Australian Government
Australian Institute of Health and Welfare

Completion of alcohol and drug treatment in Australia, 2011–12 to 2020–21: differences by drugs of concern and treatment characteristics

Web report | Last updated: **14 Mar 2023** | Topic: Alcohol & other drug treatment services

About

Understanding how clients leave specialist alcohol and other drug (AOD) treatment provides insights into how clients and AOD services engage with each other.

Between 1 July 2013 and 30 June 2021, 228,500 people sought specialist AOD treatment for either alcohol or amphetamines. Of the 648,400 treatment episodes provided to these clients across this 8 year period, 1 in 4 episodes did not end as planned. This report examines how the likelihood of planned completion varies by treatment characteristics such as drug type (alcohol compared to amphetamines), main treatment and client remoteness.

Cat. no: PHE 314

Findings from this report:

- Specialist AOD treatment ending as planned was more likely where a client was receiving more intensive treatment.
- Clients from major cities were more likely to have their treatment episodes end as planned.
- Unplanned completion of treatment was more likely if amphetamines was the main drug being treated (compared to alcohol).
- Rehabilitation was the treatment type most likely to have an unplanned completion.

Summary

Why examine completion of AOD treatment?

Alcohol and other drug (AOD) use in Australia contributes to a significant burden of physical, psychological and social harms, including chronic disease, mental illness, injury, substance dependence and premature death (AIHW 2018). Support and services for those who use alcohol and drugs, as well as their families and friends, are available through specialist AOD treatment services.

When entering AOD treatment, clients and services identify the clients' goals and develop a treatment plan accordingly. While treatment objectives vary from client to client, specialist AOD treatment commonly involves multiple treatment episodes over time.

Studies in both Australian and international contexts have found that stable retention in treatment over time is a predictor of more positive treatment outcomes (Lubman D et al 2014). As AOD treatment is often structured around multiple discrete treatment episodes, client retention can be examined through how episodes end. Episodes being completed in line with the client's treatment plan may indicate more effective engagement between a client and a service. As such, understanding how clients leave treatment may help inform the design and delivery of effective treatment services.

What does this report include?

This report examines the reasons for which clients ended their specialist AOD treatment for a principal drug of concern (PDOC) of either alcohol or amphetamines between 1 July 2011 and 30 June 2021. The report examines whether treatment completion was planned, unplanned or for other reasons (such as referral to another service, imprisonment or death), and whether this varied by:

- Clients' age and sex
- Clients' intensity of treatment (such as more treatment episodes over time)
- Treatment characteristics (such as treatment type and PDOC of alcohol or amphetamines)
- Yearly differences.

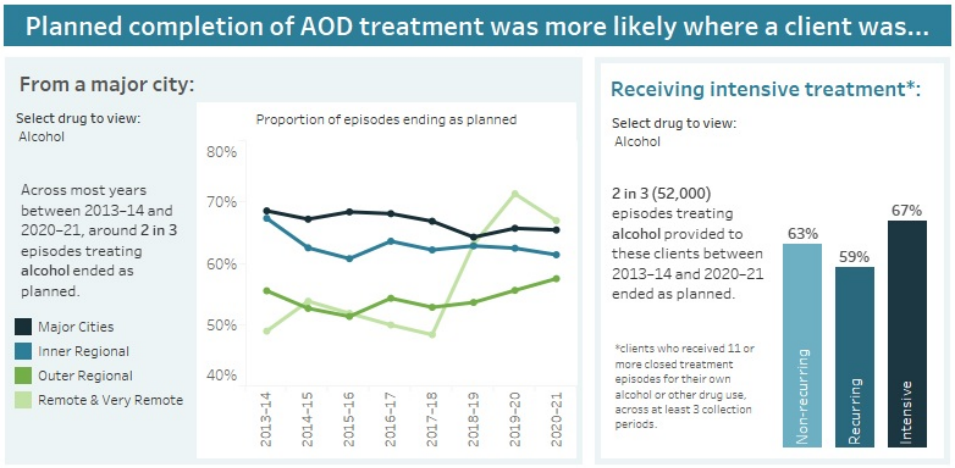
How is treatment intensity defined in this report?

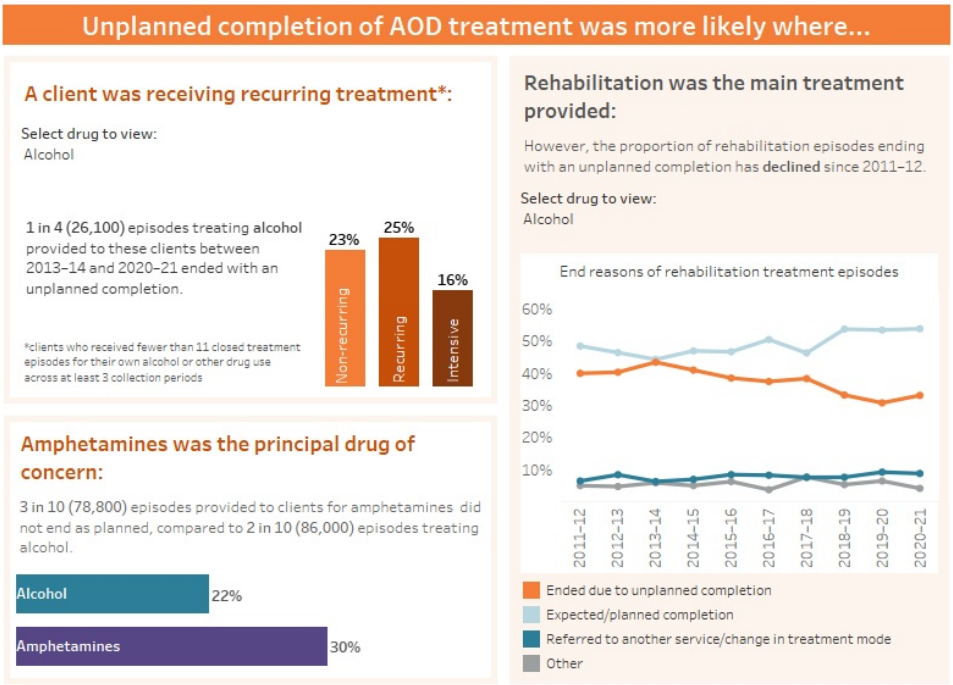
Three treatment intensity cohorts were defined using the number of treatment episodes a client received over multiple years:

- **intensive treatment** – clients who received 11 or more closed treatment episodes for their own alcohol or other drug use, across at least 3 collection periods (that is, financial years)
- **recurring treatment** – clients who received fewer than 11 closed treatment episodes for their own alcohol or other drug use across at least 3 collection periods
- **non-recurring treatment** – clients who received treatment for their own alcohol or other drug use in fewer than 3 collection periods.

For further information, see How is AOD treatment intensity defined?

This infographic shows key findings from Completion of alcohol and drug treatment in Australia, 2011–12 to 2020–21: differences by drugs of concern and treatment characteristics. Findings are for treatment episodes provided for alcohol or amphetamines as the principal drug of concern. Planned completion of treatment was more likely where a client was receiving intensive treatment or from a major city. Unplanned completion of treatment was more likely where a client was receiving recurring treatment, the episode's principal drug of concern is amphetamines, or the main treatment provided for an episode was rehabilitation. While rehabilitation episodes were the most likely to end in an unplanned completion, the proportion of rehabilitation episodes ending with an unplanned completion has declined in the last 10 years.





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Introduction

Alcohol and other drug (AOD) use in Australia contributes to a significant burden of physical and social harms, including chronic disease, mental illness, injury, substance dependence and premature death (AIHW 2018). Support for those who use alcohol and drugs, as well as their families and friends, are available through specialist AOD treatment services. These services may provide several treatment types to those seeking treatment for their own AOD use, ranging from providing one-off information and education sessions to residential rehabilitation programs and withdrawal management.

Due to the chronic nature of alcohol and drug dependence, clients seeking AOD treatment often experience cycles of treatment, recovery, relapse and repeated treatment (Lubman D et al 2014). When entering AOD treatment, clients and services will identify the clients' goals and develop a treatment plan accordingly. Such goals could include the abstinence from, or managed use of a substance and develop a treatment plan accordingly. While treatment objectives vary from client to client, specialist AOD treatment commonly involves multiple episodes of different treatment types over time. For example, a treatment plan might include assessment, supervised withdrawal and rehabilitation, and multiple episodes of follow-up counselling (Kelly JF et al 2019; Lubman D et al 2014).

Studies in both Australian and international contexts have found that stable retention in treatment over time is a predictor of more positive treatment outcomes (AIHW 2011; Lubman D et al 2014). As AOD treatment is often structured around multiple discrete treatment episodes, client engagement over the course of treatment can be examined through how each episode ends. For example:

- Treatment episodes ending as planned (such as where the client has met their treatment goals or by mutual agreement with the service) may indicate more positive client engagement with services.
- Conversely, treatment ending with an unplanned completion (such as a client ceasing to participate against advice or without notice) may indicate less effective engagement between a service and a client.

As such, understanding how clients end each treatment episode is important to the design and delivery of effective treatment services.

The Alcohol and Other Drug Treatment Services National Minimum Data Set

In Australia, publicly funded treatment services for AOD use are available in all states and territories. Data from publicly funded AOD treatment services in Australia are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). The NMDS includes information on client characteristics, such as age and sex. It also holds information on treatment episodes (the periods of contact between a client and treatment provider), including the principal drug of concern, treatment type, setting and duration.

For further information on the AODTS NMDS, see Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS).

Policy context: The National Drug Strategy 2017–2026

The National Drug Strategy (NDS) 2017–2026 provides a framework for a coordinated approach to minimising AOD-related harms in Australia. Its purpose is to build 'safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social and economic harms' (DoH 2017).

The NDS recognises measuring performance as one of its priority actions, which includes 'robust evaluation processes to effectively measure impact or outcome of work undertaken, including consistent monitoring and reporting of treatment outcomes.' The NDS also identifies priority populations, including both young and older people, and priority substances, including alcohol and methamphetamines.

Understanding why people leave AOD treatment and how these reasons vary by demographic and treatment characteristics can inform our understanding of treatment outcomes. These findings will contribute to building the evidence base for AOD treatment design and delivery.

For further information, see the National Drug Strategy 2017–2026 Australian Government Department of Health and Aged Care web page .

How is completion of AOD treatment measured?

Reason for cessation is a variable in the AODTS NMDS that records how a client completed an AOD treatment episode. In previous analyses, this variable has been treated as a proxy for treatment outcomes (AIHW 2021). Identifying the circumstances in which clients complete their treatment can inform design and delivery of treatment services.

Reason for cessation can be grouped broadly into 4 categories:

1. Treatment ended as expected/planned
2. Treatment ended unexpectedly
3. Client was referred to another service or changed their treatment mode
4. Other (imprisoned, died or reasons not elsewhere classified).

For further information on the attributes and limitations of this variable, refer to the Technical notes.

