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Alcohol and other drug treatment services in Australia 2004–05

Report on the National Minimum Data Set

July 2006

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Canberra

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Intergovernmental Committee on Drugs, Alcohol and Other Drug Treatment Services National Minimum Data Set (IGCD AODTS–NMDS) Working Group

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
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
DASR	Drug and Alcohol Service Report
DoHA	(Australian Government) Department of Health and Ageing
HIV	human immunodeficiency virus
IDRS	Illicit Drug Reporting System
IGCD	Intergovernmental Committee on Drugs
n.e.c.	not elsewhere classified
NDARC	National Drug and Alcohol Research Centre
NDSHS	National Drug Strategy Household Survey
NHDD	National Health Data Dictionary
NMDS	National Minimum Data Set
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
OATSIH	Office for Aboriginal and Torres Strait Islander Health
SAR	Service Activity Report
THC	delta-9-tetrahydrocannabinol

Highlights

Treatment agencies and episodes

- In 2004–05, 635 alcohol and other drug treatment agencies from across Australia reported data to the AODTS–NMDS collection. Broadly speaking, these are publicly funded agencies providing specialist alcohol or other drug treatment services.
- Just under half (49%) of all treatment agencies were non-government and most were located in major cities (57%) and inner regional areas (28%).
- These agencies delivered 142,144 closed treatment episodes, an increase from 136,869 episodes reported in 2003–04.

Client profile

Of the 142,144 closed treatment episodes reported in 2004–05…

- 95% (or 135,202 episodes) involved clients seeking treatment for their own alcohol or other drug use.
- One-third (33%) were for clients aged 20–29 years, and more than one-quarter (28%) were for clients aged 30–39 years.
- Male clients accounted for two-thirds (66%).
- 10% (or 13,666 episodes) involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin, which is higher than the overall proportion of Aboriginal and Torres Strait Islander peoples, aged 10 years and over, in the Australian population (2.1%).[1]
- 86% were for clients born in Australia and 95% were for clients who nominated English as their preferred language.
- 37% involved clients who were self-referred, followed by referrals from alcohol and other drug treatment services (12%).

Drugs of concern

Of the 135,202 closed treatment episodes where clients were seeking treatment for their own alcohol or other drug use…

- Alcohol (37%) was the most common principal drug of concern, followed by cannabis (23%), opioids (21%, with heroin accounting for 17%) and amphetamines (11%).
- Over half (52%) involved at least one other drug of concern in addition to the principal drug of concern, with an average of 1.6 other drugs of concern.

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1 This figure needs to be interpreted with caution due to a high number of 'not stated' responses for Indigenous status and the fact that the majority of Australian Government-funded Indigenous substance use services or Aboriginal primary health care services are not included in the AODTS–NMDS collection (see Section 7.5 for data on these services).

- Ingestion (45%), followed by injection (26%) and smoking (25%) were the most likely methods of using the principal drug of concern.
- Counselling accounted for the highest proportion of closed treatment episodes for all principal drugs of concern except benzodiazepines, where the main treatment type was withdrawal management (detoxification).

In 2004–05 alcohol was…

- The most common principal drug of concern to clients overall (37%) and for those identified as being of Aboriginal and/or Torres Strait Islander origin (43%).
- The most commonly nominated principal drug of concern for both sexes: 39% of males and 35% of females.
- The drug most likely to be reported as the principal drug of concern for clients aged 30 years and over (50%).
- Most commonly treated through counselling (44%), withdrawal management (detoxification) (21%), assessment only (15%) and rehabilitation (9%), when it was the principal drug of concern.

Where alcohol was the principal drug of concern, treatment most commonly ceased because it was completed (60%) or the client ceased to participate without notice (17%).

In 2004–05 cannabis was…

- The second most common principal drug of concern to clients overall (23%) and for those identified as being of Aboriginal and/or Torres Strait Islander origin (23%).
- The second most commonly nominated principal drug of concern for both sexes: 24% for males and 21% for females.
- The most commonly reported principal drug of concern for closed treatment episodes of clients aged 10–19 (50%) and 20–29 years (28%).
- The principal drug of concern most likely to be nominated where the client was referred to treatment through a police or court diversion process (80% and 27% respectively).
- Most commonly treated through counselling (36%), information and education only (24%), withdrawal management (detoxification) (14%) and assessment only (9%), when it was the principal drug of concern.

Where cannabis was nominated as the principal drug of concern:

- 71% of treatment episodes related to male clients and 29% to female clients.
- A higher proportion of episodes involved clients aged 10–19 and 20–29 years (26% and 41% respectively) compared with episodes for all other principal drugs of concern (8% and 31% respectively).
- Smoking was the most common method of use (91% of treatment episodes).
- Clients were less likely to be current injectors than those nominating all other principal drugs of concern (9%, compared with 29%).
- Of the other drugs of concern nominated, 36% of these were for alcohol, 21% nicotine, 20% amphetamines and 6% ecstasy.
- The most common source of referral was self-referring (28%), followed by referral from police diversion (21%).

- Treatment most commonly ceased because the treatment was completed (46%), followed by ceasing at expiation (22%)—that is, where the client had completed the required intervention.

In 2004–05 heroin was…

- The third most common principal drug of concern to clients overall (17%) and for those identified as being of Aboriginal and/or Torres Strait Islander origin (12%).
- The third most commonly nominated principal drug of concern for both sexes: 17% for males and 18% for females.
- Most commonly reported among clients aged 20–29 (24%) and 30–39 years (20%), when it was the principal drug of concern.
- Most commonly treated through counselling (29%), followed by withdrawal management (detoxification) (24%), 'other' treatment including pharmacotherapy (14%) and assessment only (13%), when it was the principal drug of concern.

Where heroin was the principal drug of concern, treatment most commonly ceased because the treatment was completed (51%) or clients ceased to participate without notice (17%).

In 2004–05 amphetamines were…

- The fourth most common principal drug of concern to clients overall (11%) and for those identified as being of Aboriginal and/or Torres Strait Islander origin (11%).
- The fourth most commonly nominated principal drug of concern for both sexes: 11% for both males and females.
- Most commonly reported among clients aged 20–29 (15%) and 30–39 years (13%), when it was the principal drug of concern.
- Most commonly treated through counselling (42%), followed by assessment only (16%), rehabilitation (15%) and withdrawal management (detoxification) (13%), when it was the principal drug of concern.

Where amphetamines were the principal drug of concern, treatment most commonly ceased because the treatment was completed (46%) or clients ceased to participate without notice (22%).

Treatment programs

Of the 142,144 closed treatment episodes where clients were seeking treatment for their own or someone else's alcohol or other drug use…

…what were the treatment types accessed by clients?

- Counselling was the most common treatment type provided (40%), followed by withdrawal management (detoxification) (18%) and assessment only (12%).
- The main treatment for female clients was more likely to be counselling (45%) than for male clients (38%), and less likely to be assessment only (9% and 14% respectively) and information and education only (7% and 10% respectively).
- Counselling as the main treatment type was more likely among older clients—from 31% of closed treatment episodes for clients aged 10–19 years to 49% of episodes for clients aged 50–59 years.

- The overall median number of treatment days for a treatment episode was 19.

…where did treatment take place and what were the reasons for ending treatment?

- 70% of treatment episodes occurred at a non-residential treatment facility, 18% in a residential treatment facility and 7% in an outreach setting such as a mobile van service.
- Treatment episodes were most likely to occur at a non-residential treatment facility where the main treatment was counselling (93% of episodes with this treatment type), assessment only (80%) and information and education only (70%), and most likely to occur at a residential treatment facility where the main treatment was rehabilitation (68%) and withdrawal management (detoxification) (58%).
- The most common reason for ending a treatment episode was because the treatment was completed (53%), followed by the client ceasing to participate without notice to the treatment agency (17%).
- Treatment was more likely to cease because it was completed where the main treatment type was assessment only (74% of episodes with this treatment type) and less likely where the main treatment type was information and education only (23%).

Data quality

- Overall, the quality of the 2004–05 AODTS–NMDS data has continued the trend of improvements across collection periods.
- The data transmission process for the 2004–05 AODTS–NMDS collection represented an improvement on that of previous years. Data were received at the AIHW earlier than in previous years.

1 Introduction

This report presents national, state and territory data about alcohol and other drug treatment services and their clients, including information about the type of drug problems for which treatment is sought and the types of treatment provided. This is the fifth report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) (AIHW 2002, 2003, 2004a, 2005a).

1.1 Background

The AODTS–NMDS was implemented to help monitor and evaluate key objectives of the National Drug Strategic Framework 1998–99 to 2003–04 and to help plan, manage and improve the quality of alcohol and other drug treatment services (see AIHW: Grant & Petrie 2001 for historical development of the AODTS–NMDS). The AODTS–NMDS will continue to support the National Drug Strategy 2004–09, particularly as trend data are becoming available.

Since 1985, Australia's drug strategies have been based on the principle of minimising harm caused by licit drugs, illicit drugs and other substances. The principle of harm minimisation incorporates strategies to reduce drug-related harm to individuals and communities as well as supply and demand reduction strategies. No single data collection can provide all of the information relating to national treatment objectives. This report therefore also presents information from a range of other data sources to provide context to the AODTS–NMDS data and present a more complete picture of the current state of alcohol and other drug treatment services in Australia today (see Chapter 7).

The data presented in this report, in conjunction with other information sources, can be used to inform issues of access to treatment services and more generally to inform debate, policy decisions and planning processes that occur within the alcohol and other drug treatment sector.

1.2 Collection method and data included

The AODTS–NMDS collection for 2004–05 consists of de-identified unit record data for treatment agencies and closed treatment episodes. Each agency record consists of three data items and each treatment episode record consists of 20 data items. The treatment episode data items collect demographic information on clients, along with information about their drug use behaviour and the types of treatment received. See Appendix 1 for a full list of data items included in the national collection for 2004–05. The methods of collecting data vary across the country. Appendix 2 outlines the policy and administrative features of the AODTS–NMDS collection within each jurisdiction. A common feature across jurisdictions is the requirement for agencies to collect and provide treatment service data consistent with the AODTS–NMDS specifications.

Responsibility for the collection

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 Australian Institute of Health and Welfare (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 Australian Bureau of Statistics (ABS) and the National Drug and Alcohol Research Centre (NDARC). The key responsibilities of each authority in regard to the AODTS–NMDS collection follow.

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 are responsible for providing data according to agreed formats and timeframes, participating in data development related to the collection, and providing advice to the IGCD AODTS–NMDS Working Group about emerging issues which may affect the AODTS–NMDS.

Government health authorities also need to 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 federal, state and territory government departments have custodianship of their own data collections under the National Health Information Agreement.

Alcohol and other drug treatment agencies

Publicly funded alcohol and other drug treatment agencies collect the agreed data elements and forward this information to the appropriate health authority as arranged. Agencies need to ensure that the required information is accurately recorded. They must ensure 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 federal 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 the secretariat for the responsible 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 prepares annual reports (at national and state/territory levels) and online interactive data cubes, in consultation with the Working Group.

1.3 Scope of the AODTS–NMDS

Agencies and clients included

The agencies, clients and treatment activities that were included in the 2004–05 AODTS–NMDS collection are as follows:

- 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 services, including residential and non-residential agencies. Specialist alcohol and drug units based in acute care hospitals or psychiatric hospitals were included if they provided treatment to non-admitted patients (i.e. outpatient services).
- All clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during the relevant reporting period (1 July 2004 to 30 June 2005).

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. For example, agencies not within the scope of the AODTS–NMDS include those whose sole activity is to prescribe and/or dose opioid pharmacotherapies, as well as Australian Government-funded Indigenous substance use services or Aboriginal primary health care services. Data sources relating to these services, along with a range of other supporting data sources, are detailed in Chapter 7.

Specifically, agencies and clients excluded from the AODTS–NMDS collection are:

- agencies whose sole activity was to prescribe and/or dose for opioid pharmacotherapy treatment
- clients who were on an opioid pharmacotherapy program and who were not receiving any other form of treatment that fell within the scope of the AODTS–NMDS
- agencies for which the main function was to provide accommodation or overnight stays such as 'halfway houses' and 'sobering-up shelters'
- agencies for which the main function was to provide services concerned with health promotion (e.g. needle and syringe exchange programs)
- treatment services based in prisons or other correctional institutions and clients receiving treatment from these services
- clients receiving support from the majority of Australian Government-funded Indigenous substance use services or Aboriginal primary health care services that also provide treatment for alcohol and other drug problems
- alcohol and drug treatment units in acute care or psychiatric hospitals that provided treatment only to admitted patients, and admitted patients in acute care or psychiatric hospitals
- people who sought advice or information but who were not formally assessed and accepted for treatment
- private treatment agencies that did not receive public funding
- clients aged under 10 years, irrespective of whether they were provided with services, or received these services from agencies included in the collection.

Some people who are concerned about their alcohol or other drug use may approach a general practitioner or pharmacy for advice and/or treatment rather than attending a specialist alcohol and other drug treatment service. Thus the estimates in this report do not reflect the total number of people in Australia receiving treatment for alcohol and other drug use. (See Section 1.5 for more details on some of these exclusions.)

1.4 Counts in the collection

The main unit of measurement for the 2004–05 AODTS–NMDS collection is closed (or completed) treatment episodes (the 2000–01 AODTS–NMDS focused on client registrations and a small amount of data are presented in this report on client registrations for continuity). The 'closed treatment episode' concept is included in the national collection because it best reflects clinical practice within the alcohol and other drug treatment sector and it enhances the quality of information on service use. This measure allows information to be reported about the nature of treatment received by clients, including the length of the treatment episode. Technical notes, including a discussion of the use of client registration and closed treatment episode data, are included in Appendix 3.

A closed treatment episode may be for a specific treatment, such as information and education only that may not be part of a larger treatment plan; or it may be for a specific treatment, such as withdrawal management (detoxification) or counselling that is part of a long-term overall treatment plan.

The following counting rules have been used for the data included in this report.

Closed treatment episodes

A closed treatment episode refers to a period of contact between a client and a treatment agency and:

- it must have a defined date of commencement and cessation
- during the period of contact there must have been no change in:
  - the principal drug of concern
  - the treatment delivery setting
  - the main treatment type

A treatment episode may cease for a number of valid reasons such as the treatment being completed or the client ceasing to participate without notice. A treatment episode is deemed to have terminated in the event that there has been no (service) contact between the client and the treatment agency for a period of 3 months or more, unless the period of non-contact was planned between the client and the treatment agency.

If a client receives treatment in multiple settings, in some cases a separate treatment episode is reported for each setting. Therefore, it is possible that more than one treatment episode may be in progress for a client at any one time. It is possible for each of these episodes to have different dates of commencement and cessation.

1.5 Features of the 2004–05 collection

In 2004–05 the overall quality and comprehensiveness of the AODTS–NMDS data continued to improve. Data quality issues relating to the scope and completeness of the 2004–05 NMDS collection are detailed further in Chapter 8. When interpreting the 2004–05 data in this report it is important to consider a number of features of the collection.

First, the national collection is a compilation of agency administrative data from state and territory health authorities. There is some diversity across Australian jurisdictions in the data collection systems and practices in place within the alcohol and other drug treatment sector.

Second, national implementation of the AODTS–NMDS collection has been done in stages. Care should be taken when comparing data across collection years for the following reasons:

- In the first year of the collection (2000–01) there was a mix of client registration and treatment episode data, and one jurisdiction (Queensland) was unable to supply data. For the 2001–02 collection period, Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data. All other jurisdictions supplied treatment episode data.
- The total number of agencies may have increased in 2004–05, compared with 2003–04, as a result of methodological changes (i.e. moving from collecting data at the administrative or management level to the service outlet level) and increased coverage of in-scope agencies.

Third, readers should be aware of the following general features of the 2004–05 AODTS–NMDS data:

- Reported numbers for each state/territory include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). (Since the 2002–03 AODTS–NMDS annual report, these data are not analysed separately under the heading 'other', as previously.)
- Reported numbers do not include the majority of Australian Government-funded Indigenous substance use services (6 out of 41 were included) or Aboriginal primary health care services (9 out of 143 were included) that also provide treatment for alcohol and other drug problems. These services are generally not under the jurisdiction of the state or territory health authority and are not included in the specific program under which the Australian Government currently reports NMDS data. In addition, the data collections relating to these services have a different collection basis to the AODTS–NMDS. As a result, most of these data are not currently included in the AODTS–NMDS collection. Therefore the number of Indigenous clients in this report underrepresents the total number of Indigenous Australians who received treatment for alcohol and other drug problems during 2004–05.

Finally, the reader should be aware of the following data completeness issues in 2004–05:

- Since 2002–03, data were provided from Queensland government AODTS agencies and/or police diversion clients but not for other non-government agencies.
- In the Australian Capital Territory, the re-inclusion of one large service provider (excluded in 2003–04) has meant that the overall number of closed treatment episodes has increased since 2003–04.
- In Victoria, the number of reported closed treatment episodes decreased slightly in 2004–05 due to a change in reporting practice which requires clinicians to report treatment outcomes for closed treatment episodes.

- In Tasmania, two agencies only supplied drug diversion data and this has meant that the overall number of closed treatment episodes for Tasmania has decreased since 2003–04.

Reported numbers do not include agencies delivering pharmacotherapy services, where their sole activity is to prescribe and/or dose for opioid pharmacotherapy treatment. Approximately 39,000 clients were recorded as receiving these services throughout Australia as at June 2005 (see Section 7.4).

1.6 Outputs from the AODTS–NMDS collection

The AODTS–NMDS collection provides national data on government-funded alcohol and other drug treatment services in Australia. AODTS–NMDS data outputs are designed to provide useful information to government health authorities, researchers and the broader community, as well as to provide an important form of feedback to treatment agencies that took part in the collection.

Each year the AODTS–NMDS data are processed and published in a detailed and comprehensive national report—this being the report for 2004–05 data—which is made available to the public free of charge on the AIHW website <www.aihw.gov.au> or in hard copy for a small fee.

As well as this detailed annual report, a national AODTS–NMDS bulletin is produced, which is a 12-page summary of the main findings from the collection. Data briefings specific to individual states and territories are also produced.

Further to this, the AIHW has an interactive alcohol and other drug treatment data site, <www.aihw.gov.au/drugs/datacubes/index.html> containing subsets of national information on alcohol and other drug treatment services from the 2004–05 collection. This also allows anyone who has access to the Internet to view a subset of the AODTS–NMDS data via the web interface. The user can look up figures and present them in a way suitable to their needs.

Each year the agencies that contribute data via the AODTS–NMDS receive a state/territory briefing containing data specifically designed to be relevant to their jurisdiction. In addition, these agencies are surveyed each year with the aim of discovering special areas of interest to treatment agencies. This input feeds into the AODTS–NMDS reporting, and in particular the special theme chapter in this report—Chapter 6 on cannabis.

1.7 Recent drug use

This section provides a brief overview of drug use patterns in the Australian population, as background to the data on treatment services in the remainder of the report. Data from the 2004 National Drug Strategy Household Survey (NDSHS) are the most recent population data on this topic, and are presented in Table 1.1 together with data from the 2001 NDSHS and 2004–05 AODTS–NMDS.

An estimated 84% of Australians aged 14 years and over had recently consumed alcohol in 2004, and just over one-fifth (21%) smoked tobacco (Table 1.1). Between 2001 and 2004, a significant increase was observed in the proportion of persons who recently consumed alcohol (from 82% in 2001 to 84% in 2004) and a significant decrease in the proportion of

persons who recently smoked tobacco (23% to 21% respectively). The proportion of the population recently using ecstasy increased significantly from 2.9% in 2001 to 3.4% in 2004.

In 2004, lower proportions of people aged 14 years and over reported using cannabis (11%) and amphetamines (3%) than in 2001, while the proportion of the population using heroin or methadone remained stable between 2001 and 2004 at 0.2% and 0.1% respectively.

Table 1.1: Summary of selected drugs recently[(a)] used, and principal drugs for which treatment was sought, Australia (per cent)

Drug/behaviour	Recent use, population aged 14 years and over[(b)] 2001	Recent use, population aged 14 years and over[(b)] 2004	Closed treatment episodes for clients aged 10 years and over 2004–05
Tobacco	23.2	20.7 #	1.8
Alcohol	82.4	83.6 #	37.2
Illicits			
Marijuana/cannabis	12.9	11.3	23.0
Heroin	0.2	0.2	17.2
Methadone[(c)]	0.1	0.1	1.8
Meth/amphetamines (speed)	3.4	3.2	10.9
Cocaine	1.3	1.0 #	0.3
Ecstasy[(d)]	2.9	3.4 #	0.4
Any illicit drug[(e)]	*16.9*	*15.3* # [(f)]	*60.9*
None of the above	**14.7**	**13.7 #**	**n.a.**

(a) Used in the last 12 months. For tobacco and alcohol, 'recent use' means daily, weekly and less than weekly smokers and drinkers.

(b) Proportion of population aged 14 years and over from 2001 and 2004 NDSHS.

(c) Non-maintenance.

(d) Before 2004, this category included substances known as 'designer drugs'.

(e) 'Any illicit drug' for 2001 and 2004 NDSHS includes the illicit drugs listed plus pain-killers/analgesics, tranquilisers/sleeping pills, steroids, barbiturates, inhalants, other opiates/opioids when used for non-medical purposes, hallucinogens and injected drugs.

(f) In 2004, also includes gamma-hydroxybutyrate (GHB) and ketamine.

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

Source: AIHW 2005b.

In the 2004–05 AODTS–NMDS collection, alcohol (37%) was the most common principal drug of concern in treatment episodes for clients aged 10 years and over (Table 1.1). This reflects the pattern of consumption among the Australian population where alcohol was the most common drug used. Tobacco was nominated as the second most used drug in the population (21%), yet accounted for less than 2% of closed treatment episodes for clients seeking treatment for its use. These differences in treatment for tobacco (nicotine) are perhaps not surprising given that most 'treatment' for nicotine addiction is through pharmacies, general practitioners (e.g. advice and nicotine patches) or 'quit' lines.

Although very low proportions of the general population reported using heroin (0.2%), 17% of closed treatment episodes of alcohol and other drug treatment services had heroin nominated as the principal drug of concern. The differences in results from the two sources of data reflect the nature of the treatment services captured by the AODTS–NMDS. These services focus on the people who have a problem with their drug use, whereas the household survey data cover all people who consume alcohol or use tobacco or other drugs, whether or not they think they have a problem. Further to this, agencies whose sole purpose

is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS, and so the collection may exclude many clients receiving treatment for heroin. See Section 7.4 for information about the estimated numbers of clients receiving treatment from pharmacotherapy programs in Australia.

2 Treatment agency profile

This chapter presents the main features of the alcohol and other drug treatment agencies that supplied data for the 2004–05 AODTS–NMDS collection. The number of treatment agencies reported does not necessarily equate to the number of service delivery outlets as some treatment agencies were only reported under the main administrative centre of the service.

2.1 Establishment sector

A total of 635 alcohol and other drug treatment agencies provided data for the period 2004–05, up from 622 agencies in 2003–04. Much of this increase is related to methodological changes and increased coverage of in-scope agencies rather than an increase in service delivery capacity (see Section 1.3 for further details). The overall response rate for in-scope treatment agencies was 96% in 2004–05, the same proportion as in 2003–04 (see Chapter 8 for further details).

In 2004–05, the largest proportion of agencies was located in New South Wales (45%), followed by Victoria (21%) and Queensland (14%). This split was similar in 2003–04, where 42% of agencies were located in New South Wales, 23% in Victoria and 15% in Queensland.

Table 2.1: Treatment agencies by sector of service and jurisdiction, Australia, 2004–05

Service type	NSW	Vic[(a)]	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia
					(number)				
Government	214	0	50	12	37	4	1	3	321
Non-government	73	136	37	28	9	8	8	15	314
Total	**287**	**136**	**87**	**40**	**46**	**12**	**9**	**18**	**635**
Total 2003–04	*259*	*143*	*94*	*34*	*53*	*12*	*8*	*19*	*622*
					(per cent)				
Government	66.7	0.0	15.6	3.7	11.5	1.2	0.3	0.9	100.0
Non-government	23.2	43.3	11.8	8.9	2.9	2.5	2.5	4.8	100.0
Total	**45.2**	**21.4**	**13.7**	**6.3**	**7.2**	**1.9**	**1.4**	**2.8**	**100.0**
Total 2003–04	*41.6*	*23.0*	*15.1*	*5.5*	*8.5*	*1.9*	*1.3*	*3.0*	*100.0*

(a) The total number of treatment agencies in Victoria is lower than in 2003–04 due to a change in reporting practice introduced in 2004–05.

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

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

Just under half of all agencies identified as non-government providers in 2004–05 (49% or 314 out of 635) with the largest proportion of non-government agencies being located in Victoria (136 or 100% of agencies), followed by Western Australia (28 or 70% of agencies), Tasmania (8 or 67% of agencies), the Australian Capital Territory (8 or 89% of agencies) and the Northern Territory (15 or 83% of agencies). In contrast, agencies were more likely to be in the government sector in New South Wales (214 or 75% of agencies) and South Australia (37 or 80% of agencies). In Queensland, more than half of all agencies were in the

government sector (57%), but this relates to the current exclusion of non-government agencies, except for those providing police diversion programs and those provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government) (see Section 1.5).

2.2 Location of treatment agencies

Treatment agencies were mostly located in major cities (57%) and inner regional areas (28%) in 2004–05 (Table 2.2). These proportions are almost identical to previous reporting periods (57% and 26% respectively in 2003–04 and 56% and 25% respectively in 2002–03) (AIHW 2004a, 2005a). It is important to note, however, that the number of agencies located in major cities may be over-represented as some treatment agencies, particularly several of those in non-metropolitan areas, were reported under the main administrative centre of the service.

As in previous reporting periods, a significant proportion of treatment agencies in the Northern Territory (50%) and, to a lesser extent, Queensland (10%) were located in remote or very remote areas.

Table 2.2: Treatment agencies by geographical location[a] and jurisdiction, Australia, 2004–05

Location	NSW	Vic[b]	Qld[c]	WA	SA	Tas[d]	ACT	NT	Australia
					(number)				
Major cities	171	88	35	30	31	0	9	0	364
Inner regional	93	40	22	4	7	9	0	0	175
Outer regional	23	8	21	4	7	3	0	9	75
Remote	0	0	6	2	1	0	0	8	17
Very remote	0	0	3	0	0	0	0	1	4
Not stated	—	—	—	—	—	—	—	—	—
Total	**287**	**136**	**87**	**40**	**46**	**12**	**9**	**18**	**635**
					(per cent)				
Major cities	59.6	64.7	40.2	75.0	67.4	0.0	100.0	0.0	57.3
Inner regional	32.4	29.4	25.3	10.0	15.2	75.0	0.0	0.0	27.6
Outer regional	8.0	5.9	24.1	10.0	15.2	25.0	0.0	50.0	11.8
Remote	0.0	0.0	6.9	5.0	2.2	0.0	0.0	44.4	2.7
Very remote	0.0	0.0	3.4	0.0	0.0	0.0	0.0	5.6	0.6
Not stated	—	—	—	—	—	—	—	—	—
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 2004–05 AODTS–NMDS has been analysed using the Remoteness Areas of the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 6 for information on how these categories are derived).

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

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

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

3 Client profile

This chapter provides a profile of the clients receiving alcohol and other drug treatment services in 2004–05, as well as an overview of the estimated number of client registrations and closed treatment episodes. The main analysis is based on 'closed treatment episodes' (see Box 3.1).

3.1 Closed treatment episodes and client registrations

There were 142,144 closed treatment episodes in alcohol and other drug treatment services reported in the 2004–05 AODTS–NMDS collection. These treatment episodes related to an estimated 121,812 client registrations (see Box 3.1). On average, each of these registrations accounted for 1.2 treatment episodes during the 2004–05 reporting period.

The number of closed treatment episodes in 2004–05 was higher than in 2003–04 (142,144 episodes, compared with 136,869), as was the number of estimated client registrations (121,812 registrations, compared with 115,163). However, it is likely that this increase relates as much to the increasing comprehensiveness of the AODTS–NMDS collection in 2004–05 as to an overall increase in the number of clients being treated nationally. For instance, the total number of closed treatment episodes for the Australian Capital Territory was underreported in 2003–04 due to the exclusion of data from one large service provider because of a data-collection error (AIHW 2005a).

