Australian Government
Australian Institute of Health and Welfare

AIHW

Patterns of alcohol and other drug treatment service use in Australia

1 July 2014 to
30 June 2018

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The Australian Institute of Health and Welfare is a major national agency whose purpose is to create authoritative and accessible information and statistics that inform decisions and improve the health and welfare of all Australians.

ISBN 978-1-76054-652-6 (Online)

ISBN 978-1-76054-653-3 (Print)

Suggested citation

Australian Institute of Health and Welfare 2019. Patterns of alcohol and other drug treatment service use in Australia: 1 July 2014 to 30 June 2018. Cat. no. HSE 239. 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.

Contents

Summary

Specialist alcohol and other drug (AOD) treatment services are part of a comprehensive approach to reducing demand in Australia—1 of the 3 pillars of harm minimisation that underpin the National Drug Strategy 2017–26.

AOD treatment services provide a broad range of services and support to people affected by substance use. Clients accessing these services commonly experience multiple episodes of treatment spanning several years.

Using the Alcohol and Other Drug Treatment Services National Minimum Data Set, this report looks at the service use patterns of clients who received treatment from publicly funded specialist AOD treatment services between 1 July 2014 and 30 June 2018, for 3 client cohorts:

- continual service users (2,436 clients or 3%)—clients who received at least 1 closed treatment episode in each collection period between 1 July 2014 and 30 June 2018
- episodic service users (24,089 clients or 30%)—clients who received at least 1 closed treatment episode in 2014–15, and at least one other closed treatment episode in at least 1 (but not all) of the 3 years after that
- transitory service users (54,423 clients or 67%)—clients who received at least 1 closed treatment episode in 2014–15 only.

Transitory service users were younger, and were more likely to receive treatment for another person's drug use than other client groups

Transitory service users had the highest proportion of clients aged 10–19 (18%), and the highest proportion of clients treated for another person's drug use (6.8%). Episodic service users had the highest proportion of clients aged 20–29 (29%). Continual service users had the highest proportion of females (36%).

Most continual service users received treatment from multiple agencies, and for a total duration of 12 months or longer

There were fewer continual service users than other client cohorts, but among continual service users, 3 in 4 (75%) clients attended at least 3 agencies, and almost 2 in 3 (64%) received treatment for a total duration of 12 months or longer. More than 1 in 3 (36%) continual service users received 10 or more closed treatment episodes. For transitory service users, the median episode duration was 13 days, almost half that of episodic and continual service users (24 days).

Alcohol was the most common principal drug of concern across service user types

Alcohol was the principal drug of concern in 37% of closed episodes for continual and transitory service users, and in 33% of closed episodes for episodic service users. Transitory service users had the highest proportion of closed episodes where cannabis was the principal drug of concern (32%). Continual service users had the highest proportion of closed episodes where amphetamine (30%) or heroin (7.3%) was the principal drug of concern.

Linking data could provide more comprehensive information

This analysis only looks at clients whose treatment episodes were reported to the AIHW for the period 1 July 2014 to 30 June 2018. Linkage to other data sets might help provide more comprehensive and nuanced information on client circumstances and patterns of service use. Similarly, investigating main treatment type and the reasons why repeat service users cease treatment would provide further understanding of the factors affecting client engagement and retention in treatment.

1 Introduction

In Australia, the use of alcohol and other drugs (AOD) is a major public health concern associated with many adverse outcomes, including injury, mental illness, violence, crime, preventable disease, and death. Substance use has significant health, social, and economic implications for the individuals using alcohol and other drugs, their friends and family, and broader society (AIHW 2019a).

Box 1.1: The cost of alcohol and other drug use in Australia

Health costs

- Tobacco, alcohol, and illicit drug use collectively account for 16% of the total burden of disease in Australia (AIHW 2019b).

Social costs

- In 2015, alcohol and illicit drug use accounted for 22.4% and 3.9%, respectively, of the total burden of motor vehicle occupant road traffic injuries, and 27.7% and 4.8%, respectively, of the total burden of motorcycle road traffic injuries (AIHW 2019c).
- More than half (55%) of adults who had experienced physical assault in the previous 12 months believed alcohol and other substance were contributing factors (ABS 2019).

Economic costs

- In 2004–05, the total cost of substance use to Australian society was estimated at $55.2 billion. This comprised nearly $30.5 billion in tangible costs (including crime, health, productivity, and road accidents), and $24.7 billion in intangible costs (including pain and suffering from road accidents and loss of life) (Collins & Lapsley 2008).

1.1 Policy context

Substance use is a chronic and recurring issue for many individuals, meaning treatment is often long-lasting, multifaceted, and complex (Best & Lubman 2012; Dennis & Scott 2012; Scott et al. 2005; Weisner et al. 2003). Clients accessing specialist AOD services commonly have multiple episodes of treatment, often at several points in time (Dennis & Scott 2012; Lundgren et al. 2006).

While AOD clients who repeatedly seek treatment commonly have more severe AOD problems than less frequent service users, repeat service use should not be seen as a failure (Best & Lubman 2012; Lundgren et al. 2006). This is because each treatment episode aims to support better management and control of substance use, bringing clients closer to their overarching treatment goals (Weisner et al. 2003).

The Australian Government recognises substance use as an important policy issue. This is established in the National Drug Strategy 2017–26, which provides a national framework for building safe, healthy, and resilient Australian communities by preventing and minimising AOD-related health, social, and economic harms among individuals, families and communities.

The strategy articulates a balanced approach across the 3 pillars of harm minimisation—demand, supply, and harm reduction actions (Department of Health 2018). Understanding the patterns of AOD treatment service use can help to inform the evidence-base for policymakers, service managers, and practitioners alike, so that they can better tailor services and interventions aimed at treating problematic AOD use.

1.2 Alcohol and other drug treatment services

AOD treatment services across Australia provide a broad range of services and support to people affected by substance use, including families and friends seeking support for another person's substance use. These treatment services aim to reduce the harms associated with problematic substance use. People commonly receive treatment for the use of 1 or more substances, the most common of which are alcohol, amphetamines, cannabis, and heroin (AIHW 2019d).

The Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) is collected by the Australian Institute of Health and Welfare (AIHW) to inform policy and optimise service provision (AIHW 2019d).

See Box 1.2 for information about the AODTS NMDS.

Box 1.2: Alcohol and Other Drug Treatment Services National Minimum Data Set

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government agencies.

Clients include people who are seeking assistance for their own drug use, and those seeking assistance for someone else's drug use. Information on clients are included in the AODTS NMDS when a treatment episode provided to a client is closed (see Glossary).

Data are collected by treatment agencies, and forwarded to the relevant state and territory health departments, who extract the data according to the specifications in the AODTS NMDS. Data are submitted to the AIHW annually for national collation and reporting.

The AODTS NMDS does not contain a unique identifier for clients—and instead information about clients is collected at the episode level only. However, for the 2012–13 collection, a statistical linkage key (SLK) was introduced to enable the number of individual clients receiving treatment to be estimated.

The SLK is constructed from information about the client's date of birth, sex, and an alpha code based on selected letters of their name.

Imputation was applied for selected key AODTS NMDS data items in instances where the response rate fell below an agreed cut-off in the states and territories. Imputation was undertaken for the 2012–13, 2013–14, and 2015–16 collections (see the relevant data quality statements for previous collection years for more detail). Analysis of the SLK data showed that approximately 98% of national data contained a valid SLK in 2017–18, reflecting high response rates and improved SLK quality for all jurisdictions.

The analysis in this report is based on AODTS NMDS data from 2013–14 to 2017–18. This is because, as a pilot collection, the 2012–13 SLK has data quality issues.

People receive treatment for AOD-related issues in various settings that are not in scope for inclusion in the AODTS NMDS. These include:

- services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding
- services whose sole function is to prescribe or provide dosing for opioid pharmacotherapy
- AOD treatment units in acute care or psychiatric hospitals that provide treatment only to admitted patients
- treatment services based in prisons, correctional facilities and detention centres
- primary health-care services, including general practitioner settings, community-based care, Aboriginal and Torres Strait Islander-specific primary health-care services, and Indigenous-specific dedicated substance use services

- health promotion services (for example, needle and syringe programs) and accommodation services (for example, halfway houses and sobering-up shelters).

