Australian Government
Australian Institute of
Health and Welfare

Alcohol and other drug treatment services in Australia 2011–12

DRUG TREATMENT SERIES NO. 21

Australian Government
Australian Institute of Health and Welfare

Authoritative information and statistics to promote better health and wellbeing

DRUG TREATMENT SERIES
NUMBER 21

Alcohol and other drug treatment services in Australia

2011–12

Australian Institute of Health and Welfare
Canberra
Cat. no. HSE 139

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

ISSN 1447-6746

ISBN 978-1-74249-474-6

Suggested citation

Australian Institute of Health and Welfare 2013. Alcohol and other drug treatment services in Australia 2011–12. Drug treatment series 21. Cat. no. HSE139. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

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

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Acknowledgments

The authors of this report were Rachel Aalders and Kristina Da Silva. Karen Webber and Arianne Schlumpp assisted with data analysis and Amber Jefferson provided essential advice and guidance. The contributions, comments and advice of the Alcohol and Other Drug Treatment Services National Minimum Data Set Working Group are gratefully acknowledged.

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

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

Department of Health and Ageing, Australian Government

Ministry of Health, New South Wales

Department of Health, Victoria

Department of Health, Queensland

Department of Health, Western Australia

Department of Health, South Australia

Department of Health and Human Services, Tasmania

Health Directorate, Australian Capital Territory

Department of Health, Northern Territory.

Abbreviations

AIHW	Australian Institute of Health and Welfare
ADCA	Alcohol and other Drugs Council of Australia
ADF	Australian Drug Foundation
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASGC	Australian Standard Geographical Classification
DoHA	Department of Health and Ageing
MDMA	3,4-methylenedioxy-N-methylamphetamine (or ecstasy)
NDSHS	National Drug Strategy Household Survey
NGOTGP	Non-Government Organisation Treatment Grants Program
NHMD	National Hospital Morbidity Database
NMDS	National Minimum Data Set
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NPHDC	National Prisoner Health Data Collection
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OSR	OATSIH Services Report
SLA	Statistical Local Area

Symbols

0	Zero
–	nil or rounded to zero
. .	not applicable
n.a.	not available
n.p.	not publishable because of small numbers, confidentiality or other concerns about the quality of the data

Notes

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

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

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

Summary

Publicly funded alcohol and other drug treatment services are available to people seeking treatment for their own drug use and people seeking treatment for someone else's drug use. This report presents data on alcohol and other drug treatment agencies and the episodes of treatment they provide.

A total of 659 alcohol and other drug treatment agencies provided 153,668 episodes that were closed in 2011–12. While the number of agencies decreased slightly from 2010–11, the number of closed episodes increased by 2%.

Most treatment was provided to clients for their own drug use

Of the treatment episodes closed in 2011–12, nearly all (96%) were for clients receiving treatment for their own drug use. Around two-thirds (68%) of these episodes were for male clients, while the reverse was true for episodes provided for someone else's drug use (63% of these were for female clients).

Episodes for someone else's drug use tended to be longer than those for the client's own drug use. More than one-third (35%) of episodes for someone else's drug use lasted 1–3 months, while over half (53%) of episodes for the client's own drug use ended within 1 month.

Alcohol was the most common principal drug of concern

As in previous years, alcohol was the most common principal drug of concern (46%), followed by cannabis (22%), amphetamines (11%) and heroin (9%). Alcohol was the most common principal drug of concern in all states and territories, while cannabis was the second most common principal drug in all states and territories except South Australia, where amphetamines were more common.

In 4 out of 5 (81%) closed episodes, the client reported additional drugs of concern. Of these, 34% reported 1 additional drug and 24% reported 2. Nicotine (21%) was the second most common additional drug after cannabis (22%), but it was the principal drug for only 1% of episodes.

Counselling was the most common type of treatment

Counselling was a main or additional treatment type in almost half (49%) of the episodes closed in 2011–12, and it was the main treatment type in 43% of episodes. Withdrawal management and assessment only were also common treatment types: withdrawal management was a treatment type in 18% of episodes and the main treatment type in 17%, while assessment only, which can only be a main treatment type, was the main treatment type in 14% of episodes.

Alcohol was the most common principal drug for most treatment types, although cannabis (50%) was the most common principal drug in episodes with a main treatment type of information and education only (this is most likely due to the use of this treatment type in episodes where the client has been diverted from the criminal justice system for minor drug offences).

1 Introduction

In Australia, publicly funded treatment services for alcohol and other drug use are available in all states and territories. Most of these services are funded by state and territory governments while some are funded by the Australian Government. Treatment services are provided to people who are seeking assistance for their own drug use, those who are diverted from the criminal justice system, and those seeking assistance for someone else's drug use.

This report presents information on treatment episodes provided by publicly funded treatment services for alcohol and other drug use using data from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) and other related sources. For more information on the data used in this report, see Chapter 2 and Appendix B.

1.1 Drug use in Australia

Drug use can be either licit or illicit. Licit drug use refers to the use of legal drugs in a legal manner, and includes tobacco smoking and alcohol consumption. Illicit drug use refers to the use of drugs that are illegal to possess or use or use of legal drugs in an illegal manner. It includes using drugs like cannabis or heroin as well as drugs like pain killers, tranquillisers and steroids for non-medical purposes or inhaling petrol, glue or paint.

Licit and illicit drug use is a significant issue in Australia and cost an estimated $56 billion in 2004–05, of which $8 billion was for illicit drug use (Collins & Lapsley 2008). The 2010 National Drug Strategy Household Survey (NDSHS) found that alcohol and tobacco were the most common drugs used in Australia, with 80% of Australians aged 14 and older drinking alcohol in the past 12 months and 15% smoking tobacco daily (AIHW 2011a). Although less prevalent than the use of licit drugs, illicit drug use is still relatively common. In 2010, about 2 in 5 people aged 14 and older reported illicit drug use in their lifetimes, while 1 in 7 reported illicit drug use in the past 12 months (AIHW 2011a). Cannabis was the most common illicit drug—1 in 3 Australians aged 14 and older had used cannabis in their lifetime, while 1 in 10 had used it in the past 12 months. Ecstasy and hallucinogens were the second and third most common drugs for lifetime use (10% and 9%, respectively), while ecstasy and pain killers (analgesics) for non-medical purposes were the second and third most common for use in the past 12 months (3% for both).

1.2 National drug strategy

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

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

- **Harm reduction** to reduce harms to individuals, families and community safety.

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

1.3 Types of agencies and treatment

Alcohol and other drug treatment services assist people to address their drug use through a range of treatments. Treatment objectives can include reduction or cessation of drug use as well as improvements to social and personal functioning. Services are also provided to people who are seeking assistance for someone else's drug use.

This report focuses on publicly funded treatment agencies. It does not include information on agencies that provide services primarily concerned with health promotion or accommodation, private treatment agencies that do not receive public funding, or needle and syringe programs. Limited information is included on agencies whose sole function is to prescribe or provide dosing for opioid pharmacotherapy, services provided in prisons, and primary health care services and substance use services funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH).

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

The main source of data for this report (see Chapter 2) contains information on 7 types of treatment:

- **Withdrawal management, both medicated and non-medicated.** This is the process of stopping or reducing drug use, often after a period of long or frequent use.
- **Counselling, both individual and group.** This is the most common treatment for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013).
- **Rehabilitation.** This focuses on supporting clients in stopping their drug use and helping to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011b).
- **Pharmacotherapy where the client receives another type of treatment in the same treatment episode.** Pharmacotherapy includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category. Due to the complexity of the pharmacotherapy sector, only limited information is provided in this report on agencies whose sole function is to provide pharmacotherapy.
- **Support and case management only.** Support includes activities such as helping a client who occasionally calls an agency worker for emotional support. Case management is usually more structured than 'support'. It can assume a more holistic approach, taking

into account all client needs including general welfare needs, and it includes assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007).

- **Assessment only.** Most types of treatment include an assessment to identify the nature of the drug issue, the needs of the client and the type of treatment most appropriate for the client. This category is used when only an assessment is provided in a treatment episode, for example, by an agency whose main function is to assess and refer people to appropriate treatment agencies.
- **Information and education only** for individuals and groups.

1.4 Report structure

This report contains the following sections:

- Chapter 1 (this chapter) introduces the report and provides a background to the alcohol and other drug sector in Australia.
- Chapter 2 outlines the data and methods used in this report.
- Chapter 3 presents data on alcohol and other drug treatment agencies and episodes closed in the financial year.
- Chapter 4 provides information on the client characteristics of the episodes closed in the financial year.
- Chapter 5 explores the drugs of concern of the episodes closed in the financial year.
- Chapter 6 explores the types of treatment provided in the episodes closed in the financial year.
- Chapter 7 summarises key information for each state and territory.
- Appendix A provides detailed information about the data and methods used in this report.
- Appendix B provides the data quality statement for the AODTS NMDS.

Supplementary tables referred to in this report (tables with a prefix of S) can be downloaded from http://www.aihw.gov.au/publications/. Past reports in this series are also available for downloading.

2 Data

The main source of data for this report is the Alcohol and Other Drug Treatment Services National Minimum Data Set. This data set contains information on treatment episodes provided by publicly funded alcohol and other drug treatment services. Data are collected by treatment agencies who forward the data to the Australian and state and territory government health departments. These departments then extract the required data according to definitions and technical specifications agreed to by the departments and the Australian Institute of Health and Welfare (AIHW).

Other sources of data in this report include the National Hospital Morbidity Database, the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection and the National Prisoner Health Data Collection.

For more information about these other sources of data, the data quality statements for the data sources and the methods used in this report, see appendixes.

2.1 Data on agencies

The AODTS NMDS contains information on publicly funded alcohol and other drug treatment services. Agencies are excluded from the AODTS NMDS if they:

- do not receive any public funding
- provide accommodation as their main function (including half-way houses and sobering-up shelters)
- are located in prisons or detention centres
- are located in acute care or psychiatric hospitals and provide treatment only to admitted patients
- have the sole function of prescribing or providing dosing for opioid pharmacotherapy (these agencies are excluded because of the complexity of this sector).

OATSIH-funded primary health care services and substance use services are in scope for the AODTS NMDS but most of these agencies do not contribute to the collection as they currently provide data to other collections.

For each agency in the AODTS NMDS, data are collected on the geographical location of the agency.

2.2 Data on treatment episodes

The AODTS NMDS contains information on all treatment episodes provided by in-scope agencies where the episode was closed in the relevant financial year. A treatment episode is considered closed where:

- the treatment is completed or has ceased
- there has been no contact between the client and treatment provider for 3 months
- there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy and not receiving any other form of treatment that falls within the scope of the collection
- include only activities relating to needle and syringe exchange
- are for a client aged under 10.

For each treatment episode in the AODTS NMDS, data are collected on:

- the client: sex, date of birth, Indigenous status, country of birth, preferred language, source of referral and injecting drug status
- whether the client is receiving treatment for their own drug use or someone else's drug use
- the drugs of concern (principal drug of concern and up to five additional drugs of concern)
- the method of use for the principal drug of concern
- types of treatment (main treatment type and up to four additional treatment types)
- the start and end dates of the episode and the reason the episode was closed.

2.3 Data on clients

The AODTS NMDS does not contain a unique identifier for clients and information about clients is collected at the episode level. Therefore, it is not possible to count the number of distinct clients receiving treatment as clients may have multiple treatment episodes in a financial year.

In future years, the AODTS NMDS will include data items that will allow distinct clients to be counted.

2.4 Data quality and coverage

Information on data quality and coverage is available in the Data Quality Statement for the AODTS NMDS in Appendix B.

3 Treatment agencies and episodes

This chapter provides information on the alcohol and other drug treatment agencies that provided data to the AODTS NMDS and the number of treatment episodes that are closed in the financial year.

3.1 Key points

- A total of 659 alcohol and other drug treatment agencies provided 153,668 episodes that were closed in 2011–12. While the number of agencies decreased slightly from 2010–11, the number of closed episodes increased by 2%.
- Three-quarters of the treatment agencies and episodes were in the three largest states: New South Wales, Victoria and Queensland. Nationally, just over half of the treatment agencies were in the non-government sector. However, treatment agencies in New South Wales, Queensland and South Australia were more likely to be in the government sector.
- Almost three-fifths of the treatment agencies were in *Major cities*, while just 11% were in *Remote* or *Very remote* areas.
- More than three-quarters (78%) of closed episodes ended within 3 months and 1 in 11 (9%) lasted 6 months or longer. Over the 9 years from 2003–04, the median length increased from 17 days to 26 days in 2011–12.

3.2 Number of closed episodes and agencies

In 2011–12, 659 alcohol and other drug treatment agencies provided 153,668 treatment episodes that were closed in the financial year (some episodes may still have been open at 30 June 2012; these episodes are not included in this report) (Table S3.1 and Table S3.2).

While there was an overall increase over the 9 years from 2003–04 to 2011–12 for both the number of agencies and the number of episodes closed in the financial year, the increase was greater for episodes (12%) than for agencies (6%) (Figure 3.1 and Figure 3.2). Although the number of episodes closed in 2011–12 increased from 2010–11 (up 2% from 150,488), the number of agencies decreased slightly over the same period (down 1% from 666).

Three-quarters (76%) of the treatment agencies and closed episodes for 2011–12 were in New South Wales, Victoria and Queensland (Table S3.1 and Table S3.2). The number of agencies ranged from 9 in the Australian Capital Territory to 263 in New South Wales, while the number of closed episodes ranged from 1,672 in Tasmania to 38,321 in New South Wales.

Over the 9 years from 2003–04 to 2011–12, the number of agencies supplying data to the AODTS NMDS increased in most states and territories, the largest increases being in Western Australia (up 85% from 34 to 63 agencies) and Tasmania (up 33% from 12 to 16) (Table S3.1). The number was unchanged in the Northern Territory, and in Victoria it fell 5% (143 to 136 agencies). Over the same period, the number of closed episodes also increased in all states and territories except New South Wales and Tasmania (Table S3.2).

Over the most recent year from 2010–11, only Western Australia had a significant increase in the number of agencies (up 13%), while the number of agencies decreased in Queensland, South Australia and the Australian Capital Territory. However, the number of closed

episodes increased in New South Wales, Victoria, Western Australia and the Australian Capital Territory.

It is important to note that changes in trends may reflect data collection methods rather than actual changes in the number of agencies or episodes, as agencies may move in and out of scope between collections and some agencies may aggregate data for a number of outlets to a single administrative level, resulting in an undercount of agencies (see Appendix B for more details).

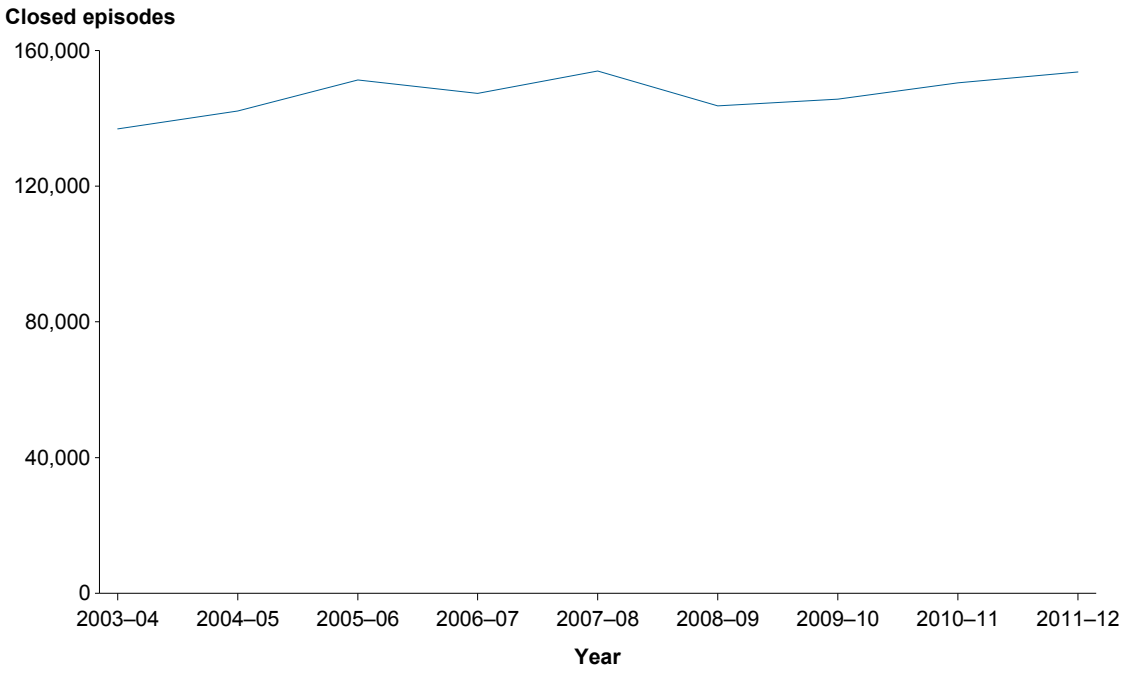

Figure 3.1: Closed episodes, 2003–04 to 2011–12, Australia

Source: Table S3.2.

3.3 Service sector: government and non-government

While all agencies supplying data to the AODTS NMDS are publicly funded, some are government agencies and others are non-government. Nationally, just over half (52%) of the treatment agencies were non-government, and these agencies provided almost three-fifths (59%) of the episodes closed in 2011–12 (Table 3.1). The proportion of government and non-government agencies has changed little from 2003–04 (Figure 3.2)

Table 3.1: Treatment agencies and closed episodes by service sector of treatment agency, 2011–12, states and territories

Service sector	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Treatment agencies				
Government	195	0	53	14	42	7	1	5	317
Non-government	68	136	44	49	14	9	8	14	342
Total	**263**	**136**	**97**	**63**	**56**	**16**	**9**	**19**	**659**
					Closed episodes				
Government	30,002	0	18,442	2,352	6,970	1,081	2,414	1,056	62,317
Non-government	8,319	53,574	6,842	16,149	1,741	591	1,666	2,469	91,351
Total	**38,321**	**53,574**	**25,284**	**18,501**	**8,711**	**1,672**	**4,080**	**3,525**	**153,668**

Note: Western Australia has a number of integrated services that include both government and non-government providers.

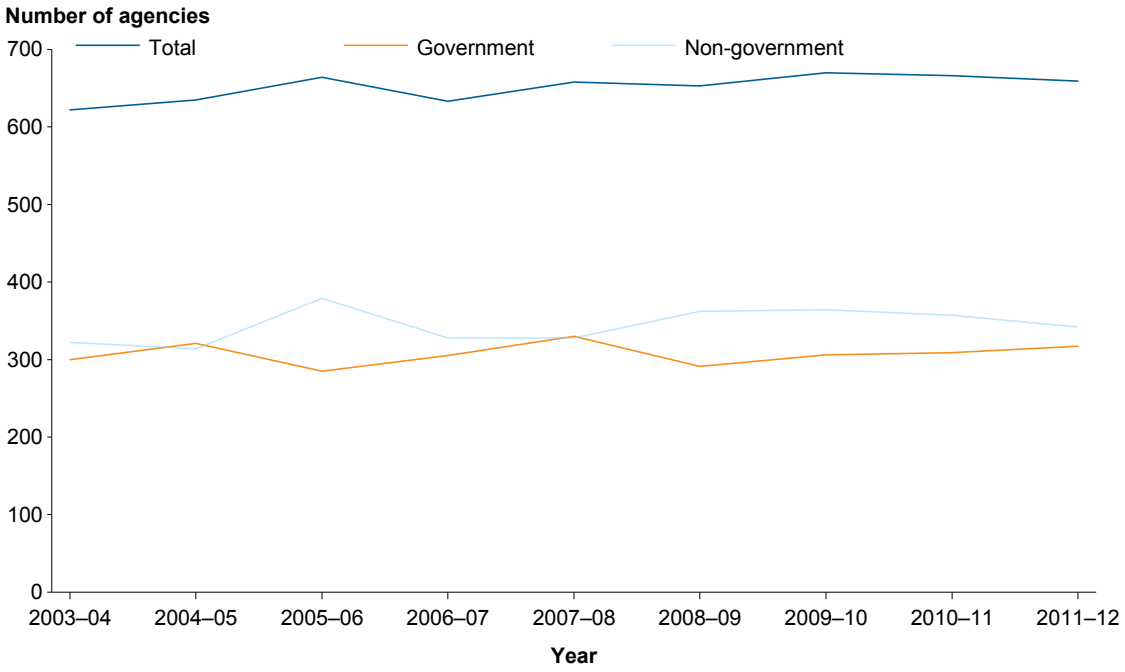

Figure 3.2: Treatment agencies by service sector, 2003–04 to 2011–12, Australia

Source: Table S3.1.

Similarly to the national picture, the majority of agencies in most states and territories were non-government, although this was not the case for South Australia (25%), New South Wales (26%) or Queensland (45%) (Figure 3.3). In the remaining states and territories, the proportion that was non-government ranged from 56% in Tasmania to 100% in Victoria.

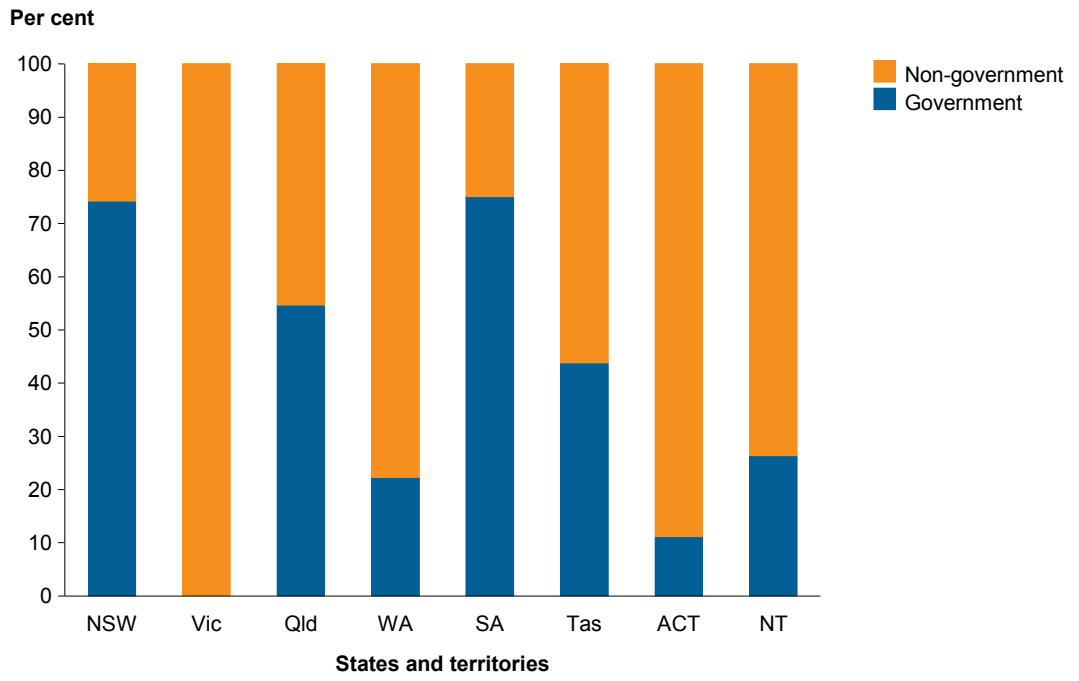

Figure 3.3: Treatment agencies by service sector, 2011–12, states and territories

Source: Table S3.1.

3.4 Remoteness

Nationally, 58% of treatment agencies and 69% of episodes closed in 2011–12 were in *Major cities*, while 24% of agencies and 18% of closed episodes were in *Inner regional* areas (Figure 3.4). Relatively few agencies and episodes were in *Remote* or *Very remote* areas. This general pattern was found across most states and territories (note that not all remoteness areas occur in all states and territories) (Table S3.4).

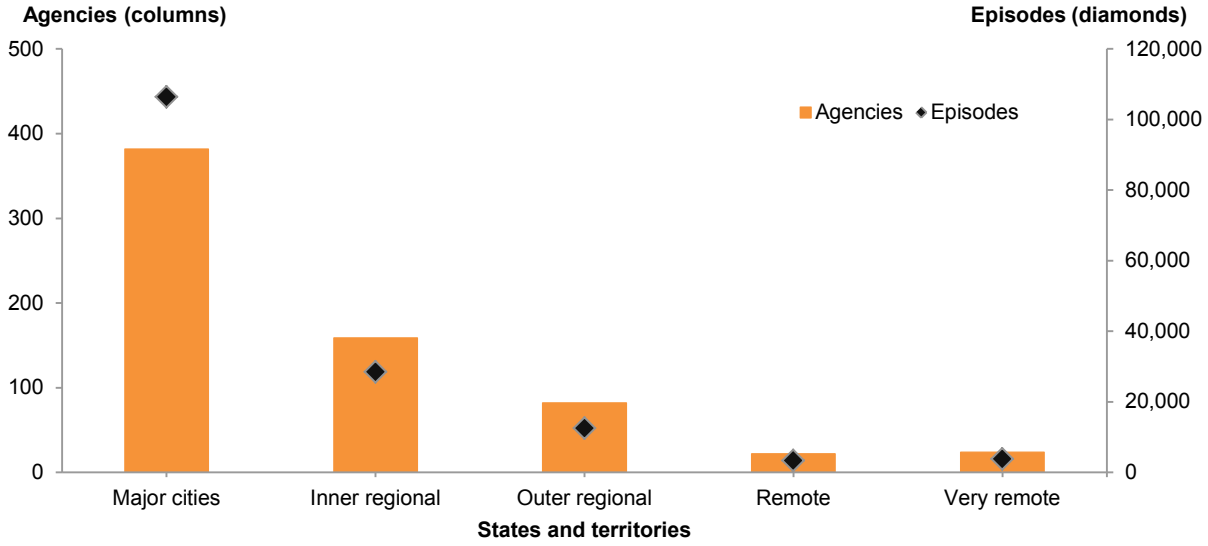

Figure 3.4: Treatment agencies and episodes by remoteness of agency, 2011–12, Australia

Source: Table S3.3 and Table S3.4.

3.5 Length of treatment episodes

More than three-quarters (78%) of closed episodes ended within 3 months: one-fifth (21%) within 1 day, almost one-third (32%) between 2 days and 1 month, and one-quarter (25%) between 1 and 3 months (Figure 3.5). Only 9% of episodes lasted 6 months or longer. Among the states and territories, the proportion of closed episodes that ended within 3 months ranged from 72% in Queensland to 81% in Victoria (Table S3.5).

Over time, the proportion of episodes that ended within 3 months remained at 82%–83% from 2003–04 to 2008–09, but decreased slightly in recent years to 78% (Table S3.5).

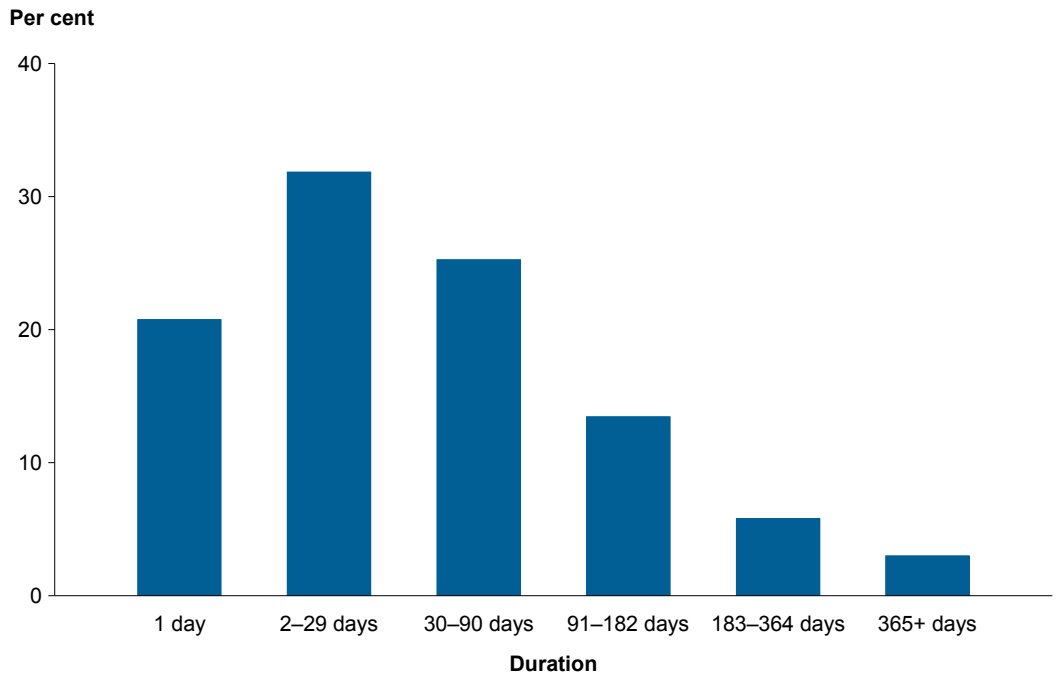

Figure 3.5: Closed episodes by duration, Australia, 2011–12

Source: Table S3.5.

Nationally, the median length of episodes closed in 2011–12 was almost 4 weeks (26 days) (Figure 3.6). Among the states and territories, the median length ranged from just over 1 week (8 days) in South Australia to more than 5 weeks (38 days) in Victoria.

The median length of closed episodes gradually increased from 17 days in 2003–04 to 23 days in 2009–10 and 2010–11, reaching 26 days in 2011–12 (Table S3.6). Although there was a general increase in most states and territories, there was no overall change for New South Wales or South Australia.

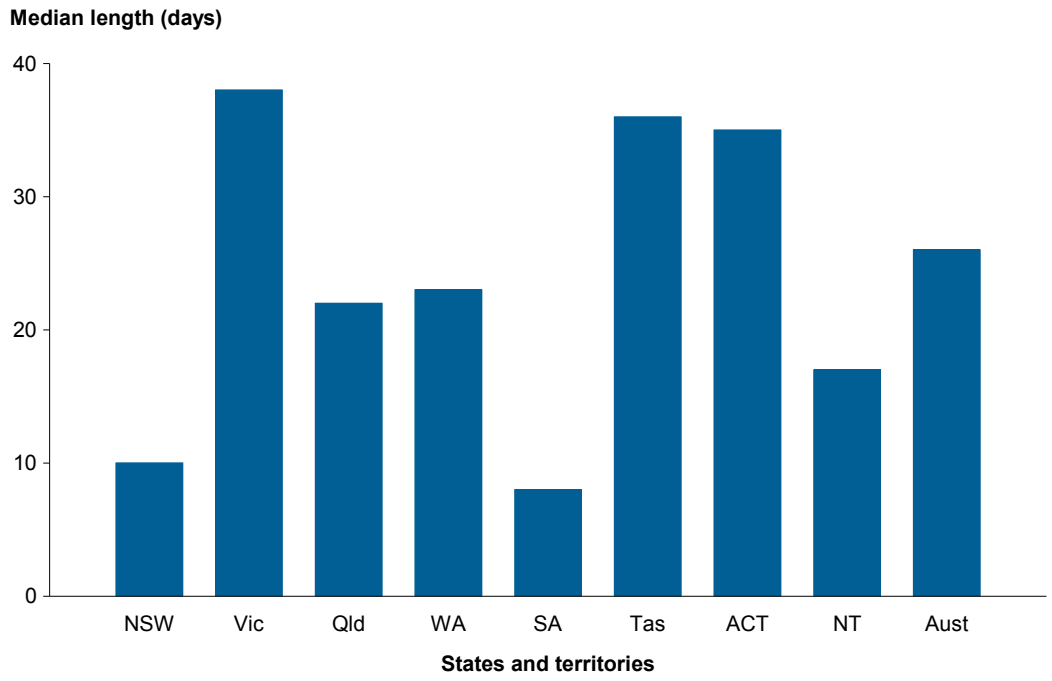

Figure 3.6: Closed episodes by median length, states and territories, 2011–12

Source: Table S3.6.

4 Clients

Clients receiving treatment from a publicly funded treatment agency are grouped into those who received treatment for their own drug use, either because they sought treatment or as part of a police or court diversion program, and those who received treatment for someone else's drug use. This chapter explores the treatment provided to these two groups. Note that throughout this chapter (and report), the primary unit is closed episodes, not distinct clients. As clients can have multiple episodes closed in a financial year, the number of episodes will not equal the number of distinct clients.

4.1 Key points

- Of the 153,668 episodes closed in 2011–12, nearly all (96%) were provided to clients receiving treatment for their own use (Figure 4.1). About two-thirds (68%) of episodes provided to those receiving treatment for their own drug use were for male clients, while the reverse was true for episodes provided for someone else's drug use, where 63% were for female clients.
- Of the episodes provided to clients for their own drug use, almost 1 in 3 (29%) were for clients aged 30–39. Where the episode was for someone else's drug use, the client tended to be older—almost 1 in 4 (23%) were for clients aged 40–49 while a further 1 in 5 (21%) were for clients aged 50–59.
- Self or family was the most common referral source for both types of clients (41% of episodes for client's own drug use and 62% for someone else's drug use).
- Episodes for someone else's drug use tended to be longer than those for the client's own drug use. More than one-third (35%) of episodes for someone else's drug use lasted 1–3 months, while over half (53%) of episodes for the client's own drug use ended within 1 month.

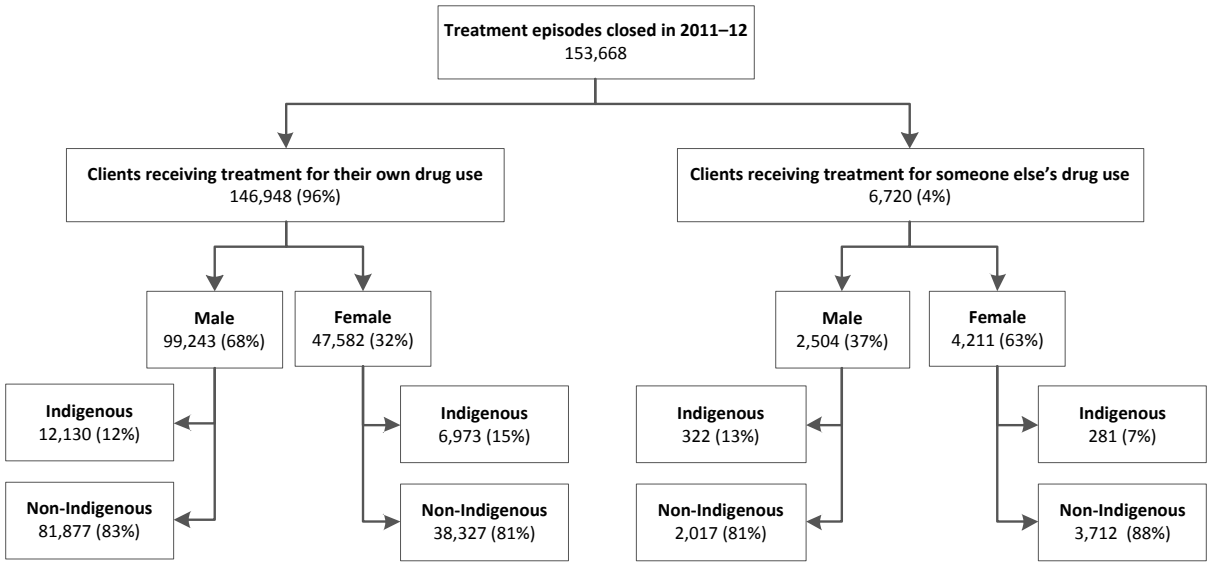

Figure 4.1: Summary client characteristics of closed treatment episodes, Australia, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S4.1 and Table S4.2.

4.2 Treatment provided to clients for their own drug use

Demographics

Nearly all (96%) of the episodes closed in 2011–12 were for people receiving treatment for their own drug use (Figure 4.1). Of these, over two-thirds (68%) were for male clients, and this has remained relatively unchanged since 2003–04 (Table S4.3). Almost 1 in 3 (29%) episodes were provided to clients aged 30–39, while a further 28% were for clients aged 20–29 (Table 4.1). One in 5 (20%) were for clients aged 40–49 and 1 in 8 (12%) were aged 10–19. Proportions were similar for males and females (Figure 4.2). There was little change in the proportion of episodes provided to clients of different age groups from 2003–04 to 2011–12 (Table S4.6).

Indigenous clients tended to be slightly younger than non-Indigenous clients—almost half (49%) of episodes provided to Indigenous people were for those aged 10–29, compared with 37% for non-Indigenous clients (Table S4.5). However, it is important to note that many Indigenous clients receive treatment from OATSIH-funded agencies and data for these agencies is largely not included in this report. Data on the number of episodes of care provided by OATSIH-funded agencies is available from the AIHW OATSIH Services Reporting Database; however, 2011–12 data were not available at the time of writing.

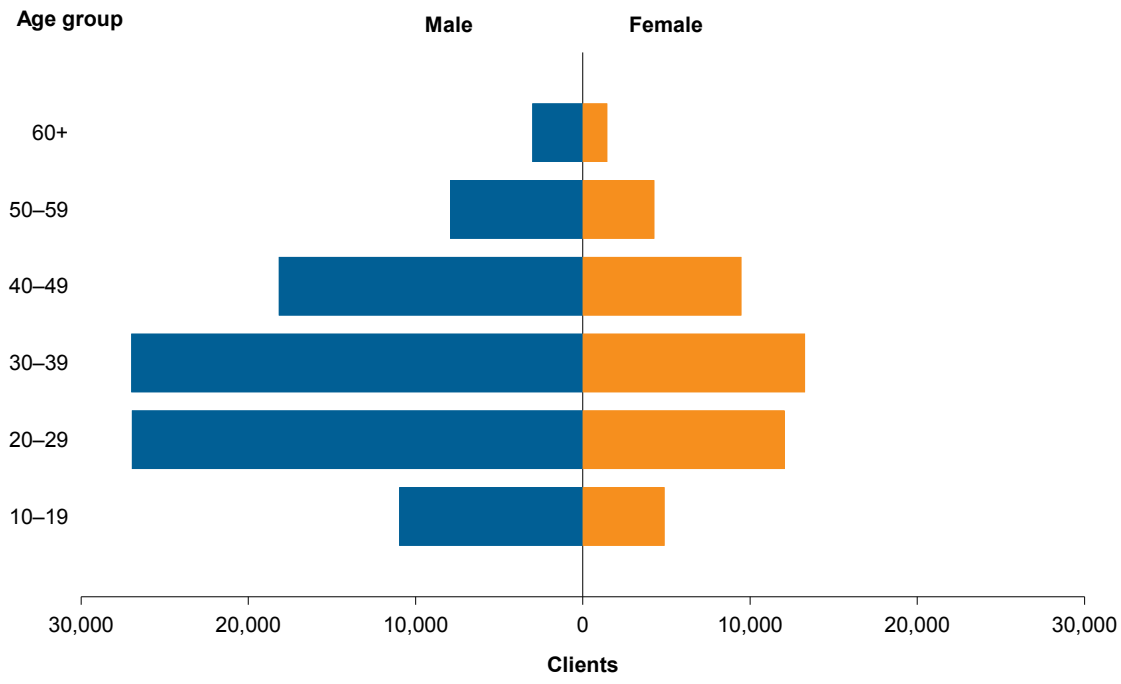

Figure 4.2: Closed episodes provided to clients for their own drug use by age group and sex, Australia, 2011–12

Source: Table S4.5.

Among the states and territories, the proportion of episodes provided to males ranged from 66% in Victoria, Western Australia and the Australian Capital Territory to 72% in Tasmania (Table 4.1). Similarly to the national picture, most episodes were provided to clients aged 20–

39. The proportion of episodes provided to clients aged 20–29 ranged from 24% in South Australia and the Australian Capital Territory to 32% in Queensland, while the proportion provided to clients aged 30–39 ranged from 26% in Tasmania to 31% in South Australia and the Northern Territory.

Table 4.1: Closed episodes provided to clients for their own drug use by age group and sex, states and territories, 2011–12

Age group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Male				
10–19	1,745	4,255	2,214	2,331	286	174	503	313	11,821
20–29	6,505	9,899	5,585	3,422	1,416	339	637	682	28,485
30–39	7,686	9,100	4,712	3,199	1,855	303	750	686	28,291
40–49	5,639	6,191	2,960	1,655	1,494	203	496	414	19,052
50–59	2,742	2,575	1,263	651	747	70	188	125	8,361
60+	1,282	862	451	174	255	28	53	37	3,142
Total	25,603	32,910	17,216	11,442	6,063	1,117	2,635	2,257	99,243
					Female				
10–19	746	2,327	751	893	126	57	232	128	5,260
20–29	3,032	4,417	2,213	1,634	621	139	313	251	12,620
30–39	3,561	4,771	2,149	1,782	790	107	390	283	13,833
40–49	2,565	3,493	1,524	1,136	634	83	278	175	9,888
50–59	1,426	1,509	630	420	263	42	116	57	4,463
60+	547	454	202	94	113	9	42	11	1,472
Total	11,879	16,999	7,478	5,961	2,548	437	1,375	905	47,582
					Total				
10–19	2,491	6,585	2,965	3,224	412	231	735	441	17,084
20–29	9,541	14,342	7,801	5,056	2,039	478	950	935	41,142
30–39	11,249	13,910	6,864	4,981	2,645	410	1,140	969	42,168
40–49	8,207	9,700	4,485	2,791	2,128	286	774	590	28,961
50–59	4,171	4,088	1,896	1,071	1,010	112	304	182	12,834
60+	1,829	1,322	653	268	368	37	95	48	4,620
Total	**37,494**	**50,004**	**24,705**	**17,403**	**8,613**	**1,554**	**4,010**	**3,165**	**146,948**

Note: Totals include episodes for people of unknown age and sex.

Most (87%) of the episodes for the client's own drug use were provided to clients whose country of birth was Australia (Table S4.7). A further 3% were born in the United Kingdom and 2% were born in New Zealand. In almost all (96%) episodes, the client had a preferred language of English.