Box 3.1: Key definitions and counts for closed treatment episodes and registrations, 2004–05

Closed treatment episode *refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2004–05 there were* ***142,144*** *closed treatment episodes.*

Client registrations *refers to the estimated number of clients who were registered or reregistered for alcohol and other drug treatment services. In 2004–05 there were an estimated* ***121,812*** *client registrations.*

It is important to note that neither number of closed treatment episodes or estimated number of client registrations equates 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 reduce duplication in client registrations that can occur where, for example, a client attends a number of different agencies throughout the collection period or reregisters with the same agency and is assigned a new record number. See Appendix 3 for more information on treatment episodes and client registrations.

Caution should be exercised when comparing the client registration data in 2000–01 with those of 2001–02 to 2004–05 as the method for calculating 'registrations' has changed. In the 2000–01 collection, registrations were based on all new or returning clients who registered or reregistered for treatment during the reporting period. For the 2001–02 to 2004–05 collections, registrations were based on the number of episodes closed within the reporting period.

See Section 1.2 and Boxes 4.1 and 5.1 for other related definitions.

3.2 Client type and jurisdictions

In 2004–05, 95% of all closed treatment episodes involved clients seeking treatment for their own alcohol or other drug use, the same proportion as in 2003–04 (Table 3.1). This proportion of episodes was observed in most states and territories except Western Australia, the Northern Territory and Tasmania, where 89%, 87% and 71% respectively of closed treatment episodes were for the client's own drug use.

Accordingly, fewer than 5% of closed treatment episodes in most states and territories were related to another person's drug use (with 29% of all closed treatment episodes in Tasmania, 13% in the Northern Territory and 12% in Western Australia for clients receiving treatment for another person's alcohol or drug use).

Overall, the majority of the 142,144 closed treatment episodes were recorded in Victoria (33%), followed by New South Wales (30%), Queensland (14%) and Western Australia (11%).

Table 3.1: Closed treatment episodes by client type and jurisdiction, Australia, 2004–05

Client type	NSW	Vic[a]	Qld[b]	WA	SA	Tas[c]	ACT	NT	Australia 2004–05	*Australia 2003–04*
					(number)					
Own drug use	41,789	44,150	19,743	14,235	7,591	1,372	4,206	2,116	135,202	*129,331*
Other's drug use	1,290	2,219	349	1,857	361	549	7	310	6,942	*7,538*
Total	**43,079**	**46,369**	**20,092**	**16,092**	**7,952**	**1,921**	**4,213**	**2,426**	**142,144**	*136,869*
					(per cent)					
Own drug use	97.0	95.2	98.3	88.5	95.5	71.4	99.8	87.2	95.1	*94.5*
Other's drug use	3.0	4.8	1.7	11.5	4.5	28.6	0.2	12.8	4.9	*5.5*
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	*100.0*
Per cent of all closed treatment episodes	***30.3***	***32.6***	***14.1***	***11.3***	***5.6***	***1.4***	***3.0***	***1.7***	***100.0***	

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

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

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

3.3 Age and sex

In 2004–05, one-third (33%) of all closed treatment episodes were for clients aged 20–29 years, more than one-quarter (28%) were for clients aged 30–39 years and almost one-fifth (19%) were for clients aged 40–49 years. Twelve per cent of treatment episodes were for clients aged 10–19 years and a small proportion of treatment episodes were for clients aged 60 years and over (2%). This age distribution is almost identical to that in previous collection periods (AIHW 2003, 2004a, 2005a).

As has been the case since 2001–02, male clients in 2004–05 accounted for two-thirds (66%) of all closed treatment episodes. Of treatment episodes for male clients, just over one-third (34% or 31,465 of 93,088) were for clients aged 20–29 years, and more than one-quarter (29%

or 26,592) for clients in the 30–39 year age group. The age distribution was similar for males and females.

Female clients were more likely than male clients to seek treatment for someone else's drug use—10% or 5,059 of 48,579 episodes compared with 2% or 1,871 of 93,088 episodes respectively—particularly females aged 40 years and older. For example, 1,278 of 8,810 treatment episodes (15%) for females aged 40–49 years, 1,128 of 3,918 episodes (29%) for females aged 50–59 years and 425 of 1,337 episodes (32%) for females aged 60 years and over were for treatment related to someone else's substance use. Overall, almost three-quarters (73% or 5,059 of 6,942) of treatment episodes for someone else's drug use were for female clients.

Table 3.2: Closed treatment episodes by sex and age group, Australia, 2004–05

	Age group (years)						
	10–19	20–29	30–39	40–49	50–59	60+	Total[(a)]
			(number)				
Males							
Own drug use	11,085	31,259	26,356	14,632	5,228	1,802	91,217
Other's drug use	363	206	236	424	406	175	1,871
Total males	*11,448*	*31,465*	*26,592*	*15,056*	*5,634*	*1,977*	*93,088*
Females							
Own drug use	5,310	14,030	12,500	7,532	2,790	912	43,520
Other's drug use	571	621	909	1,278	1,128	425	5,059
Total females	*5,881*	*14,651*	*13,409*	*8,810*	*3,918*	*1,337*	*48,579*
Persons[(b)]							
Own drug use	16,470	45,417	38,975	22,252	8,058	2,725	135,202
Other's drug use	936	827	1,148	1,704	1,535	603	6,942
Total persons	**17,406**	**46,244**	**40,123**	**23,956**	**9,593**	**3,328**	**142,144**
			(per cent)				
Males							
Own drug use	12.2	34.3	28.9	16.0	5.7	2.0	100.0
Other's drug use	19.4	11.0	12.6	22.7	21.7	9.4	100.0
Total males	*12.3*	*33.8*	*28.6*	*16.2*	*6.1*	*2.1*	*100.0*
Females							
Own drug use	12.2	32.2	28.7	17.3	6.4	2.1	100.0
Other's drug use	11.3	12.3	18.0	25.3	22.3	8.4	100.0
Total females	*12.1*	*30.2*	*27.6*	*18.1*	*8.1*	*2.8*	*100.0*
Persons[(b)]							
Own drug use	12.2	33.6	28.8	16.5	6.0	2.0	100.0
Other's drug use	13.5	11.9	16.5	24.5	22.1	8.7	100.0
Total persons	**12.2**	**32.5**	**28.2**	**16.9**	**6.7**	**2.3**	**100.0**

(a) Includes 'not stated' for age.

(b) Includes 'not stated' for sex.

3.4 Indigenous status

Of the 142,144 closed treatment episodes in 2004–05, 13,666 (or 10%) involved clients identified as being of Aboriginal and/or Torres Strait Islander origin (Table 3.3). This proportion was identical to 2003–04, while slightly higher than 2002–03 (9%) and 2001–02 (8%) (AIHW 2003, 2004a, 2005a), and is higher than the overall proportion of Aboriginal and Torres Strait Islander peoples, aged 10 years and over, in the Australian population (2.1%; ABS 2004). The proportion of closed treatment episodes where 'not stated' was reported for Indigenous status was 5% in 2004–05, a 1 percentage point reduction from 2003–04.

The data on Aboriginal and Torres Strait Islander clients in the AODTS treatment population should be interpreted with caution for a number of reasons, in particular the relatively high proportion of treatment episodes where Indigenous status was 'not stated' (5%). Furthermore, the majority of dedicated substance use services for Aboriginal and Torres Strait Islander peoples are not included in the AODTS–NMDS collection (see Section 7.5 for data on these services).

Table 3.3: Closed treatment episodes by age group, Indigenous[a] status and sex, Australia, 2004–05

Age group (years)	Indigenous			Non-Indigenous			Not stated			Total persons[c]
	Males	Females	Total[b]	Males	Females	Total[b]	Males	Females	Total[b]	
					(numbers)					
10–19	1,859	917	2,786	9,076	4,706	13,843	513	258	777	17,406
20–29	2,804	1,569	4,387	26,842	12,354	39,296	1,819	728	2,561	46,244
30–39	2,464	1,462	3,935	22,719	11,304	34,128	1,409	643	2,060	40,123
40–49	1,094	571	1,672	13,179	7,800	21,054	783	439	1,230	23,956
50–59	234	159	395	5,127	3,584	8,745	273	175	453	9,593
60+	50	30	80	1,811	1222	3,044	116	85	204	3,328
Not stated	281	130	411	562	393	959	73	50	124	1,494
Total	**8,786**	**4,838**	**13,666**	**79,316**	**41,363**	**121,069**	**4,986**	**2,378**	**7,409**	**142,144**
					(per cent)					
10–19	21.2	19.0	20.4	11.4	11.4	11.4	10.3	10.8	10.5	12.2
20–29	31.9	32.4	32.1	33.8	29.9	32.5	36.5	30.6	34.6	32.5
30–39	28.0	30.2	28.8	28.6	27.3	28.2	28.3	27.0	27.8	28.2
40–49	12.5	11.8	12.2	16.6	18.9	17.4	15.7	18.5	16.6	16.9
50–59	2.7	3.3	2.9	6.5	8.7	7.2	5.5	7.4	6.1	6.7
60+	0.6	0.6	0.6	2.3	3.0	2.5	2.3	3.6	2.8	2.3
Not stated	3.2	2.7	3.0	0.7	1.0	0.8	1.5	2.1	1.7	1.1
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent of treatment population	***6.2***	***3.4***	***9.6***	***55.8***	***29.1***	***85.2***	***3.5***	***1.7***	***5.2***	***100.0***

(a) In tables, the term 'Indigenous' refers to people who identified as being of Aboriginal and/ or Torres Strait Islander origin; 'Non-Indigenous' refers to people who said they were not of Aboriginal or Torres Strait Islander origin.

(b) There were 42 closed treatment episodes for Indigenous people where sex was not stated, 390 episodes for non-Indigenous people where sex was not stated and 45 episodes where Indigenous status and sex were not stated.

(c) Includes 'not stated' for sex.

Treatment episodes were relatively more common among Aboriginal and Torres Strait Islander males aged 10–19 years (21%) than among other Australian males aged 10–19 years (11%). This pattern was similar for female clients aged 10–19 years (19% for Indigenous females, compared with 11% for other Australian females). In contrast, treatment episodes involving clients older than 40 years were less common for Aboriginal and Torres Strait Islander clients than for other clients. This finding may relate to differences in the underlying age structures of the two populations, with Aboriginal and Torres Strait Islander peoples having a younger age profile than other Australians.

3.5 Country of birth and preferred language

The majority of closed treatment episodes in 2004–05 and in 2003–04 involved clients born in Australia (86% of closed treatment episodes in each year) (Table 3.4). Clients born in other countries were represented in only a small proportion of closed treatment episodes, with England and New Zealand (both 2%) being the next most common countries of birth in 2004–05.

As in previous reporting periods, English was the most frequently reported preferred language—95% or 135,560 of 142,144 treatment episodes involved clients who indicated English as their preferred language (Table A4.4). Of closed treatment episodes, 1% or 866 of 142,144 episodes involved clients with an Australian Indigenous language as their preferred language. Other preferred languages were relatively uncommon, with each accounting for less than 1% of treatment episodes.

Table 3.4: Closed treatment episodes by country of birth[(a)], Australia

	2004–05		*2003–04*	
Country of birth	**No.**	**%**	***No.***	***%***
Australia	121,713	85.6	*117,036*	*85.5*
England	3,420	2.4	*3,388*	*2.5*
New Zealand	2,665	1.9	*2,710*	*2.0*
Viet Nam	1,229	0.9	*1,353*	*1.0*
Scotland	777	0.6	*750*	*0.5*
Ireland	486	0.3	*495*	*0.4*
Germany	344	0.2	*355*	*0.3*
South Africa	348	0.2	*319*	*0.2*
Italy	313	0.2	*316*	*0.2*
United States of America	310	0.2	*299*	*0.2*
All other countries	6,381	4.5	*6,378*	*4.7*
Not elsewhere classified	339	0.2	*409*	*0.3*
Inadequately described	1,569	1.1	*871*	*0.6*
Not stated	2,250	1.6	*2,190*	*1.6*
Total	**142,144**	**100.0**	*136,869*	*100.0*

(a) The countries listed here are the 10 most frequently recorded countries; all other countries are combined in the row labelled 'All other countries'.

4 Drugs of concern

This chapter examines the profile and characteristics of clients in relation to the principal drug of concern nominated by the client when using treatment services in 2004–05. The analysis is based on 'closed treatment episodes' (See Box 4.1).

This chapter reports only on those 135,202 episodes where clients were seeking treatment for their own substance use. It is reasoned that only substance users themselves can accurately report on the principal drug of concern to them.

Box 4.1: Key definitions and counts for closed treatment episodes and drugs, 2004–05

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

Principal drug of concern *refers to the main substance that the client states led them to seek treatment from the alcohol and other drug treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses involving principal drug of concern. It is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2004–05,* ***135,202*** *closed treatment episodes were reported for principal drug of concern.*

Other drugs of concern *refers to any other drugs apart from principal drug of concern which clients perceive as being a health concern. Clients can nominate up to five other drugs of concern. In 2004–05, there were* ***114,502*** *other drugs of concern (apart from principal drug of concern) reported.*

All drugs of concern *refers to all drugs reported by clients including principal drug of concern and all other drugs of concern. In 2004–05, there were a total of* ***249,704*** *drugs of concern reported, either as a principal or other drug of concern.*

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

4.1 Jurisdictions and principal drug of concern

Nationally in 2004–05, alcohol (37%) and cannabis (23%) were the most common principal drugs of concern in treatment episodes, followed by opioids (21% of all closed treatment episodes, with heroin accounting for 17%) and amphetamines (11%).[2] Overall, fewer than 1% of closed treatment episodes were for the principal drugs ecstasy and cocaine (0.4% and 0.3% respectively) (Table 4.1).

Alcohol was the most common principal drug of concern reported in all jurisdictions except Queensland. Alcohol, as the principal drug of concern, accounted for 64% of all treatment episodes in the Northern Territory, 43% in South Australia and the Australian Capital

2 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 heroin use.

Territory, 42% in New South Wales, 37% in Victoria, and 33% in Western Australia. In Tasmania, alcohol and cannabis were the most common principal drugs of concern, each accounting for 31% of closed treatment episodes. Queensland reported the lowest proportion of treatment episodes where alcohol was the principal drug (26%) and the highest proportion of treatment episodes where cannabis was the principal drug (43%). The pattern of principal drugs in Queensland relates largely to the scope of their collection in 2004–05 (namely the inclusion of police diversion and government-provided services but not non-government services; see Section 1.5 for further details).

After alcohol, the three most commonly nominated drugs of concern nationally—cannabis, heroin and amphetamines—varied in their 'position' from state to state. In Victoria, cannabis was the second most common principal drug of concern (23%), followed by heroin (22%) (Table 4.1). Heroin was second most common drug of concern in New South Wales (20% of treatment episodes) and the Australian Capital Territory (27%), followed by cannabis (New South Wales 17%, the Australian Capital Territory 19%). In Western Australia and South Australia, amphetamines were second (26% and 18% respectively), followed by cannabis in Western Australia (19%) and heroin in South Australia (13%).

The pattern of principal drugs of concern varied somewhat in Tasmania and the Northern Territory. After alcohol and cannabis, nicotine was the next most common principal drug of concern in Tasmania (17%), followed by amphetamines (10%) and morphine (6%), while heroin was the principal drug of concern for only 1% of all treatment episodes. In the Northern Territory, cannabis was the second most common principal drug of concern (14%), followed by morphine (10%) and amphetamines (5%). Heroin was the principal drug of concern for fewer than 1% of all treatment episodes in the Northern Territory.

Only a small proportion of closed treatment episodes were for clients who identified nicotine as their principal drug of concern (1.8% or 2,478 treatment episodes). It is important to note, however, that this does not equate to the total number of people in Australia receiving treatment for nicotine use but, rather, to the number of clients who attended a government-funded alcohol and other drug treatment service and nominated nicotine as their principal drug of concern. The relatively low rate of treatment for nicotine identified in this data collection is not surprising, because in most states and territories the majority of people with a nicotine addiction obtain treatment through pharmacies, general practitioners (e.g. advice and nicotine patches) or 'quit' lines. Tasmania recorded the highest proportion of episodes where nicotine was reported as the principal drug of concern (17%), and the Australian Capital Territory had the lowest proportion (0.1%).

In three jurisdictions, there were principal drugs of concern that were notably higher than the corresponding national figures:

- In the Northern Territory, alcohol was the principal drug of concern in 64% of closed treatment episodes compared to the national figure of 37%.
- In Western Australia, amphetamines were the principal drug of concern in 26% of closed treatment episodes compared to the national figure of 11%.
- In the Australian Capital Territory, heroin was the principal drug of concern in 27% of closed treatment episodes compared to the national figure of 17%.

Table 4.1: Closed treatment episodes by principal drug of concern and jurisdiction, Australia, 2004–05[a] (per cent)

Principal drug	NSW	Vic[b]	Qld[c][d]	WA	SA	Tas[e]	ACT	NT	Australia	Total (no.)
Alcohol	41.5	36.8	26.4	32.5	43.4	31.0	42.7	64.4	37.2	50,324
Amphetamines	11.3	6.1	8.7	26.3	17.5	9.8	8.2	5.2	10.9	14,780
Benzodiazepines	2.1	2.4	0.8	1.3	2.5	0.8	1.0	0.5	1.9	2,538
Cannabis	17.4	23.3	42.8	19.1	11.5	31.0	18.6	13.5	23.0	31,044
Cocaine	0.6	0.2	0.1	0.1	0.3	0.0	0.2	0.0	0.3	400
Ecstasy	0.3	0.4	0.7	0.3	0.5	0.7	0.3	0.4	0.4	580
Nicotine	1.3	0.6	6.3	0.5	1.2	16.6	0.1	1.0	1.8	2,478
Opioids										
Heroin	20.1	22.4	5.2	12.0	13.1	0.2	27.4	1.3	17.2	23,193
Methadone	2.4	1.5	1.2	2.3	2.0	2.0	1.2	0.6	1.8	2,454
Morphine	0.7	0.0	2.6	0.1	3.6	5.9	0.2	10.1	1.0	1,389
Total opioids	*24.5*	*23.9*	*10.0*	*14.7*	*20.8*	*9.0*	*28.9*	*12.0*	*20.7*	*28,025*
All other drugs[f]	1.1	6.3	4.1	5.1	2.4	1.1	0.1	3.0	3.7	5,033
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**41,789**	**44,150**	**19,743**	**14,235**	**7,591**	**1,372**	**4,206**	**2,116**	**. .**	**135,202**

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

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

(c) In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and reason for cessation as 'ceased at expiation'. It is possible that the principal drug is not actually cannabis and it is expected that future modifications to data collection processes will enable this possibility to be reflected.

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

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

(f) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7 and Table A4.5.

The proportion of closed treatment episodes where alcohol was reported as the principal drug of concern has remained relatively constant at approximately 37% since 2001–02 (Table 4.2). Heroin and amphetamines as principal drugs of concern have also remained relatively constant over the four reporting periods.

The proportion of treatment episodes where cannabis was reported as the principal drug of concern has marginally increased from 21% (or 23,826 of 113,231 episodes) in 2001–02 to 23% (or 31,044 of 135,202 episodes) in 2004–05[3] (see Chapter 6 for further information on cannabis). Ecstasy as the principal drug of concern doubled between 2001–02 and 2004–05 from 0.2% (or 253 of 113,231 episodes) to 0.4% (or 580 of 135,202 episodes); while cocaine as the principal drug of concern more than halved from 0.7% (or 804 of 113,231 episodes) to

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3 When comparing data across collection years it is important to consider the caveats of the collection, in particular the coverage of in-scope agencies and data completeness. For instance, Queensland supplied data for police diversion clients only for the 2001–02 collection (see Section 1. 5 for further details).

0.3% (or 400 of 135,202 episodes) over the four reporting periods. For trends in the use of alcohol and other drugs in the Australian population see Section 7.3.

Table 4.2: Trends in closed treatment episodes by principal drug of concern, Australia, 2001–02 to 2004–05[(a)]

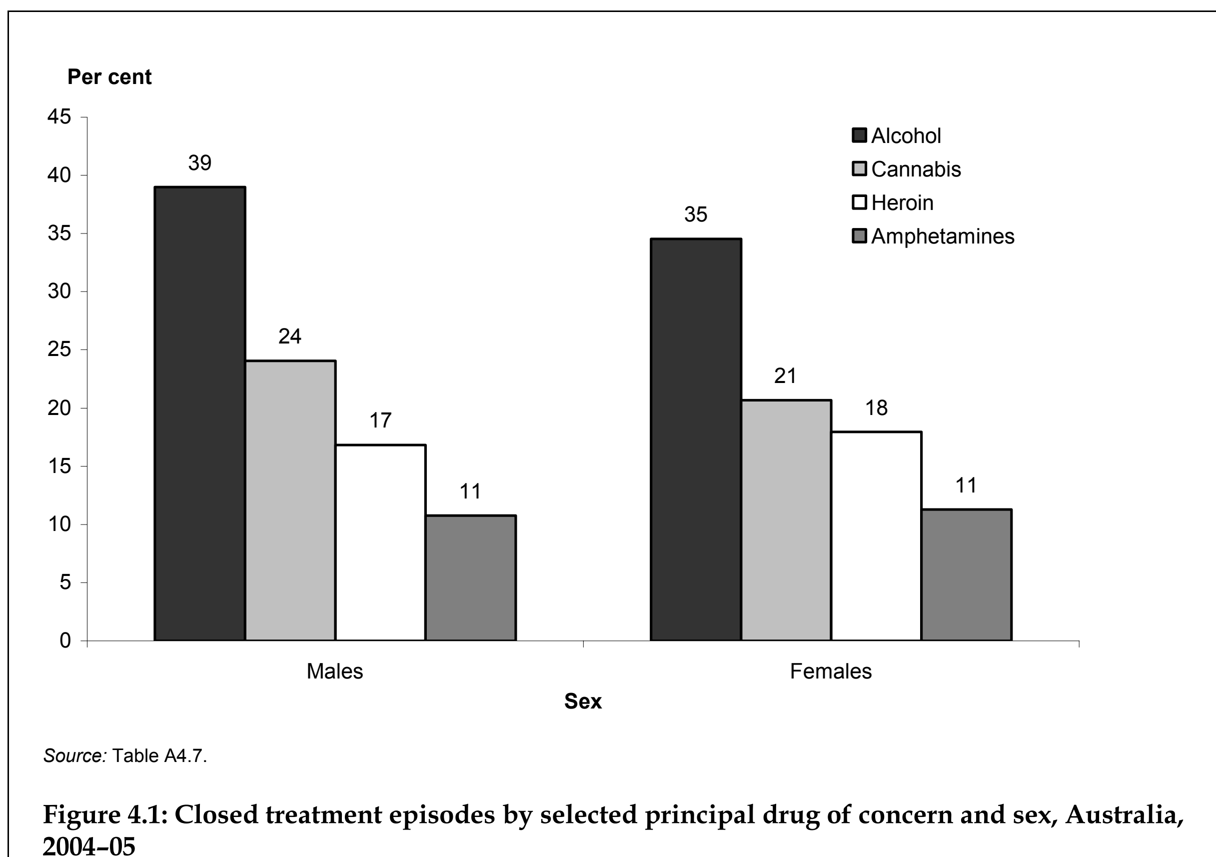
Principal drug of concern	2001–02		2002–03		2003–04		2004–05	
	No.	%	No.	%	No.	%	No.	%
Alcohol	41,886	37.0	46,747	38.0	48,500	37.5	50,324	37.2
Amphetamines	12,211	10.8	13,213	10.7	14,208	11.0	14,780	10.9
Benzodiazepines	2,745	2.4	2,609	2.1	2,711	2.1	2,538	1.9
Cannabis	23,826	21.0	27,106	22.0	28,427	22.0	31,044	23.0
Cocaine	804	0.7	323	0.3	272	0.2	400	0.3
Ecstasy	253	0.2	416	0.3	508	0.4	580	0.4
Heroin	20,027	17.7	22,642	18.4	23,326	18.0	23,193	17.2
Methadone	2,570	2.3	2,173	1.8	2,404	1.9	2,454	1.8
Nicotine	1,602	1.4	1,693	1.4	2,001	1.5	2,478	1.8
All other drugs[(b)]	6,482	5.7	5,434	4.4	6,342	4.9	5,033	5.5
Not stated	825	0.7	676	0.5	632	0.5	8	0.0
Total	**113,231**	**100.0**	**123,032**	**100.0**	**129,331**	**100.0**	**135,202**	**100.0**

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

(b) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7 and Table A4.5.

4.2 Sex, age and principal drug of concern

The principal drugs of concern followed a similar pattern in treatment episodes involving male or female clients in 2004–05 (Figure 4.1). Alcohol was the most commonly recorded principal drug of concern for both sexes (39% for males and 35% for females), followed by cannabis (24% for males and 21% for females) and heroin (17% for males and 18% for females). The proportion of treatment episodes where amphetamines were recorded as the principal drug was 11% for both males and females. These proportions were almost identical in 2003–04—alcohol (39% for males and 35% for females), cannabis (23% for males and 20% for females), heroin (18% for males and 19% for females), and amphetamines (11% for both males and females) (AIHW 2005a).



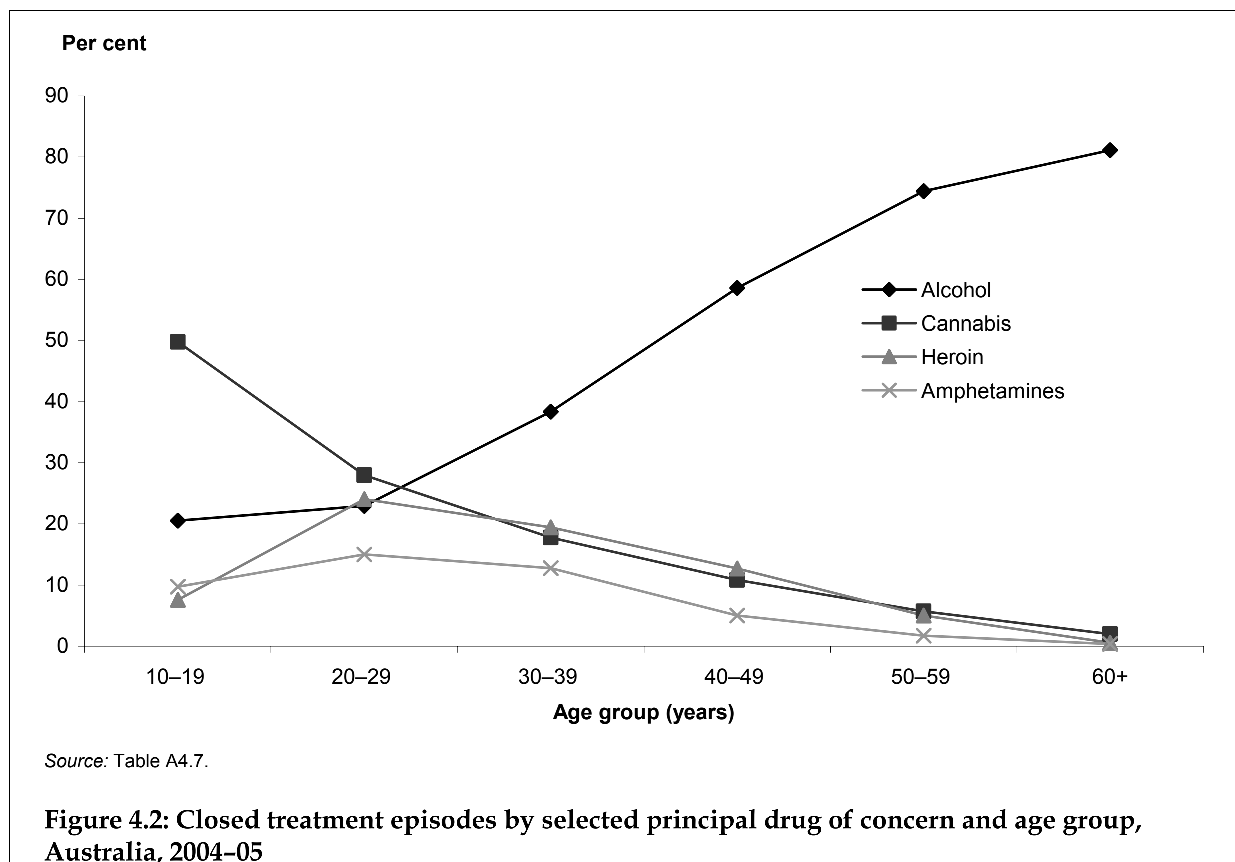
Source: Table A4.7.