Although the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government agencies, it is difficult to fully quantify the scope of AOD services in Australia. Ritter et al. (2014) reported that AOD treatment comprises 1.6 million episodes, services or contacts each year. Of this, the AODTS NMDS accounts for an estimated 10% of treatment episodes, and between 20%–30% of individual clients who received AOD treatment in Australia (Ritter et al. 2014).

1.3 Purpose of this report

The purpose of this report is to analyse the service use patterns of clients who received treatment from publicly funded (specialist) AOD treatment services. This is important for effectively tailoring treatment services, efficiently distributing resources, and informing targeted interventions to better support client needs.

To our knowledge, this study is the first to use national administrative data to look at the patterns of AOD treatment service use in Australia. As such, this report aims to:

- generate a preliminary understanding about the treatment service patterns of clients of publicly funded AOD treatment services
- address a gap in knowledge about patterns of AOD service use that has previously been unexplored at the national level in Australia, particularly using data captured in the AODTS NMDS.

To achieve this, this report categorises the service use patterns of clients, and looks at the:

- proportion of clients that fall into each service user category
- characteristics of different types of service users
- principal drug of concern that led clients to seek AOD treatment
- patterns and duration of service engagement.

Clients can receive treatment for their own or someone else's drug use (see Glossary). This report includes both client types, however information about principal drug of concern is only presented for clients receiving treatment for their own drug use.

1.4 Types of service users

This report focuses on the 80,948 clients whose first AOD treatment episode was closed between 1 July 2014 and 30 June 2015.

Three cohorts of clients were then identified based on their service use over this timeframe and the subsequent 3 collection periods (that is, each financial year from 1 July 2014 to 30 June 2018) (Figure 1). These were:

- **continual service users**—clients who received at least 1 closed treatment episode in each of the 4 collection periods between 1 July 2014 and 30 June 2018
- **episodic service users**—clients who received at least 1 closed treatment episode between 1 July 2014 and 30 June 2015, and at least 1 other closed treatment episode in at least 1, but not all, of the subsequent 3 collection periods (1 July 2015 to 30 June 2016, 1 July 2016 to 30 June 2017 and 1 July 2017 to 30 June 2018)
- **transitory service users**—clients who received at least 1 closed treatment episode in the period from 1 July 2014 to 30 June 2015, but did not receive any closed treatment episodes in any of the subsequent 3 collection periods between 1 July 2015 and 30 June 2018.

Clients were excluded from the analysis if they:

- received a treatment episode closed between 1 July 2013 and 30 June 2014
- were referred from another AOD service for their initial treatment episode in the 2014–15 collection period.

These criteria ensured that the initial cohort did not receive AOD treatment in the 12 months before 1 July 2014, so were not continuing service users from the 2013–14 collection period (Figure 1.1).

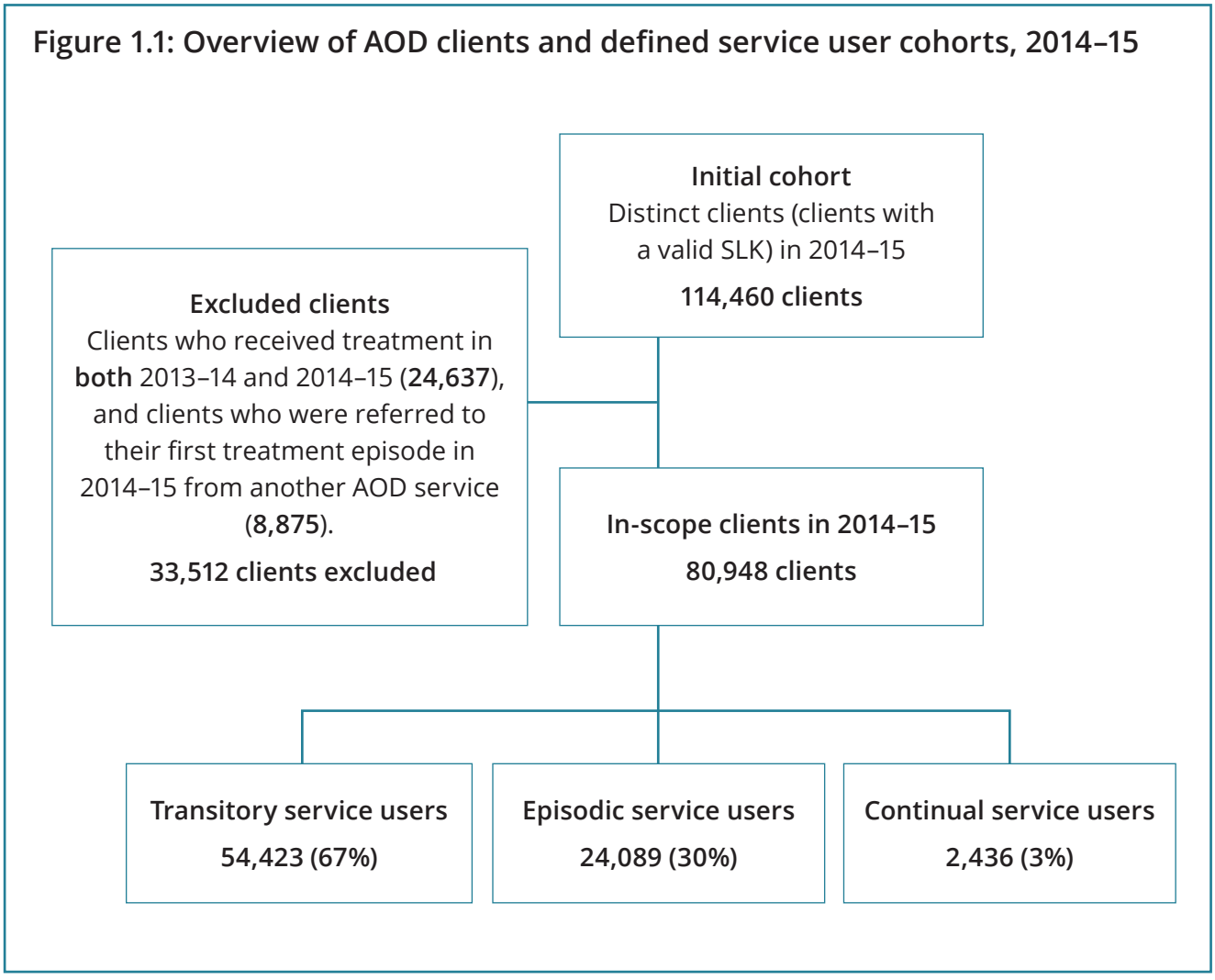
However, clients from all 3 cohorts might have received treatment before 1 July 2013, and might have continued to receive treatment beyond 30 June 2018. Services received in these periods are outside the scope of this report. Clients who began treatment in 2014–15, but did not have their episode of treatment closed until a subsequent collection period (for example, in 2015–16 or later) are not included in this analysis, as 2014–15 is the reference collection.

About 2 in 3 (67%) clients received at least 1 closed treatment episode in the initial 2014–15 collection period only (transitory service users).

Almost 1 in 3 (30%) of clients received a treatment episode in 2014–15, and at least once more over the following 3, but not all, collection periods (episodic service users).

Only 3% of clients received a closed treatment episode in each of the 4 collection periods to 2017–18 (continual service users).

Figure 1.1: Overview of AOD clients and defined service user cohorts, 2014–15



2 Comparative findings

This report looks at the service use patterns of 3 distinct cohorts of AOD treatment service clients—continual, episodic, and transitory service users.

Key findings

- Alcohol was the most common principal drug of concern for all service user groups (about one-third of closed treatment episodes).
- Continual service users had the highest proportion of heroin and amphetamines as a principal drug of concern, and the lowest for cannabis.
- Transitory service users had the highest proportion of cannabis as a principal drug of concern, and the lowest for heroin and amphetamines.
- Across the total cohort, while many clients reported multiple treatment episodes, nearly 3 in 5 (57%) clients received only 1 treatment episode.
- Continual and episodic service users had 1.8 times the median episode duration of transitory service users (24 and 13 days, respectively).