What does this report examine?

This report will examine differences in reason for cessation of AOD treatment for alcohol and amphetamines as a principal drug of concern, across treatment characteristics, including treatment intensity over time and individual treatment episode characteristics.

To achieve this, the report uses closed treatment episode data from the AODTS NMDS, spanning a 10-year period from 2011–12 to 2020–21 and client data from 2013–14 to 2020–21.

This report aims to explore:

- How patterns of service use and differences in treatment intensity over multiple episodes relate to completion of AOD treatment.
- Whether there are differences in completion of treatment for alcohol compared to amphetamines as the principal drug of concern, client remoteness and treatment type.

References

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Scope and methods

Scope and methods

The AODTS NMDS is collected annually, with collection periods beginning on July 1 and ending on June 30 of the following year. This report includes data on closed treatment episodes delivered between 2011–12 to 2020–21; however, data coverage differs by variable.

AODTS NMDS data can be counted using two measures: **clients** or **closed treatment episodes** provided to clients**.**

A typical AOD client will receive multiple treatment episodes; based on the number and frequency of all episodes received during the study period, clients are assigned to one of three cohorts reflecting their treatment intensity.
Data on both treatment intensity cohorts and treatment episodes are included in this report to capture how clients interact with AOD services over multiple episodes, as well as yearly changes in individual episode characteristics. Due to changes in data quality over time, treatment cohort-level and episode-level data varies in coverage.

Clients can receive treatment for their own or someone else's drug use. This report only presents information for clients receiving treatment for their own drug use.

Table 1 summarises the differences in treatment cohort-level and treatment episode-level data.

Table 1: Measures included from the AODTS NMDS data

	Treatment cohort	**Treatment episode**
Measure	Includes all closed treatment episodes received by a **client**: a person who receives an AOD treatment episode for their own drug use. Most clients undergo multiple treatment episodes over the course of their treatment; each episode is matched to a client and counted towards the treatment cohort the client is assigned to.	The period of contact between a client and treatment provider. Each closed treatment episode has one principal drug of concern and one main treatment type.
Time coverage	Clients who received treatment between 2013–14 to 2020–21	Closed treatment episodes provided between 2011–12 to 2020–21

For further information, refer to the *Alcohol and drug treatment services in Australia* annual report.

Scope and methods

On this page:

This section provides an outline of the analysis variables and their inclusion criteria for this report.

What is reason for cessation of specialist AOD treatment?

Reasons for cessation can be grouped broadly into 4 categories, outlined below in Table 2.

Treatment episodes without a valid reason for cessation were excluded from analysis.

Table 2: Reasons for cessation recorded in the AODTS NMDS

Expected/planned completion	Ended due to unplanned completion	Referred to another service/ change in treatment mode	Other
• Treatment was completed as planned • Client ceased to participate at expiation or by mutual agreement	• Ceased to participate against advice • Ceased without notice • Ceased due to non-compliance	• Change in main treatment type, delivery setting or principal drug of concern • Client was transferred to another service provider	• Client returned to court or jail due to non-compliance with a drug court program or sanctioned by court diversion service • Imprisoned (other than drug court sanctioned) • Died • Reasons not elsewhere classified

Whose AOD use is examined?

The AODTS NMDS captures whether a treatment episode was provided for a client's own AOD use or another person's AOD use.

Treatment episodes where a client received treatment for another person's AOD use were excluded from analysis.

How is client age and sex defined?

Client age and sex is derived from the first treatment episode a client received when they began treatment between 2013–14 to 2020–21. Clients are identified using a statistical linkage key (SLK-581).

Note that most clients receive multiple treatment episodes, and that their treatment may span several years.

The AODTS NMDS records sex information as 'male,' 'female,' or 'other.' Due to concerns about data reliability, clients whose sex was recorded as 'other' are excluded from analysis.

The AODTS NMDS only captures clients aged 10 and older at the time of their first treatment episode.

What treatment episode characteristics are included?

Which drugs of concern are included?

The principal drug of concern is the main substance that the client stated as leading them to seek treatment from the AOD treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses of principal drug of concern.

In 2020–21, the most common principal drug of concern was alcohol (37% of episodes), followed by amphetamines (24%) (AIHW 2022). Since the beginning of the AODTS NMDS collection, these two drugs have consistently been the most common principal drugs of concern for which clients seek treatment, and are identified as priority substances by the National Drug Strategy 2017–2026.

Analysis of this report was limited to alcohol and amphetamines (an aggregation of methamphetamine, amphetamine and other amphetamines; for further information, refer to the Alcohol and other drug treatment services in Australia annual report).

What treatment types are included?

Treatment type refers to the type of activity used to treat the client's AOD issues. Each treatment episode has one main treatment type, which is the principal activity identified by the treatment provider to address the client's issues with their principal drug of concern. For further information on how main treatment type is collected, refer to the Alcohol and drug treatment services in Australia annual report.

Treatment episodes with a main treatment type of 'Assessment only' were excluded from analysis. In these episodes, no treatment is provided to the client. Instead, an overall assessment of the extent and nature of their drug and/or alcohol problem is undertaken to assist the patient and clinician to identify shared treatment goals and develop a treatment plan.

How is client remoteness determined?

This report uses the Australian Bureau of Statistics' (ABS) Australian Statistical Geography Standard (ASGS) Remoteness Structure 2016 to examine the distribution of clients receiving AOD treatment by remoteness area (ABS 2018).

For this report, remoteness area of clients was determined by converting the postcode of the clients' last recorded address to the ASGS Remoteness Structure. Due to small counts, data for *Remote and Very remote* regions were aggregated.

Client location is derived from postcode of the client's last known address, which was collected for the first time in 2013–14. As such, data for episodes provided before 2013–14 are excluded from remoteness analysis. Treatment episodes where the client's last recorded address had an invalid residential postcode were also excluded, including postcodes assigned to PO boxes.

For further information on client postcode, refer to the Technical notes.

Other variables

Other variables included for analysis include treatment delivery setting, treatment duration and referral source. For further information on these variables, refer to the Data and Methods and Key Terminology and Glossary pages of the *Alcohol and other drug treatment services in Australia* annual report.

References

Australian Bureau of Statistics (ABS; 2018). "Australian Statistical Geography Standard (ASGS): volume 5—Remoteness Structure, July 2016." ABS Cat no. 1270.0.55.005. Canberra: ABS.

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Kelly JF, White WL (2011). "Addiction recovery management: theory, research and practice." *Springer Science+Business Media*. New York.

Scope and methods

On this page

Defining treatment intensity using the AODTS NMDS

Previous AIHW analysis in 2019 established criteria for clients receiving intensive AOD treatment, based on the number of episodes that a client received and the number of years over which they received treatment (AIHW 2019).

The rationale for defining AOD treatment intensity was based on the understanding that:

- treatment experiences vary among individuals; and
- there is a subset of clients which engages with AOD treatment services more regularly than others, and therefore has a higher level of contact with the sector over time (AIHW 2019; Kelly & White 2011).

This report further examines how characteristics of AOD clients and the treatment they received varies by treatment intensity, focusing on the 648,400 treatment episodes provided to the 228,500 clients who received AOD treatment between 1 July 2013 and 30 June 2021.

The three cohorts were defined as follows:

- **intensive treatment** – clients who received 11 or more closed treatment episodes for their own alcohol or other drug use, across at least 3 collection periods (that is, financial years)
- **recurring treatment** – clients who received fewer than 11 closed treatment episodes for their own alcohol or other drug use across at least 3 collection periods
- **non-recurring treatment** – clients who received treatment for their own alcohol or other drug use in fewer than 3 collection periods.

For further information on the methodology used to define these cohorts, please see Technical notes: Defining treatment intensity using the AODTS NMDS.

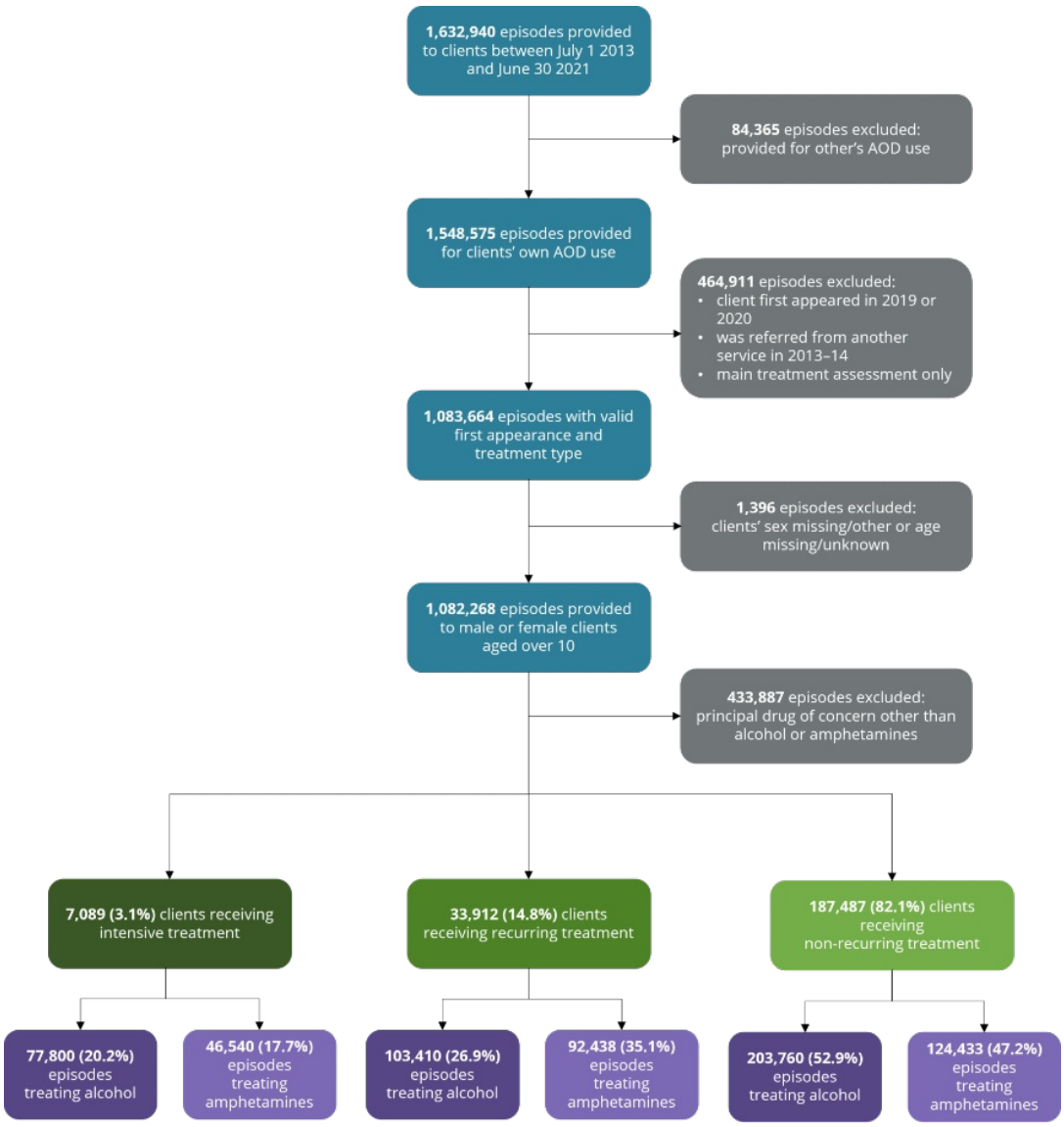
It is important to note that this report refers to clients in each cohort as well as closed treatment episodes provided to clients in each cohort. In examining the likelihood of reason for cessation of treatment and other treatment characteristics, all episodes provided to each client over the course of their treatment are considered.