Figure 4.1: Closed treatment episodes by selected principal drug of concern and sex, Australia, 2004–05

The principal drug of concern in a treatment episode was strongly related to the client's age. For closed treatment episodes involving clients in the 10–19 year age group, the most commonly reported principal drug was cannabis (50%) (Figure 4.2). This proportion varied by sex—53% for males in this age group and 43% for females (Table A4.7). Alcohol was the second most commonly reported principal drug (21%) in this age group, followed by amphetamines (10%) and heroin (8%).

For closed treatment episodes involving 20–29-year-olds, there was a fairly even distribution of drugs of concern with cannabis being the drug most commonly recorded (28%), followed by heroin (24%) and then alcohol (23%). This pattern varied by sex—for males in this age group cannabis (29%) was the most commonly reported principal drug, followed by alcohol (25%) and heroin (22%), while for female clients, the most commonly reported principal drug was heroin (28%), followed by cannabis (25%) and alcohol (18%).

Clients aged 30 years and over were much more likely to report alcohol as their principal drug of concern than younger clients (50% or 36,191 of 72,010 episodes for clients aged 30 plus years compared with 22% or 13,808 of 61,887 episodes for clients aged 10–29 years). This proportion was highest among males and females aged 60 years and over (86% and 73%, respectively).



Source: Table A4.7.

Figure 4.2: Closed treatment episodes by selected principal drug of concern and age group, Australia, 2004–05

4.3 Country of birth and principal drug of concern

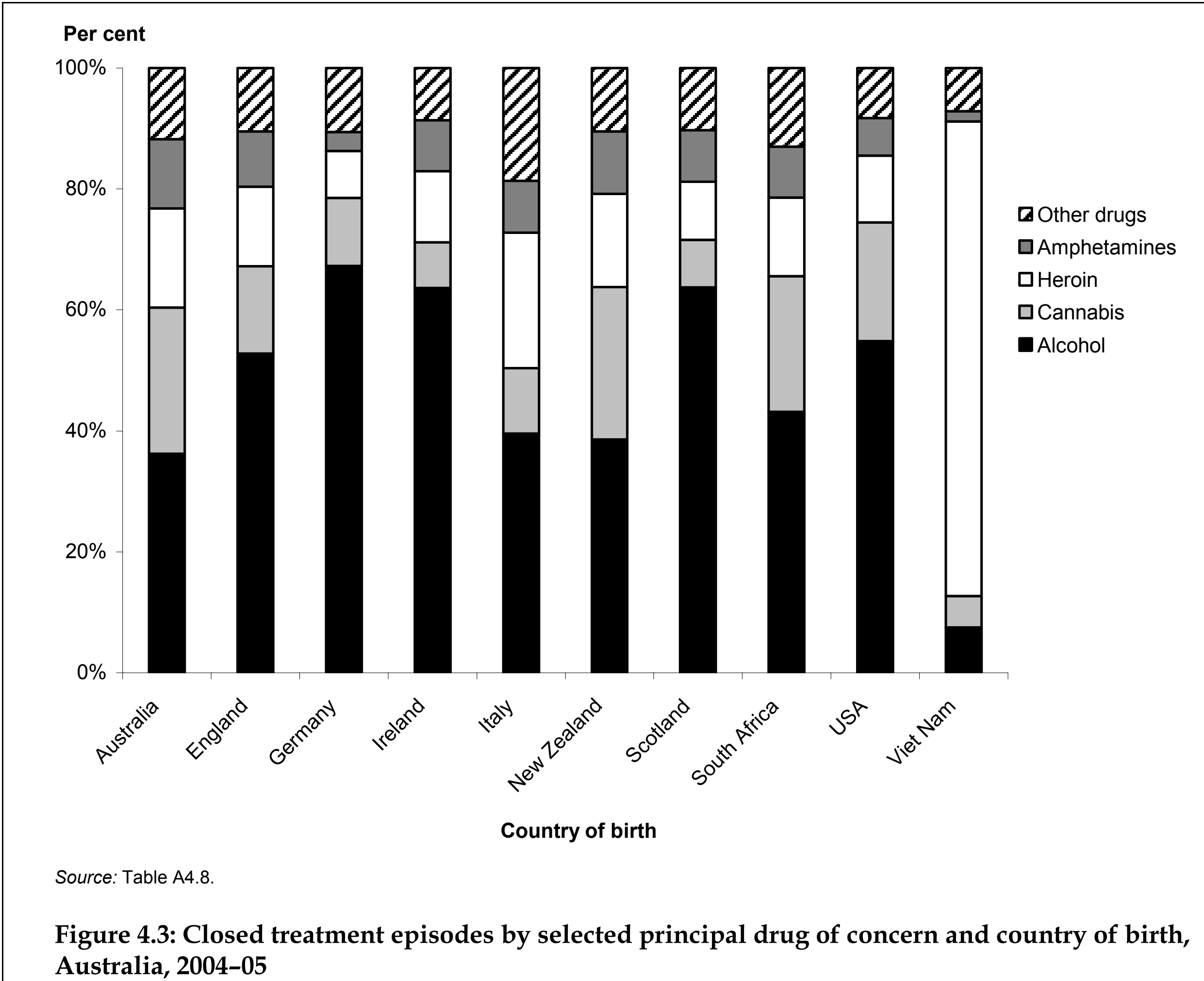
The distribution of the principal drug of concern varied somewhat with the client's country of birth (Figure 4.3). For closed treatment episodes where clients reported being born in Australia, 36% reported alcohol as their principal drug of concern, followed by cannabis (24%) and heroin (16%). This pattern was reflected for clients born in a number of other countries, including England (53% alcohol, 15% cannabis and 13% heroin), Germany (67%, 11% and 8% respectively), New Zealand (39%, 25% and 15% respectively), South Africa (43%, 22% and 13% respectively) and the United States of America (55%, 20% and 11% respectively).

The countries of birth reporting the highest proportion of closed treatment episodes for alcohol as the principal drug were Germany (68%), followed by Scotland and Ireland (64% each). In contrast, closed treatment episodes for clients born in Viet Nam reported the lowest proportion of episodes where alcohol was the principal drug (8%) and the highest proportion of episodes where the principal drug of concern is heroin (79%).

The highest proportions of treatment episodes where cannabis was reported as the principal drug of concern were for clients born in New Zealand and Australia (25% and 24% respectively), followed by South Africa (22%) and the United States of America (20%). Similarly, clients born in Australia and New Zealand had the highest proportions of treatment episodes where amphetamines were reported as the principal drug of concern (12% and 10% respectively).

It is important to note that the age distributions of migrants from these countries are not the same. For example, migrants from the United Kingdom and European countries are likely to

be older than those from many Asian countries (ABS 2006). Given the strong relationship between age and principal drug of concern, it is not surprising that alcohol is the most likely drug of concern for most European migrants seeking treatment.



Source: Table A4.8.

Figure 4.3: Closed treatment episodes by selected principal drug of concern and country of birth, Australia, 2004–05

4.4 Indigenous status and principal drug of concern

Overall, closed treatment episodes involving Aboriginal and Torres Strait Islander clients were most likely to involve the same four principal drugs of concern as the population overall—alcohol (43%), cannabis (23%), heroin (12%) and amphetamines (11%)— however, alcohol was more likely to be nominated (43%, compared with 37%) and heroin less so (12%, compared with 18%) (Table 4.3).

As previously noted, data relating to Indigenous status should be interpreted with caution for a number of reasons, in particular the relatively high proportion of treatment episodes where Indigenous status was 'not stated' (5%) (see Section 1.5 for further details).

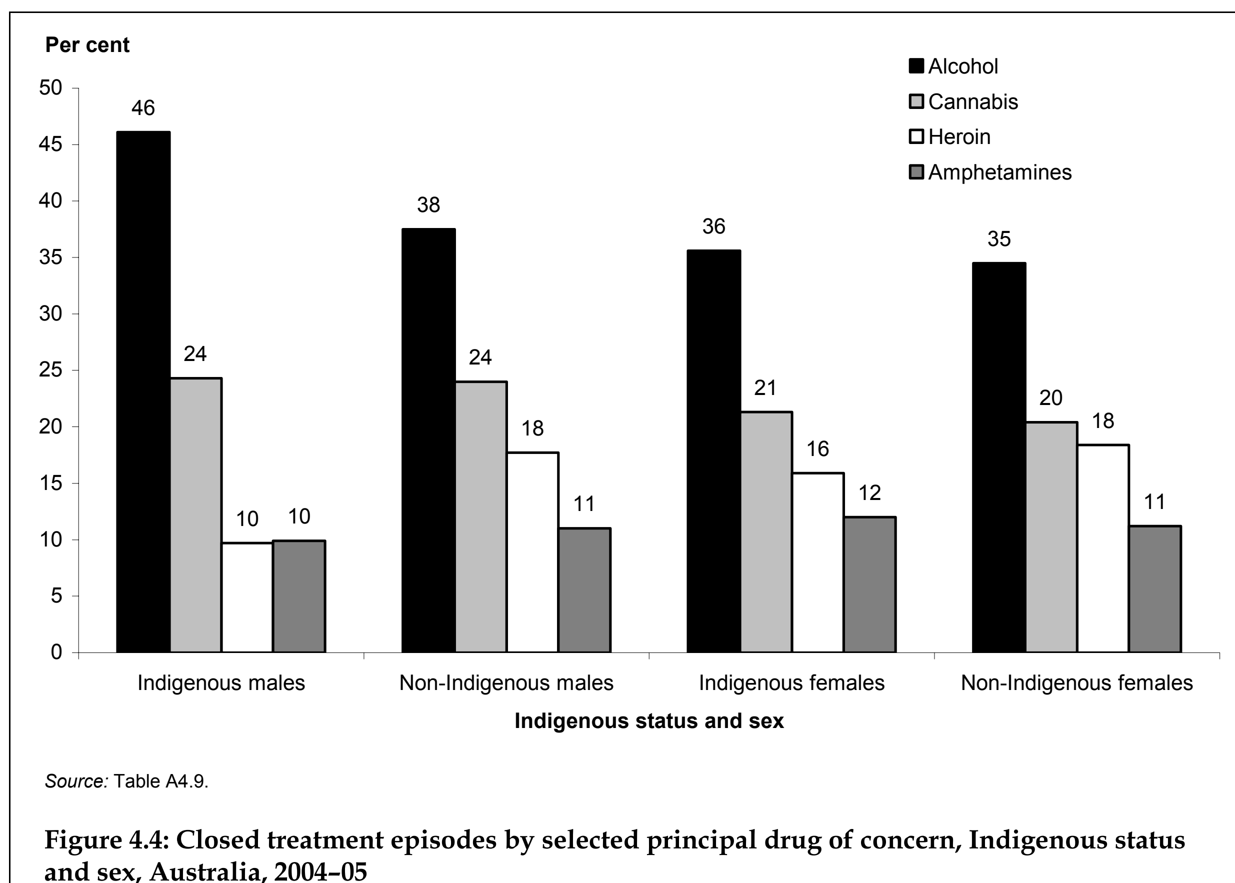
Table 4.3: Closed treatment episodes by principal drug of concern and Indigenous status, Australia, 2004–05[(a)]

Principal drug of concern	Indigenous		Non-Indigenous		Not stated		Total	
	No.	%	No.	%	No.	%	No.	%
Alcohol	5,647	42.5	41,984	36.6	2,693	38.0	50,324	37.2
Amphetamines	1,408	10.6	12,695	11.1	677	9.5	14,780	10.9
Benzodiazepines	138	1.0	2,268	2.0	132	1.9	2,538	1.9
Cannabis	3,091	23.3	26,248	22.9	1,705	24.0	31,044	23.0
Cocaine	17	0.1	367	0.3	16	0.2	400	0.3
Ecstasy	15	0.1	548	0.5	17	0.2	580	0.4
Heroin	1,570	11.8	20,546	17.9	1,077	15.2	23,193	17.2
Methadone	177	1.3	2,142	1.9	135	1.9	2,454	1.8
Nicotine	206	1.6	2,126	1.9	146	2.1	2,478	1.8
All other drugs[(b)]	1,011	7.6	5,905	5.1	495	7.0	7,411	5.5
Total	**13,280**	**100.0**	**114,829**	**100.0**	**7,093**	**100.0**	**135,202**	**100.0**
Per cent of Indigenous status	***9.8***	*..*	***84.9***	*..*	***5.2***	*..*	***100.0***	*..*

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

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

The pattern of principal drug of concern among treatment episodes for Aboriginal and Torres Strait Islander clients also varied according to clients' sex (Figure 4.4). Forty-six per cent of treatment episodes for male clients identifying as being of Aboriginal and/or Torres Strait Islander origin involved alcohol as the principal drug of concern, compared with 38% for other male clients; while 36% of closed treatment episodes for female Aboriginal and Torres Strait Islander clients involved alcohol as the principal drug of concern, only one per cent higher than that reported by other female clients (35%). As part of this pattern of sex differences, treatment episodes for female Indigenous clients were somewhat more likely than those for male Indigenous clients to involve heroin as the principal drug of concern (16% of all treatment episodes compared with 10%). This difference was not found for non-indigenous clients, where 18% of treatment episodes involved heroin as the principal drug of concern for both males and females.



Source: Table A4.9.

Figure 4.4: Closed treatment episodes by selected principal drug of concern, Indigenous status and sex, Australia, 2004–05

4.5 Geographical location and principal drug of concern

In 2004–05, 71% of all closed treatment episodes related to clients receiving services in major cities, 20% in inner regional and 9% in outer regional areas, with few closed treatment episodes in remote (1%) and very remote areas (0.1%) (see Appendix 6 for information on how these categories are derived). These proportions are very similar to those in previous reporting periods (AIHW 2003, 2004a, 2005a).

Across all areas, alcohol was the most commonly reported drug of concern in 2004–05 (36% major cities, 41% inner regional, 38% outer regional, 72% remote areas and 83% very remote areas—Table 4.4). In all areas except major cities, the second most commonly reported drug of concern was cannabis (28% inner regional, 33% outer regional, 16% remote and 15% very remote). In major cities heroin was the second most commonly reported drug of concern (22%), followed by cannabis (21%) and amphetamines (12%).

Caution should be used when interpreting geographical data—especially for remote and very remote areas—because of the small population in some areas. Furthermore, the number of agencies, and hence episodes, located in major cities may be overrepresented because some treatment agencies, particularly in non-metropolitan areas, were reported only under the main administrative centre of the services. Geographical location may also have an effect on the type of treatment services available, especially in more remote areas, with the focus of the services available possibly targeted to a particular substance.

Table 4.4: Closed treatment episodes[(a)] by principal drug of concern and geographical location, Australia, 2004–05 (per cent)

Principal drug of concern	Major cities	Inner regional	Outer regional	Remote	Very remote	Total[(b)]	Total (number)[(b)]
Alcohol	35.5	40.9	38.3	71.7	83.3	37.2	50,324
Amphetamines	11.8	9.8	7.3	4.5	0.0	10.9	14,780
Benzodiazepines	2.1	1.5	1.1	0.2	0.0	1.9	2,538
Cannabis	20.5	28.1	32.5	16.3	15.1	23.0	31,044
Cocaine	0.4	0.2	0.1	0.0	0.0	0.3	400
Ecstasy	0.5	0.3	0.4	0.2	0.0	0.4	580
Heroin	21.6	8.8	2.5	1.1	0.0	17.2	23,193
Methadone	1.9	1.8	1.0	0.4	0.0	1.8	2,454
Nicotine	1.3	2.8	3.8	1.6	1.6	1.8	2,478
All other drugs[(c)]	4.5	5.7	13.0	4.1	0.0	5.5	7,411
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**..**
Total (number)	**95,304**	**26,382**	**11,970**	**1,420**	**126**	**..**	**135,202**
Per cent of location	***70.5***	***19.5***	***8.9***	***1.1***	***0.1***	***100.0***	***..***

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

(b) Includes 'not stated' for location.

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

4.6 Source of referral and principal drug of concern

In 2004–05, self referral was the most common source of referral for clients seeking treatment for their own drug use (36%), followed by referrals from alcohol and other drug treatment services (12%) and correctional services (10%) (Table 4.5). The proportion of closed treatment episodes that followed self-referral decreased slightly from 40% in 2003–04 to 36% in 2004–05. For other sources of referral, the proportion of closed treatment episodes that followed remained relatively stable, with the exception of referrals through court diversion which increased from 2% (or 2,221 of 129,331 episodes) in 2003–04 to 5% (or 7,006 of 135,202 episodes) in 2004–05.

Of treatment episodes where the client self-referred, the principal drug of concern was most likely to be alcohol (40%), followed by heroin (20%) and cannabis (18%). This general pattern was similar for referrals from alcohol and other drug treatment services (38%, 21% and 19% respectively) and from correctional services—although cannabis was slightly more likely than heroin to be the principal drug of concern (alcohol 40%, heroin 20% and cannabis 22%).

Police and court diversion were the only two referral sources where alcohol was not the most commonly reported principal drug of concern. Of closed treatment episodes where the client was referred through the court diversion, 27% involved clients who nominated cannabis as their principal drug of concern, while a higher proportion of episodes where the client was referred through police diversion involved cannabis (80%). It is important to note that in Queensland, clients undergoing police diversion automatically have their principal drug of concern recorded as 'cannabis'.

Table 4.5: Closed treatment episodes[(a)] by principal drug of concern and source of referral, Australia, 2004–05

Principal drug of concern	Self	Family member/ friend	GP/ medical specialist	Hospital	Community mental health service	AODTS	Other community health/care services	Correctional service	Police diversion	Court diversion	Other	Not stated	Total
							(number)						
Alcohol	19,651	2,509	3,409	2,653	1,451	6,078	1,887	5,496	420	1,481	5,038	251	50,324
Amphetamines	5,282	1,192	538	415	370	1,618	626	1,893	374	1,337	1,081	54	14,780
Benzodiazepines	952	86	301	114	111	475	93	100	3	109	191	3	2,538
Cannabis	8,556	1,857	1,004	394	917	2,990	1,238	3,035	6,541	1,900	2,513	99	31,044
Cocaine	144	42	22	2	13	48	11	41	16	29	29	3	400
Ecstasy	157	55	21	7	16	20	11	65	56	108	64	0	580
Heroin	9,597	1,034	950	419	198	3,429	742	2,705	94	1,515	2,461	49	23,193
Methadone	976	107	295	114	29	439	50	111	14	66	247	6	2,454
Nicotine	625	84	341	232	41	91	152	81	476	159	187	9	2,478
All other drugs[(b)]	3,039	358	927	266	128	813	348	368	194	302	620	48	7,411
Total[(c)]	**48,979**	**7,324**	**7,808**	**4,616**	**3,274**	**16,001**	**5,158**	**13,895**	**8,188**	**7,006**	**12,431**	**522**	**135,202**
							(per cent)						
Alcohol	40.1	34.3	43.7	57.5	44.3	38.0	36.6	39.6	5.1	21.1	40.5	48.1	37.2
Amphetamines	10.8	16.3	6.9	9.0	11.3	10.1	12.1	13.6	4.6	19.1	8.7	10.3	10.9
Benzodiazepines	1.9	1.2	3.9	2.5	3.4	3.0	1.8	0.7	0.0	1.6	1.5	0.6	1.9
Cannabis	17.5	25.4	12.9	8.5	28.0	18.7	24.0	21.8	79.9	27.1	20.2	19.0	23.0
Cocaine	0.3	0.6	0.3	0.0	0.4	0.3	0.2	0.3	0.2	0.4	0.2	0.6	0.3
Ecstasy	0.3	0.8	0.3	0.2	0.5	0.1	0.2	0.5	0.7	1.5	0.5	0.0	0.4
Heroin	19.6	14.1	12.2	9.1	6.0	21.4	14.4	19.5	1.1	21.6	19.8	9.4	17.2
Methadone	2.0	1.5	3.8	2.5	0.9	2.7	1.0	0.8	0.2	0.9	2.0	1.1	1.8
Nicotine	1.3	1.1	4.4	5.0	1.3	0.6	2.9	0.6	5.8	2.3	1.5	1.7	1.8
All other drugs[(b)]	6.2	4.9	11.9	5.8	3.9	5.1	6.7	2.6	2.4	4.3	5.0	9.2	5.5
Total[(c)]	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
% of referrals	***36.2***	***5.4***	***5.8***	***3.4***	***2.4***	***11.8***	***3.8***	***10.3***	***6.1***	***5.2***	***9.2***	***0.4***	***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.

(c) Includes ‘not stated’ for principal drug of concern.

4.7 Other drugs of concern

Of the 135,202 closed treatment episodes where clients were seeking treatment for their own drug use in 2004–05, 70,068 episodes (52%) involved at least one other drug of concern—that is, episodes involved a principal drug of concern and at least one other drug of concern (Table 4.6). This proportion varied with the principal drug of concern—in closed treatment episodes where the principal drug of concern was cocaine, amphetamines or heroin, more than 65% of episodes included at least one other drug of concern. Treatment episodes where alcohol and nicotine were reported as the principal drug were least likely to report additional drugs of concern (42% and 33% respectively).

These data indicate the drugs of concern to clients and should not be used as a proxy indicator for poly-drug use.

Table 4.6: Number of closed treatment episodes[(a)] by principal drug of concern, with or without other drug of concern, Australia, 2004–05

Principal drug of concern	With other drugs	With no other drugs	Total closed treatment episodes	Proportion of episodes with 'other drugs' of concern (%)
Alcohol	21,241	29,083	50,324	42.2
Amphetamines	9,753	5,027	14,780	66.0
Benzodiazepines	1,571	967	2,538	61.9
Cannabis	16,148	14,896	31,044	52.0
Cocaine	270	130	400	67.5
Ecstasy	379	201	580	65.3
Heroin	14,395	8,798	23,193	62.1
Methadone	1,536	918	2,454	62.6
Nicotine	815	1,663	2,478	32.9
All other drugs[(b)]	3,960	3,451	7,411	53.4
Total[(b)]	**70,068**	**65,134**	**135,202**	**51.8**

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

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

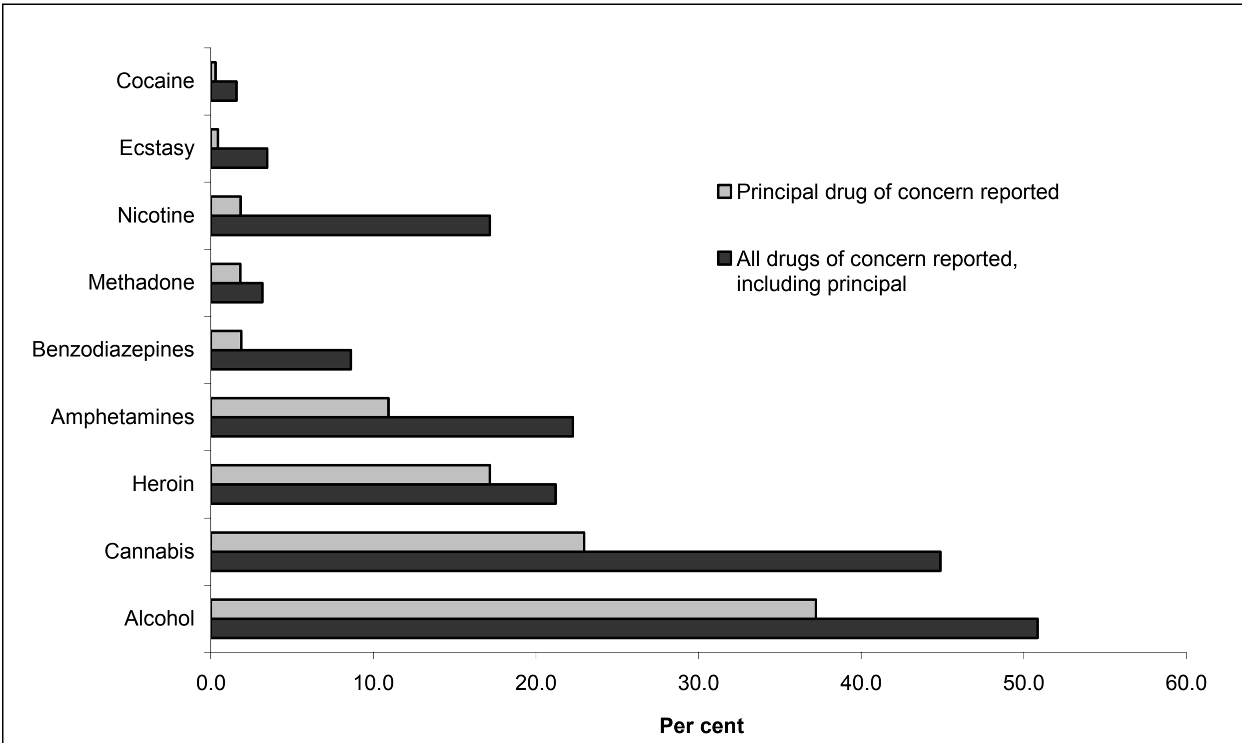
From the 70,068 closed treatment episodes that did involve at least one other drug of concern, 114,502 other drugs of concern were reported (clients are able to report up to five other drugs of concern). This equates to 1.6 other drugs of concern for clients of these treatment episodes.

When all drugs of concern are considered, alcohol and cannabis remain the two most commonly reported drugs of concern (Figure 4.5). Alcohol was reported as the principal drug of concern in 37% of treatment episodes and, when all drugs are considered, 51% of treatment episodes included alcohol as one of the drugs of concern. A similar pattern can be seen for cannabis (identified in 23% of treatment episodes as the principal drug of concern and in 45% of treatment episodes as one of the drugs of concern) (Table A4.10).

Likewise, amphetamines were reported as a principal drug of concern in 11% of treatment episodes, yet when all drugs are considered, 22% of treatment episodes included amphetamines as one of the drugs of concern. Treatment episodes involving benzodiazepines also followed this pattern—2% of treatment episodes involved

benzodiazepines as the principal drug of concern, whereas 9% of treatment episodes included them as a drug of concern. Seventeen per cent of closed treatment episodes involved heroin as the principal drug of concern, rising to 21% when all drugs of concern are considered.

Despite being reported as a principal drug of concern in only 2% of treatment episodes, nicotine was the fifth most common overall, reported in 17% of closed treatment episodes as one of the clients' drugs of concern (see Section 4.1 for further information on nicotine treatment).



Source: Table A4.10.

Figure 4.5: Closed treatment episodes by principal drug of concern and all drugs of concern, Australia, 2004–05

4.8 Injecting drug use and principal drug of concern

For the purposes of the AODTS–NMDS collection, 'injecting drug use' includes drug administration methods such as intravenous, intramuscular and subcutaneous forms of injection.

In 2004–05, 45% of closed treatment episodes involved clients who reported never having injected drugs, 25% involved clients who identified themselves as current injectors (i.e. injected within the previous 3 months) and a further 18% involved clients who reported they had injected drugs in the past (8% between 3 months and 12 months ago and 10% 12 or more months ago) (Table 4.7). Caution should be used, however, when interpreting data for 'injecting drug use' due to the high 'not stated' response for this item (12% of treatment episodes).

A relatively high proportion of closed treatment episodes for clients in the 20–29 and 30–39 year age groups reported being 'current injectors' (33% and 30% respectively), with a significant proportion of clients in these age groups also reporting having injected drugs some time in the past (around 22% of treatment episodes for each age group).

In only a small proportion of treatment episodes were clients aged 50 years and over reported as being 'current injectors' (6% of episodes in the 50–59 year age group and 1% for those aged 60 years and over). A very high proportion of treatment episodes for clients in these age groups were reported as never having injected drugs (73% and 86% respectively).

Table 4.7: Closed treatment episodes[(a)] by injecting drug use and age group, Australia, 2004–05

Injecting drug use	10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total
				(number)				
Current injector	2,281	14,995	11,504	3,722	479	32	303	33,316
Injected 3–12 months ago	887	5,153	3,820	1,237	165	7	85	11,354
Injected 12+ months ago	512	4,320	4,916	2,759	555	28	41	13,131
Never injected	10,185	16,312	14,483	11,886	5,902	2,342	263	61,373
Not stated	2,605	4,637	4,252	2,648	957	316	613	16,028
Total persons	**16,470**	**45,417**	**38,975**	**22,252**	**8,058**	**2,725**	**1,305**	**135,202**
				(per cent)				
Current injector	13.8	33.0	29.5	16.7	5.9	1.2	23.2	24.6
Injected 3–12 months ago	5.4	11.3	9.8	5.6	2.0	0.3	6.5	8.4
Injected 12+ months ago	3.1	9.5	12.6	12.4	6.9	1.0	3.1	9.7
Never injected	61.8	35.9	37.2	53.4	73.2	85.9	20.2	45.4
Not stated	15.8	10.2	10.9	11.9	11.9	11.6	47.0	11.9
Total persons	**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.