2.1 Client profile

Across the total cohort:

- the majority (68%) of clients were male
- clients were most commonly (29%) aged 20–29
- about 1 in 7 (14% or 11,500) clients identified as Aboriginal or Torres Strait Islander
- most (94%) clients sought treatment for their own drug use
- the majority (86%) of clients were born in Australia, followed by New Zealand (2.8%), and the United Kingdom (2.7%)
- English was the most common (95%) preferred language (Table 2.1).

While client demographics remained relatively consistent across all 3 service user groups, there were differences between groups (Table 2.1).

Continual service users

Compared with transitory and episodic service users, continual service users had:

- the highest proportion (36%) of females
- the highest proportion (32%) of clients aged 30–39.

Episodic service users

Compared with continual and transitory service users, episodic service users had:

- the highest proportion (29%) of clients aged 20–29
- the highest proportion (17% or 4,000) of clients who identified as Indigenous.

Transitory service users

Compared with continual and episodic service users, transitory service users had:

- the highest proportion of clients aged 10–19 (18%), and 50 and over (14%)
- the lowest proportion (13% or 7,200) of clients who identified as Indigenous
- the highest proportion (6.8%) of clients treated for another person's drug use.

Table 2.1: AOD treatment service users profile, by selected characteristics, 2014–15 (%)

Characteristics		Continual (2,436)	Episodic (24,089)	Transitory (54,423)	Total cohort (80,948)
Sex	Male	64.0	67.9	68.3	68.0
	Female	36.0	32.1	31.6	31.9
	Not stated	0.0	0.0	0.1	0.1
Age	10–19	11.0	13.6	18.0	16.5
	20–29	28.0	29.3	28.3	28.6
	30–39	31.7	28.6	22.2	24.4
	40–49	20.1	18.2	17.3	17.6
	50–59	7.2	7.5	9.2	8.7
	60 and over	2.1	2.9	5.1	4.4
Indigenous status	Indigenous	14.4	16.5	13.3	14.3
	Non-Indigenous	80.3	77.6	79.1	78.7
	Not stated	5.4	6.0	7.6	7.1
Client type	Own drug use	97.9	96.8	93.2	94.4
	Other's drug use	2.1	3.2	6.8	5.6
Country of birth	Australia	89.1	88.4	84.9	86.1
	New Zealand	1.7	2.3	3.0	2.8
	United Kingdom	2.1	2.4	2.8	2.7
	All other countries	5.7	5.4	7.5	6.8
Preferred language	English	96.6	95.9	94.7	95.1

Sources: Tables SC.2,SC.3, SC.4, SC.5, SC.6, and SC.7.

2.2 Principal drug of concern

Overall, alcohol, amphetamines, cannabis, and heroin were the 4 most common principal drugs of concern for which AOD treatment was sought by clients being treated for their own drug use across all 3 service user types.

While alcohol was the most common principal drug of concern across all 3 service user types, the proportion for continual and transitory service users varied (Table 2.2).

Continual service users

Compared with transitory and episodic service users, continual service users had:

- the highest proportion of closed treatment episodes where amphetamine (30%) and heroin (7%) was the principal drug of concern
- the lowest proportion of closed treatment episodes where cannabis (15%) was the principal drug of concern.

Transitory service users

Compared with continual and episodic service users, transitory service users had:

- the highest proportion of closed treatment episodes where cannabis (32%) was the principal drug of concern
- the lowest proportion of closed treatment episodes where amphetamines (16%) and heroin (3.5%) was the principal drug of concern.

Table 2.2: AOD treatment episodes provided for own drug use, by principal drug of concern and service user type, 2014–15 to 2017–18 (%)

Principal drug of concern	Continual (22,720)	Episodic (86,232)	Transitory (65,354)	Total cohort (174,306)
Alcohol	36.7	33.2	36.5	34.8
Amphetamines	29.7	27.2	15.9	23.4
Cannabis	14.9	20.6	31.5	23.8
Heroin	7.3	6.1	3.5	5.3

Source: Table SE.2.

Alcohol

The majority (48%) of closed treatment episodes for alcohol were provided to episodic service users, followed by transitory (38%), and continual (14%) service users.

Amphetamines

The majority (58%) of closed treatment episodes for amphetamines were provided to episodic service users, followed by transitory (25%), and continual (17%) service users.

Cannabis

The majority (48%) of closed treatment episodes were provided to transitory service users, followed by episodic (43%), and continual (8.3%) service users.

Heroin

The majority (58%) of closed treatment episodes for heroin were provided to episodic service users, followed by transitory (24%), and continual (18%) service users.

2.3 Remoteness area

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure (ABS 2011) to analyse the remoteness area of the treatment service and of the client (see Glossary).

Across the total cohort:

- the highest proportion of closed treatment episodes were provided in *Major cities* (70%) (Table 2.3)
- the proportion of female service users was highest (35%) among clients living in *Remote and very remote* areas (Table RA.4)
- the proportion of clients identifying as Indigenous was highest (61%) among clients living in *Remote and very remote* areas (Table RA.6)
- the highest proportion of treatment episodes where heroin (7%) and amphetamines (25%) were the principal drugs of concern were provided in *Major cities*
- the highest proportion (28%) of closed episodes where cannabis was the principal drug of concern were provided in *Inner regional* areas
- the highest proportion (61%) of closed episodes where alcohol was the principal drug of concern were provided in *Remote and very remote* areas (Table RA.2).

Treatment service patterns by remoteness area remained relatively consistent across the 3 service users groups. However, there were demographic differences for continual and episodic service users.

Continual service users

Compared with transitory and episodic service users, continual service users had the highest proportion of females living in *Remote and very remote* areas (40%) (Table RA.4).

Episodic service users

Compared with continual and transitory service users, episodic service users had the highest proportion of Indigenous clients (73%) living in *Remote and very remote* areas (Table RA.6).

Table 2.3: Episode-based AOD treatment service use, by remoteness area of agency and type of service user, 2014–15 to 2017–18 (%)

Remoteness area	Continual (22,720)	Episodic (86,232)	Transitory (65,354)	Total cohort (174,306)
Major cities	75.3	69.6	67.6	69.6
Inner regional	14.2	16.2	16.0	15.9
Outer regional	8.2	10.3	11.8	10.6
Remote and very remote	2.3	3.9	4.6	3.9
Regional and remote	*24.7*	*30.4*	*32.4*	*30.4*

Source: Tables RA.1.

2.4 Engagement with services

Across the total cohort:

- self/family was the most common initial source of referral
- nearly 3 in 5 (57%) clients received 1 treatment episode
- the majority (89%) of clients attended 1 or 2 treatment agencies
- 1 in 4 (25%) clients received treatment for a total duration of 1 day (tables 2.4 and 2.5; Figure 2.1).

Patterns of service engagement were similar across all 3 service user groups, but there were some differences.

Continual service users

Compared with episodic and transitory service users, continual service users had the highest proportion (47%) of treatment episodes in 2014–15 where the initial source of referral was self/family.

Continual service users accessed treatment through a higher number of agencies, and had a longer total duration of treatment than transitory and episodic users.

Among continual service users:

- 1 in 3 (36%) received 10 or more closed treatment episodes
- 3 in 4 (75%) attended at least 3 agencies
- more than 1 in 3 (35%) received treatment for a total duration of 12–24 months
- the median episode duration was 24 days, this was the same as episodic service users and 1.8 times that of transitory service users (13 days) (tables 2.4 and 2.5; Figure 2.1).

Episodic service users

Compared with continual and transitory service users, episodic service users had the highest proportion (14%) of treatment episodes in 2014–15 where the initial source of referral was corrections.

Episodic service users had shorter total duration of treatment than continual service users, but a longer total duration of treatment than transitory service users, with:

- nearly 9 in 10 (87%) episodic service users received 2–5 closed treatment episodes
- more than 2 in 5 (44%) attended 2 agencies
- more than 1 in 5 (23%) received treatment for a total duration of 6–<12 months
- the median episode duration being 24 days, the same as continual service users and 1.8 times that of transitory service users (13 days) (tables 2.4 and 2.5; Figure 2.1).

