, education, peer support, and so forth) and residents stay in the community for varying periods of time, depending on their needs (New South Wales Department of Health 2007). Community-based rehabilitation programs may begin with home-based detoxification and continue with both individual and group counselling over a period of time.

Rehabilitation as a main treatment

Rehabilitation as the main treatment accounted for 7% of episodes in 2007–08 (Table 5.1). In 2008–09, of the 9,667 episodes where rehabilitation was nominated as the main treatment received:

Client profile (Table A3.19)

- Two-thirds of episodes were for male clients.

- The median age of persons receiving treatment was 33 years (males and females both 33 years).
- Clients aged 30–39 years accounted for 33% of episodes, followed closely by 20–29 years (32%).
- 14% of episodes involved clients who identified as Aboriginal and Torres Strait Islander people. There were also 3,633 residential treatment/rehabilitation episodes of care provided to Indigenous people in DASR agencies in 2008–09 (Table 3.4). (See Appendix 6 for more information from this collection).
- Self-referral was the most common source of referral (35%), followed by referrals from alcohol and other drug treatment services (21%).

Treatment profile (tables A3.20 and A3.24)

- Treatment was most likely to occur in a residential treatment facility (66%). 30% of episodes were provided in a non-residential treatment facility.
- The most common reason reported for the cessation of episodes was treatment completion (40%). The next most common reasons for ending a treatment episode were that the client ceased to participate against advice (16%), or without notice (15%) or because of non-compliance with the expectations of the rehabilitation provider (10%).
- The median number of days for an episode increased to 42 for 2008–09 compared with 37 for 2007–08.

Principal drug profile (Table A3.27)

Where rehabilitation was nominated as the main treatment type, alcohol was the most common principal drug of concern reported (51%), followed by amphetamines (17%), cannabis (14%) and heroin (11%).

5.9 Other main treatment types

Other main treatment types are modes of treatment that do not fit the descriptions of the main treatment types discussed previously. Examples of other main treatment types may be living skills classes, relapse prevention and safe using or use reduction education and support. These may include aspects of the more common main treatment types but not to the extent that they could be coded as such. For example, where a service offers a brief intervention involving an assessment and fact sheet in one episode, this treatment may be more appropriately coded as 'other', rather than counselling, information and education only or assessment only.

Around 36% of the episodes reported here as providing an 'other main treatment type' actually involved pharmacotherapy. However, it is important to understand that AODTS–NMDS pharmacotherapy data do not tell the whole story about pharmacotherapy in Australia. Agencies that *only* provide pharmacotherapy are not required to report to the AODTS–NMDS. Those agencies that are required to report are asked to report only when they provide pharmacotherapy and another drug treatment to the same person. Information specific to opioid pharmacotherapy treatment can be found in the National Opioid Pharmacotherapy Statistical Annual Data (NOPSAD) collection (see Section 5.10).

Other main treatment reported

There were 9,424 episodes (7%) where 'Other' was the main treatment (Table 5.1). Of these episodes, 37% were pharmacotherapy. Of these episodes where 'Other' was nominated as the main treatment received:

Client profile (Table A3.19)

- 99% of episodes were for the client's own drug use.
- 61% of episodes were for males.
- The median age for treatment was 36 years (37 years for males and 35 years for females).
- 30–39 year olds account for the greatest proportion of episodes (29%) followed by 20–29 year olds (24%).
- Around 9% of episodes were for clients who identified as Aboriginal and Torres Strait Islander people. This figure may under-represent the total number of services provided to Aboriginal and Torres Strait Islander people because they receive treatment from Indigenous-specific services. One type of 'other' treatment provided in those agencies is 'sobering up/residential respite'. There were 14,289 episodes of sobering up/residential respite provided by Aboriginal and Torres Strait Islander substance use-specific agencies in 2008–09. See Chapter 3 for more details.
- Medical practitioners were the main referral source (35%) followed by self-referral (25%) and alcohol and other drug treatment services (10%).

Treatment profile (tables A3.20 and A3.24)

- Other main treatments were most likely to occur in a non-residential treatment setting (51%), followed by in a residential treatment facility (41%). Other treatments were least likely to be provided in the home of the client (less than 1%).
- The median number of days for other main treatments, regardless of the setting, was 9. In 2006–07, the median treatment duration was 48 days, and in 2007–08 it was 8 days. This change was related to the larger proportion of non-pharmacotherapy treatments included in the past two collection years.
- The majority of episodes ended because treatment had been completed (56%), followed by clients being transferred to another service provider (19%).

Principal drug profile (Table A3.27)

Of the 9,286 episodes where other main treatment types were reported for their own use (including pharmacotherapy), alcohol was the most common principal drug of concern reported (38%) followed by heroin (20%) and other opioids (10%).

5.10 National Opioid Pharmacotherapy Statistics Annual Data Collection 2009

This section is included to provide a fuller picture about pharmacotherapy treatment in Australia than is available through the AODTS–NMDS collection.

Treatment of opioid dependence using opioid pharmacotherapy is administered according to the law of the relevant state or territory, and within a framework that may include not only medical treatment but also social and psychological treatment.

The Australian Government contributes funds for the provision of pharmacotherapy drugs via pharmaceutical benefits arrangements, through clinics and pharmacies approved by state and territory governments.

The data presented in this section is from the *National opioid pharmacotherapy statistics annual data (NOPSAD) collection: 2009 report* (AIHW 2010b).

The NOPSAD collection provides national data on the provision of opioid pharmacotherapy treatment: more specifically, the practitioners who prescribe treatment, the dosing sites where pharmacotherapy drugs are dispensed, and the clients receiving opioid pharmacotherapy treatment.

Although jurisdictions strive to report data that is consistent with the agreed standards, the NOPSAD collection is not an official national minimum data set and some discrepancies do exist between jurisdictions in how they report data.

Number of clients receiving pharmacotherapy treatment

Nationally on the 'snapshot/specified' day in 2009, an estimated 43,445 clients were receiving pharmacotherapy treatment (see Table 5.4). The number of clients receiving treatment in 2009 increased by 2,098 compared with 2008. The majority of clients (70%) were receiving methadone, with the remainder receiving buprenorphine or buprenorphine/naloxone. These proportions have remained stable since 2006.

In New South Wales, clients receiving buprenorphine/naloxone are reported under the category 'buprenorphine'. It is important to note that the number of clients receiving buprenorphine/naloxone is an underestimate, because New South Wales was not able to separately identify the number of these clients.

Table 5.4: Total number of pharmacotherapy clients receiving pharmacotherapy treatment on a 'snapshot/specified' day[(a)], by type of pharmacotherapy provided and jurisdiction, 2009

Pharmacotherapy drug type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Methadone	14,415	7,856	2,814	2,172	1,834	472	625	47	30,235
Buprenorphine	3,453	1,070	750	147	402	75	56	17	5,970
Buprenorphine/naloxone[(b)]	—	3,650	1,552	868	601	87	111	57	6,926
Not reported[(c)]	—	—	—	—	314	—	—	—	314
Total	**17,868**	**12,576**	**5,116**	**3,187**	**3,151**	**634**	**792**	**121**	**43,445**

(a) The number of clients on the program on a 'snapshot/specified' day in June, except for Western Australia, where the number of clients treated through the month of June is reported.

(b) In New South Wales, clients prescribed buprenorphine/naloxone are counted under buprenorphine.

(c) The total of 314 in the *not reported* row for South Australia is the number of clients who did not enter a dosing point on the 'snapshot/specified day'. The breakdowns provided under the individual drug headings in this row are estimates.

Note: Each state and territory uses a different method to collect data on pharmacotherapy prescription and dosing. These differences may result in minor discrepancies if directly comparing one jurisdiction with another jurisdiction.

Source: AIHW 2010b

Approximately two-thirds of the clients receiving pharmacotherapy treatment in 2009 were male (65%). The majority of clients were aged between 20 and 49 years of age, while those aged 30–39 years of age made up the largest proportion (40%).

Nationally, the number of prescribers decreased from 1,393 in 2008 to 1,350 in 2009. The total number of dosing point sites (2,157) has seen a small increase since 2008 (2,143).

Of the 43,445 estimated clients receiving pharmacotherapy treatment in 2009, 64% of clients received treatment from a private prescriber, followed by 27% from a public prescriber and 8% received treatment from a prescriber in a correctional facility.

Pharmacies across Australia were the most common dosing point site for clients receiving pharmacotherapy treatment (85%). The remainder were located in public clinics, correctional facilities, private clinics and other locations.

5.11 Opioid pharmacotherapy treatment in prison health services 2009

This section is included in this report for the first time to provide further information about pharmacotherapy treatment in Australia beyond the community-based NOPSAD and AODTS–NMDS collections. This material is discussed in more depth in *The health of Australia's prisoners 2009* (AIHW 2010c).

As of January 2008, Australia was one of 29 countries following the World Health Organisation's 1993 guidelines to offer opioid pharmacotherapy in prisons (Larney & Dolan 2009). In some jurisdictions, however, this was restricted to prisoners who were receiving pharmacotherapy in the community before entering prison. Methadone was the most commonly available treatment in Australian prisons, with maintenance treatment programs offered to all detainees in all jurisdictions except Queensland, which only provided maintenance programs for female prisoners. The use of buprenorphine was less common, with New South Wales, Victoria and South Australia the only jurisdictions providing this treatment in prisons. Buprenorphine/naloxone was only provided in Victoria and Western Australia and only for prisoners who were receiving this treatment before entering prison.

Table 5.5: Availability of opioid substitution treatment in Australian prisons, states and territories, 2009

	Methadone		Buprenorphine		Buprenorphine/naloxone	
	Maintenance	Initiation	Maintenance	Initiation	Maintenance	Initiation
NSW	√	√	√	√	×	×
Vic	√	√	√	×	√	×
Qld	√ (females only)	×	×	×	×	×
WA	√	√	×	×	√	×
SA	√	√	√	√	×	×
Tas	√	×	×	×	×	×
ACT	√	√	×	×	×	×
NT	√	×	×	×	×	×

Source: AIHW 2010c.

From the NOPSAD data in Section 5.10, it can seen that on the snapshot day 8% (3,454) of the 43,445 people across Australia receiving pharmacotherapy treatment for opioid addiction received their dose in correctional facilities.

Table 5.6: Prison entrants, opioid pharmacotherapy treatment history, 2009

Opioid pharmacotherapy treatment	Currently		In the past	
	Number	Per cent	Number	Per cent
Methadone	27	5	58	11
Other opiate replacement program	16	3	42	8
Total prison entrants	**549**	**100**	**549**	**100**

Notes

1. Percentages are of all prison entrants. Note that prison entrants may have been on a program both in the past and currently.
2. Table includes New South Wales, Victoria, Queensland, Western Australia, South Australia and the Australian Capital Territory.

Source: AIHW 2010c.

In the National Prisoner Health Census 2009, prison entrants were asked whether they were currently receiving an OPT (opioid pharmacotherapy treatment) or had been in the past. Almost one-fifth (19%) of entrants reported having ever received an OPT. A small proportion of entrants indicated that they were currently receiving methadone treatment (5%) or other opiate replacement program (3%). Just over one in ten entrants (11%) had received methadone treatment at some time in the past, and 8% had received another OPT in the past (Table 5.6). One in ten (10%) Indigenous prison entrants participated in a program at some time, compared with one in five (22%) non-Indigenous entrants.

National Prisoner Health Census 2009 data regarding the number of prisoners receiving OPT during 2007–08 came from New South Wales, Victoria, Queensland and Western Australia, and reported 4,120 prisoners receiving treatment. Methadone was prescribed much more frequently than either buprenorphine or buprenorphine/naloxone. Females were over-represented among prisoners receiving OPT, with one-fifth (20%) of prisoners receiving OPT being female. This discrepancy will be in part due to methadone being available only to females in Queensland (Table 5.5).

6 Observed trends in treatment data

The AODTS–NMDS is a rich source of information about alcohol and other drug treatment provided in Australia. It provides information about treatment agencies, including where they are located and in which sector (government or non-government) they operate. The AODTS–NMDS also provides demographic data about clients who have received treatment, information about the types of treatment provided and drugs of concern. Although the collection is nationally agreed, it is open to interpretation and thus subject to variation between states and territories, and between each year's data set, because of methodological differences.

In the spirit of the National Drug Strategy's commitment to seek opportunities to improve data collections (MCDS 2004), this chapter showcases the kind of analysis that can be performed looking at trends that could enhance the information available to policy makers and program planners. A variety of novel analyses are present in this chapter, although caution should be employed regarding conclusions that could be drawn, given changes in data quality over time.

6.1 Changes in Principal drug of concern profile

In 2008–09, there were 138,027 episodes of treatment delivered to people concerned about their own drug use. This was a drop in the total number of episodes compared with 2007–08, as can be seen from Table 6.1.

AODTS–NMDS numbers are affected by fluctuations in data completeness, and different jurisdictions experience different issues with collection and submission of data. This means that careful attention needs to be given to table footnotes when considering trend data to ensure that all caveats are taken into account.

Alcohol has been consistently the most prevalent principal drug of concern in treatment episodes captured through the AODTS–NMDS. The number of alcohol episodes has increased each year of the collection, with the exception of the current year, which is likely to be an artefact of the overall reduction in reported treatment episodes in 2008–09. Cannabis is the second most prevalent principal drug of concern, although the trend in number of episodes is more erratic. There was a spike in the number of cannabis episodes in 2005–06: nearly 4000 more than the next highest year (2006–07). The peak number of episodes for heroin treatment occurred in 2003–04, and for amphetamines in 2006–07, and both have been the principal drug of proportionately fewer episodes since 2005–06. The current collection year presented the highest recorded numbers of treatment episodes for 'other opioids' (including, for example, morphine) and ecstasy.

It is important to understand that many factors may potentially contribute to changes in the pattern of drugs for which treatment is sought over time. These factors may include availability, purity and cost of substances, the perception of substance use, and accessibility and capacity of treatment services. The development of policies that focus on specific drugs, groups or treatment types may also affect treatment activity.

Table 6.1: Principal drug of concern[a] episode counts over the collection years

Principal drug of concern	2001–02[b]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09[c]
Alcohol	41,886	46,747	48,500	50,324	56,076	59,480	65,702	63,272
Amphetamines	12,211	13,213	14,208	14,780	15,935	17,292	16,588	12,739
Benzodiazepines	2,745	2,609	2,711	2,538	2,583	2,298	2,487	2,080
Cannabis	23,826	27,106	28,427	31,044	35,636	31,980	31,864	31,100
Cocaine	804	323	272	400	434	448	457	479
Ecstasy	253	416	508	580	897	1,010	1,321	1,397
Heroin	20,027	22,642	23,326	23,193	19,776	14,870	15,571	14,222
Methadone	2,570	2,173	2,404	2,454	2,462	2,268	2,296	2,136
Other opioids	2,209	2,273	2,408	2,661	2,920	3,058	3,513	4,532
All other drugs[d]	5,875	4,854	5,935	7,228	8,244	7,771	7,922	6,070
Not stated	825	676	632	—	—	—	—	—
Total	**113,231**	**123,032**	**129,331**	**135,202**	**144,963**	**140,475**	**147,721**	**138,027**

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

(b) Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data.