The likelihood of having ever injected drugs varied with the client's principal drug of concern. For closed treatment episodes where clients reported heroin as their principal drug of concern, 91% reported being current or past injectors, followed by amphetamines (82%), methadone (81%) and cocaine (53%) (Table A4.11). Closed treatment episodes where nicotine was the principal drug of concern had the lowest proportion of clients who had ever injected drugs (9%).

Almost half (45%) of clients who reported benzodiazepines as their principal drug of concern had injected drugs either some time in the past or were current injectors, while just over one-quarter (26%) of clients who reported cannabis as their principal drug of concern and almost one-fifth of clients who reported alcohol or ecstasy as their principal drug of concern reported being current or past injectors (19% each).

4.9 Method of use and principal drug of concern

As part of the AODTS–NMDS collection, clients are asked to nominate the usual method of administering their principal drug of concern, that is, their 'method of use'. The most likely methods of use in 2004–05 were ingestion (45% of all treatment episodes for clients seeking treatment for their own drug use), followed by injection (26%) and smoking (25%). Inhaling and sniffing were the methods of use for about 2% and 1% of treatment episodes, respectively (Table 4.8).

Most principal drugs of concern involved one main method of use (Table 4.8). Ingestion was the most common method of use when the principal drugs of concern were alcohol (99%), benzodiazepines (93%), ecstasy (88%) or methadone (86%). Injecting was most common method of use for heroin (91%) and amphetamines (77%) and smoking was most common method for cannabis (91%) and nicotine (96%).

Cocaine and 'other drugs' did not appear to have one foremost method of use among clients. Cocaine was sniffed (41%), injected (35%) and smoked (15%). 'Other drugs' were ingested (40%), injected (30%) and inhaled (14%).

Table 4.8: Closed treatment episodes[(a)] by principal drug of concern and method of use, Australia, 2004–05 (per cent)

Principal drug of concern	Ingests	Smokes	Injects	Sniffs	Inhales	Other	Not stated	Total
Alcohol	98.7	0.3	0.1	0.0	0.1	0.1	0.6	100.0
Amphetamines	11.3	4.9	76.5	4.5	0.4	0.2	2.3	100.0
Benzodiazepines	93.1	0.3	4.9	0.2	0.1	0.2	1.3	100.0
Cannabis	1.5	91.1	0.4	0.0	4.6	0.2	2.1	100.0
Cocaine	3.8	14.8	35.0	41.3	2.5	0.3	2.5	100.0
Ecstasy	87.8	1.2	7.1	1.2	0.5	0.3	1.9	100.0
Heroin	1.4	5.5	90.8	0.2	0.8	0.1	1.1	100.0
Methadone	85.5	0.2	12.6	0.0	0.1	0.1	1.5	100.0
Nicotine	1.7	96.4	0.2	0.0	0.8	0.1	0.8	100.0
Other drugs[(b)]	40.0	2.2	29.7	0.5	14.0	1.7	11.9	100.0
Total (per cent)	**44.5**	**24.5**	**26.2**	**0.7**	**2.1**	**0.2**	**1.9**	**100.0**
Total (numbers)	**60,127**	**33,058**	**35,399**	**940**	**2,820**	**315**	**2,543**	**135,202**

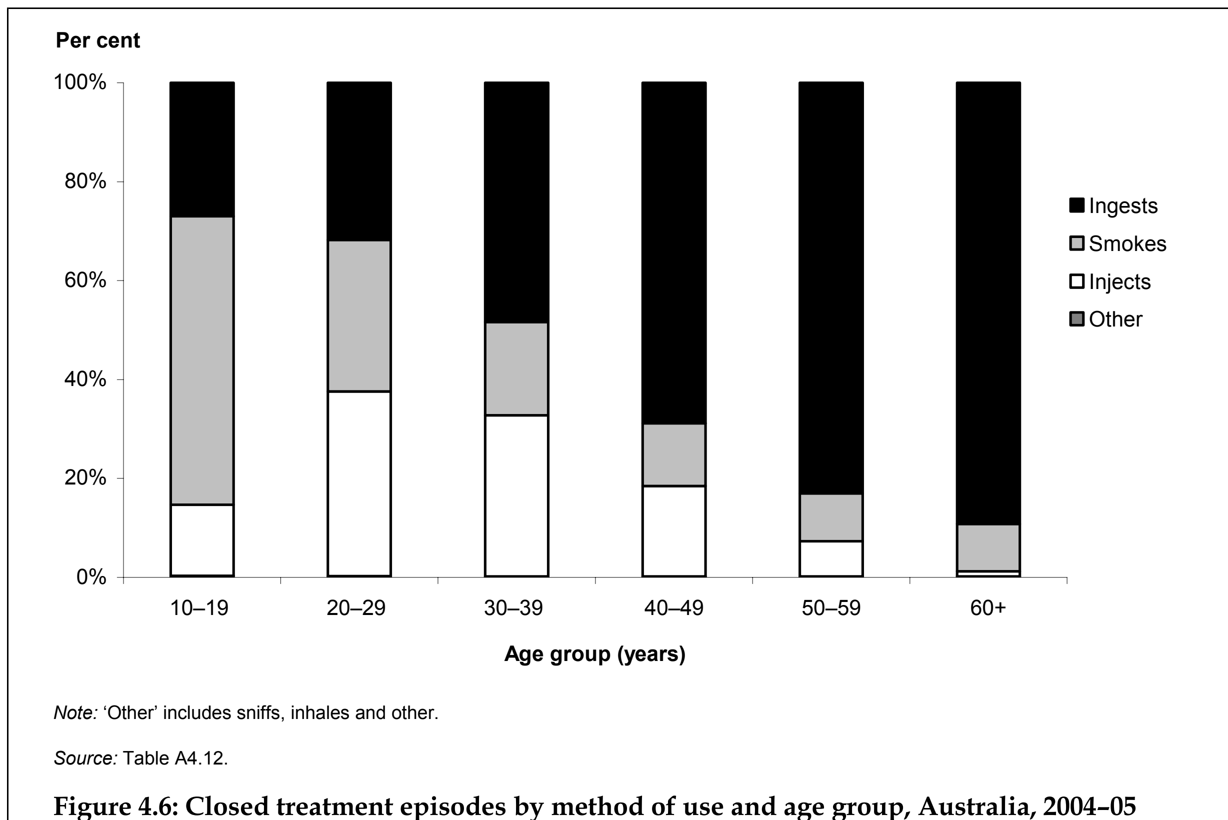
(a) Excludes treatment episodes for clients seeking treatment for the drug use of others.

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

The most common method of use varied with the client's age, with the distribution of the different methods of use among age groups being related to the most common principal drug of concern for the age groups (Figure 4.6). For example, ingestion as a method of use increased in prevalence with age, whereas smoking and injection decreased. This corresponds to alcohol being a more likely principal drug of concern in older years and cannabis, heroin and amphetamines decreasing in likelihood from 20–29 years onwards. More specifically:

- For clients aged 10–19 years, smoking was the most common method of use, related to cannabis being the most common principal drug of concern for this age group.

- For clients aged 20–29 years, injecting was the most common method of use, related to heroin being the second most common principal drug of concern for this age group and amphetamines being commonly nominated as a principal drug of concern by clients in this age group.
- For clients aged 30 years and over, ingestion was the most common method of use, related to alcohol being the most common principal drug of concern for these age groups.



Note: 'Other' includes sniffs, inhales and other.

Source: Table A4.12.

Figure 4.6: Closed treatment episodes by method of use and age group, Australia, 2004–05

4.10 Reason for cessation and principal drug of concern

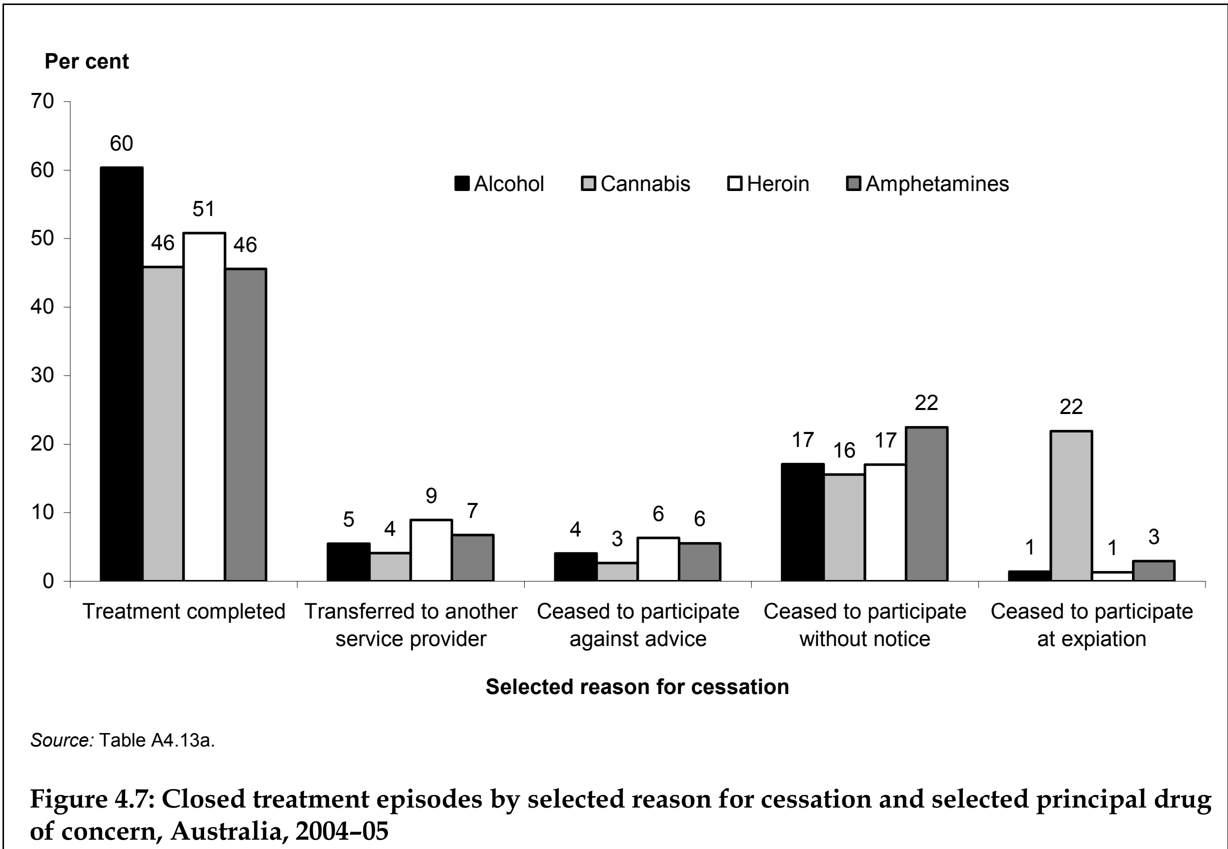
There are a number of reasons a treatment episode can cease, according to the AODTS–NMDS definition. The treatment may be completed, which in the context of this collection means that all of the immediate goals of the treatment plan have been fulfilled. Other reasons include the client ceasing to participate without notice, or by mutual agreement with the service provider, or the client being imprisoned or dying.

In 2004–05, more than half of closed treatment episodes involving clients seeking treatment for their own drug use ceased because the treatment was completed (53%; Table A4.13a). The next most common reason for treatment episodes to end was that the client ceased to participate without notice (17%). The client ceasing to participate at expiation—that is, where the client had completed the required intervention—accounted for 7%, closely followed by the client transferring to another service provider (6%). Only 4% of episodes ended because the client ceased to participate against advice. Nationally, a very small proportion of treatment episodes ceased because the client was imprisoned (0.8%), or because the client had died (0.1%).

This pattern of distribution was similar to that in 2003–04, where 53% of treatment episodes ending involved clients whose treatment was completed, 16% where clients ceased to participate without notice, 7% transferred to another service provider, 8% ceased at expiation and 5% ended treatment against the advice of the service provider (AIHW 2005a).

The reason for cessation varied across treatment episodes according to the principal drug of concern. For example, treatment episodes where alcohol was the principal drug of concern were more likely to end because treatment was completed (60%) than treatment episodes where heroin (51%), cannabis (46%) or amphetamines (46%) were the principal drug (Figure 4.7). Just over one-fifth of all treatment episodes with cannabis as the principal drug ceased at expiation (22%). A relatively high proportion of treatment episodes with amphetamines as the principal drug ended because the client ceased to participate without notice (22%), compared with alcohol, heroin and cannabis (17%, 17% and 16% respectively).

Examining these figures from another angle we see that, of all treatment episodes ending at expiation—that is, where the client had expiated their offence by completing a recognised education or information program—74% involved cannabis as the principal drug of concern[4] (Table A4.13b). Only a small proportion of treatment episodes where alcohol, amphetamines or heroin was the principal drug ended at expiation (8% of episodes for alcohol, 5% for amphetamines and 3% for heroin).



Source: Table A4.13a.

Figure 4.7: Closed treatment episodes by selected reason for cessation and selected principal drug of concern, Australia, 2004–05

4 In Queensland, clients undergoing police diversion automatically have their principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and the reason for cessation as 'ceased to participate at expiation'. It is possible that their principal drug of concern is not actually cannabis. It is expected that future modifications to data collection processes will enable this possibility to be reflected.

5 Treatment programs

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

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

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

Main treatment type *refers to the principal activity, as judged by the treatment provider, that is necessary for the completion of the treatment plan for the principal drug of concern. In 2004–05, main treatment type was reported for* ***142,144*** *treatment episodes.*

Caution should be used when comparing the number of closed treatment episodes for main treatment type from the collection periods 2002–03 to 2004–05 with those of 2001–02. In 2001–02 records from South Australia were excluded from tables using main treatment type as South Australia did not provide this data item. Details of each treatment type included in the AODTS–NMDS are included in Appendix 5.

Main treatment type and principal drug of concern. *In 2004–05, data on the combination of these two data items were reported for* **135,202** *closed treatment episodes. This count excludes closed treatment episodes for clients seeking treatment for the drug use of others.*

Other treatment type *refers to all other forms of treatment provided to the client in addition to the main treatment type (up to four other treatment types can be recorded for each client). In 2004–05, there were* **18,432** *closed treatment episodes which provided a total of* **21,434** *other treatment types. As in previous collections, in 2004–05 closed treatment episodes from Victoria were excluded from any analysis involving 'other treatment types' as Victoria does not provide data for 'other treatment types'.*

All treatment types *refers to all treatment types reported by a client including main treatment and other treatment. In 2004–05, there were a total of* ***163,578*** *treatment types reported, either as a main or other treatment type.*

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

5.1 Jurisdictions and treatment programs

Nationally, counselling (40%) was the most common main treatment type provided within alcohol and other drug treatment services in 2004–05, followed by withdrawal management (detoxification) (18%) and assessment only (12%) (Table 5.1). See Appendix 5 for further details of each treatment type.

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

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

Nationally, 4,299 closed treatment episodes were provided where the main treatment type was pharmacotherapy. This is a small proportion of pharmacotherapy treatment nationally, as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are excluded from the AODTS–NMDS (see also Section 7.4).

Table 5.1: Closed treatment episodes by main treatment type and jurisdiction, Australia, 2004–05 (per cent)

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

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

(b) In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and the reason for cessation as 'ceased to participate at expiation'. It is possible that the principal drug is not actually cannabis and it is expected that future modifications to data collection processes will enable this possibility to be reflected.

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

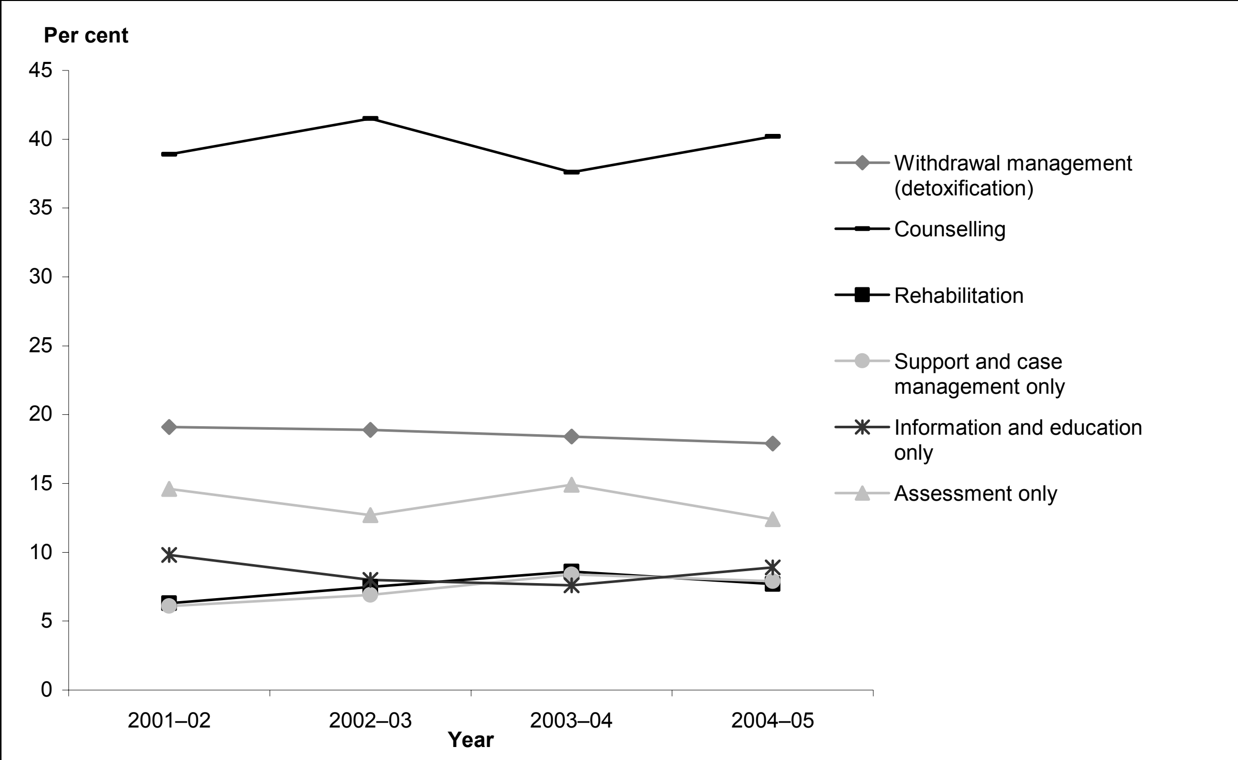
(d) The total number of closed treatment episodes for Tasmania may be undercounted because two agencies only supplied drug diversion data.

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

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

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

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



Source: Table A4.16.

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

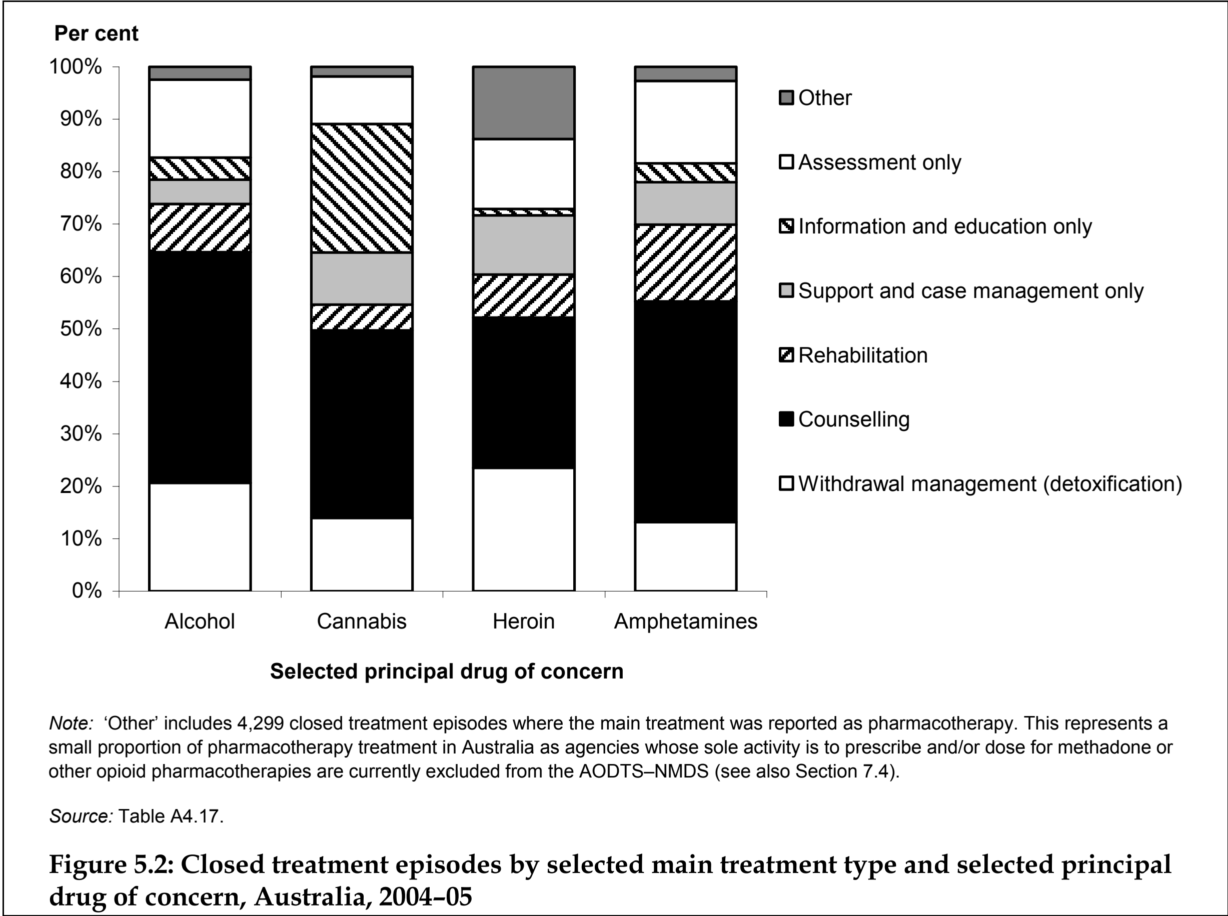
5.2 Main treatment for selected principal drugs

In 2004–05, the main treatment type varied with the principal drug of concern the client sought treatment for. Overall, counselling accounted for the highest proportion of closed treatment episodes when alcohol (44%), cannabis (36%), heroin (29%) and amphetamines (42%) were the principal drug of concern (Figure 5.2). Where alcohol was the principal drug, the next most common treatment type was withdrawal management (detoxification) (21%), followed by assessment only (15%) and rehabilitation (9%).

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

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

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



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

Source: Table A4.17.

Figure 5.2: Closed treatment episodes by selected main treatment type and selected principal drug of concern, Australia, 2004–05

Duration of treatment episode—principal drug of concern

The duration of a closed treatment episode is determined by calculating the number of days between the date the client commenced a treatment episode and the date the client ended the treatment episode. The following analysis investigates duration using the 'median number of days' per treatment episode.

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

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

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

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

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

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

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

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

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

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

5.3 Client type, source of referral and treatment programs

Overall, the most common sources of referral to services in 2004–05 were self-referrals (37% of treatment episodes), followed by referrals from alcohol and other drug treatment services (12%) (Table 5.3). Compared with 2003–04, closed treatment episodes in 2004–05 were slightly less likely to have resulted from self-referral (37%, compared with 41%) and slightly more likely to have resulted from referrals from alcohol and other drug treatment services (12%, compared with 11%) (AIHW 2005a). Section 4.6 contains further information on source of referral, in relation to principal drug of concern.

As noted in Section 3.2, a very high proportion of closed treatment episodes were for clients seeking treatment for their own drug use (95%), and so the pattern of referral for this client group is seen to mirror the overall referral patterns. The referral pattern for clients seeking treatment for others' drug use, however, was different from those seeking treatment for their own drug use. Where treatment is sought for someone else's drug use, a higher proportion of closed treatment episodes followed self-referral (49%) or referral from family members or

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

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

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

(a) Includes residential and non-residential services.

(b) Comprises other residential community care unit; non-residential medical and/or allied health care agency; other non-residential community health care agency/outpatient clinic; and other community service agency.

When closed treatment episodes for clients seeking treatment for their own drug use are considered, the most common main treatments received were counselling (38%), withdrawal management (detoxification) (19%) and assessment only (13%) (Table 5.4). These proportions are very similar to those for the treatment population overall (see Section 5.1).

Of the treatment types used by people seeking treatment for others' drug use, the highest proportion of closed treatment episodes were for counselling (83%), then support and case management and information and education only (6% each).

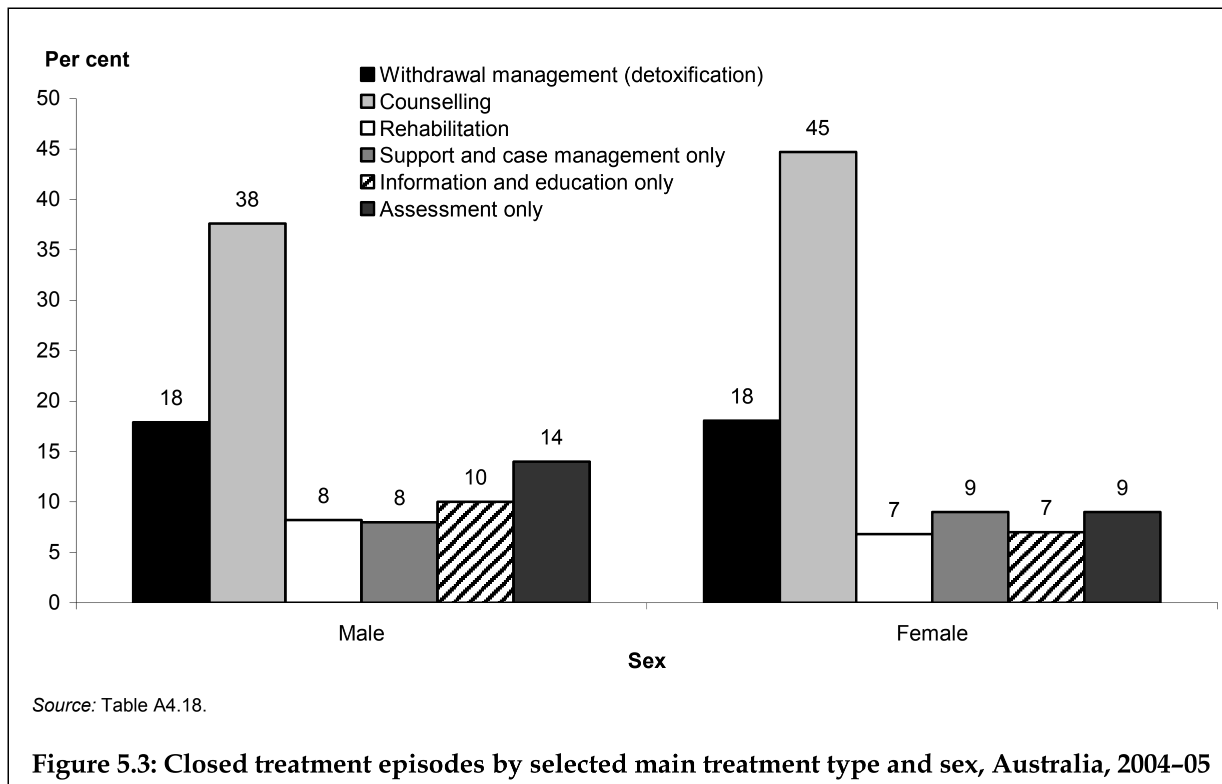
Table 5.4: Closed treatment episodes by client type and main treatment type, Australia, 2004–05

	Own drug use		Others' drug use		Total	
Main treatment type	**No.**	**%**	**No.**	**%**	**No.**	**%**
Withdrawal management (detoxification)	25,457	18.8	1	0.0	25,458	17.9
Counselling	51,308	37.9	5,768	83.1	57,076	40.2
Rehabilitation	10,959	8.1	0	0.0	10,959	7.7
Support and case management only	10,808	8.0	432	6.2	11,240	7.9
Information and education only	12,184	9.0	425	6.1	12,609	8.9
Assessment only	17474	12.9	189	2.7	17,663	12.4
Other[(a)]	7,012	5.2	127	1.8	7,139	5.0
Total	**135,202**	**100.0**	**6,942**	**100.0**	**142,144**	**100.0**

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

5.4 Sex, age and treatment program

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



Source: Table A4.18.