For example, where a client receiving intensive treatment received 11 treatment episodes over the course of 3 collection periods, each episode's reason for cessation is counted separately towards the intensive treatment cohort.

How many clients and treatment episodes were in each treatment cohort?

Table 5 and Figure 2 illustrate the numbers of clients in each cohort and treatment episodes provided to these clients. While clients receiving intensive treatment represented less than 1 in 20 (3.1%)clients who sought AOD treatment between 1 July 2013 to 30 June 2021, 1 in 5 (20% episodes treating alcohol; 18% episodes treating amphetamines) treatment episodes were provided to this cohort.

Figure 1: Analysis criteria of clients and treatment episodes by treatment intensity, 2013-14 to 2020-21



How does treatment completion vary by treatment intensity?

How does treatment completion vary by treatment intensity?

Clients accessing alcohol and other drug treatment services often receive multiple episodes of treatment, with some clients requiring more intensive treatment (more treatment episodes spanning multiple years) to achieve their treatment goals. This section of the report examines how clients' contact with services over multiple episodes and years relates to the likelihood of planned or unplanned treatment episode completion.

To examine treatment intensity, three cohorts were defined based on both the number of treatment episodes that clients had received and the number of years in which they received treatment between 1 July 2013 to 30 June 2021. Those clients interacting with AOD services the least were captured in the non-recurring treatment cohort while those interacting the most were captured in the intensive treatment cohort.

For further information, see How is AOD treatment intensity defined and Technical notes.

Client age and sex

Across clients receiving AOD treatment between 2013–14 and 2020–21, the majority of clients were male. Age and sex characteristics were similar across all three treatment cohorts, as shown in Figure 2:

- **intensive treatment**: almost 3 in 5 (56%) clients were male and over 2 in 5 (44%) were female, making intensive treatment the cohort with the highest proportion of females. The median age at which clients entered treatment for the first time between 2013–14 and 2019–20* was 35 years
- **recurring treatment**: around 2 in 3 (65%) clients were male and the median age at which clients entered treatment for the first time between 2013–14 and 2019–20 was 34 years
- **non-recurring treatment**: over 2 in 3 (68%) clients were male and the median age at which clients entered treatment for the first time between 2013–14 and 2019–20 was 35 years.

The likelihood of treatment ending as a planned completion was higher among episodes provided to older clients across all cohorts. For further detail, refer to Supplementary Tables BLTN.3 and BLTN.4.

*Note that clients were excluded from analysis if they received their first treatment episode after the 2019–20 collection period. This ensures that there was enough time for clients to have received treatment in 3 or more collection periods and thus meet the criteria for identifying intensive treatment. Please refer to How is AOD treatment intensity defined? for further information.

Figure 2: Clients who received treatment for alcohol and amphetamines between 2013-14 and 2020-21, by age group and treatment intensity

This interactive data visualisation shows the number and proportion of clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines by age and sex.

View by age group | View by age group and sex

Select measure:
(•) Number
( ) Per cent

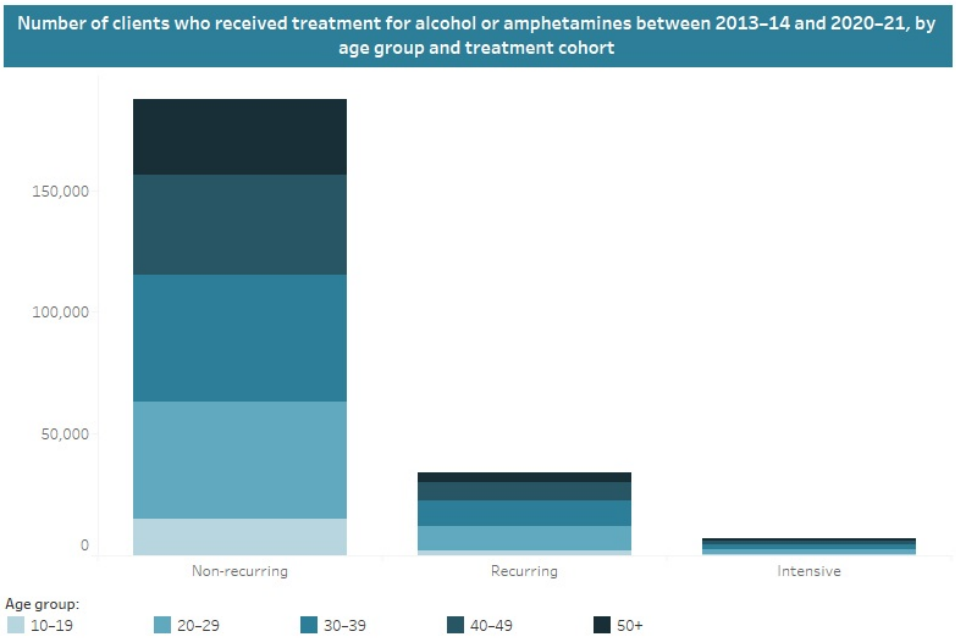


Figure 2: Clients who received treatment for alcohol and amphetamines between 2013–14 and 2020–21, by age group and treatment intensity
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

See notes >

How does treatment completion vary by treatment intensity?

Across all treatment intensity cohorts, episodes treating **amphetamines** as a principal drug of concern were more likely to end with an unplanned completion than episodes treating alcohol (Figure 3).

Figure 3: End reasons of episodes treating alcohol or amphetamines between 2013-14 and 2020-21, by treatment intensity cohort

This interactive data visualisation shows the number and proportion of episodes provided to clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines. Episodes are presented by reason for cessation.

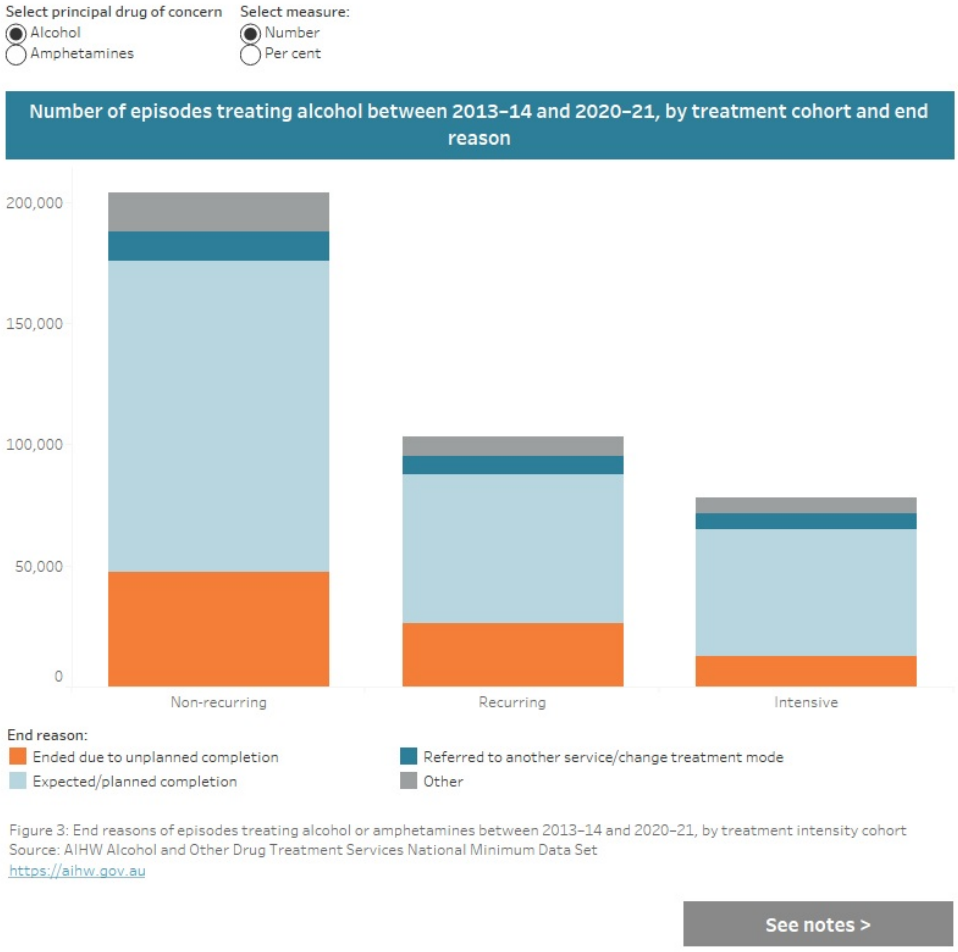


Figure 3: End reasons of episodes treating alcohol or amphetamines between 2013–14 and 2020–21, by treatment intensity cohort
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

See notes >

The likelihood of unplanned completion was lower among treatment episodes provided to clients who received intensive treatment:

- around 2 in 10 episodes (16% for alcohol; 23% for amphetamines) provided to clients who received **intensive** treatment
- around 3 in 10 episodes (25% for alcohol, 32% for amphetamines) provided to clients who received **recurring** treatment
- around 2 in 10 episodes (23% for alcohol), and 3 in 10 episodes (31% for amphetamines) provided to clients who received **non-recurring** treatment.

For further details, refer to Supplementary tables BLTN.3 and BLTN.4.

How does treatment completion vary by treatment intensity?

Across all treatment intensity cohorts, the likelihood of a treatment episode ending as planned varied by treatment type and principal drug of concern (Figure 4).

Figure 4: End reasons of episodes treating alcohol or amphetamines between 2013–14 and 2020–21, by treatment intensity cohort and main treatment type

This interactive data visualisation shows the number and proportion of episodes provided to clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines. Episodes are presented by reason for cessation and main treatment type.

Visualisation not available for printing

What types of specialist AOD treatment are provided in Australia?

Based on clients' needs and agreed treatment goals, services may provide a number of interventions.

Counselling	Can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing.
Information and education	Where information and education is provided to the client (service providers would normally include an information and education component in all treatment types)
Support and case management	Support includes helping a client who occasionally calls an agency worker for emotional support, while case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs (including general welfare needs) and it includes assessment, planning, linking, monitoring and advocacy.
Withdrawal management (detoxification)	Includes medicated and non-medicated treatment to help manage, reduce or stop the use of a drug of concern.
Rehabilitation	Focuses on supporting clients in stopping their drug use, and to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in several ways, including residential treatment services, therapeutic communities and community-based rehabilitation services.