Transitory service users

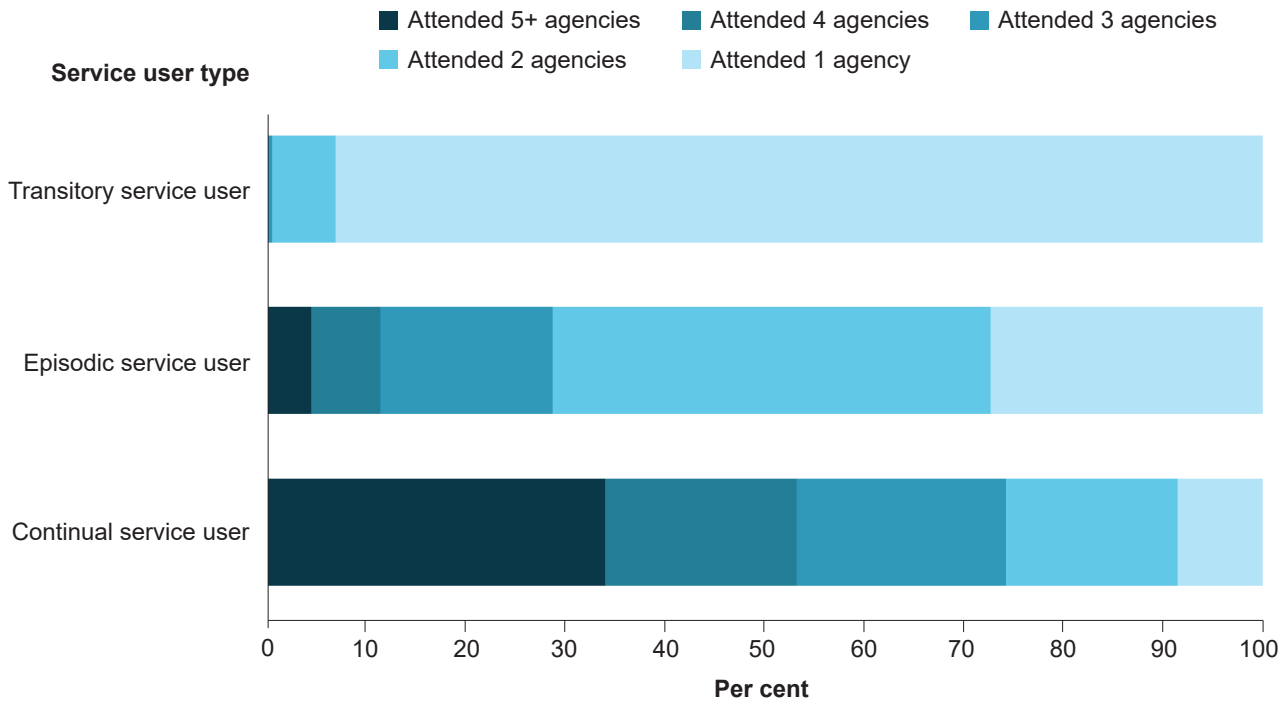
Compared with continual and episodic service users, transitory service users had the highest proportion (31%) of treatment episodes in 2014–15 where the initial source of referral was diversion (Table 2.4).

Transitory service users had the shortest total duration of treatment, and attended the lowest number of agencies of all service user groups, with:

- more than 4 in 5 (85%) transitory service users received 1 closed treatment episode
- more than 9 in 10 (93%) attended 1 agency
- more than 1 in 3 (36%) received treatment for a total duration of 1 day
- the median episode duration being 13 days, 1.8 times shorter than that of episodic and continual service users (24 days) (tables 2.4 and 2.5; Figure 2.1).

The differences in service engagement between the continual, episodic, and transitory service users could be attributed to several factors, with a potential explanation being the type/s of treatment a client receives. While outside the scope of this bulletin, the most common main treatment types across each of the 3 service user cohorts could be an important avenue for future analysis.

Figure 2.1: Clients, by service user type and number of agencies attended, 2014–15 to 2017–18 (%)



Source: Table SC.15.

Table 2.4: Episode-based AOD treatment service use, by source of referral, duration, and service user type, 2014–15 to 2017–18 (%)

		Continual (22,720)	Episodic (86,232)	Transitory (65,354)	Total cohort (174,306)
Initial source of referral[(a)]	Self/family	46.6	39.6	33.6	35.8
	Health service	19.5	18.2	18.0	18.1
	Corrections	9.9	13.6	9.4	10.7
	Diversion	14.5	19.7	31.1	27.2
	Other	9.4	8.9	8.0	8.3
Median episode duration (days)		24	24	13	20

(a) Refers to source of referral at initial episode in the 2014–15 collection period.

Sources: Tables SE.7 and SE.8.

Table 2.5: Client-based AOD treatment service use by agency, closed treatment episodes, duration and service user type, 2014–15 to 2017–18 (%)

		Continual (2,436)	Episodic (24,089)	Transitory (54,423)	Total cohort (80,948)
Number of agencies attended	1	8.1	27.0	92.8	70.6
	2	17.2	44.0	6.3	17.9
	3	21.1	17.4	0.8	6.3
	4	19.2	6.9	0.1	2.7
	5+	34.4	4.8	0.0	2.5
Number of closed episodes	1	0.0	0.0	85.3	57.3
	2	0.0	39.7	11.3	19.4
	3	0.0	24.9	2.3	9.0
	4	9.4	14.3	0.7	5.0
	5	13.5	7.9	0.2	2.9
	6	13.2	4.6	0.1	1.8
	7	12.2	2.9	0.0	1.3
	8	9.0	1.9	0.0	0.8
	9	7.2	1.2	0.0	0.6
	10+	35.6	2.5	0.0	1.8
Total duration of treatment	1 day	0.0	0.0	36.4	24.5
	2 days– <1 month	2.5	17.8	19.9	18.8
	1–<3 months	3.8	16.2	21.5	19.4
	3–<6 months	9.2	21.8	13.4	15.8
	6–<12 months	20.9	23.4	5.6	11.4
	12–<24 months	34.6	14.6	1.9	6.7
	24+ months	29.2	6.3	1.2	3.6

Sources: Tables SC.15, SC.16, and SC.17.

2.5 Overview of similarities and differences across service user groups

While there were subtle differences between the 3 groups in principal drugs of concern and some aspects of service use, such as median duration of closed episodes, overall there were many similarities. This evidence generates useful insight about the complexities of characterising continual, episodic, and transitory service users.

Due to the descriptive nature of this analysis, it is difficult to infer whether certain patterns are unique to 1 service user group. Further research is required to gain a more comprehensive understanding of the patterns of AOD treatment service use in Australia.

The following chapters provide a descriptive summary of each of the 3 service user cohorts.

3 Continual service users

Continual service users are clients who received at least 1 closed treatment episode in each collection period between 1 July 2014 and 30 June 2018.

Continual service users accounted for 3.0% of the total cohort, and 13% of total episodes.

Of the 2,436 continual service users:

Nearly 2 in 3 (64%) were male.

Nearly 1 in 3 (32%) were aged 30–39.

1 in 7 (14% or 350) identified as Indigenous.

3 in 4 (75%) closed episodes were provided in *Major cities*.

1 in 3 (36%) received 10 or more closed treatment episodes.

3 in 4 (75%) attended at least 3 agencies.

More than 1 in 3 (35%) received treatment for total duration 12–<24 months.

The median episode duration was 24 days.

Top 4 principal drugs of concern:

37% Alcohol

30% Amphetamines

15% Cannabis

7.3% Heroin

3.1 Who were continual service users?

Client profile

Continual service users accounted for 3.0% of the total cohort, and 13% of total episodes (tables SC.1 and SE.1). Among all continual service users, 64% of clients were male and 36% were female (Table SC.3).

Client type

Clients can receive treatment for their own or someone else's drug use (see Glossary). Of all continual service users, 98% received treatment for their own drug use, and 2.1% received treatment for someone else's drug use (Table SC.2).

Continual service users who received treatment for their own drug use were more likely to be male (64%), aged 30–39 (32%), and non-Indigenous (80%) (tables SC.8, SC.9, and SC.10). Comparatively, continual service user clients receiving treatment for someone else's drug use were more likely to be female (57%), and aged either 20–29 or 40–49 (both 25%) (tables SC.8 and SC.9).

Indigenous status

About 1 in 7 (14% or 350) continual service users identified as Indigenous. Of these clients:

- 58% were male, and 42% were female (Table SC.12)
- 97% sought treatment for their own drug use, and 3.1% sought treatment for someone else's drug use (Table SC.11)
- 31% were aged 20–29, and 29% were aged 30–39 (Table SC.13).