Figure 5.3: Closed treatment episodes by selected main treatment type and sex, Australia, 2004–05

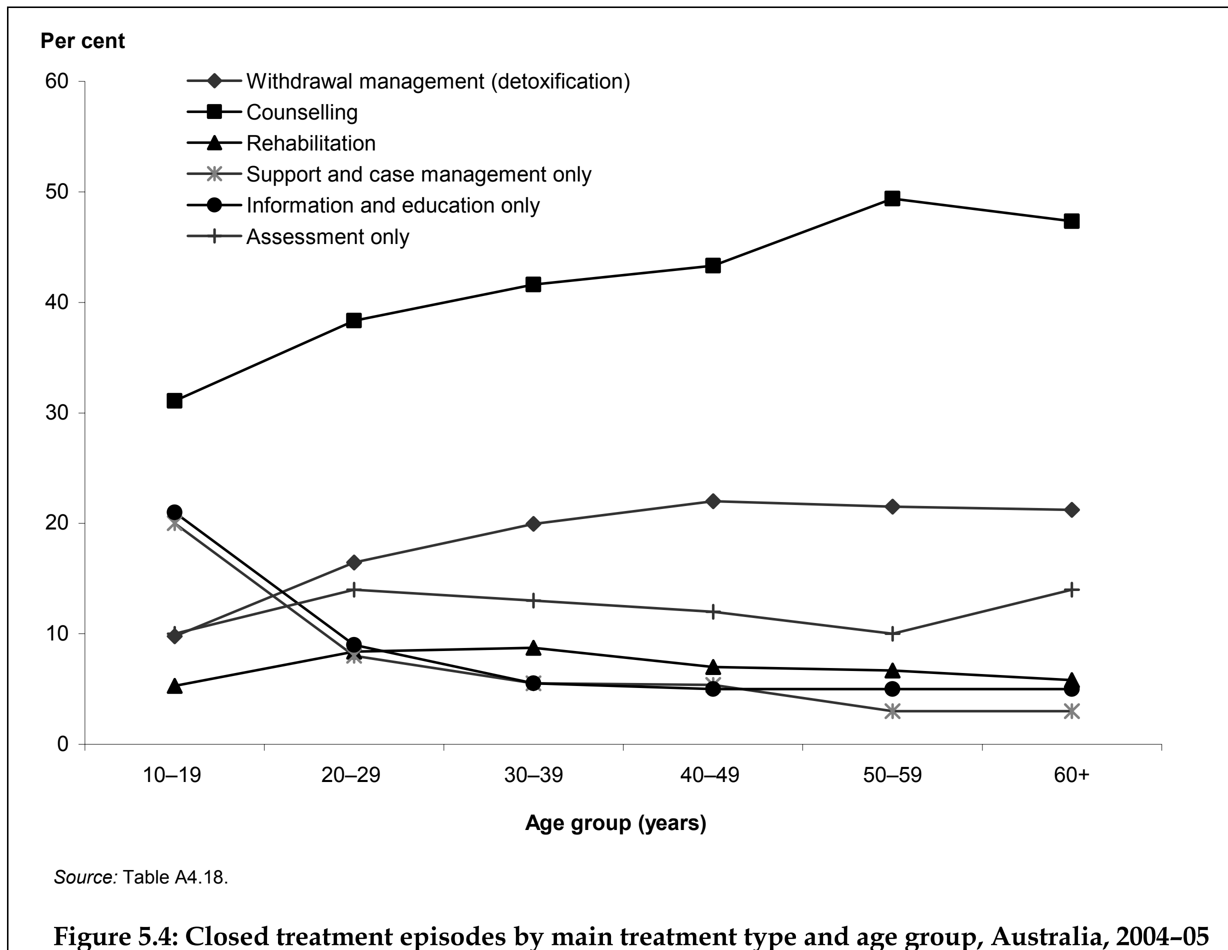
Counselling accounted for 40% of closed treatment episodes nationally in 2004–05; however, the proportion of treatment episodes where counselling was the main treatment increased with the age of the client, from 31% of closed treatment episodes for clients aged 10–19 years to 49% of episodes for clients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

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

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

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

over age groups may be related to the most common principal drug of concern for each age group. For example, cannabis was the principal drug of concern with the highest rate of information and education only as a treatment type (Figure 5.2), and, in the 10–19 year age group, cannabis was the most common principal drug of concern, more common than in the 20–29 year age group (50% compared with 28%) (Figure 4.2). Figure 5.4 shows that information and education only was correspondingly much more common with younger age groups.



Source: Table A4.18.

Figure 5.4: Closed treatment episodes by main treatment type and age group, Australia, 2004–05

5.5 Indigenous status and treatment program

There are a number of differences when comparing treatment types for Aboriginal and Torres Strait Islander clients and other Australians. Closed treatment episodes involving Aboriginal and Torres Strait Islander clients were less likely to have withdrawal management (detoxification) (12% of treatment episodes for Indigenous clients, compared with 19% of episodes for other Australians) or counselling as the main treatment (38% compared with 41%) (Table 5.5). In contrast, treatment episodes involving Aboriginal and Torres Strait Islander clients were more likely to have information and education only and assessment only as the main treatments (13% and 14% respectively), compared with episodes for other Australian clients (8% and 12% respectively).

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

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

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

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

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

5.6 Geographical location and treatment program

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

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

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

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

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

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

(a) The geographical location of treatment agencies in the 2004–05 AODTS–NMDS has been analysed using the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 6).

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

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

5.7 Additional treatments

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

Of the 95,775 closed treatment episodes where clients were seeking treatment in 2004–05, 18,432 episodes (19%) reported at least one other treatment type—that is, a main treatment type and at least one other treatment type (Table 5.7). This proportion varied with the main treatment type—where 'other' treatment type was recorded, 51% of clients reported at least one other treatment type; where withdrawal management (detoxification) was the main treatment type, 41% of clients reported at least one other treatment; and where rehabilitation was the main treatment, 38% of clients reported more than one treatment type. Only 17% of clients reported at least one other treatment type when counselling was the main treatment.

The nature of some treatments—such as support and case management only, information and education only and assessment only—means that they cannot be reported as a secondary treatment type, so these treatments were recorded only as main treatments.

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

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

Main treatment type	With other treatment type	With no other treatment type	Total episodes	Proportion of episodes with other treatment type (%)	*Proportion of episodes with other treatment type 2003–04 (%)*
Withdrawal management (detoxification)	6,176	8,870	15,046	41.0	*45.1*
Counselling	5,887	29,440	35,327	16.7	*15.0*
Rehabilitation	3,521	5,721	9,242	38.1	*36.4*
Support and case management only	—	5,247	5,427	—	—
Information and education only	—	12,286	12,286	—	—
Assessment only	—	13,054	13,054	—	—
Other[(b)]	2,848	2,725	5,573	51.1	*44.0*
Total	**18,432**	**77,343**	**95,775**	**19.2**	*18.8*

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

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

From the 18,432 closed treatment episodes that did report at least one other treatment type, 21,434 other treatment types were reported (clients are able to report up to four other treatment types) (Table A4.15). This equates to an average of 1.2 other treatments for clients of these treatment episodes.

5.8 Reason for cessation and treatment program

As described in Section 4.9, in the AODTS–NMDS there are a number of reasons a treatment episode can end. When all closed treatment episodes are considered, the most common reason for ending a treatment episode in 2004–05 was because the treatment was completed (53%), followed by the client ceasing to participate without notice to the treatment agency (17%)[5] (Table 5.8).

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

5 This number is different from that reported in Chapter 4, as data reported in this chapter include all client types, not just those receiving treatment for their own drug use or their own and someone else's drug use (as is the case in Chapter 4).

(detoxification) (63%), and less likely where the main treatment type was information and education only (23%) (Table 5.8). The low proportion of completed episodes of information and education only related to the fact that the majority of these treatment episodes ended at expiation (61%). This finding may be expected, since expiation, as defined in the AODTS–NMDS, refers to when a client has completed the required education or information program. This relates closely to the use of expiation for cannabis use—70% of all treatment episodes where information and education was the main treatment type involved cannabis as the principal drug of concern[6] (Table A4.17).

A relatively high proportion of treatment episodes for counselling were recorded as ending because the client ceased to participate without notice (26% of all episodes for counselling). Rehabilitation and withdrawal management (detoxification) were the treatment types with the highest proportion of episodes ending with a client ceasing to participate against advice (15% and 10% of treatment episodes respectively).

Table 5.8: Closed treatment episodes by main treatment type and selected reason for cessation, Australia, 2004–05 (per cent)

Main treatment type	Treatment completed	Transferred to another service provider	Ceased to participate without notice	Ceased to participate against advice	Ceased to participate at expiation	Other[(a)]	Total[(b)]	Total (no.)
Withdrawal management (detoxification)	63.4	5.2	10.5	10.4	0.8	9.0	100.0	25,458
Counselling	52.3	4.5	26.1	1.8	2.0	11.9	100.0	57,076
Rehabilitation	37.9	6.4	15.5	15.2	1.1	23.4	100.0	10,959
Support & case management only	56.3	10.2	15.2	1.6	0.7	14.6	100.0	11,240
Information and education only	23.4	1.8	5.6	0.3	60.7	6.5	100.0	12,609
Assessment only	73.9	8.6	6.3	0.7	0.4	7.5	100.0	17,663
Other[(c)]	44.5	14.4	20.5	1.9	0.6	15.5	100.0	7,139
Total (per cent)	**53.2**	**6.0**	**17.1**	**4.1**	**6.5**	**11.6**	**100.0**	**..**
Total (number)	***75,680***	***8,501***	***24,275***	***5,827***	***9,280***	***16,527***	***..***	***142,144***

(a) Includes change in main treatment type; change in delivery setting; change in the principal drug of concern; all other ceased to participate categories; drug court and/or sanctioned by court diversion service; imprisoned other than drug court sanctioned; and died.

(b) Includes 'not stated' for reason for cessation.

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

6 In Queensland, clients undergoing police diversion automatically have the principal drug of concern recorded as 'cannabis', the main treatment type as 'information and education only' and reason for cessation as 'ceased to participate at expiation'. It is possible that the principal drug of concern is not actually cannabis and it is expected that future modifications to data collection processes will enable this to be reflected.

5.9 Treatment delivery setting and treatment program

Treatment delivery setting refers to the setting in which the main treatment is provided—settings include non-residential or residential facilities, homes, outreach settings or other settings. In 2004–05, 70% of treatment episodes occurred at a non-residential facility[7] (Table 5.9). Almost one-fifth (18%) of treatment episodes occurred in residential facilities and 7% in an outreach setting such as a mobile van service.

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

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

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

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

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

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

Duration of treatment episode—treatment delivery setting

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

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

The median duration of treatment episodes involving withdrawal management (detoxification) was 8 days. The highest median length for this treatment type was for clients receiving services at home or in a non-residential treatment facility (17 and 16 days respectively). The shortest median duration for this treatment type was for clients receiving treatment through an outreach setting (4 days).

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

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

(a) As stated in Section 5.2, duration of a closed treatment episode is determined in the AODTS–NMDS by calculating the number of days between the date the client commenced a treatment episode and the date the client ended a treatment episode. This analysis investigates duration using the 'median number of days' per treatment episode for treatment delivery setting.

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

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

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

Treatment delivery setting and principal drug of concern

In 2004–05, for treatment episodes where the treatment delivery setting was either a non-residential treatment facility, a residential treatment facility, the client's home, or an outreach setting, the principal drug of concern of the client was most likely to be alcohol (37%, 42%, 38% and 30% respectively) (Table 5.11). This was similar in 2003–04 (38%, 39%, 39% and 31% respectively) (AIHW 2005a). Cannabis was the next most common principal drug for clients in non-residential facilities (24%), at home (25%) and in outreach settings (30%), followed by heroin for these three treatment delivery settings (16%, 12% and 13% respectively). This pattern was reversed for residential treatment facilities, where heroin was the second most common principal drug of concern (22%), and the third was cannabis (15%).

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

These patterns largely reflect the fact that alcohol, cannabis, heroin and amphetamines are the four most common principal drugs of concern in the AODTS–NMDS for 2004–05.

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

Principal drug of concern	Non-residential treatment facility	Residential treatment facility	Home	Outreach setting	Other	Total
Alcohol	37.3	41.7	38.3	29.9	22.1	37.2
Amphetamines	10.7	12.3	9.5	8.2	17.4	10.9
Benzodiazepines	1.8	2.4	5.0	0.9	0.7	1.9
Cannabis	24.1	14.7	24.5	29.4	31.9	23.0
Cocaine	0.3	0.4	0.0	0.2	0.1	0.3
Ecstasy	0.5	0.1	0.3	0.6	0.1	0.4
Heroin	16.4	21.9	12.1	13.3	19.0	17.2
Methadone	1.8	1.9	2.2	1.5	0.6	1.8
Nicotine	1.6	0.3	0.7	7.1	4.8	1.8
Other drugs[(b)]	5.5	4.2	7.4	8.9	3.4	5.5
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**93,101**	**25,413**	**3,069**	**10,000**	**3,619**	**135,202**
Per cent of closed treatment episodes	***68.9***	***18.8***	***2.3***	***7.4***	***2.7***	***100.0***

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

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

6 Special theme: cannabis

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

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

Box 6.1: Key definitions and counts for closed treatment episodes and treatment programs, 2004–05

Principal drug of concern *refers to the main substance that the client states led them to seek treatment from the alcohol and other drug treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses involving principal drug of concern. It is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2004–05 there were:*

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

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

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

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

6.1 Introduction

What is cannabis and what are its effects?

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

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

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

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

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

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

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

- impaired immune function
- impaired reproductive function
- dependence.

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

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

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

Cannabis and the law

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

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

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

Cannabis use in Australia

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

- Just over one in three (34%) had used cannabis[9] at some stage in their lifetime, and one in nine (11%) had used it at least once in the last 12 months (Table 6.1).
- The 20–29 and 30–39 year age groups were more likely to have ever used cannabis (55% each) than any other age group, while the 20–29 year age group was most likely to have used cannabis in the last 12 months (26%). Males aged 30–39 years were most likely to have ever used cannabis (59%) and males aged 20–29 were most likely to have recently used cannabis (32%).
- Males were more likely than females to have used cannabis in the last 12 months (14% and 8% respectively). This was also true for lifetime use (37% compared with 30% respectively); however, females aged between 14 and 19 years were slightly more likely to have ever used cannabis than males in the same age group (26% and 25% respectively).
- Of those who have ever used cannabis, the average age of initiation was 18.7 years.

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

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

	Ever used[a]			Recent use[b]		
Age group	**Males**	**Females**	**Persons**	**Males**	**Females**	**Persons**
14–19	24.9	26.2	25.5	18.4	17.4	17.9
20–29	57.4	51.6	54.5	32.4	19.5	26.0
30–39	59.1	50.0	54.5	21.4	10.6	15.9
40–49	47.0	36.2	41.6	11.9	5.7	8.7
50–59	27.6	16.5	22.1	4.3	2.1	3.2
60+	5.7	3.3	4.4	0.4	0.2	0.3
Aged 14+	37.4	29.9	33.6	14.4	8.3	11.3

(a) Used at least once in lifetime.

(b) Used in the last 12 months.

Source: AIHW 2005b.

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

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

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

	Males				Females			
Age group	**1995**	**1998**	**2001**	**2004**	**1995**	**1998**	**2001**	**2004**
14–19	35.9	35.0	26.6	18.4 #	20.1	34.2	22.6	17.4 #
20–29	43.7	43.7	35.1	32.4 #	23.4	29.3	23.2	19. 5 #
30–39	19.0	24.1	20.8	21.4	8.2	16.3	11.7	10.6 #
40–49	8.0	16.6	10.7	11.9 #	2.2	6.3	6.6	5.7 #
50–59	1.9	5.6	4.5	4.3	1.2	7.6	2.0	2.1
60+	—	1.1	0.7	0.4 #	0.5	1.2	0.3	0.2
Aged 14+	**18.0**	**21.3**	**15.8**	**14.4 #**	**8.6**	**14.7**	**10.0**	**8.3 #**

(a) Used in the last 12 months.

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

Source: AIHW 2005b.

Cannabis and other drug use

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

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

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

Notes

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

Source: AIHW 2005c.

Availability of cannabis

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

Data from the Illicit Drug Reporting System (IDRS) are compiled through interviews with injecting drug users and key experts who have regular contact with illicit drug users through their work (NDARC 2006; see also Section 7.2 for further details). Although these data are not representative of the population as a whole, they serve as an early warning system for emerging trends in local and national illicit drug markets. Data from the national 2005 IDRS (NDARC 2006) indicated that:

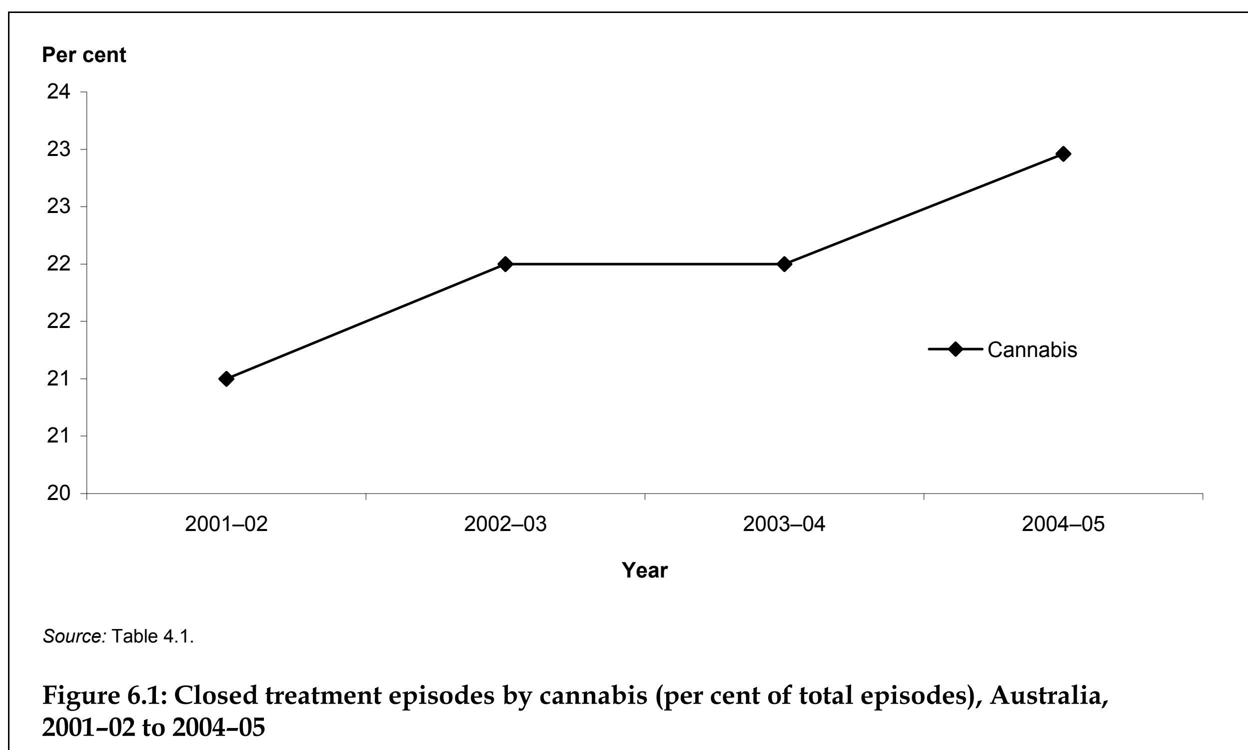
- the majority of interviewees across Australia reported it was 'easy' or 'very easy' to obtain hydroponic cannabis and outdoor cultivated (bush) cannabis (89% and 56% respectively)
- most injecting drug users purchased hydroponic and bush cannabis from a friend or at a dealer's home (75% and 74% respectively)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

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

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

Cannabis as a principal drug of concern

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



Source: Table 4.1.

Figure 6.1: Closed treatment episodes by cannabis (per cent of total episodes), Australia, 2001–02 to 2004–05

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

Results of this analysis showed that:

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

6.2 Client profile

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

Age and sex

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

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

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

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

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

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

(c) Includes 'not stated' for sex.

Method of use

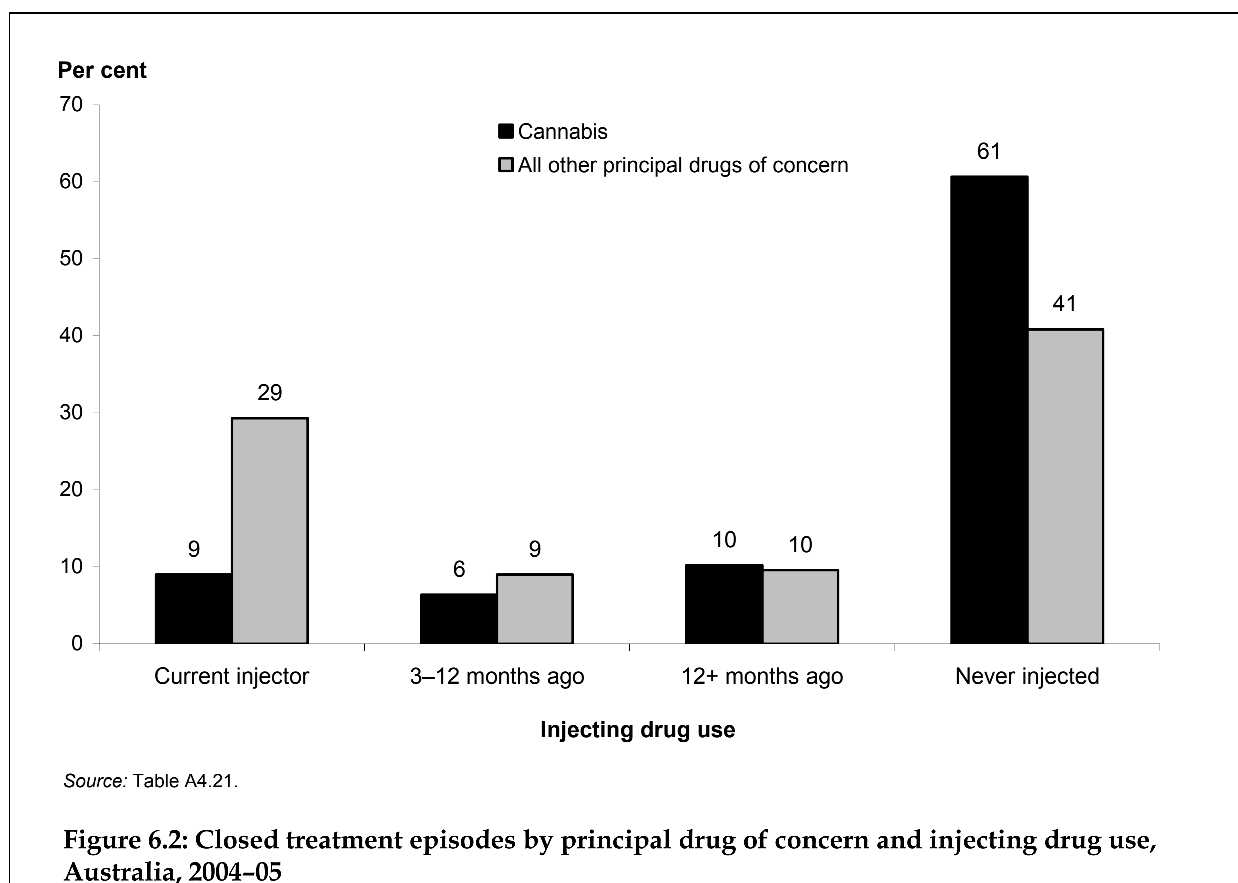
As part of the AODTS–NMDS, clients are asked to nominate the usual method of administering their principal drug of concern, that is, their 'method of use'. As mentioned in Section 4.9 for all closed treatment episodes in 2004–05 the most likely methods of use were ingestion (45%), followed by injection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

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

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

Injecting drug use

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



Source: Table A4.21.

Figure 6.2: Closed treatment episodes by principal drug of concern and injecting drug use, Australia, 2004–05

Other drugs of concern

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

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

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

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

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

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

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

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

Source of referral

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

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

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

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

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

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

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

6.3 Treatment programs

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

Main treatment type

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

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

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

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

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

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

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

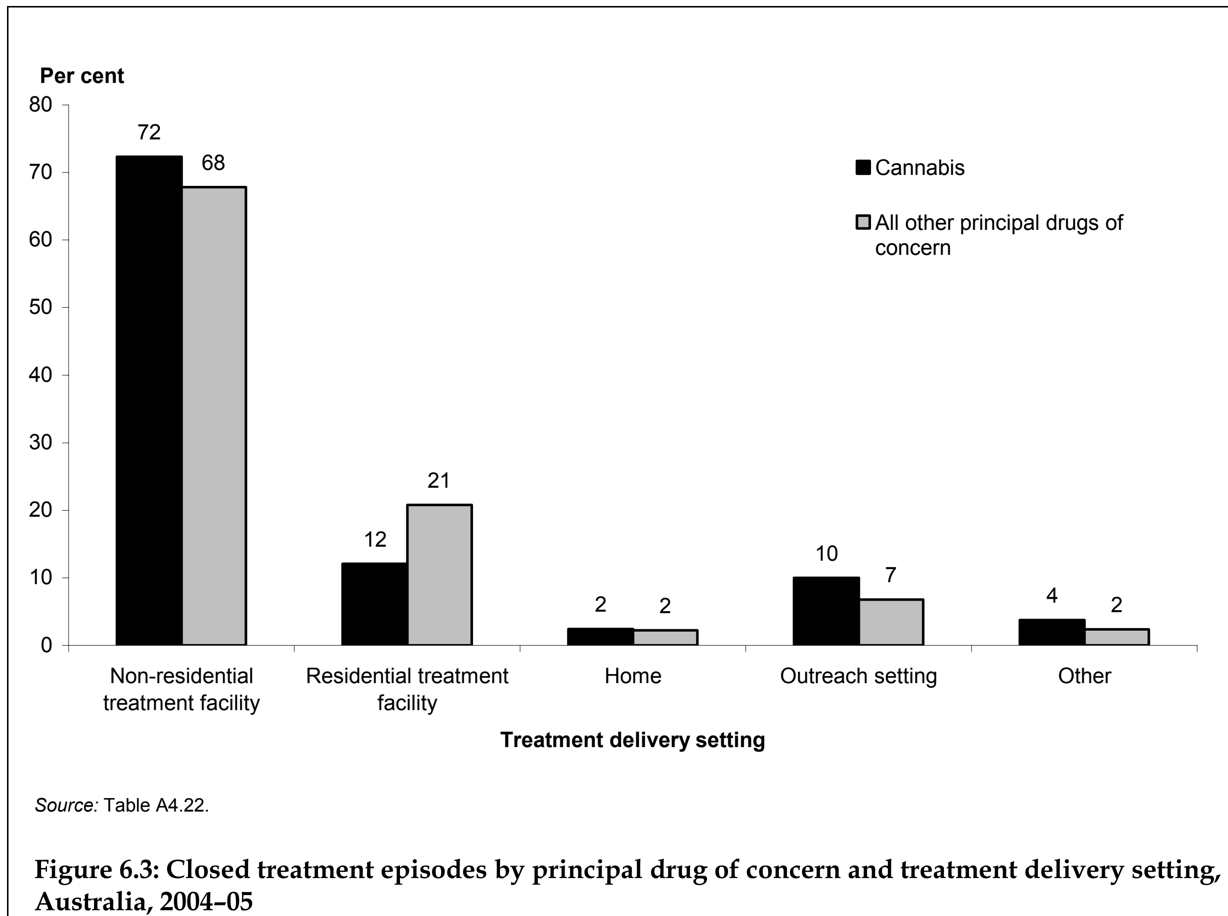
(c) 'Other' includes 4,299 closed treatment episodes (33 episodes for the cannabis group and 4,266 episodes for all other drugs of concern group) where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole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

Treatment delivery setting

In 2004–05, just over two-thirds of all closed treatment episodes were conducted in non-residential treatment facilities (69%), almost one-fifth in residential treatment facilities (19%) and 7% in outreach settings[11] (Table A4.22).

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

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



Source: Table A4.22.

Figure 6.3: Closed treatment episodes by principal drug of concern and treatment delivery setting, Australia, 2004–05

Reason for cessation of treatment episode

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

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

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

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

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

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

7 Other data collections

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

7.1 Background

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

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

In recent times there has been an increased recognition of the importance of drug information systems and great interest in attaining a coordinated approach to data collection. An effective and integrated drug information system should be able to 'address questions about emerging drug trends, general population prevalence, treatment seeking, demographics of drug users, at-risk groups, the drugs–crime nexus, drug-related harms (mortality and morbidity) and the effectiveness of education, health and law enforcement strategies' (Shand et al. 2003). In Australia, data are already collected in all of these areas. For example, the AODTS–NMDS provides data about a large proportion of the treatment-seeking population (those attending government-funded treatment services), the National Drug Strategy Household Survey provides information about national prevalence of drug use and perceptions of drugs, and school-based surveys provide information about at-risk groups. These and a range of other Australian data sources relating to drugs are described below.