(c) The total number of episodes for New South Wales has been under-reported owing to system issues for the reporting period of 2008–09.

(d) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Information from 2001–02 was used sparingly in these trend analyses because the data was not comparable with subsequent years (Queensland and South Australia did not provide data consistent with the AODTS–NMDS specifications at that time). We can observe how the principal drug of concern profile has changed over time between 2002–03 and 2008–09 using percentage-point change (direct comparison of percentage values between one collection year and another) or per cent change (the change in a drug profile from one period to another expressed as a percentage of its value in the first period).

Table 6.2: Principal drug of concern[a] per cent change and percentage-point change 2002–03 to 2008–09

Principal drug of concern	Percentage-point change 2002–03 to 2008–09	Per cent change 2002–03 to 2008–09
Alcohol	7.8	35.3
Amphetamines	–1.5	–3.6
Benzodiazepines	–0.6	–20.3
Cannabis	0.5	14.7
Cocaine	0.1	48.3
Ecstasy	0.7	235.8
Heroin	–8.1	–37.2
Methadone	–0.2	–1.7
Other opioids	1.4	99.4
All other drugs[b]	0.5	25.1
Total	**—**	**12.2**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Where big jumps in numbers of episodes for particular principal drugs appear to have taken place, it is possible to identify in which specific years the increases have occurred (Table 6.3). The drug profile has changed over the previous six collections, with the decline in the proportion of heroin and increase in alcohol. It is possible to track the increases in the proportion of other opioids and ecstasy, and the steady decline in benzodiazepines as a principal drug. There is a large percentage-point change (increase) in ecstasy episodes from 2004–05 to 2005–06, and another one from 2006–07 to 2007–08. Other opioids episodes have risen considerably in the most recent two collection years, in contrast with heroin episodes, which have steadily declined.

Table 6.3: Proportion of Principal drug of concern[a] trends (per cent)

Principal drug of concern	2002–03	2004–05	2005–06	2006–07	2007–08	2008–09
Alcohol	38.0	37.2	38.7	42.3	44.5	45.8
Amphetamines	10.7	10.9	11.0	12.3	11.2	9.2
Benzodiazepines	2.1	1.9	1.8	1.6	1.7	1.5
Cannabis	22.0	23.0	24.6	22.8	21.6	22.5
Cocaine	0.3	0.3	0.3	0.3	0.3	0.3
Ecstasy	0.3	0.4	0.6	0.7	0.9	1.0
Heroin	18.4	17.2	13.6	10.6	10.5	10.3
Methadone	1.8	1.8	1.7	1.6	1.6	1.5
Other opioids	1.8	2.0	2.0	2.2	2.4	3.3
All other drugs[b]	3.9	5.3	5.7	5.5	5.4	4.4
Not stated	0.5	—	—	—	—	—
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

The data presented in Table 6.4 supplements the analysis of Table 6.1, by helping to identify which specific collection years experienced notable shifts in treatment activity. Declines or increases in certain principal drug episodes in particular years can be subject to administrative anomalies in the data. There have been clear drops in episodes for amphetamines, benzodiazepines and other drugs in 2008–09 compared with the previous year. There has also been a large per cent change in episodes for other opioids in that time. Alcohol demonstrated a steady rise year-on-year, and even though the number of actual episodes declined in the current collection year, the proportion of episodes for alcohol has continued to increase. The large relative increase in ecstasy treatment appears to have occurred on two occasions: in 2005–06 (a 55% increase in episodes) and in 2007–08 (a 31% increase). Important drops in heroin treatment activity seem to have taken place in 2005–06 and 2006–07. Heroin treatment activity fell again in the current year compared with the previous one.

Table 6.4: Principal drug of concern[a], per cent change and percentage-point change, year-on-year

Principal drug of concern	% point change 2004–05 to 2005–06	% change 2004–05 to 2005–06	% point change 2005–06 to 2006–07	% change 2005–06 to 2006–07	% point change 2006–07 to 2007–08	% change 2006–07 to 2007–08	% point change 2007–08 to 2008–09	% change 2007–08 to 2008–09
Alcohol	1.5	11.4	3.7	6.1	2.1	10.5	1.4	–3.7
Amphetamines	0.1	7.8	1.3	8.5	–1.1	–4.1	–2.0	–23.2
Benzodiazepines	–0.1	1.8	–0.1	–11.0	<0.1	8.2	–0.2	–16.4
Cannabis	1.6	14.8	–1.8	–10.3	–1.2	–0.4	1.0	–2.4
Cocaine	<0.1	8.5	<0.1	3.2	<0.1	2.0	<0.1	4.8
Ecstasy	0.2	54.7	0.1	12.6	0.2	30.8	0.1	5.8
Heroin	–3.5	–14.7	–3.1	–24.8	<0.1	4.7	–0.2	–8.7
Methadone	–0.1	0.3	–0.1	–7.9	–0.1	1.2	<0.1	–7.0
Other opioids	<0.1	9.7	0.2	4.7	0.2	14.9	0.9	29.0
All other drugs[b]	0.3	14.1	–0.2	–5.7	–0.2	1.9	–1.0	–23.4
Total	**—**	**7.2**	**—**	**–3.1**	**—**	**5.2**	**—**	**–6.6**

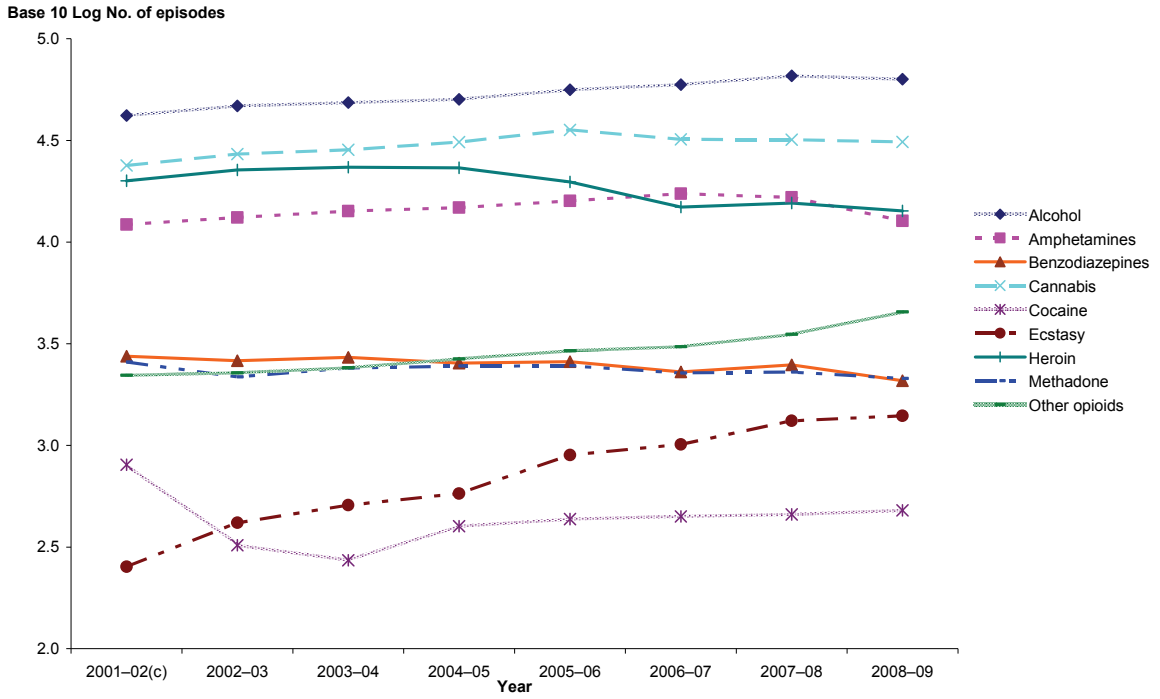
(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

By whichever comparison (proportion, per cent change and percentage-point change) considered, the trend for alcohol as a principal drug has risen year-on-year until the current year, which has seen a drop in per cent change, possibly resulting from the significant drop in the overall number of treatment episodes. An unremitting rise can also be observed in ecstasy episodes (although actual numbers are relatively low).

Figure 6.1 shows how proportions of different Principal drugs of concern in the AODTS–NMDS have changed over time. It indicates trend increases in proportion of treatment delivery to ecstasy users, 'other opioid' users and those seeking treatment for alcohol. It would also be possible to infer that delivery of treatment for heroin and amphetamine has waned in recent years. Proportions of treatment delivered to clients for cannabis, methadone and benzodiazepines have remained fairly stable over the 8 year period. Unfortunately, it is

not clear what the relative influence of system changes and other reporting issues have contributed to variation, and what are genuine changes in the treatment population.



(a) Actual values are transformed into the base 10 logarithm values in orders to visualise the trends more easily and clarify the graph. The new values are the exponent of the power to which the base (in this case 10) must be raised in order to produce the old values.

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

(c) Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data.

Source: Table A3.25

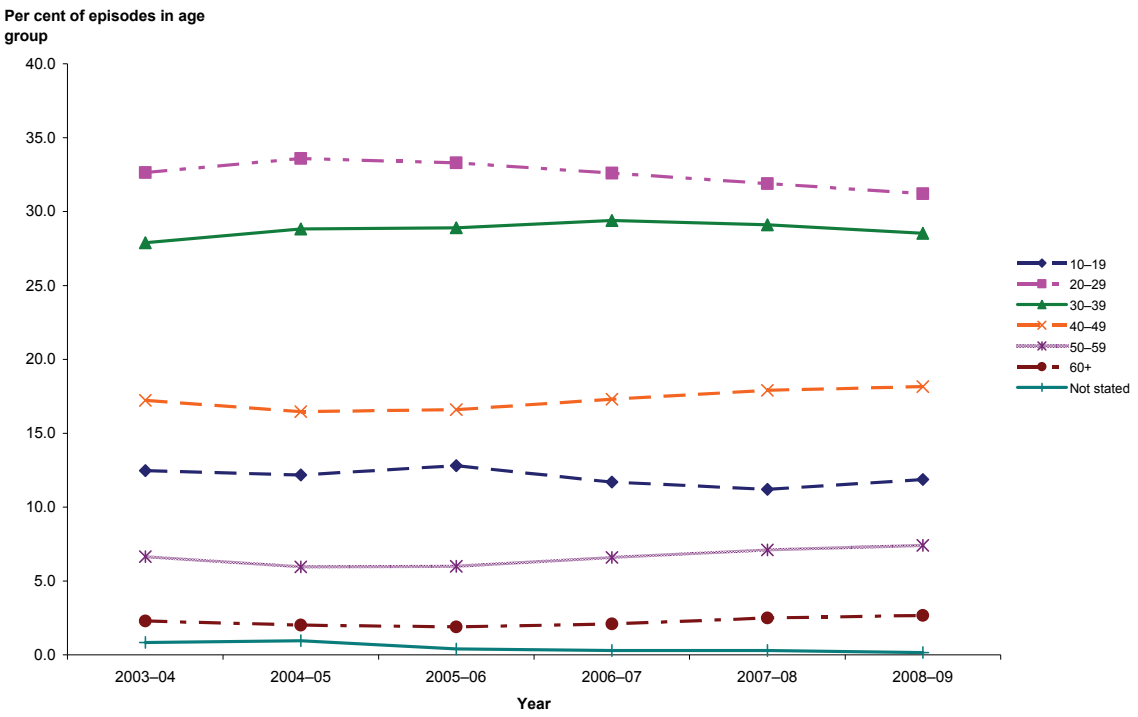
Figure 6.1 Trends in number of AODTS–NMDS treatment episodes (transformed log10)[(a)] by Principal drug of concern[(b)] from 2001–02 to 2008–09

By transforming the data using base 10 logarithm[5], it is possible to plot clear comparable trends for presenting Principal drug of concern proportions over the years of the collection. Essentially, the transformation allows us to create a figure that is easier to read and interpret: instead of the alcohol and cannabis rates presented as relatively high and other substances lines bunched together in the lower section, we can clearly identify what each substance profile is doing over time. Although this flattens some of the change curves for the more prevalent principal drugs (particularly alcohol and cannabis), this demonstrates better any changes over time in less widely treated drugs, such as ecstasy and cocaine.

5 The power to which a base must be raised to equal a given number. For example, the logarithm of 8 to the base 2 is 3, since $2^3 = 8$.

6.2 Changes in age profile

It would appear from Figure 6.2 that the age profile of the AODTS–NMDS cohort is relatively constant. The most prevalent age group for AODTS–NMDS episodes is 20–29 years, followed by 30–39 years.



Source: Table A3.21

Figure 6.2 Trends in age profile of AODTS–NMDS episodes for those seeking treatment for their own drug use from 2003–04 to 2008–09

There appears to have been very slight increases in the older age groups, which might be associated with the proportional increase in alcohol as a principal drug of concern. There seems to be a corresponding slight decrease in the proportion in the 20–29 year age group, although that group is still predominant. The proportion of 10–19 year olds has remained relatively constant. The proportion of episodes where age information is not collected or not reported has declined over the life of AODTS–NMDS, which is a welcome data quality improvement.

6.3 Changes in Indigenous status profile

Indigenous status profile is stable over the AODTS–NMDS collection years, yet it could be considered that there is an emerging trend increase in the proportion of treatment episodes delivered to Aboriginal and Torres Strait Islander people. It is important to bear in mind that the overall reduction in closed treatment episodes submitted in 2008–09 will have increased the sensitivity of this variable, and jurisdictions where numbers of closed episodes were significantly down demonstrated stable figures for Indigenous clients. The drop in numbers appeared to be in the 'non-Indigenous' cohort. This may be due to issues associated with agencies in specific areas or dealing with specific substances.

In most instances, the shifts in principal drug of concern profile over time is comparable between episodes for Indigenous and non-Indigenous Australians (see Table 6.5). The proportion of episodes for alcohol as a principal drug of concern is reliably greater for Indigenous Australians than it is for their non-Indigenous counterparts, although the trend is an increasing proportion of alcohol treatment, compared with other principal drugs, for all Australians.