Age

In 2014–15, nearly 1 in 3 (32%) continual service users were aged 30–39 (Table SC.4). Male continual service users were most commonly aged 30–39 (32%), whereas female continual service users were most commonly aged either 20–29 or 30–39 (both 31%) (Table 3.1).

Table 3.1: Continual service users, by age and sex, 2014–15 (%)

Age	Male	Female
10–19	12.0	9.1
20–29	26.3	30.9
30–39	32.4	30.6
40–49	19.2	21.6
50–59	7.8	6.3
60+	2.4	1.5

Source: Table SC.14.

3.2 For which principal drugs of concern did continual service users seek treatment?

Alcohol was the most common principal drug of concern (37% of closed treatment episodes) for which clients sought treatment for their own use, followed by amphetamines (30%), cannabis (15%), and heroin (7.3%) (Table SE.2).

Among male continual service users, alcohol was the most common principal drug of concern (37% of closed episodes), followed by amphetamines (28%), and cannabis (15%). These proportions were similar for female continual service users, whose most common principal drug of concern was also alcohol (36%), followed by amphetamines (32%), and cannabis (14%) (Table SE.3).

About 3,100 closed treatment episodes were provided to continual service users who identified as Indigenous. Among those service users, amphetamines were the most common principal drugs of concern (33% of closed episodes), followed by alcohol (30%), cannabis (20%), and heroin (6.7%) (Table SE.4).

3.3 How did continual service users engage with services?

Service use

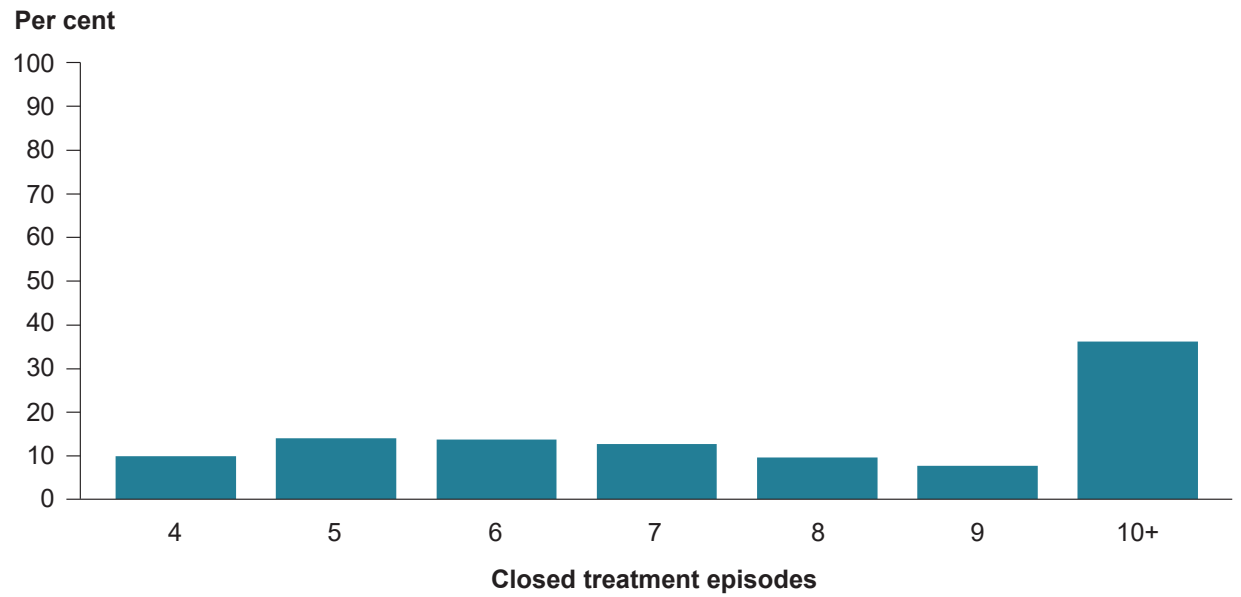
A total of 22,720 closed treatment episodes were provided to 2,436 continual service users from 2014–15 to 2017–18 (tables SE.1 and SC.1).

Compared with other service user types:

- the number of agencies was highest among continual service users, with 75% of clients attending at least 3 agencies over the 4 collection periods (Table SC.15)
- the proportion of clients (34%) attending 5 or more treatment agencies was highest among continual service users (Table SC.15)
- continual service users received treatment for longer durations, with 35% of clients receiving treatment for a total duration of 12–<24 months, 29% receiving treatment for 24 months and over, and 21% receiving treatment for 6–<12 months (Table SC.17)
- continual service users had a median episode duration of 24 days—23 days for those receiving treatment for their own drug use, and 42 days for those receiving treatment for another person's drug use (Table SE.8)
- the average number of closed episodes per client was highest among continual service users (9.3 episodes per client).

More than 1 in 3 (36%) continual service users reported receiving 10 or more closed episodes across the 4 collection periods (Figure 3.1). The higher number of closed treatment episodes per client for continual service users is, in part, due to this cohort receiving AOD treatment in each financial year of the reporting period.

Figure 3.1: Continual service users, by number of closed treatment episodes, 2014–15 to 2017–18 (%)



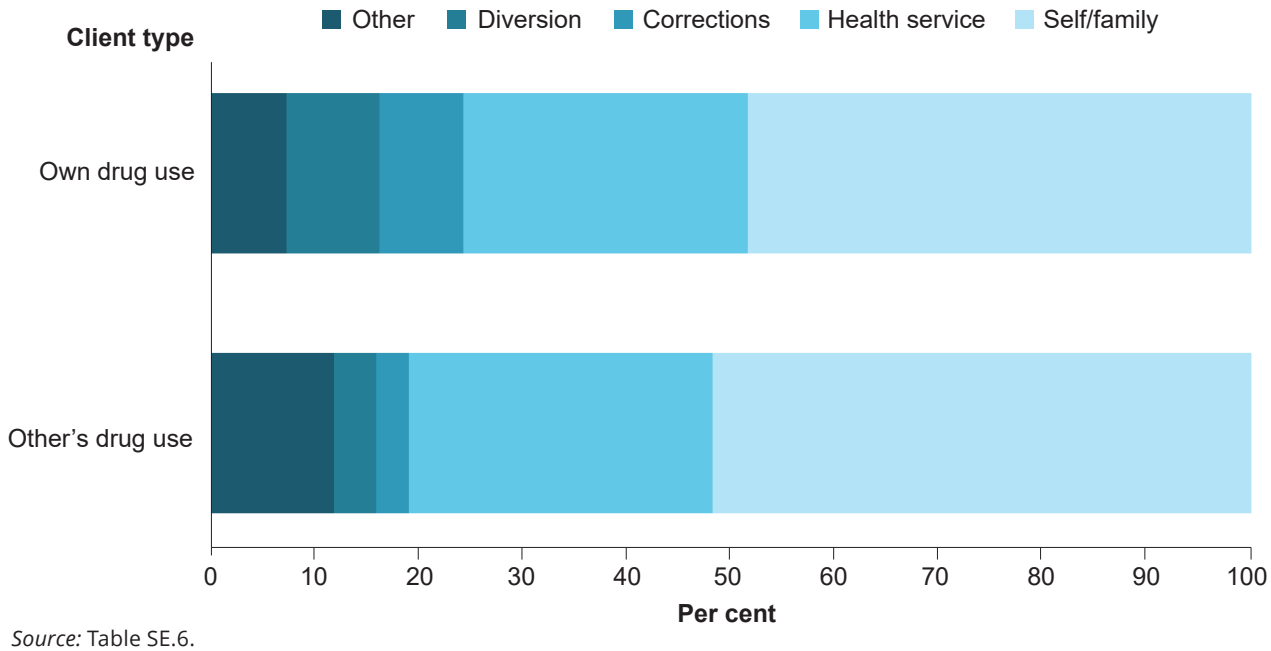
Source: Table SC.16.

Source of referral

Nearly half (47%) of continual service users were referred to their initial treatment episode in 2014–15 by themselves or family, followed by a health service (20%), diversion (15%), and corrections (9.9%) (Table SE.7).