Referral source

Nationally, the most common source of referral for clients receiving treatment for their own drug use in 2011–12 was self or family (41%), and this was the most common referral source in all states and territories except South Australia (Figure 4.3). Self or family was the referral source for over half of episodes closed in the Australian Capital Territory (55%) and

Tasmania (54%). Referral from a health service was also common (27% nationally), and this was the most common referral source in South Australia (38%). Referrals from police or court diversion programs accounted for 14% of episodes (these programs divert people with minor drug offences from the criminal justice system). Among the states and territories, this ranged from 9% in New South Wales and South Australia to 22% in Tasmania (Table S4.8). Clients referred by diversion programs tended to be younger—20% of these episodes were for clients aged 10–19 and 38% were for clients aged 20–29, compared with 12% and 28%, respectively, for all episodes. In 1 in 11 (9%) episodes, the client was referred by a correctional service.

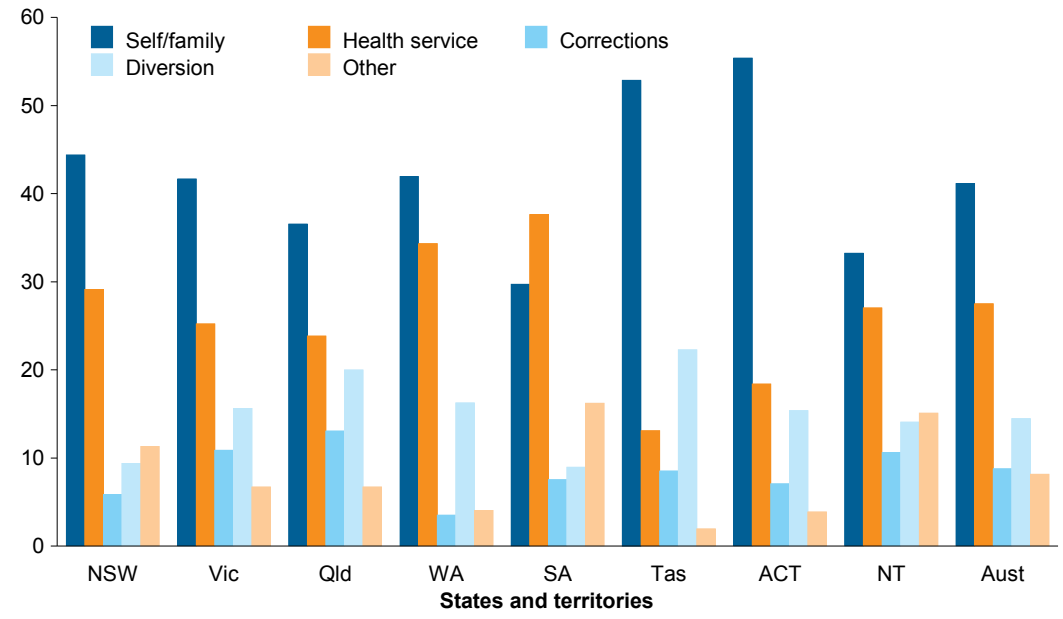

Figure 4.3: Closed episodes provided to clients for their own drug use by referral source, states and territories, 2011–12

Source: Table S4.8.

Over the 9 years from 2003–04, the proportion of episodes where the client was referred by a diversion program increased from 9% to 14% with a peak of 19% in 2009–10, while the proportion of episodes with a referral source of self or family decreased from 45% to 41% with a low of 37% in 2009–10 (Table S4.9). There was little change in the other sources of referral.

Length of treatment episodes

More than three-quarters (78%) of closed episodes for the client's own drug use ended within 3 months, and more than half (53%) ended within 1 month—one-fifth (21%) ended within 1 day (Figure 4.4). Just 9% of episodes lasted 6 months or more. Among the states and territories, the proportion of closed episodes that ended within 3 months ranged from 72% in Queensland to 81% in New South Wales (Table S4.10).

Over the 9 years from 2003–04, the proportion of episodes that ended within 3 months decreased slightly from 83% to 78% (Table S4.10).

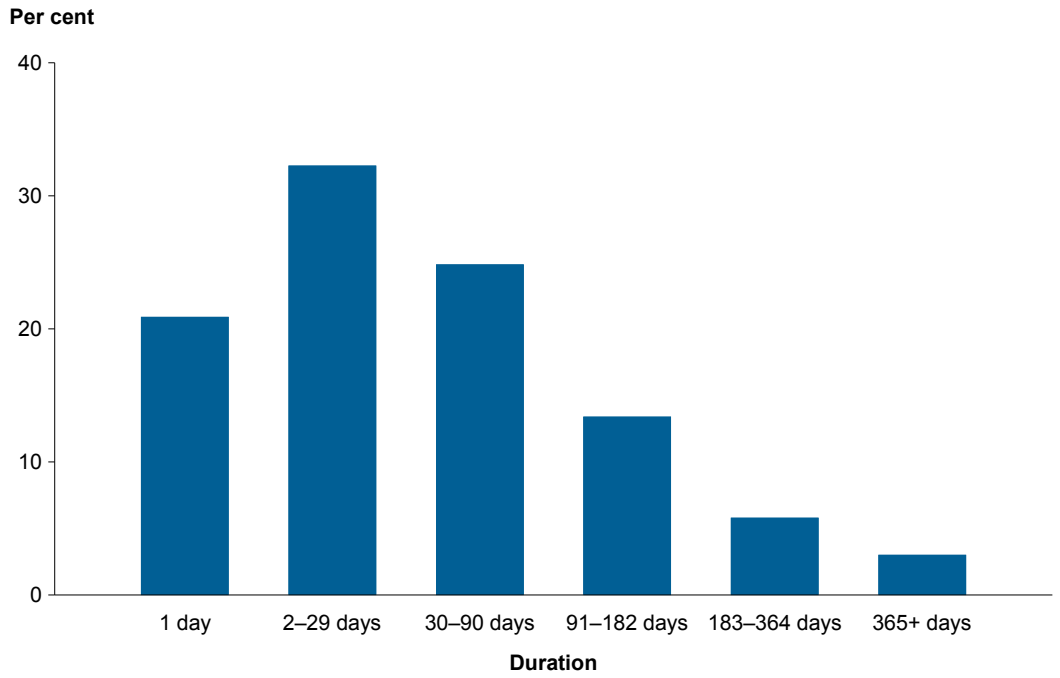

Figure 4.4: Closed episodes provided to clients for their own drug use by duration, Australia, 2011–12

Source: Table S4.10.

Nationally, the median length of closed episodes for the client's own drug use was almost 4 weeks (25 days), and this ranged from just over 1 week (8 days) in South Australia to more than 5 weeks (38 days) in Victoria (Figure 4.5).

The median length of closed episodes for the client's own drug use increased over the 9 years from 2003–04 from 16 days to a high of 25 days in 2011–12; however, there was no overall change for New South Wales or South Australia (Table S4.11).

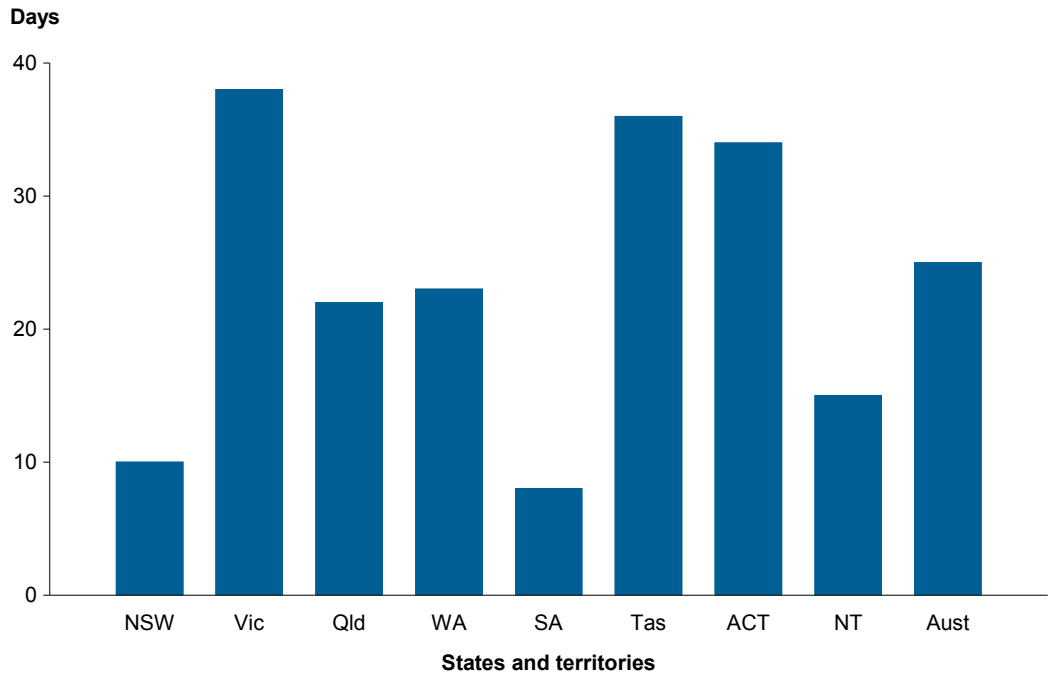

Figure 4.5: Closed episodes provided to clients for their own drug use by median length, states and territories, 2011–12

Source: Table S4.11.

4.3 Assistance provided to clients for someone else's drug use

Demographics

Just 4% of episodes closed in 2011–12 were for people receiving treatment for someone else's drug use. Of these 6,720 episodes, 63% were for female clients, which is the same proportion as for 2010–11 but a decline from 74% in 2003–04 (Table S4.4). These clients tended to be older than those receiving treatment for their own drug use; almost one-quarter (23%) of episodes were for clients aged 40–49 while a further one-fifth (21%) were for clients aged 50–59 (Table S4.12). There was little change in the distribution of episodes among the different age groups in the 9 years from 2003–04 (Table S4.13).

Male clients tended to be slightly younger than female clients (Figure 4.6). Six in 10 (61%) episodes provided to female clients were for people aged 40 or older, compared with 5 in 10 (49%) for those provided to male clients. Indigenous clients were also younger than non-Indigenous clients—episodes for non-Indigenous clients were twice as likely to be for a client aged 40 or older (59%) than those for Indigenous clients (29%) (Table S4.12).

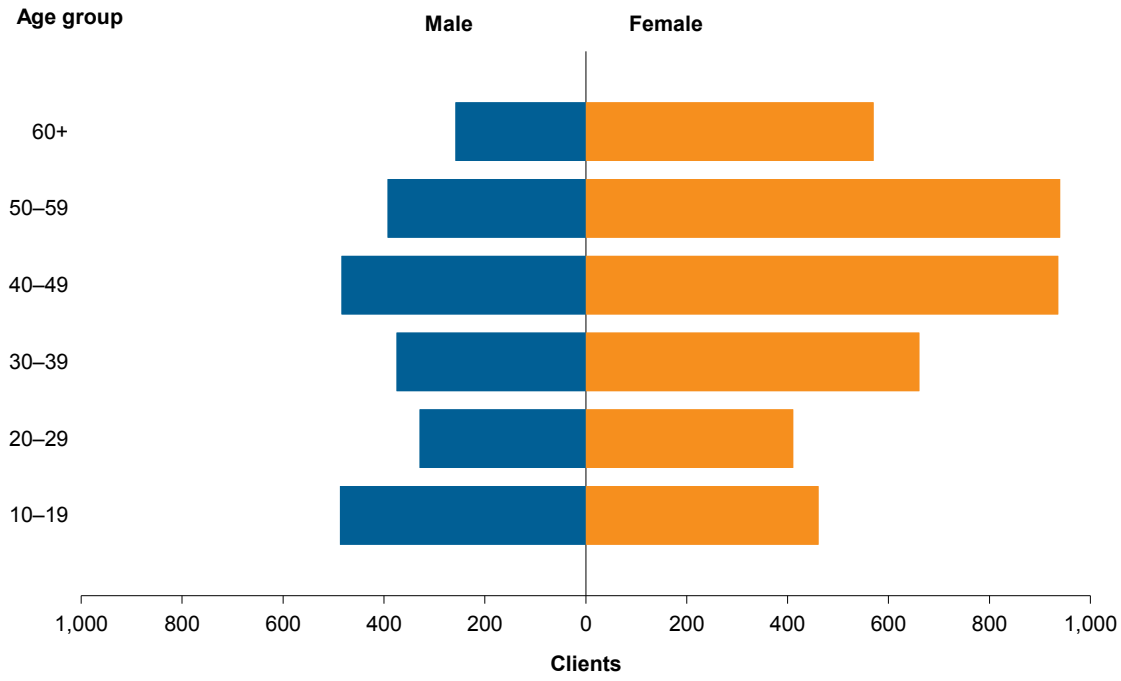

Figure 4.6: Closed episodes provided to clients for someone else's drug use by age group and sex, Australia, 2011–12

Source: Table S4.12.

In nearly all states and territories, most episodes relating to someone else's drug use were provided to female clients—only in the Northern Territory were these episodes more likely to be provided to male clients (54%) (Table 4.2). In the remaining states and territory, the proportion of episodes provided to female clients ranged from 59% in Victoria to 82% in Tasmania. In the Northern Territory, the majority (61%) of episodes for someone else's drug use were for those aged 10–19, and for episodes provided to male clients, three-quarters (75%) were for clients in this age group. In contrast, in the remaining states and territory most episodes were provided to clients aged 40 or older (from 54% in Victoria to 70% in Western Australia).

Table 4.2: Closed episodes provided to clients for someone else's drug use by age group and sex, states and territories, 2011–12

Age group	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
					Male				
10–19	54	237	28	30	5	n.p.	n.p.	144	505
20–29	54	253	30	19	4	n.p.	n.p.	13	374
30–39	39	292	28	28	n.p.	n.p.	n.p.	11	405
40–49	54	325	45	63	10	n.p.	n.p.	10	516
50–59	67	210	46	76	8	n.p.	6	n.p.	420
60+	36	132	14	69	n.p.	n.p.	5	n.p.	265
Total	**305**	**1,452**	**192**	**291**	**34**	**21**	**16**	**193**	**2,504**
					Female				
10–19	52	293	24	34	6	n.p.	n.p.	74	487
20–29	54	212	52	84	n.p.	n.p.	n.p.	22	447
30–39	75	355	73	122	13	n.p.	n.p.	21	685
40–49	130	492	98	200	9	n.p.	n.p.	23	997
50–59	136	452	95	224	13	n.p.	14	n.p.	981
60+	74	301	43	141	n.p.	n.p.	6	n.p.	593
Total	**521**	**2,115**	**386**	**807**	**64**	**97**	**54**	**167**	**4,211**
					Total				
10–19	106	530	52	64	11	5	6	218	992
20–29	109	465	82	103	10	11	7	35	822
30–39	114	647	101	150	15	22	9	32	1,090
40–49	184	820	143	263	19	37	17	33	1,516
50–59	203	662	142	300	21	27	20	27	1,402
60+	110	433	57	210	14	16	11	7	858
Total	**827**	**3,570**	**579**	**1,098**	**98**	**118**	**70**	**360**	**6,720**

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Note: Totals include episodes for people of unknown age and sex.

Almost four-fifths (79%) of the episodes for someone else's drug use were provided to clients whose country of birth was Australia (Table S4.14). A further 4% were born in the United Kingdom and 2% were born in New Zealand. In nearly all (94%) episodes, the client had a preferred language of English.

Referral source

More than 3 in 5 episodes (62%) provided to clients for someone else's drug use had a referral source of self or family, while 1 in 5 (20%) were referred by a health service. Self or family was the most common referral source in all states and territories except the Northern Territory, where 'other' was the most common referral source (47%). In the remaining states and territory, the proportion of episodes where self or family was the referral source ranged from 53% in the Australian Capital Territory to 82% in Western Australia (Figure 4.7).

There was little change in the trends for referral source over the 9 years from 2003–04.

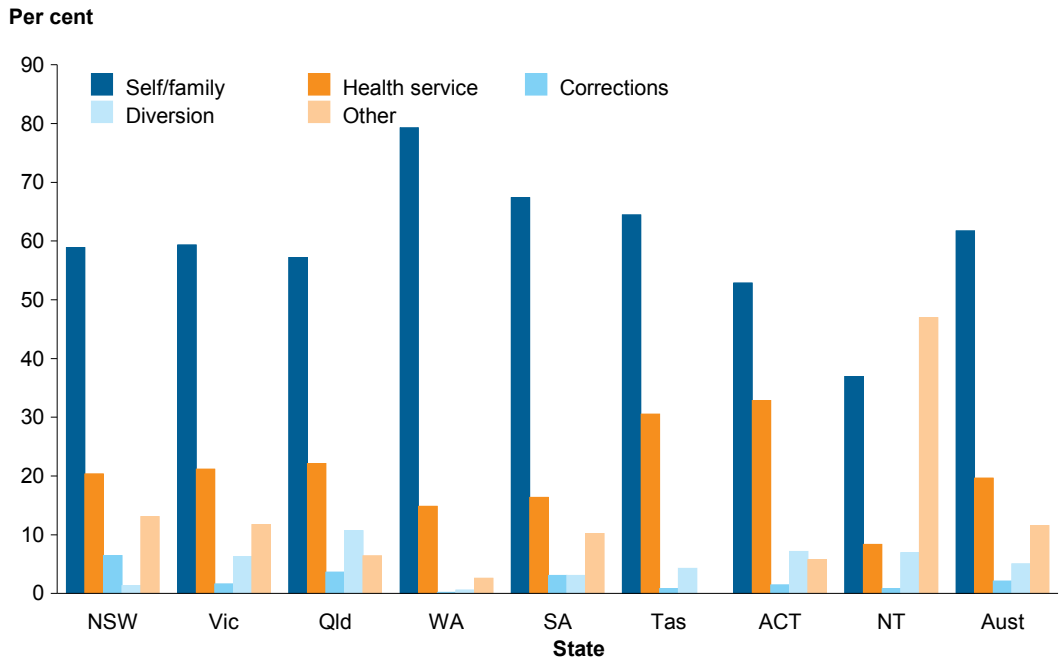

Figure 4.7: Closed episodes provided to clients for someone else's drug use by referral source, states and territories, 2011–12

Source: Table S4.15.

Length of treatment episodes

More than three-quarters (76%) of episodes provided to clients for someone else's drug use ended within 3 months—more than one-third (35%) lasted 1–3 months (Figure 4.8). Among the states and territories, the proportion of episodes that ended within 3 months ranged from 33% in the Australian Capital Territory to 81% in Victoria (Table S4.17).

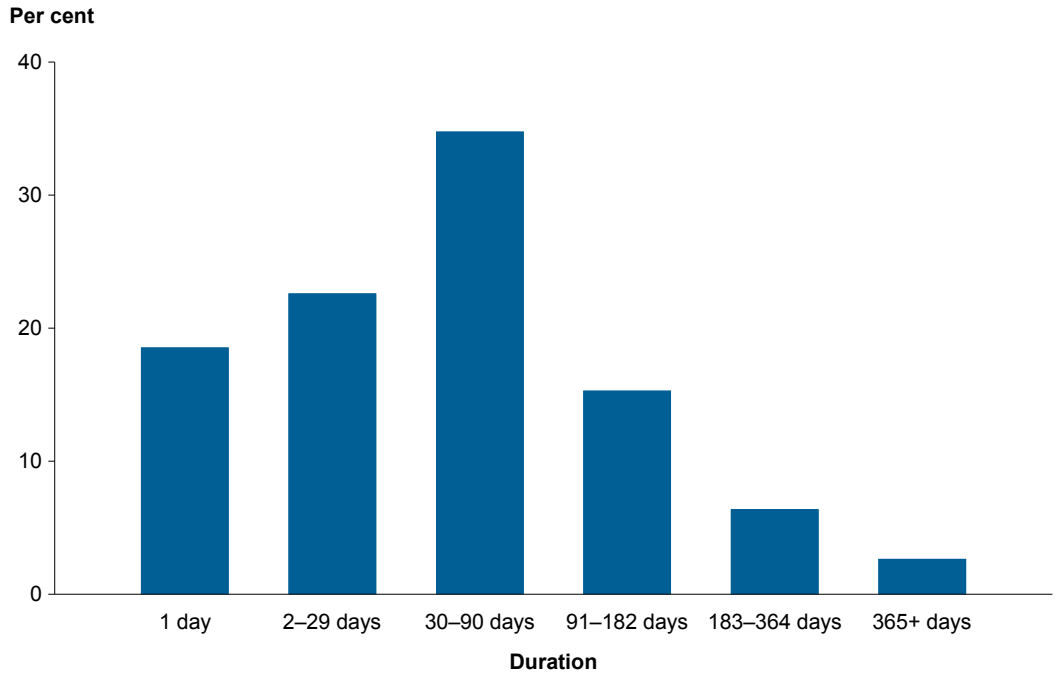

Figure 4.8: Closed episodes provided to clients for someone else's drug use by duration, Australia, 2011–12

Source: Table S4.17.

Nationally, the median length of closed episodes for someone else's drug use was 6 weeks (42 days); this ranged from 2 weeks (15 days in New South Wales, Queensland and Western Australia) to 27 weeks (192 days) in the Australian Capital Territory (Figure 4.9).

Over the 9 years from 2003–04, the median length of closed episodes increased from 31 days to a high of 42 days in 2011–12 (Table S4.18).

Figure 4.9: Closed episodes provided to clients for someone else's drug use by median length, states and territories, 2011–12

Source: Table S4.18.

5 Drugs of concern

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

5.1 Key points

- Alcohol was the most common principal drug (46%) and the most common drug overall when additional drugs are considered (62%).
- Alcohol was the most common principal drug of concern in all states and territories, while cannabis was the second most common principal drug in all states and territories except South Australia, where amphetamines were more common.
- Over the 9 years from 2003–04, the four most common principal drugs (alcohol, cannabis, amphetamines and heroin) have remained unchanged.

5.2 Principal and additional drugs of concern

In 4 of every 5 (81%) closed episodes, the client reported drugs of concern in addition to their principal drug of concern (Table S5.3). More than one-third (34%) had one additional drug and 24% had two, while 4% had the maximum possible five additional drugs. When both principal and additional drugs are considered, alcohol was the most common drug (62%), followed by cannabis (44%), amphetamines (24%), nicotine (22%) and heroin (13%) (Figure 5.1).

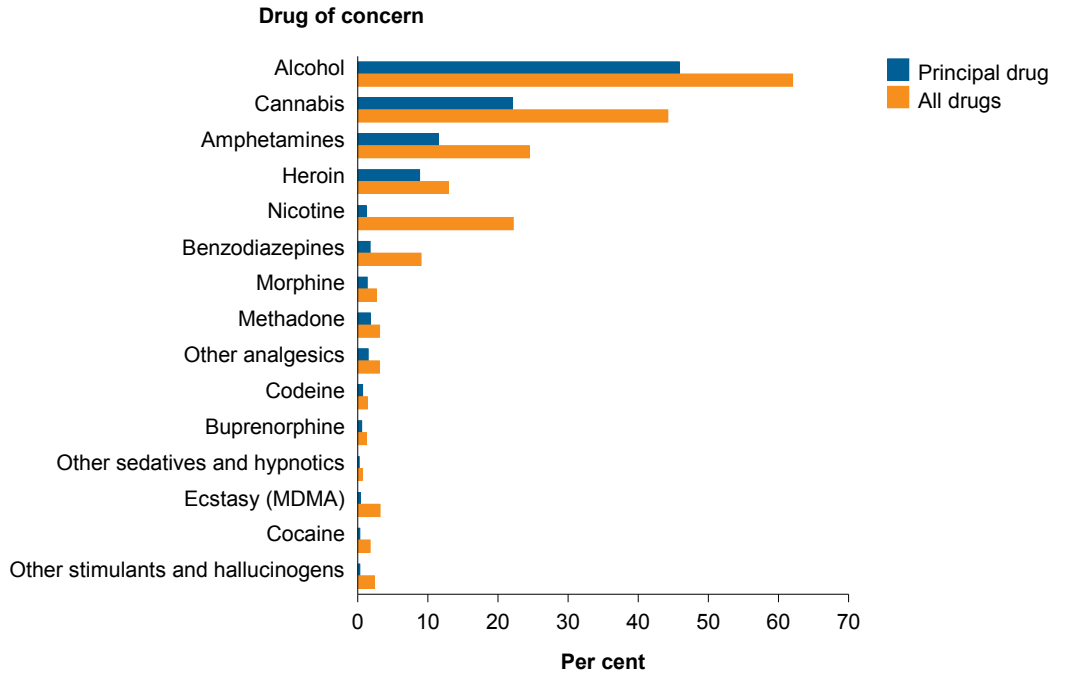

Figure 5.1: Closed episodes provided to clients for their own drug use by principal drug of concern and all drugs of concern, Australia, 2011–12

Source: Table S5.6.

Four of the top five drugs of concern were also the most common principal drugs of concern: alcohol (46%), cannabis (22%), amphetamines (11%) and heroin (9%) (Figure 5.2). Nicotine was the principal drug of concern in just 1% of episodes, but it was the second most common additional drug (21%) after cannabis (22%) (Figure 5.2). The low proportion of episodes with nicotine as a principal drug may be because people with nicotine dependence can access support and treatment from other services including pharmacies and general practitioners.

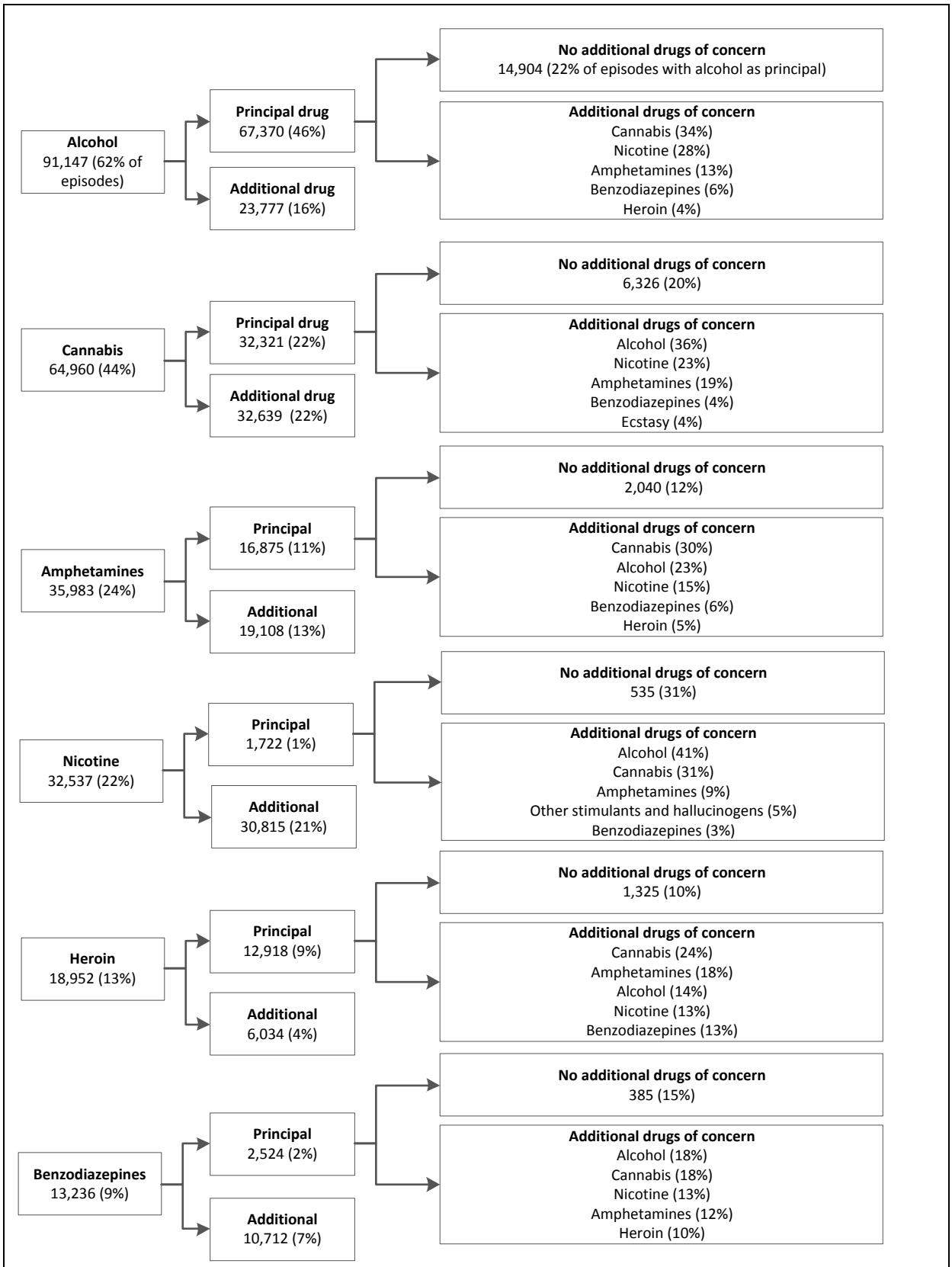

Figure 5.2: Closed episodes provided to clients for their own drug use by principal drug of concern and additional drugs of concern, Australia, 2011–12

Source: Table S5.2and Table S5.3 and Table S5.4.

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs since 2003–04, although in contrast to 2011–12, heroin was typically the third most common principal drug while amphetamines was the fourth (Figure 5.3).

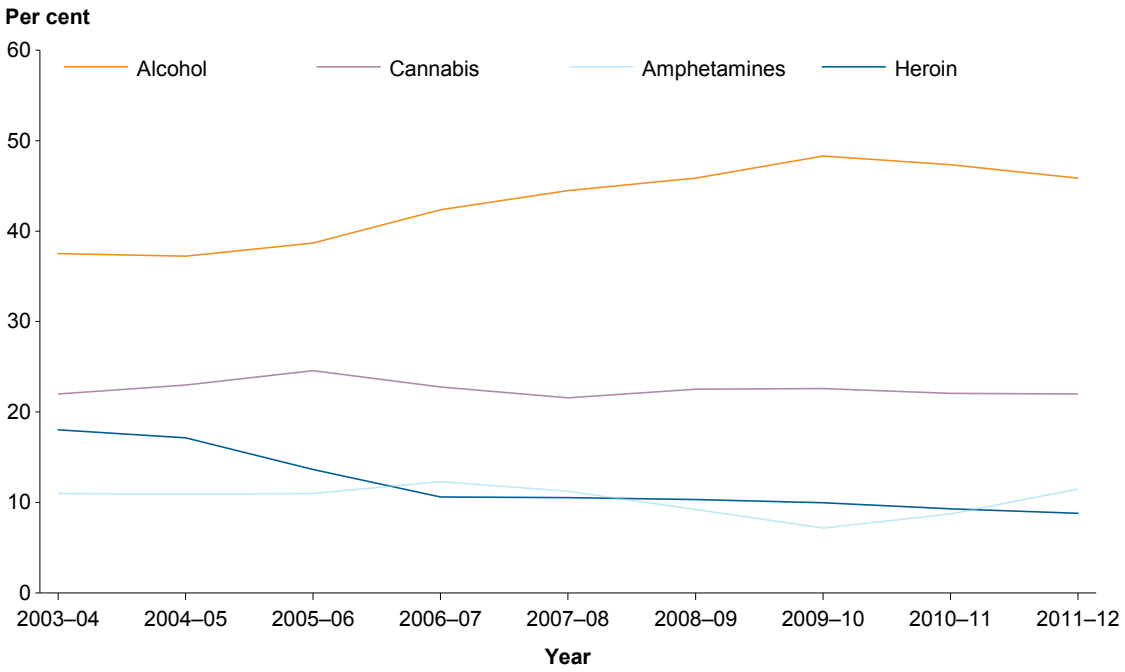

Figure 5.3: Closed episodes provided to clients for their own drug use by selected principal drugs of concern, Australia, 2003–04 to 2011–12

Source: Table S5.1.

Alcohol was the most common principal drug in all remoteness areas, ranging from 36% of episodes in *Remote* agencies to 23% of episodes in *Major cities* (Figure 5.4).

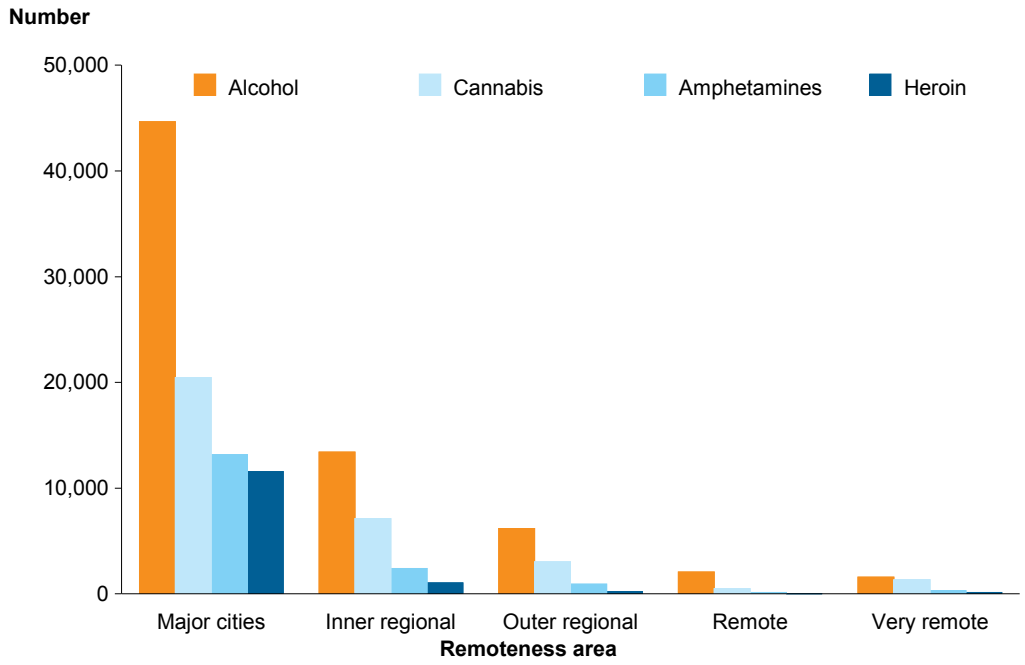

Figure 5.4: Closed episodes provided to clients for their own drug use by selected principal drugs of concern and remoteness area of treatment agency, Australia, 2011–12

Source: Table S5.5.

Alcohol was the most common principal drug of concern in all states and territories, ranging from 40% of episodes in Tasmania to 64% in the Northern Territory (Figure 5.5). Cannabis was the next most common principal drug in all states and territories except South Australia, where amphetamines were more common.

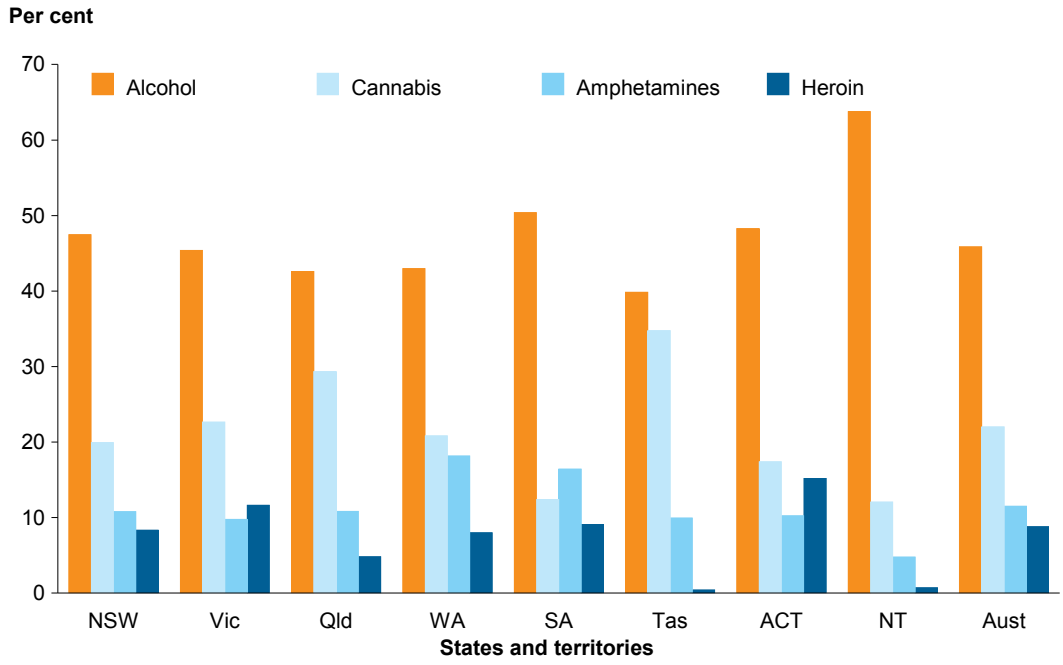

Figure 5.5: Closed episodes provided to clients for their own drug use by selected principal drugs of concern, states and territories, 2011–12

Source: Table S5.2.

5.3 Alcohol

Alcohol is a central nervous system depressant that inhibits brain functions, dampens the motor and sensory centres and makes judgment, coordination and balance more difficult (NDARC 2010).

According to the 2009 Australian guidelines to reduce health risks from drinking alcohol (NHMRC 2009), people who drink more than two standard drinks on any day have a lifetime risk of harm from alcohol-related disease or injury, while those who drink more than four standard drinks on a single occasion are at risk of harm from that occasion (AIHW 2011a).

Results from the 2010 NDSHS (AIHW 2011a) showed:

- About 80% of Australians aged over 13 drank alcohol in the past 12 months.
- A significant proportion of the Australian population drink at risky levels—1 in 5 aged over 13 drink at a level that puts them at risk of alcohol-related harm over their lifetime, while 2 in 5 drank at levels that put them at risk of harm from a single drinking occasion at least once in the past 12 months.
- Males are more likely than females to drink at levels that place them at risk of harm over their lifetime and on a single occasion.

- People living in *Remote* or *Very remote* areas are more likely to drink at risky levels than those living in other areas.
- Indigenous Australians are more likely to drink at risky levels than non-Indigenous Australians, although they are also more likely to abstain.

Alcohol was a drug of concern (principal or additional) in 62% of episodes closed in 2011–12 and was the principal drug in almost half of episodes (46%). The proportion of closed episodes where alcohol was the principal drug of concern increased steadily from 38% in 2003–04 to 48% in 2009–10, and has since remained around 46% (Figure 5.3).

In almost 8 in 10 (78%) episodes with alcohol as the principal drug of concern, the client reported additional drugs of concern (Figure 5.2). This was most commonly cannabis (34%) or nicotine (28%).

Client demographics

Where alcohol was the principal drug of concern, 68% of episodes were for male clients and 80% were for non-Indigenous clients, while for episodes where alcohol was an additional drug of concern, 72% were for male clients and 81% were for non-Indigenous clients (Table S5.10 and Table S5.11). The most common source of referral for clients where alcohol was a principal drug of concern was self or family (42%) followed by a health service (31%) (Table S5.12).

In two-thirds (65%) of episodes, the client reported they had never injected a drug (injecting status was not reported for 16% of episodes) (Table S5.8).

More than one-quarter (27%) of episodes with alcohol as a drug of concern were provided to clients aged 30–39, followed by those aged 40–49 (22%) and 20–29 (25%) (Figure 5.6). Only 6% of these episodes were provided to clients aged 60 or older; however, for nearly all of these episodes, alcohol was the principal drug. In contrast, in only half (51%) of the episodes where alcohol was a drug of concern for clients aged 10–19 was alcohol the principal drug.

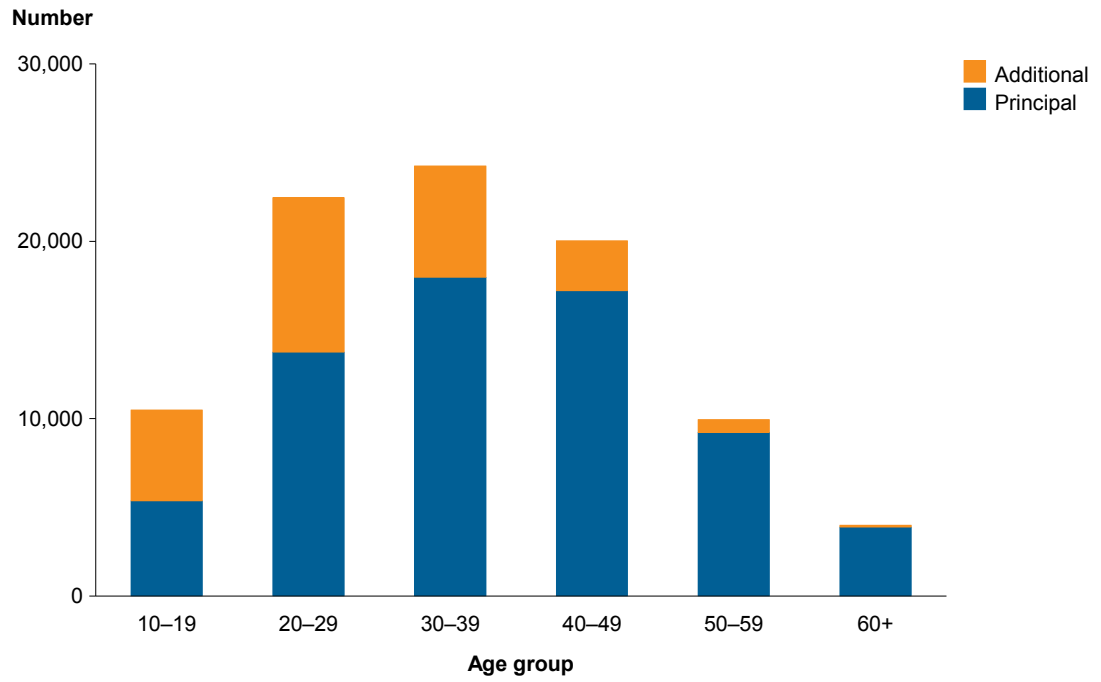

Figure 5.6: Closed episodes provided to clients for their own drug use where alcohol was a drug of concern by age group, Australia, 2011–12

Source: Table S5.10 and Table S5.11.