Table 6.5: Trends in principal drug of concern[a] by Indigenous status, 2005–06 to 2008–09 (per cent)

	2005–06		2006–07		2007–08		2008–09	
Principal drug of concern	**Indigenous**	**Non-Indigenous**	**Indigenous**	**Non-Indigenous**	**Indigenous**	**Non-Indigenous**	**Indigenous**	**Non-Indigenous**
Alcohol	44.9	37.8	49.0	41.4	52.8	43.5	53.7	44.8
Amphetamines	9.9	11.2	10.9	12.6	9.2	11.6	7.5	9.6
Benzodiazepines	0.9	1.9	0.7	1.7	0.8	1.8	0.6	1.6
Cannabis	24.9	24.7	22.0	22.9	21.6	21.6	23.4	22.3
Cocaine	0.1	0.3	0.2	0.3	0.2	0.3	0.2	0.4
Ecstasy	0.1	0.7	0.3	0.8	0.4	1.0	0.3	1.1
Nicotine	1.1	1.8	1.7	1.7	1.5	1.8	1.6	1.8
Opioids								
Heroin	9.6	14.3	7.6	11.0	6.8	11.0	6.1	10.9
Methadone	1.3	1.7	1.5	1.6	1.1	1.6	1.3	1.6
Morphine	0.9	0.9	1.1	0.9	1.1	0.9	1.1	1.4
Total opioids[b]	*12.5*	*18.0*	*10.9*	*14.8*	*9.9*	*15.0*	*9.5*	*16.0*
All other drugs[c]	5.5	3.6	4.3	3.6	3.6	3.5	3.2	2.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) 'Total opioids' includes the balance of opioid drugs coded according to ASCDC. See Appendix 5.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

A different pattern appears to be emerging regarding Indigenous status and opioids: there has been a continual decline in total opioid treatment episode proportions for Indigenous Australians. By contrast, following a drop in proportion of opioid treatment in 2006–07, the proportion of opioid treatment episodes for non-Indigenous Australians has risen slightly in

each subsequent year. Morphine episodes would appear to account for this particular increase in non-Indigenous clients: heroin and methadone treatment proportions appear relatively stable.

Proportions of treatment for ecstasy remain consistently low for Indigenous Australians, whereas there is a notable year-on-year rise in non-Indigenous clients. There are higher proportions of 'other drugs' reported for Indigenous Australians rather than non-Indigenous clients.

6.4 How has the main treatment type changed over time?

Generally (with the exception of 2006–07 and 2008–09), the total number of treatment episodes delivered each year has increased over the life of the AODTS–NMDS collection (see Table 6.6). Actual numbers of episodes have recently remained relatively constant at around 25,000 per year for withdrawal management (detoxification) and 57,000 per year for counselling, although both have dropped in the current collection year—these are consistently the two most prevalent main treatment types reported for AODTS–NMDS episodes.

Table 6.6: Trends in main treatment type in AODTS–NMDS episodes

Main treatment type	2001–02[a]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Withdrawal management (detoxification)	21,744	24,767	25,123	25,458	25,828	24,467	24,999	23,599
Counselling	44,184	54,395	51,514	57,076	57,277	57,017	57,470	53,787
Rehabilitation	7,195	9,865	11,717	10,959	11,331	10,950	11,099	9,667
Support and case management only	6,951	9,097	11,494	11,240	12,417	12,290	12,279	12,740
Information and education only	11,197	10,478	10,465	12,609	14,655	13,723	15,086	13,283
Assessment only	16,647	16,632	20,414	17,663	23,125	22,295	21,976	21,172
Other[b]	5,787	5,696	6,142	7,139	6,729	6,583	11,089	9,424
Total	113,705	130,930	136,869	142,144	151,362	147,325	153,998	143,672[c]

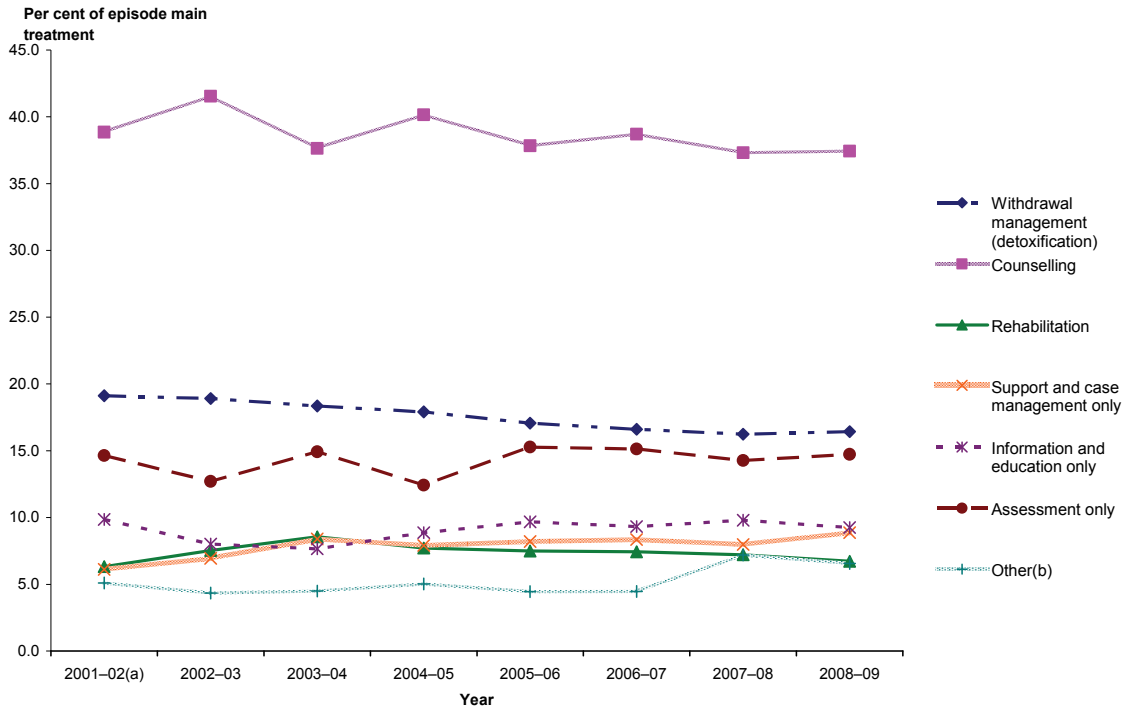
(a) Excludes South Australia.

(b) 'Other' includes closed treatment episodes where the main treatment was reported as pharmacotherapy.

(c) Significant reduction in number of episodes principally due to New South Wales incomplete data submission because of system issues.

The highest number of episodes was in 2007–08 for Counselling and 2005–06 for withdrawal management (detoxification). Other collection record high counts include rehabilitation in 2003–04 (approaching 12,000 episodes) and 2005–06 for Assessment only (over 23,000 episodes). The current year features the highest number of episodes for Support and case management only (12,740 episodes). In common with other trend data reported in this chapter, it is unclear what the relative influence of system changes and other reporting issues might have contributed to variation, and what are actual changes in the treatment policies or capacity within or across jurisdictions.

Counselling has consistently been the most prevalent main treatment type in the AODTS–NMDS. Withdrawal management (detoxification) has been the next most prevalent, although there appears to be a gradual decline in the proportion of this as main treatment type (see Figure 6.3). It could be inferred that this reflects the reduction trend in the proportion of episodes for heroin treatment. Because withdrawal management (detoxification) is a popular treatment option for heroin and other opiates, it is possible that because the proportion of clients presenting for treatment with these drugs is declining, thus the demand for medicated withdrawal is also declining. Issues around data completeness of the AODTS–NMDS and differences in the classification of withdrawal management (detoxification) across agencies and jurisdictions mean we should be cautious in drawing this conclusion.



(a) Excludes South Australia.

(b) Other includes closed treatment episodes where the main treatment type was reported as pharmacotherapy.

Source: Table A3.21.

Figure 6.3: Trends in proportion of main treatment type reported in the AODTS–NMDS from 2001–02 to 2008–09

It is possible to look at year-on-year changes and, from 2002–03 to the current collection, to observe when major shifts have taken place in the national treatment focus (see Table A3.22). Looking at the per cent change from 2002–03 to 2008–09, there appears to have been a large increase in episodes of interventions such as support and case management only, assessment only, and information and education only. The largest rise is seen in the category 'other', suggesting that any review of the AODTS–NMDS should consider refining definitions of existing treatment types. The majority of this change took place between the 2006–07 and 2007–08 collections. This coincided with a notable increase (5%) in the overall quantity of treatment episodes. Information and education only saw a large increase from the 2004–05 to 2005–06 collections. Proportionally there was less withdrawal management (detoxification)

taking place in 2008–09 than in earlier collections. Analysing the year-on-year changes, there were drops in rehabilitation, information and education only, and 'other' in 2008–09 compared with the previous year, and a rise in Support and case management only.

It appears that fluctuations in counselling and assessment only proportions are inversely proportional in early collections—this could be a genuine relationship either in terms of treatment delivered or in coding practice by relevant data managers. It is important to be aware that the data in Figure 6.3 includes episodes of treatment delivered for someone else's drug use as well as that delivered to clients for their own drug use.

7 Collection methods and data quality

7.1 Collection method and data included

While reading this report, it is important to keep in mind that the data reported are administrative by-product data. This means that the data have been collected as part of the process of providing treatment. Some items, such as principal drug of concern, will be based on information collected from the client. Other data items, such as main treatment type, will be supplied by agencies from their records.

The NMDS is effectively a subset of a larger collection of jurisdictional data sets. Although all states and territories have agreed to report the data items that make up this NMDS, most jurisdictions collect more data for their own planning and monitoring purposes. The policy and administrative features of the AODTS–NMDS collection within each jurisdiction are outlined in Appendix 2.

Features of the national collection include:

- Data are reported by each state and territory regardless of funding source. For example, this report does not distinguish between services funded by the Australian Government's NGOTGP and services funded by states and territories. The data simply show where treatment occurred.
- National data are affected by variations in service structures and collection practices between states and territories. Care should be taken when making comparisons between states and territories. The administrative and policy features of each jurisdiction are outlined in Appendix 2. Footnotes throughout the report also highlight jurisdictional differences.

7.2 Comprehensiveness of the data

In 2008–09, excluding Queensland, data were provided from 531 (86%) of the 619 agencies that were in scope for this collection. This represents a drop of 5% from the previous year's proportion of in-scope agencies submitting (91%). Because of system issues, New South Wales submitted data from fewer agencies in 2008–09 than in 2007–08. This has compromised the New South Wales submission by reducing their data set by an estimated 5,000 records. This high number would have represented one-sixth of the New South Wales submission, and made a considerable contribution to the national data set.

In 2007, Queensland Health funded the establishment of the Queensland Network of Alcohol and Drug Agencies (QNADA), the peak body for non-government organisations (NGOs) that provide alcohol and drug services. One of the key objectives for QNADA was the establishment of a database to collect the AODTS–NMDS. It is expected that this database will enable a more comprehensive data set to be submitted to the AIHW in future.

Table 7.1 shows the states and territories' relative contributions to these data.

Table 7.1: In-scope agencies submitting data to AODTS–NMDS

Agency NMDS status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Submitted	250	136	122	44	55	15	10	21	653
In-scope	336	138	n.a.	44	55	15	10	21	n.a.
(difference)	86	2	—	0	0	0	0	0	—
					Per cent				
In-scope agencies submitting	74.4	98.6	—	100.0	100.0	100.0	100.0	100.0	—

As in previous years, the majority of Indigenous substance use-specific services and Aboriginal primary health care services funded directly by the OATSIH that provide alcohol and other drug treatment are not included in the 2008–09 collection. More detailed information on the under-count of services provided to Aboriginal and Torres Strait Islander people, as well as other data caveats, is available in Section 1.3.

Australian Government data

Data reported for each state and territory in 2008–09 includes services provided under the National Illicit Drug Strategy NGOTGP. Since the 2002–03 AODTS–NMDS report, Australian Government data have not been analysed separately; rather they have been analysed as part of the jurisdiction in which the NGOTGP agency was located.

7.3 Data quality

Overall, the quality of the 2008–09 AODTS–NMDS data has declined slightly. The proportions of 'not stated' are largely similar to those seen in 2007–08. The proportion of 'not stated' responses for Country of birth continued to increase in the Northern Territory and 'not stated' rates also increased in the Australian Capital Territory for Reason for cessation (Table 7.2).

The proportion of 'not stated' responses for Indigenous status has increased slightly since 2005–06. As in previous years, there was variation in the rates of 'not stated' for Indigenous status across the states and territories, with Western Australia reporting the lowest rate of 1.3% and Victoria and the Australian Capital Territory reporting the highest rates of 10% and 9%, respectively.

The proportion of 'not stated' responses for injecting drug use remains high. In 2008–09, the proportion of 'not stated' episodes was 13%, which is slightly higher than 12% for 2007–08.

Table 7.2: Not stated /missing/unknown responses for data items, by jurisdiction, 2008–09[a] (per cent)

Data Item	NSW[b]	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	0.7	3.0	1.4	0.3	1.0	0.9	1.1	17.4[c]	2.0
Date of birth/age	—	0.4	0.2	—	0.1	0.9	0.3	0.2	0.2
Indigenous status	2.3	10.2	6.5	1.3	2.8	8.6	9.0	1.8	5.8
Preferred language	—	6.1	—	—	—	—	—	—	2.0
Sex	—	0.1	—	—	—	—	—	0.1	0.1
Source of referral	0.3	0.9	0.3	—	0.9	0.1	1.2	1.5	0.6
Drug data items[d]									
Principal drug of concern[d]	—	—	—	—	—	—	—	—	—
Method of use[d]	1.2	5.9	2.8	0.4	1.0	3.8	0.2	0.5	2.9
Injecting drug use[d]	7.7	17.8	14.3	8.4	7.1	19.6	13.5	9.9	12.6[c]
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation[d]	0.3	2.0	1.1	1.0	0.1	0.2	6.3[c]	5.0	1.3
Treatment delivery setting	—	—	—	—	—	—	—	—	—

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

(b) New South Wales under-reported owing to system issues for the reporting period of 2008–09.

(c) These categories saw an increase of more than 4 percentage points since 2007–08.

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

Note: Includes 'inadequately described' for all data items except Date of birth and Indigenous status.

Appendixes

Appendix 1: Data elements in the AODTS–NMDS for 2008–09

The detailed data definitions for the data elements included in the AODTS–NMDS for 2008–09 are published in the National Health Data Dictionary (NHDD) version 14 (HDSC 2008) and are available on the AIHW's Metadata Online Registry (METeOR) at <meteor.aihw.gov.au/content/index.phtml/itemId/362318>.

Table A1.1 lists all data elements collected for 2008–09.