Among continual service users who received treatment for their own drug use, the most common source of referral across all treatment episodes in 2014–15 to 2017–18 was themselves or family (48%), followed by a health service (27%), diversion (9.0%), and corrections (8.1%). Just over half (51%) of continual service users who received treatment for someone else's drug use were referred via themselves or family (Figure 3.2).

Figure 3.2: Closed treatment episodes provided to continual service users, by client type and source of referral, 2014–15 to 2017–18 (%)



Source: Table SE.6.

3.4 Where did continual service users live and access treatment?

Among continual service users:

- the majority (70%) of closed treatment episodes were provided by non-government agencies (Table SE.5)
- three-quarters (75%) of closed episodes were provided in *Major cities*, followed by *Inner regional* areas (14%), and *Outer regional* areas (8.2%) (Table RA.1)
- while the proportion of female continual service users (36%) was slightly higher than that for all female service users (32%), a higher proportion of female continual service users living in *Outer regional* and *Remote and very remote* areas (both 40%) received treatment than those living in *Major cities* (35%) and *Inner regional* areas (37%) (Table RA.4)
- age distribution varied among remoteness areas, with:
  - the majority of continual service users living in *Major cities, Outer regional* areas, and *Remote and very remote* areas being aged 30–39, and the majority of clients in *Inner regional* areas being aged 20–29
  - *Remote and very remote* areas having the highest proportion of clients aged 10–19 (23%), more than twice the proportion of all other remoteness areas (Table RA.5) (this might reflect specific issues for this age group in these areas, which might warrant further investigation)
- the proportion of continual service users who identified as Indigenous was highest for those living in *Remote and very remote* areas (64%), followed by *Outer regional* areas (30%), *Inner regional* areas (16%), and *Major cities* (8%) (Table RA.6).

3.5 Case study 1: Continual service user

Ashleigh, 26, experienced traumas as a child, becoming disengaged, anxious, and depressed. She left home and school early, and stayed with her sister or friends. A boyfriend introduced her to amphetamines, which she smoked regularly. When Ashleigh experienced a psychotic episode in her early 20s, she was taken to hospital. An alcohol and other drug clinical liaison nurse referred her to a local treatment service. Although she felt wary, Ashleigh attended her appointment. Her counsellor used a number of techniques to put her at ease as they completed paperwork, and Ashleigh answered questions about her history, her drug use, and her physical and mental health.

During the next few appointments, Ashleigh and her counsellor created a care plan that encouraged Ashleigh to set realistic goals about what she wanted to achieve. When Ashleigh explained that she didn't feel ready to stop using amphetamines, her counsellor provided her with harm reduction information.

Ashleigh moved to the country. She found it difficult to settle and make new friends, and her drug use continued. Her mother died, she had some bad experiences with new acquaintances, and she started injecting drugs. Over several years, Ashleigh moved 4 times and engaged with 3 different alcohol and other drug treatment services. Counsellors from the different services supported her to set goals, provided information and support, and referred her to various services for bloodborne virus screening, housing, and emergency relief.

Counsellors found Cognitive Behavioural Therapy and a trauma-informed approach to be effective in their work with Ashleigh. Although Ashleigh attended these treatment services sporadically, she did reduce her use. When police found her in possession of drugs, Ashleigh chose to accept the opportunity to engage in alcohol and other drug treatment through a diversion program. Ashleigh continued with counselling after completing the program, due to the strong rapport she had developed with her counsellor.

Ashleigh decided to move on once more to be with her sister. Her counsellor referred her to a service in the new location, and, with her consent, sent Ashleigh's details to the service, so that she did not have to repeat her story. When her anxiety and cravings increased, Ashleigh approached the new service, as she felt it was time to explore the option of residential treatment. Ashleigh is now accessing group therapies and individual counselling in preparation for a residential program. The service has supported Ashleigh to organise her finances, and she feels committed to attend residential treatment knowing it will be an intensive program.

* This case story is not based on an actual person. It is based on de-identified data collated from the patterns of AOD treatment service use cohort analyses. It is intended to present an example of a 'typical' continual service user to demonstrate common patterns of service use for this cohort. The experience of each individual client is different.

4 Episodic service users

Episodic service users are clients who received at least 1 closed treatment episode between 1 July 2014 and 30 June 2015, and another closed treatment episode in at least 1 (but not all) of the 3 collection periods after that (between 1 July 2015 and 30 June 2018).

Episodic service users accounted for 30% of the total cohort, and 49% of total episodes.

Of the 24,089 episodic service users:

More than 2 in 3 (68%) were male.

2 in 7 (29%) were aged 20–29.

1 in 6 (16% or 3,900) identified as Indigenous.

70% of closed episodes were provided in *Major cities*.

Nearly 9 in 10 (87%) received 2–5 closed treatment episodes.

More than 2 in 5 (44%) attended 2 agencies.

More than 1 in 5 (23%) received treatment for total duration 6–<12 months.

Top 4 principal drugs of concern:

33% Alcohol

27% Amphetamines

21% Cannabis

6.1% Heroin

4.1 Who were episodic service users?

Client profile

Episodic service users accounted for 30% of the total cohort, and 49% of total episodes (tables SC.1 and SE.1). Among all episodic service users, 68% of clients were male and 32% were female (Table SC.3).

Client type

Clients can receive treatment for their own or someone else's drug use (see Glossary). Of all episodic service users, 97% received treatment for their own drug use, and 3.2% received treatment for someone else's drug use (Table SC.2).

Episodic service user clients who received treatment for their own drug use were more likely to be male (69%), aged 20–29 (30%), and non-Indigenous (78%) (tables SC.8, SC.9, and SC.10). Comparatively, episodic service user clients receiving treatment for someone else's drug use were more likely to be female (59%), and aged 50–59 (19%) or 10–19 (18%) (tables SC.8 and SC.9).

Indigenous status

About 1 in 6 (16% or 3,900) episodic service users identified as Indigenous (Table SC.5). Of these clients:

- 64% were male, and 36% were female (Table SC.12)
- 97% sought treatment for their own drug use, and 3.0% sought treatment for someone else's drug use (Table SC.11)
- 33% were aged 20–29, and 28% were aged 30–39 (Table SC.13).

Age

About 2 in 7 (29%) episodic service users were aged 20–29 (Table SC.4). Male episodic service users were most commonly aged 20–29 (30%), whereas female episodic service users were most commonly aged 30–39 (29%) (Table 4.1).

Table 4.1: Episodic service users, by age and sex, 2014–15 to 2017–18 (%)

Age	Male	Female
10–19	14.4	11.8
20–29	30.2	27.3
30–39	28.4	29.0
40–49	17.8	19.0
50–59	6.8	9.0
60+	2.4	3.9

Source: Table SC.14.

4.2 For which principal drugs of concern did episodic service users seek treatment?

Alcohol was the most common principal drug of concern (33% of closed treatment episodes) for which clients sought treatment for their own use, followed by amphetamines (27%), cannabis (21%), and heroin (6.1%) (Table SE.2).

Among male episodic service users, alcohol was the most common principal drug of concern (32% of closed episodes), followed by amphetamines (27%), and cannabis (21%). This was similar among female episodic service users, whose most common principal drug of concern was also alcohol (35%), followed by amphetamines (27%), and cannabis (19%) (Table SE.3). Female episodic service users had a higher proportion of alcohol, and lower proportion of cannabis as their principal drug of concern than male episodic service users.

About 14,000 closed treatment episodes provided to episodic service users who identified as Indigenous. Among those service users, alcohol was the most common principal drug of concern (37% of closed episodes), followed by cannabis (24%), amphetamines (24%), and heroin (4.5%) (Table SE.4).