Pharmacotherapy (included in 'other')	Where the client receives another type of treatment in the same treatment episode and includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who experience dependence on certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the withdrawal category.

For further information, please see Alcohol and other drug treatment services in Australia annual report: Key terminology and glossary.

Alcohol

Among clients seeking treatment for alcohol as a principal drug of concern:

- **Rehabilitation** episodes had a similar likelihood of unplanned completion across all treatment cohorts (around 37%) and was the treatment with the highest likelihood of unplanned completions.
- **Counselling** episodes provided to clients receiving intensive treatment had the highest likelihood of ending with a planned completion (62%), while episodes provided to clients receiving recurring treatment had the lowest (53%).

Amphetamines

Among clients seeking treatment for amphetamines as a principal drug of concern:

- Around 1 in 2 (45%) **rehabilitation** episodes provided across all three cohorts ended as an unplanned completion and was the treatment with the highest likelihood of unplanned completions.
- Around 3 in 5 (57%) **counselling** episodes provided to clients receiving intensive treatment ended in a planned completion, higher than clients receiving non-recurring and recurring treatments (52% and 49%, respectively).

For further details, refer to Supplementary table BLTN.5.

How does treatment completion vary by treatment intensity?

Clients receiving intensive treatment for alcohol and amphetamines had a shorter median duration of treatment episodes than recurring and non-recurring clients, as shown in Table 3. Across most treatment types (with the exception of withdrawal management and other treatment types), clients receiving intensive treatment had the shortest median duration of episodes, while clients receiving recurring treatment had the longest.

Figure 5 presents reasons for cessation by duration interval and treatment type.

Table 3: Median duration (days) of episodes for clients receiving treatment for alcohol or amphetamines, by treatment intensity cohort

Principal drug of concern	Intensive	Recurring	Non-recurring
Alcohol	22	43	40
Amphetamines	31	48	42

Figure 5: End reasons of episodes treating alcohol and amphetamines between 2013-14 and 2020-21, by treatment intensity cohort, main treatment and treatment duration

This interactive data visualisation shows the number and proportion of episodes provided to clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines. Episodes are presented by reason for cessation, main treatment type and treatment duration.

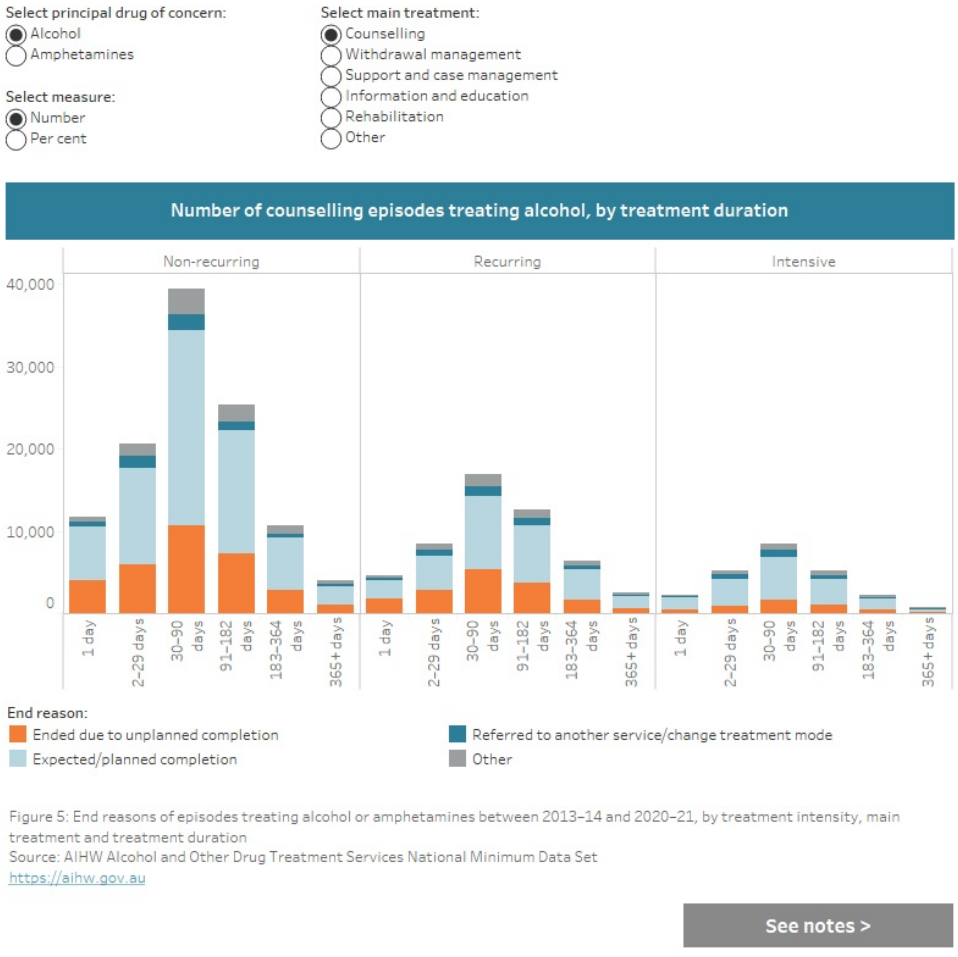


Figure 5: End reasons of episodes treating alcohol or amphetamines between 2013–14 and 2020–21, by treatment intensity, main treatment and treatment duration
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

See notes >

Counselling

Counselling episodes for both alcohol and amphetamines most commonly lasted 30–90 days. Treatment episodes that lasted **1 day** had the highest proportion of unplanned completion across all treatment cohorts for both alcohol and amphetamines (19–38% for alcohol; 27–47% for amphetamines) with the proportion of planned completion increasing with treatment duration.

Rehabilitation

Rehabilitation episodes for alcohol and amphetamines most commonly lasted 30–90 days. Treatment episodes that lasted **2–29 days** had the highest proportion of unplanned completion across all 3 treatment cohorts:

- more than 5 in 10 (52–56%) of episodes provided for alcohol
- around 6 in 10 (55–64%) of episodes provided for amphetamines.

Across all treatment cohorts, rehabilitation episodes that ended with a planned completion had a higher median duration than episodes that ended for all other reasons (unplanned, referred to other service and other).

The median duration of rehabilitation episodes treating **alcohol** that ended with a planned completion was:

- **intensive:** 59 days, compared to 38–44 days for episodes that ended for all other reasons
- **recurring:** 82 days, compared to 41–54 days
- **non-recurring:** 82 days, compared to 37–48 days.

The median duration of rehabilitation episodes treating **amphetamines** that ended with a planned completion was:

- **intensive:** 50 days, compared to 30–36 days for episodes that ended for all other reasons
- **recurring:** 76 days, compared to 34–44 days
- **non-recurring:** 70 days, compared to 32–41 days.

Information and education

The majority of information and education episodes provided to all treatment cohorts lasted 1 day. Of treatment episodes that lasted 1 day, the majority ended with a planned completion:

- 87–97% episodes provided for **alcohol**
- 93–96% episodes provided for **amphetamines**.

Treatment episodes that lasted longer had a higher proportion of unplanned completion.

For further detail, refer to Supplementary tables BLTN.6 to BLTN.9.

How does treatment completion vary by treatment intensity?

The proportion of episodes delivered in **residential** settings increased with treatment intensity, with clients receiving intensive treatment more likely to receive treatment in this facility than in any other settings (Figure 6):

- **non-recurring**: around 1 in 7 episodes for alcohol (14%; 28,712 episodes) and amphetamines (15%; 18,666)
- **recurring**: around 1 in 5 episodes for alcohol (22%; 22,353 episodes) and amphetamines (18%; 16,994)
- **intensive**: around 1 in 3 episodes for alcohol (32%; 25,046 episodes) and amphetamines (31%; 14,535).

Episodes were more likely to end in unplanned completion where they were delivered in non-residential or residential treatment facilities, compared to outreach or home settings.

Figure 6: End reasons of episodes treating alcohol or amphetamines between 2013-14 and 2020-21, by treatment intensity cohort and delivery setting

This interactive data visualisation shows the number and proportion of episodes provided to clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines. Episodes are presented by reason for cessation, delivery setting and treatment duration.

Figure 6: End reasons of episodes treating alcohol or amphetamines between 2013–14 and 2020–21, by treatment intensity and treatment setting
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

See notes >

Alcohol

Among clients seeking treatment for alcohol as a principal drug of concern:

- Episodes delivered in **residential** settings had a similar likelihood of ending with an unplanned completion across all treatment cohorts (around 1 in 5, or 20–22%).
- In **non-residential** settings, episodes delivered to clients receiving recurring treatment had the highest likelihood of ending in an unplanned completion (27%) while episodes provided to clients receiving intensive treatment had the lowest (16%).

Amphetamines

Among clients seeking treatment for amphetamines as a principal drug of concern:

- In **residential** settings, episodes delivered to clients receiving intensive treatment had a lower likelihood of ending as an unplanned completion (30%) compared to those receiving non-recurring and recurring treatment (37% each).
- In **non-residential** settings, episodes delivered to clients receiving intensive treatment had the lowest likelihood of ending as an unplanned completion (22%) compared to those receiving non-recurring and recurring treatment (32% and 33%, respectively).

For further detail, refer to Supplementary table BLTN.10.

How does treatment completion vary by treatment intensity?

Geographic location is a prominent factor in treatment accessibility, particularly for clients living or seeking treatment in *Remote & very remote* areas of Australia (AIHW 2019).

Across all treatment episodes provided in the study period, the proportions broadly follow the population distribution with the majority (61% of episodes for alcohol; 68% of episodes for amphetamines) provided to clients living in *Major cities*, followed by those in:

- *Inner regional* areas (21% or 77,141 episodes for alcohol; 21% or 52,939 episodes for amphetamines)
- *Outer regional* areas (12% or 42,338 episodes for alcohol; 9.1% or 22,933 episodes for amphetamines)
- *Remote & very remote* areas (6.5% or 23,818 episodes for alcohol; 1.8% or 4,621 episodes for amphetamines).

Clients who received intensive treatment were more likely to live in *Major cities* (71% episodes for alcohol; 75% for amphetamines) than those who received non-recurring (58% for alcohol; 67% for amphetamines) or recurring treatment (59% alcohol; 66% amphetamines) (Figure 7).

Across all treatment cohorts for both alcohol and amphetamines, the likelihood of unplanned completion increased with remoteness. This may be due to a range of factors, including accessibility to treatment services and travel time (AIHW 2019).

These trends varied by treatment type and principal drug of concern, as shown in Figure 8.

Figure 7: End reasons of episodes treating alcohol or amphetamines between 2013-14 and 2020-21, by treatment intensity cohort and client remoteness

This interactive data visualisation shows the number and proportion of episodes provided to clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines. Episodes are presented by reason for cessation and remoteness area.