Table A1.1: Data elements for the AODTS–NMDS, 2008–09

Data element	METeOR identifier
Establishment-level data elements	
Establishment identifier (comprising)	269973
– state identifier	269941
– establishment sector	269977
– region code	269940
– establishment number	269975
Geographical location of establishment	341802
Client-level data elements	
Client type	270083
Country of birth	270277
Date of birth	287007
Date of cessation of treatment episode for alcohol and other drugs	270067
Date of commencement of treatment episode for alcohol and other drugs	270069
Establishment identifier	269973
Indigenous status	291036
Injecting drug use	270113
Main treatment type for alcohol and other drugs	270056
Method of use for principal drug of concern	270111
Other drugs of concern	270110
Other treatment type for alcohol and other drugs	270076
Person identifier	290046
Preferred language	304128
Principal drug of concern	270109
Reason for cessation of treatment episode for alcohol and other drugs	270011
Sex	287316
Source of referral to alcohol and other drug treatment services	269946
Treatment delivery setting for alcohol and other drugs	270068

(continued)

Table A1.1 (continued): Data elements for the AODTS–NMDS, 2008–09

Data element	METeOR identifier
Supporting items	
Cessation of treatment episode for alcohol and other drugs	327302
Commencement of treatment episode for alcohol and other drugs	327216
Treatment episode for alcohol and other drugs	268961
Service delivery outlet	268970

Appendix 2: Policy and administrative features in each jurisdiction

New South Wales

New South Wales Health collects data from all Australian Government/state government-funded agencies as part of requirements stipulated in a signed service agreement at the commencement/renewal of each funding agreement. Data are provided monthly by agencies to their respective Area Health Service (AHS) Drug and Alcohol Data Coordinator (DADC) on treatment episodes currently open and those closed in the preceding month. The AHS DADC is responsible for checking and cleaning the data and forwarding it to the Mental Health and Drug and Alcohol Office at New South Wales Health. Frequency and data quality reports are provided by New South Wales Health to AHSs and by AHS DADCs to agencies every 6 months detailing services in the previous 6 or 12 months. New South Wales Health forwards cleaned data on treatment episodes closed during the reporting period to the AIHW annually.

New South Wales Health has developed a state-wide data collection system in Microsoft Access®, called MATISSE, which is provided free-of-charge to agencies to enable the registration of clients and the collection of the New South Wales Minimum Data Set and the AODTS–NMDS. This data collection system will gradually be replaced in public sector agencies as the Community Health Information Management Enterprise is rolled out across New South Wales.

Victoria

The Victorian Drug Treatment Service Program provides a range of services to cover the needs of clients experiencing substance abuse issues. The Victorian Government purchases these drug treatment services from independent agencies (non-government organisations) on behalf of the community, and has developed the concept of an 'episode of care' as the fundamental unit for service funding. An episode of care is a particular course of treatment in which the client achieves at least one significant treatment goal under the care of an alcohol and drug worker.

The episode of care is a measure of successful client outcomes. It aims to develop performance measurement beyond activities, throughputs and outputs, to measure what the client gets out of treatment. Agencies funded to provide drug treatment services in Victoria have service provision targets, which are defined in terms of number of episodes of care to be provided by service type and by target group (for example, youth or adult). As a requirement of their funding agreement with the Victorian Department of Health, agencies are required to submit data on a quarterly basis detailing their provision of drug treatment services and achievement of episodes of care. A subset of this data is contributed to the AODTS–NMDS annually.

The majority of Victorian AOD service providers continue to use the SWITCH or FullADIS information systems to report quarterly activity. However, hospitals and community health centres have since 2007–08 used the HealthSMART client management systems to report on alcohol and other drug treatment activity.

Queensland

Queensland Health collects data from all Queensland Government AODT service providers and from all Queensland Illicit Drug Diversion Initiative—Police and Court Diversion clients. The Australian Government currently collects data from the Australian Government-funded agencies operating in Queensland.

Queensland Health has a state-wide web-based clinical information management system supporting the collection of AODTS–NMDS items for all Queensland Government AODT services. Queensland Health will shortly be the sole data custodian of all AODT services in Queensland.

In 2007, Queensland Health funded the establishment of the Queensland Network of Alcohol and Drug Agencies (QNADA), the peak body for NGOs that provide alcohol and drug services. One of the key objectives for QNADA was the establishment of a database to collect the AODTS–NMDS. It is expected that this database will enable a more comprehensive data set to be submitted to the AIHW in future.

Western Australia

Data are provided by both government and non-government sectors. Non-government services are contracted by the Drug and Alcohol Office (DAO) to provide alcohol and drug services. They have contractual obligations to incorporate the data elements of the AODTS–NMDS in their collections. They are also obliged to provide data in a regular and timely manner to DAO. These data are collated and checked by DAO before submission to the AIHW annually.

South Australia

Data are provided by government (Drug and Alcohol Services South Australia—DASSA) and non-government alcohol and other drug treatment services.

Non-government alcohol and other drug treatment services in South Australia are subject to service agreements with the South Australian Minister for Mental Health and Substance Abuse. As part of these service agreements, non-government organisations are required to provide timely client data in accordance with the AODTS–NMDS guidelines. Data are forwarded to DASSA for collation and checking. DASSA then forwards cleaned data to the AIHW annually. DASSA does not collect information directly from those services funded by the NGOTGP. Data are provided directly to the DoHA.

Tasmania

All Tasmanian-funded alcohol and other drug treatment agencies sign a service agreement at commencement of funding each financial year. A key element of the agreement is a requirement to input AODTS–NMDS data into the current collection application, as well as report against specific performance indicators in their annual reports to the Department of Health and Human Services.

Australian Capital Territory

Australian Capital Territory service providers supply ACT Health with data for the NMDS at the end of the financial year, as specified in their Service Funding Agreement. In the past, service providers used a range of systems to collect their data, but since 1 July 2007 the

service providers have been encouraged to use a standardised reporting system developed by ACT Health to enhance uniformity and reliability of data.

Northern Territory

Alcohol and other drug treatment services in the Northern Territory are provided by government and non-government agencies. The bulk of services provided through non-government agencies are funded via service-level agreements with the Northern Territory Department of Health and Families. All funded agencies are required to provide the AODTS–NMDS data items to the department on a regular and timely basis as a part of a larger data collection. Summary statistical reports are sent to all agencies every 6 months detailing client activity for the previous 12 months.

Australian Government Department of Health and Ageing

The DoHA funds a number of alcohol and other drug treatment services under the National Illicit Drug Strategy NGOTGP. These agencies are required to collect data (according to the AODTS–NMDS specifications) to facilitate the monitoring of their activities and to provide quantitative information to the Australian Government on their activities. Data from these agencies are generally submitted to the relevant state/territory health authority, except for a number of agencies in Western Australia, South Australia and Queensland, which submit data annually to the DoHA.

Reported numbers for each state and territory in the AODTS–NMDS annual report include services provided under the National Illicit Drug Strategy NGOTGP.

Appendix 3: Detailed tables

Client profile tables

Table A3.1: Client data items by jurisdiction, 2008–09

Client item	NSW	Vic	Qld[a]	WA	SA	Tas[b]	ACT	NT	Australia
Client type									
Own drug use	34,250	44,691	24,984	15,570	9,399	1,983	3,629	3,521	138,027
Others' drug use	643	2,398	539	1,345	265	98	121	236	5,645
Sex									
Male	23,684	30,418	17,966	10,678	6,720	1,451	2,478	2,457	95,852
Female	11,197	16,611	7,547	6,237	2,944	630	1,272	1,295	47,733
Not stated	12	60	10	—	—	—	—	5	87
Age group (years)									
10–19	2,075	6,786	3,756	2,597	635	376	531	560	17,316
20–29	9,521	14,440	9,057	5,106	2,727	676	1,164	1,132	43,823
30–39	10,654	12,829	6,688	4,682	2,908	499	972	1,042	40,274
40–49	7,582	8,177	3,860	2,792	2,098	300	689	707	26,205
50–59	3,574	3,328	1,593	1,262	951	150	296	258	11,412
60+	1,484	1,320	526	469	340	62	88	50	4,339
Not stated	3	209	43	7	5	18	10	8	303
Indigenous status									
Indigenous	3,793	2,933	3,309	3,328	821	208	353	2,298	17,043
Not Indigenous	30,281	39,358	20,563	13,375	8,568	1,695	3,059	1,390	118,289
Not stated	819	4,798	1,651	212	275	178	338	69	8,340
Country of birth									
Australia	30,864	40,779	22,330	14,013	8,333	2,009	3,341	2,990	124,659
England	714	629	478	1,046	379	9	52	20	3,327
Italy	41	128	22	41	39	—	6	—	277
New Zealand	634	772	1,088	494	96	4	40	43	3,171
South Africa	88	74	63	113	15	5	5	3	366
All other countries	2,295	3,315	1,177	1,157	702	36	263	47	8,992
Inadequately described	6	1,392	88	—	10	—	—	—	1,496
Not stated	251	—	277	51	90	18	43	654	1,384

(continued)

Table A3.1 (continued): Client data items by jurisdiction, 2008–09

Client item	NSW	Vic	Qld[a]	WA	SA	Tas[b]	ACT	NT	Australia
Preferred language									
Arabic	50	62	13	5	4	—	—	—	134
Australian Indigenous languages	21	24	33	107	32	—	—	993	1,210
English	34,314	43,415	25,098	16,690	9,343	2,078	3,691	2,350	136,979
Greek	15	9	—	—	3	—	—	—	27
Italian	5	22	15	4	3	—	—	—	49
Turkish	5	14	—	3	—	—	—	—	22
All other languages	300	653	221	84	189	n.p.	n.p.	12	1483
Inadequately described	3	2,890	4	—	—	—	—	—	2,897
Not stated	180	—	139	22	90	n.p.	n.p.	402	871
Source of referral									
Self	—	16,831	6,972	6,313	3,053	1,024	1,632	1,508	50,272
Family member/ friend	1,324	1,308	709	1,282	523	53	183	168	5,550
Medical practitioner	4,978	2,113	890	742	488	73	21	101	9,406
Hospital	1,636	650	1,488	306	1,085	18	156	105	5,444
Mental health care service	1,427	1,003	840	449	163	28	115	79	4,104
AODTS	3,794	6,472	787	2,270	898	78	251	224	14,774
Other community/health care services	667	2,222	361	549	393	128	169	323	4,812
Correctional service	2,868	6,247	2,754	1,066	377	97	264	331	14,004
Police diversion	56	925	5,498	696	709	416	163	79	8,542
Court diversion	2,815	5,677	3,870	2,188	190	107	433	427	15,707
Other	2,292	3,202	1,267	1,048	1,695	56	318	355	10,233
Not stated	97	439	87	6	90	3	45	57	824
Total	**34,893**	**47,089**	**25,523**	**16,915**	**9,664**	**2,081**	**3,750**	**3,757**	**143,672**

(a) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(b) The total number of closed treatment episodes for Tasmania may be under-counted because two agencies only supplied drug diversion data.

Table A3.2: Client data items by geographical location, 2008–09

Data items	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Sector[(a)]			**Number**			
Government	36,941	14,086	5,877	1,755	295	58,954
Non-government	61,620	14,554	6,626	1,395	523	84,718
			Per cent			
Government	37.5	49.2	47.0	55.7	36.1	41.0
Non-government	62.5	50.8	53.0	44.3	63.9	59.0
Sex			**Number**			
Male	65,726	19,177	8,297	2,101	551	95,852
Female	32,771	9,446	4,203	1,046	267	47,733
Not stated	64	17	3	3	—	87
			Per cent			
Male	66.7	67.0	66.4	66.7	67.4	66.7
Female	33.2	33.0	33.6	33.2	32.6	33.2
Not stated	0.1	0.1	<0.1	0.1	—	0.1
Age group (years)			**Number**			
10–19	11,386	3,423	1,856	616	35	17,316
20–29	30,225	8,714	3,581	917	386	43,823
30–39	28,018	7,846	3,395	800	215	40,274
40–49	17,837	5,423	2,287	522	136	26,205
50–59	7,939	2,317	906	212	38	11,412
60+	2,977	855	428	71	8	4,339
Not stated	179	62	50	12	—	303
			Per cent			
10–19	11.6	12.0	14.8	19.6	4.3	12.1
20–29	30.7	30.4	28.6	29.1	47.2	30.5
30–39	28.4	27.4	27.2	25.4	26.3	28.0
40–49	18.1	18.9	18.3	16.6	16.6	18.2
50–59	8.1	8.1	7.2	6.7	4.6	7.9
60+	3.0	3.0	3.4	2.3	1.0	3.0
Not stated	0.2	0.2	0.4	0.4	—	0.2

(continued)

Table A3.2 (continued): Client data items by geographical location, 2008–09

Data items	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Indigenous status			**Number**			
Indigenous	7,761	3,410	3,146	2,045	681	17,043
Not Indigenous	84,897	23,450	8,911	919	112	118,289
Not stated	5,903	1,780	446	186	25	8,340
			Per cent			
Indigenous	7.9	11.9	25.2	64.9	83.3	11.9
Not Indigenous	86.1	81.9	71.3	29.2	13.7	82.3
Not stated	6.0	6.2	3.6	5.9	3.1	5.8
Total	**98,561**	**28,640**	**12,503**	**3,150**	**818**	**143,672**

(a) Total treatment episodes provided in public (government) and private (non-government) sectors. Agencies funded by the DoHA under the NGOTGP are included in the non-government sector.

Drugs of concern tables

Table A3.3: Drug-related data items and jurisdiction, 2008–09[a]

Drug-related item	NSW	Vic	Qld[b]	WA	SA	Tas[c]	ACT	NT	Australia
Injecting drug use									
Current injector	6,943	7,406	3,217	3,888	2,106	244	803	382	24,989
Injected 3–12 months ago	1,639	4,687	1,048	1,127	498	98	231	80	9,408
Injected 12+ months ago	4,167	4,889	2,684	1,955	1,153	195	256	195	15,494
Never injected	18,874	19,768	14,471	7,290	4,978	1,058	1,850	2,514	70,803
Not stated	2,627	7,941	3,564	1,310	664	388	489	350	17,333
Method of use									
Ingests	19,966	21,609	10,755	8,285	6,094	909	2,132	2,610	72,360
Smokes	7,576	9,751	10,488	3,110	1,344	712	620	378	33,979
Injects	5,974	8,366	2,726	3,905	1,811	259	815	322	24,178
Sniffs (powder)	201	310	74	80	42	5	12	—	724
Inhales (vapour)	32	1,679	191	94	8	11	12	192	2,219
Other	85	334	58	30	9	12	30	3	561
Not stated	416	2,642	692	66	91	75	8	16	4,006
Principal drug of concern									
Alcohol	17,476	19,588	8,943	7,088	4,978	748	1,962	2,489	63,272
Amphetamines	2,919	2,970	1,935	3,076	1,242	169	343	85	12,739
Benzodiazepines	670	787	258	124	177	27	24	13	2,080
Cannabis	6,316	10,552	9,097	2,477	953	767	568	370	31,100
Cocaine	267	90	49	29	31	n.p.	n.p.	n.p.	479
Ecstasy	148	368	581	107	139	26	20	8	1,397
Heroin	3,706	6,668	960	1,322	983	10	544	29	14,222
Methadone	830	483	182	328	228	26	40	19	2,136
Nicotine	365	364	1,518	104	63	n.p.	n.p.	n.p.	2,461
Balance of drugs of concern(d)	1553	2821	1461	915	605	188	116	482	8141
Total	**34,250**	**44,691**	**24,984**	**15,570**	**9,399**	**1,983**	**3,629**	**3,521**	**138,027**

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

(b) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(c) The total number of closed treatment episodes for Tasmania may be under-counted because two agencies only supplied drug diversion data.