Treatment

The most common main treatment type for episodes where alcohol was the principal drug of concern was counselling (44%), followed by withdrawal management (19%) and assessment only (15%) (Figure 5.7). Counselling was the most common main treatment type for all age groups (from 35% of episodes for those aged 60 and older to 49% for those aged 20–29), followed by withdrawal management for those aged 30–39 and older, while support and case management and assessment only respectively were the second most common types of main treatment for those aged 10–19 and 20–29 (Table S5.14).

Counselling was also the most common main treatment type where alcohol was an additional drug of concern (43%), followed by withdrawal management (15%) (Figure 5.7).

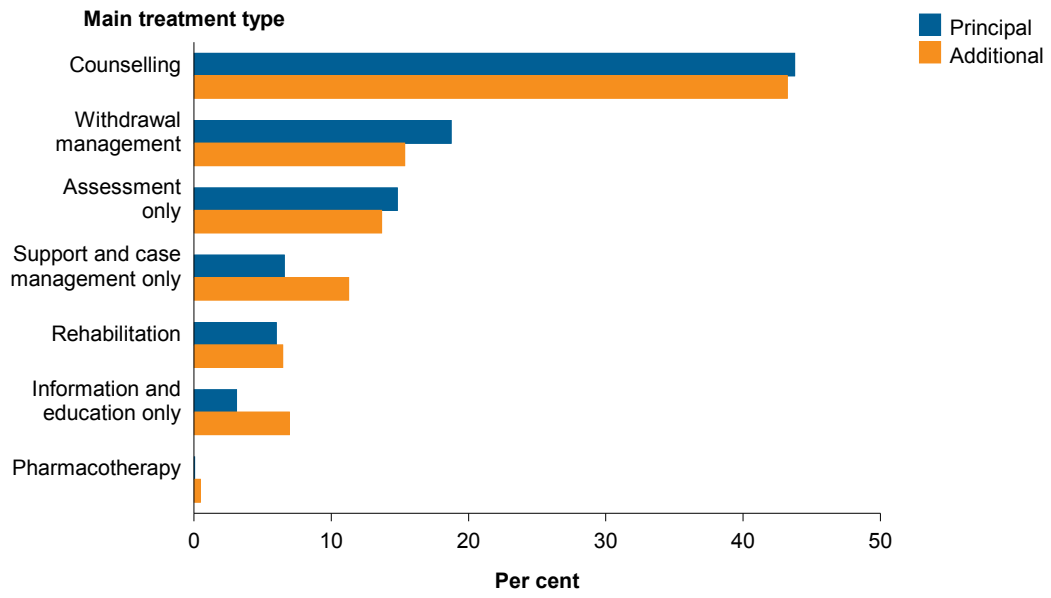

Figure 5.7: Closed episodes provided to clients for their own drug use where alcohol was a drug of concern by main treatment type, Australia, 2011–12

Source: Table S5.14 and Table S5.16.

Treatment episodes where alcohol was the principal drug of concern were most likely to take place in a non-residential treatment facility (63%) or a residential treatment facility (22%) (Table S5.19). Most (91%) episodes where counselling was the main treatment type took place in a non-residential treatment facility, while episodes with a main treatment type of withdrawal management were most likely to take place in a residential treatment facility (62%).

Two-thirds (66%) of closed episodes where alcohol was the principal drug of concern ended with an expected or compliant completion, while one-fifth (21%) ended due to the client's non-compliance (see Glossary for explanation of terms) (Table S5.20). Expected or compliant completions were most common where the referral source was diversion (75%), and where the main treatment type was information or education only (82%).

More than half (54%) of the episodes with alcohol as the principal drug lasted less than 1 month (20% ended within 1 day) (Table S5.22). The median length of episodes with alcohol as the principal drug of concern was almost 3.6 weeks (25 days). Episodes with counselling as the main treatment type were almost 8 times as long as episodes with withdrawal management as the main treatment type (median length of 62 days compared with 8) (Table S5.23).

5.4 Cannabis

Cannabis or marijuana is derived from the cannabis plant (*Cannabis sativa*) and is used in three main forms: marijuana, hashish and hash oil. It results in a sense of mild euphoria and relaxation (NCPIC 2011). Long-term effects of cannabis include damage to lungs and lung functioning, decreases in motivation and concentration, difficulties with memory and

decreased sex drive (AMA 2008). Regular users can become psychologically dependent on cannabis.

Results from the 2010 NDSHS (AIHW 2011a) showed:

- 1 in 3 Australians aged 12 and over have used cannabis at some point in their lifetime, while 1 in 10 have used it in the past 12 months.
- Males were more likely to use cannabis than females.
- There was little difference in the levels of use between people living in different remoteness areas.
- Indigenous Australians were more likely to use cannabis than non-Indigenous Australians.

Cannabis was the second most common drug of concern (principal or other) in episodes closed in 2011–12 (44%) (Figure 5.2), and was the principal drug for more than 1 in 5 treatment episodes (22%) (Figure 5.3). The proportion of closed episodes where cannabis was the principal drug of concern increased from 22% in 2003–04 to 25% in 2005–06, and has since remained around 22%.

In 80% of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern (Figure 5.2). The most common of these were alcohol (36%) and nicotine (23%).

Smoking was the most common usual method of use in most episodes (87%) where cannabis was the principal drug (Table S5.7).

Client demographics

Where cannabis was the principal drug of concern, 70% of episodes were for male clients and 80% were for non-Indigenous clients, while for episodes where cannabis was an additional drug of concern, 72% were for male clients and 80% were for non-Indigenous clients (Table S5.27 and Table S5.28). The most common source of referral for clients where cannabis was a principal drug of concern was self or family (34%), followed by diversion (25%) and a health service (23%) (Table S5.29).

In almost two-thirds (63%) of episodes, clients reported that they had never injected a drug (injecting status was not reported for 15% of episodes) (Table S5.8).

Almost two-thirds (63%) of episodes with cannabis as a drug of concern were provided to clients aged 20–39, while almost one-fifth (18%) were for those aged 10-19 (Figure 5.8). Of these episodes, cannabis was more likely to be the principal drug (rather than an additional drug) among younger age groups. Almost 9 in 10 (86%) episodes with cannabis as the principal drug of concern were for clients aged under 40.

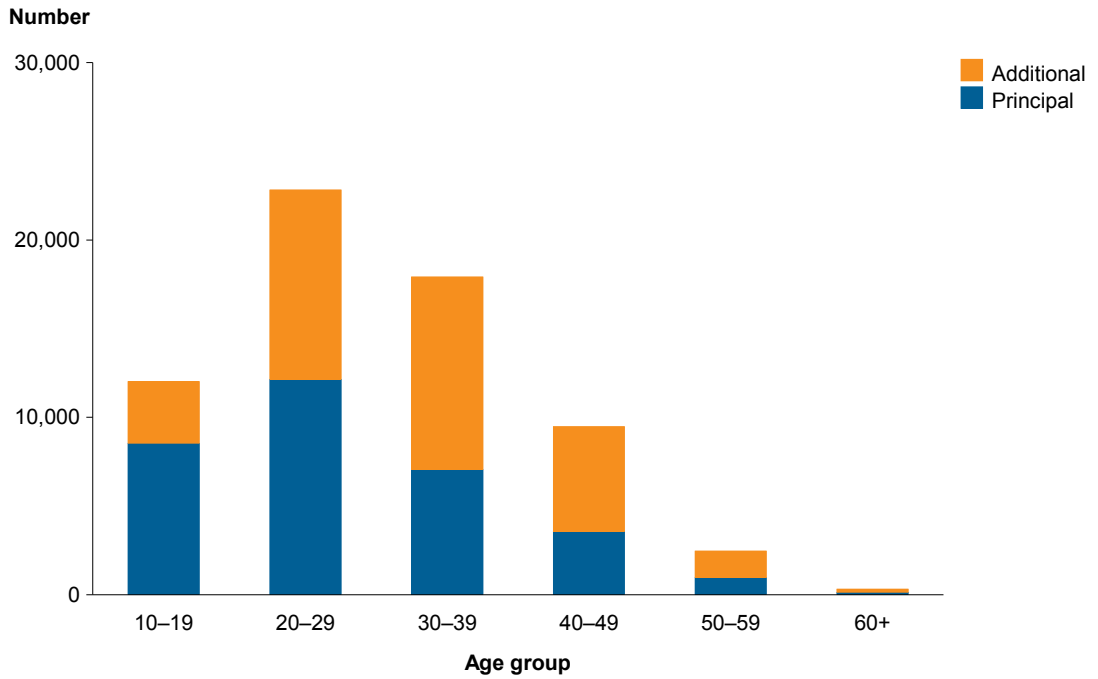

Figure 5.8: Closed episodes provided to clients for their own drug use where cannabis was a drug of concern by age group, Australia, 2011–12

Source: Table S5.27 and Table S5.28.

Treatment

The most common main treatment type for episodes where cannabis was the principal drug of concern was counselling (43%), followed by withdrawal management (13%). Assessment only, information and education only and support and case management only were also common main treatment types (all 12%) (Figure 5.9).

Counselling was also the most common main treatment type where cannabis was an additional drug of concern (41%), followed by withdrawal management (20%) and assessment only (16%) (Figure 5.9).

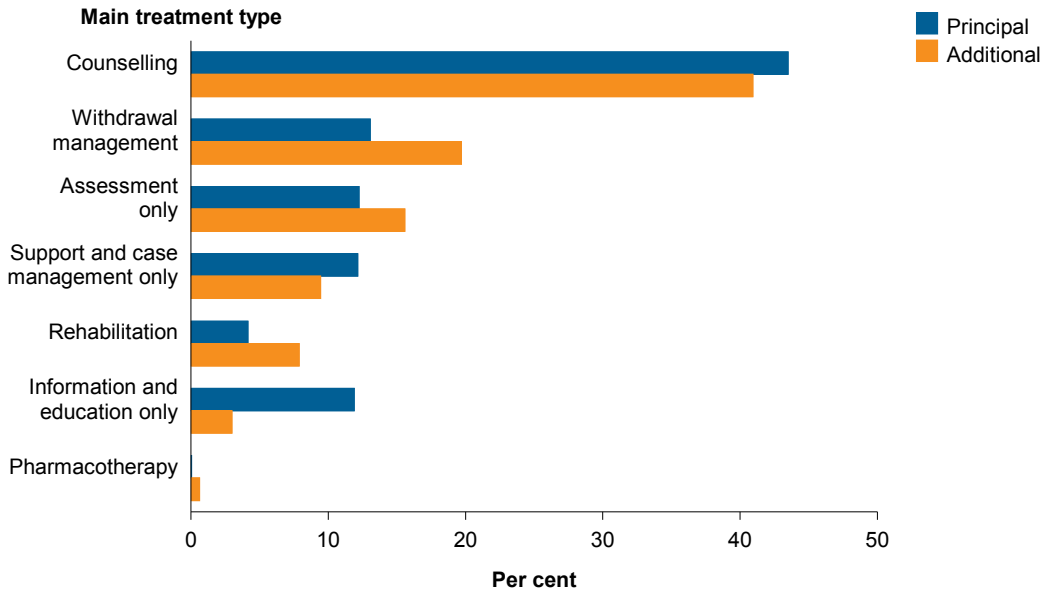

Figure 5.9: Closed episodes provided to clients for their own drug use where cannabis was a drug of concern by main treatment type, Australia, 2011–12

Source: Table S5.31 and Table S5.33.

Seven in 10 (70%) closed episodes where cannabis was the principal drug of concern ended with an expected or compliant completion, while one-fifth (20%) ended due to the client's non-compliance (Table S5.37). Expected or compliant completions were most common for episodes where the referral source was diversion (86%) and least common for referrals from corrections (56%). For main treatment types, expected or compliant completions were most common for information and education only (95%) and least common for pharmacotherapy (33%).

Treatment episodes where cannabis was the principal drug of concern were most likely to take place in a non-residential treatment facility (70%) (Table S5.38). Most (90%) episodes where counselling was the main treatment type took place in a non-residential treatment facility.

More than half (54%) of the episodes with cannabis as the principal drug lasted less than 1 month (26% ended within 1 day) (Table S5.39). The median length of episodes with cannabis as the principal drug of concern was almost 3.5 weeks (24 days). Episodes with counselling as the main treatment type had a median length of more than 7 weeks (52 days),

compared with 1 week (9 days) for withdrawal management and 1 day for information and education only and assessment only (Table S5.40).

5.5 Amphetamines

Amphetamines stimulate the central nervous system and can result in euphoria, increased energy, decreased appetite and increased blood pressure (ADCA 2013). Long-term effects include high blood pressure, extreme mood swings, paranoia, depression and anxiety and seizures. Evidence is inconclusive regarding the efficacy of pharmacotherapies in managing amphetamine withdrawal or relapse; however, trials with dexamphetamine show promise as a replacement therapy (NCETA 2004).

Results from the 2010 NDSHS (AIHW 2011a) showed:

- 1 in 14 Australians aged 12 and over have used amphetamines at some point in their lifetime, while 1 in 50 have used it in the past 12 months.
- Males were more likely to use amphetamines than females.
- There was a slight difference in the levels of use between people living in different remoteness areas, with remote and very remote areas having a higher level of recent users.
- Indigenous Australians were more likely to use amphetamines than non-Indigenous Australians.

Amphetamines were a drug of concern (principal or additional) in 24% of closed episodes in 2011–12 (Table S5.1) and were the principal drug in 1 in 9 episodes (11%) (Figure 5.3). There was little change in the proportion of episodes for which amphetamines were the principal drug from 2003–04 to 2011–12.

In 88% of episodes with amphetamines as the principal drug, the client reported additional drugs of concern (Figure 5.2). The most common of these were cannabis (30%) and alcohol (23%).

In half (51%) of the episodes where amphetamines were the principal drug, clients reported that the most usual common method of use was injecting (Table S5.7).

Client demographics

Where amphetamines were the principal drug of concern, 70% of episodes were for male clients and 86% were for non-Indigenous clients (Table S5.44), while for episodes where amphetamines were an additional drug of concern, 69% were for male clients and 83% were for non-Indigenous clients. The most common source of referral for clients where amphetamines were drugs of concern was self or family (43%), followed by a health service (21%) (Table S5.46).

In 41% of episodes, clients reported that they had last injected drugs in the previous 3 months, while in a further 30%, clients reported they had never injected drugs (note that injecting status was not reported for 12% of episodes) (Table S5.8).

Almost three-quarters (73%) of episodes with amphetamines as a drug of concern were for clients aged 20–39, followed by those aged 40–49 (13%) and 10–19 (10%) (Figure 5.10).

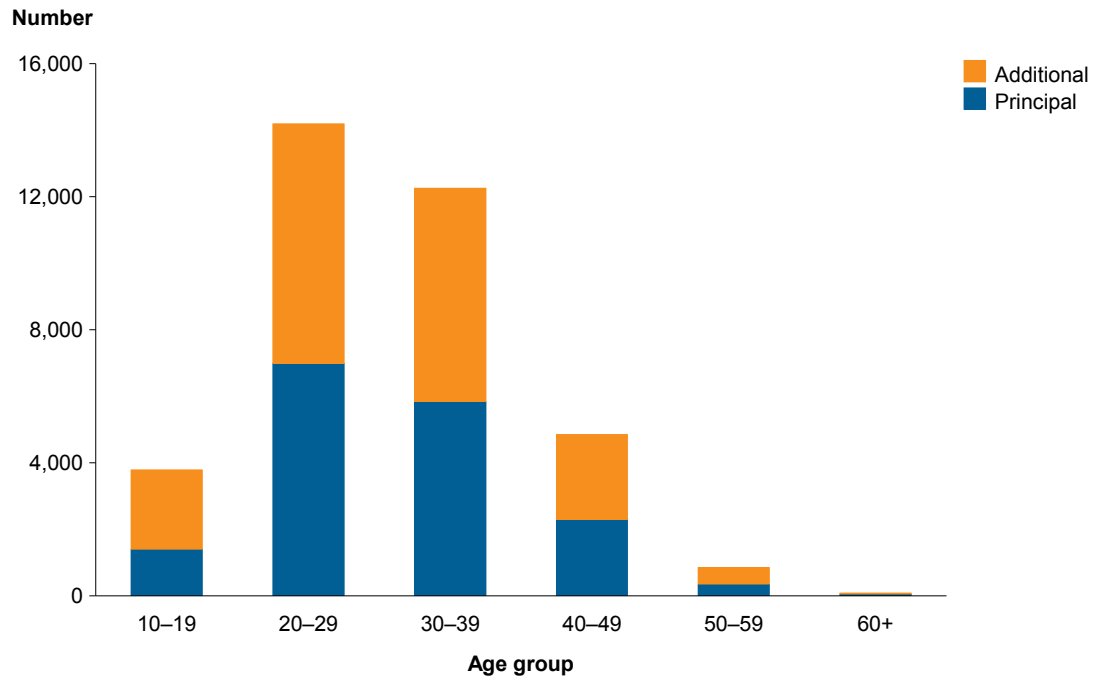

Figure 5.10: Closed episodes provided to clients for their own drug use where amphetamines were a drug of concern by age group, Australia, 2011–12

Source: Table S5.44 and Table S5.45.

Treatment

The most common main treatment type for episodes where amphetamines were the principal drug of concern was counselling (45%), followed by assessment only (16%) and withdrawal management (13%) (Figure 5.11).

Counselling was also the most common main treatment type where amphetamines were an additional drug of concern (41%), followed by withdrawal management (19%) and assessment only (15%) (Figure 5.11).

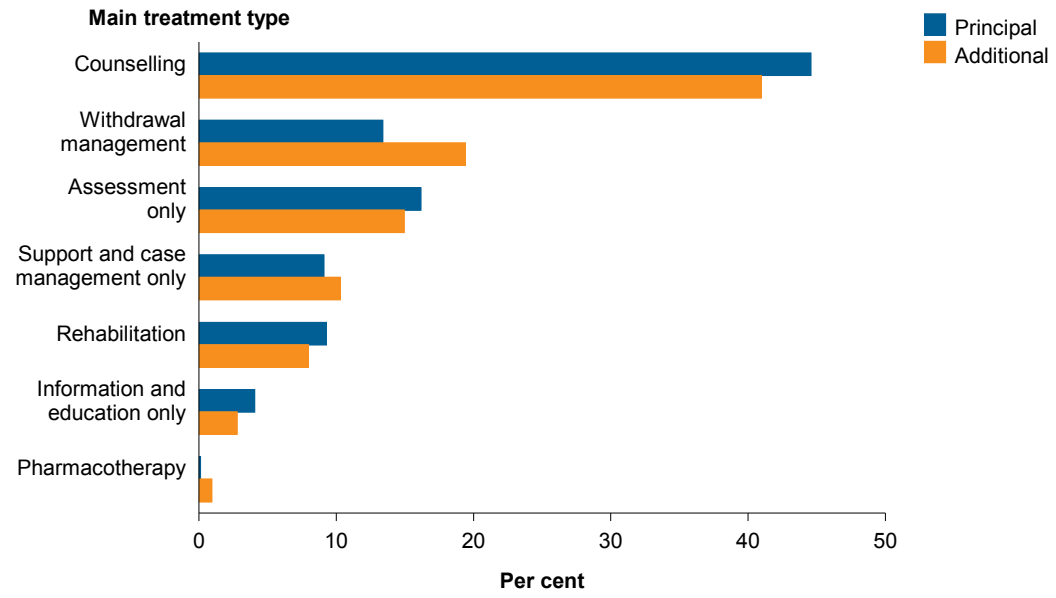

Figure 5.11: Closed episodes provided to clients for their own drug use where amphetamines were a drug of concern by main treatment type, Australia, 2011–12

Source: Table S5.48 and Table S5.50.

Almost two-thirds (62%) of closed episodes where amphetamines were the principal drug of concern ended with an expected or compliant completion, while one-quarter (25%) ended due to the client's non-compliance. Expected or compliant completions were most common for episodes where diversion was the referral source (72%) and least common for referrals from corrections (56%). For main treatment types, expected or compliant completions were most common for information and education only (78%) and least common for pharmacotherapy (33%) (Table S5.54).

Treatment episodes where amphetamines were the principal drug of concern were most likely to take place in a non-residential treatment facility (64%) or a residential treatment facility (20%). Most (88%) episodes where counselling was the main treatment type took place in a non-residential treatment facility (Table S5.55).

More than half (54%) of the episodes with amphetamines as the principal drug lasted less than 1 month (21% ended within 1 day) (Table S5.56). The median length of episodes with amphetamines as the principal drug of concern was almost 4 weeks (26 days). Episodes with counselling as the main treatment type had a median length of more than 7 weeks (53 days),

compared with 1 week (7 days) for withdrawal management and 1 day for assessment only (Table S5.59).

5.6 Nicotine

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

Results from the 2010 NDSHS (AIHW 2011a) showed:

- Almost 1 in 5 Australians have smoked tobacco in the past 12 months, and 1 in 7 are daily smokers.
- Males are more likely to smoke than females.
- People living in *Remote* and *Very remote* areas are more likely to smoke than those living in *Major cities*.
- Indigenous Australians are more likely to smoke than non-Indigenous Australians.

Most of the population generally access various forms of treatment for nicotine addiction through their local GP, pharmacy, helplines or web services. Evidence-based smoking cessation treatment and support services include brief intervention by trained health professionals, individual or group counselling, telephone counselling, and pharmacotherapies including Nicotine Replacement Therapies (NRT) and non-nicotine products.

Although nicotine was a drug of concern (principal or other) in 22% of episodes closed in 2011–12, it was the principal drug in just 1% of episodes (Figure 5.2). The proportion of episodes with nicotine as the principal drug has remained at 1–2% since 2003–04 (Table S5.1). Possible reasons for the low proportion of episodes in which nicotine was the principal drug include the wide availability of support and treatment for nicotine use in the community, and that people tend to view alcohol and other drug treatment services as most appropriate for drug use that is beyond the expertise of general practitioners.

Client demographics

Where nicotine was a principal drug of concern, 52% of episodes were for male clients and 77% were for non-Indigenous clients (Table S5.61), while for episodes where nicotine was an additional drug of concern, 66% were for male clients and 82% were for non-Indigenous clients (Table S5.62). The most common source of referral for clients where nicotine was a drug of concern was a health service (38%), followed by self or family (33%) (Table S5.62).

More than one-quarter (28%) of episodes with nicotine as a drug of concern were provided to clients aged 30–39, followed by those aged 20–29 (26%) and 40–49 (20%) (Figure 5.12).

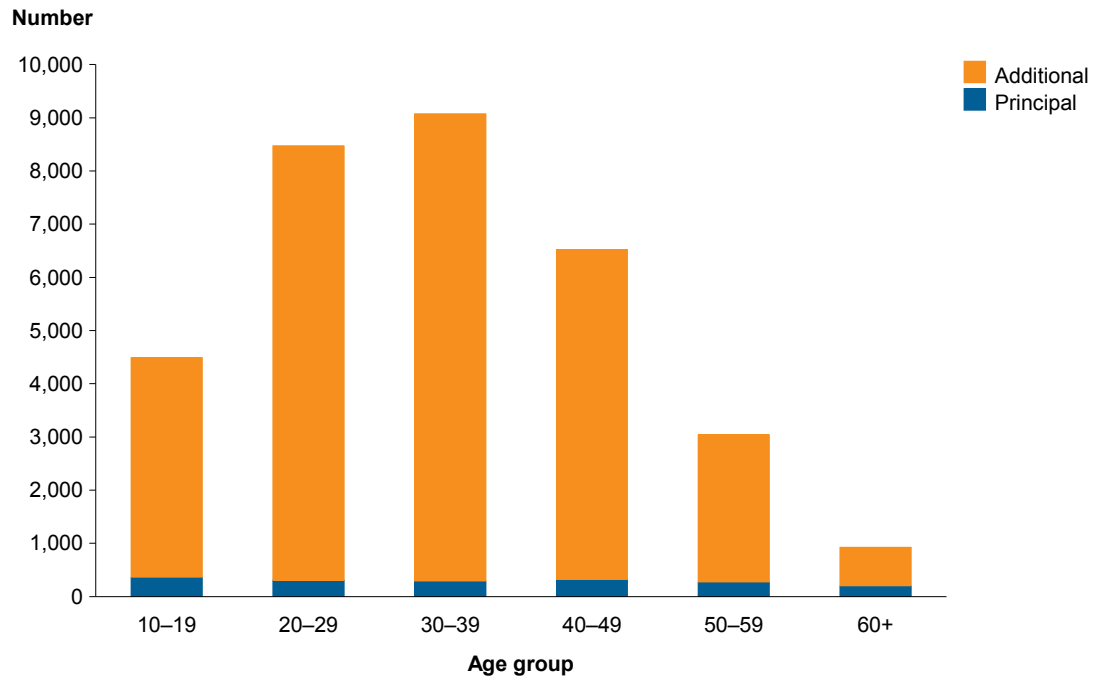

Figure 5.12: Closed episodes provided to clients for their own drug use where nicotine was a drug of concern by age group, Australia, 2011–12

Source: Table S5.61 and Table S5.62.

Treatment

The most common types of main treatment in episodes with nicotine as the principal drug of concern were counselling (43%), information and education only (14%) and withdrawal management (12%) (Figure 5.13). Counselling was also the most common type of main treatment where nicotine was an additional drug of concern (35%).

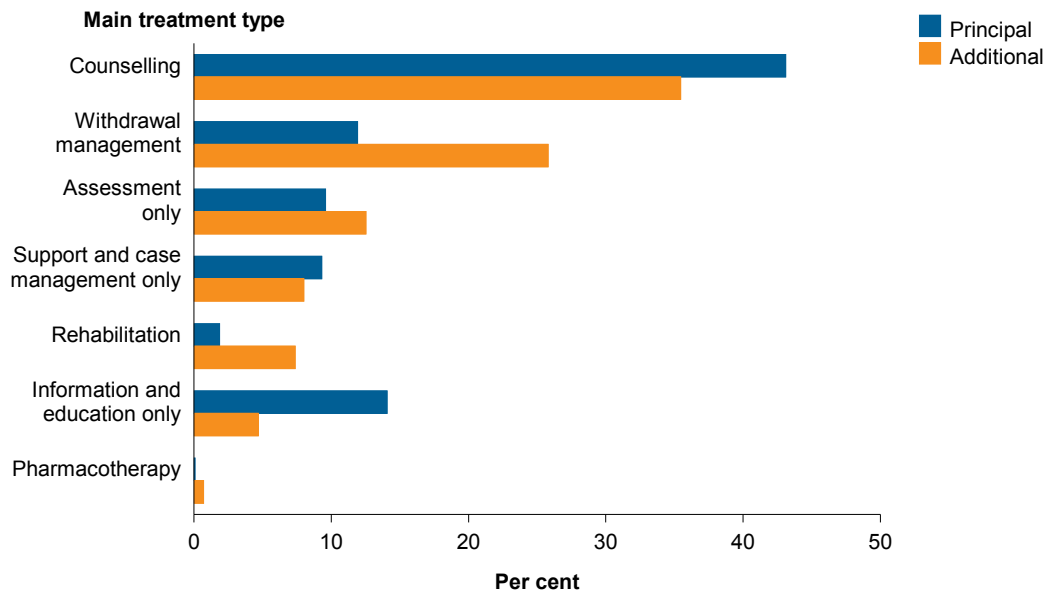

Figure 5.13: Closed episodes provided to clients for their own drug use where nicotine was a drug of concern by main treatment type, Australia, 2011–12

Source: Table S5.65 and Table S5.67.

Seven in 10 (71%) episodes with nicotine as the principal drug of concern ended with an expected or compliant completion, while one-fifth (18%) ended due to the client's non-compliance (Table S5.71). Expected or compliant completions were most common where the main treatment type was information and education only (83%).

Treatment episodes where nicotine was the principal drug of concern were most likely to take place in a non-residential treatment facility (63%) or an outreach service (19%) (Table S5.70).

Half (50%) of the episodes with nicotine as the principal drug lasted less than 1 month (24% ended within 1 day) (Table S5.73). The median length of episodes with nicotine as the principal drug of concern was 4 weeks (29 days) (Table S5.76). Episodes with counselling as the main treatment type had a median length of 9 weeks (63 days), compared with 5 weeks (35 days) for withdrawal management and 1 day for assessment only and information and education only.

5.7 Heroin

Heroin is an opioid, which are strong pain killers with addictive properties. It can result in euphoria and wellbeing and pain relief, while long-term effects can include lowered sex drive and infertility (for women), along with risk of overdose, coma and death (ADCA 2013).

Heroin users seeking treatment can enter a withdrawal program or attend an opioid maintenance substitution program (NCETA 2004).

Results from the 2010 NDSHS (AIHW 2011a) showed:

- In 2010, 1.4% of people in Australia aged 14 years or older had used heroin in their lifetime and 0.2% in the previous 12 months.
- There was no change in the proportion of people using heroin between 2007 and 2010.
- Males aged 14 or older were twice as likely as their female counterparts to have used heroin.

Heroin was a drug of concern (principal or additional) in 13% of episodes closed in 2011–12 (Figure 5.2). It was the principal drug in 1 in 11 episodes (9%), a decrease from 18% in 2003–04 (Figure 5.3).

Most of the episodes with heroin as the principal drug of concern had an additional drug of concern—only 10% did not have an additional drug of concern. The most common additional drugs of concern were cannabis (24%) and amphetamines (18%) (Figure 5.2).

Injecting was the most common usual method of use for clients whose principal drug of concern was heroin (88% of episodes) (Table S5.7).

Client demographics

Where heroin was the principal drug of concern, 67% of episodes were for male clients and 87% were for non-Indigenous clients (Table S5.78), while for episodes where heroin was an additional drug of concern, 68% were for male clients and 85% were for non-Indigenous clients (Table S5.79). The most common source of referral for clients where heroin was a principal drug of concern was self or family (48%), followed by a health service (21%) and diversion programs (16%) (Table S5.80).

In 3 in 5 (58%) episodes, the client reported they had injected drugs in the past 3 months, while in 16%, they reported they last injected 3–12 months ago (injecting status was not reported for 10% of episodes) (Table S5.8).

More than two-fifths (43%) of episodes with heroin as a drug of concern were provided to clients aged 30–39, followed by those aged 20–29 (29%) and 40–49 (19%) (Figure 5.14). For all age groups, heroin was more likely to be the principal drug rather than an additional drug.

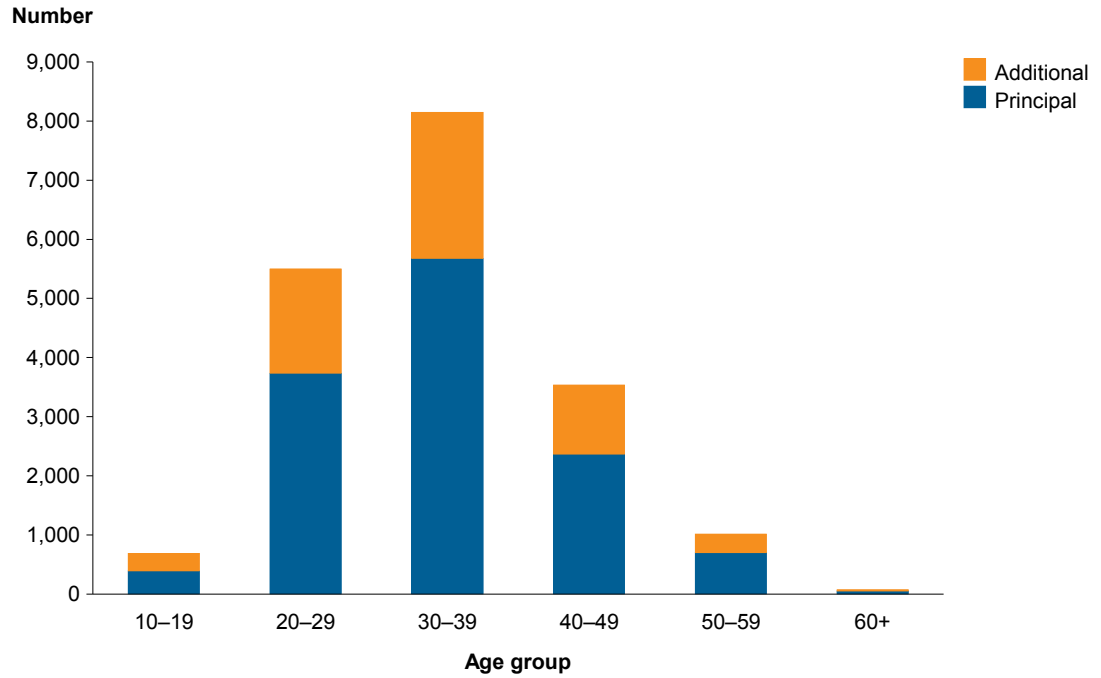

Figure 5.14: Closed episodes provided to clients for their own drug use where heroin was a drug of concern by age group, Australia, 2011–12

Source: Table S5.78 and Table S5.79.

Treatment

The most common types of main treatment for episodes with heroin as the principal drug of concern were counselling (34%), withdrawal management (26%) and assessment only (15%) (Figure 5.15).

Counselling was the most common type of main treatment for clients aged 20–29 (33%), 30–39 (36%), 40–49 (34%) and 60 and older (44%), while support and case management only was most common for clients aged 10–19 (33%) and withdrawal management was most common for clients aged 50–59 (34%) (Table S5.82).

Similar to episodes with heroin as the principal drug, counselling (39%), withdrawal management (21%) and assessment only (18%) were the most common types of main treatment in episodes with heroin as an additional drug (Figure 5.15).

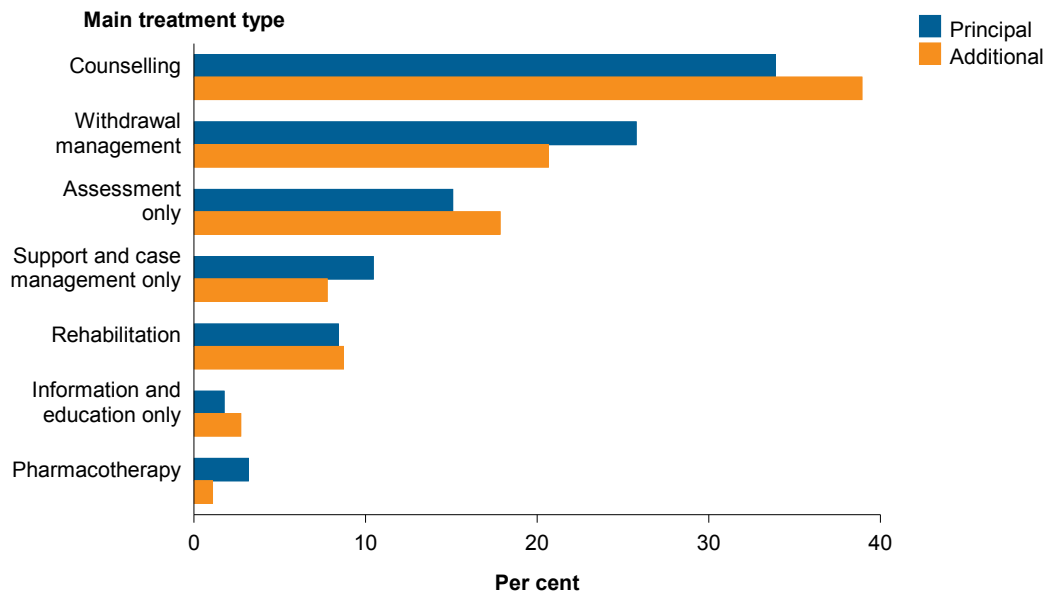

Figure 5.15: Closed episodes provided to clients for their own drug use where heroin was a drug of concern by main treatment type, Australia, 2011–12

Source: Table S5.82 and Table S5.84.

Almost 3 in 5 (58%) closed episodes with heroin as the principal drug of concern ended with an expected or compliant completion, while one-fifth (21%) ended due to the client's non-compliance (Table S5.88). Expected or compliant completions were most common for episodes where the main treatment was information and education only (77%).

Treatment episodes with heroin as the principal drug of concern were most likely to take place in a non-residential treatment facility (64%) or a residential treatment facility (21%) (Table S5.87). Most (94%) episodes where counselling was the main treatment type took place in a non-residential treatment facility.

Almost half (48%) of the episodes with heroin as the principal drug lasted less than 1 month (16% ended within 1 day) (Table S5.90). The median length of episodes with heroin as the principal drug of concern was almost 5 weeks (32 days) (Table S5.93). Episodes with counselling as the main treatment type had a median length of almost 10 weeks (67 days), compared with almost 2 weeks (11 days) for withdrawal management and 1 day for assessment only.

5.8 Benzodiazepines

Benzodiazepines are depressant drugs—they slow down the activity of the central nervous system and the speed of messages going between the brain and the body. Also known as minor tranquillisers, benzodiazepines are most commonly prescribed by doctors to relieve stress and anxiety and to help people sleep. Some people use benzodiazepines illegally to

become intoxicated or to 'come down' from the effects of stimulants such as amphetamines or cocaine (ADF 2013a).

According to the 2010 NDSHS, 3.2% of the Australian population had used tranquillisers/sleeping pills (including benzodiazepines) for non-medical purposes at some stage in their lifetime.

Benzodiazepines were a drug of concern (principal or other) in 9% of episodes closed in 2011–12 and they were the principal drug in 2% (Figure 5.2). There was no change in the proportion of episodes with benzodiazepines as the principal drug in the 9 years from 2003–04.

In 85% of the episodes with benzodiazepines as the principal drug, the client reported additional drugs of concern (Figure 5.2). The most common additional drugs were alcohol and cannabis (both 18%).

Ingestion was the most common usual method of use (89%) in episodes with benzodiazepines as the principal drug (Table S5.7).

Client demographics

Where benzodiazepines were the principal drug, 51% of episodes were for male clients and 89% were for non-Indigenous clients, while for episodes where benzodiazepines were an additional drug of concern, 61% were for male clients and 88% were for non-Indigenous clients (Table S5.95 and Table S5.96). The most common source of referral for clients where benzodiazepines were a drug of concern was self or family (44%), followed by a health service (36%) (Table S5.97).

In almost 2 out of every 5 episodes (37%), the client reported they had never injected a drug, while in 1 out of every 5 episodes (20%), the client reported they had injected drugs in the previous 3 months (injecting status was not reported for 18% of episodes) (Table S5.8).

More than one-third (35%) of episodes with benzodiazepines as a drug of concern were provided to clients aged 30–39, followed by those aged 20–29 (29%) and 40–49 (20%). Only 3% of these episodes were provided to clients aged 60 or older (Figure 5.16).

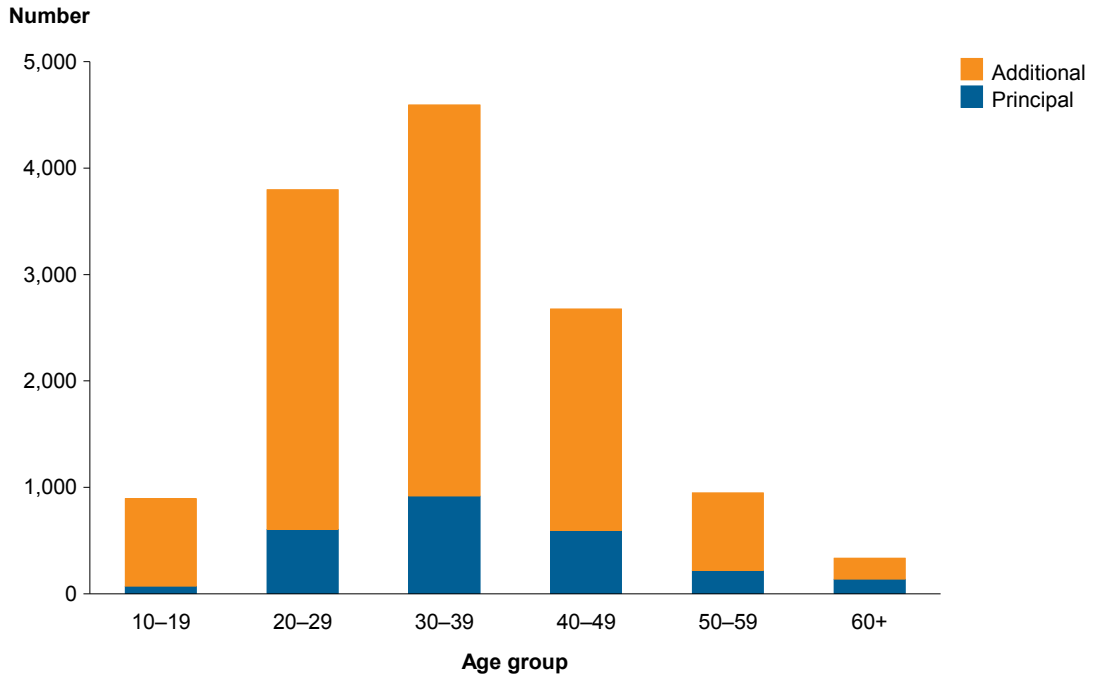

Figure 5.16: Closed episodes provided to clients for their own drug use where benzodiazepines were a drug of concern by age group, Australia, 2011–12

Source: Table S5.95 and Table S5.96.

Treatment

The most common types of main treatment in episodes with benzodiazepines as the principal drug of concern were counselling (32%), withdrawal management (28%) and assessment only (15%) (Figure 5.17). Counselling was most common for clients aged 10019 (40%) and least common for clients aged 50–59 (26%) (Table S5.99). Withdrawal management was most common for clients aged 50–59 (37%) and least common for clients aged 10–19 (16%).

Counselling was also the most common type of main treatment type where benzodiazepines were an additional drug of concern (33%) (Figure 5.17).