4.3 How did episodic service users engage with services?

Service use

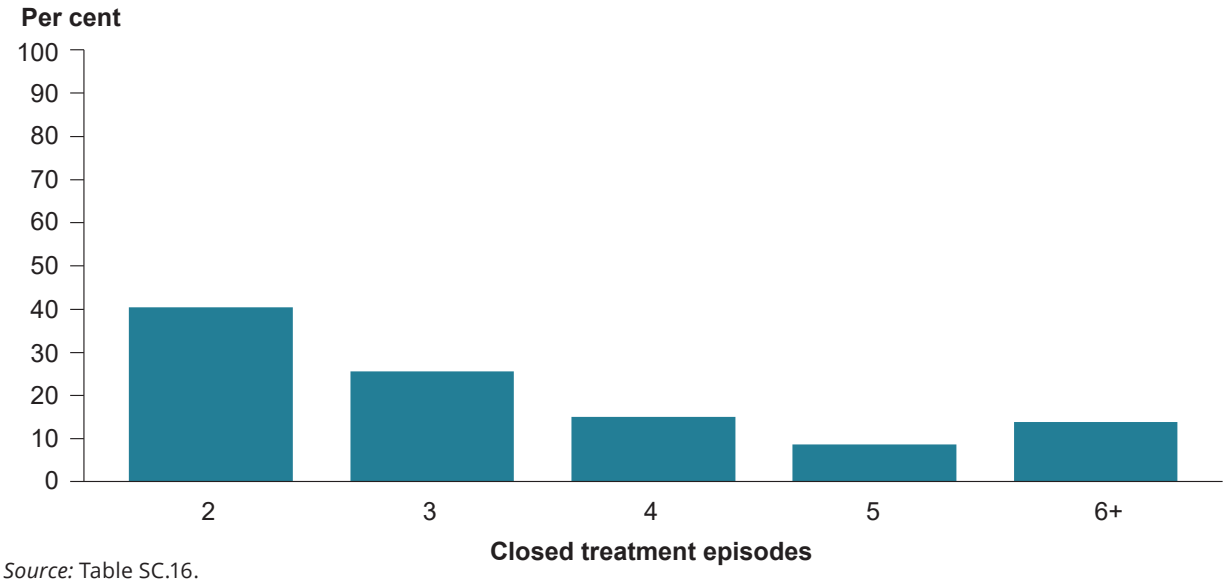
A total of 86,232 closed treatment episodes were provided to 24,089 episodic service users from 2014–15 to 2017–18 (tables SE.1 and SC.1).

Compared with other service user types:

- the proportion of clients (44%) attending 2 agencies was highest among episodic service users (Table SC.15)
- episodic service users reported higher proportions of clients receiving treatment for a total duration of 6–<12 months (23%), 3–<6 months (22%) and 2 days–<1 month (18%) (Table SC.17)
- episodic service users had a median episode duration of 24 days—24 days for those receiving treatment for their own drug use, and 42 days for those receiving treatment for another person's drug use (Table SE.8)
- the average number of closed episodes per client was second highest for episodic service users (3.6 episodes per client).

More than 2 in 5 (44%) episodic service users attended 2 treatment agencies (Table SC.15). A total of 2 in 5 (40%) episodic service users received 2 closed episodes, 25% received 3 episodes, and 13% received 6 or more episodes (Figure 4.1). Compared with continual service users, only a small proportion (2.5%) of episodic service users received 10 or more episodes (Table SC.16).

Figure 4.1: Episodic service users, by number of closed treatment episodes, 2014–15 to 2017–18 (%)



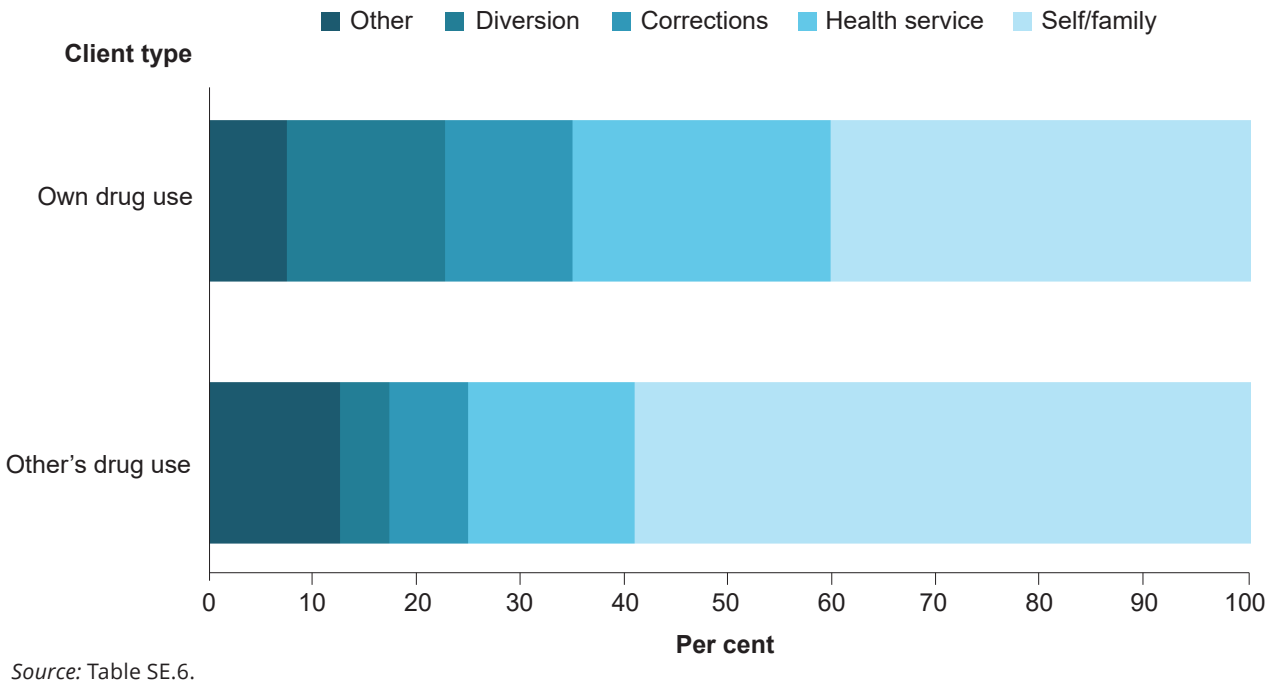
Source: Table SC.16.

Source of referral

A total of 2 in 5 (40%) episodic service users were referred to their initial treatment episode in 2014–15 by themselves or family, followed by diversion (20%), a health service (18%), and corrections (14%) (Table SE.7).

Among episodic service users who received treatment for their own drug use, the most common source of referral across all treatment episodes in 2014–15 to 2017–18 was themselves or family (40%), followed by a health service (25%), diversion (15%), and corrections (12%). Nearly 3 in 5 (59%) episodic service users who received treatment for someone else's drug use were referred via themselves or family (Figure 4.2).

Figure 4.2: Closed treatment episodes provided to episodic service users, by client type and source of referral, 2014–15 to 2017–18 (%)



Source: Table SE.6.

4.4 Where did episodic service users live and access treatment?

Among episodic service users:

- the majority (63%) of closed treatment episodes were provided by non-government agencies (Table SE.5)
- about 7 in 10 (70%) closed episodes were provided in *Major cities*, followed by *Inner regional* areas (16%), and *Outer regional* areas (10%) (Table RA.1)
- while the proportion of male (68%) and female (32%) episodic service users followed the distribution of all service users, a slightly higher proportion of male episodic service users living in *Inner regional* areas (70%) received treatment than those living in *Major cities* (67%), *Outer regional* areas (68%), and *Remote and very remote* areas (68%) (Table RA.4)
- age distribution varied between remoteness areas, with:
  - nearly 3 in 5 episodic service users living in *Major cities* being aged 20–29 or 30–39 (both 29%)
  - the majority of episodic service users living in *Inner regional* areas (31%) and *Outer regional* areas (32%) being aged 20–29
  - the majority of episodic service users living in *Remote and very remote* areas being aged 30–39 (28%) (Table RA.5)
- the proportion of episodic service users who identified as Indigenous was highest for those living in *Remote and very remote* areas (73%), followed by *Outer regional* areas (31%), *Inner regional* areas (14%), and *Major cities* (9%) (Table RA.6).

4.5 Case study 2: Episodic service user

John, 35, grew up in a household where both parents drank alcohol excessively. His parents weren't violent, but he and his siblings were neglected, and often left to fend for themselves.

John's first engagement with an alcohol and other drug treatment service occurred while he was in hospital after fracturing his ankle and dislocating his shoulder. John had been out drinking with friends, and had continued to drink when he went home. He fell over the coffee table on his way to bed.

He was referred to a treatment service by an alcohol and other drug clinical liaison nurse. John attended his initial assessment, but was unsure about undertaking treatment for his alcohol use. However, John reported that he did have concerns about his alcohol use, and was able to identify that his drinking was problematic. John booked a further appointment, but did not attend.