(d) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.4: Other drugs of concern[a] by jurisdiction, 2008–09

Other drugs of concern	NSW	Vic	Qld[b]	WA	SA	Tas[c]	ACT	NT	Australia
Analgesics									
Heroin	1,107	2,950	484	544	250	8	137	31	5,511
Methadone	556	454	143	169	129	12	40	15	1,518
Balance of analgesics[d]	1,061	2,022	524	467	285	37	122	49	4,567
Total analgesics	*2,724*	*5,426*	*1,151*	*1,180*	*664*	*57*	*299*	*95*	*11,596*
Sedatives and hypnotics									
Alcohol	3,693	9,693	4,928	2,410	981	73	475	283	22,536
Benzodiazepines	1,940	4,715	729	1,028	620	63	238	84	9,417
Balance of sedatives and hypnotics[d]	85	245	27	123	9	—	7	8	504
Total sedatives and hypnotics	*5,718*	*14,653*	*5,684*	*3,561*	*1,610*	*136*	*720*	*375*	*32,457*
Stimulants and hallucinogens									
Amphetamines	3,168	8,623	2,125	2,060	888	100	463	149	17,576
Cannabis	6,486	12,797	4,063	3,717	1,824	91	867	678	30,523
Ecstasy	1,053	3,832	1,364	964	333	44	220	117	7,927
Cocaine	718	703	259	263	109	7	55	21	2,135
Nicotine	5,390	8,168	4,914	2,419	2,116	68	768	709	24,552
Balance of stimulants and hallucinogens[d]	195	1,624	588	414	41	25	75	27	2,989
Total stimulants and hallucinogens	*17,010*	*35,747*	*13,313*	*9,837*	*5,311*	*335*	*2,448*	*1,701*	*85,702*
Balance of drugs of concern[d]	312	1,253	144	387	3,937	4	95	151	6,283
Total	**25,764**	**57,079**	**20,292**	**14,965**	**11,522**	**532**	**3,562**	**2,322**	**136,038**

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

(b) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(c) The total number of closed treatment episodes for Tasmania may be under-counted because two agencies only supplied drug diversion data.

(d) Includes balance of other drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.5: Principal drug of concern[a] by geographical location[b], 2008–09 (per cent)

Principal drug of concern	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Alcohol	43.6	49.5	47.1	70.6	80.8	45.8
Amphetamines	10.6	7.0	5.9	2.4	3.0	9.2
Benzodiazepines	1.8	1.1	0.8	0.3	0.2	1.5
Cannabis	20.6	28.4	27.2	14.2	10.6	22.5
Cocaine	0.5	0.1	0.1	—	—	0.3
Ecstasy	1.1	0.8	0.7	0.5	—	1.0
Nicotine	1.4	1.7	4.4	3.1	3.0	1.8
Opioids						
Heroin	13.7	3.8	1.6	0.6	1.0	10.3
Methadone	1.8	1.2	1.0	0.2	—	1.5
Morphine	0.9	1.8	4.3	0.6	0.4	1.4
Total opioids	*18.3*	*8.9*	*8.5*	*1.8*	*1.4*	*15.1*
All other drugs	2.2	2.3	5.2	7.1	1.0	2.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Geographical location of the treatment agency.

Table A3.6: Principal drug of concern[a] by age group, 2008–09 (per cent)

Principal drug of concern	Age group (years)						Not stated	Total	Total (number)
	10–19	20–29	30–39	40–49	50–59	60+			
Alcohol	34.0	34.4	43.5	60.4	73.0	83.1	37.0	45.8	63,272
Amphetamines	6.0	12.3	11.8	6.3	1.9	0.4	7.9	9.2	12,739
Benzodiazepines	0.3	1.2	2.0	1.8	1.8	2.3	0.9	1.5	2,080
Cannabis	46.4	29.0	17.8	12.4	7.3	2.0	27.3	22.5	31,100
Cocaine	0.1	0.5	0.5	0.3	0.1	—	—	0.3	479
Ecstasy	2.4	1.9	0.3	0.1	0.1	—	—	1.0	1,397
Nicotine	2.3	1.4	1.3	1.6	3.2	5.9	2.2	1.8	2,461
Opioids									
Heroin	3.2	12.4	13.9	9.1	5.4	0.8	15.4	10.3	14,222
Methadone	0.2	1.5	2.1	1.8	1.5	0.4	0.9	1.5	2,136
Morphine	0.3	1.2	1.8	1.7	1.6	0.9	1.3	1.4	1,877
Total opioids	*4.1*	*16.7*	*20.3*	*15.1*	*10.8*	*3.2*	*19.8*	*15.1*	*20,890*
All other drugs[b]	4.3	2.6	2.5	2.0	1.8	3.2	4.8	2.6	3,609
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**16,378**	**43,076**	**39,375**	**25,054**	**10,228**	**3,689**	**227**	**. .**	**138,027**

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

(b) Includes balance of other drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.7: Principal drug of concern[a] and all drugs of concern, 2008–09

Drug of concern	Principal drug of concern reported	Proportion of all closed treatment episodes (per cent)	All drugs of concern reported, including principal	Proportion of all closed treatment episodes[b] (per cent)
Alcohol	63,272	45.8	85,808	62.2
Amphetamines	12,739	9.2	30,315	22.0
Benzodiazepines	2,080	1.5	11,497	8.3
Cannabis	31,100	22.5	61,623	44.6
Cocaine	479	0.3	2,614	1.9
Ecstasy	1,397	1.0	9,324	6.8
Heroin	14,222	10.3	19,733	14.3
Methadone	2,136	1.5	3,654	2.6
Morphine	1,877	1.4	3,183	2.3
Nicotine	2,461	1.8	27,013	19.6
Other drugs[c]	6,264	4.5	19,301	14.0
Total	**138,027**	**—**	**274,065**	**—**

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

(b) The total for 'all drugs of concern' adds to more than the total number of closed treatment episodes, and the total for 'per cent of all closed treatment episodes' adds to more than 100%, because closed treatment episodes have more than one drug of concern.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.8: Selected data items by principal drug of concern[a] , 2008–09 (per cent)

Client data item	Alcohol	Ampheta-mines	Benzodiaz-epines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
						(years)					
Median age											
Males	36	30	34	25	31	22	32	36	35	30	32
Females	38	29	37	25	29	21	30	32	34	32	32
All persons	*36*	*30*	*35*	*25*	*30*	*22*	*31*	*34*	*35*	*31*	*32*
						Per cent					
Age group (years)											
10–19	8.8	7.8	2.5	24.4	4.6	28.6	3.6	1.7	2.5	17.8	11.9
20–29	23.4	41.6	25.4	40.2	40.9	59.2	37.5	29.7	26.7	28.6	31.2
30–39	27.1	36.4	37.6	22.6	38.4	9.7	38.6	39.0	37.4	24.4	28.5
40–49	23.9	12.5	21.3	10.0	13.2	1.9	16.0	21.5	23.1	15.0	18.2
50–59	11.8	1.6	8.9	2.4	2.9	0.5	3.9	7.3	8.6	8.4	7.4
60+	4.8	0.1	4.1	0.2	—	—	0.2	0.7	1.6	5.5	2.7
Not stated	0.1	0.1	0.1	0.2	—	—	0.2	0.1	0.2	0.3	0.2
Sex											
Male	69.8	67.6	50.0	69.7	76.4	80.2	66.6	52.9	59.4	58.6	68.0
Female	30.2	32.4	50.0	30.2	23.6	19.8	33.3	47.1	40.5	41.2	32.0
Not stated	0.1	0.1	—	—	—	—	0.1	—	0.1	0.1	0.1
Indigenous status											
Indigenous	14.1	9.8	4.8	12.5	5.6	3.0	7.2	10.2	7.5	13.4	12.1
Not Indigenous	80.3	85.0	89.8	81.1	90.8	92.1	87.2	85.3	86.1	79.3	82.1
Not stated	5.6	5.2	5.4	6.4	3.5	4.9	5.7	4.6	6.4	7.4	5.8

(continued)

Table A3.8 (continued): Selected data items by principal drug of concern[a] , 2008–09 (per cent)

Client data item	Alcohol	Ampheta-mines	Benzodiaz-epines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
Source of referral											
Self	36.3	34.4	40.8	26.5	37.0	17.5	43.7	35.8	45.8	30.1	34.6
Family member/ friend	3.3	4.9	2.8	3.3	5.8	3.5	3.5	2.3	2.0	3.7	3.4
Medical practitioner	8.3	3.4	14.3	3.6	5.4	1.8	3.8	16.7	14.9	8.6	6.7
Hospital	5.4	2.3	6.0	1.4	1.9	1.2	1.9	8.1	6.0	6.7	3.9
Mental health care service	3.3	2.7	4.4	3.3	1.3	1.4	1.1	1.0	2.8	2.2	2.9
AODTS	10.6	9.7	12.2	9.1	7.5	3.2	12.5	14.7	11.3	7.0	10.2
Other community/health care service	3.4	2.7	2.3	3.3	4.0	1.9	3.2	1.9	2.4	3.0	3.2
Correctional service	10.4	14.0	5.0	9.2	11.5	8.0	12.8	4.5	3.9	5.7	10.1
Police diversion	2.1	4.5	0.4	17.5	4.2	16.2	0.7	0.2	0.6	12.5	6.2
Court diversion	7.6	15.5	7.2	16.4	18.8	42.3	12.3	7.1	4.7	12.5	11.3
Other	8.7	5.5	4.2	6.0	2.3	2.3	4.2	7.2	4.6	6.7	6.9
Not stated	0.6	0.4	0.4	0.5	0.4	0.6	0.3	0.5	0.9	1.2	0.6
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**63,272**	**12,739**	**2,080**	**31,100**	**479**	**1,397**	**14,222**	**2,136**	**4,532**	**6,070**	**138,027**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.9: Selected drug-related data items by principal drug of concern[a] , 2008–09 (per cent)

Drug-related data item	Alcohol	Ampheta-mines	Benzo-diazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
Method of use											
Ingests	97.6	11.5	93.0	1.8	4.4	88.5	1.0	86.3	51.3	18.0	52.4
Smokes	0.4	16.4	n.p.	90.6	16.5	2.7	6.0	n.p.	0.6	40.3	24.6
Injects	0.1	64.4	3.7	0.2	24.4	1.9	89.0	10.3	43.8	12.0	17.5
Sniffs (powder)	<0.1	3.4	n.p.	<0.1	47.4	0.5	0.1	n.p.	0.1	0.2	0.5
Inhales (vapour)	0.1	1.2	—	4.0	2.3	n.p.	0.6	n.p.	0.1	10.8	1.6
Other	0.1	0.3	0.2	0.2	—	n.p.	0.2	n.p.	1.5	4.8	0.4
Not stated	1.7	2.8	2.4	3.1	5.0	5.8	3.1	3.2	2.7	13.8	2.9
Injecting drug use											
Current injector	5.4	49.4	21.7	7.8	25.3	3.4	61.7	31.4	44.5	12.8	18.1
Injected 3–12 months ago	3.6	12.7	11.5	5.6	6.5	1.6	17.2	14.7	9.8	3.9	6.8
Injected 12+ months ago	11.0	9.6	16.9	11.6	6.5	4.1	10.5	29.8	13.3	8.8	11.2
Never injected	66.4	21.7	36.4	60.9	51.1	81.5	4.9	5.3	23.0	51.1	51.3
Not stated	13.6	6.6	13.5	14.0	10.6	9.4	5.6	18.9	9.4	23.3	12.6
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**63,272**	**12,739**	**2,080**	**31,100**	**479**	**1,397**	**14,222**	**2,136**	**4,532**	**6,070**	**138,027**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.10: Principal drug of concern[a], with or without other drugs of concern, 2008–09

Principal drug of concern	With other drugs	With no other drugs	Total closed treatment episodes	Proportion of episodes with 'other drugs' of concern (per cent)
Alcohol	29,233	34,039	63,272	46.2
Amphetamines	8,542	4,197	12,739	67.1
Benzodiazepines	1,402	678	2,080	67.4
Cannabis	19,447	11,653	31,100	62.5
Cocaine	330	149	479	68.9
Ecstasy	886	511	1,397	63.4
Heroin	9,528	4,694	14,222	67.0
Methadone	1,263	873	2,136	59.1
Other opioids	2,705	1,827	4,532	59.7
All other drugs[b]	2,683	3,387	6,070	44.2
Total	**76,019**	**62,008**	**138,027**	**55.1**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.11: Other drugs of concern[a] nominated for selected principal drugs of concern, 2008–09

Other drugs of concern	Alcohol		Ampheta-mines		Benzo-diazepines		Cannabis		Cocaine		Ecstasy		Heroin		Methadone		All principal drugs[b]	
	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%	No.	%
Alcohol	12	<0.1	3,759	22.3	486	18.7	12,330	36.2	6	0.9	544	33.0	2,774	14.3	244	10.1	22,536	16.6
Amphetamines	6,277	13.0	149	0.9	319	12.3	5,800	17.0	105	16.5	296	18.0	3,322	17.2	183	7.6	17,576	12.9
Benzodiazepines	2,821	5.8	947	5.6	29	1.1	1,500	4.4	46	7.2	19	1.2	2,559	13.2	397	16.5	9,417	6.9
Cannabis	16,655	34.5	5,205	30.9	491	18.9	—	—	94	14.7	379	23.0	4,834	25.0	462	19.2	30,523	22.4
Cocaine	648	1.3	531	3.2	26	1.0	354	1.0	—	—	86	5.2	410	2.1	23	1.0	2,135	1.6
Ecstasy	2,495	5.2	1,645	9.8	49	1.9	2,996	8.8	93	14.6	—	—	400	2.1	11	0.5	7,927	5.8
Heroin	1,839	3.8	1,109	6.6	258	9.9	1,319	3.9	7	1.1	11	0.7	—	—	341	14.1	5,511	4.1
Methadone	301	0.6	131	0.8	116	4.5	202	0.6	n.p.	n.p.	n.p.	n.p.	647	3.3	—	—	1,518	1.1
Nicotine	11,546	23.9	1,694	10.1	304	11.7	7,046	20.7	49	7.7	168	10.2	2,245	11.6	386	16.0	24,552	18.0
Other opioids	1013	2.1	342	2.0	305	11.7	602	1.8	n.p.	n.p.	n.p.	n.p.	1047	5.4	128	5.3	3,801	2.8
Other drugs[c]	4,713	9.8	1,330	7.9	216	8.3	1,939	5.7	157	24.6	139	8.4	1,111	5.7	235	9.8	10,542	7.7
Total	**48,320**	**100.0**	**16,842**	**100.0**	**2,599**	**100.0**	**34,088**	**100.0**	**638**	**100.0**	**1,647**	**100.0**	**19,349**	**100.0**	**2,410**	**100.0**	**136,038**	**100.0**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

(c) Includes balance of other drugs of concern coded according to ASCDC.