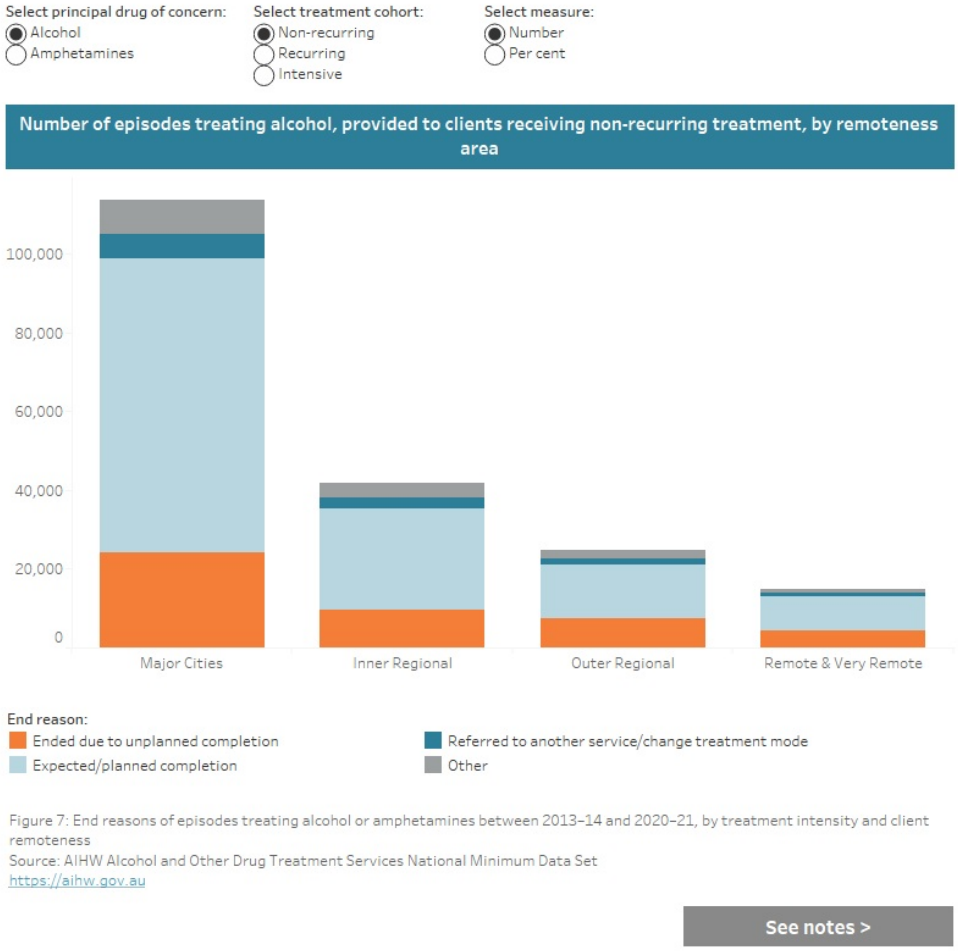


Figure 7: End reasons of episodes treating alcohol or amphetamines between 2013–14 and 2020–21, by treatment intensity and client remoteness
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

See notes >

Figure 8: End reasons of episodes treating alcohol or amphetamines between 2013-14 and 2020-21, by treatment intensity cohort, client remoteness and main treatment type

This interactive data visualisation shows the number and proportion of episodes provided to clients receiving intensive, recurring and non-recurring treatment for alcohol or amphetamines. Episodes are presented by reason for cessation, remoteness area and main treatment.

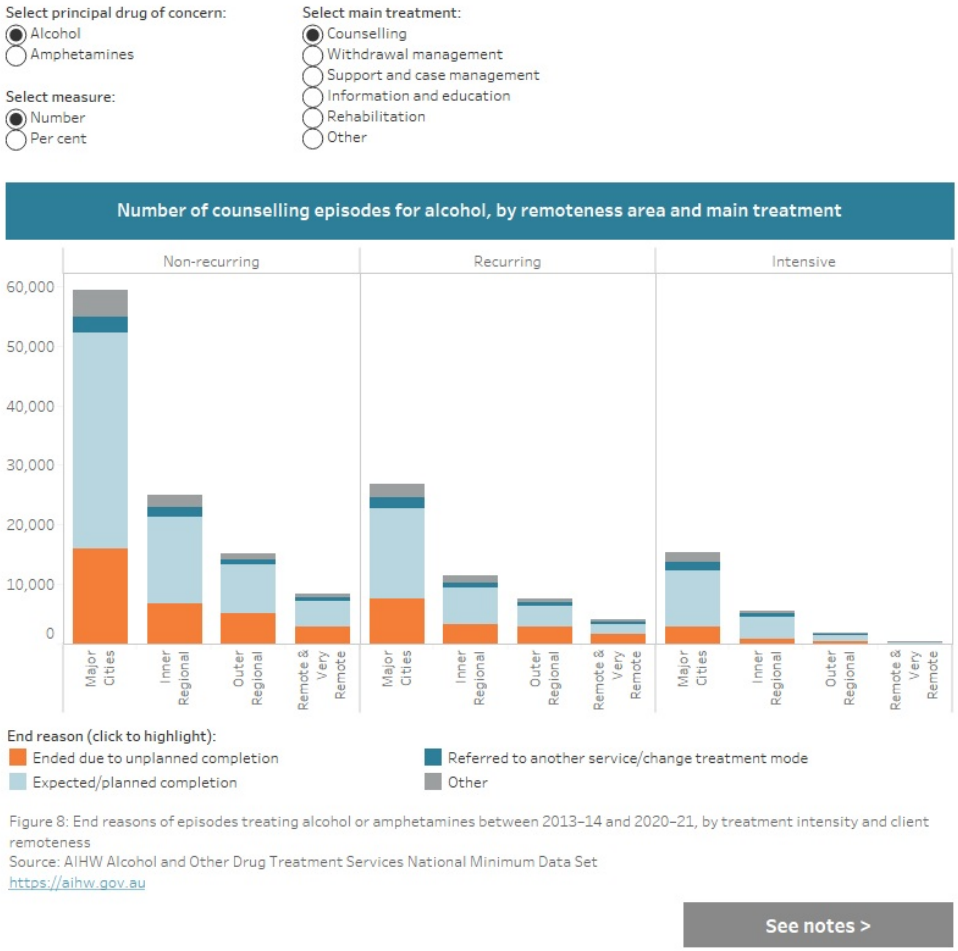


Figure 8: End reasons of episodes treating alcohol or amphetamines between 2013–14 and 2020–21, by treatment intensity and client remoteness
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

See notes >

Alcohol

Among treatment episodes for alcohol:

- Rehabilitation episodes had similar likelihood of unplanned completion across most cohorts and remoteness areas (35–38%), with the exception of non-recurring clients in *Inner regional* areas (42%) and *Remote & very remote* areas (31%).
- Among other treatment types, episodes provided in *Outer regional* and *Remote & very remote areas* had a higher likelihood of unplanned completion than episodes provided in *Major cities* and *Inner regional* areas across all three treatment cohorts.
- Counselling provided to clients in *Remote & very remote* areas had a lower likelihood of planned completion where clients received intensive treatment, compared to those who received non-recurring and recurring treatment:
  - 31% of counselling episodes provided to clients receiving intensive treatment for alcohol ended as planned
  - 43% and 52% of episodes provided to clients receiving recurring and non-recurring treatment ended as planned.

Amphetamines

Among treatment episodes for amphetamines:

- Rehabilitation episodes had similar likelihood of unplanned completion across most cohorts and remoteness areas (40–50%), with the exception of the relatively small number of episodes provided to clients living in *Remote & very remote* areas.
- Among other treatment types, episodes provided in *Outer regional* and *Remote & very remote* areas had a higher likelihood of unplanned completion than episodes provided in *Major cities* and *Inner regional* areas across all three treatment cohorts.

For further detail, refer to Supplementary tables BLTN.11 and BLTN.12.

References

AIHW (2019). "Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment, 2016–17." *Cat. no. HSE 212*. Canberra: AIHW.

How has treatment completion changed over time?

This section of the report examines how individual treatment episode characteristics relate to the likelihood of planned or unplanned episode completion, and how this varies by year between 2011–12 and 2020–21.

The analysis criteria applied to data in this section is different to those applied in previous sections of this report, which examined aggregated episodes provided to clients between 2013–14 and 2020–21, assigned to cohorts by treatment intensity.

This section examines trends in episode characteristics disaggregated by year between 2011–12 and 2020–21.
Please see Technical notes for further information.

How has treatment completion changed over time?

Principal drug of concern

Alcohol and amphetamines have consistently been the most common principal drugs of concern for which clients have sought treatment since 2011–12 (AIHW 2022). In 2020–21, nearly 4 in 10 treatment episodes were for alcohol as the principal drug of concern (37% of episodes), and 1 in 4 episodes were for amphetamines (24%).

Completion of treatment episodes for a client's own AOD use varies by principal drug of concern, with treatment for amphetamines more likely to end in unplanned completion than treatment for alcohol. This trend has been consistent over time:

- around 3 in 10 episodes providing treatment for **amphetamines** had an unplanned completion (ranging from 28% in 2011–12 to 33% in 2018–19)
- around 2 in 10 episodes providing treatment for **alcohol** had an unplanned completion (ranging from 22% in 2011–12, peaking at 24% in 2018–19).

For further detail, refer to Supplementary table BLTN.13.

Main treatment type

Figure 9 shows yearly trends in completion of episodes treating alcohol and amphetamines between 2011–12 to 2020–21, by main treatment type.

Figure 9: End reasons of episodes treating alcohol or amphetamines, by main treatment type, 2011–12 to 2020–21

This interactive data visualisation shows yearly trends in number and proportion of episodes treating alcohol or amphetamines between 2011–12 to 2020–21. Episodes are presented by reason for cessation and main treatment.