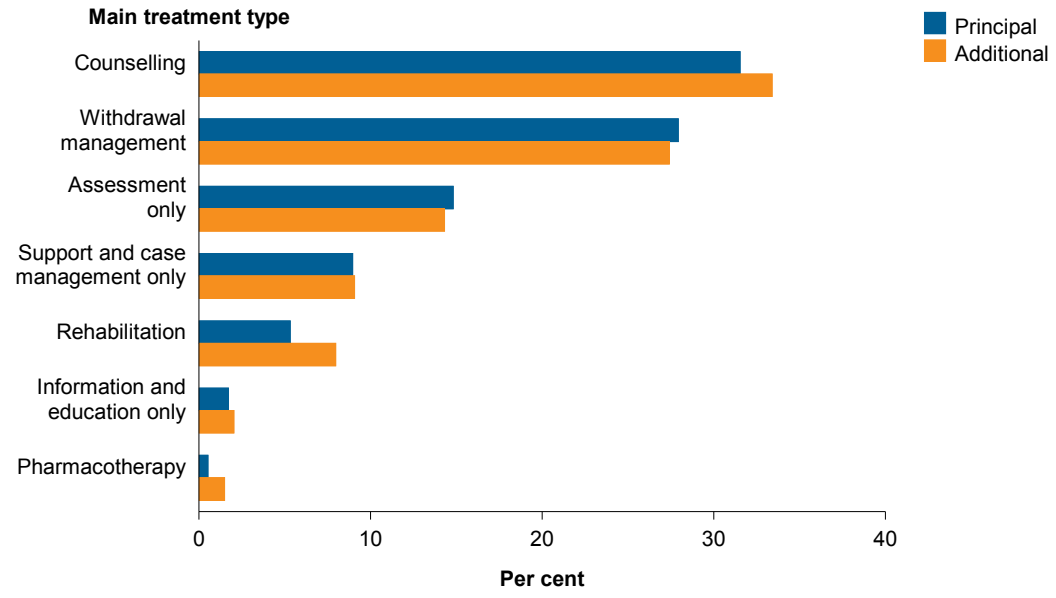

Figure 5.17 : Closed episodes provided to clients for their own drug use where benzodiazepines were a drug of concern by main treatment type, Australia, 2011–12

Source: Table S5.99.

Two-thirds (64%) of episodes with benzodiazepines as the principal drug of concern ended with an expected or compliant completion, while one-fifth (19%) ended due to the client's non-compliance (Table S5.105). Expected or compliant completions were more common for episodes where the main treatment type was information and education only (86%) or withdrawal management (70%).

Treatment episodes where benzodiazepines were the principal drug of concern were most likely to take place in a non-residential treatment facility (61% of closed episodes) or a residential treatment facility (26%) (Table S5.106). Most (95%) episodes where counselling was the main treatment type took place in a non-residential treatment facility.

More than half (55%) of the episodes with benzodiazepines as the principal drug lasted less than 1 month (18% ended within 1 day) (Table S5.107). The median length of episodes with benzodiazepines as the principal drug of concern was 3 weeks (23 days) (Table S5.110). Episodes with counselling as the main treatment type had a median length of almost 9 weeks (60 days), compared with more than 1 week (10 days) for withdrawal management and 1 day for assessment only and information and education only.

5.9 Selected other drugs

Ecstasy

Ecstasy is the popular street name for a range of drugs containing the substance 3, 4-methylenedioxymethamphetamine (MDMA)—a stimulant with hallucinogenic properties. Ecstasy is usually sold in tablet or pill form, but is sometimes found in capsule or powder form. The short-term effects of ecstasy include euphoria and a feeling of wellbeing

and closeness to others and increased energy. Other serious harms include psychosis, heart attack and stroke. Little is known about the long-term effects of ecstasy use, but there is some research linking regular and heavy use of ecstasy to memory problems and depression (ADCA 2013).

Results from the 2010 NDSHS (AIHW 2011a) showed:

- Ecstasy was the second most commonly used illicit drug in Australia after cannabis with 3% of people aged 14 or older using ecstasy in the previous 12 months in 2010.
- Males were more likely to use ecstasy than females.
- People living in *Inner regional* areas had the lowest levels of use.
- There was no difference between Indigenous Australians and non-Indigenous Australians in the use of ecstasy.

Ecstasy was a drug of concern (principal or additional) in 3% of closed episodes in 2011–12 and was the principal drug in just 0.4% (Figure 5.1).

Counselling was the most common type of main treatment in episodes with ecstasy as the principal drug (51%), followed by information and education only (20%) and assessment only (17%) (Table S5.116). Counselling was also the most common main treatment type where ecstasy was an additional drug of concern (46%), followed by assessment only (14%), withdrawal management and support and case management only, both 12% (Table S5.118).

Cocaine

Cocaine belongs to a group of drugs known as stimulants. Cocaine is extracted from leaves of the coca bush, which is native to South America. The coca leaf extract is then processed to create cocaine hydrochloride, freebase and crack. High doses and frequent heavy use can cause 'cocaine psychosis', characterised by paranoid delusions, hallucinations and bizarre, aggressive or violent behaviour (ADF 2013b).

Results from the 2010 NDSHS (AIHW 2011a) showed:

- Two per cent of Australians had used cocaine in the previous 12 months.
- Males were more likely to use cocaine than females.
- There were greater levels of use of cocaine for people living in *Major cities* than in other remoteness areas.
- Indigenous Australians were less likely to use cocaine than non-Indigenous Australians.

Cocaine was a drug of concern (principal or additional) in 2% of episodes closed in 2011–12 and was the principal drug in just 0.3% (Figure 5.1).

Counselling was the most common type of main treatment in episodes with cocaine as the principal drug (45%), followed by assessment only (17%) (Table S5.133). Counselling was also the most common main treatment type where cocaine was an additional drug of concern (41%), followed by withdrawal management and assessment only (both 15%) (Table S5.135).

6 Treatment

Clients receive one main treatment type in each episode and additional treatment types as appropriate, of which up to four are recorded in the AODTS NMDS.

Some types of treatment are only available to clients receiving treatment for their own drug use (withdrawal management, rehabilitation and pharmacotherapy), while others are only main treatment types, not additional (assessment only, support and case management only and information and education only). Note that in this chapter, pharmacotherapy refers to episodes where pharmacotherapy was the main treatment and at least one additional treatment was provided, or where it was an additional type of treatment (see Chapter 2 for details).

Note that Victoria and Western Australia do not supply data on additional treatment types; instead, each type of treatment (main or additional) results in a separate episode. Nationally, this will result in an underestimation of the number of episodes with additional treatment types.

6.1 Key points

- Counselling was the most common type of treatment (main or additional), accounting for almost half (49%) of episodes closed in 2011–12.
- Alcohol was the most common principal drug for most treatment types.
- Cannabis (50%) was the most common principal drug in episodes with a main treatment type of information and education only (this is most likely due to the use of this treatment type in episodes where the client has been diverted from the criminal justice system for minor drug offences) and heroin (45%) was the most common principal drug in episodes with a main treatment type of pharmacotherapy (pharmacotherapy is used for the treatment of opioid dependency).

6.2 Main and additional treatment types

When both main and additional types of treatment are considered, counselling was the most common type of treatment (49% of episodes), followed by withdrawal management (which is only possible for clients receiving treatment for their own drug use) (18%), assessment only (14%) and support and case management only (9%) (Figure 6.1). These types of treatments were also the most common main treatment types: counselling (43%), withdrawal management (17%), assessment only (14%) and support and case management only (9%) (note that the last two are available only as main treatments).

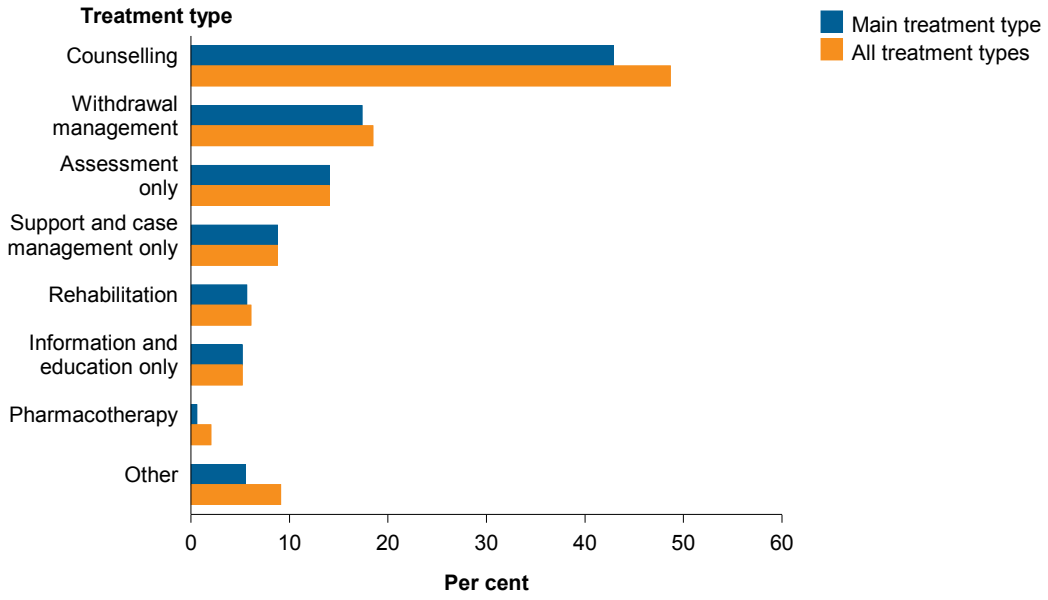

Figure 6.1: Closed episodes by treatment type, Australia, 2011–12

Source: Table S6.2.

Of the treatment types that were available both to clients receiving treatment for their own drug use and to those receiving treatment for someone else's drug use, most episodes were clients receiving treatment for their own drug use—this ranged from 92% for counselling to 99% for assessment only (Figure 6.2).

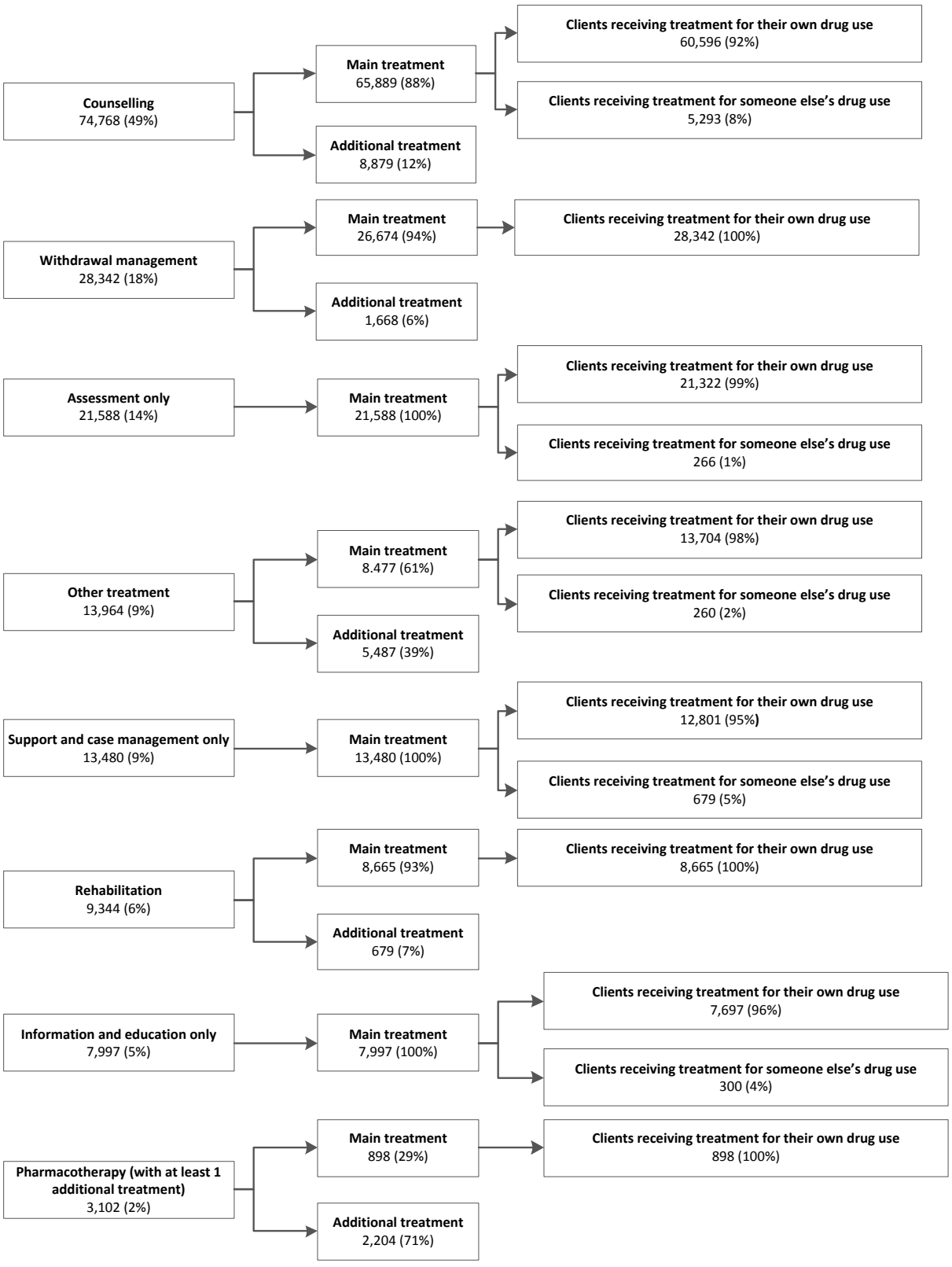

Figure 6.2: Summary treatment characteristics (main and additional) of closed episodes, Australia, 2011–12

Source: Table S6.1 and Table S6.2 and Table S6.4 and Table S6.5.

For episodes provided to clients receiving treatment for their own drug use, counselling was the most common main treatment type provided in 2011–12 (41%), followed by withdrawal management (18%) and assessment only (15%) (Table S6.4). There was little difference in the main treatment types provided to males and females, although assessment only was slightly more common in episodes provided to males (16%) than to females (12%). Withdrawal management (detoxification) was more common in episodes provided to non-Indigenous clients (19%) than in those for Indigenous clients (12%).

For episodes provided to clients for someone else's drug use, counselling was also the most common main treatment type (79%) (Table S3.5). Support and case management only, the next most common main treatment type, accounted for 1 in 10 episodes (10%). Females were slightly more likely than males to have episodes where the main treatment type was counselling (80% compared with 76%).

Episodes provided to non-Indigenous clients were more likely than those for Indigenous clients to have a main treatment type of counselling (81% compared with 59%), while episodes for Indigenous clients were more likely to have a main treatment type of other (18% compared with 1%) or information and education only (14% compared with 3%) (Table S3.5).

Counselling, withdrawal management and assessment only remained the most common types of treatment over the 9 years from 2003–04 to 2011–12 (Figure 6.3). Support and case management only, rehabilitation, and information and education only accounted for a similar proportion of episodes until recent years, with a small decrease in both rehabilitation and information and education only (from around 7–9% to 5–6%).

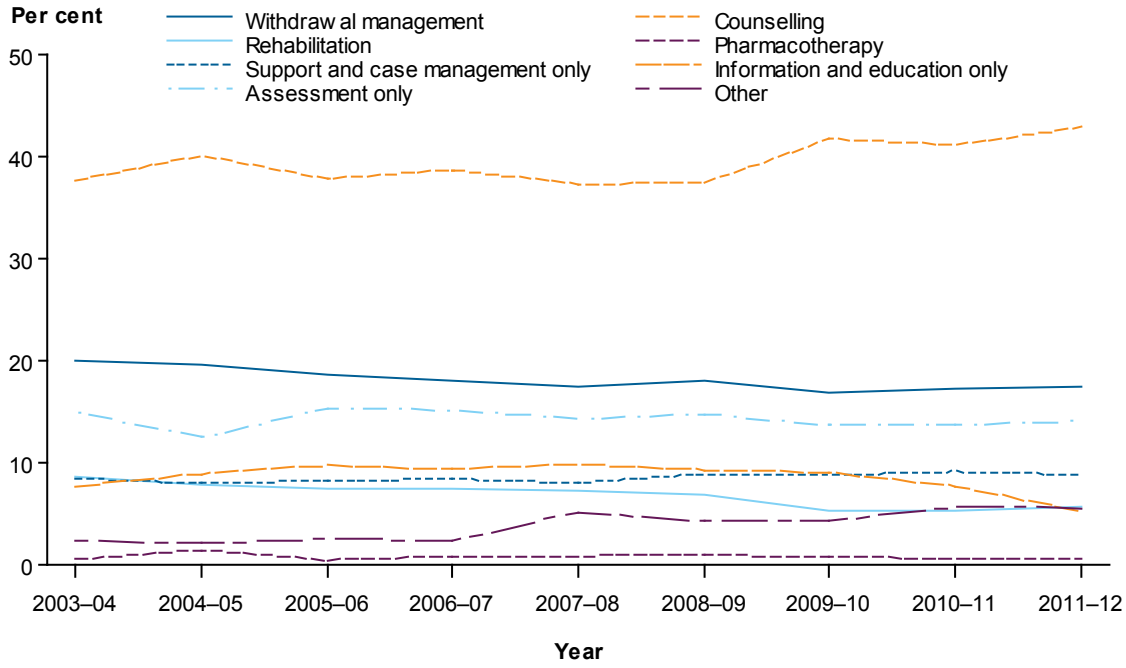

Figure 6.3: Closed episodes by main treatment type, Australia, 2003–04 to 2011–12

Source: Table S6.3.

Counselling was the most common type of main treatment in most states and territories in 2011–1, while withdrawal management was the most common type of main treatment in the Australian Capital Territory and assessment only was the most common type in the

Northern Territory (Table S6.3). Withdrawal management was the second most common in most states and territories, although assessment only was more common in Queensland, South Australia and the Northern Territory and counselling was the second most common type in the Australian Capital Territory.

6.3 Counselling

Counselling was a treatment type for 49% of the episodes closed in 2011–12—it was the main treatment type in 43% of episodes and an additional treatment type in 6% (Figure 6.2). Most (92%) of the episodes with counselling as the main treatment type were provided to clients for their own drug use.

Almost two-fifths (38%) of the episodes for the client's own drug use with a main treatment type of counselling were provided in Victoria, while just over one-fifth (23%) were provided in New South Wales (Figure 6.4). More than half (57%) of the episodes for someone else's drug use with a main treatment type of counselling were provided in Victoria, while almost one-fifth (18%) were provided in Western Australia.

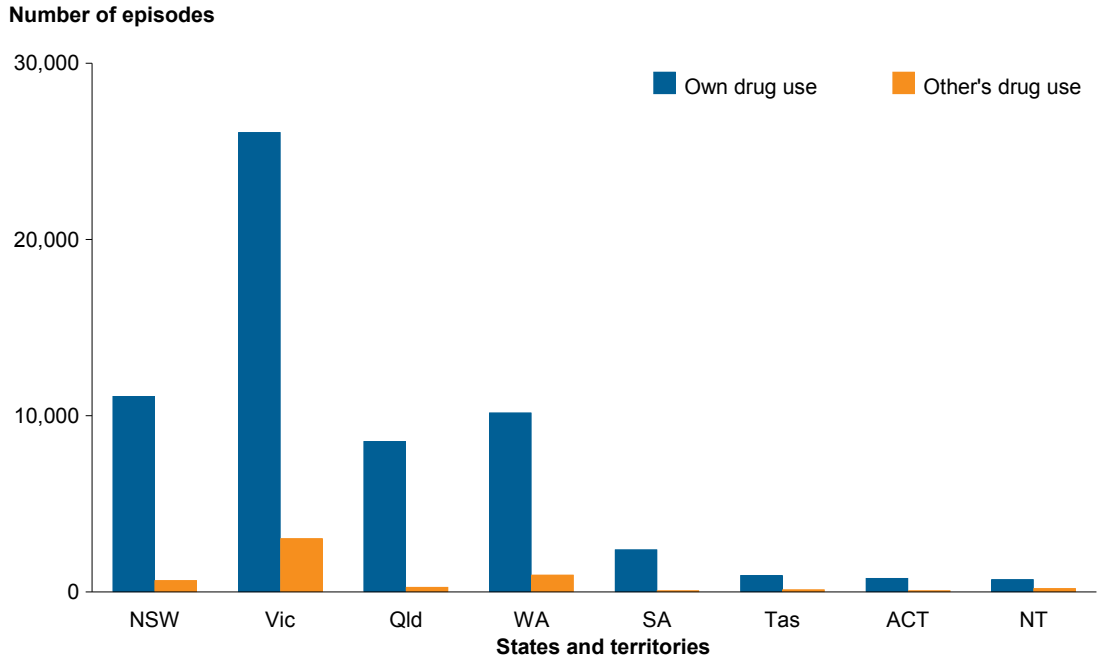

Figure 6.4: Closed episodes with a main treatment type of counselling by type of client, states and territories, 2011–12

Source: Table S6.6.

More than one-third (35%) of the episodes for the client's own use with a main treatment type of counselling lasted 1–3 months, while a further one-fifth (21%) lasted 3–6 months (Table S6.8). There was little change in the distributions over the 9 years from 2003–04 (Table S6.9). Short counselling episodes were common in Western Australia and Queensland, where 22% and 17%, respectively, lasted just 1 day (Figure 6.5). In the Australian Capital Territory, 17% of episodes lasted more than 12 months, compared with a national average of 4%.

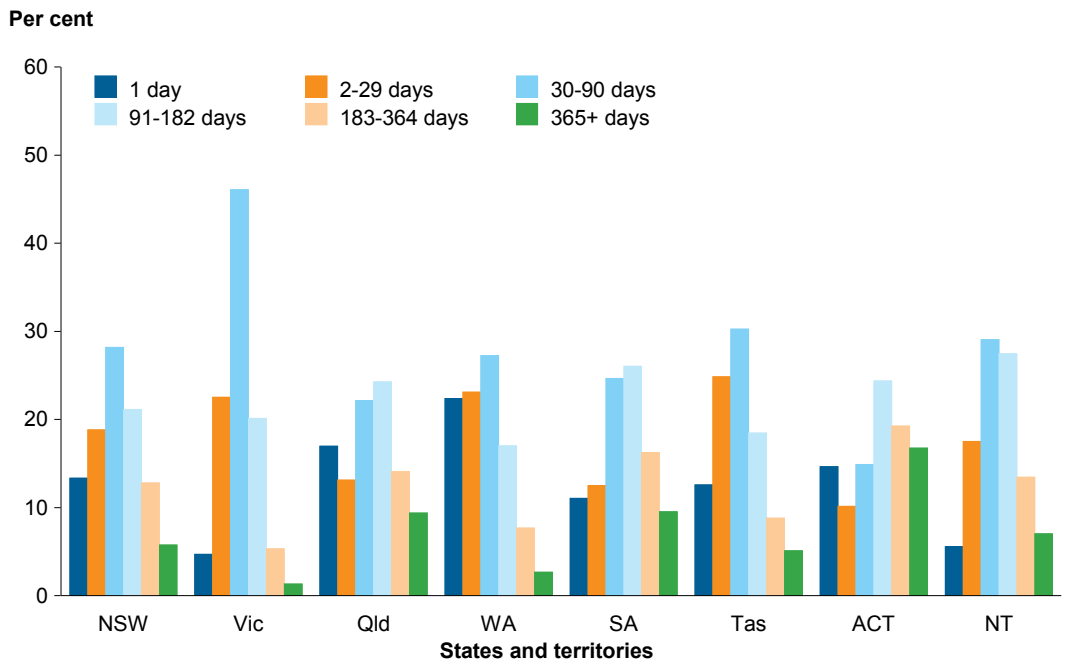

Figure 6.5: Closed episodes provided to clients for their own drug use with a main treatment type of counselling by duration, states and territories, 2011–12

Source: Table S6.8.

Almost two-fifths (38%) of the closed episodes provided to clients for someone else's drug use with a main treatment type of counselling lasted 1–3 months, while a further one-fifth (22%) lasted 2–29 days (Table S6.8). Over the 9 years from 2003–04, the proportion of closed episodes ending within 1 day decreased (from 21% to 13%), while the proportion lasting 1–3 months increased (from 29% to 38%) (Table S6.9).

In 2011–12, about 30% of closed episodes in New South Wales and Western Australia lasted just 1 day (27% and 32%, respectively), higher than the national average of 13%, while 20% of episodes in South Australia lasted more than 1 year (compared with the national average of 3%) (Figure 6.6).

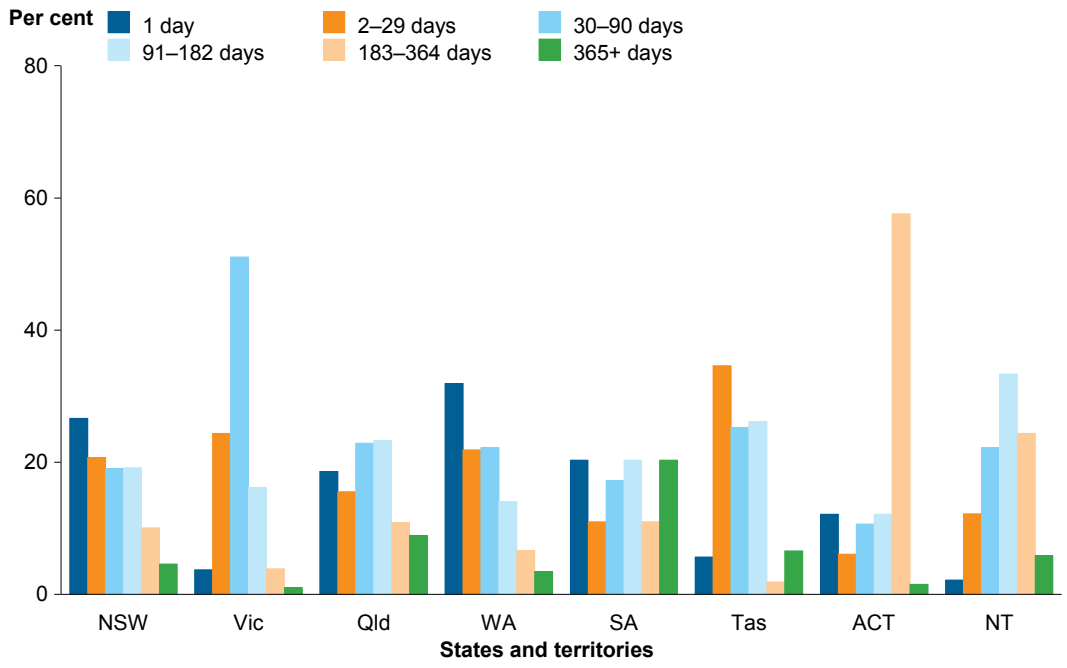

Figure 6.6: Closed episodes provided to clients for someone else's drug use with a main treatment type of counselling by duration, states and territories, 2011–12

Source: Table S6.8.

Client demographics

More than two-thirds (67%) of the closed episodes provided to clients for their own drug use with a main treatment type of counselling were provided to male clients, and 81% were for non-Indigenous clients (Table S6.10). Female clients were slightly more likely to be Indigenous than male clients (14% compared with 12%).

Most (59%) of these episodes were for those in the 20–29 (30%) and 30–39 (29%) age groups (Figure 6.7). A further 10% were for clients aged 10–19; 3% were for clients aged 60 and older.

Male clients, particularly Indigenous male clients, tended to be younger. More than half (52%) of the episodes provided to Indigenous males were for clients aged 10–29, compared with 46% for Indigenous females, 41% for non-Indigenous males and 33% for non-Indigenous females (Table S6.10).

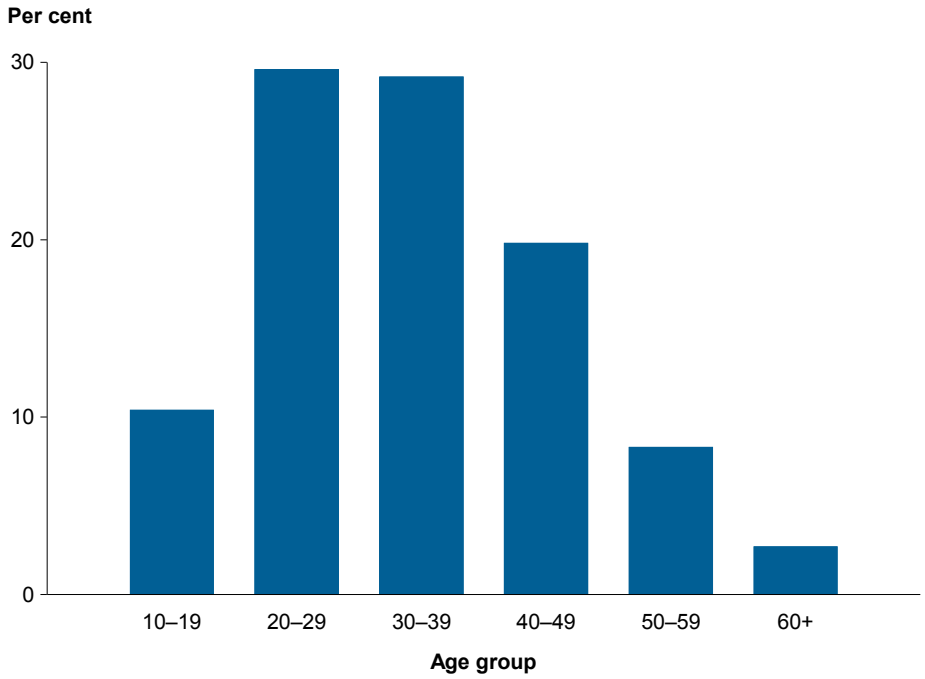

Figure 6.7: Closed episodes provided to clients for their own drug use with a main treatment type of counselling by age group, Australia, 2011–12

Source: Table S6.10.

As opposed to episodes for the client's own drug use, episodes for someone else's drug use with a main treatment type of counselling were more likely to be provided to female clients (64%), while male clients were more likely to be Indigenous than female clients (10% compared with 5%) (Table S6.11).

These episodes tended to be provided to older clients. Almost half (48%) were for clients in the 40–49 (25%) or 50–59 (23%) age groups (Figure 6.8). Female clients were more likely to be older than males: 52% of episodes provided to females were for clients aged 40–59, compared with 42% of episodes for male clients (Table S6.11).

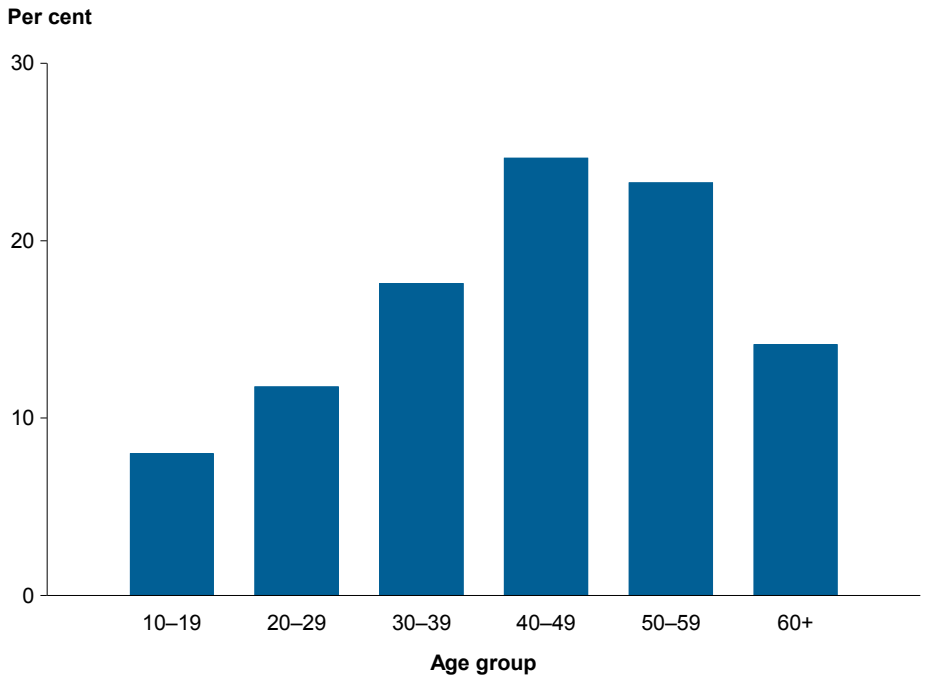

Figure 6.8: Closed episodes provided to clients for someone else's drug use with a main treatment type of counselling by age group, Australia, 2011–12

Source: Table S6.11.

Drugs of concern

Of the closed episodes provided to clients for their own drug use with a main treatment type of counselling, almost half (49%) had alcohol as a principal drug of concern, while almost one-quarter (23%) had a principal drug of cannabis (Figure 6.9). Amphetamines (12% of episodes) were also a common principal drug of concern. Cannabis was a common additional drug of concern (24%), along with nicotine (19%).

Alcohol was the most common principal drug in all states and territories, ranging from 45% of the episodes where counselling was the main treatment type in Western Australia to 67% in the Northern Territory (Table S6.12).

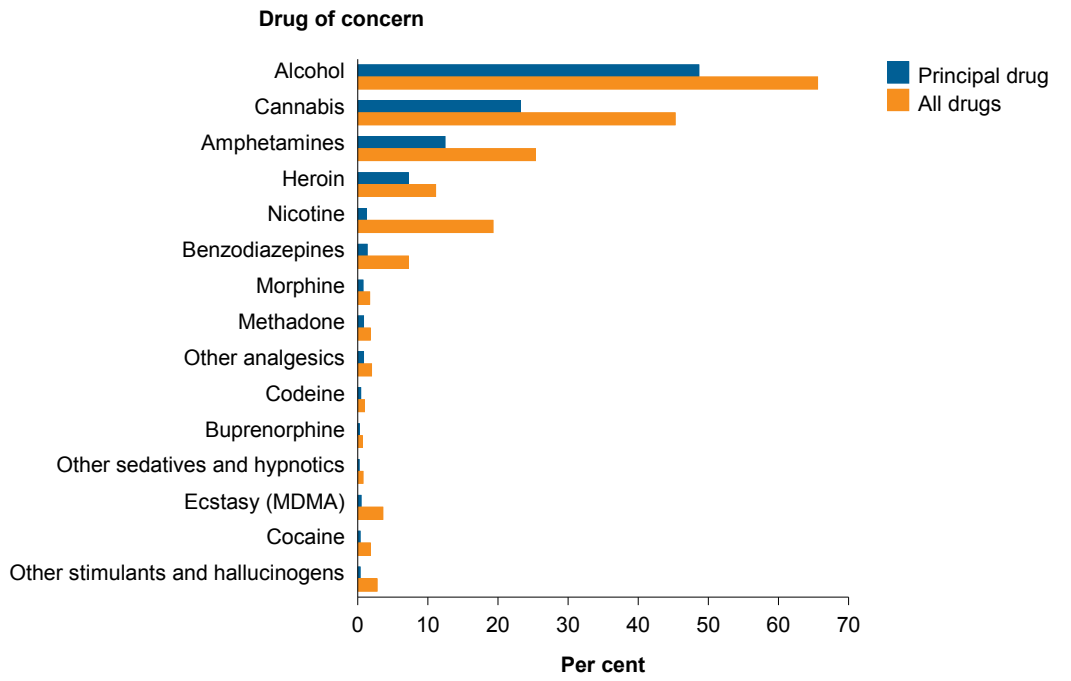

Figure 6.9: Closed episodes provided to clients for their drug use with a main treatment type of counselling by drugs of concern, Australia, 2011–12

Source: Table S6.12.

Additional treatment types

Most (94%) episodes for client's own drug use with a main treatment of counselling did not have an additional treatment type (Table S6.14). Similarly, nearly all (99%) of the episodes for someone else's drug use with a main treatment type of counselling did not have an additional treatment type (Table S5.16).

6.4 Withdrawal management

Withdrawal management is only provided in episodes for clients receiving treatment for their own drug use. Withdrawal management was a treatment type for 18% of episodes closed in 2011–12—it was the main type of treatment in 17% of episodes and an additional treatment type in 1% (Figure 6.2).

Among the states and territories, almost 2 in 5 (42%) episodes with a main treatment type of withdrawal management were in Victoria, while a further 28% were in New South Wales (Figure 6.10). The low number of withdrawal management episodes in Tasmania is partly the result of a lack of ambulatory withdrawal programs (outpatient detoxification), which is related to difficulties in recruiting appropriate staff. In all states and territories, in most of the episodes with a treatment type of withdrawal management it was the main treatment type (rather than an additional treatment type) (Table S6.17).

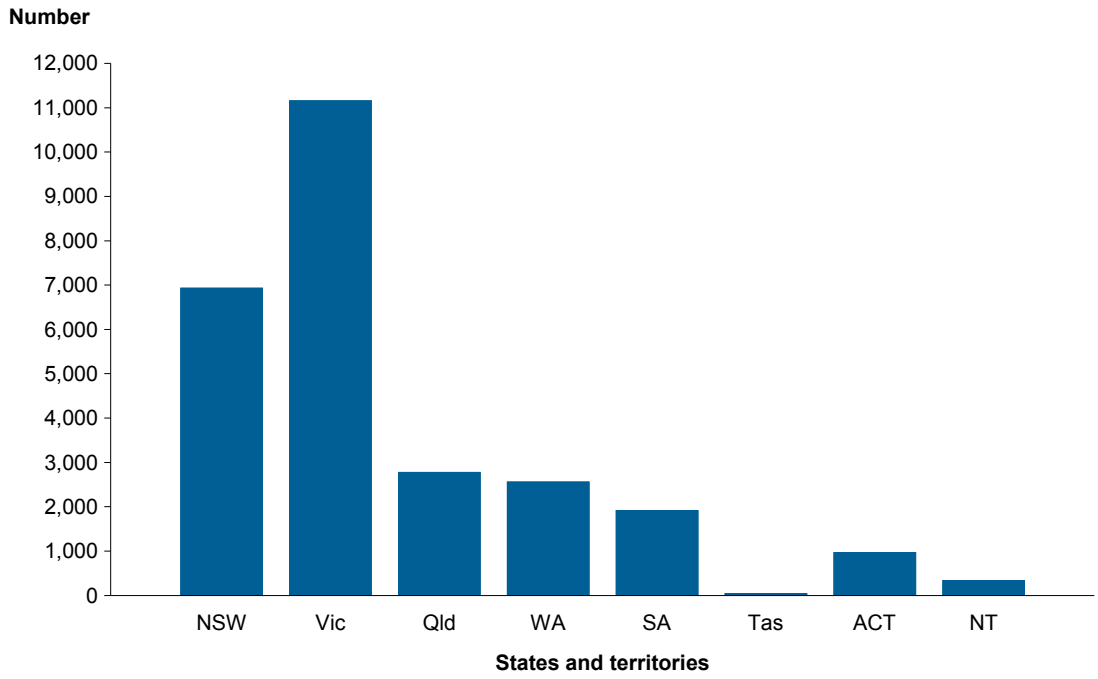

Figure 6.10: Closed episodes with a main treatment type of withdrawal management by states and territories, 2011–12

Source: Table S6.17.

More than 7 in 10 (71%) episodes with a main treatment type of withdrawal management lasted 2–29 days while a further one-seventh (15%) lasted 1–3 months. Short withdrawal management episodes were common in Tasmania and South Australia, where 42% and 16%, respectively, lasted 1 day (Figure 6.11). Short treatment durations may reflect a lack of engagement by clients in ambulatory withdrawal programs (outpatient detoxification). They may also be the result of a change to a more appropriate treatment type (for example, providing opioid pharmacotherapy for opioid dependence).

Over the 9 years from 2003–04, the proportion of closed episodes ending within 1 day decreased slightly (from 8% to 5%), while the proportion lasting 1–3 months increased (from 11% to 15%) (Table S6.20).

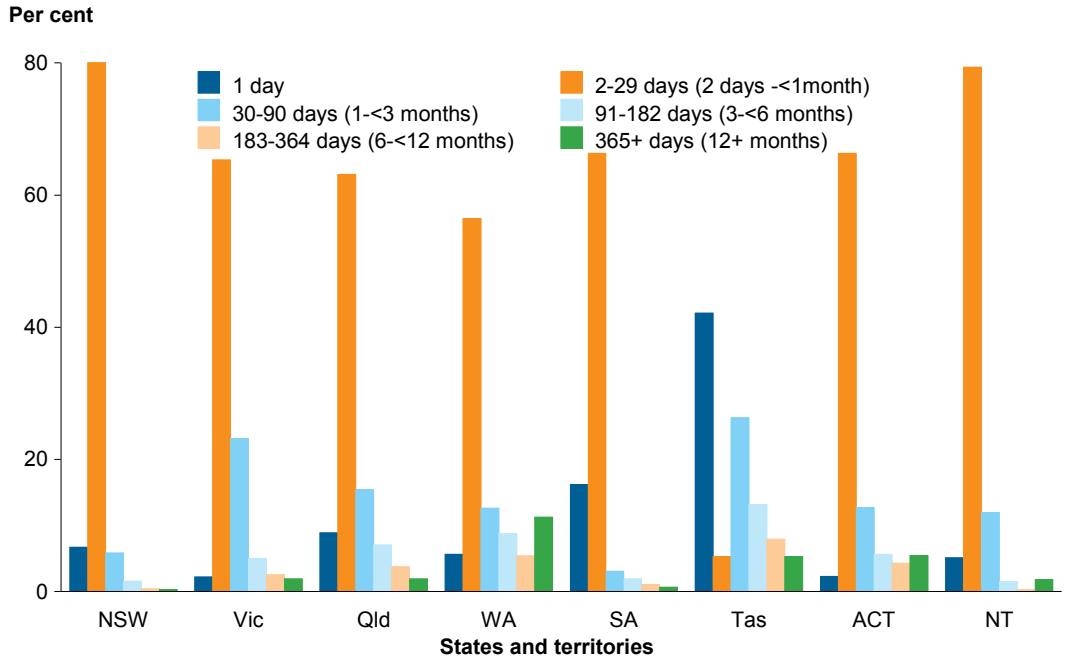

Figure 6.11: Closed episodes provided to clients for their own drug use with a main treatment type of withdrawal management by duration, states and territories, 2011–12

Source: Table S6.19.