Table A3.12: Selected treatment data items[a] by principal drug of concern, 2008–09 (per cent)

Treatment data item	Alcohol	Amphetamines	Benzodiazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
Main treatment type											
Withdrawal management (detoxification)	19.2	10.8	30.7	12.5	13.6	2.5	21.9	17.1	26.8	12.7	17.1
Counselling	39.0	41.8	31.3	33.6	39.5	37.8	30.4	18.7	22.0	31.2	35.8
Rehabilitation	7.8	13.2	4.7	4.3	8.8	4.2	7.3	4.5	4.3	3.4	7.0
Support and case management only	6.7	9.3	7.4	12.2	12.3	8.2	10.7	9.9	20.1	10.0	8.8
Information and education only	4.4	4.1	1.5	24.0	5.2	33.7	1.4	1.2	7.6	8.4	9.4
Assessment only	17.4	17.7	13.6	10.7	15.7	12.2	14.9	10.6	2.5	22.3	15.2
Other[c]	5.6	3.1	10.7	2.8	5.0	1.3	13.3	37.9	16.7	12.0	6.7
Treatment delivery setting											
Non-residential treatment facility	61.5	65.7	60.5	67.2	71.2	79.7	62.2	65.3	65.9	65.4	63.8
Residential treatment facility	21.8	16.6	24.8	12.1	20.5	4.2	21.2	24.0	20.6	9.7	18.4
Home	2.7	2.0	3.6	2.4	0.8	1.1	1.4	2.5	2.4	2.9	2.4
Outreach setting	8.3	6.9	7.1	12.3	2.9	9.7	5.6	6.3	8.5	17.8	9.2
Other	5.7	8.8	4.0	6.0	4.6	5.3	9.7	1.9	2.6	4.1	6.2
Reason for cessation											
Treatment completed	61.0	52.7	55.3	48.4	58.0	47.5	54.0	53.9	53.2	46.4	55.4
Change in main treatment type	0.4	0.5	0.3	0.3	n.p.	0.4	0.5	1.1	3.2	0.8	0.5
Change in delivery setting	0.6	1.6	2.7	0.2	n.p.	0.4	1.0	2.0	1.8	0.5	0.7
Change in principal drug of concern	n.p.	n.p	n.p.	<0.1	—	n.p.	n.p	—	0.1	n.p	<0.1

(continued)

Table A3.12 (continued): Selected treatment data items[a] by principal drug of concern, 2008–09 (per cent)

	Alcohol	Ampheta-mines	Benzo-diazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
Transferred to another service provider	5.3	4.7	7.9	3.3	4.8	1.2	7.2	13.3	8.2	4.9	5.2
Ceased to participate against advice	4.2	5.1	5.1	3.2	3.5	1.9	6.2	4.7	5.8	2.4	4.2
Ceased to participate without notice	15.7	19.8	12.5	13.1	17.5	9.9	15.7	11.5	12.7	15.2	15.2
Ceased to participate involuntary (non-compliance)	1.8	3.1	3.7	2.1	4.4	1.2	2.7	1.9	2.7	0.7	2.1
Ceased to participate at expiation	2.7	3.9	2.4	22.1	4.6	33.7	1.4	0.8	1.4	18.5	8.0
Ceased to participate by mutual agreement	2.7	3.0	3.8	2.3	1.9	1.2	1.9	0.5	2.1	3.4	2.5
Drug court and/or sanctioned by court diversion service	0.4	0.8	0.5	0.4	n.p.	0.3	0.5	0.3	0.3	0.3	0.4
Imprisoned, other than drug court sanctioned	0.6	1.4	1.9	0.6	1.0	0.3	2.9	3.7	2.0	1.0	1.0
Died	0.2	0.1	0.3	0.1	—	—	0.3	0.5	0.2	0.3	0.2
Other	3.3	3.5	2.9	2.9	3.6	1.5	5.1	4.4	5.1	5.1	3.3
Not stated	1.3	0.9	0.7	0.9	0.6	0.6	1.5	1.5	1.3	1.4	1.2
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**63,272**	**12,739**	**2,080**	**31,100**	**479**	**1,397**	**14,222**	**2,136**	**4,532**	**6,070**	**138,027**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

(c) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.13: Main treatment type[a] by principal drug of concern, clients aged 10–19 years of age, 2008–09 (per cent)

	Alcohol	Ampheta-mines	Benzo-diazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
Main treatment type											
Withdrawal management (detoxification)	9.0	10.5	22.6	10.5	n.p.	n.p.	23.3	22.2	21.2	10.9	10.4
Counselling	40.7	38.0	26.4	28.4	40.9	33.5	20.5	16.7	25.7	27.6	33.0
Rehabilitation	4.8	6.7	n.p.	3.8	n.p.	3.8	1.7	—	n.p.	1.8	4.1
Support and case management only	19.6	23.2	34.0	19.4	n.p.	n.p.	33.1	19.4	25.7	18.4	20.0
Information and education only	11.4	4.7	—	27.6	n.p.	34.8	4.5	n.p.	n.p.	27.2	19.8
Assessment only	11.1	12.8	n.p.	7.4	18.2	n.p.	6.8	n.p.	10.6	7.4	9.0
Other[c]	3.5	4.3	n.p.	2.8	n.p.	1.8	10.1	33.3	13.3	6.7	3.7
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**5,571**	**988**	**53**	**7,597**	**22**	**400**	**516**	**36**	**113**	**1,082**	**16,378**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

(c) 'Other' includes 18 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.14: Median duration in days of closed treatment episodes[a] by principal drugs of concern, 2008–09

Principal drug of concern	Total median number of days	Total number of treatment episodes
Alcohol	17	63,272
Amphetamines	25	12,739
Benzodiazepines	17	2,080
Cannabis	14	31,100
Cocaine	16	479
Ecstasy	1	1,397
Heroin	27	14,222
Methadone	23	2,136
Other opioids	17	4,532
All other drugs[b]	13	6,070
Total	**18**	**138,027**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.15: Selected age groups[a] by principal drug of concern, 2008–09 (per cent)

Age group (years)	Alcohol	Ampheta-mines	Benzo-diazepines	Cannabis	Ecstasy	Heroin	Methadone	Other opioids	Other drug[b]	Total
					(column per cent)					
10–11	<0.1	n.p.	—	<0.1	n.p.	n.p.	—	n.p.	0.4	<0.1
12–13	0.4	n.p.	—	0.5	n.p.	n.p.	—	n.p.	1.5	0.4
14–15	1.7	0.5	0.3	3.9	1.3	0.2	—	0.2	4.0	1.9
16–17	2.8	2.3	0.6	9.1	5.9	0.9	0.5	0.5	5.0	4.0
18–19	3.9	4.9	1.6	10.9	21.1	2.5	1.2	1.8	6.1	5.6
20+	91.1	92.1	97.4	75.4	71.4	96.1	98.2	97.3	82.9	88.0
Not stated	0.1	0.1	0.1	0.2	—	0.2	0.1	0.2	0.2	0.2
Total (column per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
					(row per cent)					
10–11	37.1	1.6	—	14.5	4.8	1.6	—	3.2	37.1	100.0
12–13	47.3	1.7	—	31.0	0.4	0.2	—	0.2	19.2	100.0
14–15	40.4	2.5	0.2	45.4	0.7	1.0	—	0.3	9.6	100.0
16–17	32.2	5.3	0.2	51.8	1.5	2.3	0.2	0.4	6.0	100.0
18–19	32.2	8.1	0.4	44.1	3.8	4.7	0.3	1.1	5.2	100.0
20+	47.5	9.7	1.7	19.3	0.8	11.3	1.7	3.6	4.5	100.0
Not stated	37.0	7.9	0.9	27.3	—	15.4	0.9	3.5	7.0	100.0
Total (row per cent)	**45.8**	**9.2**	**1.5**	**22.5**	**1.0**	**10.3**	**1.5**	**3.3**	**4.7**	**100.0**
Total (number)	**63,272**	**12,739**	**2,080**	**31,100**	**1,397**	**14,222**	**2,136**	**4,532**	**6,549**	**138,027**

(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.
(b) Other drug includes all totals for cocaine

Table A3.16: Treatment[(a)] where amphetamines were the principal drug of concern by usual method of use, 2001–02 to 2008–09

Usual method of use	2001–02	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
				Number				
Ingests	913	1,271	1,558	1,671	1,788	1,907	1,778	1,466
Smokes	117	173	420	718	1,437	2,377	2,784	2,091
Injects	10,487	10,915	11,241	11,309	11,670	11,926	10,900	8,203
Sniffs	419	511	630	665	645	622	554	437
Inhales	4	27	65	59	97	133	168	147
Other	23	20	26	23	24	31	33	38
Not stated	248	296	268	335	274	296	371	357
Total	**12,211**	**13,213**	**14,208**	**14,780**	**15,935**	**17,292**	**16,588**	**12,739**
				Per cent				
Ingests	7.5	9.6	11.0	11.3	11.2	11.0	10.3	11.5
Smokes	1.0	1.3	3.0	4.9	9.0	13.7	16.1	16.4
Injects	85.9	82.6	79.1	76.5	73.2	69.0	63.0	64.4
Sniffs	3.4	3.9	4.4	4.5	4.0	3.6	3.2	3.4
Inhales	—	0.2	0.5	0.4	0.6	0.8	1.0	1.2
Other	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3
Not stated	2.0	2.2	1.9	2.3	1.7	1.7	2.1	2.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

Treatment program tables

Table A3.17: Selected treatment data items by jurisdiction, 2008–09

Treatment item	NSW	Vic	Qld[a]	WA	SA	Tas[b]	ACT	NT	Australia
Main treatment type									
Withdrawal management (detoxification)	7,124	9,915	1,640	1,731	1,684	134	797	574	23,599
Counselling	10,457	21,994	6,375	9,539	2,483	1,190	1,115	634	53,787
Rehabilitation	2,521	1,825	672	2,326	1,391	177	235	520	9,667
Support and case management only	3,373	6,454	1,459	529	116	54	507	248	12,740
Information and education only	442	376	10,296	611	564	344	332	318	13,283
Assessment only	5,673	5,007	4,590	1,283	2,599	156	617	1,247	21,172
Other[c]	5,303	1,518	491	896	827	26	147	216	9,424
Cessation reason									
Treatment completed	22,738	33,699	5,580	7,595	5,958	619	2,214	1,690	80,093
Change in main treatment type	—	—	268	30	70	29	50	308	755
Change in delivery setting	—	—	566	271	114	n.p.	n.p.	44	1,020
Change in principal drug of concern	—	—	8	n.p.	7	n.p.	—	n.p.	19
Transferred to another service provider	2,810	1,628	989	1,237	425	42	86	72	7,289
Ceased to participate against advice	2,023	1,084	1,119	572	662	91	240	257	6,048
Ceased to participate without notice	4,590	4,185	5,155	4,723	1,579	104	582	806	21,724
Ceased to participate involuntary (non-compliance)	842	519	172	394	271	576	92	55	2,921
Ceased to participate at expiation	—	634	9,368	676	52	356	n.p.	n.p.	11,094
Ceased to participate by mutual agreement	—	1,439	1,000	741	270	38	100	133	3,721
Drug court and/or sanctioned by court diversion service	124	41	25	221	23	142	7	29	612
Imprisoned, other than drug court sanctioned	325	418	288	218	104	5	29	36	1,423
Died	69	54	53	25	15	11	20	4	251
Other	1,269	2,457	662	n.p.	102	n.p.	65	129	4,784
Not stated	103	931	270	171	12	4	238	189	1,918

(continued)

Table A3.17 (continued): Selected treatment data items by jurisdiction, 2008–09

Treatment item	NSW	Vic	Qld[a]	WA	SA	Tas[b]	ACT	NT[c]	Australia
Treatment delivery setting									
Non-residential treatment facility	22,191	28,081	17,609	12,858	7,137	1,553	2,165	1,147	92,741
Residential treatment facility	11,375	6,727	1,419	1,571	1,509	171	1,384	1,344	25,500
Home	210	1,762	290	955	102	n.p.	n.p.	37	3,389
Outreach setting	494	5,512	5,013	722	521	235	134	716	13,347
Other[d]	623	5,007	1,192	809	395	n.p.	n.p.	513	8,695
Total	**34,893**	**47,089**	**25,523**	**16,915**	**9,664**	**2,081**	**3,750**	**3,757**	**143,672**

(a) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(b) The total number of closed treatment episodes for Tasmania may be under-counted because two agencies only supplied drug diversion data.

(c) The total number of closed treatment episodes may be under-counted in the Northern Territory because of technical difficulties that prevented data being collected from one in-scope agency, and under-counted data from government agencies in two quarters.

(d) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.18: Other treatment type by jurisdiction, 2008–09[a]

Other treatment type	NSW	Qld[b]	WA	SA	Tas[c]	ACT	NT	Australia
Withdrawal management (detoxification)	1,119	106	159	529	31	6	23	1,973
Counselling	5,082	744	130	1,137	104	21	668	7,886
Rehabilitation	637	123	15	187	n.p.	n.p.	174	1,152
Other[d]	3,172	2,389	25	1,749	n.p.	n.p.	109	7,516
All other treatments	**10,010**	**3,362**	**329**	**3,602**	**157**	**93**	**974**	**18,527**

(a) Excludes analyses of Victorian data because this jurisdiction does not provide data for 'other treatment type'.