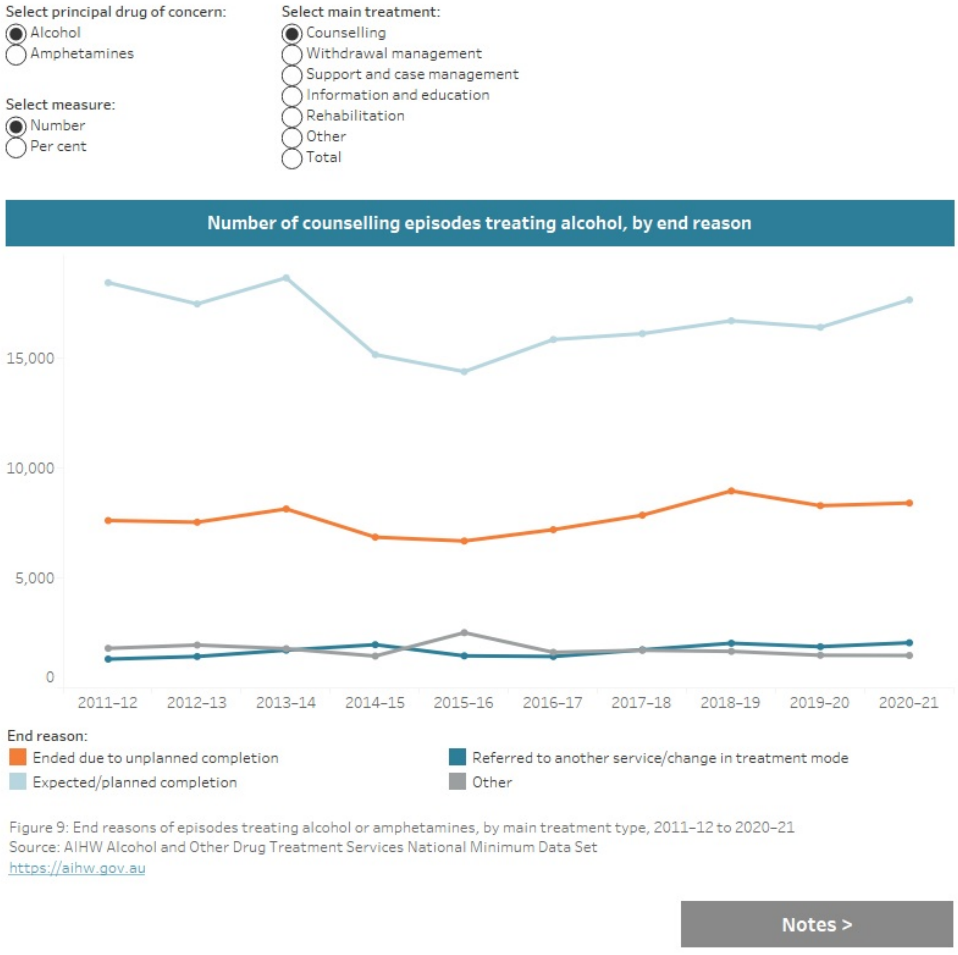


Figure 9: End reasons of episodes treating alcohol or amphetamines, by main treatment type, 2011–12 to 2020–21
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

Notes >

In 2020–21, **counselling** was the most common main treatment provided to clients for their own use of either alcohol or amphetamines (AIHW 2022). Counselling episodes were also the most likely to end in a planned completion. However, the proportion of counselling episodes ending as planned has declined since 2011–12:

- over 3 in 5 (63%) episodes for **alcohol** ended in a planned completion in 2011–12, falling to 60% in 2020–21
- 3 in 5 (61%) of episodes for **amphetamines** ended in a planned completion in 2011–12, falling to 52% in 2020–21.

The main treatment type with the highest likelihood of episodes ending with an unplanned completion was **rehabilitation**. However, the proportion of rehabilitation episodes ending with an unplanned completion has declined since 2011–12:

- 2 in 5 (40%) episodes for **alcohol** ended in an unplanned completion in 2011–12, falling to 1 in 3 (33%) in 2020–21
- around half (49%) of episodes for **amphetamines** ended in an unplanned completion in 2011–12, falling to around 2 in 5 (39%) in 2020–21.

For further detail, refer to Supplementary tables BLTN.14 and BLTN.15.

References

AIHW (2022). *Alcohol and other drug treatment services in Australia annual report.*

How has treatment completion changed over time?

Large changes in referral sources were observed in 2019–20, which likely reflects the impact of the COVID-19 pandemic and associated public health restrictions in the first half of the 2020 calendar year. For further information, please see Alcohol and other drug treatment services in Australia annual report, Treatment referral and completion.

Figure 10 shows yearly trends in end reasons of episodes treating alcohol or amphetamines between 2011–12 to 2020–21, by referral source and main treatment type.

Figure 10: End reasons of episodes treating alcohol or amphetamines, by main treatment type and referral source, 2011-12 to 2020-21

This interactive data visualisation shows yearly trends in number and proportion of episodes treating alcohol or amphetamines between 2011–12 to 2020–21. Episodes are presented by reason for cessation, main treatment and referral source.

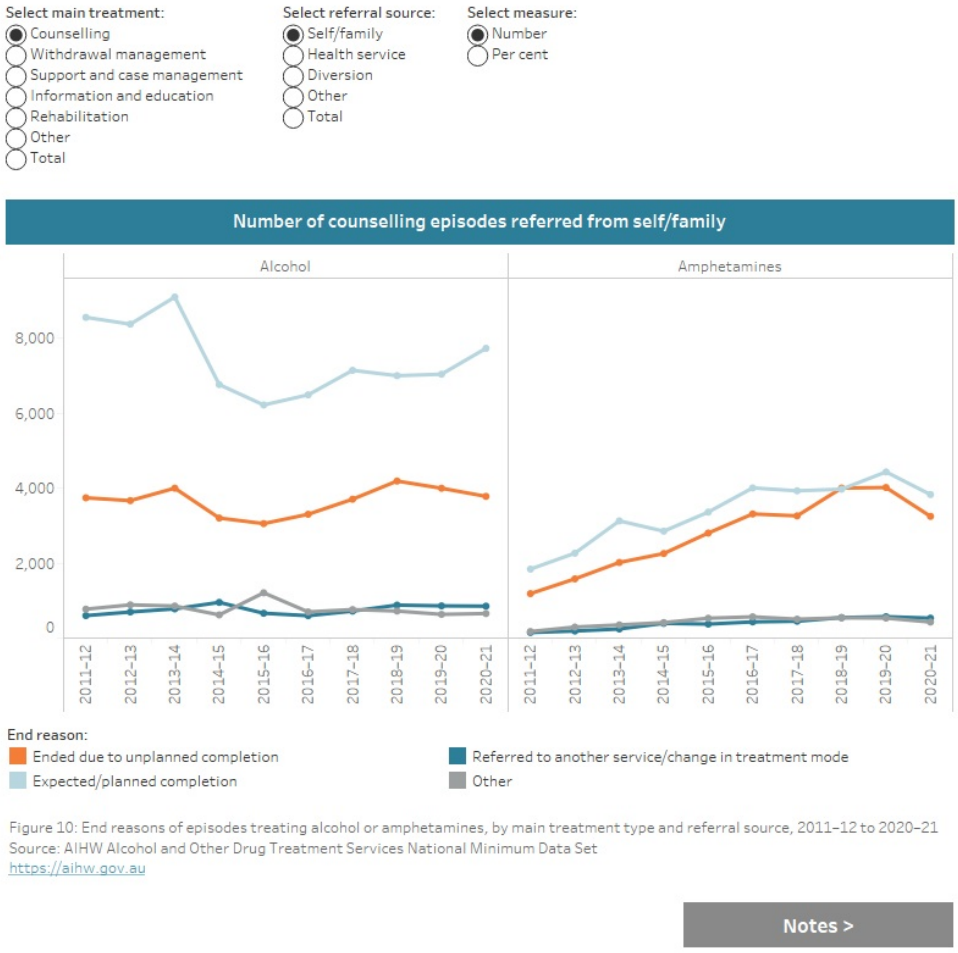


Figure 10: End reasons of episodes treating alcohol or amphetamines, by main treatment type and referral source, 2011–12 to 2020–21
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

Notes >

Among episodes involving a **referral from a diversion program**, the proportion of episodes ending in a planned completion decreased sharply from 2018–19 to 2019–20:

- Among **support and case management** episodes for **amphetamines** as a principal drug of concern, episodes ending with a planned completion fell from 66% to 43%, while episodes ending with an unplanned completion increased from 21% to 38%.
- Among **rehabilitation** episodes treating:
  - **Alcohol**: episodes ending in a planned completion fell from 54% to 45% while episodes with unplanned completion increased from 33% to 39%. Episodes involving referral to another service/change in treatment mode also increased from 3.3% to 13%.
  - **Amphetamines**: episodes with planned completion fell from 45% to 38%, while episodes with unplanned completion increased from 42% to 50%.

These changes likely relate to changes to the delivery of diversion programs after the introduction of COVID-19 restrictions in March 2020, which saw sessions postponed or scheduled to occur by telephone. For further information, see COVID-19 impact on state and territory AOD treatment services.

For further detail, refer to Supplementary tables BLTN.14 and BLTN.15.

References

AIHW. 2022. *Alcohol and other drug treatment services in Australia annual report.*

How has treatment completion changed over time?

Geographic location is a prominent factor in treatment accessibility, particularly for clients living or seeking treatment in *Remote & very remote* areas of Australia (AIHW 2019).

While the greatest numbers of treatment episodes for alcohol and amphetamines were provided in *Major cities*, accounting for population differences, the remoteness area with the highest rate differed based on principal drug of concern:

- **Alcohol:** in 2020–21, 953 episodes per 100,000 people were delivered to clients living in *Remote & very remote* areas, more than 4 times greater than the 229 episodes per 100,000 people delivered to clients in *Major cities*. The rate of episodes per 100,000 people increased with increasing remoteness, a trend consistently observed from 2014–15 to 2020–21.
  - Between 2013–14 and 2020–21, the proportion of end reasons of episodes treating alcohol remained relatively consistent across most remoteness areas. The exception was *Remote & very remote* areas, which saw a sharp increase in numbers of information and education episodes in 2018–19 (1,240 episodes, or a 10-fold increase from the previous year) and 2019–20 (2,028 episodes). The majority of this increase was episodes that ended as planned (89% and 97% respectively).
- **Amphetamines:** in 2020–21, clients living in *Inner regional* areas had the highest rate of episodes (220 episodes per 100,000 people), with the rate of episodes then decreasing with increasing remoteness. This trend is observed in most years from 2013–14 to 2020–21.

For further detail, refer to Supplementary tables BLTN.16 and BLTN.17.

Figure 11: End reasons of episodes treating alcohol or amphetamines, by client remoteness and treatment type, 2014–15 to 2020–21

This interactive data visualisation shows yearly trends in number, proportion and rate per 100,000 population of episodes treating alcohol or amphetamines between 2011–12 to 2020–21. Episodes are presented by reason for cessation, remoteness area and main treatment.