Client demographics

About two-thirds (65%) of the closed episodes provided to clients for their own drug use with a main treatment type of withdrawal management were provided to male clients, and 87% were for non- Indigenous clients. Female clients were slightly more likely to be Indigenous than male clients (10% compared with 8%) (Table S5.21).

Most (55%) of these episodes were for those in the 30–39 (31%) and 40–49 (24%) age groups (Figure 6.12). A further 23% were for clients aged 20–29; just 4% were for clients aged 60 and older.

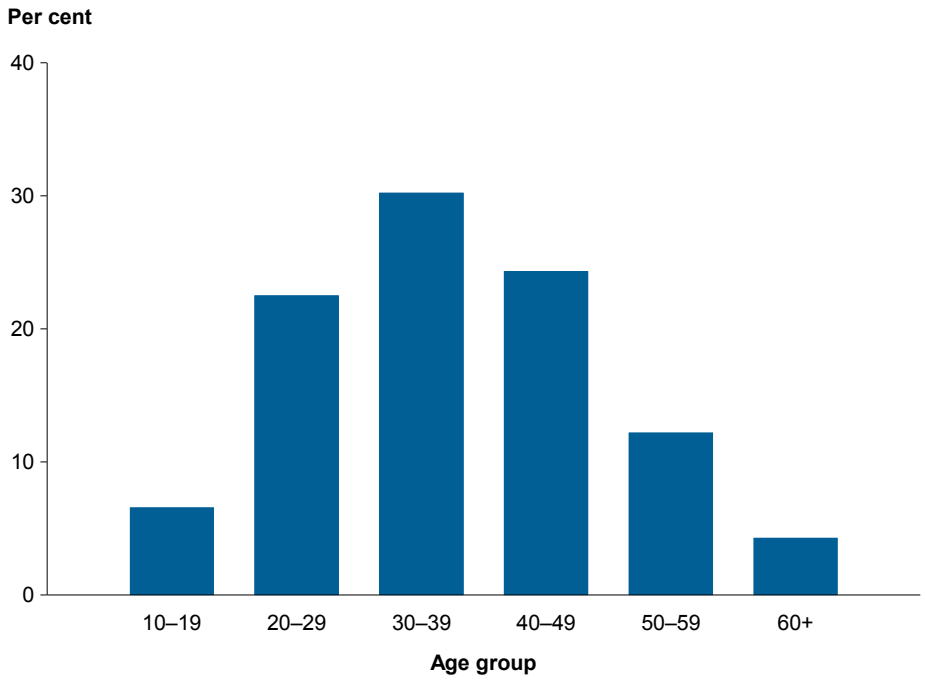

Figure 6.12: Closed episodes provided to clients for their own drug use with a main treatment type of withdrawal management by age group, Australia, 2011–12

Source: Table S6.21.

Drugs of concern

Of the closed episodes provided to clients for their own drug use with a main treatment type of withdrawal management, almost half (47%) had alcohol as a principal drug of concern, while almost one-sixth (16%) had a principal drug of cannabis (Figure 6.13). Heroin (12% of episodes) was also a common principal drug of concern.

Alcohol was the most common principal drug in all states and territories except Tasmania, where morphine (29%) was the most common (Table S6.22). In the remaining states and territories, the proportion of episodes with alcohol as the principal drug ranged from 30% in Western Australia to 57% in South Australia.

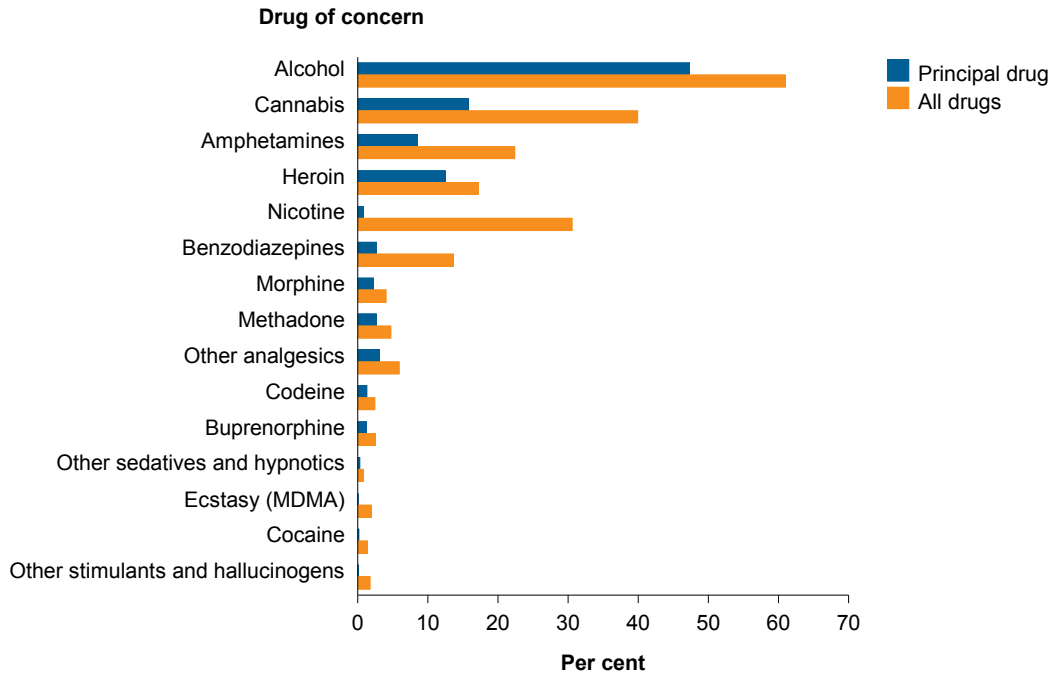

Figure 6.13: Closed episodes provided to clients for their own drug use with a main treatment type of withdrawal management by drugs of concern, Australia, 2011–12

Source: Table S6.22.

Other treatment

One-quarter (25%) of episodes with a main treatment type of withdrawal management also had an additional treatment type (Table S6.24). For these episodes, counselling (58%) and pharmacotherapy (21%) were the most common additional treatment types (Table S6.23).

6.5 Assessment only

Assessment only was the main type of treatment for 14% of episodes closed in 2011–12 (it is not available as an additional treatment type) (Figure 6.1). Nearly all (99%) of the closed episodes where assessment only was a main treatment type were provided to clients for their own drug use (Figure 6.2). In some states and territories (such as Tasmania), assessments relate directly to drug use and are only conducted with clients receiving treatment for their own drug use.

Almost 3 in 10 (29%) of the episodes for the client's own drug use with a main treatment type of assessment only were provided in New South Wales, while just over one-quarter (26%) were provided in Queensland (Figure 6.14). More than one-third (34%) of the episodes for someone else's drug use were provided in New South Wales, while over one-quarter (27%) were provided in Queensland.

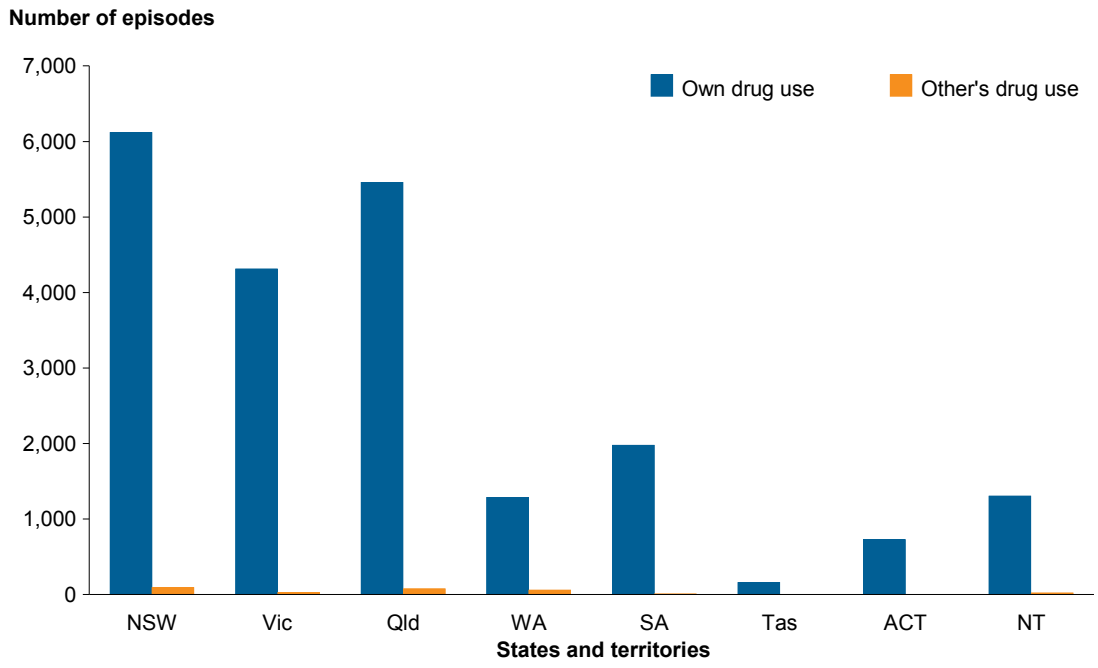

Figure 6.14: Closed episodes with a main treatment type of assessment only by type of client, states and territories, 2011–12

Source: Table S6.25.

Three in 5 (60%) episodes for the client's own drug use with a main treatment type of assessment only lasted just 1 day, while a further 23% lasted from 2 days to less than 1 month (Figure 6.15). The proportion of episodes that lasted 1 day ranged from 24% in the Australian Capital Territory to 86% in Western Australia.

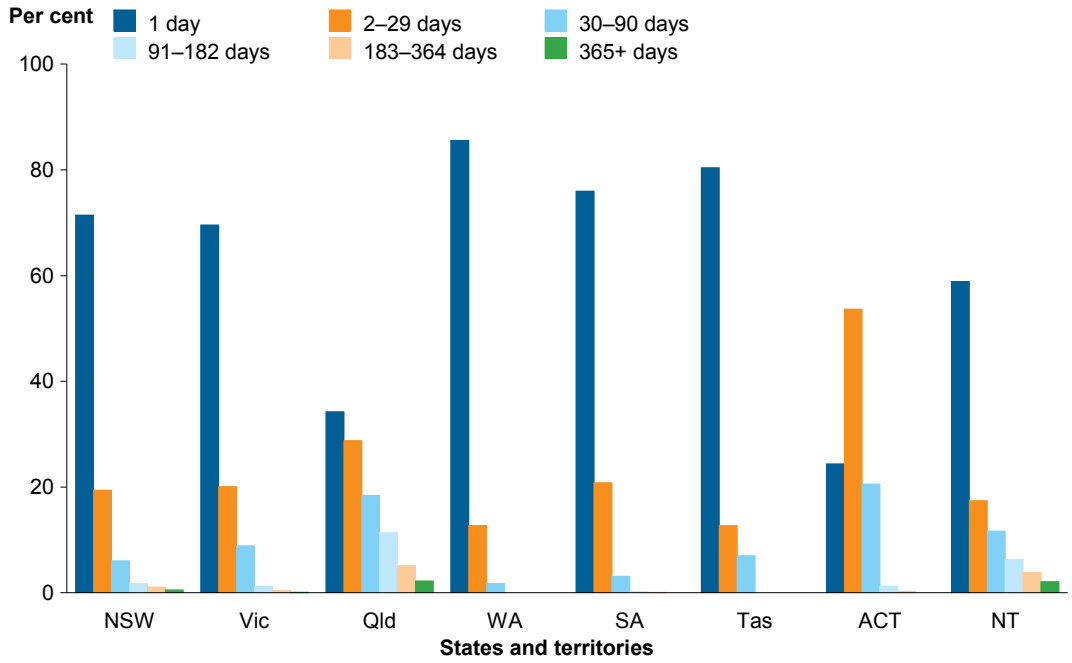

Figure 6.15: Closed episodes provided to clients for their own drug use with a main treatment type of assessment only by duration, states and territories, 2011–12

Source: Table S6.27.

Three-quarters (75%) of the episodes for someone else's drug use with a main treatment type of assessment only lasted 1 day (Figure 6.16). This ranged from 100% of closed episodes in Victoria to 31% in the Northern Territory. There were no episodes for someone else's drug use with a main treatment type of assessment only in Tasmania or the Australian Capital Territory. This may be because formal assessment processes do not exist for the delivery of services to people concerned about someone else's drug use.

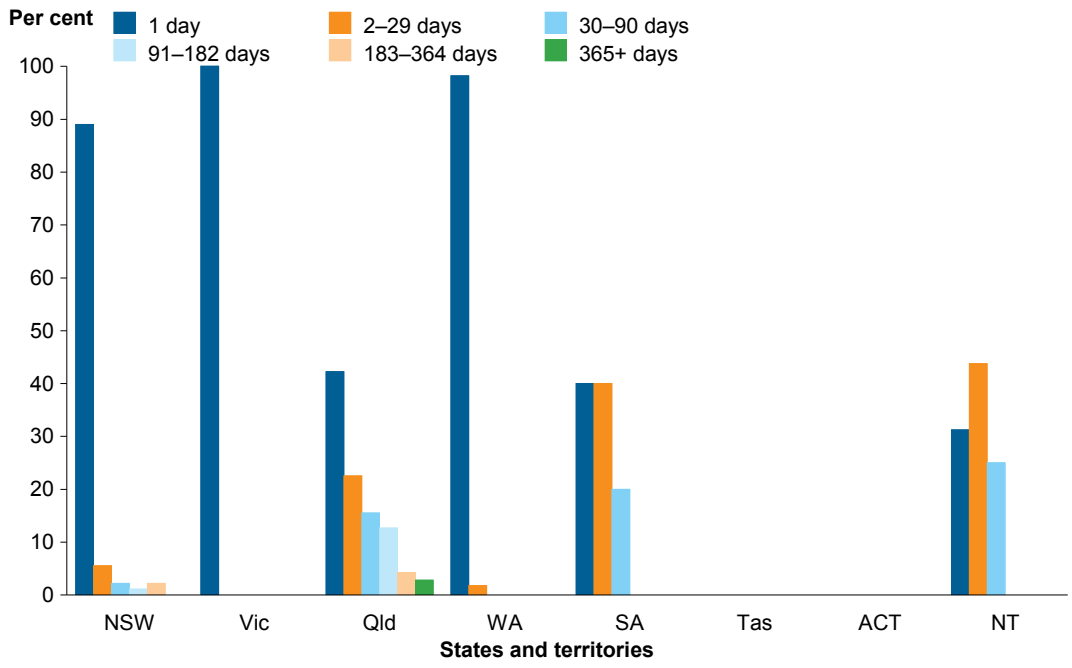

Figure 6.16: Closed episodes provided to clients for someone else's drug use with a main treatment type of assessment only by duration, states and territories, 2011–12

Source: Table S6.27.

Client demographics

Almost three-quarters (74%) of the closed episodes for the client's own drug use with a main treatment type of assessment only were provided to male clients, and 81% were for non-Indigenous clients (Table S6.29). Female clients were slightly more likely to be Indigenous than male clients (17% compared with 14%).

Three-fifths (61%) of these episodes were for those in the 20–29 (30%) and 30–39 (31%) age groups (Figure 6.17). A further 8% each were for clients aged 10–19 and for those aged 50–59; just 3% were for clients aged 60 and older. Some of the assessment only episodes for young people are conducted as part of early intervention and diversion from the youth justice system.

Male clients, particularly Indigenous male clients, tended to be younger. Almost half (48%) of the episodes provided to Indigenous males were for clients aged 10–29, compared with 43% for Indigenous females, 38% for non-Indigenous males, and 33% for non-Indigenous females (Table S6.29).

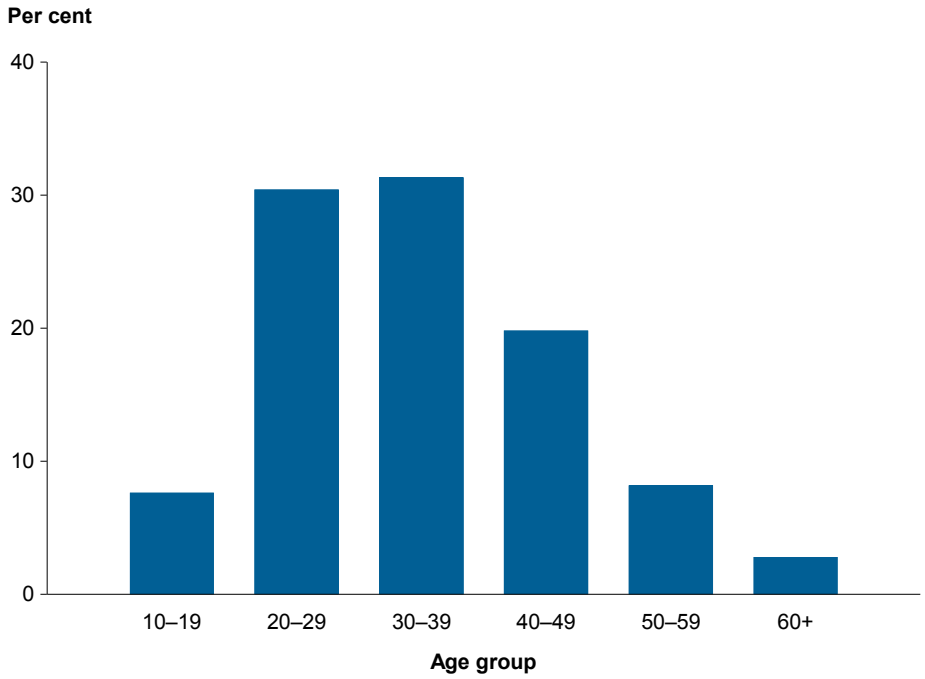

Figure 6.17: Closed episodes provided to clients for their own drug use with a main treatment type of assessment only by age group, Australia, 2011–12

Source: Table S6.29.

Episodes for someone else's drug use with a main treatment type of assessment only were more likely to be provided to female clients (58%) (Table S6.30).

The episodes for someone else's drug use tended to be provided to older clients. More than 2 in 5 (42%) were for clients in the 40–49 (20%) or 50–59 (22%) age groups (Figure 6.18).

Female clients were more likely to be older than males: 48% of episodes provided to females were for clients aged 40–59, compared with 31% of episodes for male clients (Table S6.30).

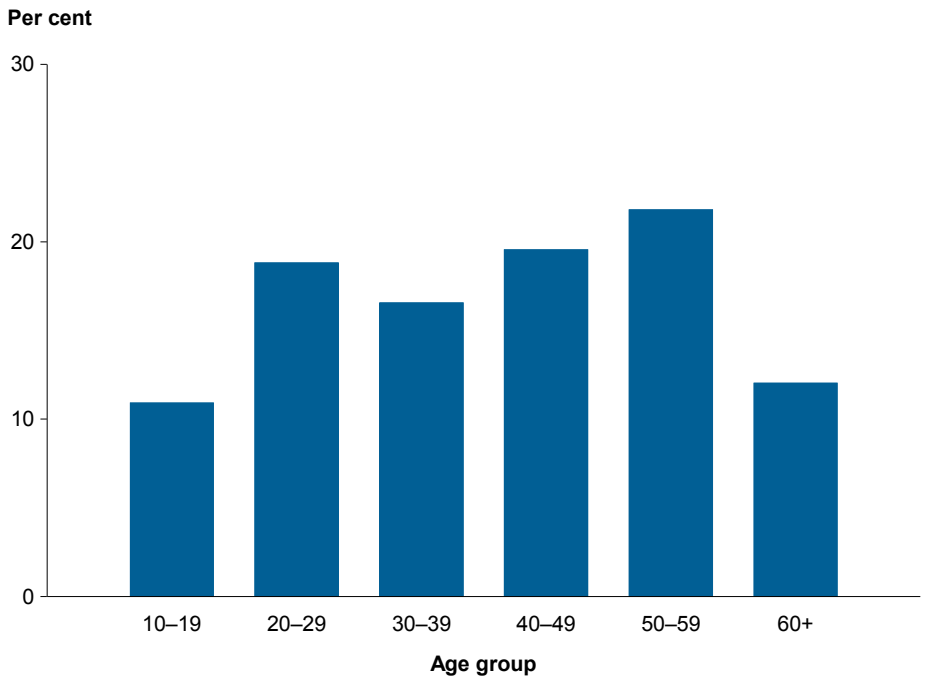

Figure 6.18: Closed episodes provided to clients for someone else's drug use with a main treatment type of assessment only by age group, Australia, 2011–12

Source: Table S6.30.

Drugs of concern

Of the closed episodes provided to clients for their own drug use with a main treatment type of assessment only, almost half (47%) had alcohol as a principal drug of concern, while almost one-fifth (19%) had a principal drug of cannabis (Figure 6.19). Amphetamines (13%) and heroin (9%) were also common principal drugs of concern.

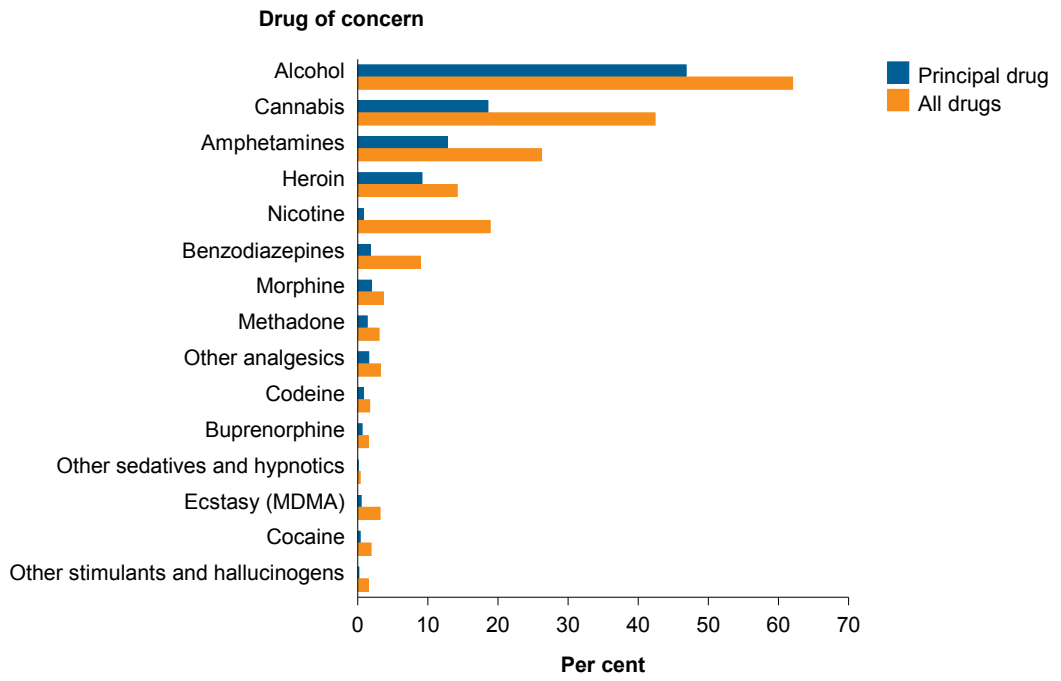

Figure 6.19: Closed episodes provided to clients for their own drug use with a main treatment type of assessment only by drugs of concern, Australia, 2011–12

Source: Table S6.31.

6.6 Support and case management only

Support and case management only was the main treatment type for 9% of episodes closed in 2011–12 (it is not available as an additional treatment type) (Figure 6.1). Nearly all (95%) of these episodes were provided to clients for their own drug use (Figure 6.2). This may be because clinicians view this treatment type as most appropriate for clients seeking treatment for their own alcohol and drug issues.

Almost half (46%) of the episodes for the client's own drug use with a main treatment type of support and case management were provided in Victoria, while 31% were provided in New South Wales (Figure 6.20). Three-quarters (75%) of those provided to clients for someone else's drug use were in Victoria, while 19% were in Queensland.

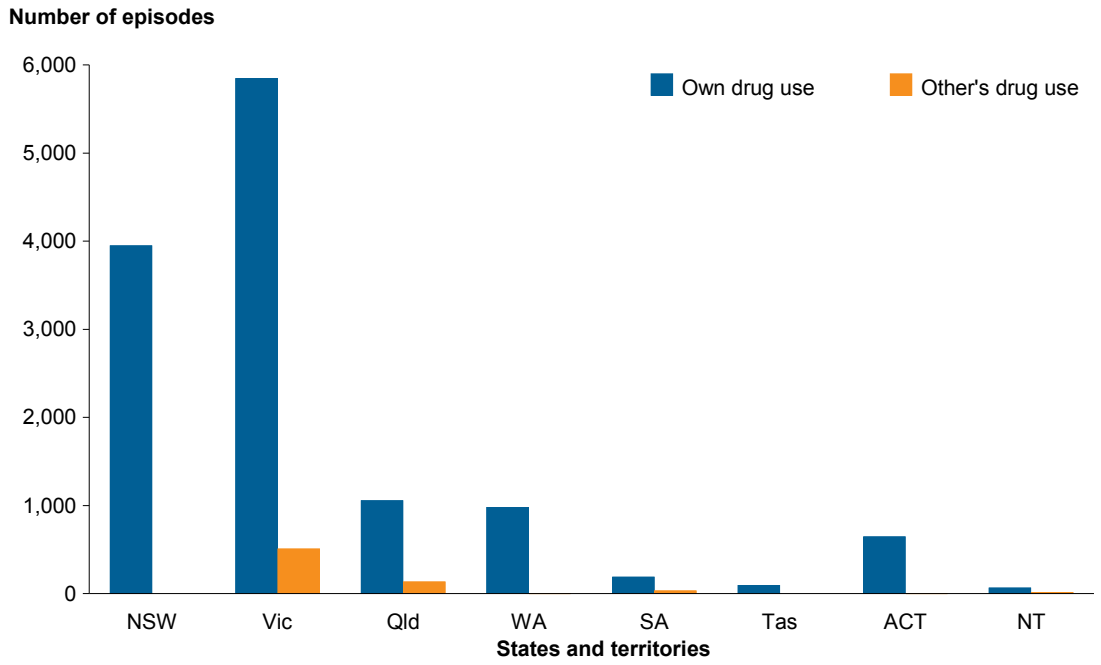

Figure 6.20: Closed episodes with a main treatment type of support and case management only by type of client, states and territories, 2011–12

Source: Table S6.32.

More than one-third (36%) of the episodes for the client's own drug use with a main treatment type of support and case management lasted 1–3 months, while almost one-third (32%) lasted up to 3 months, while over one-quarter (26%) lasted 3–6 months (Table S5.32). Long episodes were common in Tasmania, where more than half (56%) of these episodes lasted more than 12 months, compared with a national average of 4%. This may reflect an increase in complex and polydrug issues.

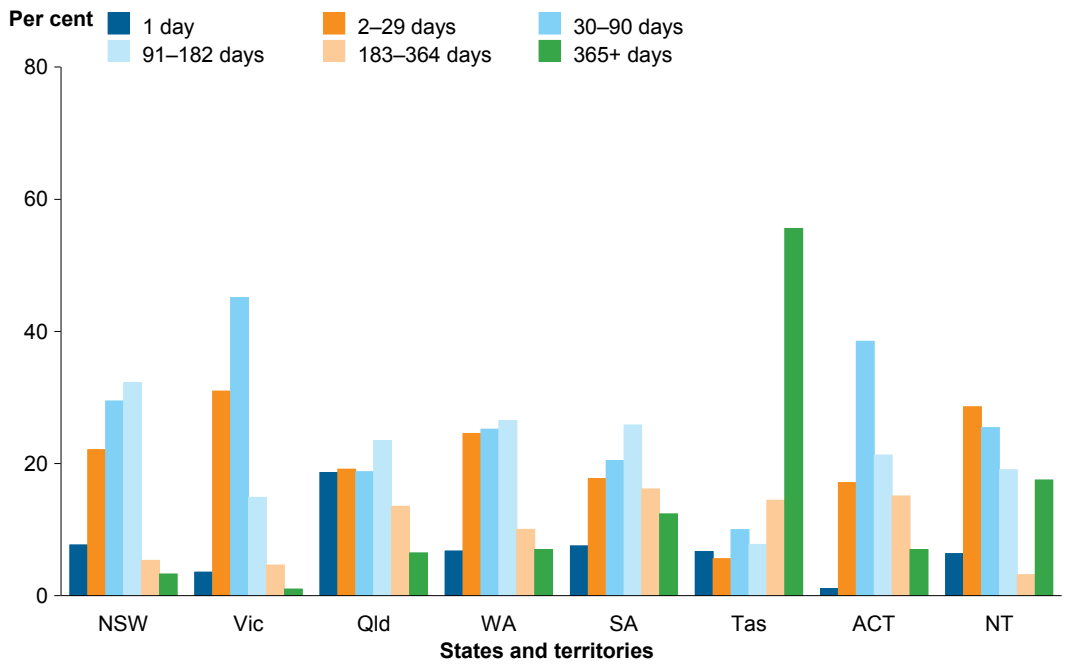

Figure 6.21: Closed episodes provided to clients for their own drug use with a main treatment type of support and case management only by duration, states and territories, 2011–12

Source: Table S6.34.

More than one-third (36%) of the closed episodes provided to clients for someone else's drug use with a main treatment type of support and case management only lasted 1–3 months, while over one-quarter (27%) lasted 2–29 days (Figure 6.22). Very short episodes were common in the Australian Capital Territory and Queensland, where 100% and 69%, respectively, lasted just 1 day. There were no episodes provided to clients for someone else's drug use with a main treatment type of support and case management in New South Wales or Tasmania.

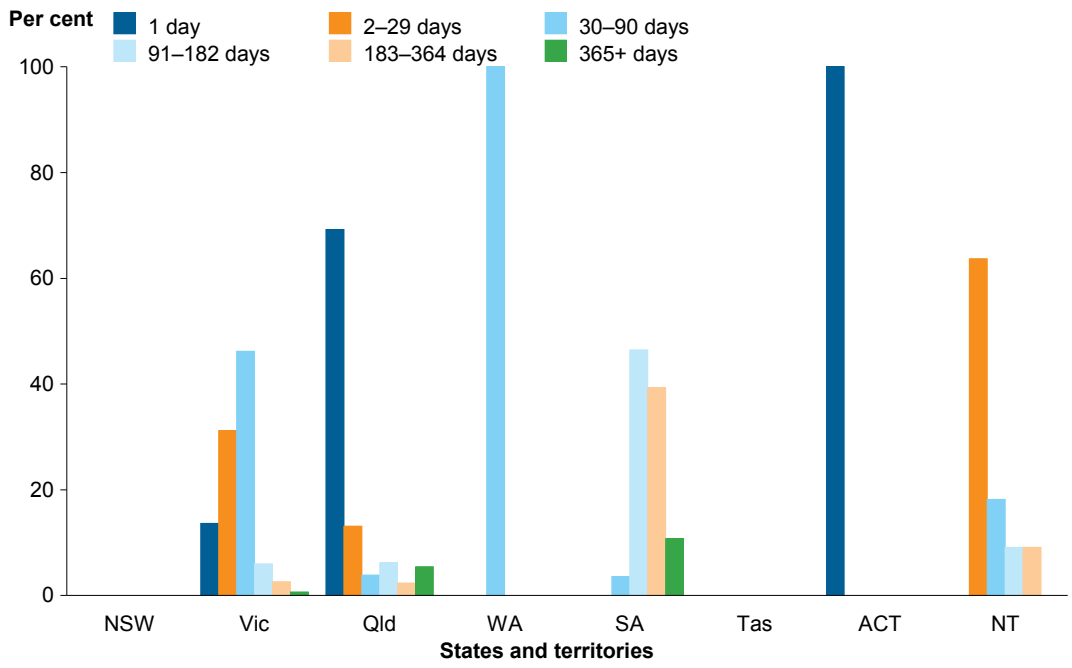

Figure 6.22: Closed episodes provided to clients for someone else's drug use with a main treatment type of support and case management only by duration, states and territories, 2011–12

Source: Table S6.34.

Client demographics

Almost two-thirds (64%) of the closed episodes provided to clients for their own drug use with a main treatment type of support and case management only were provided to male clients, and 80% were for non-Indigenous clients (Table S6.36). Female clients were slightly more likely to be Indigenous than male clients (17% compared with 14%).

Most of these episodes were for those in the 10–19 (30%) and 20–29 (29%) age groups (Figure 6.23). A further 21% were for clients aged 30–39; just 1% were for clients aged 60 and older.

Female clients, particularly Indigenous female clients, tended to be younger. More than three-fifths (62%) of the episodes provided to Indigenous females were for clients aged 10–29, compared with 57% for Indigenous males, 58% for non-Indigenous males, and 57% for non-Indigenous females (Table S6.36).

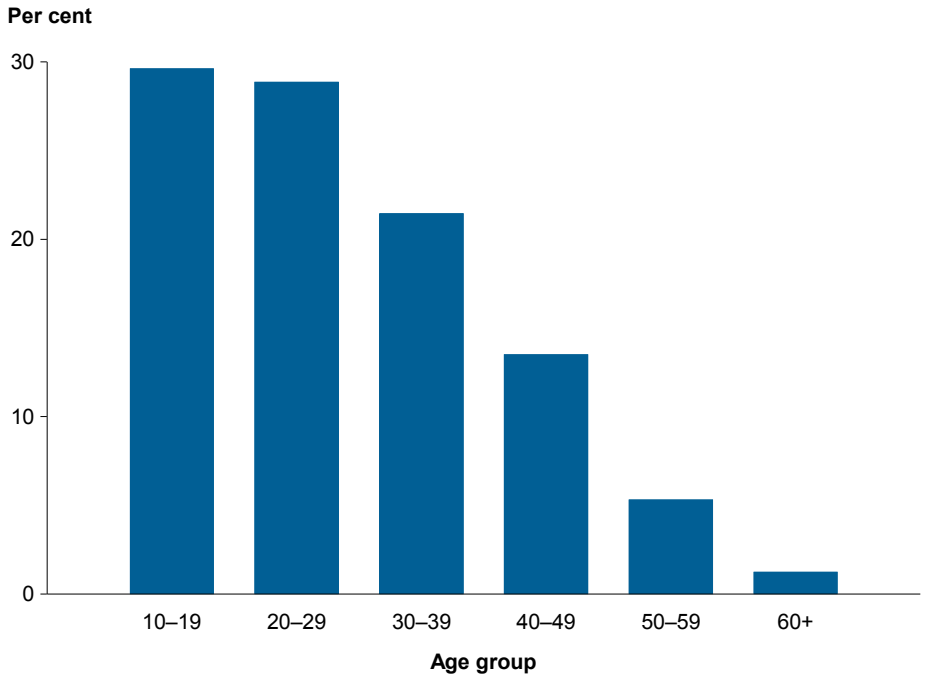

Figure 6.23: Closed episodes provided to clients for their own drug use with a main treatment type of support and case management only by age group, Australia, 2011–12

Source: Table S6.36.

Episodes for someone else's drug use with a main treatment type of support and case management only were more likely to be provided to female clients (63%) (Table S6.37). They also tended to be provided to younger clients, with more than half (54%) for clients in the 10–19 age group (Figure 6.24).

Female clients were more likely to be older than males: 38% of episodes provided to females were for clients aged 30 and over, compared with 29% of episodes for male clients.

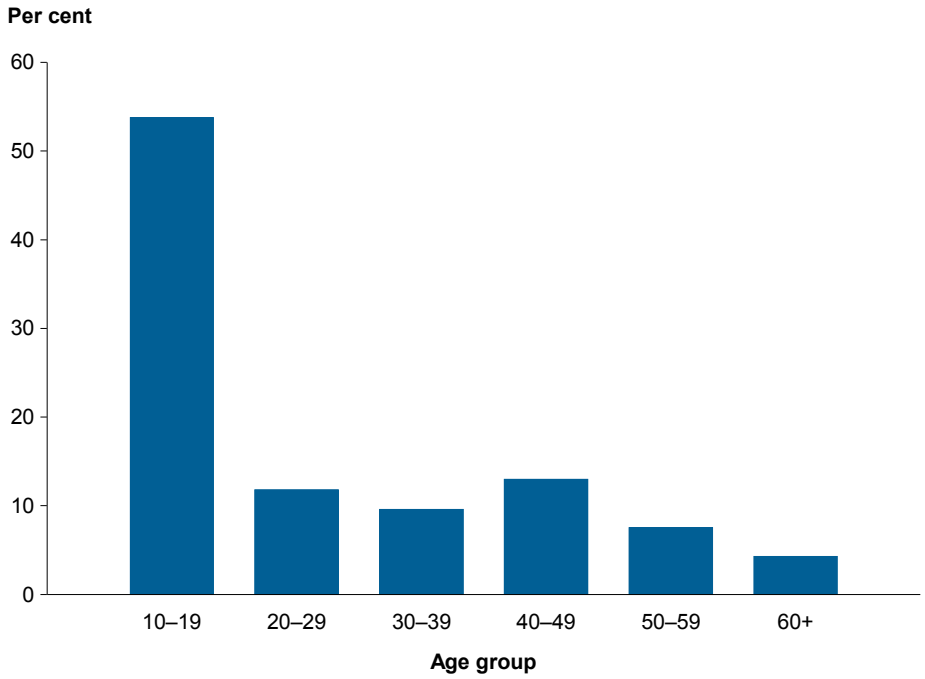

Figure 6.24: Closed episodes provided to clients for someone else's drug use with a main treatment type of support and case management only by age group, Australia, 2011–12

Source: Table S6.37.

Drugs of concern

More than one-third (35%) of the episodes provided to clients for their own drug use with a main treatment type of support and case management had alcohol as the principal drug of concern, while cannabis was the principal drug for 31% (Figure 6.25). Alcohol was a common principal drug of concern for most states and territories, although cannabis was the most common principal drug in New South Wales (31%) and it was equally common with alcohol in the Australian Capital Territory (36%). Amphetamines were the most common principal drug in Tasmania (33%), followed by morphine (32%) (Table S6.38).

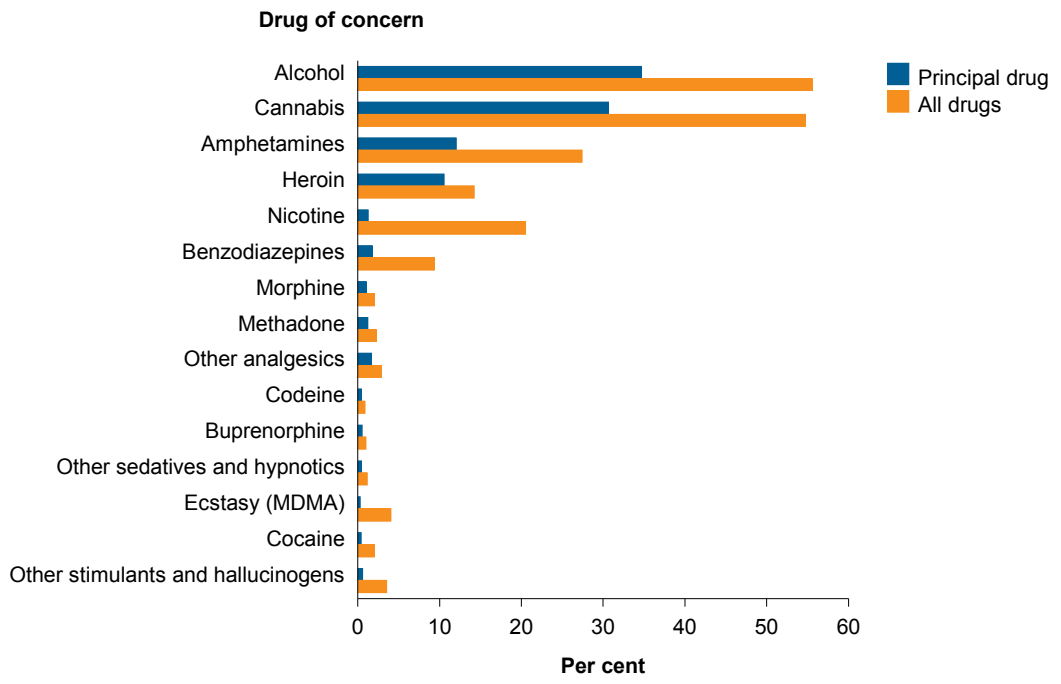

Figure 6.25: Closed episodes provided to clients for their drug use with a main treatment type of support and case management only by drugs of concern, Australia, 2011–12

Source: Table S6.38.

6.7 Information and education only

Information and education only was the main treatment type for 5% of the episodes closed in 2011–12 (it is not available as an additional treatment type) (Figure 6.1). Nearly all (96%) of these episodes were provided to clients receiving treatment for their own drug use (Figure 6.2).

More than three-fifths (63%) of these episodes for the client's own drug use were in Queensland, while almost one-third (32%) of those for someone else's drug use were provided in New South Wales and a further 32% were in Queensland (Figure 6.26).

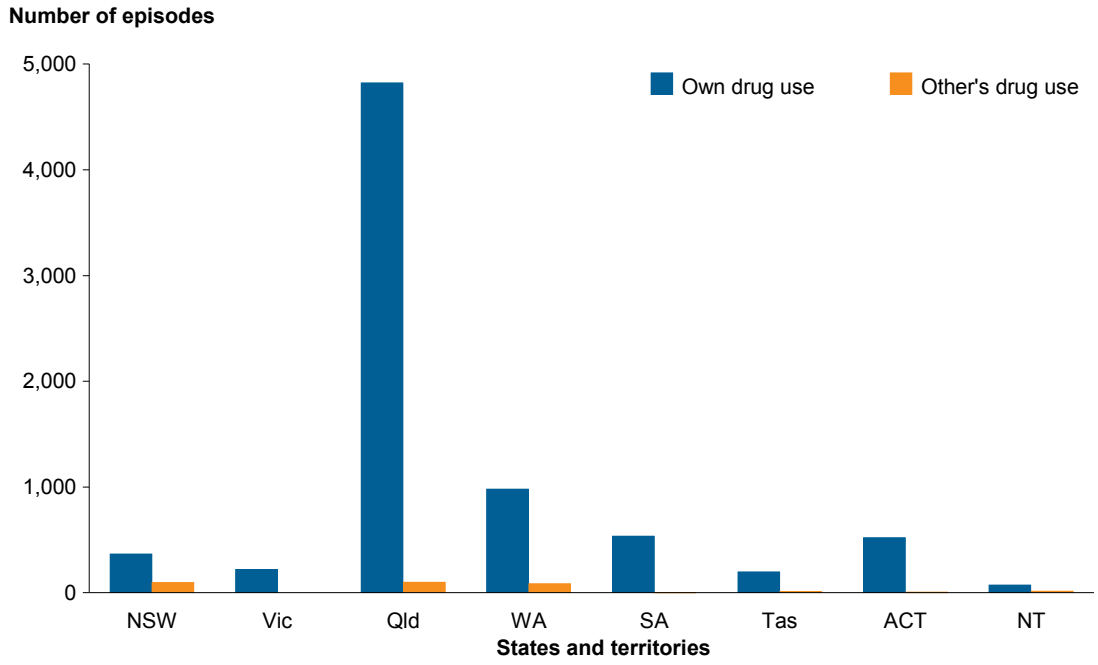

Figure 6.26: Closed episodes with a main treatment type of information and education only by type of client, states and territories, 2011–12

Source: Table S6.39.