(b) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(c) The total number of closed treatment episodes for Tasmania may be under-counted because two agencies only supplied drug diversion data.

(d) 'Other' includes 1,822 closed treatment episodes where other/additional treatment type was reported as pharmacotherapy.

Table A3.19: Selected client data items by main treatment type, 2008–09

Client item	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[(a)]	Total
				Years				
Median age (years)								
Males	36	32	33	25	24	31	37	32
Females	35	34	33	24	26	33	35	33
All persons	*36*	*33*	*33*	*25*	*25*	*32*	*36*	*32*
				Per cent				
Age group (years)								
10–19	7.2	11.0	6.9	28.2	24.7	7.2	6.8	12.1
20–29	24.5	29.5	31.7	34.2	38.8	34.7	23.6	30.5
30–39	30.8	28.5	33.0	20.2	20.5	30.4	29.0	28.0
40–49	23.3	18.8	19.4	11.5	10.6	18.0	21.4	18.2
50–59	10.4	8.4	6.6	4.5	4.2	7.2	12.0	7.9
60+	3.6	3.4	2.1	1.2	0.9	2.4	7.1	3.0
Not stated	0.1	0.4	0.1	0.2	0.2	<0.1	0.1	0.2
Client type								
Own drug use	100.0	91.9	100.0	95.2	97.7	99.0	98.5	96.1
Others' drug use	—	8.1	—	4.8	2.3	1.0	1.5	3.9
Sex								
Male	65.3	64.4	65.6	63.9	72.2	75.3	61.4	66.7
Female	34.6	35.5	34.4	36.1	27.8	24.6	38.6	33.2
Not stated	0.1	0.1	<0.1	0.1	<0.1	0.1	<0.1	0.1

(continued)

Table A3.19 (continued): Selected client data items by main treatment type, 2008–09

Client item	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[a]	Total
Indigenous status								
Indigenous	8.6	11.8	13.8	12.3	13.8	14.7	8.8	11.9
Not Indigenous	85.4	81.6	83.3	82.6	80.7	79.0	87.4	82.3
Not stated	5.9	6.7	2.9	5.1	5.6	6.3	3.8	5.8
Source of referral								
Self	52.6	39.6	34.6	33.7	10.7	24.0	25.5	35.0
Family member/ friend	2.7	4.9	6.2	4.8	1.9	3.0	1.5	3.9
Medical practitioner	8.4	4.6	3.1	2.2	0.8	4.3	35.5	6.5
Hospital	4.7	2.4	4.7	2.3	1.5	5.8	9.4	3.8
Mental health care service[b]	2.3	3.2	2.4	2.9	1.0	2.7	5.7	2.9
AODTS	15.9	9.5	21.4	12.6	2.4	4.7	10.0	10.3
Other community/health care service[c]	4.0	4.0	4.5	4.0	0.8	2.2	1.9	3.3
Correctional service	1.3	7.2	7.8	8.9	1.4	35.1	3.5	9.7
Police diversion	0.1	2.4	1.6	2.5	47.2	2.1	0.3	5.9
Court diversion	2.9	13.0	7.7	17.8	28.9	5.1	1.4	10.9
Other	4.6	8.2	5.6	7.9	3.2	10.7	5.0	7.1
Not stated	0.4	0.9	0.4	0.5	0.2	0.4	0.4	0.6
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**23,599**	**53,787**	**9,667**	**12,740**	**13,283**	**21,172**	**9,424**	**143,672**

(a) Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

(b) Includes residential and non-residential services.

(c) Includes outpatient clinics and aged care facilities.

Table A3.20: Selected treatment items by main treatment type, 2008–09 (per cent)

Treatment item	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[(a)]	Total
Treatment delivery setting								
Non-residential treatment facility	29.3	92.2	29.7	48.4	70.3	61.4	51.1	64.6
Residential treatment facility	59.4	0.5	65.6	1.1	1.0	3.1	41.5	17.7
Home	9.0	1.8	0.2	0.5	0.3	0.5	0.6	2.4
Outreach setting	2.2	3.7	1.5	48.5	19.3	7.5	3.7	9.3
Other	0.2	1.7	3.0	1.4	9.0	27.4	3.2	6.1
Reason for cessation								
Treatment completed	64.2	53.0	39.6	61.6	21.1	79.0	55.7	55.7
Change in main treatment type	0.5	0.4	0.3	0.5	0.3	1.1	0.9	0.5
Change in delivery setting	1.2	0.5	1.6	0.1	0.1	0.8	1.0	0.7
Change in principal drug of concern	n.p.	<0.1	—	<0.1	—	<0.1	n.p.	<0.1
Transferred to another service provider	4.5	4.9	4.8	5.3	0.6	2.9	18.7	5.1
Ceased to participate against advice	10.4	2.1	16.1	3.5	0.7	0.8	1.8	4.2
Ceased to participate without notice	9.3	23.8	15.5	15.2	4.5	8.3	9.9	15.1
Ceased to participate involuntary (non compliance)	2.5	1.8	9.9	1.8	0.4	0.3	0.7	2.0
Ceased to participate at expiation	0.6	2.2	1.2	0.5	71.2	0.5	0.3	7.7
Ceased to participate by mutual agreement	2.8	3.3	4.8	2.3	0.6	1.9	0.5	2.6
Drug court and/or sanctioned by court diversion service	n.p.	0.8	0.6	0.6	<0.1	0.2	n.p.	0.4

(continued)

Table A3.20 (continued): Selected treatment items by main treatment type, 2008–09 (per cent)

Treatment item	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[(a)]	Total
Imprisoned, other than drug court sanctioned	0.6	1.0	1.1	2.0	0.1	0.5	2.9	1.0
Died	0.1	0.2	0.2	0.2	<0.1	0.1	0.5	0.2
Other	2.4	4.5	2.6	5.3	0.2	1.7	5.0	3.3
Not stated	0.7	1.6	1.6	1.0	0.2	1.9	1.9	1.3
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**23,599**	**53,787**	**9,667**	**12,740**	**13,283**	**21,172**	**9,424**	**143,672**

(a) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.21: Trends in main treatment type, 2001–02 to 2008–09

Main treatment type	2001–02[a]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
				(per cent)				
Withdrawal management (detoxification)	19.1	18.9	18.4	17.9	17.1	16.6	16.2	16.4
Counselling	38.9	41.5	37.6	40.2	37.8	38.7	37.3	37.4
Rehabilitation	6.3	7.5	8.6	7.7	7.5	7.4	7.2	6.7
Support and case management only	6.1	6.9	8.4	7.9	8.2	8.3	8.0	8.9
Information and education only	9.8	8.0	7.6	8.9	9.7	9.3	9.8	9.2
Assessment only	14.6	12.7	14.9	12.4	15.3	15.1	14.3	14.7
Other[b]	5.1	4.4	4.5	5.0	4.4	4.5	7.2	6.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Excludes South Australia

(b) 'Other' includes closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.22: Per cent change and percentage-point changes in main treatment type, 2002–03 to 2008–09

Main treatment type	% point change 02–03 to 08–09	% change 02–03 to 08–09	% point change 04–05 to 05–06	% change 04–05 to 05–06	% point change 05–06 to 06–07	% change 05–06 to 06–07	% point change 06–07 to 07–08	% change 06–07 to 07–08	% point change 07–08 to 08–09	% change 07–08 to 08–09
Withdrawal management (detoxification)	–2.5	–4.7	–0.8	1.5	–0.5	–5.3	–0.4	2.2	0.2	–5.6
Counselling	–4.1	–1.1	–2.4	0.4	0.9	–0.5	–1.4	0.8	0.1	–6.4
Rehabilitation	–0.8	–2.0	–0.2	3.4	–0.1	–3.4	–0.2	1.4	–0.5	–12.9
Support and case management only	2.0	40.0	0.3	10.5	0.1	–1.0	–0.4	–0.1	0.9	3.8
Information and education only	1.2	26.8	0.8	16.2	–0.4	–6.4	0.5	9.9	–0.6	–12.0
Assessment only	2.0	27.3	2.9	30.9	–0.2	–3.6	–0.9	–1.4	0.5	–3.7
Other(a)	2.2	65.4	–0.6	–5.7	0.1	–2.2	2.7	68.4	–0.6	–15.0
Total	**–**	**9.7**	**–**	**6.5**	**–**	**–2.7**	**–**	**4.5**	**–**	**–6.7**

(a) 'Other' includes closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.23: Selected age groups by main treatment type, 2008–09 (per cent)

Age group (years)	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[(a)]	Total
				Column per cent				
10–11	<0.1	0.2	<0.1	0.2	0.1	0.1	0.1	**0.1**
12–13	0.1	0.8	0.1	0.5	0.7	0.1	0.2	**0.4**
14–15	1.2	2.6	0.9	4.4	3.1	0.8	1.0	**2.1**
16–17	2.3	3.2	2.9	11.0	8.9	2.0	2.1	**4.0**
18–19	3.6	4.3	3.0	12.2	12.0	4.2	3.4	**5.4**
10–19	*7.2*	*11.0*	*6.9*	*28.2*	*24.7*	*7.2*	*6.8*	***12.1***
20+	92.7	88.6	92.9	71.6	75.1	92.8	93.1	**87.7**
Not stated	0.1	0.4	0.1	0.2	0.2	<0.1	0.1	**0.2**
Total (column per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
				Row per cent				
10–11	3.6	64.9	1.2	11.9	7.1	7.1	4.2	**100.0**
12–13	5.4	63.2	0.9	9.6	13.8	4.6	2.5	**100.0**
14–15	9.5	46.2	3.0	18.8	13.8	5.6	3.1	**100.0**
16–17	9.3	30.0	4.9	24.4	20.5	7.4	3.5	**100.0**
18–19	10.9	29.6	3.8	19.9	20.5	11.3	4.1	**100.0**
10–19	*9.8*	*34.2*	*3.9*	*20.7*	*19.0*	*8.7*	*3.7*	***100.0***
20+	17.4	37.8	7.1	7.2	7.9	15.6	7.0	**100.0**
Not stated	7.6	62.4	4.3	10.2	10.2	1.7	3.6	**100.0**
Total (row per cent)	**16.4**	**37.4**	**6.7**	**8.9**	**9.2**	**14.7**	**6.6**	**100.0**
Total (number)	**23,599**	**53,787**	**9,667**	**12,740**	**13,283**	**21,172**	**9424**	**143672**

(a) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.24: Median duration in days of closed treatment episodes by main treatment type, 2008–09

Main treatment type	Median number of days	Total number of treatment episodes
Withdrawal management (detoxification)	8	23,599
Counselling	44	53,787
Rehabilitation	42	9,667
Support and case management only	47	12,740
Information and education only	1	13,283
Assessment only	2	21,172
Other[(a)]	9	9,424
Total	**18**	**143,672**

(a) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Table A3.25: Transformed proportions (base 10 log) of principal drug of concern from 2001–02 to 2008–09

Principal drug of concern	2001–02[(a)]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
Alcohol	4.6	4.7	4.7	4.7	4.7	4.8	4.8	4.8
Amphetamines	4.1	4.1	4.2	4.2	4.2	4.2	4.2	4.1
Benzodiazepines	3.4	3.4	3.4	3.4	3.4	3.4	3.4	3.3
Cannabis	4.4	4.4	4.5	4.5	4.6	4.5	4.5	4.5
Cocaine	2.9	2.5	2.4	2.6	2.6	2.7	2.7	2.7
Ecstasy	2.4	2.6	2.7	2.8	3.0	3.0	3.1	3.1
Heroin	4.3	4.4	4.4	4.4	4.3	4.2	4.2	4.2
Methadone	3.4	3.3	3.4	3.4	3.4	3.4	3.4	3.3
Other opioids	3.3	3.4	3.4	3.4	3.5	3.5	3.5	3.7

(a) Refer to Section 6.1 for information regarding data quality of this collection year.

Table A3.26: Proportions of age groups from 2003–04 to 2008–09, Australia (per cent)

Age group	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09
10–19	12.5	12.2	12.8	11.7	11.2	11.9
20–29	32.6	33.6	33.3	32.6	31.9	31.2
30–39	27.9	28.8	28.9	29.4	29.1	28.5
40–49	17.2	16.5	16.6	17.3	17.9	18.2
50–59	6.7	6.0	6	6.6	7.1	7.4
60+	2.3	2.0	1.9	2.1	2.5	2.7
Not stated	0.8	1.0	0.4	0.3	0.3	0.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

Table A3.27: Principal drug of concern [a] by main treatment type, 2008–09 (per cent)

Principal drug of concern	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[b]	Total
Alcohol	51.5	49.9	50.8	34.9	21.4	52.5	38.1	45.8
Amphetamines	5.8	10.8	17.3	9.8	4.0	10.8	4.3	9.2
Benzodiazepines	2.7	1.3	1.0	1.3	0.2	1.4	2.4	1.5
Cannabis	16.4	21.1	13.8	31.3	57.4	15.9	9.3	22.5
Cocaine	0.3	0.4	0.4	0.5	0.2	0.4	0.3	0.3
Ecstasy	0.1	1.1	0.6	0.9	3.6	0.8	0.2	1.0
Heroin	13.2	8.7	10.8	12.6	1.5	10.1	20.4	10.3
Methadone	1.6	0.8	1.0	1.7	0.2	1.1	8.7	1.5
Other opioids	5.1	2.0	2.0	2.8	0.9	3.6	9.8	3.3
Other drugs[c]	3.3	3.8	2.1	4.2	10.5	3.5	6.5	4.4
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**23,599**	**49,421**	**9,667**	**12,124**	**12,975**	**20,955**	**9,286**	**138,027**

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

(b) 'Other' includes 3,441 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table A3.28: Principal drug of concern[a] by main treatment type, clients aged 10–19 years of age, 2008–09 (per cent)

Principal drug of concern	Withdrawal management (detox)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other[b]	Total
Alcohol	29.4	42	39.6	33.3	19.7	41.8	31.6	34
Amphetamines	6.1	6.9	9.9	7	1.4	8.5	6.9	6
Benzodiazepines	n.p.	0.3	n.p.	n.p.	—	0.5	n.p.	0.3
Cannabis	46.9	40	43.5	45.1	64.7	37.7	35	46.4
Cocaine	n.p.	0.2	n.p.	n.p.	n.p.	n.p.	n.p.	0.1
Ecstasy	0.9	2.5	2.2	1.6	4.3	2.5	1.1	2.4
Heroin	7	2	1.3	5.2	0.7	2.4	8.5	3.2
Methadone	0.5	0.1	—	0.2	n.p.	n.p.	2	0.2
Other opioids	1.4	0.5	n.p.	0.9	n.p.	0.8	2.5	0.7
Other drugs[c]	6.9	5.5	2.8	6.1	9.1	5.4	11.9	6.6
Total (per cent)	100	100	100	100	100	100	100	100
Total (number)	1,703	5,400	669	3,274	3,240	1,481	611	16,378

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

(b) 'Other' includes 18 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5

Appendix 4: Australian Standard Geographical Classification

In 2001, the ABS included the Remoteness Area Structure (ASGC Remoteness Areas) to the Australian Standard Geographical Classification (ASGC). It is based on an enhanced measure of remoteness (ARIA+) developed by the National Key Centre for Social Applications of Geographical Information (AIHW 2004).