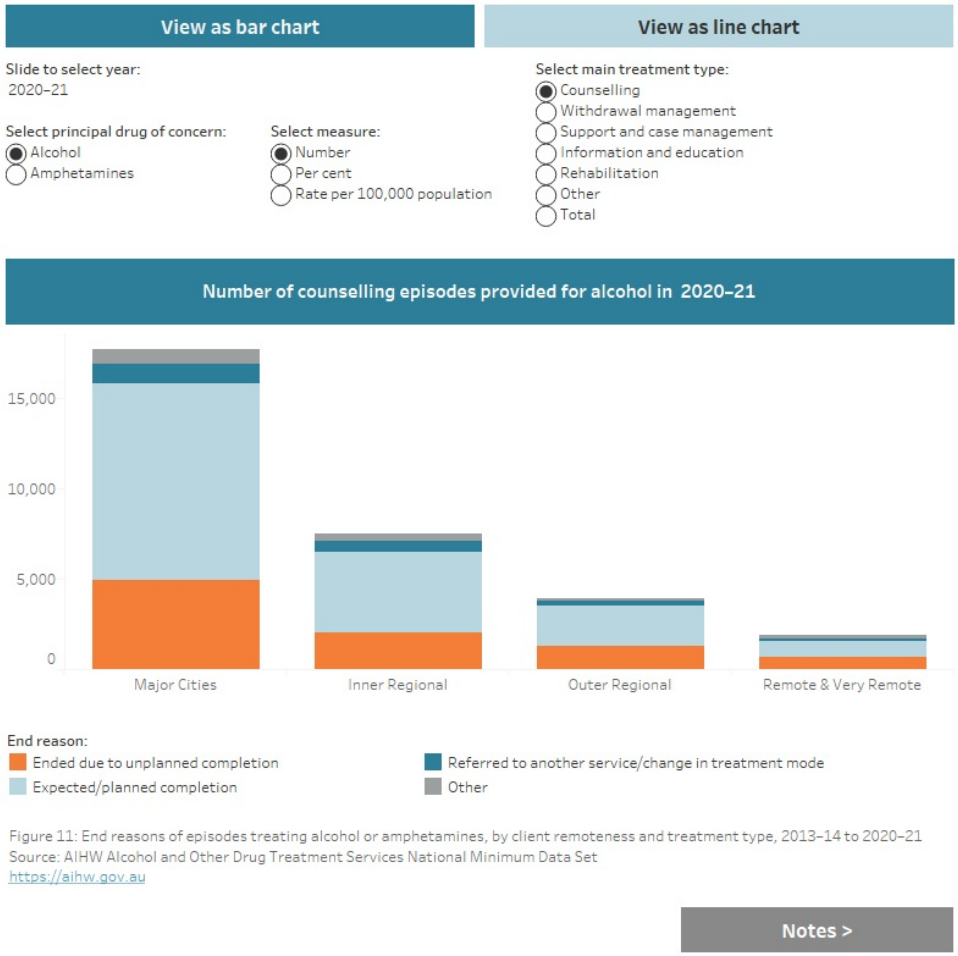


Figure 11: End reasons of episodes treating alcohol or amphetamines, by client remoteness and treatment type, 2013–14 to 2020–21
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Data Set
https://aihw.gov.au

Alcohol

Among alcohol treatment episodes:

- **Counselling** episodes were delivered to clients in *Remote & very remote* areas at a much higher rate than other areas in 2020–21 (379 episodes per 100,000 people, almost 4 times higher than *Major cities*).
  - The proportion of planned completions in *Remote & very remote* areas increased from less than half (44%) in 2016–17, peaking at 54% in 2019–20. In 2020–21, around half (49%) of counselling episodes in *Remote & very remote* areas had a planned completion.
- **Rehabilitation** episodes were delivered to clients in *Remote & very remote* areas at a much higher rate than other areas in 2020–21 (144 episodes per 100,000 people, more than 8 times higher than *Major cities*).
  - The proportion of planned completion was lower in *Inner* and *Outer regional* areas (49% each), where there was a higher proportion of episodes where the client was referred to another service or changed their treatment type (around 12% each).
  - The proportion of unplanned completion was similar across all remoteness areas (32–36%).
- **Withdrawal management** episodes were delivered to clients in *Major cities* and *Inner regional* areas (46 episodes per 100,000 people in each) at a higher rate than in more remote areas in 2020–21.
  - The proportion of planned completion decreased with increasing remoteness (76% in *Major cities* and *Inner regional* areas compared to 59% in *Remote & very remote* areas) in 2020–21.
  - The proportion of episodes ending with clients being referred to another service or changing their treatment mode increased (7.4% in *Major cities*, compared to 18% in *Remote & very remote* areas) in 2020–21.

Amphetamines

Among amphetamines treatment episodes:

- Counselling episodes were delivered to clients in *Major cities* at a lower rate (77 episodes per 100,000 people) compared to *Inner regional*, *Outer regional* and *Remote and very remote* areas (117–118 episodes per 100,000 people).
  - Episodes delivered in *Major cities* had a slightly higher likelihood of planned completions (53%) than other regions (48–51%).
- Rehabilitation episodes were delivered to clients in *Inner regional* areas at a higher rate (35 episodes per 100,000 people) compared to other regions (19 episodes per 100,000 people in *Major cities*; 25 episodes in *Outer regional* areas; 17 episodes in *Remote & very remote* areas).
  - Rehabilitation episodes delivered to clients from *Major cities*, *Inner regional* and *Outer regional* areas had similar proportions of unplanned completion (39–41%), higher than those delivered to clients from *Remote & very remote* areas (29%).

References

AIHW (2019). "Alcohol and other drug use in regional and remote Australia: consumption, harms and access to treatment, 2016–17." *Cat. no. HSE 212*. Canberra: AIHW.

AIHW (2022). *Alcohol and other drug treatment services in Australia annual report*.

Limitations and future work

This report examined the likelihood of treatment episode completions as a proxy for an outcome measure for clients who received AOD treatment, using data included in the AODTS NMDS from 2011–12 to 2020–21. Reasons for cessation of treatment episodes provided in this time differed based on characteristics such as:

- treatment intensity over multiple episodes and collection periods
- client characteristics such as age, sex and geographic location, and
- treatment characteristics such as principal drug of concern, main treatment, duration, setting and referral source.

In interpreting the findings from this report, it is important to consider the following limitations in the analyses presented:

- This report only examines alcohol and amphetamines separately and does not account for clients having received treatment for multiple drugs of concern during the study period, nor the order in which they seek treatment for these drugs.
- The definition of treatment intensity does not account for treatment duration. For example, 3 information and education episodes within a year would be classified as a similar intensity to 3 rehabilitation episodes, despite the likely differences in client profiles and needs.
- Reason for cessation does not provide a direct indication of treatment outcome, and therefore should be interpreted with caution when making inferences using this variable.

Future work may focus on data development of the reason for cessation variable to provide a multi-dimensional measure of treatment outcomes (including focusing on client experiences and clinical relevance). Client pathways through treatment, accounting for the order of episodes and treatment characteristics, may also be investigated.

Further work may also incorporate global measurement standards for treatment outcomes, such as the patient-centred outcome measures provided by the International Consortium for Health Outcomes Measurement (ICHOM). For further information, please see Technical notes.

Technical notes

Technical notes

The Alcohol and Other Drug Treatment National Minimum Dataset (AODTS NMDS) includes government publicly funded alcohol and other drug treatment specialist services across Australia, including government and non-government agencies. Data is collected annually.

Although the AODTS NMDS collection covers most publicly funded AOD treatment services, it is difficult to quantify the full scope of AOD services in Australia. In 2013–14 it was estimated that AOD treatment comprised 1.6 million treatment episodes, services or contacts each year. Of these, the AODTS NMDS accounts for an estimated 10% of episodes, and between 20–30% of individual clients who received AOD treatment in Australia (Ritter A et al 2014).

Further details on scope, coverage and data quality are available from the AODTS NMDS Data Quality Statement and via the AIHW's Metadata Online Registry (METEOR).

On this page:

Analysis variables and exclusion criteria

Table 4 provides an overview of variables included in this report and their relevant analysis criteria.

Table 4: Summary of analysis criteria

Variable	Analysis criteria
Treatment cohort-level data	
Age	Clients aged less than 10 years and over aged over 100 excluded Clients with age missing excluded
Sex	Sex listed as 'other' and missing excluded
Treatment intensity	Clients were excluded from treatment intensity cohort analysis if they: • received their first recorded closed treatment episode between 1 July 2019 and 30 June 2021 • were referred from another AOD treatment service for their initial episode in the 2013–14 collection period • received treatment only for another person's AOD use
Treatment episode-level data	
Reason for cessation	Missing or invalid excluded
Client type	Clients receiving treatment for others' AOD use excluded
Principal drug of concern	Alcohol and amphetamines included
Main treatment type	Exclude 'assessment only'
Client remoteness area	Episodes delivered prior to 2013–14 excluded. Episodes with an invalid postcode excluded.
Duration	No exclusions
Delivery setting	No exclusions
Referral source	No exclusions

Reason for cessation variable – capabilities and limitations

In 2011, a review was undertaken to assess the AODTS NMDS as an information source for services policy development, data gaps, and options for future development within the collection.

This review examined the capabilities and limitations of variables included in the NMDS, including reason for cessation. Further details on the capabilities and potential future development of this data element can be viewed at Review of the Alcohol and Other Drug Treatment Services National Minimum Data Set (AIHW 2011).

Capabilities:

- provides a general overview for why clients cease treatment
- can be generally categorised into expected and unexpected/administrative reasons which have been used as proxies for treatment episode outcome.

Limitations:

- the number of codes available in the AODTS-NMDS is fewer than those available in some jurisdiction. Consequently, there is some detail lost in the mapping required for national reporting and agencies may feel that they are not accurately reporting their activity
- differences in agency philosophy or service delivery model may influence how this is coded; for example, favouring the codes for mutually agreed and treatment completed as opposed to involuntary/without notice/against advice
- the reason for cessation 'treatment completed' is problematic because there is no record of the original intention for that episode
- where episodes are forced closed due to unintended lack of contact with the client for 3 months, the reason of cessation may be inconsistently recorded
- from stakeholder consultation, there is reason to believe that some agencies record reason for cessation as 'transfer to another AOD provider' and a new episode is opened at the same agency, inflating the number of episodes that that agency provides
- where a client is receiving treatment for more than one drug and these have been coded as separate episodes (principal drugs of concern) the reason for cessation 'change in the principal drug of concern' is unlikely to be used. This is also a method of inflating the number of treatment episodes provided by an agency
- the reason 'change in the delivery setting' poses administrative problems, especially for some treatment types such as counselling and outreach case management where contacts may occur in several different locations during a single episode. This characteristic of the collection appears unmanageable for continuum of care models of treatment services
- some agencies perceive this element as a measure of efficacy and tend to code for 'treatment completed' regardless of the actual reason for cessation
- where the main treatment type is assessment only, there is no information on the result of that assessment

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Identifying clients in the AODTS NMDS

Unique clients were identified using a statistical linkage key (SLK-581).

See the AODTS NMDS *SLK-581 Guide for use* (PDF, 95kB) for further info.

Defining treatment episodes

An episode of treatment for alcohol and other drugs is the period of contact, with defined dates of commencement and cessation, between a client and a treatment provider or team of providers in which there is no change in the main treatment type or the principal drug of concern, and there has not been a non-planned absence of contact for greater than 3 months.

For further information, please refer to Alcohol and other drug treatment services in Australia annual report, Key terminology and glossary.

Client postcode and remoteness

In 2013–14, the data element *Postcode–of client* was added to the AODTS NMDS episode file to enable geographic analysis of clients. This data item refers to the postal code of the client's last known home address at the start of the treatment episode.