As expected for this type of treatment, almost two-thirds (65%) of the information and education only episodes for the client's own drug use lasted just 1 day (Figure 6.27). Episodes of 1 day were common in Victoria (99%), South Australia (91%), the Northern Territory (75%), Queensland (70%) and Western Australia (62%).

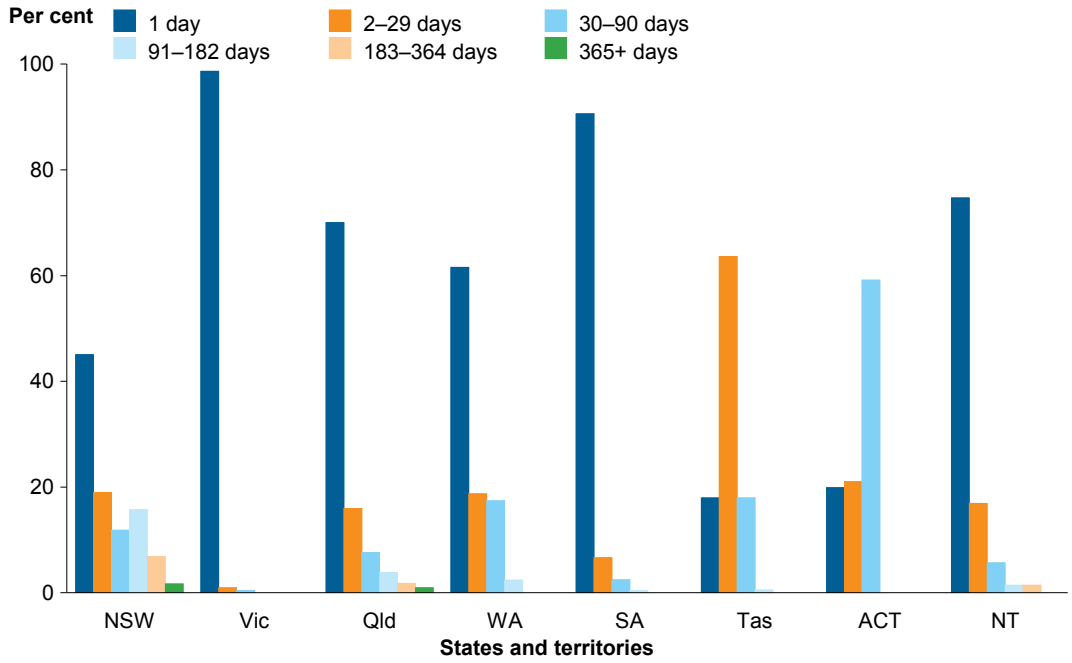

Figure 6.27: Closed episodes provided to clients for their own drug use with a main treatment type of information and education only by duration, states and territories, 2011–12

Source: Table S6.41.

Similarly to those provided for the client's own drug use and as expected for this type of treatment, almost two-thirds (65%) of the episodes provided for someone else's drug use lasted 1 day, while a further 15% lasted 2–29 days (Figure 6.28). All (100%) of these episodes lasted 1 day in South Australia and Tasmania, while in the Australian Capital Territory more than two-thirds (67%) lasted 2–29 days.

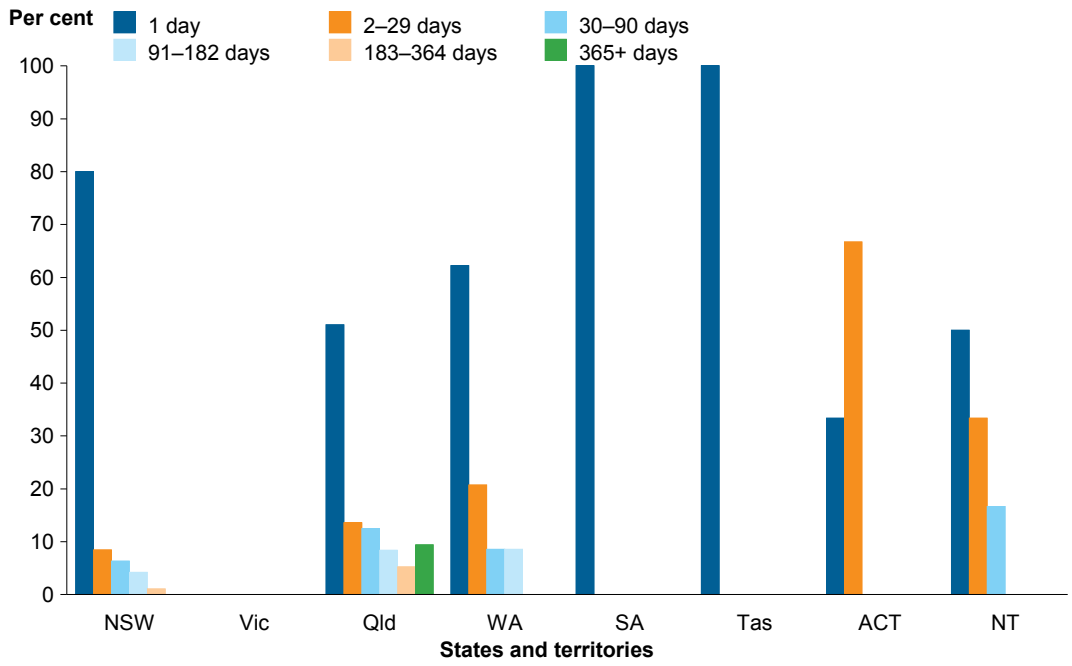

Figure 6.28: Closed episodes provided to clients for someone else's drug use with a main treatment type of information and education only by duration, states and territories, 2011–12

Source: Table S6.41.

Client demographics

More than 7 in 10 (72%) of the closed episodes provided to clients for their own drug use with a main treatment type of information and education only were provided to male clients, and 74% were for non-Indigenous clients (Table S6.43). Female clients were slightly more likely to be Indigenous than male clients (25% compared with 14%).

Almost three-fifths (59%) of these episodes were for those in the 20–29 (32%) and 10–19 (27%) age groups (Figure 6.29). A further 21% were for clients aged 30–39; 1% were for clients aged 60 and older.

Female clients, particularly Indigenous female clients, tended to be older. More than 3 in 10 (31%) of the episodes provided to Indigenous females were for clients aged 40 and over, compared with 23% for Indigenous males, 18% for non-Indigenous males, and 19% for non-Indigenous females (Table S6.43).

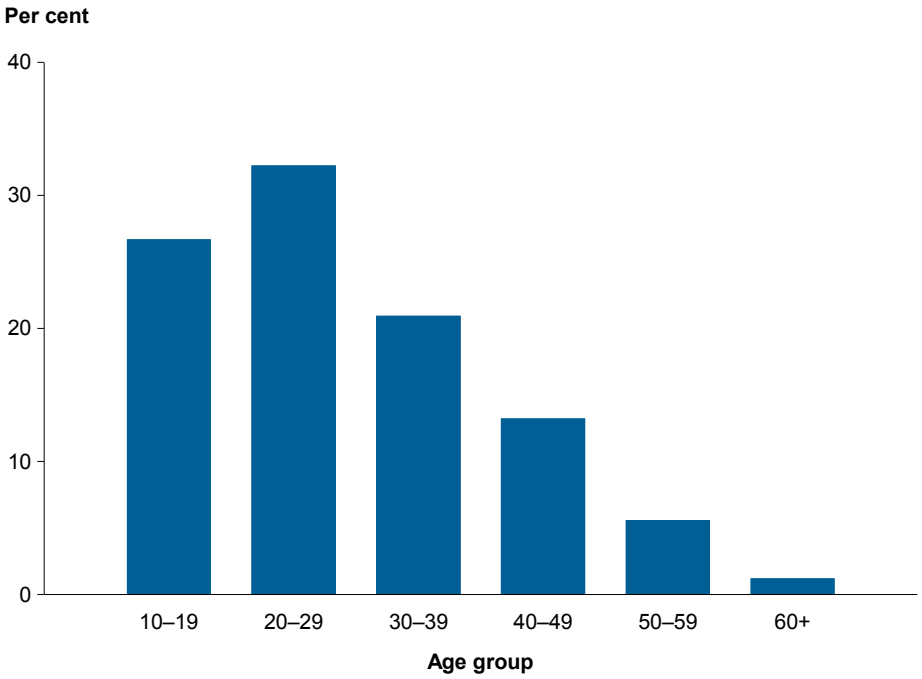

Figure 6.29: Closed episodes provided to clients for their own drug use with a main treatment type of information and education only by age group, Australia, 2011–12

Source: Table S6.43.

Episodes for someone else's drug use with a main treatment type of information and education only were more likely to be provided to female clients (54%)Table S6.44).

These episodes tended to be provided to older clients. More than half (53%) were for clients in the 40–49 (20%), 50–59 (19%) or 60 and older (14%) age groups (Figure 6.30). Female clients were more likely to be older than males: 42% of episodes provided to females were for clients aged 40–59, compared with 35% of episodes for male clients (Table S6.44).

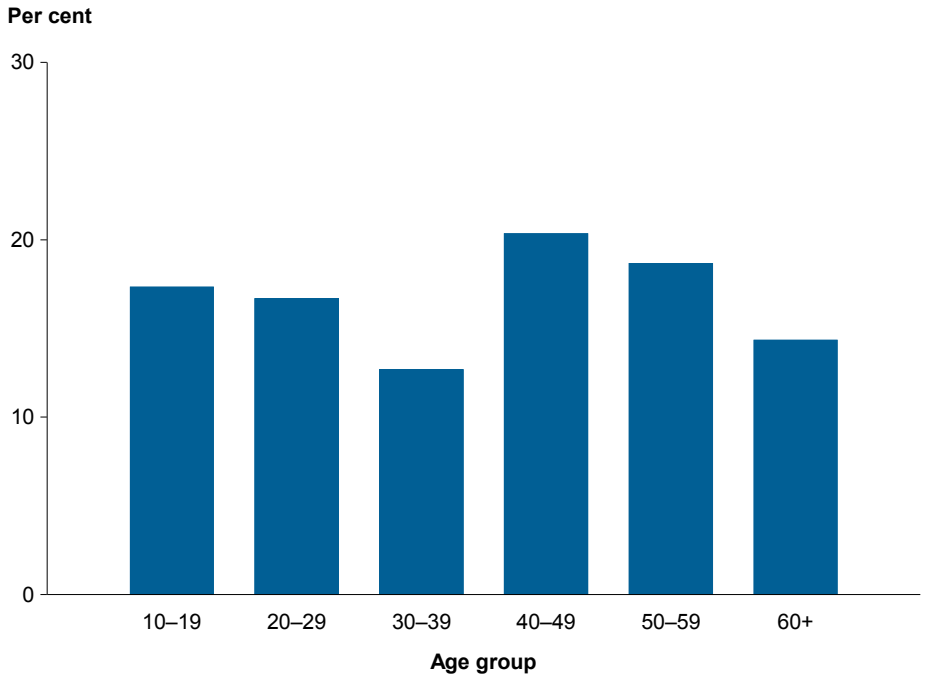

Figure 6.30: Closed episodes provided to clients for someone else's drug use with a main treatment type of information and education only by age group, Australia, 2011–12

Source: Table S6.44.

Drugs of concern

Of the closed episodes provided to clients for their own drug use with a main treatment type of information and education only, half (50%) had cannabis as a principal drug of concern, while more than one-quarter (27%) had a principal drug of alcohol (Figure 6.31).

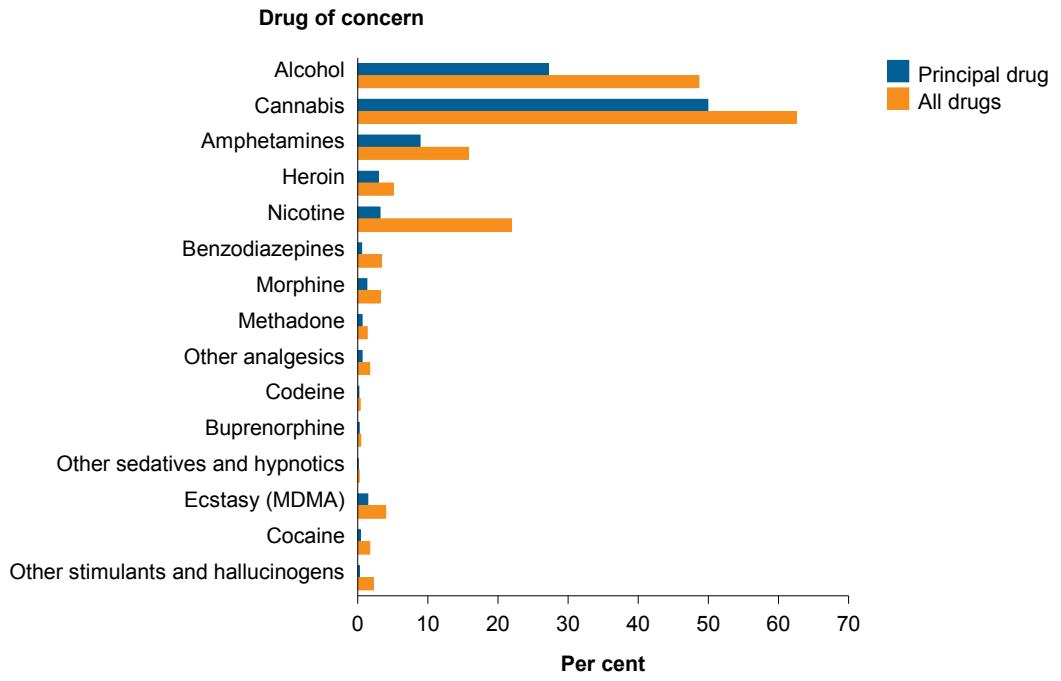

Figure 6.31: Closed episodes provided to clients for their own drug use with a main treatment type of information and education only by drugs of concern, Australia, 2011–12

Source: Table S6.45.

6.8 Rehabilitation

Rehabilitation is only provided in episodes for clients receiving treatment for their own drug use. Rehabilitation was the main type of treatment in 6% of episodes and an additional treatment type in less than 1% (Figure 6.1 and Figure 6.2).

Almost 3 in 10 (29%) of the episodes with a main treatment type of rehabilitation were provided in New South Wales, while one-fifth (21%) were provided in Victoria (Figure 6.32). Over one-third (36%) of the episodes as an additional treatment were provided in New South Wales, while almost one-quarter (24%) were provided in Queensland. The low number of rehabilitation episodes in Tasmania is due to the small number of rehabilitation services, which are mostly delivered in a residential setting.

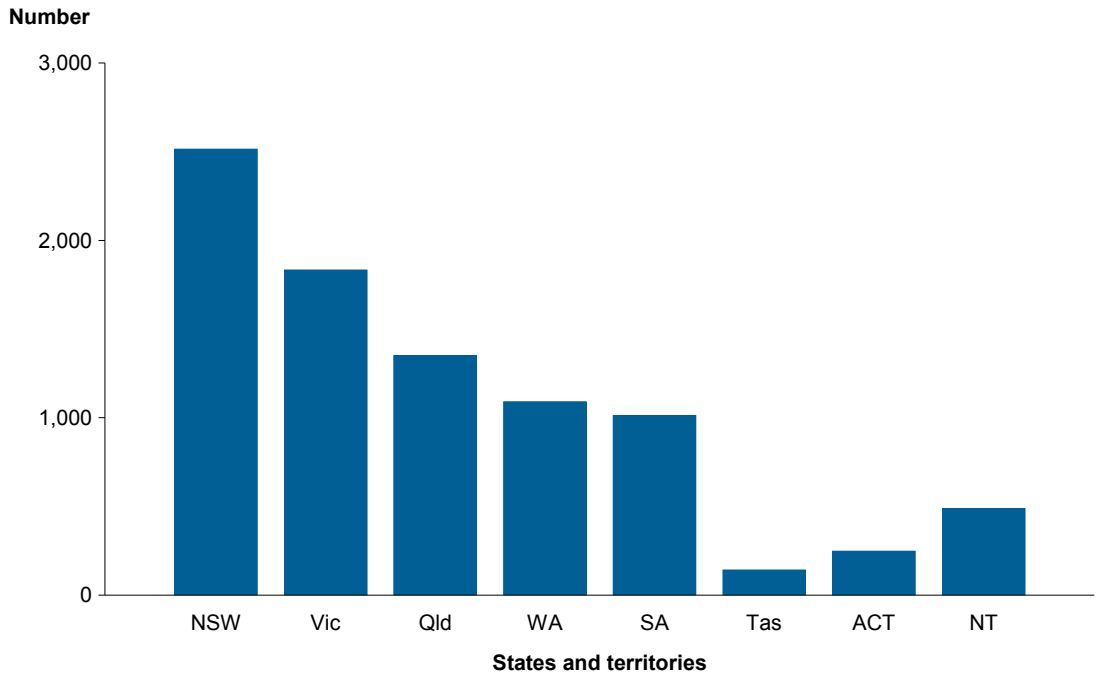

Figure 6.32: Closed episodes with a main treatment type of rehabilitation, states and territories, 2011–12

Source: Table S6.46.

More than one-third (35%) of the episodes with a main treatment type of rehabilitation lasted from 2 days to 1 month, while a further one-third (34%) lasted 1–3 months (Table S6.48). In South Australia, 19% lasted 6 months or more, compared with a national average of 11% (Figure 6.33).

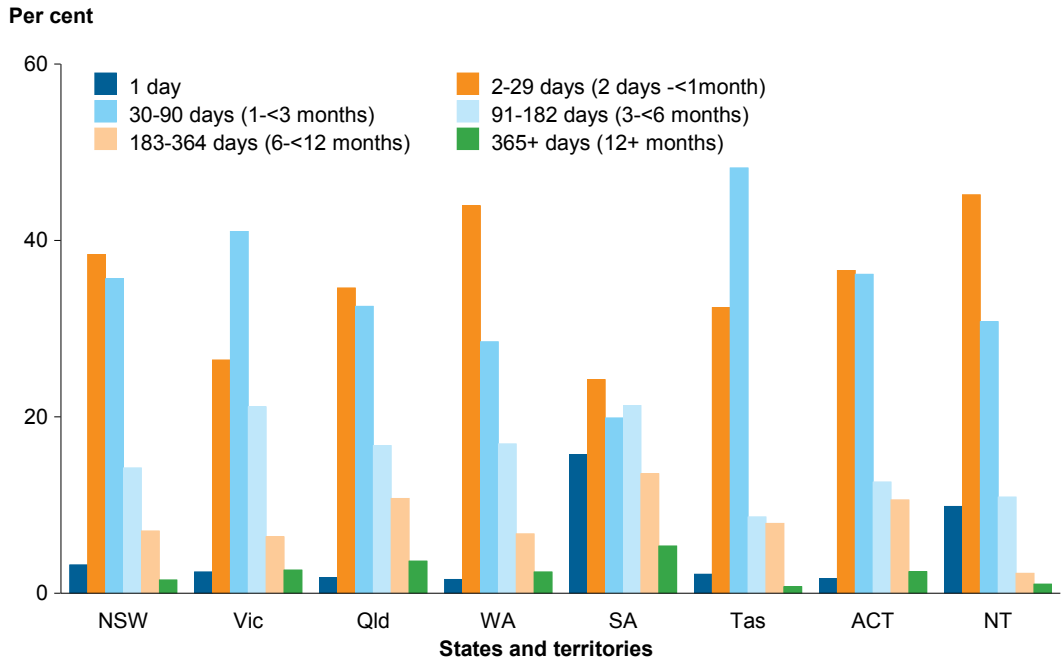

Figure 6.33: Closed episodes provided to clients for their own drug use with a main treatment type of rehabilitation by duration, states and territories, 2011–12

Source: Table S6.48.

Client demographics

Almost two-thirds (65%) of the closed episodes with a main treatment type of rehabilitation were provided to male clients, and 81% were for non-Indigenous clients (Table S6.50).

Two-thirds (64%) of these episodes were for those in the 20–29 (31%) and 30–39 (33%) age groups (Figure 6.34). A further 19% were for clients aged 40–49; just 2% were for clients aged 60 and older.

Indigenous clients tended to be younger. More than half (54%) of the episodes provided to Indigenous males were for clients aged 10–29, compared with 52% for Indigenous females, 36% for non-Indigenous males and 37% for non-Indigenous females (Table S6.50).

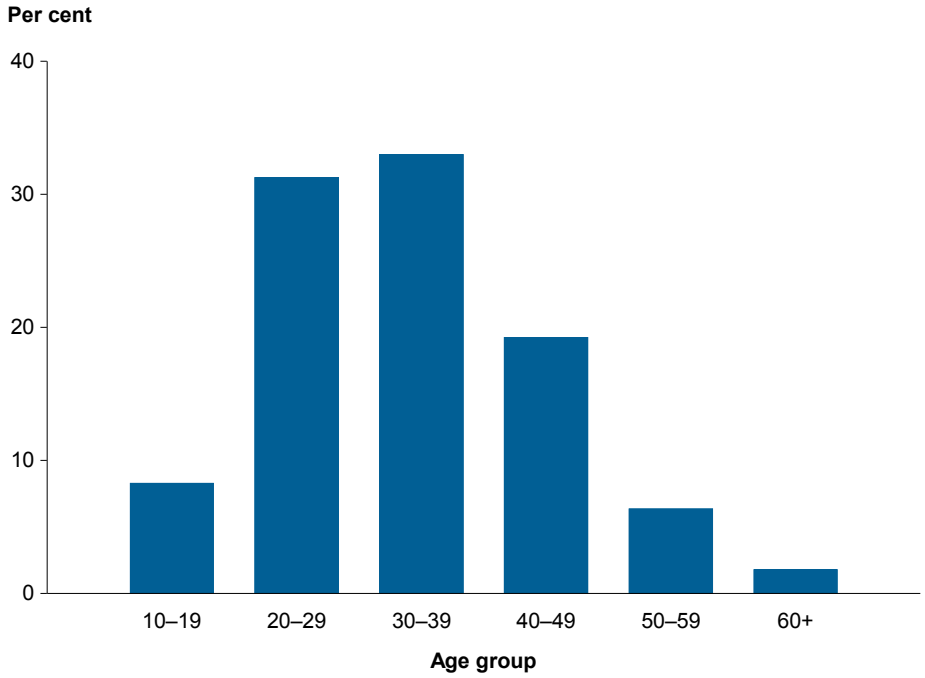

Figure 6.34: Closed episodes provided to clients for their own drug use with a main treatment type of rehabilitation by age group, Australia, 2011–12

Source: Table S6.50.

Drugs of concern

Of the closed episodes provided to clients for their own drug use with a main treatment type of rehabilitation, almost half (47%) had alcohol as a principal drug of concern, while almost one-fifth (18%) had a principal drug of amphetamines (Figure 6.35).

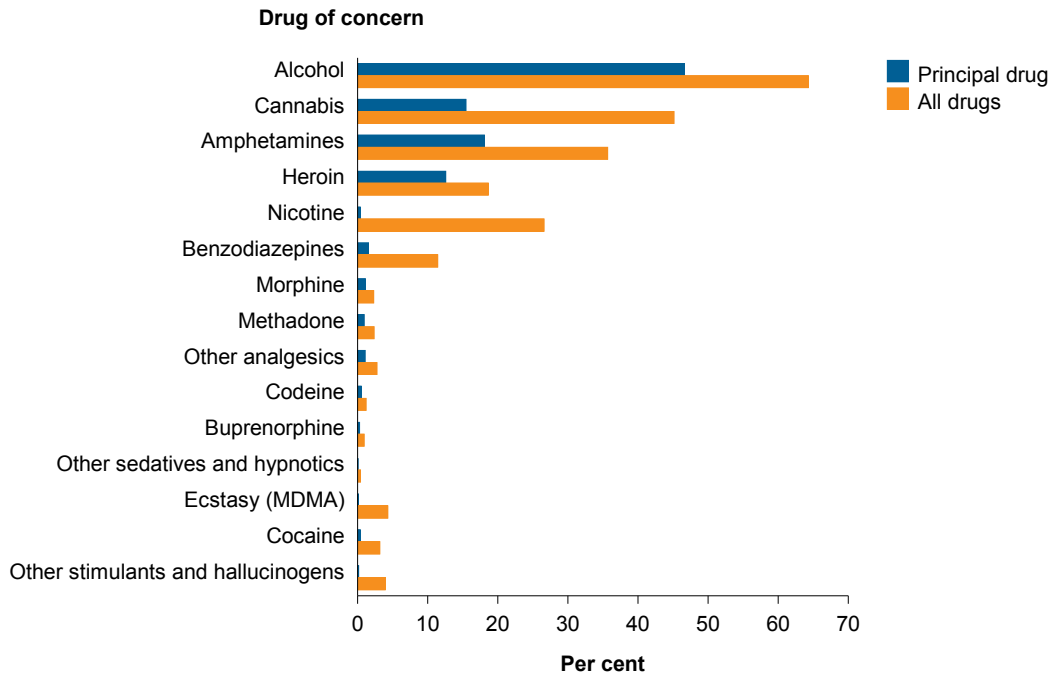

Figure 6.35: Closed episodes provided to clients for their drug use with a main treatment type of rehabilitation by drugs of concern, Australia, 2011–12

Source: Table S6.51.

Additional treatment types

Half (50%) of the episodes for the client's own drug use with a main treatment type of rehabilitation had one or more additional treatment types (Table S6.53). Of these, counselling (63%) was the most common type of additional treatment, and this was the case in New South Wales, Queensland, South Australia, Tasmania and the Northern Territory (the remaining states and territory did not have any episodes with additional treatment types) (Table S6.52).

6.9 Other treatment types

Pharmacotherapy

Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment and an additional treatment was provided, are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded from the AODTS NMDS. Pharmacotherapy is only available to clients receiving treatment for their own drug use.

Nationally in 2011–12, 2% of episodes were provided with a treatment type of pharmacotherapy (main or additional) (Figure 6.1). In almost three-quarters (71%) of these episodes, pharmacotherapy was an additional treatment (Figure 6.2)—this is a result of the AOTDS NMDS scope, which excludes episodes in which pharmacotherapy is the main treatment type and no additional treatment is provided.

Of the closed episodes where pharmacotherapy was the main treatment type, almost one-third (31%) lasted up to 1 month, while a further one-fifth (21%) lasted 1–3 months (Table S6.56).

Seven in 10 (70%) of the closed episodes with a main treatment type of pharmacotherapy were provided to male clients, and 83% were for non-Indigenous clients (Table S6.58). More than two-thirds (68%) of these episodes were for those in the 20–29 (28%) and 30–39 (40%) age groups. A further 22% were for clients aged 40–49; just 1% were for clients aged 60 and older.

Of the closed episodes provided to clients with a main treatment type of pharmacotherapy, almost half (45%) had heroin as a principal drug of concern, while almost 1 in 6 (17%) had a principal drug of methadone. Morphine (13% of episodes) was also a common principal drug of concern (Table S6.59).

More comprehensive information on pharmacotherapy treatment provided in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics Annual Data (NOSPAD) collection. The most recent report on the NOPSAD collection (AIHW 2013b) showed that almost 47,000 Australians were on a course of pharmacotherapy treatment for their opioid dependence on a snapshot day in June 2012. About two-thirds (68%) of these were treated with methadone (the remainder were treated with either buprenorphine or buprenorphine-naloxone). Most clients attend dosing points regularly to receive their pharmacotherapy, and in 2012 most of these dosing points were in pharmacies (88%).

Other treatment

Nationally in 2011–12, 'other' was the treatment type (main or additional) for 9% of episodes. Of these, it was the main treatment type in 61% of episodes (for the remainder, it was an additional treatment type) (Figure 6.2). Nearly all (98%) were provided to clients receiving treatment for their own drug use.

More than three-fifths (62%) of the episodes for the client's own drug use were in New South Wales, while three-fifths (60%) of those for someone else's drug use were provided in the Northern Territory and a further 23% were in Queensland (Table S6.62).

Of the closed episodes provided to clients for their own drug use with a main treatment type of other, almost half (46%) lasted up to 1 month, while more than one-third (37%) lasted 1 day (Table S6.64). In Queensland, 11% of episodes lasted more than 12 months, compared with a national average of 2%.

Almost two-thirds (63%) of the closed episodes with a main treatment type of other were provided to male clients, and 81% were for non-Indigenous clients (Table S6.66). Episodes for someone else's drug use with a main treatment type of other were more likely to be provided to male clients (51%), and the clients were more likely to be Indigenous (59% compared with 35% for non-Indigenous) (Table S5.66).

More than half (54%) of the episodes provided to clients for their own drug use were for those in the 10–19 (12%), 20–29 (19%) and 30–39 (23%) age groups (Table S5.67). A further 11% were for clients aged 60 and older.

Of the closed episodes provided to clients with a main treatment type of other, almost three-fifths (57%) had alcohol as a principal drug of concern, while almost 1 in 8 (12%) had a principal drug of cannabis. Methadone (9% of episodes) was also a common principal drug of concern.

6.10 Hospitalisations associated with drug use

Information on hospitalisations is available from the National Hospital Morbidity Database (NHMD). This database includes almost all public hospitals that provided data for the NHMD in 2011–12. The exception was a mothercraft hospital in the Australian Capital Territory. The great majority of private hospitals also provided data, the exceptions being the private free-standing day hospital facilities in the Australian Capital Territory, the single private free-standing day hospital in the Northern Territory and a private free-standing day hospital in Victoria.

A hospital separation refers to a completed episode of admitted hospital care ending with discharge, death, transfer or a portion of a hospital stay beginning or ending in a change to another type of care (for example, from acute care to rehabilitation). Drug-related separations refer to hospital care with selected diagnoses of substance use disorder or harm (accidental, intended or self-inflicted) due to selected substances (see Appendix A for details). The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. Hospital separations where the diagnosis of drug-related harm or disorder is additional to another diagnosis have been excluded from this section. This includes problems related to certain chronic conditions caused by the use of drugs like tobacco and alcohol. Hospital separations for drug-related injuries and drug-related allergic responses have also been excluded.

Drugs described in this section include legal, accessible drugs such as alcohol and tobacco, drugs that are available by prescription or over the counter, such as analgesics and antidepressants, and drugs that are generally not obtained through legal means, such as heroin and ecstasy. Therefore, a proportion of the separations reported here may result from harm arising from the therapeutic use of drugs, and the inclusion of therapeutic use may mean the burden of drugs and alcohol on the hospital system appears larger than expected.

About 107,800 hospital separations with a drug-related principal diagnosis were reported in 2011–12 (Table 6.1), which represents 1% of all hospital separations, a slightly higher proportion than in previous years.

In 2011–12, sedatives and hypnotics continued to account for the highest proportion of hospital separations with a drug-related principal diagnosis (64% of all such separations), with alcohol making up 89% of separations for sedatives and hypnotics. On its own, alcohol accounted for 57% of all drug-related hospital separations (Table 6.1). Of all separations with a drug-related principal diagnosis, 14% were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for half of this group (7% of all drug-related separations). Stimulants and hallucinogens, including cannabis and cocaine, accounted for 10% of all separations where the principal diagnosis was drug-related.

Separations can be either same-day (where the patient is admitted and separated on the same day) or overnight (where the patient is admitted to hospital and separates on a different date). The admitted patient care data have limitations; for example, variations in admission practices and policies lead to variation among providers in the number of admissions for some conditions and procedures. In 2011–12, overnight separations continued to be more common for drug-related treatment than same-day separations, accounting for 60% of all drug-related separations.

Table 6.1: Hospital separations by drug-related principal diagnosis and duration, 2011–12

	Same-day separations		Overnight separations		Total separations	
Drug- related principal diagnosis	No.	%	No.	%	No.	%
Analgesics						
Opioids (includes heroin, opium & methadone)	2,440	5.6	5,245	8.1	7,685	7.1
Non-opioid analgesics (includes paracetamol)	1,882	4.3	5,141	8	7,023	6.5
Total analgesics	*4,322*	*10*	*10,386*	*16.1*	*14,708*	*13.6*
Sedatives & hypnotics						
Alcohol	28,769	66.3	32,650	50.7	61,419	57
Other sedatives & hypnotics	2,331	5.4	5,621	8.7	7,952	7.4
Total sedatives and hypnotics	*31,100*	*71.7*	*38,271*	*59.4*	*69,371*	*64.3*
Stimulants & hallucinogens						
Cannabinoids (includes cannabis)	1,250	2.9	2,907	4.5	4,157	3.9
Hallucinogens (includes LSD & ecstasy)	24	0.1	18	0	42	0
Cocaine	145	0.3	141	0.2	286	0.3
Tobacco & nicotine	18	0	41	0.1	59	0.1
Other stimulants (includes amphetamines, volatile solvents)	1,820	4.2	3,933	6.1	5,753	5.3
Total stimulants and hallucinogens	*3,257*	*7.5*	*7,040*	*10.9*	*10,297*	*9.6*
Antidepressants & antipsychotics	2,081	4.8	5,826	9	7,907	7.3
Volatile solvents	353	0.8	470	0.7	823	0.8
Other drugs of concern and conditions						
Multiple drug use	2,232	5.1	2,290	3.6	4,522	4.2
Unspecified drug use and other drugs not elsewhere classified	44	0.1	115	0.2	159	0.1
Foetal and perinatal related conditions		0	25	0	25	0
Total other drugs of concern and conditions	*2,276*	*5.2*	*2,430*	*3.8*	*4,706*	*4.4*
Total	**43,389**	**100.0**	**64,423**	**100.0**	**107,812**	**100.0**

Note: Care types 7.3, 9 and 10 were excluded from analysis.

Source: AIHW analysis of the National Hospitals Morbidity Database 2011–12.

The total number of drug-related hospital separations has gradually increased from 80,910 in 2003–04 to 107,812 in 2011–12 (Table 6.2). At the same time, total hospital separations have increased, with drug-related hospital separations consistently making up 1%–2% of all hospital separations across this period.

Alcohol has consistently been the drug-related principal diagnosis with the highest number of hospital separations from 2003–04 to 2011–12, with the number of separations increasing from 40,774 to 61,419 in that time.

Table 6.2: Hospital separations by drug-related principal diagnosis, 2003–04 to 2011–12

Drug of concern	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10	2010–11	2011–12
Analgesics									
Opioids	6,060	5,852	5,602	6,622	6,998	7,179	7,525	7,526	7,685
Non opioid analgesics	6,003	6,522	6,497	5,600	5,673	6,693	6,681	6,548	7,023
Sedatives and hypnotics									
Alcohol	40,774	42,976	46,683	52,021	54,923	57,532	61,125	59,719	61,419
Other sedatives & hypnotics	9,568	9,698	9,750	10,059	10,421	10,618	10,402	7,932	7,952
Stimulants and hallucinogens									
Cannabinoids	2,672	2,881	3,497	3,263	3,047	3,270	3,364	3,745	4,157
Hallucinogens	190	416	412	362	449	187	169	44	42
Cocaine	188	305	235	220	236	230	290	179	286
Tobacco & nicotine	49	37	46	59	34	51	50	51	59
Other stimulants	4,550	4,005	4,350	4,621	3,844	385	3,182	3,966	5,753
Antidepressants & Antipsychotics	6,575	6,756	6,615	6,701	6,753	7,661	7,540	7,650	7,907
Volatile solvents	925	1,022	872	816	734	825	780	753	823
Other drugs of concern and conditions									
Multiple drug use	3,065	2,845	3,112	3,415	3,339	3,134	3,333	4,329	4,522
Unspecified drug use & Other drugs of concern	239	206	172	156	135	146	143	150	159
Foetal and perinatal conditions	52	46	45	41	43	50	30	34	25
Total	**80,910**	**83,567**	**87,888**	**93,956**	**96,629**	**97,961**	**104,614**	**102,656**	**107,812**

Note: Care types 7.3, 9 and 10 were excluded from analysis.

Source: AIHW analysis of the National Hospitals Morbidity Database.

6.11 Alcohol and other drug problems among Australia's prisoners

Prisoners typically have far greater health needs than the general population, with high levels of drug use, mental health disorders, chronic disease, communicable disease and disability (AIHW 2013a; Hockings et al. 2002; Indig et al. 2010). State and territory governments are responsible for providing health services to prisoners; in most states and territories, health departments deliver these, although in some, these services are provided by the department responsible for corrective services or by private organisations (AIHW 2013a). The AIHW's National Prisoner Health Data Collection (NPHDC) contains data on prisoner health in Australia. This chapter provides information from the 2012 NPHDC. For information on method and scope, see *The health of Australia's prisoners 2012* (AIHW 2013a).

Alcohol and other drug issues

Tobacco

Almost four-fifths (78%) of prison entrants during the survey period were daily smokers and a further 6% were weekly or irregular smokers (AIHW 2013a). Those aged 45 or older were less likely to be current (daily, weekly or irregular) smokers than those in younger age groups (Entrant form, 2012 NPHDC).

Risky alcohol consumption

Nearly half (46%) of prison entrants consumed alcohol in the previous 12 months at levels that placed them at a high risk of alcohol-related harm and a further 29% were at a low risk of alcohol-related harm (AIHW 2013a). Consuming alcohol at levels that result in a high risk of alcohol-related harm was more likely for those in the younger age groups (50% for those aged 18–24 compared with 39% for those aged 45 and older), although there was little difference in the proportion at a low risk of alcohol-related harm (Entrant form, 2012 NPHDC). Note that in this chapter, risk of alcohol-related harm is determined using the World Health Organization's Alcohol Use Disorder Identification Test (AUDIT).

Illicit drug use

Seven in 10 (70%) prison entrants reported using illicit drugs in the 12 months before their current imprisonment (AIHW 2013a). Illicit drug use was less common among entrants aged 45 and older (44%).

Cannabis was the most common illicit drug used for all age groups, although entrants aged 45 and older were least likely to use it (27%, compared with 59% for those aged 18–24) (Entrant form, 2012 NPHDC). Use of amphetamines was also common, particularly in the younger age groups (39% for 18–24 and 43% for 25–34, compared with 16% for those aged 45 and older). There was little difference among the age groups in the use of analgesics (16%–18%).

Comorbidity

A high proportion of prison entrants have comorbid mental health and drug issues. Of those who had been told they had a mental health disorder, 50% had a high risk of alcohol-related harm, 86% were current smokers and 76% had used drugs in the 12 months before their current imprisonment (Figure 6.36). Proportions were similar for those referred to mental health services after assessment.

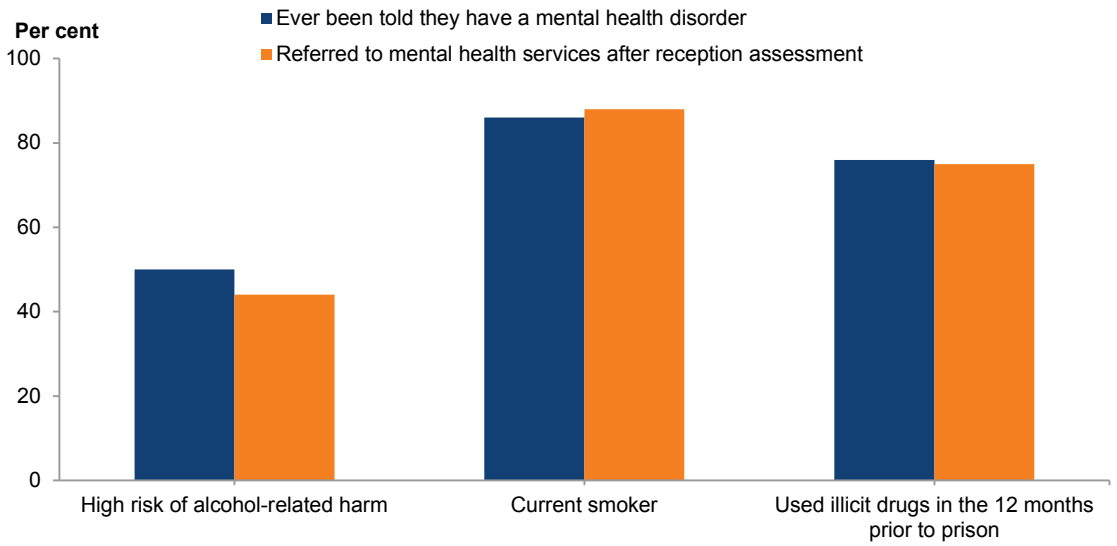

Figure 6.36: Prison entrants with comorbid mental health and drug issues, 2012

Source: Entrant form, 2012 NPHDC.

Health services provided to prisoners

Of the 9,027 visits to prison clinics during the 2-week collection period, 5% related to alcohol or other drug use (AIHW 2013a). Three-fifths (61%) of these visits resulted in treatment being provided and a further two-fifths (42%) resulted in advice and education (more than one service could be provided) (Figure 6.37). For almost half (46%), only assessment was provided.