7.2 Monitoring alcohol and other drug problems

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

Key data collections relating to alcohol and other drug treatment services

- Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) (annual, from 2000–01).
- Aboriginal and Torres Strait Islander substance use specific services data from the Australian Government Department of Health and Ageing. See for example, Drug and

alcohol service report (DASR): 2003–2004 key results (DoHA 2005a) (annual, from 1999–2000, except for 2001–02).

- Indigenous primary health care services (includes substance use services) data from a joint initiative of the Office for Aboriginal and Torres Strait Islander Health and the National Aboriginal Community Controlled Health Organisations. See, for example, *A national profile of Australian government funded Aboriginal and Torres Strait Islander primary health care services, service activity reporting: 2003–2004 key results* (DoHA 2005b).
- National Opioid Pharmacotherapy Statistics Annual Data Collection (held by AIHW) provides data on the number of pharmacotherapy clients and the type and location of their prescribers (see Section 7.4).
- National Hospital Morbidity database (held by AIHW) on the estimated numbers of hospital episodes and bed-days caused by alcohol, cigarettes and illicit drug use in Australia (see Section 7.3) (annual, from 1993).
- National Mortality database (held by AIHW) for deaths related to alcohol, tobacco and illicit drug use (see Section 7.3) (annual).

Key population surveys relating to drug use and treatment

- National Drug Strategy Household Survey (see Section 7.3) (approximately triennial, from 1985).
- Australian Secondary School Alcohol and Drugs Survey (1996, 1999 and 2002) samples school students aged 12–17 years across Australia and uses a self-completion questionnaire to identify drug and alcohol knowledge, attitudes, awareness and behaviours among secondary school students. The data are collected by the Cancer Council Victoria (approximately triennial, from 1996).

Other data collections and surveys relating to drug use and treatment

The following collections include information of relevance to drug and alcohol use and treatment activities:

- Clients of Treatment Services Agencies: a one-day snapshot census of all clients using drug and alcohol treatment services across Australia, conducted in 1990, 1992, 1995 and 2001 (e.g. Shand & Mattick 2002). This census has effectively been superseded by the AODTS–NMDS.
- The Council of Australian Governments Illicit Drug Diversion Initiative: provides drug users with the opportunity to be diverted from the criminal justice system to receive education, treatment and support to tackle their drug problem (DoHA 2004). All government and non-government agencies funded under this initiative are asked to collect data, and available data are held centrally by the Australian Government Department of Health and Ageing (ongoing).
- Drug Use Monitoring in Australia: an ongoing quarterly collection that measures recent drug use among persons detained by police and includes information on demographic characteristics and financial, criminal, drug use, drug market and treatment activities. Treatment information includes current and previous treatment history, types of

treatment used, substance being treated for and reasons for entering treatment (AIC 2005) (quarterly).

- Drug Use Careers of Offenders: a survey of a random sample from prisons in all states and territories which examines the relationship between drug-using careers and criminal careers. Key objectives are to examine the relationship between illicit drug use and violent and property crime in the adult and juvenile incarcerated population; links between criminal careers and family background and mental health; and the nature of alcohol and other drug treatment both in and outside prison. The interviewer-administered questionnaire includes questions on sociodemographic characteristics, past criminal history, past drug history, illicit drug market activity, offender decision-making processes, estimated costs associated with drug use, and use of alcohol and other drug treatment, including perceptions of effectiveness of treatment currently received (AIC 2004) (irregular).
- Illicit Drug Reporting System: a survey that monitors emerging trends in the use and supply of illicit drugs in Australia. The system collects data annually about the price, purity, availability and patterns of use of heroin, methamphetamine, cocaine and cannabis. The system has three components: interviews with injecting drug users; interviews with key informants (professionals who have regular contact with illicit drug users through their work); and analysis of other sources of indicator data related to illicit drugs. The survey is designed to be sensitive to trends over time rather than to describe issues in detail, and is not based on a representative sample of intravenous drug users (NDARC 2006). The Ecstasy and Related Drugs Reporting System (previously known as the Party Drug Initiative) uses a similar methodology— for example, surveys with regular ecstasy users, interviews with people who have had contact with users, and analysis of existing indicator data sources to monitor emerging issues in party drugs markets. This collection was conducted nationally for the first time in 2003 (see, for example, Breen et al. 2004) (annual).
- Bettering the Evaluation and Care of Health survey data: a continuous survey of general practice activity covering about 100,000 general practitioner–patient encounters each year. Information is available on the number of encounters that provide advice, education, counselling or rehabilitation for alcohol, tobacco and illicit drug use and alcohol and tobacco risk factors (see, for example, AIHW: Britt et al. 2005) (annual).
- National Survey of Mental Health and Wellbeing of Adults (ABS 1998): provided estimates of the population prevalence of the more common forms of illicit drug use and on alcohol use and misuse and comorbid disorders.
- National Coroners Information System: a national Internet-based data storage and retrieval system for coronial cases in Australia. The system draws on coroners' files including police investigation reports, autopsy reports, supporting forensic medical reports and coroners' findings, and the core data set includes case demographics, cause of death details, and incident information such as the activity the person was engaged in at the time of death (MUNCCI 2004) (ongoing).
- National Community Mental Health Care Database (held by AIHW): contains information on non-admitted-patient service contacts provided by public community mental health establishments. Data include basic demographic details of patients such as date of birth and sex, clinically relevant information such as principal diagnosis and mental health legal status, and the date of service contact (e.g. AIHW 2005d) (annual).

- Australian Needle and Syringe Programme Survey: collected and collated by the National Centre in HIV Epidemiology and Clinical Research annually since 1995. This collection surveys intravenous drug users to monitor the prevalence of HIV and hepatitis (B and C) among injecting drug users and examines injecting and sexual behaviours associated with these infections (NCHECR 2005).

Detailed information on a range of data sources relating to substance use and mental health disorders is available from the AIHW publication *National comorbidity initiative: a review of data collections relating to people with coexisting substance use and mental health disorders* (2005e). Also, information on a range of national data sources relating to drug use among Aboriginal and Torres Strait Islander peoples is due for release in 2006 (AIHW forthcoming). A report detailing a range of data sources relating to alcohol is available from the AIHW publication *A guide to Australian alcohol data* (AIHW 2004b), and information on a range of national sources of data relating to illicit drug use is available from the ABS publication *Illicit drug use, sources of Australian data* (ABS 2001).

The following sections outline more detailed information from the National Drug Strategy Household Survey, National Hospital Morbidity database, National Mortality database, and pharmacotherapy client statistics.

7.3 Use, mortality and morbidity data

This section provides an overview of trends in alcohol and other drug use, as well as trends in mortality and morbidity that can be attributed to the use of alcohol and other drugs.

National Drug Strategy Household Survey

The National Drug Strategy Household Survey provides information on patterns and trends in the use of alcohol and other drugs in the Australian population. Surveys have been conducted every 2 to 3 years from 1985 onwards, with the most recent survey conducted in 2004. The 1998, 2001 and 2004 surveys have been managed by the AIHW on behalf of the Australian Government Department of Health and Ageing.

In 2004, almost 30,000 participants aged 12 years and over were surveyed from a stratified random sample of households across Australia. As the sample was based on households, it excluded homeless and institutionalised persons which is consistent with previous years. Participants in the 2004 survey were asked about their knowledge of and attitudes towards drugs, their drug consumption histories, and related behaviours (AIHW 2005b, 2005c).

In 2004, more than four-fifths (84%) of Australians aged 14 years and over had recently consumed alcohol and more than one-fifth (21%) smoked tobacco (Table 7.1). Illicit drugs were used by fewer than one in six Australians (15%) in the last 12 months. Marijuana/cannabis was the most commonly used illicit drug in 2004, with 11% of the population aged 14 years and over using the drug in the last 12 months. A much smaller proportion of Australians aged 14 years and over had used other illicit drugs such as ecstasy (3%), cocaine (1%), hallucinogens (1%) or heroin (0.2%).

Between 1993 and 2004, the proportion of the population who had recently consumed alcohol increased from 73% to 84%, with a significant increase occurring between 2001 (82%) and 2004 (84%) (Table 7.1). Comparisons between recent tobacco use are only possible between 1998 and 2004 due to a change in definition (see AIHW 2005c for further details).

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

With few exceptions, the proportion of the population using illicit drugs generally declined between 1993 and 2004. For example, the proportion of the population aged 14 years and over recently using marijuana/cannabis declined from 13% in 1993 to 11% in 2004 (see Chapter 6 for further details on cannabis). Overall, the use of any illicit drugs in the last 12 months prior to the NDSHS being conducted dropped significantly from 17% in 2001 to 15% in 2004.

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

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

(a) Used in the last 12 months. For tobacco and alcohol, 'recent use' means daily, weekly and less than weekly smokers and drinkers.

(b) For non-medical purposes.

(c) Non-maintenance.

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

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

n.a. not available

2001 result significantly different from 2004 result (2-tailed α = 0.05).

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

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

People aged 20–29 years were more likely to have used an illicit drug in the 12 months prior to the 2004 NDSHS—32% of 20–29-year-olds compared with 21% of 14–19-year-olds, 20% of 30–39-year-olds, and 7% of people aged 40 years and over (Table 7.2). People in the younger age groups (14–19 years and 20–29 years) were more likely to have used marijuana/cannabis, inhalants, heroin and hallucinogens in the previous 12 months compared with people in older age groups. Cocaine is the only illicit drug that was more likely to have been used by people in the 30–39 year age group than people in the 14–19 year age group.

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

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

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

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

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

Alcohol and other drug treatment reported by the population

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

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

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

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

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

Mortality and morbidity attributable to tobacco, alcohol and illicit drug use

Mortality

The misuse of alcohol and the use of tobacco and illicit drugs are responsible, directly and indirectly, for a considerable number of accidents, injuries, illnesses and deaths. Various estimates of mortality attributable to alcohol, tobacco and illicit drugs have been calculated. For example:

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

Morbidity

There were 74,917 hospital separations reported in 2004–05 with a substance use disorder as the principal diagnosis (Table 7.4). This represents 1.1% of all separations in Australia in that year (AIHW 2006a). This section refers only to these separations. Separations are reported separately by same day (where the patient was admitted and separated on the same day) and overnight (where the patient spends at least one night in hospital) as well as by drugs of concern.

Hospital separations by drugs of concern

As in previous years, sedatives and hypnotics accounted for the highest number of hospital separations (45,449 or 61% of all separations), with alcohol the main contributor in this category (35,864 or 48% of all separations) (Table 7.4). Fifteen per cent (or 11,238) of all separations reported were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for more than half of this group (52%) and 8% of all separations. Stimulants and hallucinogens accounted for 10% (or 7,518) of all separations.

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

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

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

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

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

Source: AIHW National Hospital Morbidity Database 2004–05.

Same-day versus overnight separations

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

7.4 National pharmacotherapy statistics

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

National Opioid Pharmacotherapy Statistics Annual Data collection 2005

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

The broad goal of treatment for opioid dependence is to reduce the health, social and economic harms to individuals and the community arising from illicit opioid use (IGCD MOTS 2004).

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

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

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

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

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
1998	12,107	5,334	3,011	1,654	1,839	306	406	—	24,657
1999	12,500	6,700	3,341	2,449	1,985	370	559	2	27,906
2000	13,594	7,647	3,588	2,140	2,198	423	615	32	30,237
2001	15,069	7,743	3,745	2,307	2,522	464	641	25	32,516
2002	15,471	7,700	3,896	3,602	2,417	513	590	21	34,210
2003	16,165	8,685	4,289	4,079	2,486	498	686	98	36,986
2004	15,719	10,003	4,470	4,437	2,706	576	748	82	38,741
2005	16,469	10,753	4,440	2,883	2,857	588	764	183	38,937

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

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

Number of clients by prescriber type

Nationally, an estimated 38,937 clients were receiving pharmacotherapy treatment as at 30 June 2005 (Tables 7.5 and 7.6). Of these, the majority of clients received treatment in New South Wales (42%), followed by Victoria (28%), Queensland (11%), and Western Australia[13] and South Australia (7% each). The Australian Capital Territory and Tasmania accounted for 2% each, while the Northern Territory accounted for less than 1% of all the clients receiving pharmacotherapy treatment.

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

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

The category 'public/private prescribers' refers to New South Wales prescribers working in dual clinics, which are private clinics receiving some public funding, and where client data can not be segregated into either section. Clients scripted by 'public/private prescribers' accounted for less than 0.5% of all clients in New South Wales.

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

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

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

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

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

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

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

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

Number of clients by dosing point

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

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

Of the 38,797 clients, the majority were dosed at pharmacies (69%, or 26,615), followed by public clinics (11%), private clinics (8%) correctional facilities (7%) and public/private prescribers (1%). Four per cent of all clients were dosed at a location other than a pharmacy, public or private clinic, correctional facility or public/private prescriber. In most jurisdictions, 'other' dosing point related to clients dosing in a hospital setting, at a community health centre or at a doctor's surgery. In New South Wales, this category included clients where their dosing point was not stated. In the Northern Territory, clients dosing at public clinics or pharmacies can not be distinguished and are in turn reported as 'other'.

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

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

(a) Number of clients on the program at 30 June 2005, except for Western Australia and Queensland, where the number of clients that had picked up a dose at anytime during the month of June 2005 is reported. The 2005 figures reported for Western Australia are substantially lower than the ones reported in 2004, which included the number of clients through the year.

(b) In New South Wales, the total of 'other' includes 651 clients where dosing point was not stated.

(c) In Victoria, specialist methadone services are considered 'private clinics', although they are agencies receiving State Government funding. The total for 'other' includes dosing to out-patients, as well as clients being dosed in public hospitals while in treatment for unrelated conditions.

(d) In Queensland, the total for 'other' comprises 220 clients receiving doses at public and private hospitals, 23 clients receiving doses from doctors and 4 clients receiving doses from a Government Department.

(e) In Queensland, dosing figures are based on the number of clients registered on 30 June 2005 and that had picked up a dose at any time during June 2005. In Queensland, the total number of clients 'registered' (Table 7.6) and 'dosed' (Table 7.7) varies due to outstanding paper work in the jurisdiction.

(f) In South Australia, the total for 'other' refers to a pharmacy department within a state government hospital in a regional area, which dispenses for clients prescribed by local private prescribers.

(g) In the Northern Territory the number of clients dosing at public clinics or pharmacies can not be distinguished. 'Other' comprises 177 clients receiving doses from either a public clinic or a pharmacy.

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

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

Number of pharmacotherapy prescribers

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

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

The data presented in Table 7.8 relate to all 'registered prescribers', except for prescribers in New South Wales, Queensland and South Australia. Prescribers in these states relate to 'active prescribers' only—that is, practitioners who are prescribing at least one client as at 30 June 2005.

Nationally, 1,234 practitioners were authorised to prescribe at 30 June 2005 (Table 7.8). Those registered to prescribe both methadone and buprenorphine accounted for 74% of the total pharmacotherapy prescribers; 26% (or 315) were registered to prescribe methadone only, while only 0.2% (or 2) were registered to prescribe buprenorphine only. Prescribers in South

Australia and the Northern Territory follow a single accreditation process which allows them to prescribe both methadone and buprenorphine.

The majority of prescribers were located in Victoria (35% or 428), followed by New South Wales (34%), Queensland (10%), Tasmania (7%) and Western Australia and South Australia (6% each). The Australian Capital Territory and the Northern Territory had the lowest percentages of prescribers (2% and 1% respectively).

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

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

(a) Data presented in this table relate to all registered prescribers, except in New South Wales, Queensland and South Australia, where active prescribers are counted—that is, prescribers who were scripting at least one client at 30 June 2005.

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

(c) In Victoria, prior to the development of the current training course, prescribers were trained and approved indefinitely to prescribe methadone only, and had to apply separately to become approved to prescribe buprenorphine. Since the implementation of new training, all prescribers undertaking the training in Victoria are approved indefinitely to prescribe methadone and buprenorphine. In Victoria, no prescriber is authorised to prescribe only buprenorphine. However, a small number of practitioners in Victoria (about 3) are authorised to prescribe pharmacotherapy drugs, although they have not undergone the training course for prescribing pharmacotherapy drugs.

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

(e) In South Australia, prescribers are authorised to prescribe both methadone and buprenorphine. The number of prescribers reported in Table 7.8 for South Australia relates only to authorised private and prison active prescribers. This number excludes prescribers working in government drug treatment clinics who are accredited automatically only while employed in that facility.

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

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

Data on opioid pharmacotherapies from the AODTS–NMDS

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

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

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

Reported numbers in the 2004–05 annual report on the AODTS–NMDS do not include the majority of Australian government-funded Aboriginal and Torres Strait Islander substance use services or Aboriginal and Torres Strait Islander primary health care services. These services are generally not under the jurisdiction of the state or territory health authority and are not included in the specific program under which the Australian Government currently reports AODTS–NMDS data. Data are collected in relation to these services under two data collections:

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

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

In 2004–05, 6 out of 41 Australian Government-funded services reporting in the DASR also reported under the AODTS–NMDS and 9 out of 143 Aboriginal and Torres Strait Islander primary health care services, reporting in the SAR, also reported under the AODTS–NMDS. From these 15 agencies, approximately 1,300 closed treatment episodes were reported in the 2004–05 AODTS–NMDS, with 92% of these closed treatment episodes relating to clients who identified as being of Aboriginal and/or Torres Strait Islander origin.

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

*The **DASR** definition of 'episode of care' starts at admission and ends at discharge (from residential treatment/rehabilitation and sobering-up/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 commence a new 'episode of care' when the main treatment type ('treatment type') or primary drug of concern ('substance/drug') changed. It is therefore likely that this concept of 'episode of care' produces smaller estimates of activity than the AODTS–NMDS concept of 'closed treatment episode'.*

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

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

Australian Government-funded Aboriginal and Torres Strait Islander substance use services (Drug and Alcohol Service Report)

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

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

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

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

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

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

In 2004–05, an estimated 4,300 episodes of care were provided for clients accessing sobering-up or residential respite services. Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation. Residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. More than three-fifths (62%) of episodes of care were for male clients.

'Other care' refers to services such as counselling and therapy, after-care follow-up and preventive care, all of which are not residential-based. In 2004–05, there were an estimated 49,600 episodes for other care services. The number of episodes of care for this service group is much higher than for residential-based services because of the way 'episodes' are counted for these services (see Box 7.1). Just over half (51%) of episodes for other care were for male clients.

Table 7.10: Estimated number of 'episodes of care'[(a)] provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services by sex and treatment type, 2004–05

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

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

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

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

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

Note: Figures have been rounded to the nearest hundred.

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

During 2004–05, all (100%) Australian Government-funded Aboriginal and Torres Strait Islander substance use specific services reported providing treatment or assistance for client alcohol use (Table 7.11). Other common substances/drugs for which services provided treatment or assistance included cannabis (95%), multiple drug use (78%), amphetamines and tobacco/nicotine (61% each).

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

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

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

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

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

Aboriginal and Torres Strait Islander primary health care services tackle a range of substance use issues. In many cases, substance use issues are covered on an individual client basis as they arise during client care. Table 7.12 shows the proportion of services that covered substance use issues on an individual basis as they arise by substance/drug type. Most services covered issues relating to alcohol (89%), tobacco/nicotine (84%) or cannabis (82%) on an individual basis as they arose. Around half of all primary health care services had

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

Table 7.12: Substances/drugs for which Australian Government-funded Aboriginal and Torres Strait Islander primary health care services cover substance use issues on an individual basis as they arise, 2003–04

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

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

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

8.1 Introduction

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

- communication between the AIHW and jurisdictions before the supply of data, including written guidelines and file specifications
- agreeing on guidelines on the validation process to improve data collating and editing (see AIHW 2004c)
- jurisdictions improving their own data quality and checking mechanisms, and providing training to service providers and written guidelines for collecting the National Minimum Data Set
- the validation processes that occur in each jurisdiction before forwarding the data to the AIHW, and in the AIHW on receipt of the data.

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

Comprehensiveness of the data

In 2004–05, data were provided from 565 (96%) of the 586 agencies that were in scope for this collection. This calculation excludes Queensland agencies as the number of missing non-government agencies has not been recorded.

More detailed information on the undercount of Indigenous substance use services and Aboriginal health care services, as well as other data caveats, are available in Section 1.3.

Presentation of Australian Government data

Data reported for each state and territory in 2004–05 include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme (funded by the Australian Government). Since the 2002–03 annual report, Australian Government data are not analysed separately under the heading 'other'; rather, they have been analysed as part of the jurisdiction in which the agency was located.

8.2 Data quality

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

For the client data items:

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

For drug data items:

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

For treatment data items:

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

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

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

8.3 Data transmission

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

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

Data item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					2004–05				
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	2.4	3.7	3.9	0.2	2.5	0.1	0.0	0.8	**2.7**
Date of birth/age	0.1	1.5	2.5	1.5	0.0	0.1	0.4	0.2	**1.1**
Indigenous status	1.9	7.7	6.3	1.4	5.3	18.2	17.3	1.1	**5.2**
Preferred language	1.8	3.6	2.8	0.3	2.4	0.0	0.1	5.7	**2.4**
Sex	0.0	0.1	2.1	0.0	0.1	0.0	0.0	0.0	**0.3**
Source of referral	0.2	0.6	0.4	0.1	1.3	0.3	0.5	0.7	**0.4**
Drug data items[(b)]									
Principal drug of concern	—	—	—	—	—	—	—	—	—
Method of use	1.7	2.2	3.1	0.3	1.5	4.4	0.1	2.0	**1.9**
Injecting drug use	8.0	15.2	17.7	4.1	6.1	38.7	16.8	9.6	**11.9**
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation	1.2	0.3	5.4	0.5	0.6	2.6	0.6	5.7	**1.4**
Treatment delivery setting	—	—	—	—	—	—	—	—	—
					2003–04				
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	1.7	3.2	2.0	0.2	4.6	0.0	1.5	0.2	**2.2**
Date of birth/age	0.1	1.8	0.2	1.2	0.1	0.0	1.3	0.1	**0.8**
Indigenous status	4.5	8.1	6.3	1.4	8.7	17.8	3.7	1.7	**6.1**
Preferred language	0.8	3.7	2.1	0.3	4.2	0.0	0.8	4.9	**2.2**
Sex	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	**0.1**
Source of referral	0.0	0.4	0.4	1.3	1.2	0.0	0.9	4.5	**0.5**
Drug data items[(b)]									
Principal drug of concern	1.4	0.0	0.0	0.4	0.0	0.5	0.0	0.0	**0.5**
Method of use	2.2	2.2	1.2	0.3	2.0	1.2	0.3	1.3	**1.8**
Injecting drug use	10.1	15.6	15.8	2.4	15.1	28.5	7.5	41.2	**13.1**
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation	0.0	0.3	1.5	0.5	0.4	1.7	1.2	9.0	**0.6**
Treatment delivery setting	—	—	—	—	—	—	—	—	—

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

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

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

Appendixes

Appendix 1: Data elements included in the AODTS–NMDS for 2004–05

The detailed data definitions for the data elements included in the AODTS–NMDS for 2004–05 are published in the *National Health Data Dictionary* (NHDD) version 12 (NHDC 2003) and are available on AIHW's Metadata Online Registry (METeOR) at <http://meteor.aihw.gov.au/content/index.phtml/itemId/334288>.

Table A1.1 lists all data elements collected for 2004–05.

Table A1.1: Data elements for the AODTS–NMDS, 2004–05

Data element	NHDD code
Establishment-level data elements	
Establishment identifier (comprising)	000050
– state identifier	000380
– establishment sector	000379
– region code	000378
– establishment number	000377
Establishment type	000327
Geographical location of establishment	000260
Client-level data elements	
Client type	000426
Country of birth	000035
Date of birth	000036
Date of cessation of treatment episode for alcohol and other drugs	000424
Date of commencement of treatment episode for alcohol and other drugs	000430
Establishment identifier	000050
Indigenous status	000001
Injecting drug use	000432
Main treatment type for alcohol and other drugs	000639
Method of use for principal drug of concern	000433
Other drugs of concern	000442
Other treatment type for alcohol and other drugs	000642
Person identifier	000127
Preferred language	000132
Principal drug of concern	000443
Reason for cessation of treatment episode for alcohol and other drugs	000423
Sex	000149
Source of referral to alcohol and other drug treatment services	000444
Treatment delivery setting for alcohol and other drugs	000646
Supporting data element concepts	
Cessation of treatment episode for alcohol and other drugs	000422
Commencement of treatment episode for alcohol and other drugs	000427
Treatment episode for alcohol and other drugs	000647

Appendix 2: Policy and administrative features in each jurisdiction

New South Wales

New South Wales Health collects data from all federal/state government-funded agencies as part of requirements stipulated within a signed service agreement at commencement/ renewal of each funding agreement. Data are provided monthly by agencies to their respective Area Health Service (AHS) Drug and Alcohol Data Co-ordinator (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 Centre for Drug and Alcohol at New South Wales Health. Frequency and data-quality reports are provided by New South Wales Health to AHS/agencies and by AHS DADCs to agencies every 6 months detailing the previous 6 or 12 months services. 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 statewide 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 and National MDS–AODTS. 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 defined as 'a completed course of treatment, undertaken by a client under the care of an alcohol and drug worker, which achieves significant agreed treatment goals'.

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 (e.g. youth or adult). As a requirement of their funding agreement with the Victorian Department of Human Services, agencies are required to submit data detailing their provision of drug treatment services and achievement of episodes of care on a quarterly basis. A subset of this data is contributed to the AODTS NMDS annually.

Victorian AODT service providers use the SWITCH or FullADIS information systems to report quarterly activity. Both are ageing systems and SWITCH, used by hospitals and community health centres, is about to be replaced by two purpose built client managements systems known as HealthSMART. Lead agencies will commence migration to HealthSMART systems in 2006–07.

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 recently introduced a state wide web-based clinical information management system supporting the collection of AODTS–NMDS items for all Queensland Government AODT services. Queensland Health is also currently moving towards being the sole data custodian of all AODT services in Queensland.

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 SA—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 between themselves and the South Australian Minister of Health. As part of these service agreements, non-government organisations are required to provide timely client data in accordance with the AODTS–NMDS guidelines, and forward the data to DASSA for collation and checking. DASSA then forwards cleaned data to the AIHW annually.

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.

The department is in the final stage of conducting a business, gap analysis and business case with a view to implementing a clinical information management system (the ADS IMPS project). This project aims to provide a clinical information management system with a client and outcomes focus, whereas the current system was specifically designed to meet AODTS–NMDS requirements. It is expected that the new system will be in place in 2007–08.

Australian Capital Territory

ACT service providers supply ACT Health with data for the NMDS, as specified in their service agreement. These data are required to be submitted to ACT Health at the end of the financial year. At present, these service providers use a range of systems to collect their data.

The Australian Capital Territory is currently exploring the development of a standardised reporting system to be implemented in non-government alcohol and drug service agencies.

This is expected to enhance uniformity and reliability of the data and increase the user-friendliness of the system for service providers.

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 NT Department of Health and Community Services. All funded agencies are required to provide the AODTS–NMDS data items to the department on a regular and timely basis. Summary statistical reports are sent to all agencies every 6 months detailing client activity for the previous 12 months.

The department has recently implemented an intranet-based data entry system for NMDS data collection and is now working on developing this into a web-based system for use by non-government organisations.

Australian Government Department of Health and Ageing

The Australian Government Department of Health and Ageing funds a number of alcohol and other drug treatment services under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme. 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 submitted to the department annually.

Reported numbers for each state/territory in the AODTS–NMDS annual report include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Programme.

Appendix 3: Technical notes

This appendix provides information on data presentation and population definitions. As noted previously, the state/territory data collection systems for the AODTS–NMDS are highly diverse. As a result:

- it is important to understand the agreed definitions, terms and collection rules—these are outlined in this appendix, with full specifications available in (see AIHW 2004c)
- there is a need to edit the data in a number of ways to enable their meaningful presentation in this report and to maximise comparability of the data between jurisdictions (see AIHW 2004c).

A3.1 Data presentation

The tables in this report include data only for government-funded in-scope alcohol and other drug treatment services from the Australian Government, states and territories for which data were available. Percentages may not add up to 100.0 due to rounding.