The ASGC Remoteness Areas replace the former national standard classification of Rural, Remote and Metropolitan Area (RRMA). The Remoteness Area classification summarises the remoteness of an area based on the road distance to different-sized urban centres, where the population size of an urban centre is considered to govern the range and type of services available.

There are five major Remoteness Areas into which the statistical local areas of the alcohol and other drug treatment agencies are placed:

- Major Cities of Australia
- Inner Regional Australia
- Outer Regional Australia
- Remote Australia
- Very Remote Australia.

For further information on how Remoteness Areas are calculated, see *Rural, regional and remote health: a guide to remoteness classifications* (AIHW 2004).

Appendix 5: Australian Standard Classification of Drugs of Concern (ASCDC)

The main classification structure is presented below. For detailed information, supplementary codes and the full version of the coding index, see Australian Standard Classification of Drugs of Concern (ABS 2000).

1 ANALGESICS

11 Organic Opiate Analgesics

1101 Codeine
1102 Morphine
1199 Organic Opiate Analgesics, n.e.c.

12 Semisynthetic Opioid Analgesics

1201 Buprenorphine
1202 Heroin
1203 Oxycodone
1299 Semisynthetic Opioid Analgesics, n.e.c.

13 Synthetic Opioid Analgesics

1301 Fentanyl
1302 Fentanyl analogues
1303 Levomethadyl acetate hydrochloride
1304 Meperidine analogues
1305 Methadone
1306 Pethidine
1399 Synthetic Opioid Analgesics, n.e.c.

14 Non Opioid Analgesics

1401 Acetylsalicylic acid
1402 Paracetamol
1499 Non Opioid Analgesics, n.e.c.

2 SEDATIVES AND HYPNOTICS

21 Alcohols

2101 Ethanol

2102 Methanol

2199 Alcohols, n.e.c.

22 Anaesthetics

2201 Gamma-hydroxybutyrate

2202 Ketamine

2203 Nitrous oxide

2204 Phencyclidine

2299 Anaesthetics, n.e.c.

23 Barbiturates

2301 Amylobarbitone

2302 Methylphenobarbitone

2303 Phenobarbitone

2399 Barbiturates, n.e.c.

24 Benzodiazepines

2401 Alprazolam

2402 Clonazepam

2403 Diazepam

2404 Flunitrazepam

2405 Lorazepam

2406 Nitrazepam

2407 Oxazepam

2408 Temazepam

2499 Benzodiazepines, n.e.c.

29 Other Sedatives and Hypnotics

2901 Chlormethiazole

2902 Kava lactones

2903 Zopiclone

2999 Other Sedatives and Hypnotics, n.e.c.

3 STIMULANTS AND HALLUCINOGENS

31 Amphetamines

3101 Amphetamine
3102 Dexamphetamine
3103 Methamphetamine
3199 Amphetamines, n.e.c.

32 Cannabinoids

3201 Cannabinoids

33 Ephedra Alkaloids

3301 Ephedrine
3302 Norephedrine
3303 Pseudoephedrine
3399 Ephedra alkaloids, n.e.c.

34 Phenethylamines

3401 DOB
3402 DOM
3403 MDA
3404 MDEA
3405 MDMA
3406 Mescaline
3407 PMA
3408 TMA
3499 Phenethylamines, n.e.c.

35 Tryptamines

3501 Atropinic alkaloids
3502 Diethyltryptamine
3503 Dimethyltryptamine
3504 Lysergic acid diethylamide
3505 Psilocybin
3599 Tryptamines, n.e.c.

36 Volatile Nitrates

3601 Amyl nitrate
3602 Butyl nitrate
3699 Volatile Nitrates, n.e.c.

39 Other Stimulants and Hallucinogens

3901 Caffeine

3902 Cathinone

3903 Cocaine

3904 Methcathinone

3905 Methylphenidate

3906 Nicotine

3999 Other Stimulants and Hallucinogens, n.e.c.

4 ANABOLIC AGENTS AND SELECTED HORMONES

41 Anabolic Androgenic Steroids

4101 Boldenone

4102 Dehydroepiandrosterone

4103 Fluoxymesterone

4104 Mesterolone

4105 Methandriol

4106 Methenolone

4107 Nandrolone

4108 Oxandrolone

4111 Stanozolol

4112 Testosterone

4199 Anabolic Androgenic Steroids, n.e.c.

42 Beta Agonists

4201 Eformoterol

4202 Fenoterol

4203 Salbutamol

4299 $Beta_2$ Agonists, n.e.c.

43 Peptide Hormones, Mimetics and Analogues

4301 Chorionic gonadotrophin

4302 Corticotrophin

4303 Erythropoietin

4304 Growth hormone

4305 Insulin

4399 Peptide Hormones, Mimetics and Analogues, n.e.c.

49 Other Anabolic Agents and Selected Hormones

4901 Sulfonylurea hypoglycaemic agents

4902 Tamoxifen

4903 Thyroxine

4999 Other Anabolic Agents and Selected Hormones, n.e.c.

5 ANTIDEPRESSANTS AND ANTIPSYCHOTICS

51 Monoamine Oxidase Inhibitors

5101 Moclobemide

5102 Phenelzine

5103 Tranylcypromine

5199 Monoamine Oxidase Inhibitors, n.e.c.

52 Phenothiazines

5201 Chlorpromazine

5202 Fluphenazine

5203 Pericyazine

5204 Thioridazine

5205 Trifluoperazin

5299 Phenothiazines, n.e.c.

53 Serotonin Reuptake Inhibitors

5301 Citalopram

5302 Fluoxetine

5303 Paroxetine

5304 Sertraline

5399 Serotonin Reuptake Inhibitors, n.e.c.

54 Thioxanthenes

5401 Flupenthixol

5402 Thiothixene

5499 Thioxanthenes, n.e.c.

55 Tricyclic Antidepressants

5501 Amitriptyline

5502 Clomipramine

5503 Dothiepin

5504 Doxepin

5505 Nortriptyline

5599 Tricyclic Antidepressants, n.e.c.

59 Other Antidepressants and Antipsychotics

5901 Butyrophenones

5902 Lithium

5903 Mianserin

5999 Other Antidepressants and Antipsychotics, n.e.c.

6 VOLATILE SOLVENTS

61 Aliphatic Hydrocarbons

6101 Butane

6102 Petroleum

6103 Propane

6199 Aliphatic Hydrocarbons, n.e.c.

62 Aromatic Hydrocarbons

6201 Toluene

6202 Xylene

6299 Aromatic Hydrocarbons, n.e.c.

63 Halogenated Hydrocarbons

6301 Bromochlorodifluoromethane

6302 Chloroform

6303 Tetrachloroethylene

6304 Trichloroethane

6305 Trichloroethylene

6399 Halogenated Hydrocarbons, n.e.c.

69 Other Volatile Solvents

6901 Acetone

6902 Ethyl acetate

6999 Other Volatile Solvents, n.e.c.

9 MISCELLANEOUS DRUGS OF CONCERN

91 Diuretics

9101 Antikaliuretics

9102 Loop diuretics

9103 Thiazides

9199 Diuretics, n.e.c.

92 Opioid Antagonists

9201 Naloxone

9202 Naltrexone

9299 Opioid Antagonists, n.e.c.

99 Other Drugs of Concern

9999 Other Drugs of Concern

Appendix 6: Alcohol and other drug treatment provided by services funded to assist Aboriginal and Torres Strait Islander people

The number of treatment episodes reported through the AODTS–NMDS for Aboriginal and Torres Strait Islander people does not represent all alcohol and other drug treatments provided to Indigenous people in Australia for 2008–09. Data for the majority of Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services are available from the OATSIH Services Reporting (OSR) data collection. In 2008–09, the OSR replaced the two previous data collections, Drug and Alcohol Service Report (DASR) and Service Activity Reporting (SAR). In the 2008–09 OSR, 45 of the 50 substance use-specific services (90% of funded services) provided data.

This appendix presents a selection of data from the 2008–09 OSR. The OSR and AODTS–NMDS have different collection purposes, scope and counting rules. For example, the OSR collects service-level estimates for client numbers and episodes of care, whereas the AODTS–NMDS collects unit records for closed treatment episodes. The definitions of 'closed treatment episodes' (AODTS–NMDS) and 'episodes of care' (SAR/DASR) are not consistent.

In 2008–09, 10 out of the 45 Australian Government-funded substance use-specific services reporting in the OSR also reported under the AODTS–NMDS.

Box A6.1: Comparison of treatment episode definitions in the OATSIH Services Reporting (OSR) and AODTS–NMDS

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

The OSR collection records information about clients of any age, whereas the AODTS–NMDS reports only about clients aged 10 years and over. Any comparisons drawn between the collections should therefore be made with caution.

The OATSIH Services Reporting (OSR): substance use-specific services

In 2008–09, an estimated 23,178 people were seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services.

Table A6.1 Estimated number of clients seen by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services, by jurisdiction and Indigenous status, 2008–09

Indigenous status	NSW	Vic and SA	Qld	WA	NT	Total
Aboriginal and Torres Strait Islander	749	4,540	3,388	3,993	5,051	17,721
Non-Indigenous	349	1,056	3,242	557	149	5,353
Unknown Indigenous status	—	—	—	104	—	104
Total clients (number)	**1,098**	**5,596**	**6,630**	**4,654**	**5,200**	**23,178**
Total clients (per cent)	**4.7**	**24.1**	**28.6**	**20.1**	**22.4**	**100.0**

Note: The total estimated number of clients refers to individual clients, and does not include clients that attended groups only.

Source: OATSIH Services Reporting Database, 2008–09.

In addition to the number of clients seen, treatment agencies report on the drugs for which they provide treatment during the year. During 2008–09, the Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services (agencies) reported a decrease of 9 percentage points in the provision of treatment for client alcohol use: namely from 100% (2007–08) to 91%(Table A6.2). Other common substances/drugs for which services provided treatment or assistance included cannabis (80%), multiple drug use (58%) and tobacco/nicotine (49%). There was an overall decrease in percentages for all substances in 2008–09; this may have been due to the change in reporting practices and a reduced agency response.

Table A6.2: Substances/drugs for which treatment/assistance provided as a targeted program by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services, 2008–09

Substance/drug	Percentage of services that provided treatment/assistance for this substance/drug
Alcohol	91
Cannabis/marijuana	80
Multiple drug use	58
Tobacco/nicotine	49
Amphetamines	36
Petrol	33
Other solvents/inhalants	31
Benzodiazepines	29
Heroin	27
Ecstasy/MDMA	22
Morphine	20
Cocaine	20
Methadone	18
Barbiturates	18
LSD	16
Other drugs	9
Kava	2
Steroids/anabolic agents	2

Note: Percentage of services that cover substance use issues as a specifically targeted program.

Source: OATSIH Services Reporting Database, 2008–09.

The OATSIH Services Reporting (OSR): primary care health services

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

However, the drug types for which treatment was provided are known. In 2008–09, most services covered issues relating to alcohol (89%), cannabis (87%) and both tobacco/nicotine and multiple drug use (76%) (Table A6.3). Many services also provided treatment for amphetamines (60%) and other solvents/inhalants (58%).

Table A6.3: Substances/drugs for which treatment/assistance provided on an individual client basis by Australian Government-funded Aboriginal and Torres Strait Islander primary health care services, 2008–09

Substance/drug	Percentage of services that cover substance use issues on an individual basis as they arise
Alcohol	89
Cannabis/marijuana	87
Tobacco/nicotine	76
Multiple drug use	76
Amphetamines	60
Other solvents/inhalants	58
Benzodiazepines	56
Petrol	53
Heroin	47
Morphine	42
Barbiturates	42
Methadone	40
Ecstasy/MDMA	40
Cocaine	33
LSD	18
Steroids/anabolic agents	13
Kava	11
Other drugs	7

Source: OATSIH Services Reporting Database, 2008–09.

Appendix 7: Mapping of ICD-10-AM codes to ASCDC output categories

The following table provides technical details about the mapping process applied to produce the hospital separations data in Chapter 4. Please note that these codes are not a complete list of ICD-10-AM codes for which a hospital separation may be attributed as (wholly or partially) drug-related.

Table A7.1: Mapping of ICD-10-AM codes to ASCDC output categories[(a)]

Drug of concern identified in diagnosis	ICD-10-AM codes
Analgesics	
Opioids (includes heroin, opium, morphine and methadone)	F11 (11.0–11.9), T40.0, T40.1, T40.2, T40.3, T40.4
Non opioid analgesics (includes paracetamol)	T39.0, T39.1, T39.9
Sedatives and hypnotics	
Alcohol	F10 (10.0–10.9), T51 (51.0–51.9), Z71.4
Other sedatives and hypnotics (includes barbiturates and benzodiazepines; excludes alcohol)	F13 (13.0–13.9), F55.6, T41.2, T42.6, T42.3, T42.4, T42.7
Stimulants and hallucinogens	
Cannabinoids (includes cannabis)	F12 (12.0–12.9), T40.7
Hallucinogens (includes LSD and ecstasy)	F16 (16.0–16.9), T40.8, T40.9
Cocaine	F14 (14.0–14.9), T40.5
Tobacco and nicotine	F17 (17.2–17.9), T65.2,
Other stimulants (includes amphetamines, pseudoephedrine, volatile nitrates and caffeine)	F15 (15.0–15.9), T40.6, T44.9, T43.6, T46.3
Antidepressants and antipsychotics	
Antidepressants and antipsychotics	T43 (43.0–43.5)
Volatile solvents	
Volatile solvents	F18 (18.0–18.9), T52 (52.0–52.9), T53.6, T53.7, T59.8
Other and unspecified drugs of concern	
Multiple drug use	F19 (19.0–19.9)
Unspecified drug use and other drugs not elsewhere classified (includes psychotropic drugs not elsewhere classified; diuretics; anabolic and androgenic steroids and opiate antagonists)	Z71.5, T38.7, T43.8, T43.9, T50.1, T50.2, T50.3, T50.7

(a) This list of codes included in analyses of hospital data has changed from previous reports, with the exclusion of codes Z72.0, Z72.1 and Z72.2

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