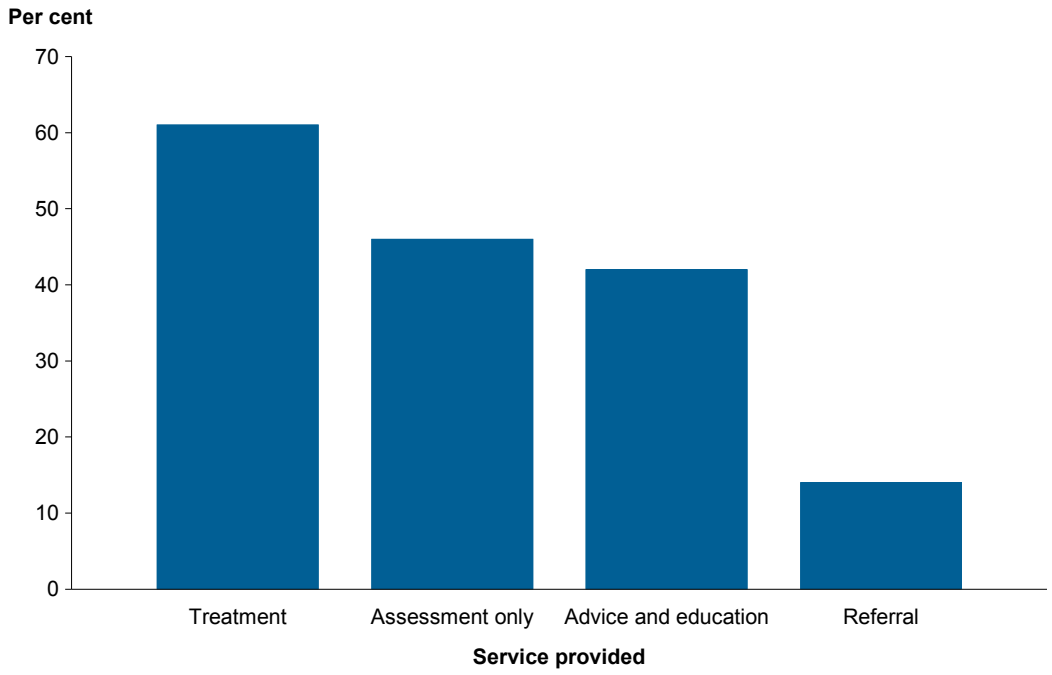

Figure 6.37: Visits to prison clinics where the problem related to alcohol and other drug use by service provided, 2012

Source: Clinic form, 2012 NPHDC.

During the 1-day collection period, 5% of prisoners received drugs for opioid dependence and 1% received drugs for nicotine dependence (AIHW 2013a). Those in the 25–34 and 35–44 age groups were most likely to receive drugs for opioid dependence (9% and 7%, respectively), while those in the 18–24 age group were most likely to receive drugs for nicotine dependence (3%) (Figure 6.38).

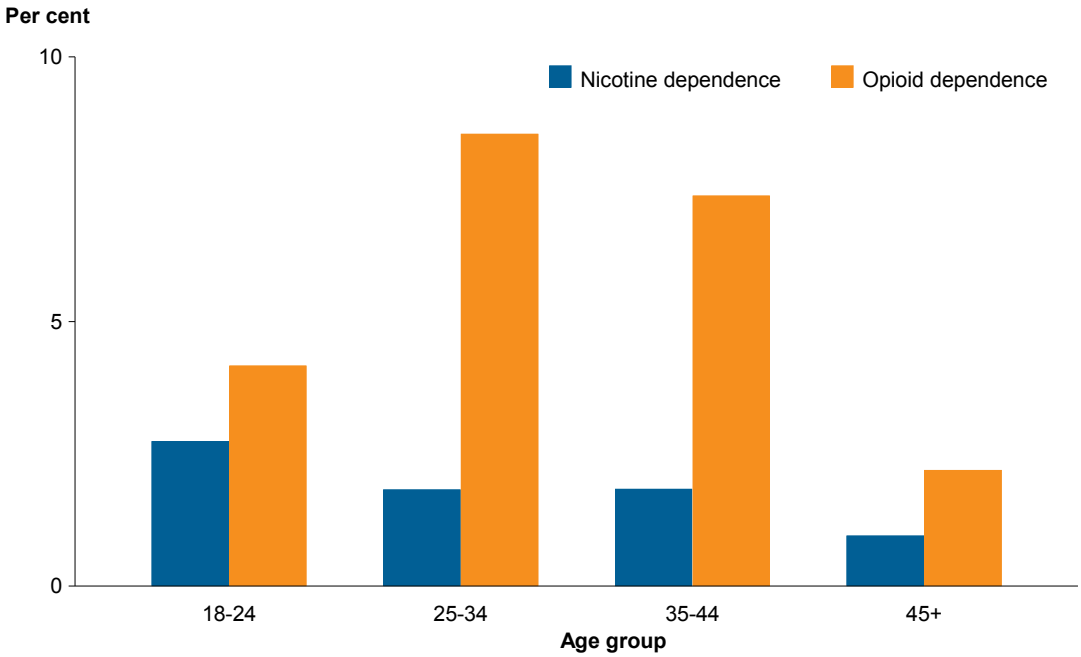

Figure 6.38: Prisoners provided with prescribed medication during the collection period, 2012

Source: Repeat Medications form, 2012 NPHDC.

7 State and territory summaries

7.1 New South Wales

Nearly all (98%) episodes closed in New South Wales in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.1). Of the episodes for the client's own drug use, more than two-thirds (68%) were for male clients, while the reverse was true for episodes for someone else's drug use (63% were for females).

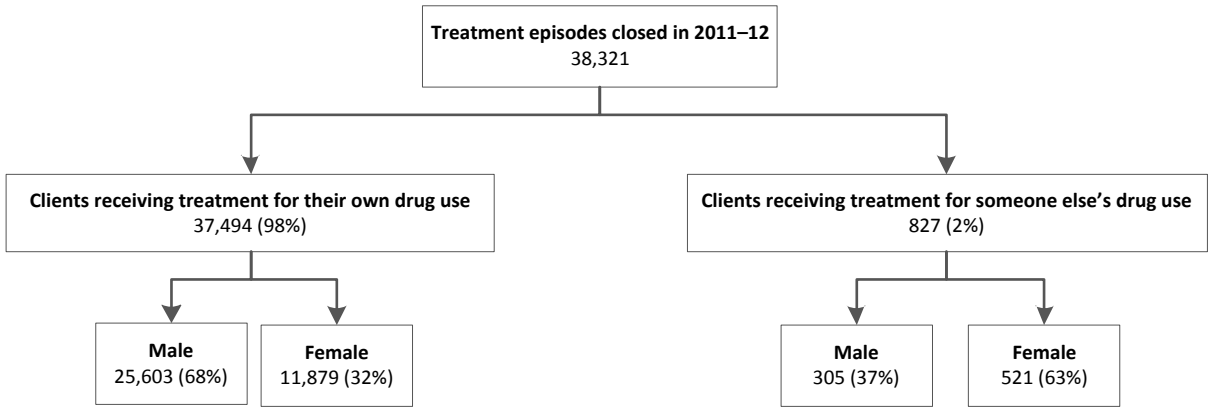

Figure 7.1: Summary client characteristics of closed treatment episodes, New South Wales, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.1 and Table S7.2 and Table S7.3.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for almost half (47%) of these episodes (Figure 7.2). Cannabis was also relatively common as a principal drug, accounting for one-fifth (20%), followed by amphetamines (11%) and heroin (8%).

Alcohol was also the most common drug when additional drugs were taken into account, accounting for 57% of closed episodes, followed by cannabis (36%), amphetamines (20%) and nicotine (19%) (clients can nominate up to five additional drugs of concern).

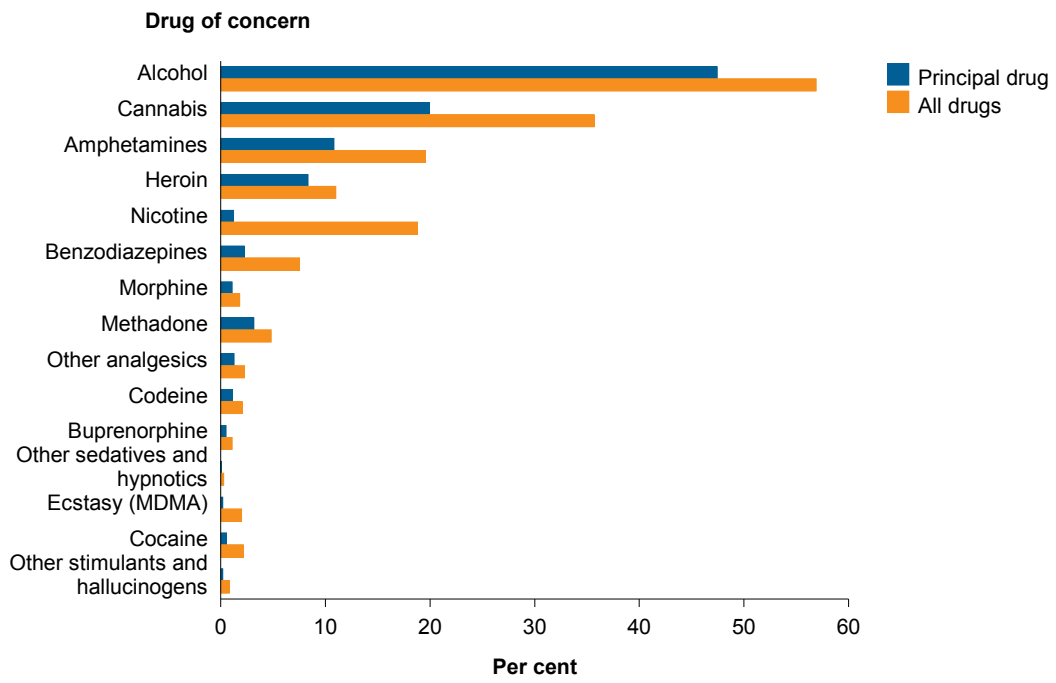

Figure 7.2: Closed episodes provided to clients for their own drug use by drugs of concern, New South Wales, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.5.

Counselling was the most common type of main treatment (31% of closed episodes), followed by withdrawal management (18%) (Figure 7.3). Counselling was also the most common type of treatment when additional treatments were taken into account (44%), followed by other (22%).

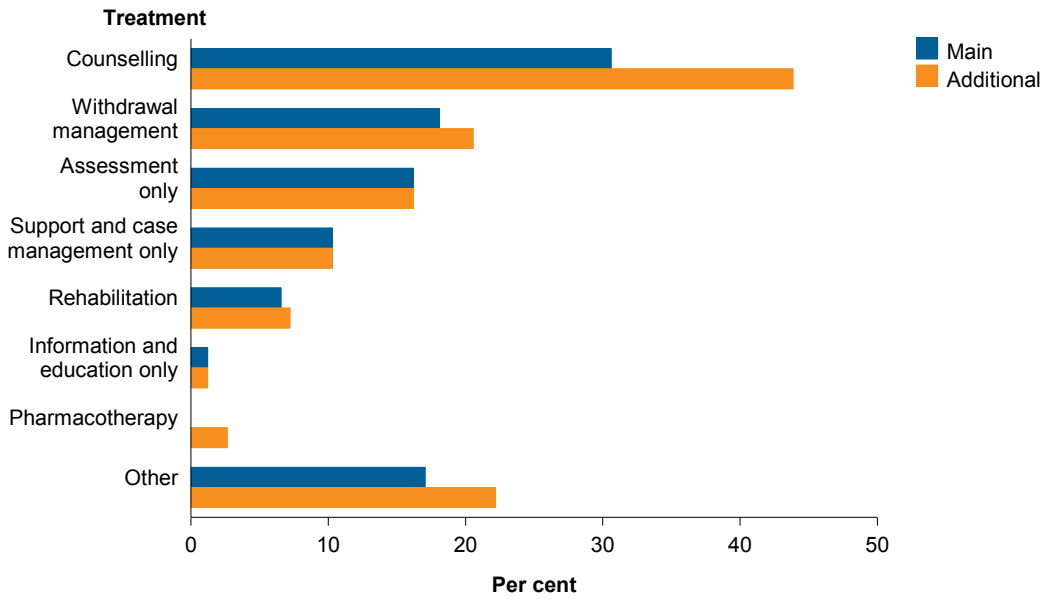

Figure 7.3: Closed episodes by treatment type, New South Wales, 2011–12

Source: Table S7.6.

7.2 Victoria

Nearly all (93%) episodes closed in Victoria in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.4). Of the episodes for the client's own drug use, most (66%) were for male clients, while the reverse was true for episodes for someone else's drug use (59% were for females).

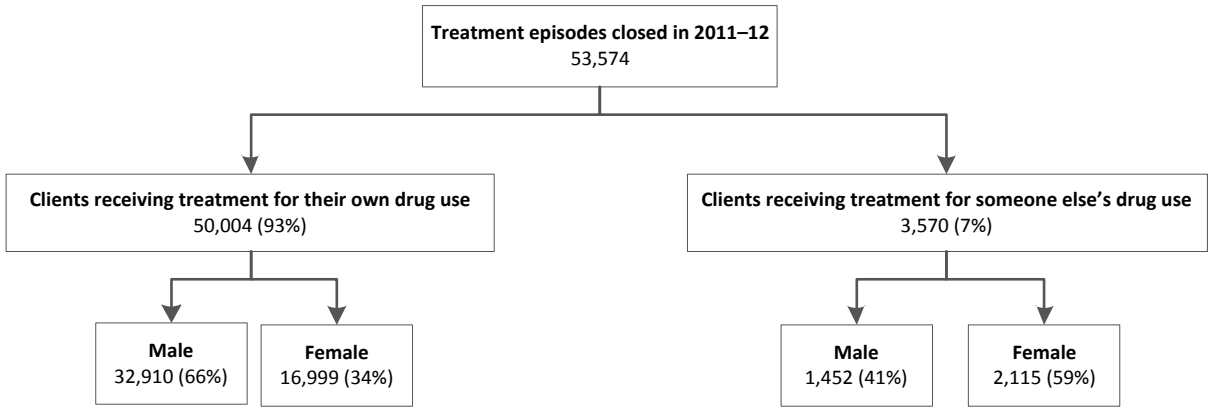

Figure 7.4: Summary client characteristics of closed treatment episodes, Victoria, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.7 and Table S7.8 and Table S7.9.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for almost half (45%) of these episodes (Figure 7.5). Cannabis was also relatively common as a principal drug, accounting for almost one-quarter (23%), followed by heroin (12%) and amphetamines (10%).

When both principal and additional drugs are considered, alcohol was the most common drug, accounting for 66% of closed episodes, followed by cannabis (49%) and amphetamines (26%).

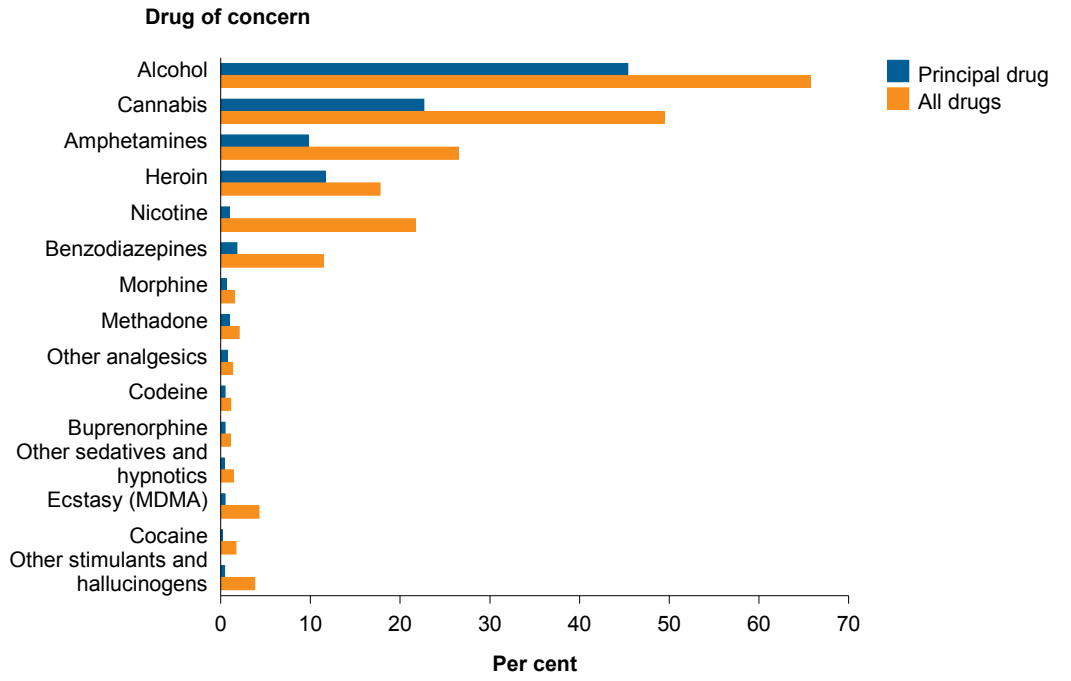

Figure 7.5: Closed episodes provided to clients for their own drug use by drugs of concern, Victoria, 2011–12

Source: Table S7.11.

Counselling was the most common type of main treatment (54% of closed episodes), followed by withdrawal management (21%) and support and case management only (12%) (Figure 7.6). Note that Victoria does not supply data on additional treatment types. Each type of treatment results in a separate episode.

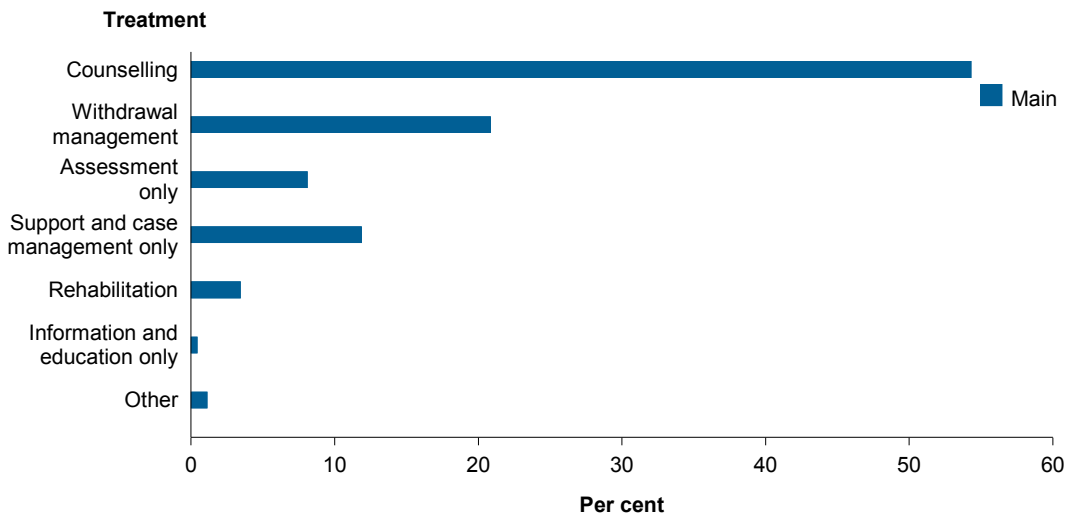

Figure 7.6: Closed episodes by treatment type, Victoria, 2011–12

Source: Table S7.12.

7.3 Queensland

Nearly all (98%) episodes closed in Queensland in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.7). Of the episodes for the client's own drug use, 7 in 10 (70%) were for male clients, while the reverse was true for episodes for someone else's drug use (67% were for females).

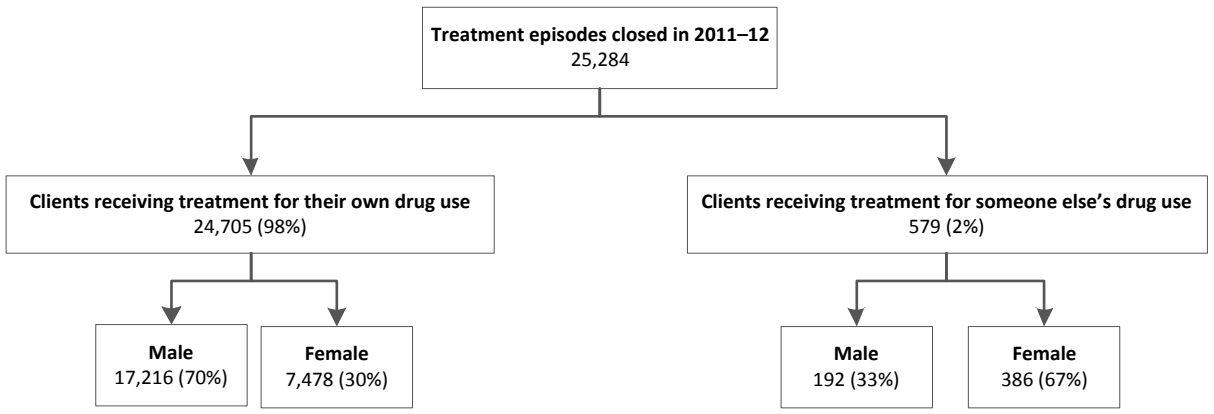

Figure 7.7: Summary client characteristics of closed treatment episodes, Queensland, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.13 and Table S7.14 and Table S7.15.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for more than 2 in 5 (43%) of these episodes (Figure 7.8). Cannabis was also relatively common as a principal drug, accounting for almost one-third (29%), followed by amphetamines (11%).

When both principal and additional drugs are considered, alcohol (60%) was the most common drug, followed by cannabis (50%) and amphetamines (23%).

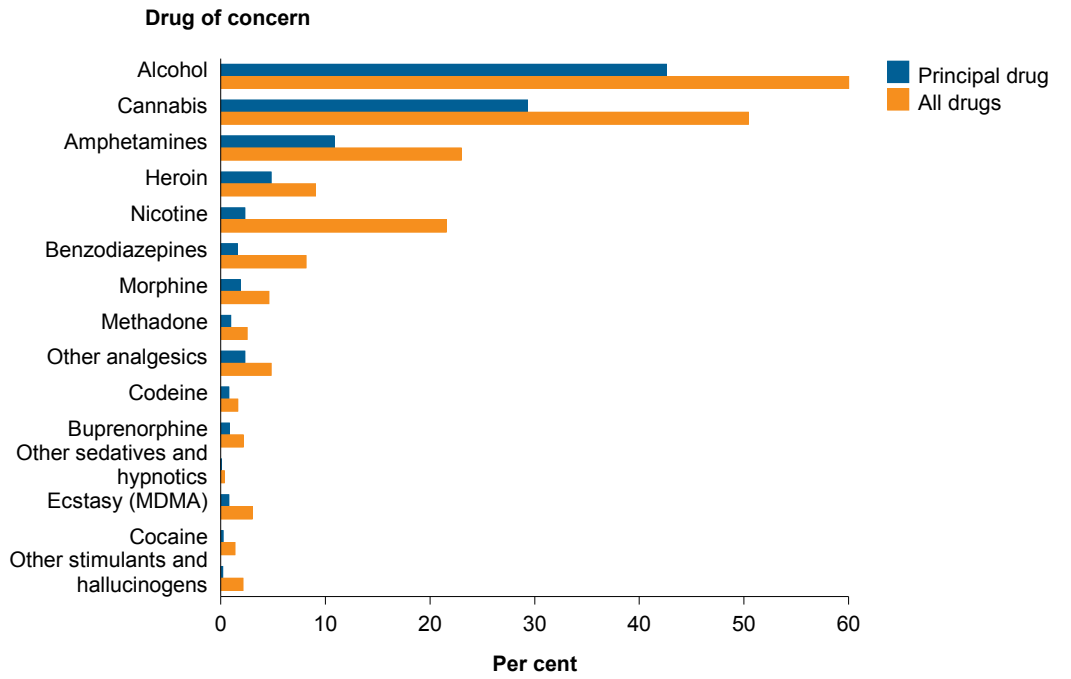

Figure 7.8: Closed episodes provided to clients for their own drug use by drugs of concern, Queensland, 2011–12

Source: Table S7.17.

Counselling was the most common type of main treatment (35% of closed episodes), followed by assessment only (22%) and information and education only (19%) (Figure 7.9). Counselling was also the most common type of treatment when additional treatments were taken into account (43%), followed by assessment only (22%) and information and education only (19%).

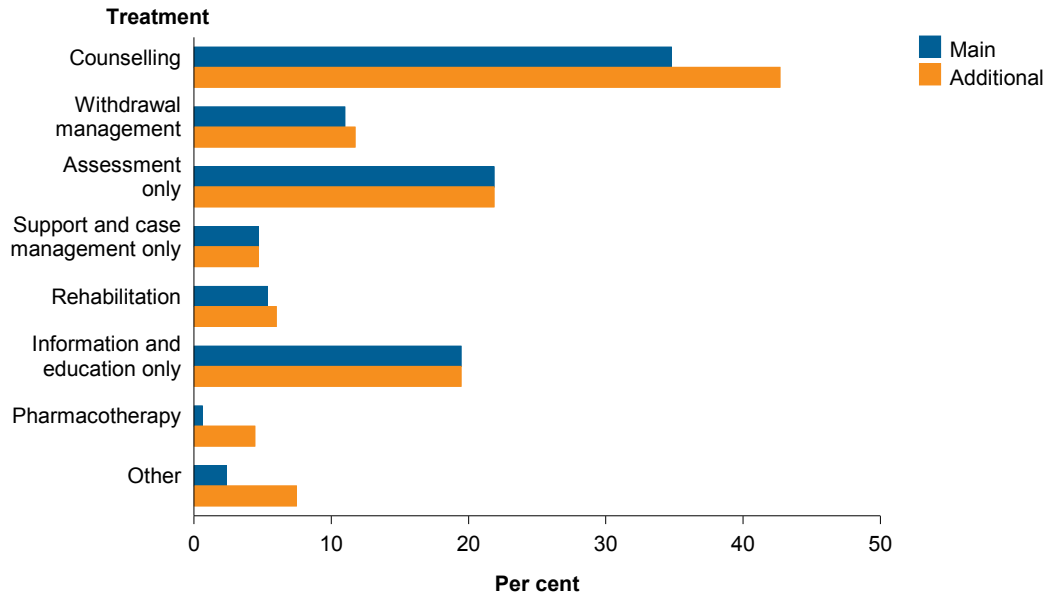

Figure 7.9: Closed episodes by treatment type, Queensland, 2011–12

Source: Table S7.18.

7.4 Western Australia

Nearly all (94%) episodes closed in Western Australia in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.10). Of the episodes for the client's own drug use, most (66%) were for male clients, while the reverse was true for episodes for someone else's drug use (73% were for females).

Figure 7.10: Summary client characteristics of closed treatment episodes, Western Australia, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.19 and Table S7.20 and Table S7.21.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for 2 in 5 (43%) of these episodes (Figure 7.11). Cannabis was also relatively common as a principal drug, accounting for one-fifth (21%), followed by amphetamines (18%) and heroin (8%).

When both principal and additional drugs are considered, alcohol (65%) was the most common drug, followed by cannabis (48%), amphetamines (34%) and nicotine (30%).

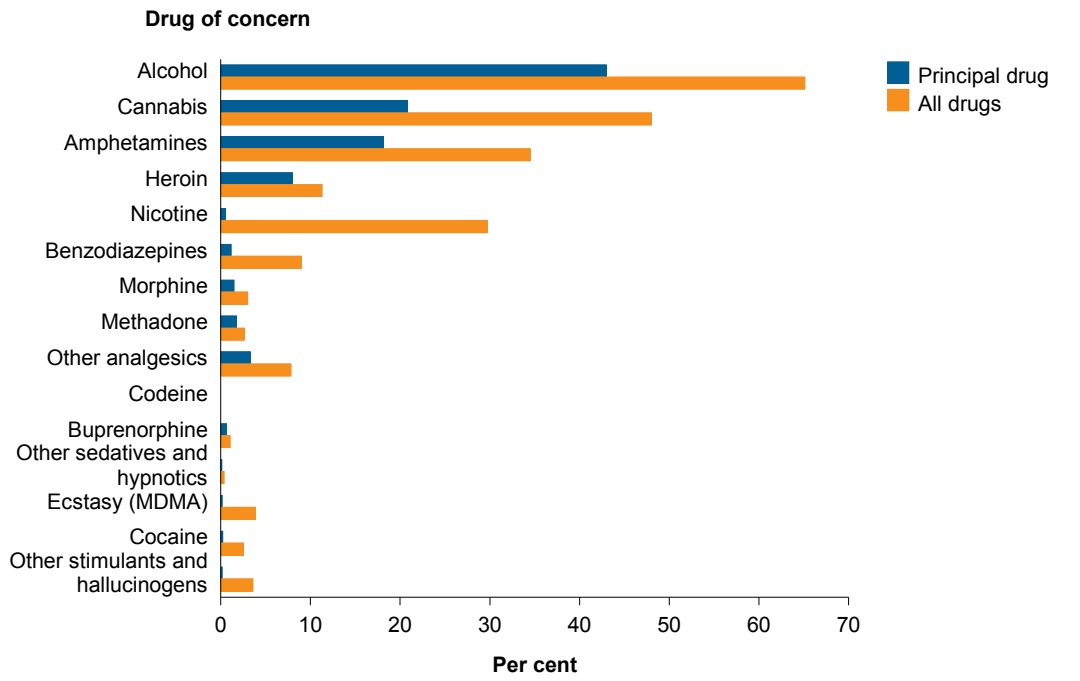

Figure 7.11: Closed episodes provided to clients for their own drug use by drugs of concern, Western Australia, 2011–12

Source: Table S7.23.

Counselling was the most common type of main treatment (60% of closed episodes), followed by withdrawal management (14%) (Figure 7.12). Note that Western Australia does not supply data on additional treatment types. Each type of treatment results in a separate episode (a small number of episodes provided in Western Australia through the Non-Government Organisation Treatment Grants Program (NGOTGP) will have additional treatment types).

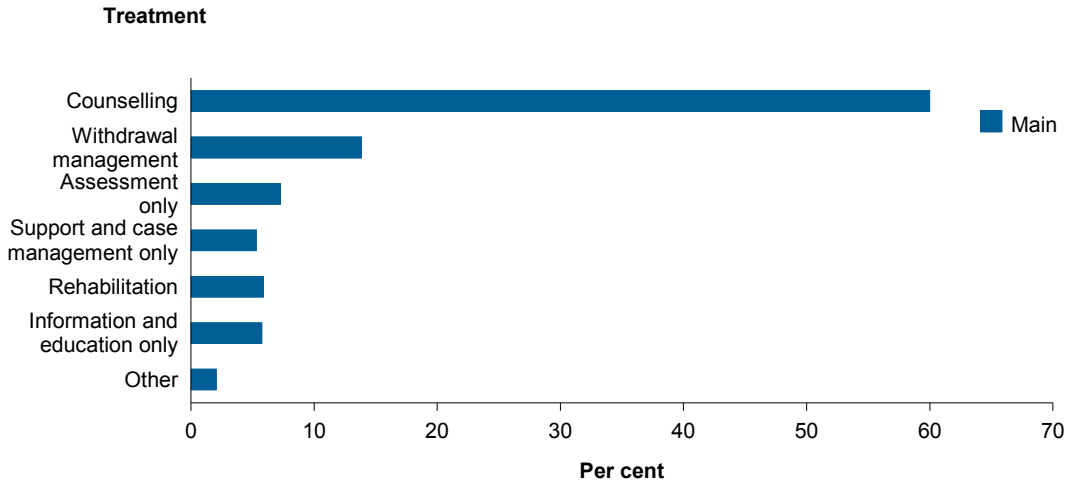

Figure 7.12: Closed episodes by treatment type, Western Australia, 2011–12

Source: Table S7.24.

7.5 South Australia

Nearly all (99%) episodes closed in South Australia in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.13). Of the episodes for the client's own drug use, 7 in 10 (70%) were for male clients, while the reverse was true for episodes for someone else's drug use (65% were for females).

Figure 7.13: Summary client characteristics of closed treatment episodes, South Australia, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.25 and Table S7.26 and Table S7.27.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for half (50%) of these episodes (Figure 7.14). Amphetamines were also relatively common as a principal drug, accounting for one-sixth (16%), followed by cannabis (12%) and heroin (9%).

When both principal and additional drugs are considered, alcohol was the most common drug, accounting for 61% of closed episodes, followed by cannabis (33%), nicotine (31%) and amphetamines (26%).

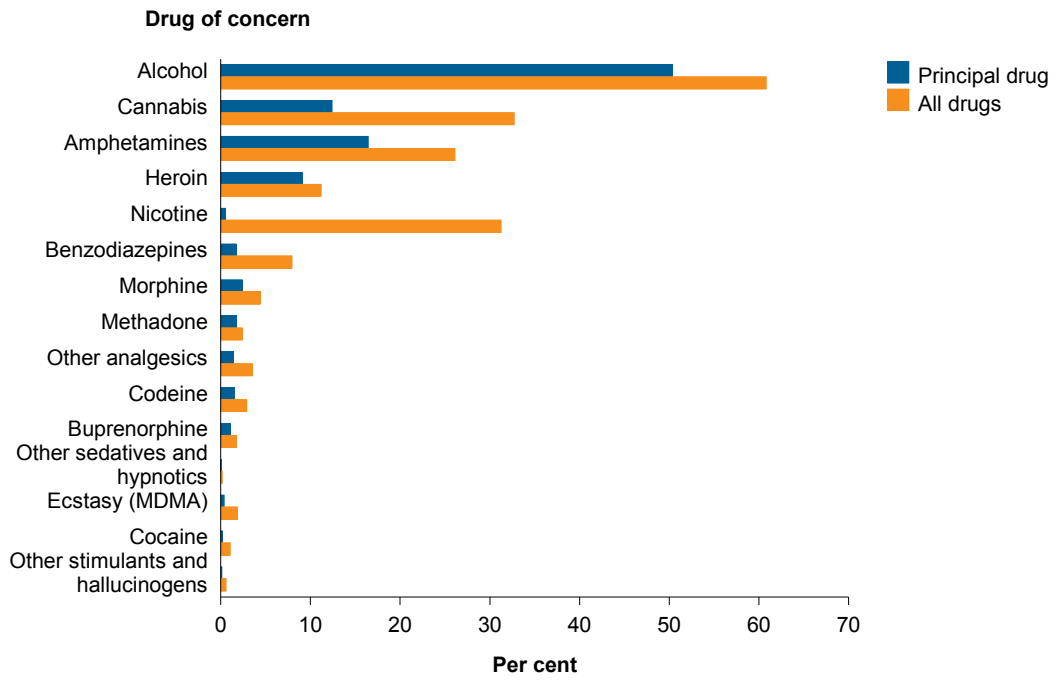

Figure 7.14: Closed episodes provided to clients for their own drug use by drugs of concern, South Australia, 2011–12

Source: Table S7.29.

Counselling was the most common type of main treatment (28% of closed episodes), followed by assessment only (23%) and withdrawal management (22%) (Figure 7.15). Counselling (42%) was the most common type of treatment when additional treatments were taken into account, followed by withdrawal management (26%) and assessment only (23%).

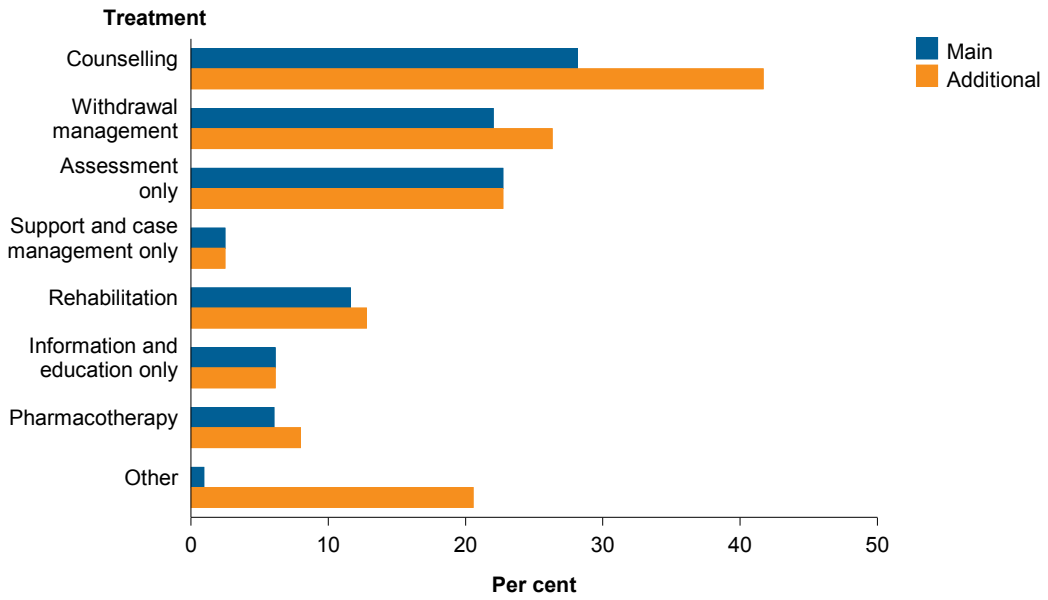

Figure 7.15: Closed episodes by treatment type, South Australia, 2011–12

Source: Table S7.30.

7.6 Tasmania

Nearly all (93%) episodes closed in Tasmania in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.16). Of the episodes for the client's own drug use, most (72%) were for male clients, while the reverse was true for episodes for someone else's drug use (82% were for females).

Figure 7.16: Summary client characteristics of closed treatment episodes, Tasmania, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.31 and Table S7.32 and Table S7.33.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for 2 in 5 (40%) of these episodes (Figure 7.17). Cannabis was also relatively common as a principal drug, accounting for over one-third (35%), followed by amphetamines (10%) and morphine (7%).

When both principal and additional drugs are considered, cannabis and alcohol were the most common drugs (50% each), followed by amphetamines (18%).

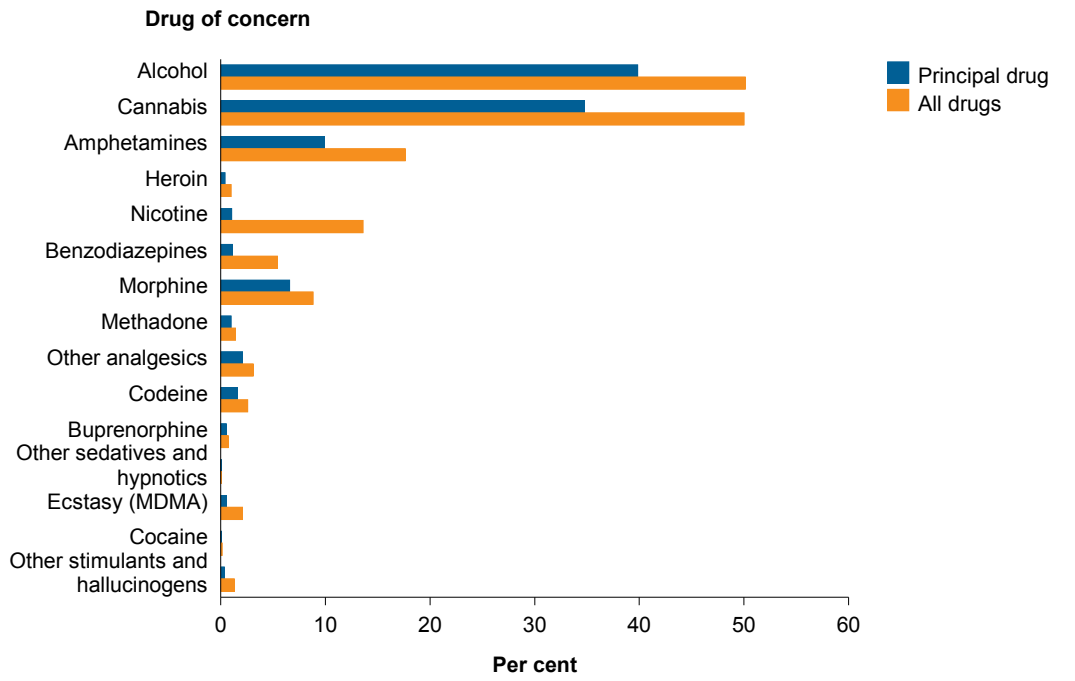

Figure 7.17: Closed episodes provided to clients for their own drug use by drugs of concern, Tasmania, 2011–12

Source: Table S7.35.

Counselling was the most common type of main treatment (62% of closed episodes), followed by information and education only (12%) and assessment only (9%) (Figure 7.18). Counselling was also the most common type of treatment when additional treatments were taken into account (64%), followed by information and education only (12%).

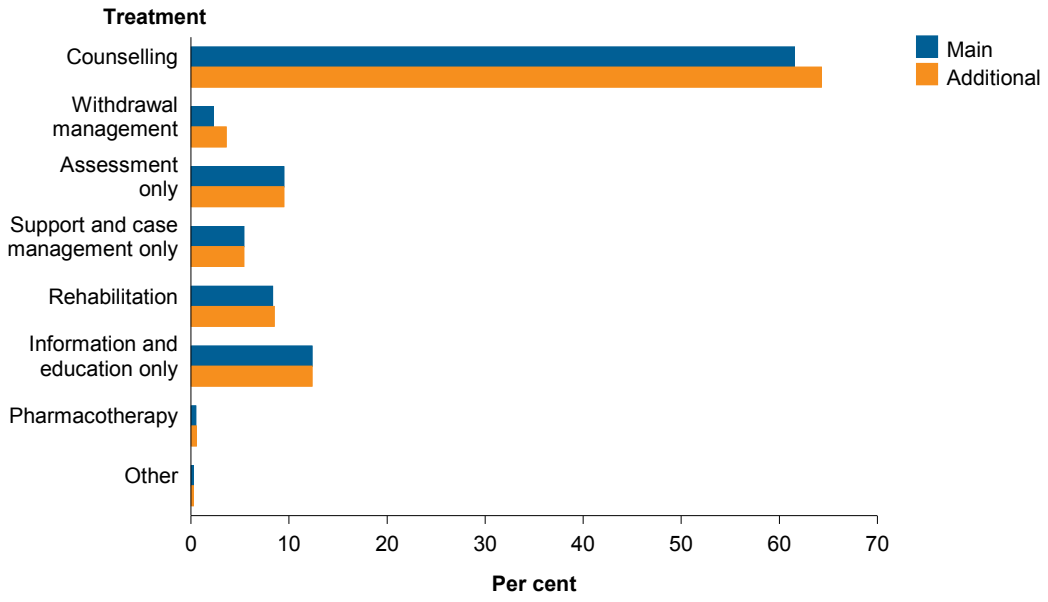

Figure 7.18: Closed episodes by treatment type, Tasmania, 2011–12

Source: Table S7.36.