Population definitions

Populations used in the publication comprise treatment agencies, client registrations and closed treatment episodes:

- *Treatment agency population* refers to the number of alcohol and other drug treatment agencies that provided data for 2004–05.
- *Client registration population* refers to the number of clients registering or re-registering during 2004–05 (see also Section A3.2).
- *Closed treatment episode population* refers to the number of treatment episodes that closed during 2004–05. For all tables using this population that include principal drug of concern, other drug of concern, or injecting drug use status, the treatment episode population excludes clients seeking treatment for the drug use of others.

See also Boxes 3.1, 4.1, 5.1 and 6.1 for other key definitions and counts.

A3.2 Client registration data versus treatment episode data

Client registration data, 2000–01

In 2000–01, unit record data were collected for both establishment level and client level. For the establishment data, a single unit record was reported for each agency/organisation that provided client data. For client-level data, all new or returning clients who registered or re-registered for treatment during the reporting period were required to be included in the collection. Data were reported as a single unit record for each new client registration on commencement of treatment. A client is identified as commencing treatment when one or more of the following applies:

(a) they are a new client

(b) they have had no contact with the service for a period of 3 months, nor have they a plan in place for further contact

(c) they are a current client whose principal drug of concern has changed.

For the 2000–01 collection, the AODTS–NMDS was to be a registration-based data collection that consisted of an establishment-level component and a client-level component. The establishment-level data items collected information about the type and location of the service provider. The client-level data items collected demographic and drug-related information about clients using the services in scope for the NMDS.

In practice, the 2000–01 collection also contained treatment episode data. New South Wales, Victoria and the Australian Capital Territory provided data based on the forthcoming treatment episode approach and a further three jurisdictions provided data that were a mixture of both collection types. This had a number of implications for the data analysis phase and for obtaining comparable counts across jurisdictions. For example, the data based on completed treatment episodes excluded clients with open episodes or records at 30 June 2001. This resulted in an undercounting of actual client numbers from these jurisdictions for the 2000–01 collection period as clients with open records were to be included under the client registration-based collection system. All data were converted back to client registration data and reported on that basis (see AIHW 2002).

Treatment episode data, 2001–02 to 2004–05

For the 2001–02 collection, the majority of jurisdictions provided treatment episode data based on treatment episodes that closed during the period 1 July 2001 to 30 June 2002. South Australia supplied client registration data based on clients who opened treatment episodes during this period. For the 2002–03 to 2004–05 collections, all jurisdictions were able to provide treatment episode data.

For the purposes of calculating a closed treatment episode, a treatment episode is considered closed when one or more of the following applies:

- a client's treatment plan has been completed
- there has been no treatment contact between the client and the treatment agency for a period of 3 months, unless that period of non-contact was planned
- the client's principal drug of concern has changed
- the client's main treatment type has changed
- the treatment delivery setting for the client's main treatment type has changed
- the client's treatment has ceased for other reasons (e.g. imprisoned, ceased treatment against advice or died).

Estimates of number of client registrations in 2001–02 to 2004–05

Although the majority of data presented in this report are based on closed treatment episodes, the report also includes estimates of the number of client registrations in agencies (Section 3.1 and Tables A4.1–A4.3). These estimates were obtained through a data transformation process (see below). More detailed information on factors affecting these estimates is available in Section 1.3.

Transformation of 2004–05 treatment episode data to estimates of number of client registrations was done as follows:

1. Select all records where the establishment identifier, person identifier, date of birth and sex are the same.
2. For each group of records where the above variables are the same, filter the records so that only the record with the earliest date of cessation remains.
3. Use the sum total of these filtered records as the equivalent of an estimate of number of client registrations.

Note that, in contrast to 2000–01 client registration data, the 2001–02 to 2004–05 estimates of client registrations, for all jurisdictions, were based on the date the client ceased treatment for an alcohol or other drug problem. In 2001–02, South Australian registration data were based on the date treatment commenced.

Appendix 4: Detailed tables

Client registrations

Table A4.1: Estimated number of client registrations[(a)] by age group and sex, Australia, 2004–05

	Males		Females		Not stated		Persons	
Age group (years)	No.	%	No.	%	No.	%	No.	%
10–19	10,090	8.3	4,964	4.1	77	0.1	15,131	12.4
20–29	27,657	22.7	12,394	10.2	125	0.1	40,176	33.0
30–39	22,862	18.8	11,430	9.4	119	0.1	34,411	28.2
40–49	12,589	10.3	7,329	6.0	88	0.1	20,006	16.4
50–59	4,641	3.8	3,270	2.7	39	0.0	7,950	6.5
60+	1,675	1.4	1,135	0.9	14	0.0	2,824	2.3
Not stated	793	0.7	516	0.4	5	0.0	1,314	1.1
Total	**80,307**	**65.9**	**41,038**	**33.7**	**467**	**0.4**	**121,812**	**100.0**

(a) Client registrations refer to the estimated number of clients who registered or re-registered for alcohol and other drug treatment services.

Table A4.2: Estimated number of client registrations[(a)] by client type and sex, Australia, 2004–05

	Males		Females		Not stated		Persons	
Client type	No.	%	No.	%	No.	%	No.	%
Own drug use	78,575	64.5	36,331	29.8	455	0.4	115,361	94.7
Others' drug use	1,732	1.4	4,707	3.9	12	0.0	6,451	5.3
Total	**80,307**	**65.9**	**41,038**	**33.7**	**467**	**0.4**	**121,812**	**100.0**

(a) Client registrations refer to the estimated number of clients who registered or re-registered for alcohol and other drug treatment services.

Table A4.3: Estimated number of client registrations[(a)] by age group and Indigenous status, Australia, 2004–05

	Indigenous		Non-Indigenous		Not stated		Total	
Age group (years)	No.	%	No.	%	No.	%	No.	%
10–19	2,592	2.1	11,837	9.7	702	0.6	15,131	12.4
20–29	3,892	3.2	34,034	27.9	2,250	1.8	40,176	33.0
30–39	3,428	2.8	29,155	23.9	1,828	1.5	34,411	28.2
40–49	1,381	1.1	17,589	14.4	1,036	0.9	20,006	16.4
50–59	311	0.3	7,272	6.0	367	0.3	7,950	6.5
60+	64	0.1	2,592	2.1	168	0.1	2,824	2.3
Not stated	357	0.3	847	0.7	110	0.1	1,314	1.1
Total	**12,025**	**9.9**	**103,326**	**84.8**	**6,461**	**5.3**	**121,812**	**100.0**

(a) Client registrations refer to the estimated number of clients who registered or re-registered for alcohol and other drug treatment services.

Client profile tables

Table A4.4: Closed treatment episodes by client data items and jurisdiction, Australia, 2004–05

	NSW	Vic[(a)]	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia
Client type									
Own drug use	41,789	44,150	19,743	14,235	7,591	1,372	4,206	2,116	135,202
Others' drug use	1,290	2,219	349	1,857	361	549	7	310	6,942
Sex									
Male	29,022	29,570	13,497	10,017	5,317	1,139	2,933	1,593	93,088
Female	14,044	16,761	6,176	6,072	2,631	782	1,280	833	48,579
Not stated	13	38	419	3	4	0	0	0	477
Age group (years)									
10–19	2,724	6,491	4,221	2,417	687	234	437	195	17,406
20–29	13,767	15,429	6,727	5,244	2,287	588	1,609	593	46,244
30–39	13,689	12,762	4,482	4,324	2,458	496	1,117	795	40,123
40–49	8,416	7,332	2,576	2,402	1,595	333	697	605	23,956
50–59	3,199	2,830	1,144	1,126	662	187	254	191	9,593
60+	1,253	833	437	339	260	82	83	41	3,328
Not stated	31	692	505	240	3	1	16	6	1,494
Indigenous status									
Indigenous	4,187	2,694	2,238	2,444	535	141	294	1,133	13,666
Not Indigenous	38,074	40,093	16,598	13,425	6,992	1,431	3,190	1,266	121,069
Not stated	818	3,582	1,256	223	425	349	729	27	7,409
Country of birth									
Australia	37,234	38,991	17,429	13,342	6,803	1,838	3,826	2,250	121,713
England	915	571	383	1,094	342	19	56	40	3,420
Germany	78	127	50	46	30	4	8	1	344
Ireland	181	108	39	103	37	0	16	2	486
Italy	87	133	16	44	25	0	7	1	313
New Zealand	790	665	611	426	75	10	47	41	2,665
Scotland	186	260	83	153	61	8	17	9	777
South Africa	97	93	59	69	13	2	14	1	348
United States of America	115	72	54	40	9	3	12	5	310
Viet Nam	221	826	32	57	62	0	24	7	1,229
All other countries	2,119	2,466	555	678	294	35	185	49	6,381
Not elsewhere classified	16	323	0	0	0	0	0	0	339
Inadequately described	11	767	781	0	8	2	0	0	1,569
Not stated	1,029	967	0	40	193	0	1	20	2,250

(continued)

Table A4.4 (continued): Closed treatment episodes by client data items and jurisdiction, Australia, 2004–05

	NSW	Vic[(a)]	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia
Preferred language									
Arabic	54	37	5	1	1	0	0	0	98
Australian Indigenous languages	8	370	5	33	0	0	1	449	866
English	41,665	42,975	19,410	15,876	7,710	1,921	4,201	1,802	135,560
Greek	22	37	1	4	3	0	0	0	67
Italian	24	33	15	2	5	0	1	0	80
Polish	27	14	2	10	0	0	1	0	54
Serbian	30	18	1	0	4	0	0	0	53
Spanish	60	28	9	2	1	0	1	0	101
Turkish	12	33	2	2	0	0	0	0	49
Vietnamese	139	421	7	21	14	0	0	3	605
All other languages	284	723	69	87	24	0	5	33	1,225
Inadequately described	7	275	1	0	0	0	0	5	288
Not stated	747	1,405	565	54	190	0	3	134	3,098
Source of referral									
Self	17,047	17,133	4,874	5,794	2,886	994	2,518	1,108	52,354
Family member/ friend	2,383	1,816	1,052	2,077	560	75	476	148	8,587
GP/medical specialist	3,031	2,055	1,338	887	552	196	18	75	8,152
Hospital	1,564	753	1,031	383	827	98	7	48	4,711
Community mental health services[(d)]	1,289	940	699	240	108	14	10	77	3,377
AODTS	6,835	6,743	709	1,066	617	84	325	145	16,524
Other community/health care services[(e)]	753	2,529	606	755	447	74	176	210	5,550
Community-based corrections	3,547	5,489	1,376	2,985	129	42	117	288	13,973
Police diversions	226	181	6,541	467	400	272	82	56	8,225
Court diversions	3,500	1,070	1,315	586	122	0	326	125	7,044
Other	2,801	7,395	478	842	1,202	66	139	130	13,053
Not stated	103	265	73	10	102	6	19	16	594
Total	**43,079**	**46,369**	**20,092**	**16,092**	**7,952**	**1,921**	**4,213**	**2,426**	**142,144**

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

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

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

(d) Includes residential and non-residential services.

(e) Comprises other residential community care unit; non-residential medical and/or allied health care agency; other non-residential community health care agency/outpatient clinic; and other community service agency.

Drugs of concern tables

Table A4.5: Closed treatment episodes by drug-related data items and jurisdiction, Australia, 2004–05[(a)]

	NSW	Vic[(b)]	Qld[(c)]	WA	SA	Tas[(d)]	ACT	NT	Australia
Injecting drug use									
Current injector	12,361	9,464	3,183	4,132	2,414	217	1,204	341	33,316
Injected 3–12 months ago	2,488	6,032	859	1,068	443	49	330	85	11,354
Injected 12+ months ago	4,028	4,038	1,836	1,957	795	70	299	108	13,131
Never injected	19,582	17,901	10,371	6,491	3,478	505	1,667	1,378	61,373
Not stated	3,330	6,715	3,494	587	461	531	706	204	16,028
Method of use									
Ingests	20,209	19,645	6,275	5,745	4,317	535	1,946	1,455	60,127
Smokes	8,538	9,253	9,495	3,074	1,001	598	804	295	33,058
Injects	11,910	11,744	2,689	5,065	2,086	170	1,434	301	35,399
Sniffs (powder)	295	364	77	143	48	3	9	1	940
Inhales (vapour)	88	2,014	541	131	17	1	7	21	2,820
Other	36	174	52	38	10	5	0	0	315
Not stated	713	956	614	39	112	60	6	43	2,543
Principal drug of concern									
Analgesics									
Heroin	8,388	9,892	1,027	1,710	994	3	1,151	28	23,193
Methadone	1,004	643	228	332	154	28	52	13	2,454
Balance of analgesics[(e)]	948	171	745	536	548	102	11	220	3,281
Total analgesics	*10,340*	*10,706*	*2,000*	*2,578*	*1,696*	*133*	*1,214*	*261*	*28,928*
Sedatives and hypnotics									
Alcohol	17,344	16,261	5,208	4,631	3,296	425	1,797	1,362	50,324
Benzodiazepines	866	1,075	158	191	186	11	40	11	2,538
Balance of sedatives and hypnotics[(e)]	53	0	17	17	7	0	2	1	97
Total sedatives and hypnotics	*18,263*	*17,336*	*5,383*	*4,839*	*3,489*	*436*	*1,839*	*1,374*	*52,959*

(continued)

Table A4.5 (continued): Closed treatment episodes by drug-related data items and jurisdiction, Australia, 2004–05[(a)]

	NSW	Vic[(b)]	Qld[(c)]	WA	SA	Tas[(d)]	ACT	NT	Australia
Stimulants and hallucinogens									
Amphetamines	4,720	2,680	1,724	3,741	1,325	135	345	110	14,780
Cannabis	7,253	10,268	8,447	2,713	871	426	781	285	31,044
Ecstasy	141	195	136	42	38	9	11	8	580
Cocaine	230	101	24	19	19	0	7	0	400
Nicotine	545	264	1,251	72	90	228	6	22	2,478
Balance of stimulants and hallucinogens[(e)]	47	8	34	32	5	3	2	2	133
Total stimulants and hallucinogens	*12,936*	*13,516*	*11,616*	*6,619*	*2,348*	*801*	*1,152*	*427*	*49,415*
Balance of drugs of concern[(e)]	250	2,592	744	199	58	2	1	54	3,900
Total	**41,789**	**44,150**	**19,743**	**14,235**	**7,591**	**1,372**	**4,206**	**2,116**	**135,202**

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

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

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

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

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

Table A4.6: Number of other drugs of concern by jurisdiction, Australia, 2004–05[(a)]

Other drug of concern	NSW	Vic[(b)]	Qld[(c)]	WA	SA	Tas[(d)]	ACT	NT	Australia
Analgesics									
Heroin	1496	2,660	420	494	234	4	141	25	5,474
Methadone	880	523	177	142	65	5	42	3	1,837
Balance of analgesics[(e)]	727	111	420	461	252	20	12	16	2,019
Total analgesics	*3,103*	*3,294*	*1,017*	*1,097*	*551*	*29*	*195*	*44*	*9,330*
Sedatives and hypnotics									
Alcohol	4,506	7,849	2,891	1,849	829	52	436	6	18,418
Benzodiazepines	2,467	4,136	597	961	614	18	314	15	9,122
Balance of sedatives and hypnotics[(e)]	63	0	17	67	11	4	5	1	168
Total sedatives and hypnotics	*7,036*	*11,985*	*3,505*	*2,877*	*1,454*	*74*	*755*	*22*	*27,708*
Stimulants and hallucinogens									
Amphetamines	4,258	6,654	1,420	1,673	836	54	405	34	15,334
Cannabinoids	8,897	12,065	3,043	3,013	1,557	104	856	86	29,621
Ecstasy	998	1,890	480	457	179	6	73	36	4,119
Cocaine	892	486	105	142	86	2	18	6	1,737
Nicotine	6,386	6,536	3,922	1,578	1,335	37	885	56	20,735
Balance of stimulants and hallucinogens[(e)]	449	31	147	247	19	4	20	6	923
Total stimulants and hallucinogens	*21,880*	*27,662*	*9,117*	*7,110*	*4,012*	*207*	*2,257*	*224*	*72,469*
Balance of drugs of concern[(e)]	484	3,926	227	287	35	3	18	15	4,995
Not stated/missing	0	0	2	0	80	0	2	0	84

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

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

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

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

(e) Includes balance of other drugs of concern coded according to ASCDC. See Appendix 7.

Table A4.7: Closed treatment episodes by principal drug of concern, sex and age group, Australia, 2004–05(a)

Principal drug	Age group (years) 10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total	Total (number)
	(per cent)								
Males									
Alcohol	21.4	25.4	39.3	59.4	76.2	85.6	27.5	38.5	35,105
Amphetamines	8.6	14.4	12.8	5.3	2.0	0.4	10.6	10.8	9,813
Benzodiazepines	0.3	1.2	1.5	1.5	1.6	1.7	0.5	1.2	1,140
Cannabis	53.2	29.2	18.2	10.9	5.7	2.4	23.0	24.1	21,941
Cocaine	0.3	0.4	0.4	0.2	0.1	0.1	0.4	0.3	300
Ecstasy	1.0	0.8	0.3	0.1	0.0	0.1	0.7	0.5	435
Heroin	6.0	22.3	19.9	13.8	5.9	0.4	15.7	16.8	15,345
Methadone	0.2	1.5	1.8	2.2	0.9	0.3	1.5	1.5	1,346
Nicotine	2.7	0.9	0.9	1.6	3.2	6.4	6.3	1.5	1,389
Other(b)	6.3	4.0	5.0	5.0	4.4	2.8	13.8	4.8	4,403
Total males (per cent)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	..
Total males (number)	*11,085*	*31,259*	*26,356*	*14,632*	*5,228*	*1,802*	*855*	..	*91,217*
Females									
Alcohol	18.7	17.5	36.4	57.1	71.1	72.7	20.2	34.5	15,033
Amphetamines	12.1	16.2	12.7	4.3	1.2	0.3	12.1	11.3	4,910
Benzodiazepines	0.8	2.3	3.3	5.3	5.1	7.9	0.9	3.2	1,393
Cannabis	42.6	25.1	16.9	10.7	5.7	1.2	25.3	20.7	8,997
Cocaine	0.3	0.3	0.2	0.2	0.1	0.0	0.0	0.2	99
Ecstasy	0.9	0.5	0.2	0.0	0.0	0.0	1.6	0.3	144
Heroin	10.8	28.1	18.7	10.6	3.4	0.9	15.7	18.0	7,815
Methadone	0.8	3.0	3.3	2.3	1.1	0.4	1.6	2.5	1,106
Nicotine	3.9	1.1	1.5	2.9	5.4	10.4	9.0	2.4	1,046
Other(b)	9.1	5.9	6.8	6.6	6.9	6.1	13.7	6.8	2,977
Total females (per cent)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	..
Total females (number)	*5,310*	*14,030*	*12,500*	*7,532*	*2,790*	*912*	*446*	..	*43,520*

(continued)

Table A4.7 (continued): Closed treatment episodes by principal drug of concern, sex and age group, Australia, 2004–05[a]

	Age group (years)								
Principal drug	**10–19**	**20–29**	**30–39**	**40–49**	**50–59**	**60+**	**Not stated**	**Total**	**Total (number)**
				(per cent)					
Persons[c]									
Alcohol	20.6	22.9	38.4	58.6	74.4	81.1	24.9	37.2	50,324
Amphetamines	9.7	15.0	12.7	5.0	1.7	0.4	11.2	10.9	14,780
Benzodiazepines	0.5	1.6	2.1	2.8	2.8	3.8	0.6	1.9	2,538
Cannabis	49.7	27.9	17.8	10.8	5.7	2.0	23.8	23.0	31,044
Cocaine	0.3	0.4	0.4	0.2	0.1	0.0	0.2	0.3	400
Ecstasy	1.0	0.7	0.2	0.0	0.0	0.0	1.0	0.4	580
Heroin	7.6	24.0	19.5	12.7	5.0	0.6	15.7	17.2	23,193
Methadone	0.4	2.0	2.3	2.2	0.9	0.3	1.6	1.8	2,454
Nicotine	3.1	0.9	1.1	2.1	4.1	7.9	7.2	1.8	2,478
Other drugs[b]	7.2	4.6	5.6	5.6	5.2	3.9	13.7	5.5	7,411
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**..**
Total (number)	**16,470**	**45,417**	**38,975**	**22,252**	**8,058**	**2,725**	**1,305**	**..**	**135,202**

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

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

(c) Includes 'not stated' for sex.

Table A4.8: Closed treatment episodes by principal drug of concern and country of birth, Australia, 2004–05(a)

	Alcohol	Cannabis	Heroin	Amphetamines	Other drugs(b)	Total
			(number)			
Australia	41,994	28,040	18,995	13,283	13,643	115,955
England	1,633	448	406	283	325	3,095
Germany	216	36	25	10	34	321
Ireland	287	34	53	38	39	451
Italy	106	29	60	23	50	268
New Zealand	985	642	393	263	269	2,552
Scotland	464	57	70	62	75	728
South Africa	133	69	40	26	40	308
United States of America	159	57	32	18	24	290
Viet Nam	89	62	933	20	85	1,189
All other countries	2,543	849	1,528	412	691	6,023
Inadequately described	661	299	202	106	263	1,531
Not elsewhere classified	179	43	66	13	24	325
Not stated	875	379	390	223	299	2,166
Total	**50,324**	**31,044**	**23,193**	**14,780**	**15,861**	**135,202**
			(per cent)			
Australia	36.2	24.2	16.4	11.5	11.8	100.0
England	52.8	14.5	13.1	9.1	10.5	100.0
Germany	67.3	11.2	7.8	3.1	10.6	100.0
Ireland	63.6	7.5	11.8	8.4	8.6	100.0
Italy	39.6	10.8	22.4	8.6	18.7	100.0
New Zealand	38.6	25.2	15.4	10.3	10.5	100.0
Scotland	63.7	7.8	9.6	8.5	10.3	100.0
South Africa	43.2	22.4	13.0	8.4	13.0	100.0
United States of America	54.8	19.7	11.0	6.2	8.3	100.0
Viet Nam	7.5	5.2	78.5	1.7	7.1	100.0
All other countries	42.2	14.1	25.4	6.8	11.5	100.0
Inadequately described	43.2	19.5	13.2	6.9	17.2	100.0
Not elsewhere classified	55.1	13.2	20.3	4.0	7.4	100.0
Not stated	40.4	17.5	18.0	10.3	13.8	100.0
Total	**37.2**	**23.0**	**17.2**	**10.9**	**11.7**	**100.0**

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

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

Table A4.9: Closed treatment episodes by principal drug of concern, Indigenous status and sex, Australia, 2004–05[(a)]

Principal drug of concern	Males		Females		Persons[(b)]		
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Total[(c)]
				(number)			
Alcohol	3,996	29,121	1,629	12,714	5,647	41,984	50,324
Amphetamines	860	8,514	547	4,132	1,408	12,695	14,780
Benzodiazepines	50	1,017	88	1,246	138	2,268	2,538
Cannabis	2,106	18,657	976	7,505	3,091	26,248	31,044
Cocaine	12	276	5	90	17	367	400
Ecstasy	13	409	2	138	15	548	580
Heroin	840	13,757	726	6,763	1,570	20,546	23,193
Methadone	82	1,172	95	969	177	2,142	2,454
Nicotine	115	1,196	88	896	206	2,126	2,478
Other drugs[(d)]	592	3,510	416	2,368	1,011	5,905	7,411
Total	**8,666**	**77,629**	**4,572**	**36,821**	**13,280**	**114,829**	**135,202**
				(per cent)			
Alcohol	46.1	37.5	35.6	34.5	42.5	36.6	37.2
Amphetamines	9.9	11.0	12.0	11.2	10.6	11.1	10.9
Benzodiazepines	0.6	1.3	1.9	3.4	1.0	2.0	1.9
Cannabis	24.3	24.0	21.3	20.4	23.3	22.9	23.0
Cocaine	0.1	0.4	0.1	0.2	0.1	0.3	0.3
Ecstasy	0.2	0.5	0.0	0.4	0.1	0.5	0.4
Heroin	9.7	17.7	15.9	18.4	11.8	17.9	17.2
Methadone	0.9	1.5	2.1	2.6	1.3	1.9	1.8
Nicotine	1.3	1.5	1.9	2.4	1.6	1.9	1.8
Other drugs[(d)]	6.8	4.5	9.1	6.4	7.6	5.1	5.5
Total	**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) Includes 'not stated' for sex.

(c) Includes 'not stated' for Indigenous status.

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

Table A4.10: Closed treatment episodes by principal drug of concern and all drugs of concern, Australia, 2004–05[(a)]

	Principal drug of concern reported	Per cent of all closed treatment episodes	All drugs of concern reported, including principal	Per cent of all closed treatment episodes[(b)]
Alcohol	50,324	37.2	68,742	50.8
Amphetamines	14,780	10.9	30,114	22.3
Benzodiazepines	2,538	1.9	11,660	8.6
Cannabis	31,044	23.0	60,665	44.9
Cocaine	400	0.3	2,137	1.6
Ecstasy	580	0.4	4,699	3.5
Heroin	23,193	17.2	28,667	21.2
Methadone	2,454	1.8	4,291	3.2
Nicotine	2,478	1.8	23,213	17.2
Other drugs[(c)]	7,411	5.5	15,516	11.5
Not stated	0	0.0	84	0.1
Total[(d)]	**135,202**	**—**	**249,704**	**—**

(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%, since closed treatment episodes may be counted in more than one drug of concern.

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

(d) Excludes 'not stated'.

Table A4.11: Closed treatment episodes[(a)] by principal drug of concern and injecting drug use, Australia, 2004–05

Principal drug of concern	Injected[(b)]	Never injected	Not stated	Total
		(number)		
Alcohol	9,339	34,056	6,929	50,324
Amphetamines	12,086	1,867	827	14,780
Benzodiazepines	1,131	1,075	332	2,538
Cannabis	7,937	18,829	4,278	31,044
Cocaine	212	150	38	400
Ecstasy	110	406	64	580
Heroin	21,121	1,104	968	23,193
Methadone	1,977	167	310	2,454
Nicotine	225	1,592	661	2,478
All other drugs[(c)]	3,663	2,127	1,621	7,411
Total	**57,801**	**61,373**	**16,028**	**135,202**
		(per cent)		
Alcohol	18.6	67.7	13.8	100.0
Amphetamines	81.8	12.6	5.6	100.0
Benzodiazepines	44.6	42.4	13.1	100.0
Cannabis	25.6	60.7	13.8	100.0
Cocaine	53.0	37.5	9.5	100.0
Ecstasy	19.0	70.0	11.0	100.0
Heroin	91.1	4.8	4.2	100.0
Methadone	80.6	6.8	12.6	100.0
Nicotine	9.1	64.2	26.7	100.0
All other drugs[(c)]	49.4	28.7	21.9	100.0
Total	**42.8**	**45.4**	**11.9**	**100.0**

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

(b) Injected includes those clients who reported being a current injector, having injected 3–12 months ago, or having injected 12+ months ago.

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

Table A4.12: Closed treatment episodes by method of use and age, Australia, 2004–05[(a)]

	Age group (years)							
	10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total
				(number)				
Ingests	3,978	13,727	18,226	14,904	6,534	2,372	386	60,127
Smokes	8,605	13,232	7,104	2,736	762	255	364	33,058
Injects	2,114	16,129	12,268	3,965	558	27	338	35,399
Sniffs	225	427	206	60	13	1	8	940
Inhales	1,097	938	453	152	29	8	143	2,820
Other	45	123	85	41	15	5	1	315
Not stated	406	841	633	394	147	57	65	2,543
Total	**16,470**	**45,417**	**38,975**	**22,252**	**8,058**	**2,725**	**1,305**	**135,202**
				(per cent)				
Ingests	24.2	30.2	46.8	67.0	81.1	87.0	29.6	44.5
Smokes	52.2	29.1	18.2	12.3	9.5	9.4	27.9	24.5
Injects	12.8	35.5	31.5	17.8	6.9	1.0	25.9	26.2
Sniffs	1.4	0.9	0.5	0.3	0.2	0.0	0.6	0.7
Inhales	6.7	2.1	1.2	0.7	0.4	0.3	11.0	2.1
Other	0.3	0.3	0.2	0.2	0.2	0.2	0.1	0.2
Not stated	2.5	1.9	1.6	1.8	1.8	2.1	5.0	1.9
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.