Postcode data collected in the AODTS NMDS has varied greatly in its quality since its introduction in the 2013–14 collection period. In particular, these variations may affect data quality for clients experiencing circumstances such as having no fixed address.

It is also important to note that postcodes were not developed with geospatial analysis in mind. While there are issues with using postcode for geospatial analysis, postcodes can be converted to various ASGS ABS and non-ABS structures to produce overall fit for purpose geography.

In this report, the Postcode 2018 listing was converted to the ASGS 2016 Remoteness Area Structure, using the ABS Postcode 2018 to Remoteness Area 2016 correspondence file. This correspondence is listed as a 'good' conversion, indicating that it is expected to convert data to a high degree of accuracy, and that the converted data will reflect the actual characteristics of the geographic areas involved.

Australian Statistical Geography Standard (ASGS) Remoteness Structure 2016

The ASGS has been developed by the ABS to allow areas that share common characteristics of remoteness (such as relative access to services) to be classified into broad geographic regions of Australia. These areas are:

1. Major cities
2. Inner regional
3. Outer regional
4. Remote
5. Very remote

Further information on ASGS geographical correspondences can be viewed on the ABS website.

References

AIHW (2011). *Review of the Alcohol and Other Drug Treatment Services National Minimum Data Set*. Drug treatment series no. 11. Cat. no. HSE 94. Canberra: AIHW.

Ritter A, Berends L, Chalmers J, Hull P, Lancaster K & Gomez M. (2014). "New horizons: the review of alcohol and other drug treatment services in Australia." Sydney: University of New South Wales

Technical notes

This report examines the treatment patterns of subsets of clients based on their treatment intensity, where intensive treatment was conceptualised as treatment that took place across many episodes over a long period of time. This required the development of set criteria for classifying any given series of treatment episodes.

From this goal, 2 broad criteria were developed:

1. treatment across multiple years
2. treatment across many episodes.

Each of these criteria required specific values to determine the treatment cohort. Before establishing these treatment criteria, episodes of treatment for another person's alcohol and other drug (AOD) use, or episodes with the main treatment type of 'assessment only' were removed. The goal was specifically to examine people accessing treatment for their own AOD use, and the cohort of interest was people who had received direct AOD treatment over set periods of time, rather than many assessment episodes.

Criteria 1: Treatment across multiple years

To define treatment across multiple years, the smallest possible number of collection periods over which treatment could be considered long-term was identified as a threshold.

Treatment was considered long-term where a person has received treatment over 3 or more collection periods (aligning with financial years), with treatment episodes ending more than a year apart.

Receiving treatment in 2 collection periods or less was not considered sufficient; for example, a client could be counted in 2 separate collection periods if they received 2 episodes in May and August of the same calendar year.

Criteria 2: Treatment across multiple episodes

To define treatment across multiple episodes, the smallest possible number of episodes over which treatment could be considered long-term was identified as a threshold.

Treatment was considered long-term where a client received 11 episodes or more. This threshold was selected as it captures the top quartile of episodes received per client.

Note that this is an adjustment from the methodology previously used in previous AIHW treatment cohort analysis, due to the additional years included in the study period for this report (AIHW 2021).

Defining the treatment cohorts

Using the above criterion, the treatment cohorts were defined as follows in Table 5 illustrates examples of client pathways through treatment that would be assigned to each cohort.

Clients were excluded from treatment intensity cohort analysis if they:

- were referred from another AOD treatment service for their initial episode between 1 July 2013 and 30 June 2014
- received their first recorded closed treatment episode between 1 July 2019 and 30 June 2021.

These criteria ensure that the initial cohort received treatment for their own drug use and did not receive AOD treatment in the 12 months before 1 July 2013. They also ensured that there was enough time for clients to have received treatment in 3 or more collection periods. However, it is important to note that clients may have received treatment before 1 July 2013, and/or continued to receive treatment beyond 30 June 2021. Services accessed in these periods are outside the scope of this report.

Table 5: Definition of AODTS NMDS treatment intensity cohorts

Treatment cohort	Number of collection periods	Number of episodes
Non-recurring	< 3	< 11
Recurring	>3	< 11
Intensive	> 3	> 11

Figure 12: Examples of client pathways through specialist AOD treatment, by treatment intensity cohort

This interactive data visualisation illustrates the timing and number of episodes in 3 different examples of specialist AOD treatment, which are defined as intensive, recurring and non-recurring.

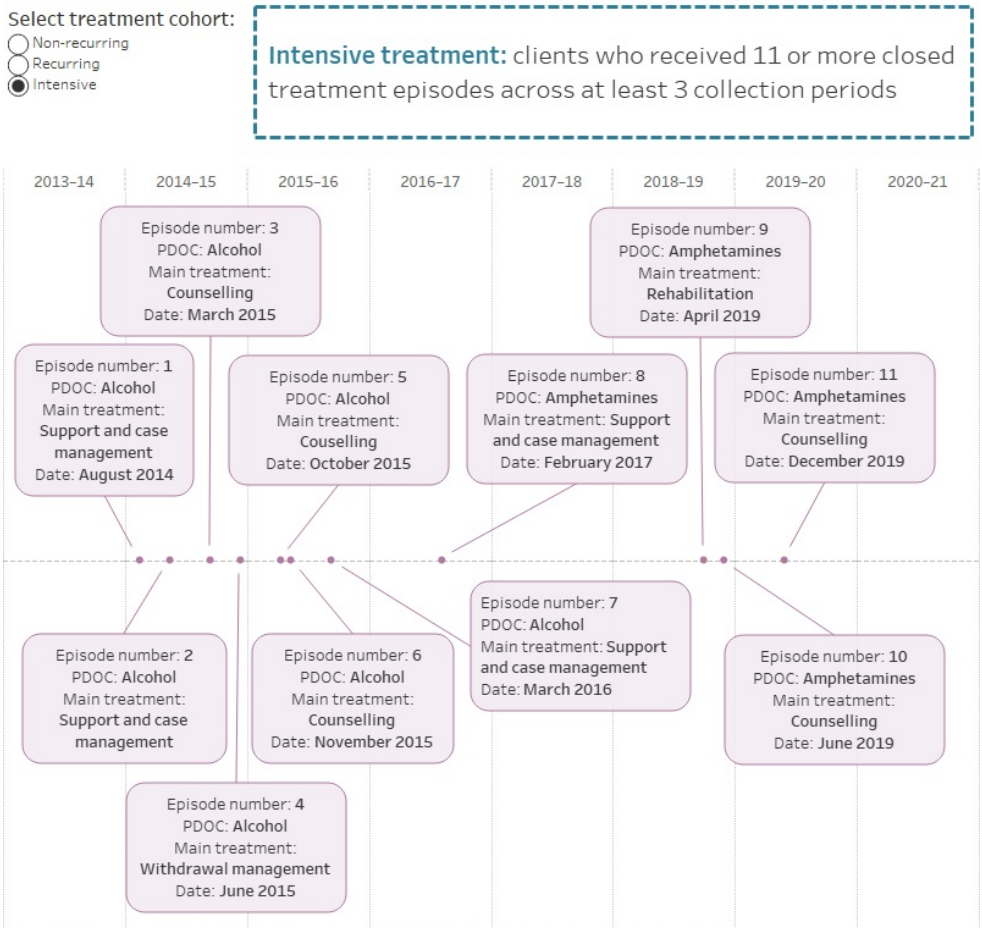

Figure 12: Examples of client pathways through specialist AOD treatment, by treatment intensity cohort
Source: AIHW Alcohol and Other Drug Treatment Services National Minimum Dataset
https://aihw.gov.au

Logistic modelling of jurisdictional differences

States and territories take different approaches to treatment, both in terms of the mix of treatment types offered across treatment services, and how episode data from treatment episodes are recorded. One potential consequence of these differences is that clients in some jurisdictions may, on average, record more or fewer distinct treatment episodes. This in turn means that treatment may be more likely to be categorised as intensive in some jurisdictions than in others.

The AIHW has previously undertaken logistic regression modelling to collection period data between 2014–15 and 2019–20 to determine whether these jurisdictional differences affect national results by treatment cohort *(AIHW 2021)*. To ensure accurate representation of the alcohol and other drugs treatment service client population, a similar logistic regression model was applied to AODTS collection period data between 2013–14 and 2020–21.

Modelling was undertaken to determine whether known treatment and reporting differences between states and territories were influencing the national results of clients receiving intensive, recurring and non-recurring treatment.

For example, while 23% of the clients in the AODTS NMDS recorded treatment in Victoria, 44% of clients receiving intensive treatment were based in Victoria (Table 6). However, it is important to note that Victorian data is not directly comparable with data for other jurisdictions as every treatment type provided is reported as a separate episode, regardless of whether it is a main or additional treatment type. This results in greater numbers of episodes compared to other states and territories, where main and additional treatment types are recorded under a single episode (AIHW 2022).

Table 6: Proportion of clients receiving intensive, recurring and non-recurring treatment by state and territory

State/territory	Intensive treatment (%)	Recurring treatment (%)	Non-recurring treatment (%)	All clients (%)
NSW	25.2	25.5	23.8	24.1
Vic	44.1	23.3	22.7	23.5
Qld	11.1	22.0	23.8	23.2
WA	8.9	17.7	15.6	15.7
SA	4.2	4.4	6.4	6.0

Tas	1.0	2.0	2.1	2.1
ACT	4.2	3.0	2.7	2.8
NT	1.5	2.1	2.8	2.7
Total	**100**	**100**	**100**	**100**

Differences between jurisdictions may affect the generalisability of the results. For example, if clients receiving AOD treatment in one state tend to be younger, and that state is more likely to have clients who received intensive treatment, then there may appear to be a relationship between age and intensive treatment that is purely caused by jurisdictional differences.

Modelling other client and treatment differences

To ensure differences between states and territories are not causing the differences between clients receiving intensive, recurring and non-recurring treatment in this report, a logistic model was applied. This model allows for exploration of the association between personal and treatment-level characteristics, while controlling for potential confounding effects between them. By controlling for state and territory in this model, it is possible to examine whether the other variables were still associated with intensive or recurring treatment.

The likelihood of a client receiving intensive or recurring treatment was modelled against the characteristics of the first two episodes that they received in the study period of 2013–14 and 2018–19 (noting that clients who first entered treatment from 2019–20 onwards are excluded, due to not meeting the minimum requirement of appearing in at least 3 collection periods).

After controlling for state and territory differences, the likelihood of a client receiving intensive or recurring treatment generally aligned with the results prior to controlling for state and territory differences.

References

AIHW (2021). *Patterns of intensive alcohol and other drug treatment service use in Australia: 1 July 2014 to 30 June 2019*. Cat. no. HSE 251. Canberra: AIHW.

AIHW (2022). *Alcohol and other drug treatment services in Australia annual report.*

Data

Related material

Resources

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