7.7 Australian Capital Territory

Nearly all (98%) episodes closed in the Australian Capital Territory in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.19). Of the episodes for the client's own drug use, most (66%) were for male clients, while the reverse was true for episodes for someone else's drug use (77% were for females).

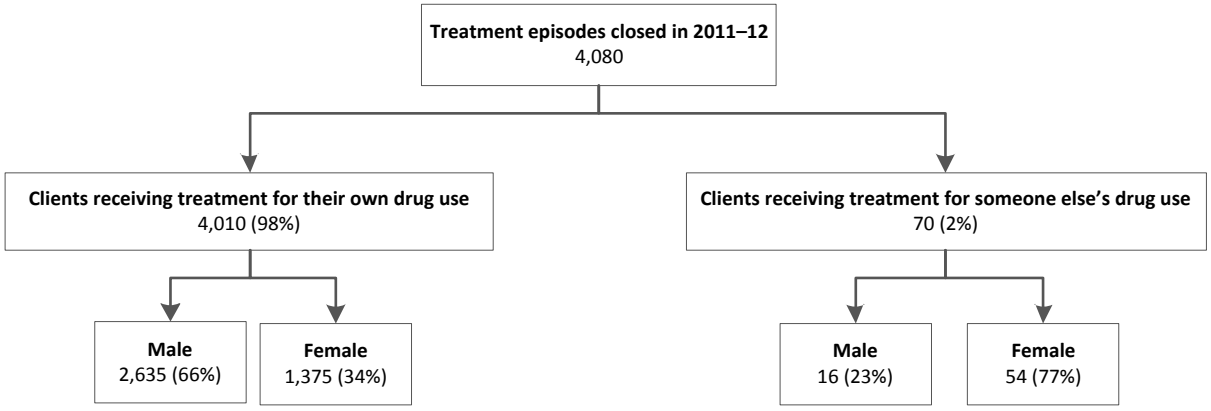

Figure 7.19: Summary client characteristics of closed treatment episodes, Australian Capital Territory, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.37 and Table S7.38 and Table S7.39.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for almost half (48%) of these episodes (Figure 7.20). Cannabis was also relatively common as a principal drug, accounting for one-sixth (17%), followed by heroin (15%) and amphetamines (10%).

When both principal and additional drugs are considered, alcohol (62%) was the most common drug, followed by cannabis (38%) and heroin (18%).

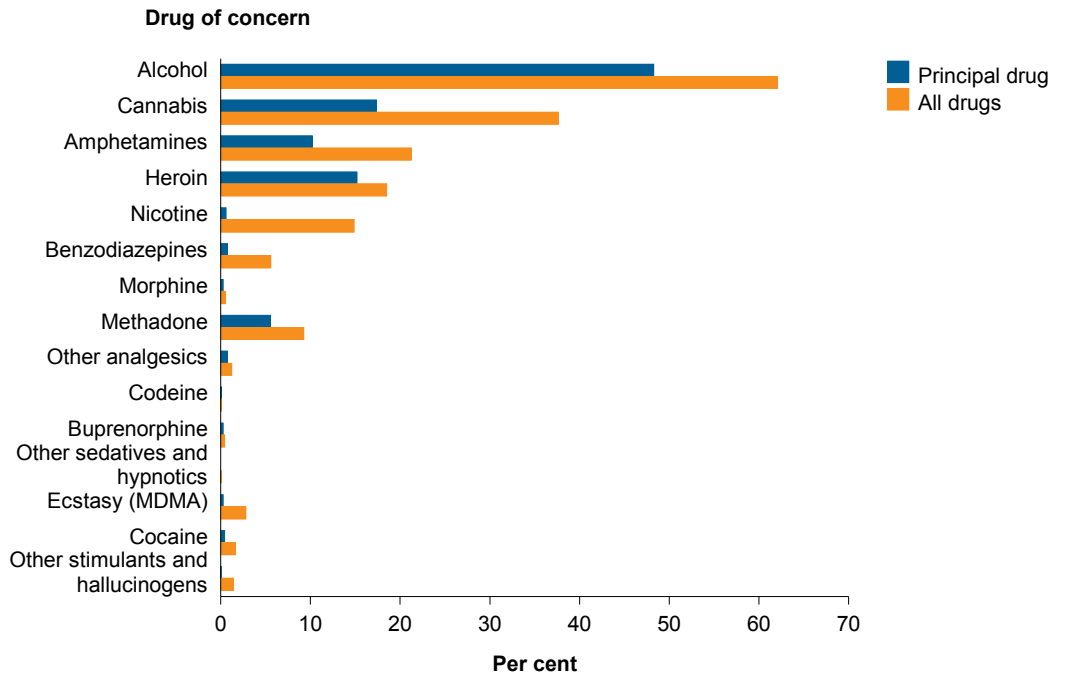

Figure 7.20: Closed episodes provided to clients for their own drug use by drugs of concern, Australian Capital Territory, 2011–12

Source: Table S7.41.

Withdrawal management was the most common type of main treatment (24% of closed episodes), followed by counselling (20%), assessment only (18%) and support and case management only (16%) (Figure 7.21). Withdrawal management and counselling were the most common types of treatment when additional treatments were taken into account (both 24%).

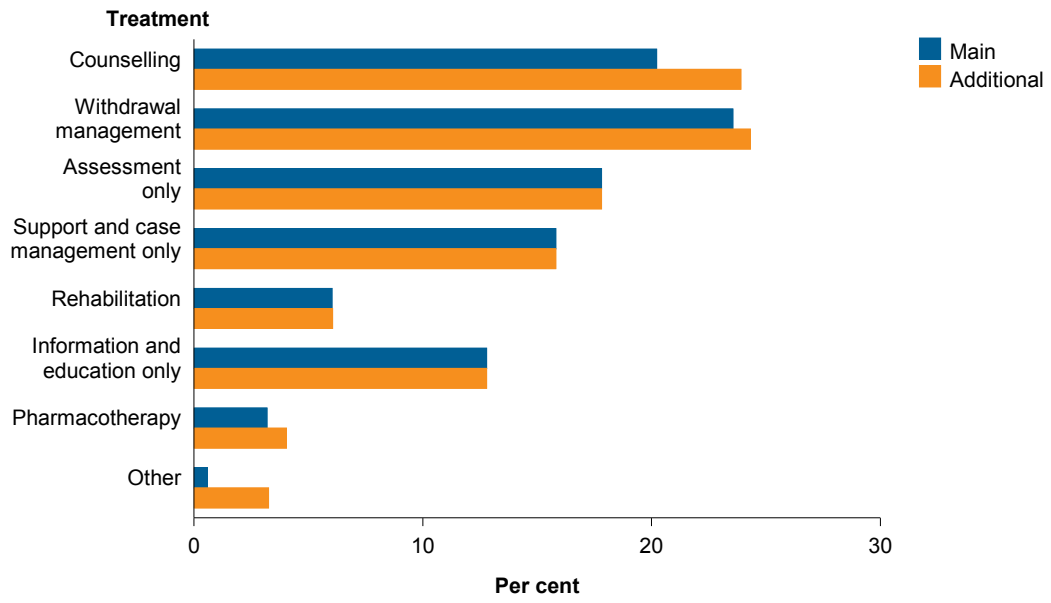

Figure 7.21: Closed episodes by treatment type, Australian Capital Territory, 2011–12

Source: Table S7.42 .

7.8 Northern Territory

Most (90%) of the episodes closed in the Northern Territory in 2011–12 were for clients receiving treatment for their own drug use (Figure 7.22). Of the episodes for the client's own drug use, most (71%) were for male clients, as was the case for episodes for someone else's drug use (54% were for males).

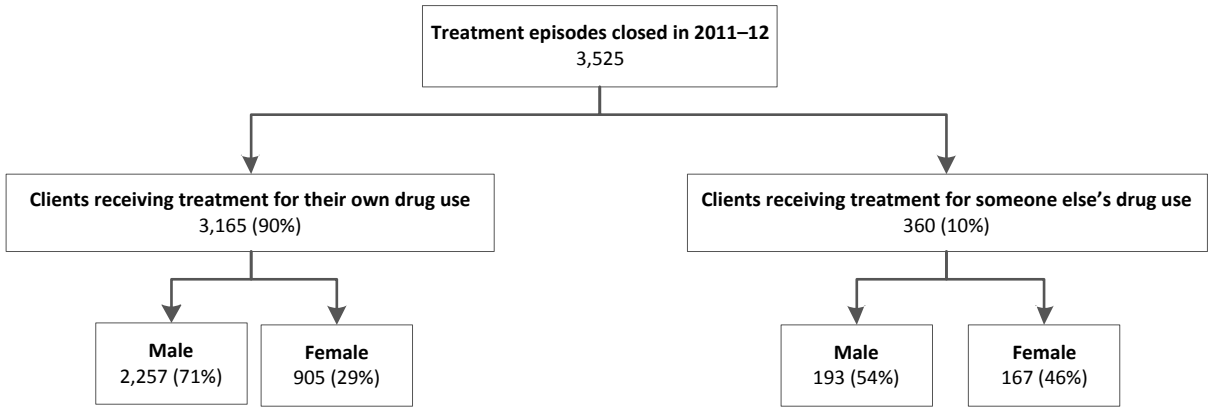

Figure 7.22: Summary client characteristics of closed treatment episodes, Northern Territory, 2011–12

Note: Totals include episodes for people of unknown age and Indigenous status.

Source: Table S7.43 and Table S7.44 and Table S7.45.

Alcohol was the most common principal drug of concern in episodes provided to clients for their own drug use, accounting for almost two-thirds (64%) of these episodes (Figure 7.23). Cannabis was also relatively common as a principal drug, accounting for one-eighth (12%).

When both principal and additional drugs are considered, alcohol (73%) was the most common drug, followed by cannabis (30%), nicotine (20%) and amphetamines (12%).

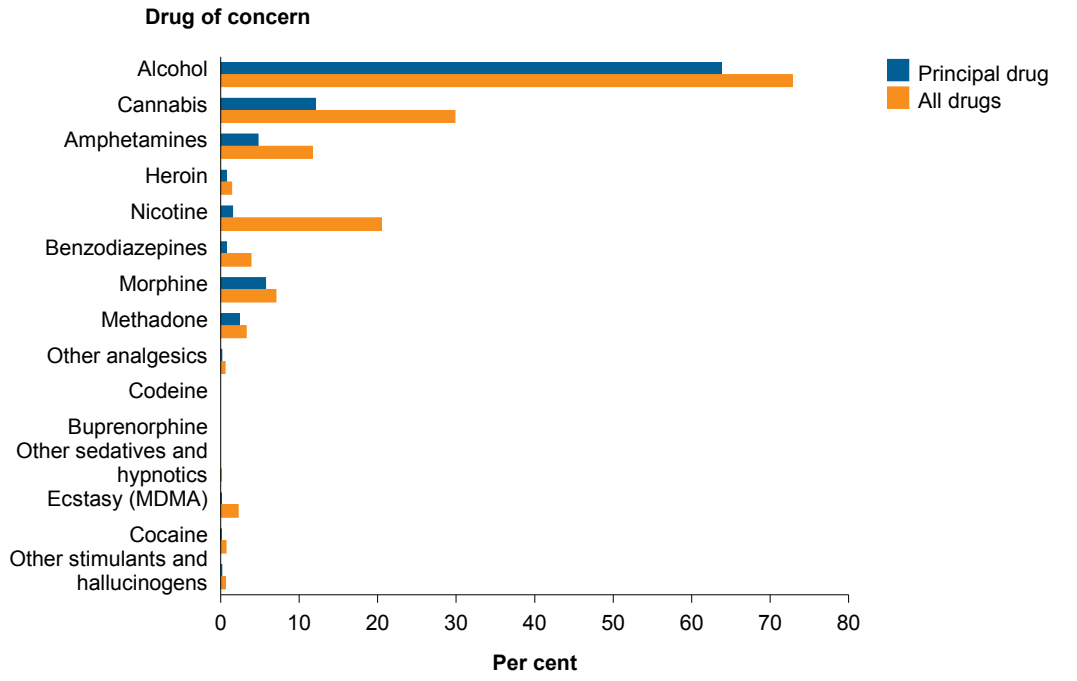

Figure 7.23: Closed episodes provided to clients for their own drug use by drugs of concern, Northern Territory, 2011–12

Source: Table S7.47.

Assessment only was the most common type of main treatment (37% of closed episodes), followed by counselling (25%) and rehabilitation (14%) (Figure 7.24). Assessment only and counselling were the most common types of treatment when additional treatments were taken into account (both 37%), followed by rehabilitation (18%).

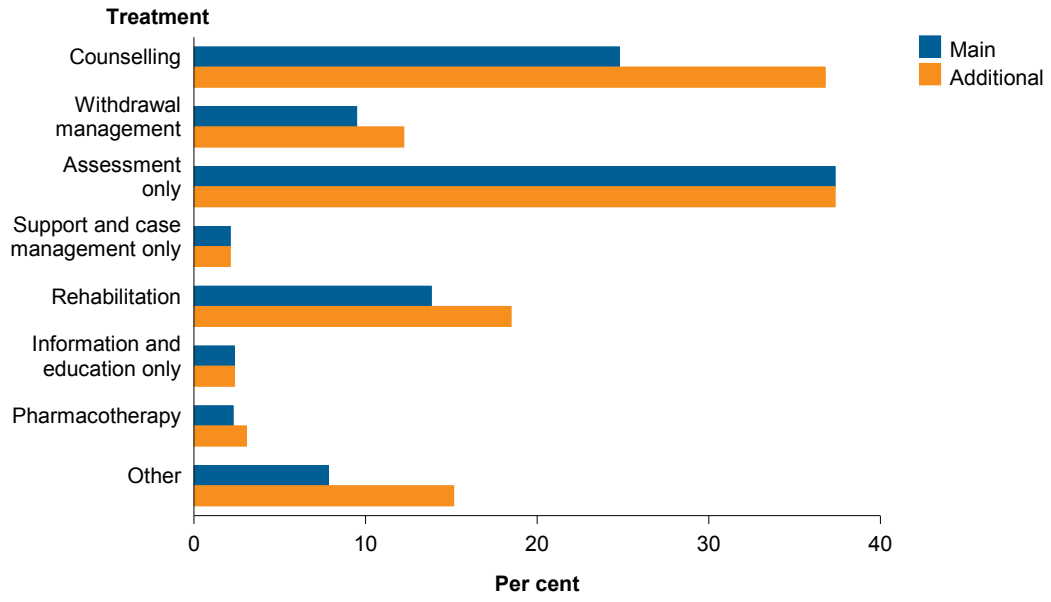

Figure 7.24: Closed episodes by treatment type, Northern Territory, 2011–12

Source: Table S7.48.

Appendix A: Information about the data and methods

Age

Age is calculated as at the start of the episode.

Data quality statements

Data quality statements for the National Hospital Morbidity Database, National Opioid Pharmacotherapy Statistics Annual Data and National Prisoner Health Data Collection are available from https://www.aihw.gov.au

The data quality statement for the AODTS NMDS is available in Appendix B.

Duration

Duration is calculated in whole days.

Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's Australian Standard Classification of Drugs of Concern. In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	Value	Category	Includes
Analgesics	1000-1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other analgesics	paracetamol
Sedatives and Hypnotics	2000-2999	Alcohol	ethanol, methanol and other alcohols
		Benzodiazepines	Clonazepam, Diazepam and Temazepam
		Other sedatives and hypnotics	ketamine, nitrous oxide, barbiturates and kava
Stimulants and Hallucinogens	3000-3999	Amphetamines	amphetamine, dexamphetamine and methamphetamine
		Cannabis	
		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Other	9000-9999	Other	anabolic agents and selected hormones, antidepressants and antipsychotics, diuretics and opioid antagonists
Not stated	0000-0002	Not stated	

End reason

The AODTS NMDS contains data on the episode end reason (reason for cessation). In this report, these end reasons are grouped (Table A2). Data for the individual end reasons are available in the online supplementary tables.

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

Table A2: Grouping of episode end reasons

Group	End reason
Expected or compliant completion	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Ended due to non-compliance	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Ended due to change in treatment component	Change in main treatment type
	Change in delivery setting
	Change in principal drug of concern
	Transferred to another service provider
Other	Drug court or sanctioned by court diversion service
	Imprisoned (other than drug court sanctioned)
	Died
	Other

Hospitals separations data

The hospitals separation data included in this report was extracted from the AIHW National Hospitals Morbidity Database using a selection of codes from the *International statistical classification of diseases and related health problems, 10th revision, Australian Modification 7th edition* (ICD-10-AM) (see Table A3).

Table A3: Relationship between the drug of concern and the ICD-10-AM codes

Drug of concern identified in principal diagnosis	ICD-10-AM codes
Analgesics	
Opioids (includes heroin, opium, morphine & methadone)	F11.0–11.9, T40.0–40.4, F55.2
Non-opioid analgesics (includes paracetamol)	T39.0, T39.1, T39.3, T39.4, T39.8, T39.9,
Sedatives and hypnotics	
Alcohol (ethanol)	E52, F10.0–10.9, G31.2, I42.6, K29.2, K70.0–70.9, K85.2, K86.0, T51.0–51.9, Z71.4
Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes ethanol)	F13.0–13.9, T41.2, T42.3–42.8
Stimulants and hallucinogens	
Cannabinoids (includes cannabis)	F12.0–12.9, T40.7
Hallucinogens (includes LSD & ecstasy)	F16.0–16.9, T40.8, T40.9
Cocaine	F14.0–14.9, T40.5, Z58.7, Z71.6
Tobacco & nicotine	F17.0–17.9, T65.2
Other stimulants (includes amphetamines, pseudoephedrine, volatile nitrates & caffeine)	F15.0–15.9, T40.6, T43.6, T46.0, T46.3
Antidepressants and antipsychotics	
Antidepressants & antipsychotics	F55.0, T43.0–43.5
Volatile solvents	
Volatile solvents	F18.0–18.9, T52.0–52.9, T53.0–9
Other and unspecified drugs of concern	
Multiple drug use	F19.0–19.9, F55.8–9, N14.1–3
Unspecified drug use & other drugs not elsewhere classified (includes psychotropic drugs not elsewhere classified; diuretics; anabolic and androgenic steroids & opiate antagonists)	Z71.5, T38.7, T43.8–9, T50.1–3, T50.7, F55.1, F55.3–6, F55.8, F55.9
Foetal and perinatal related conditions	
Foetal and perinatal related conditions (include conditions from alcohol, tobacco & nicotine & drugs of addiction use of the mother)	P04.2–4, Q86.0

Note: Data for 2011–12 were reported to the NHMD by using the 7th edition of the International statistical classification of diseases and related health problems, 10th revision, Australian modification (ICD-10-AM) (NCCH 2010), incorporating the Australian classification of health interventions (ACHI).

Remoteness

This report uses the Australian Standard Geographical Classification (ASGC) Remoteness Structure that the ABS has developed to analyse the remoteness of usual residence of the town or suburb of young people under supervision. This structure allows areas that share common characteristics of remoteness to be classified into broad geographical regions of Australia. These areas are:

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

In this classification, remoteness is determined based on the minimum road distance to differently sized urban centres, where the population size of the urban centre is assumed to determine the availability of goods and services (AIHW 2004).

Examples of places that are considered *Major cities* in the ASGC classification include Canberra and Newcastle. Hobart and Bendigo are *Inner regional* areas and Mackay and Darwin are *Outer regional* areas. Alice Springs and Mount Isa are *Remote* areas and Tennant Creek and Meekatharra are *Very remote*.

For this report, the remoteness of the agency was determined using the Statistical Local Area (SLA) of the agency. Some SLAs are split between multiple remoteness areas. Where this was the case, the data were weighted according to the proportion of the population of the SLA in each remoteness area. A different method was used for previous reports and therefore trend comparisons across reports should be made with caution.

Service sectors

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

Trends

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

Appendix B: Data quality statement for the AODTS NMDS

Summary of key data quality issues

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

National data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between them. Also, the AODTS NMDS has been implemented in stages, so comparisons across years, particularly the earlier years of the collection, need to be made with caution. Data for 2001–02 and 2003–04 have not been included in the 2011–12 annual report due to these comparability issues.

As a unit of measurement, the 'closed treatment episode' used in the AODTS NMDS cannot provide information on the number of clients who access publicly funded alcohol and other drug treatment, nor can it provide information on the extent of concurrent, sequential or recurrent service use. This is because it is possible for a single individual to access more than one service at a time, for different treatments and for different substance use problems.

Description

The AODTS NMDS presents data about alcohol and other drug treatment services, their clients, drugs of concern and the types of treatment received. The AODTS NMDS counts treatment episodes completed during the collection period, which for this collection was 1 July 2011 to 30 June 2012. This includes all clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during 1 July 2011 to 30 June 2012.

The AODTS NMDS is a collection of data from publicly funded treatment services in all states and territories, including those directly funded by the Australian Government Department of Health and Ageing (DoHA). Publicly funded alcohol and other drug treatment agencies collect the agreed data items and forward this information to the appropriate health authority as arranged. Agencies ensure that the required information is accurately recorded.

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning at that level.

Institutional environment

Under a Memorandum of Understanding with the DoHA, the AIHW is responsible for the management of the AODTS NMDS. The AIHW maintains a coordinating role in the collection, including providing secretariat duties to the AODTS NMDS Working Group, undertaking data development and highlighting national and jurisdictional implementation

and collection issues. The AIHW is also the data custodian of the national collection and is responsible for collating data from jurisdictions into a national data set and analysing and reporting on the data.

The AIHW is a major national agency set up by the Australian Government under the *Australian Institute of Health and Welfare Act 1987* to provide reliable, regular and relevant information and statistics on Australia's health and welfare. It is an independent statutory authority established in 1987, governed by a management board, and accountable to the Australian Parliament through the Health and Ageing portfolio.

The AIHW aims to improve the health and wellbeing of Australians through better health and welfare information and statistics. It collects and reports information on a wide range of topics and issues, from health and welfare expenditure, hospitals, disease and injury and mental health to ageing, homelessness, disability and child protection.

The Institute also plays a role in developing and maintaining national metadata standards. This work contributes to improving the quality and consistency of national health and welfare statistics. The Institute works closely with governments and non-government organisations to achieve greater adherence to these standards in administrative data collections to promote national consistency and comparability of data and reporting.

One of the main functions of the AIHW is to work with the states and territories to improve the quality of administrative data and, where possible, to compile national data sets based on data from each jurisdiction, to analyse these data sets and disseminate information and statistics.

The *Australian Institute of Health and Welfare Act 1987*, in conjunction with compliance with the *Privacy Act 1988* (Cwlth), ensures that the data collections managed by the AIHW are kept securely and under the strictest conditions with respect to privacy and confidentiality.

For further information see the AIHW website <www.aihw.gov.au/>.

Timeliness

The state and territory health departments and the DoHA provide data to the AIHW using the AIHW's online data validation tool (Validata™). This tool allows data suppliers to upload their data files and have them validated immediately. For the 2011–12 collection, data were due for submission through the Validata™ at the end of November 2012 with final approval of all data due at the end of December 2012. The 2011–12 collection was finalised in late February 2013.

Accessibility

Publications containing AODTS NMDS data, including the annual *Alcohol and other drug treatment services in Australia* reports, are available on the AIHW website https://www.aihw.gov.au. These reports are available for download free of charge. To enhance data availability, a series of extensive supplementary tables accompanying the annual report is also available online.

Requests for unpublished data can be made by contacting the AIHW on (02) 6244 1000 or by email to info@aihw.gov.au. A cost-recovery charge may apply to requests that require substantial resources. Depending on the nature of the request, requests for access to unpublished data may require approval from the data custodians or the AIHW Ethics Committee.

Interpretability

Contextual information on the alcohol and other drug treatment sector is available in the annual *Alcohol and other drug treatment services in Australia* reports. Supporting information about the data includes footnotes to tables and figures and details about the data items and methods used in reporting, as well as glossary items.

Metadata for the AODTS NMDS is available from METeOR, the AIHW's online metadata repository. METeOR specifications for the collection can be accessed from http://meteor.aihw.gov.au/content/index.phtml/itemId/466861.

Relevance

The AODTS NMDS contains information on treatment episodes provided by publicly funded alcohol and other drug treatment services.

Data on agencies

The AODTS NMDS contains information on publicly funded alcohol and other drug treatment services. Agencies are excluded from the AODTS NMDS if they:

- do not receive any public funding
- provide accommodation as their main function (including half-way houses and sobering-up shelters)
- are located in prisons or detention centres
- are located in acute care or psychiatric hospitals and only provide treatment to admitted patients
- have the sole function of prescribing or providing dosing for opioid pharmacotherapy (these agencies are excluded because of the complexity of this sector).

OATSIH-funded primary health care services and substance use services are in scope for the AODTS NMDS but most of these agencies do not contribute to the collection as they currently provide data to other collections.

For each agency in the AODTS NMDS, data are collected on the geographical location of the agency.

Data on treatment episodes

The AODTS NMDS contains information on all treatment episodes provided by in-scope agencies where the episode was closed in the relevant financial year. A treatment episode is considered closed where:

- the treatment is completed or has ceased
- there has been no contact between the client and treatment provider for 3 months
- there is a change in the main treatment type, principal drug of concern or delivery setting.

Treatment episodes are excluded from the AODTS NMDS if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy and not receiving any other form of treatment that falls within the scope of the collection

- only include activities relating to needle and syringe exchange
- are for a client aged under 10.

For each treatment episode in the AODTS NMDS, data are collected on:

- the client: sex, date of birth, Indigenous status, country of birth, preferred language, source of referral and injecting drug status
- whether the client is receiving treatment for their own drug use or someone else's drug use
- the drugs of concern (principal drug of concern and up to five additional drugs of concern)
- the method of use for the principal drug of concern
- types of treatment (main treatment type and up to four additional treatment types)
- the start and end dates of the episode and the reason the episode was closed.

Data on clients

The AODTS NMDS does not contain a unique identifier for clients and information about clients is collected at the episode level. Therefore, it is not possible to count the number of distinct clients receiving treatment as clients may have multiple treatment episodes in a financial year.

In future years, the AODTS NMDS will include data items that will allow distinct clients to be counted.

Accuracy

Data for the AODTS NMDS are extracted each year from the administrative systems of the health departments or are provided by the treatment agencies directly to the health departments. These data are then collated by the health departments according to the definitions and technical specifications agreed to by the departments and the AIHW.

Data for the AODTS NMDS are available from 2001–02; however, due to comparability issues, only data from 2003–04 onwards are used in this report.

Almost 90% of in-scope treatment services provided data for the AODTS NMDS in 2011–12; this ranged from 82% in the Australian Capital Territory to 100% in Western Australia, the Northern Territory and Tasmania. Each in-scope treatment service is required to provide information on each agency related to the service (including delivery outlets). However, some services only provide information on the main administrative centre. As a result, the number of treatment agencies may be under counted (information on the number of agencies for which data are not provided is not available).

Overall, the coverage of episode data in the AODTS NMDS for 2011–12 is good. For most data elements, less than 2% of records have missing data (including not stated or unknown responses) while about 5% of records have an unknown Indigenous status. Of the records relating to episodes provided to clients receiving treatment for their own drug use, reason for cessation is not available for 3%, method of drug use is not available for 4% and injecting drug use status is not available for 15%.

State and territory issues

New South Wales

New South Wales Health collects data from all Australian Government/state government-funded agencies as part of requirements stipulated in a signed service agreement at the commencement or renewal of each funding agreement. Data are provided monthly by agencies to their respective Local Health Districts (LHD).There are a number of data collection systems in use and development. The New South Wales Minimum Data Set is collected by these systems from which the collection of the AODTS NMDS is provided. NSW is developing a State Baseline Build related to alcohol and other drugs that will roll out to NSW through the CHIME and Cerner systems over the next few years. The majority of NGO data are collected via the NADA online system. NADA (Network of Alcohol and other Drug Agencies) is the peak organisation for the non-government drug and alcohol sector in NSW.

For 2008–09, the total number of agencies and episodes for New South Wales was under-reported by about 12 agencies because of system issues. As these agencies had a relatively high proportion of methamphetamine clients, the number of episodes for amphetamine use will be under-reported.

Victoria

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

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

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

Victoria does not differentiate between main and other treatment types. Caution should be used in comparing Victorian episodes with those of other states and territories. As such, Victoria is not directly comparable with other jurisdictions because every treatment type provided is reported as a separate episode.

Victoria only provides information about non-government agencies that receive public funding.

In Victoria, assessment only episodes include brokerage services wherein clients with drug conditions who have received sentences are assessed, a treatment plan developed, and the

necessary treatment purchased from community-based alcohol and other drug treatment agencies. The very nature of these types of episodes results in durations that may exceed 90 days. Following the implementation of a new operational system for brokerage services, from October 2011 brokerage assessments for treatment are closed when the client is referred to the nominated agency funded to delivery, rather than at the completion of treatment by that agency. This will result in a significant reduction in the duration of these episodes. As the actual completion date was not available for episodes from October 2011 onwards, episodes for these brokerage assessments were given a nominal completion date that was equal to the commencement date as most assessments are completed within 1 day. Actual completion dates will be available from 2012–13.

Queensland

The Queensland Department of Health collects data from all Queensland Government alcohol and other drug treatment service providers and from all Queensland Illicit Drug Diversion Initiatives—Police and Court Diversion clients. The Australian Government currently collects data from the Australian Government–funded agencies operating in Queensland.

The Queensland Department of Health has a state-wide web-based clinical information management system supporting the collection of AODTS NMDS items for all Queensland Government alcohol and other drug treatment services.

Since 2007, the Queensland Department of Health has funded the Queensland Network of Alcohol and Drug Agencies Ltd. (QNADA) to collate and deliver to the Queensland Department of Health aggregated AODTS NMDS data for the Alcohol and Other Drug Non-Government Sector.

Care should be taken when interpreting principal drug of concern over time for Queensland, as Queensland did not provide data consistent with the AODTS NMDS specifications in 2001–02.

The proportion of 'not stated' responses for injecting drug use and method of use in Queensland in 2010–11 was high (59% and 58%, respectively). This high 'not stated' rate was due to a one-off anomaly with the introduction of a new collection database and data entry issues related to staff training and compliance. An ongoing strategy of re-engagement with alcohol and other drug treatment services Queensland staff commenced in November 2011 to mitigate this low response rate for the 2010–11 and future collection periods.

Treatment provided to people diverted to services by police and the courts is recorded as 'information and education only'. Actual treatment involves a 2-hour treatment session that includes extensive alcohol and drug assessment to determine dependence, assessment of risk-taking behaviours, provision of advice and information on reducing/ceasing drug use and harm minimisation, motivational intervention, provision of resources and referral.

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.

Due to the increase in integrated services that include government and non-government service providers, caution should be used in comparing services in Western Australia with those in other states and territories and across years. Services in Western Australia are not directly comparable with other states, or previous years, because of the growth of integrated services that include government and non-government service providers.

In Western Australia, a reform in the way non-residential treatment services are provided in the Perth metropolitan area has resulted in the co-location and integration of some government and non-government services. Time series data do not adequately illustrate these changes.

Western Australia reviews the geographical demographics of their clients regularly throughout the year and adjusts the locations of their service delivery outlets accordingly to meet the demands of the population. Therefore, variation between remote and very remote locations exists between years.

Clients are generally able to access the agencies from multiple sites within any one episode depending on the client's need and the availability of appointments within the alcohol and other drug treatment service. Examples of where these situations occur are when clients:

- follow a specific worker from one service delivery outlet to another
- change workers during an episode and the workers are located at different service delivery outlets
- attend one service delivery outlet for the initial service contact (commencement of episode) due to availability of appointment times and move to a more convenient service delivery outlet during the episode
- move between service delivery outlets to fit service contacts within clients' other personal needs.

Western Australia does not differentiate between main and other treatment types. Caution should be used in comparing Western Australian episodes with those of other states and territories. As such, Western Australia is not directly comparable with other jurisdictions because every treatment type provided is reported as a separate episode. Note that a small number of episodes provided in Western Australia through the Non-Government Organisation Treatment Grants Program (NGOTGP) will have additional treatment types.

South Australia

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

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

Tasmania

Data are provided by both government (Alcohol and Drug Services – ADS) and non-government organisations (NGOs).

NGOs funded by the Tasmanian Government provide AODTS NMDS and key performance indicator data under the provisions of a service agreement. AODTS NMDS data are submitted to ADS State Office either 6-monthly or yearly. Data quality reports are fed back to the NGOs and training/information on data capture practices are provided as required.

ADS uses the iPM patient administration system as its key business system. This state-wide system is in use across the three Tasmanian Health Organisations (THOs), which include inpatient, residential, outpatient and community service settings. It has been modified to capture the AODTS NMDS data items. A range of online self-service reporting is used to monitor performance activity and data quality.

Tasmania's illicit drug diversion treatment data are managed and extracted from the Drug Offence Reporting System (DORS). This system resides with Tasmania Police. A high proportion of treatment episodes in Tasmania with the principal drug of cannabis can be attributed largely to the inclusion of this data.

The Tasmania Early Intervention Project (TEIP) commenced in 2011. This project focuses on young people and involves a police caution that facilitates a referral for young people to an alcohol and other drug treatment service for brief or opportunistic intervention. AODTS NMDS data for this program are entered via the iPM patient administration system.

Training in culturally sensitive practice has been provided for service providers across the Tasmanian alcohol and other drug service sector. Despite this, Tasmanian data reporting for Indigenous status remains low.

Australian Capital Territory

Australian Capital Territory alcohol and other drug treatment service providers supply the Health Directorate with their complete data collection for the AODTS NMDS by 31 August each financial year, as specified in their Service Funding Agreement. Since 1 July 2007 the treatment service providers have been encouraged to use a standardised reporting system developed by the Health Directorate to enhance uniformity and reliability of data.

The observed increase in assessment only episodes between 2009–10 and 2010–11 was related to one agency which increased assessment activity that resulted in increased numbers of clients being assessed as unsuitable or not attending treatment.

The number of counselling treatment services in the Australian Capital Territory has decreased between 2009–10 and 2010–11. The ACT noted two agencies that provide the majority of counselling treatment in the ACT reported a reduced number of closed treatment episodes since 2009-10. One agency advised that a number of variables had contributed to the low number of occasions of service, such as significant staff shortages for the counselling team and a high number of vacancies for allotted counselling sessions.

Northern Territory

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

Australian Government Department of Health and Ageing (DoHA)

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

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

To ensure consistency with previous years' data, where an organisation's sub-agencies have been given more than one establishment identifier, those identifiers were used and so sub-agencies were counted as separate agencies. When an organisation's subprojects have been given one establishment identifier, only this establishment identifier was used, and so counted as one agency.

In 2011–12, the DoHA conducted a review of the processes used to collate and provide NGOTGP agencies. The review resulted in an additional 14 agencies submitting data to the 2011–12 collection to those observed in 2009–10.

Coherence

The AODTS NMDS was initially developed from 1996 to 2001 and the first report containing data from the data set was published in 2002. The data specifications were significantly altered for the 2003–04 collection and data from 2000–01 to 2002–03 are not comparable with data from later years.

Glossary

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

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

alcohol: a central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgment, coordination and balance more difficult (NDARC 2010).

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

assessment only treatment type: where only assessment is provided to the client. Note that service providers would normally include an assessment component in all treatment types.

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

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

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

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

ended due to non-compliance: includes episodes where the client ceased to participate against advice, without notice or due to non-compliance (see Appendix A for more information on end reasons).

expected or compliant completion: includes episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement (see Appendix A for more information on end reasons).

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

heroin: one of a group of drugs known as opioids, which are strong pain killers with addictive properties. Heroin and other opioids are classified as depressant drugs. It is also

known as smack, skag , dope, H, junk, hammer, slow, gear, harry, big harry, horse, black tar, China white, Chinese H, white dynamite, dragon, elephant, boy, home-bake or poison.

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

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

nicotine: the stimulant drug in tobacco. It is highly addictive.

outreach-treatment delivery setting: Refers to an outreach environment, excluding a client's home or usual place of residence, where treatment is provided. An outreach environment may be any public or private location that is not covered by residential and non-residential settings. Mobile/outreach alcohol and other drug treatment service providers would usually provide treatment within this setting.

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

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

- **ceased to participate against advice**: where the service provider is aware of the client's intention to stop participating in treatment, and the client ceases despite advice from staff that such action is against the client's best interest
- **ceased to participate at expiation:** where the client has fulfilled their obligation to satisfy expiation requirements (for example, participation in a treatment program to avoid having a criminal conviction being recorded against them) as part of a police or court diversion scheme and chooses not to continue with further treatment
- **ceased to participate by mutual agreement**: where the client ceases participation by mutual agreement with the service provider, even though the treatment plan has not been completed. This may include situations where the client has moved out of the area.
- **ceased to participate involuntarily:** where the service provider stops the treatment due to non-compliance with the rules or conditions of the program
- **ceased to participate without notice**
- **change in the delivery setting**
- **change in the principal drug of concern**
- **change in the main treatment type**
- **death**
- **drug court or sanctioned by court diversion service:** where the client is returned to court or jail due to non-compliance with the program
- **imprisoned (other than sanctioned by a drug court or diversion service)**
- **treatment completed:** where the treatment was completed as planned
- **transferred to another service provider:** this includes situations where the service provider is no longer the most appropriate and the client is transferred or referred to another service. For example, transfers could occur for clients between non-residential and residential services or between residential services and a hospital. Excludes situations where the original treatment was completed before the client transferred to a different provider for other treatment.

withdrawal management (detoxification) treatment: includes medicated and non-medicated treatment to assist in managing, reducing or stopping the use of a drug of concern.

tobacco: see nicotine.

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

References

ADCA (Alcohol and other Drugs Council of Australia) 2013. Tips and tricks for new players: a guide to becoming familiar with the alcohol and other drugs sector. Canberra: Alcohol and other Drugs Council of Australia.

ADF (Australian Drug Foundation) 2013a. ADF fact sheet: Benzodiazepine facts. Melbourne: Australian Drug Foundation.

ADF 2013b. ADF fact sheet: Cocaine facts. Melbourne: Australian Drug Foundation.

AIHW (Australian Institute of Health and Welfare) 2011a. 2010 National Drug Strategy Household Survey report. Drug Statistics Series no. 25. Cat. no. PHE 145. Canberra: AIHW.

AIHW 2011b. Drugs in Australia 2010: tobacco, alcohol and other drugs. Drug statistics series no. 27. Cat. no. PHE 154. Canberra: AIHW.

AIHW 2013a. The health of Australia's prisoners 2012. Cat. no. PHE 170. Canberra: AIHW.

AIHW 2013b. National Opioid Pharmacotherapy Statistics Annual Data Collection 2012. Drug treatment series no. 20. Cat. no. HSE 136. Canberra: AIHW.

AMA (Australian Medical Association) 2008. Take a closer look: cannabis and your health 2008. Australian Medical Association.

Collins D & Lapsley H 2008. The costs of tobacco, alcohol and illicit drug abuse to Australian society in 2004/05. National Drug Strategy Monograph Series No. 64.

Hockings B, Young M, Falconer A & O'Rourke P 2002. Queensland women prisoners' health survey. Brisbane: Queensland Department of Corrective Services.

Indig D, Topp L, Ross B, Mamoon H, Border B, Kumar S et al. 2010. 2009 NSW inmate health survey: key findings report. Sydney: NSW Justice Health.

Ministerial Council on Drug Strategy 2011. National drug strategy 2010–2015. Canberra: Commonwealth of Australia.

NCETA (The National Centre for Education and Training on Addiction)) 2004. Alcohol and other drugs: a handbook for health professionals. Canberra: Australian Government Department of Health and Ageing.

NCPIC (National Cannabis Prevention and Information Centre) 2011. Fact sheet: what is cannabis? National Cannabis Prevention and Information Centre.

NDARC (National Drug and Alcohol Research Centre) 2010. Alcohol Fact Sheet: NDARC. NDARC UNSW.

NHMRC (National Health and Medical Research Council) 2009. Australian Guidelines to Reduce Health Risks from Drinking Alcohol. Canberra: Commonwealth of Australia.

Vanderplaschen W, Wolf J, Rapp R & Broekaert E 2007. Effectiveness of different models of case management for substance-abusing populations. Journal of Psychoactive Drugs 2007 March 39 (1):81-5.

Vos T, Barker B, Stanley L & Lopez A 2007. The burden of disease and injury in Aboriginal and Torres Strait Islander peoples 2003. Brisbane: University of Queensland.

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Related publications

This report, *Alcohol and other drug treatment services in Australia 2011-12,* is part of an annual series. This publication, as well as past and future reports in this series, can be downloaded free from the AIHW website, <www.aihw.gov.au/alcohol-and-other-drugs-publications/>. The website also includes information on ordering printed copies.

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

- AIHW 2013. National opioid pharmacotherapy statistics annual data collection 2012 report. Drug treatment series no. 15. Cat. no. HSE 136. Canberra: AIHW.
- AIHW 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.
- AIHW 2011. Drugs in Australia 2010: tobacco, alcohol and other drugs. Drug statistics series no. 27. Cat. no. PHE 154. Canberra: AIHW.

Almost 700 agencies provided over 150,000 treatment episodes for alcohol and other drug issues in Australia in 2011–12. Most of the closed episodes were for clients receiving treatment for their own drug use, and these clients tended to be male and in their 20s and 30s. Alcohol was the most common principal drug of concern, accounting for almost half of these closed episodes, and counselling was the most common type of treatment.