Table A4.13a: Closed treatment episodes[a] by principal drug of concern and reason for cessation, Australia, 2004–05 (per cent)

Reason for cessation	Alcohol	Amphetamines	Benzodiazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Nicotine	Other drug[b]	Total[c]	Total (number)
Treatment completed	60.4	45.6	56.1	45.9	57.3	54.1	50.8	51.6	44.4	49.6	52.6	71,153
Change in main treatment type	1.0	1.0	2.4	0.9	0.5	1.2	1.6	2.2	0.5	3.8	1.3	1,718
Change in delivery setting	0.7	2.2	1.2	0.5	0.5	0.5	1.1	1.3	0.6	1.6	1.0	1,304
Change in principal drug of concern	0.1	0.1	0.2	0.0	0.0	0.0	0.2	0.2	0.0	0.1	0.1	165
Transferred to another service provider	5.5	6.7	9.8	4.1	7.8	5.0	9.0	12.7	1.7	6.7	6.1	8,260
Ceased to participate against advice	4.1	5.5	4.6	2.6	6.0	3.1	6.4	4.4	1.4	4.0	4.3	5,763
Ceased to participate without notice	17.1	22.4	13.4	15.6	14.5	16.6	17.0	13.7	18.5	16.1	17.1	23,180
Ceased to participate involuntary (non-compliance)	1.6	4.2	3.0	1.7	4.0	1.4	3.0	2.6	0.4	1.6	2.2	2,909
Ceased to participate at expiation	1.4	2.9	0.9	21.9	2.0	11.9	1.3	0.9	23.7	3.9	6.8	9,235
Ceased to participate by mutual agreement	2.9	2.6	3.5	2.2	0.8	2.2	1.7	2.0	1.9	3.3	2.5	3,352
Drug court and/or sanctioned by court diversion service	0.1	0.6	0.1	0.3	0.3	0.3	0.4	0.1	0.0	0.2	0.2	320
Imprisoned, other than drug court sanctioned	0.4	0.9	0.3	0.4	0.8	0.3	2.0	2.2	0.1	1.2	0.8	1,071
Died	0.2	0.1	0.2	0.0	0.0	0.2	0.2	0.4	0.2	0.2	0.1	190
Other	3.3	3.1	2.9	2.9	3.3	1.9	3.6	4.3	5.4	5.6	3.4	4,614
Not stated	1.4	2.0	1.3	0.9	2.5	1.2	1.7	1.5	1.3	2.2	1.5	1,968
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)	**50,324**	**14,780**	**2,538**	**31,044**	**400**	**580**	**23,193**	**2,454**	**2,478**	**7,411**	**..**	**135,202**

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

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

(c) Includes ‘not stated’ for principal drugs of concern.

Table A4.13b: Closed treatment episodes[(a)] by reason for cessation and principal drug of concern, Australia, 2004–05 (per cent)

Reason for cessation	Alcohol	Amphetamines	Benzodiazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Nicotine	Other drug[(b)]	Total[(c)]	Total (number)
Treatment completed	42.7	9.5	2.0	20.0	0.3	0.4	16.6	1.8	1.5	5.2	100.0	71,153
Change in main treatment type	28.6	8.6	3.6	16.5	0.1	0.4	22.1	3.2	0.7	16.2	100.0	1,718
Change in delivery setting	27.0	24.9	2.4	13.0	0.2	0.2	19.9	2.4	1.1	9.0	100.0	1,304
Change in principal drug of concern	39.4	11.5	3.0	8.5	0.0	0.0	29.1	3.0	0.0	5.5	100.0	165
Transferred to another service provider	33.4	12.1	3.0	15.4	0.4	0.4	25.1	3.8	0.5	6.0	100.0	8,260
Ceased to participate against advice	35.6	14.2	2.0	14.2	0.4	0.3	25.6	1.9	0.6	5.2	100.0	5,763
Ceased to participate without notice	37.1	14.3	1.5	20.9	0.3	0.4	17.0	1.5	2.0	5.1	100.0	23,180
Ceased to participate involuntary (non-compliance)	27.2	21.1	2.6	17.9	0.6	0.3	23.8	2.2	0.3	4.1	100.0	2,909
Ceased to participate at expiation	7.7	4.7	0.2	73.6	0.1	0.7	3.2	0.2	6.4	3.1	100.0	9,235
Ceased to participate by mutual agreement	43.0	11.6	2.7	20.5	0.1	0.4	11.7	1.4	1.4	7.2	100.0	3,352
Drug court and/or sanctioned by court diversion service	12.5	25.6	0.9	24.7	0.3	0.6	30.6	0.9	0.0	3.8	100.0	320
Imprisoned, other than drug court sanctioned	16.6	13.0	0.7	11.5	0.3	0.2	44.3	5.0	0.2	8.2	100.0	1,071
Died	46.3	6.3	2.6	6.3	0.0	0.5	22.6	4.7	2.1	8.4	100.0	190
Other	35.8	9.8	1.6	19.8	0.3	0.2	18.3	2.3	2.9	9.0	100.0	4,614
Not stated	36.8	15.1	1.7	14.3	0.5	0.4	19.5	1.9	1.6	8.2	100.0	1,968
Total (per cent)	**37.2**	**10.9**	**1.9**	**23.0**	**0.3**	**0.4**	**17.2**	**1.8**	**1.8**	**5.5**	**100.0**	**135,202**

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

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

(c) Includes 'not stated' for principal drugs of concern.

Treatment program tables

Table A4.14: Closed treatment episodes by treatment data items and jurisdiction, Australia, 2004–05

	NSW	Vic[(a)]	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia
Main treatment type									
Withdrawal management (detoxification)	9,574	10,412	889	1,457	1,654	60	1,125	287	25,458
Counselling	14,776	21,749	6,505	8,826	2,001	1,215	1,167	837	57,076
Rehabilitation	4,500	1,717	627	1,969	1,493	117	217	319	10,959
Support and case management only	3,600	5,993	895	454	93	57	114	34	11,240
Information and education only	997	323	9,129	1,094	107	256	484	219	12,609
Assessment only	6,891	4,609	1,610	1,191	1,814	157	817	574	17,663
Other[(d)]	2,741	1,566	437	1,101	790	59	289	156	7,139
Cessation reason									
Treatment completed	23,562	32,295	3,891	6,856	4,463	784	2,408	1,421	75,680
Change in main treatment type	0	1,113	363	54	76	32	78	108	1,824
Change in delivery setting	0	0	358	244	357	67	294	17	1,337
Change in principal drug of concern	0	92	4	2	2	1	67	0	168
Transferred to another service provider	4,661	1,743	652	823	344	89	133	56	8,501
Ceased to participate against advice	2,759	1,259	534	473	474	42	168	118	5,827
Ceased to participate without notice	7,697	4,688	3,802	5,162	1,480	427	734	285	24,275
Ceased to participate involuntary (non-compliance)	1,442	523	116	446	201	68	104	31	2,931
Ceased to participate at expiation	166	696	7,410	692	30	232	45	9	9,280
Ceased to participate by mutual agreement	0	1,720	632	824	291	85	107	95	3,754
Drug court and/or sanctioned by court diversion service	132	31	42	94	19	0	3	5	326
Imprisoned, other than drug court sanctioned	424	300	82	173	58	8	20	16	1,081
Died	64	64	25	14	18	4	2	4	195
Other	1,673	1,702	1,101	161	93	33	25	123	4,911
Not stated	499	143	1,080	74	46	49	25	138	2,054

(continued)

Table A4.14 (continued): Closed treatment episodes by treatment data items and jurisdiction, Australia, 2004–05

	NSW	Vic[(a)]	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia
Treatment delivery setting									
Non-residential treatment facility	29,507	32,786	14,810	11,696	6,364	1,277	1,738	1,140	99,318
Residential treatment facility	11,155	6,815	873	2,014	1,423	144	2,271	776	25,471
Home	536	1,780	164	554	37	16	3	42	3,132
Outreach setting	1,022	4,988	3,146	411	68	483	201	247	10,566
Other	859	0	1,099	1,417	60	1	0	221	3,657
Total	**43,079**	**46,369**	**20,092**	**16,092**	**7,952**	**1,921**	**4,213**	**2,426**	**142,144**

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

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

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

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

Table A4.15: Numbers of other treatment type by jurisdiction, Australia, 2004–05[(a)]

Other treatment type	NSW	Qld[(b)]	WA	SA	Tas[(c)]	ACT	Australia
Withdrawal management (detoxification)	797	70	2	613	18	0	1,520
Counselling	6,916	640	67	1,124	18	363	9,500
Rehabilitation	614	352	1	246	8	7	1,314
Other[(d)]	4,602	2,334	163	1,514	192	143	9,100
All other treatments	12,929	3,396	233	3,497	236	513	21,434

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

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

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

(d) 'Other' includes 4,299 closed treatment episodes where other/additional treatment type was reported as pharmacotherapy.

Table A4.16: Closed treatment episodes by main treatment type, Australia, 2001–02 to 2004–05

Main treatment type	2001–02	2002–03	2003–04	2004–05
		(number)		
Withdrawal management (detoxification)	21,744	24,767	25,123	25,458
Counselling	44,184	54,395	51,514	57,076
Rehabilitation	7,195	9,865	11,717	10,959
Support and case management only	6,951	9,097	11,494	11,240
Information and education only	11,197	10,478	10,465	12,609
Assessment only	16,647	16,632	20,414	17,663
Other(a)	5,787	5,696	6,142	7,139
Total	**113,705**	**130,930**	**136,869**	**142,144**
		(per cent)		
Withdrawal management (detoxification)	19.1	18.9	18.4	17.9
Counselling	38.9	41.5	37.6	40.2
Rehabilitation	6.3	7.5	8.6	7.7
Support and case management only	6.1	6.9	8.4	7.9
Information and education only	9.8	8	7.6	8.9
Assessment only	14.6	12.7	14.9	12.4
Other(a)	5.1	4.4	4.5	5
Total	**100.0**	**100.0**	**100.0**	**100.0**

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

Table A4.17: Closed treatment episodes[(a)] by principal drug of concern and main treatment type, Australia, 2004–05

Main treatment type	Alcohol	Amphetamines	Benzodiazepines	Cannabis	Cocaine	Ecstasy	Heroin	Methadone	Nicotine	Other drug[(b)]	Total
						(number)					
Withdrawal management (detoxification)	10,395	1,945	980	4,335	74	28	5,454	537	115	1,594	25,457
Counselling	22,150	6,225	890	11,101	136	284	6,645	652	994	2,231	51,308
Rehabilitation	4,612	2,158	121	1,535	58	31	1,906	126	40	372	10,959
Support and case management only	2,347	1,202	157	3,090	36	73	2,610	294	154	845	7,012
Information and education only	2,110	526	36	7,590	17	73	285	40	807	700	10,808
Assessment only	7,491	2,331	258	2,823	61	83	3,104	272	255	796	12,184
Other[(c)]	1,219	393	96	570	18	8	3,189	533	113	873	17474
Total	**50,324**	**14,780**	**2,538**	**31,044**	**400**	**580**	**23,193**	**2,454**	**2,478**	**7,411**	**135,202**
						(per cent)					
Withdrawal management (detoxification)	20.7	13.2	38.6	14.0	18.5	4.8	23.5	21.9	4.6	21.5	18.8
Counselling	44.0	42.1	35.1	35.8	34.0	49.0	28.7	26.6	40.1	30.1	37.9
Rehabilitation	9.2	14.6	4.8	4.9	14.5	5.3	8.2	5.1	1.6	5.0	8.1
Support and case management only	4.7	8.1	6.2	10.0	9.0	12.6	11.3	12.0	6.2	11.4	5.2
Information and education only	4.2	3.6	1.4	24.4	4.3	12.6	1.2	1.6	32.6	9.4	8.0
Assessment only	14.9	15.8	10.2	9.1	15.3	14.3	13.4	11.1	10.3	10.7	9.0
Other[(c)]	2.4	2.7	3.8	1.8	4.5	1.4	13.7	21.7	4.6	11.8	12.9
Total	**100.0**	**100.0**	**100.0**	**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) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 7.

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

Table A4.18: Closed treatment episodes by main treatment type, sex and age group, Australia, 2004–05

Main treatment type	Age group (years) 10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total
				(per cent)				
Males								
Withdrawal management (detoxification)	8.6	15.7	20.3	22.7	24.5	24.5	6.0	17.9
Counselling	30.7	36.9	39.2	39.8	42.3	38.9	35.4	37.6
Rehabilitation	5.7	8.7	9.3	8.0	7.3	6.4	2.0	8.2
Support and case management only	17.3	7.9	5.3	4.6	3.3	3.3	14.2	7.5
Information and education only	23.5	10.6	6.0	5.7	5.3	5.7	29.4	9.9
Assessment only	11.6	15.9	14.7	13.7	12.6	17.5	1.1	14.4
Other[(a)]	2.8	4.2	5.0	5.4	4.7	3.6	12.0	4.6
Total males (per cent)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total males (number)	*11,448*	*31,465*	*26,592*	*15,056*	*5,634*	*1,977*	*916*	*93,088*
Females								
Withdrawal management (detoxification)	12.3	18.3	19.3	20.9	17.4	16.5	7.5	18.1
Counselling	31.8	41.0	46.1	48.9	59.3	59.4	41.0	44.7
Rehabilitation	4.6	7.7	7.6	6.6	5.8	5.0	2.3	6.8
Support and case management only	24.7	9.5	6.0	4.4	2.7	1.8	13.4	8.7
Information and education only	15.2	6.9	5.1	5.0	4.3	4.8	20.2	7.0
Assessment only	6.7	9.8	9.3	8.7	6.8	8.8	1.0	8.7
Other[(a)]	4.7	6.8	6.5	5.4	3.6	3.7	14.5	6.0
Total females (per cent)	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*	*100.0*
Total females (number)	*5,881*	*14,651*	*13,409*	*8,810*	*3,918*	*1,337*	*573*	*48,579*
Persons[(b)]								
Withdrawal management (detoxification)	9.8	16.5	19.9	22.0	21.5	21.2	6.6	17.9
Counselling	31.1	38.3	41.6	43.3	49.4	47.3	37.5	40.2
Rehabilitation	5.3	8.4	8.7	7.5	6.7	5.8	2.1	7.7
Support and case management only	19.9	8.4	5.5	4.6	3.0	2.7	13.9	7.9
Information and education only	20.6	9.5	5.7	5.5	4.9	5.4	25.8	8.9
Assessment only	9.9	14.0	12.9	11.8	10.2	13.9	1.1	12.4
Other[(a)]	3.4	5.0	5.5	5.4	4.2	3.6	13.1	5.0
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**17,406**	**46,244**	**40,123**	**23,956**	**9,593**	**3,328**	**1,494**	**142,144**

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

(b) Includes 'not stated' for sex.

Special theme: cannabis tables

Table A4.19: Closed treatment episodes[(a)] where cannabis was nominated as the principal drug of concern by age group and method of use, Australia, 2004–05

	Age group (years)						
	10–19	**20–29**	**30–39**	**40–49**	**50–59**	**60+**	**Total[(b)]**
				(number)			
Ingests	106	193	104	42	10	2	465
Smokes	7,556	11,525	6,301	2,175	416	44	28,283
Injects	45	65	13	4	0	0	127
Sniffs	3	8	1	0	0	0	12
Inhales	302	620	361	114	13	3	1,438
Other	20	27	20	8	2	0	77
Not stated	159	255	133	61	17	5	642
Total	**8,191**	**12,693**	**6,933**	**2,404**	**458**	**54**	**31,044**
				(per cent)			
Ingests	1.3	1.5	1.5	1.7	2.2	3.7	1.5
Smokes	92.2	90.8	90.9	90.5	90.8	81.5	91.1
Injects	0.5	0.5	0.2	0.2	0.0	0.0	0.4
Sniffs	0.0	0.1	0.0	0.0	0.0	0.0	0.0
Inhales	3.7	4.9	5.2	4.7	2.8	5.6	4.6
Other	0.2	0.2	0.3	0.3	0.4	0.0	0.2
Not stated	1.9	2.0	1.9	2.5	3.7	9.3	2.1
Total	**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) Includes ‘not stated’ for age.

Table A4.20: Closed treatment episodes[a] where a principal drug of concern other than cannabis was nominated by age group and method of use, Australia, 2004–05

	Age group (years)						
	10–19	20–29	30–39	40–49	50–59	60+	Total[b]
				(number)			
Ingests	3,872	13,534	18,122	14,862	6,524	2,370	59,662
Smokes	1,049	1,707	803	561	346	211	4,775
Injects	2,069	16,064	12,255	3,961	558	27	35,272
Sniffs	222	419	205	60	13	1	928
Inhales	795	318	92	38	16	5	1,382
Other	25	96	65	33	13	5	238
Not stated	247	586	500	333	130	52	1,901
Total	**8,279**	**32,724**	**32,042**	**19,848**	**7,600**	**2,671**	**104,158**
				(per cent)			
Ingests	46.8	41.4	56.6	74.9	85.8	88.7	57.3
Smokes	12.7	5.2	2.5	2.8	4.6	7.9	4.6
Injects	25.0	49.1	38.2	20.0	7.3	1.0	33.9
Sniffs	2.7	1.3	0.6	0.3	0.2	0.0	0.9
Inhales	9.6	1.0	0.3	0.2	0.2	0.2	1.3
Other	0.3	0.3	0.2	0.2	0.2	0.2	0.2
Not stated	3.0	1.8	1.6	1.7	1.7	1.9	1.8
Total	**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) Includes 'not stated' for age.

Table A4.21: Closed treatment episodes[a] by principal drug of concern and injecting drug use, Australia, 2004–05

	Cannabis		All other drugs of concern[b]		Total	
	No.	%	No.	%	No.	%
Current injector	2,793	9.0	30,523	29.3	33,316	24.6
3–12 months ago	1,980	6.4	9,374	9.0	11,354	8.4
12+ months ago	3,164	10.2	9,967	9.6	13,131	9.7
Never injected	18,829	60.7	42,544	40.8	61,373	45.4
Not stated	4,278	13.8	11,750	11.3	16,028	11.9
Total	**31,044**	**100.0**	**104,158**	**100.0**	**135,202**	**100.0**

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

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

Table A4.22: Closed treatment episodes[a] by principal drug of concern and treatment delivery setting, Australia, 2004–05

	Cannabis		All other drugs of concern[b]		Total	
	No.	**%**	**No.**	**%**	**No.**	**%**
Non-residential treatment facility	22,451	72.3	70,650	67.8	93,101	68.9
Residential treatment facility	3,743	12.1	21,670	20.8	25,413	18.8
Home	752	2.4	2,317	2.2	3,069	2.3
Outreach setting	2,943	9.5	7,057	6.8	10,000	7.4
Other	1,155	3.7	2,464	2.4	3,619	2.7
Total	**31,044**	**100.0**	**104,158**	**100.0**	**135,202**	**100.0**

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

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

Appendix 5: AODTS–NMDS treatment types

The AODTS–NMDS covers a wide variety of treatment interventions and includes, among others, detoxification and rehabilitation programs, pharmacotherapy and counselling treatments, and information and education courses. These treatments are summarised below.

Assessment

All new or returning clients are assessed in some form to determine the most appropriate treatment. The method of assessment depends on the type of treatment offered, and the client's drug use, personal history and individual needs. A combination of interview and questionnaire may be used to obtain information on the client's lifestyle and drug taking habits, such as levels of use and dependence, previous drug history, motivation to change, and other health and lifestyle factors (ADF 2003b). Assessment itself is not a treatment; rather, its general aim is to match clients with an appropriate treatment intervention.

Withdrawal management (detoxification)

Withdrawal management, or detoxification, refers to the elimination of toxic levels of a drug from the body. Detoxification usually also involves counselling and is often a gradual process, taking a number of days or weeks, and may occur in a variety of settings including general hospitals, specialist drug and alcohol units, outpatient clinics and homes (Gowing et al. 2001). Although the detoxification process can be a treatment in itself, it can also be a precursor to a full treatment program.

Information gained on the type of drug used and the duration of use during the assessment period will guide the choice of detoxification program. For opiate detoxification these can range from several months on a stable dose of methadone before gradual reduction, through to detoxification using only non-opiates to alleviate withdrawal symptoms.

The following are the main types of opiate detoxification programs available (Ghodse 2002). These programs are not distinguished within the AODTS–NMDS collection but are grouped under the general heading 'withdrawal management (detoxification)'.

Non-opiate treatment includes neuroleptic drugs which reduce the symptoms of withdrawal, beta-adrenoreceptor blocking drugs which abolish the euphoric effect and reduce cravings, or other drugs such as clonidine which suppress the autonomic signs of withdrawal but are less successful at reducing subjective discomfort. These drugs are administered for periods ranging from 5 days to 3 weeks. They are suitable for clients who are not opiate-dependent or who do not want to use opiates in their withdrawal program. Clients are usually treated on an outpatient basis.

Accelerated detoxification over 4 days uses an opiate antagonist such as naloxone or naltrexone to displace the existing opiates in the body. During this process, withdrawal symptoms are treated with non-opiate medication and hospital or in-patient treatment is required.

Detoxification using opiates generally involves the administration of an opiate such as methadone or buprenorphine to stabilise the client before a dose reduction regime is implemented. Dose reduction programs can take one month or more and treatment can be provided on an in-patient or outpatient basis (see also 'Pharmacotherapy treatment' below).

Detoxification may also be required for alcohol or other non-opiate illicit drugs (Kasser et al. 2002).

For **alcohol detoxification**, sedative-hypnotics such as benzodiazepine are most commonly used to reduce withdrawal symptoms and prevent seizures and delirium. Clients are usually treated as in-patients, but outpatient detoxification is also possible.

Sedative-hypnotic withdrawal does not usually require detoxification, although clients may be stabilised on a substitute medication such as diazepam before being tapered off. Treatment may occur in an in-patient or outpatient setting or a combination of both.

Stimulant withdrawal such as from cocaine or amphetamine does not usually require detoxification but symptoms can be alleviated by the use of bromocriptine or amantadine, tricyclic antidepressants or short-acting benzodiazepines (Kasser et al. 2002). In cases of severely dependent clients or those who have consumed large quantities of stimulants, in-patient detoxification may be necessary (Ghodse 2002).

Where clients require detoxification from multiple drugs of a different pharmacological class, the program must provide treatment for each drug class (Kasser et al. 2002).

Relapse involving resumption of illicit drug use can occur both during the detoxification program or after it has been completed. As a result, for many individuals detoxification may need to be repeated (Ghodse 2002).

Pharmacotherapy treatment

Pharmacotherapy treatments are provided by pharmacies, public and private clinics, general practitioners, or hospitals. In the AODTS–NMDS collection, pharmacotherapy treatment includes treatments used as maintenance therapies or relapse prevention (e.g. naltrexone, buprenorphine, LAAM (levo alpha acetyl methadol) and specialist methadone treatment). However, agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS, as are treatments provided by pharmacies, private clinics or general practitioners.

Pharmacotherapy treatments include reduction therapy, where the aim is to reduce the quantity of all drugs used, and maintenance therapy (also known as substitution treatment) which aims to stabilise the user by prescribing a less harmful drug rather than eliminate drug use in the short term (Drugscope 2000).

The drugs prescribed for reduction therapy usually consist of blocking and aversive agents that either stop the drug of dependence having an effect or produce an undesirable effect when combined with the drug of dependence (e.g. naltrexone) (Gowing et al. 2001).

Maintenance therapy is most commonly used for opiate addiction but can also be used for addiction to alcohol or other illicit drugs. There are two main drugs generally prescribed for opiate addiction, with methadone being the most common maintenance drug used in Australia. As a synthetic opioid antagonist it has reduced but similar effects to heroin and, although it is not a cure for heroin dependence, it can lead to improvements in clients' mental and physical health and the stability of their lifestyle. It is usually provided in syrup form and the effect lasts for around 24 hours; consequently, most clients must attend on a daily basis to receive their treatment.

Buprenorphine is the other main drug used for maintenance therapy for opiate addiction. It is a partial opioid antagonist, that is, it blocks the effects of heroin. Unlike methadone, one dose may last up to 3 days so clients are not required to attend daily to receive their treatment. It is provided in tablet form and is dissolved under the tongue (ADF 2003b). It is quite common for clients to switch between buprenorphine and methadone treatments.

LAAM is a similar substance to methadone but has a milder effect. It is available in Australia under clinical trial arrangements and is being actively investigated as an additional treatment for opioid maintenance programs. One benefit of using LAAM is that it needs to be administered only every 3 days and therefore offers greater flexibility to clients and staff (Gowing et al. 2001).

For clients who want to maintain abstinence from heroin or other opioids, the drug naltrexone may be prescribed. Its effectiveness depends heavily on clients' commitment to remain off heroin, the level of support they receive and the continuation of regular counselling. Tablets are taken orally from 1 to 3 days apart depending on dose. It is more expensive than methadone or buprenorphine. In addition, because naltrexone reduces tolerance to heroin, there is a greater risk of a heroin overdose if treatment is discontinued and heroin use resumes (ADF 2003b).

Naltrexone can also be used to support abstinence or harm-reduction measures for alcohol-dependent clients, although the drug acamprosate is normally considered the treatment drug of choice for a total abstinence approach (Graham et al. 2002).

Counselling

There are many different types of alcohol and other drug counselling available, including individual and group counselling in both outpatient and residential settings. The following discussion outlines the main types of counselling programs available. These programs are not distinguished within the AODTS–NMDS collection, but are grouped under the general heading 'counselling'.

At its most basic level, drug counselling provides advice and support to the client from a professional counsellor on an appointment basis. Areas discussed can include clients' drug-taking behaviour, their school, work and leisure activities, and relationships with family and friends.

Types of counselling include motivational interviewing, cognitive and behavioural techniques such as problem-solving skills, drink and drug refusal skills, relapse prevention, contingency management and aversive conditioning, and other skills-based training such as anger or sleep management, relaxation, assertiveness training and vocational rehabilitation (Ghodse 2002). The treatment can be provided at the individual or group level and by a range of specialists such as psychologists, social workers, community nurses, drug and alcohol workers, medical practitioners, Alcoholics Anonymous or Narcotics Anonymous and others (New South Wales Health Department 2003).

The goal of counselling is to encourage and support emotional and behavioural change. Lifestyle adjustment is facilitated by the development of skills to cope with factors that trigger drug use or prevent full relapse to regular drug use (Gowing et al. 2001).

Rehabilitation

Rehabilitation programs begin with a thorough assessment and detoxification, if necessary. A specific treatment plan is then developed which may be provided as residential or out-patient treatment. This plan may include regular counselling, group and/or family therapy sessions, a pharmacotherapy program, an education program providing advice on ways to achieve and maintain recovery, exercise and relaxation sessions, plus support with employment and living arrangements (Ghodse 2002).

Residential rehabilitation programs may be short term (4–6 weeks) or long term (2–6 months). Short-term programs are suitable for people without a long-term history of substance dependence, who have not succeeded at outpatient treatment, do not have significant cognitive impairment or comorbidity and have better psychosocial supports. Long-term programs are preferred for people who have severe alcohol and drug use problems, or whose substance use problems were not overcome by outpatient or short-term residential treatment, or people with significant comorbid disorders (New South Wales Health Department 2003).

The goals of rehabilitation and treatment activities in general include reducing the use of illicit drugs, reducing the risk of infectious diseases, improving physical and psychological health, reducing criminal behaviour and improving social functioning (Gowing et al. 2001).

Information and education

Federal, state and territory governments provide a number of information and education programs, as well as 24-hour telephone information services, on alcohol and other drugs as part of their public health programs. National initiatives to provide information on drug-related harm to the wider community include the Australian Drug Information Network and the Community Partnership Initiative (MCDS 1998). Services provided by the states and territories include 24-hour telephone services and fact sheets on specific drugs and other drug-related reports available from the Internet. The telephone services provide information on drugs, access to drug and alcohol counselling, and referrals to appropriate services.

Information and education programs are also provided specifically for clients of alcohol and other drug treatment services. These include education on the effects of cannabis or other drugs for clients who have been required to attend the service as a result of a police or court diversion order, information on what the client can expect during the withdrawal (detoxification) process, and information on harm minimisation strategies to increase the client's ability to maintain behaviour that reduces drug-related harm.

Appendix 6: Australian Standard Geographical Classification

The Australian Standard Geographical Classification (ASGC) was released in 2001 by the ABS, and was based on an enhanced measure of remoteness (ARIA+) developed by the National Key Centre for Social Applications of Geographical Information (AIHW 2004d).

The Remoteness Areas of the ASGC 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 drugs 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 AIHW (2004d).

Appendix 7: 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).

TYPE OF DRUG CLASSIFICATION: BROAD GROUPS, NARROW GROUPS AND DRUGS OF CONCERN

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 $Beta_2$ 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

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