Two months later John called the service enquiring if he could re-engage. As his treatment episode had not been closed, John was not required to undertake an initial assessment again, and saw the same counsellor. John spoke in that session about wanting to stop drinking, but being unsure how he would do this.

John and his counsellor explored service options for him, including inpatient withdrawal, home withdrawal, and long-term rehabilitation. John was referred to an outpatient withdrawal facility, and attended 1 appointment, but did not continue treatment.

After some time, John's drinking began to escalate. He felt like a burden to his family and compared his drinking to that of his father. John was determined to address his drinking and booked an appointment with the long-term rehabilitation service. Given his levels of drinking, John was advised to undertake medical-assisted detoxification before entering long-term rehabilitation. John agreed to this, and was referred to an outpatient withdrawal service for assessment.

John attended his assessment with the outpatient withdrawal service, but at the last minute decided that he could manage his alcohol concerns on his own, with the help of his family.

* This case story is not based on an actual person. It is based on de-identified data collated from the patterns of AOD treatment service use cohort analyses. It is intended to present an example of a 'typical' episodic service user to demonstrate common patterns of service use for this cohort. The experience of each individual client is different.

5 Transitory service users

Transitory service users are clients who received at least 1 closed treatment episode in the 1 July 2014 to 30 June 2015 collection period only. These clients did not receive any further closed treatment episodes in the 3 years after that.

Transitory service users accounted for 67% of the total cohort, and 37% of the total episodes.

Of the 54,423 transitory service users:

More than 2 in 3 (68%) were male.

Nearly 2 in 7 (28%) were aged 20–29.

About 1 in 8 (13% or 7,200) identified as Indigenous.

About 7 in 10 (68%) closed episodes were provided in *Major cities.*

85% received 1 treatment episode.

More than 9 in 10 (93%) attended 1 agency.

More than 1 in 3 (36%) received treatment for a total duration of 1 day.

Top 4 principal drugs of concern:

37%	31%	16%	3.5%
Alcohol	Cannabis	Amphetamines	Heroin

5.1 Who were transitory service users?

Client profile

Transitory service users accounted for 67% of the total cohort, and 37% of the total episodes (tables SC.1 and SE.1). Among all transitory service users, 68% of clients were male and 32% were female (Table SC.3).

Client type

Clients can receive treatment for their own or someone else's drug use (see Glossary). Of all transitory service users, 93% received treatment for their own drug use, and 6.8% received treatment for someone else's drug use (Table SC.2).

Transitory service user clients who received treatment for their own drug use were more likely to be male (71%), aged 20–29 (30%), and non-Indigenous (79%) (tables SC.8, SC.9, and SC.10). Comparatively, transitory service user clients receiving treatment for someone else's drug use were more likely to be female (64%), and aged 50–59 (21%) (tables SC.8 and SC.9).

Indigenous status

About 1 in 8 (13% or 7,200) transitory service users identified as Indigenous (Table SC.5). Of these clients:

- 62% were male, and 38% were female (Table SC.12)
- 95% sought treatment for their own drug use, and 4.7% sought treatment for someone else's drug use (Table SC.11)
- 29% were aged 20–29, and 27% were aged 10–19 (Table SC.13).

Age

Nearly 2 in 7 (28%) transitory service users were aged 20–29 (Table SC.4). Nearly 1 in 3 (30%) male transitory service users were aged 20–29, compared with nearly 1 in 4 female transitory service users (24%) (Table 5.1).

Table 5.1: Transitory service users, by age and sex, 2014–15 (%)

Age	Male	Female
10–19	18.3	17.4
20–29	30.1	24.3
30–39	22.3	22.0
40–49	16.7	18.5
50–59	8.2	11.4
60+	4.5	6.5

Source: Table SC.14.

5.2 For which principal drugs of concern did transitory service users seek treatment?

Alcohol was the most common principal drug of concern (37% of closed treatment episodes) for which clients sought treatment for their own use, followed by cannabis (31%), amphetamines (16%), and heroin (3.5%) (Table SE.2).

Among female transitory service users, alcohol was the most common principal drug of concern (38% of closed episodes), followed by cannabis (28%), and amphetamines (16%). This was similar among male transitory service users, whose most common principal drug of concern was also alcohol (36%), followed by cannabis (33%), and amphetamines (16%) (Table SE.3). Female transitory service users had a higher proportion of alcohol, and lower proportion of cannabis as their principal drug of concern than male transitory service users.

About 8,600 closed treatment episodes were provided to transitory service users who identified as Indigenous. Among those service users, alcohol was the most common principal drug of concern (50% of closed episodes), followed by cannabis (27%), amphetamines (12%), and heroin (2.4%) (Table SE.4).

5.3 How did transitory service users engage with services?

Service use

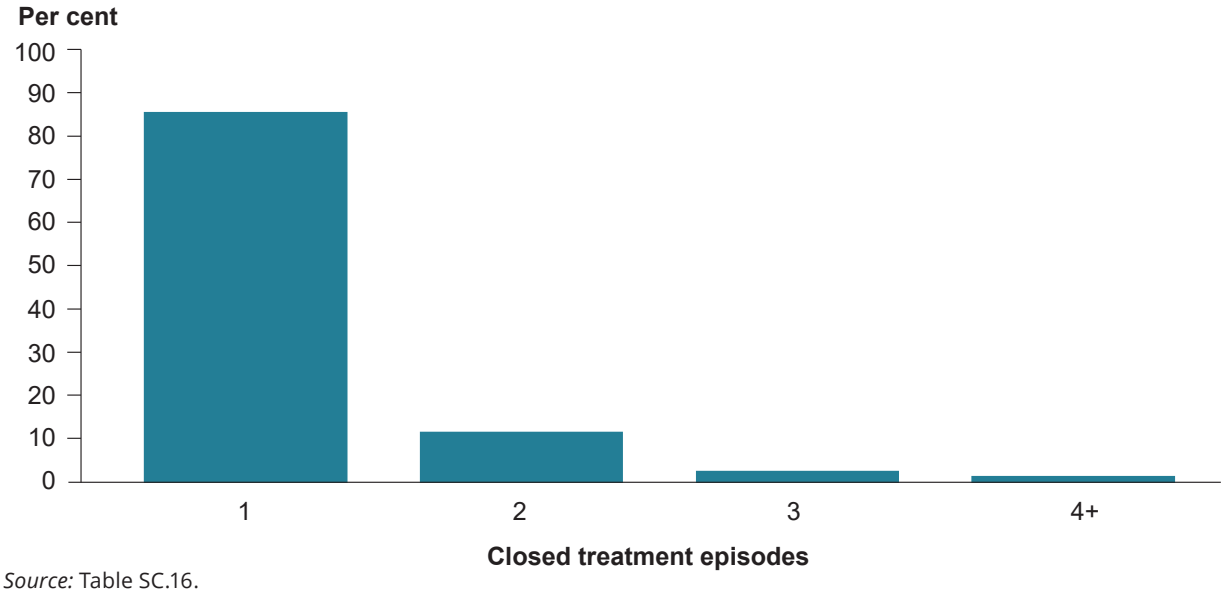
A total of 65,354 closed treatment episodes were provided to 54,423 transitory service users in 2014–15.

Compared with other service user types:

- the proportion of clients (93%) attending 1 treatment agency was highest among transitory service users (Table SC.15)
- transitory service users were more likely to report shorter durations of treatment, with 36% receiving treatment for 1 day, 22% receiving treatment for 1–<3 months, and 20% receiving treatment for 2 days–<1 month (Table SC.17)
- transitory service users had a median episode duration of 13 days—11 days for those receiving treatment for their own drug use, and 27 days for those receiving treatment for another person's drug (Table SE.8)
- the average number of closed treatment episodes per client was lowest for transitory service users (1.2 episodes per client).

The majority (85%) of transitory service users received 1 closed episode. Another 11% received 2 closed episodes, and 2.3% received 3 episodes (Figure 5.1). Transitory service users have a lower number of closed episodes per client in part due to this cohort receiving AOD treatment in only the first collection period of the reporting period.

Figure 5.1: Transitory service users, by number of closed treatment episodes, 2014–15 to 2017–18 (%)



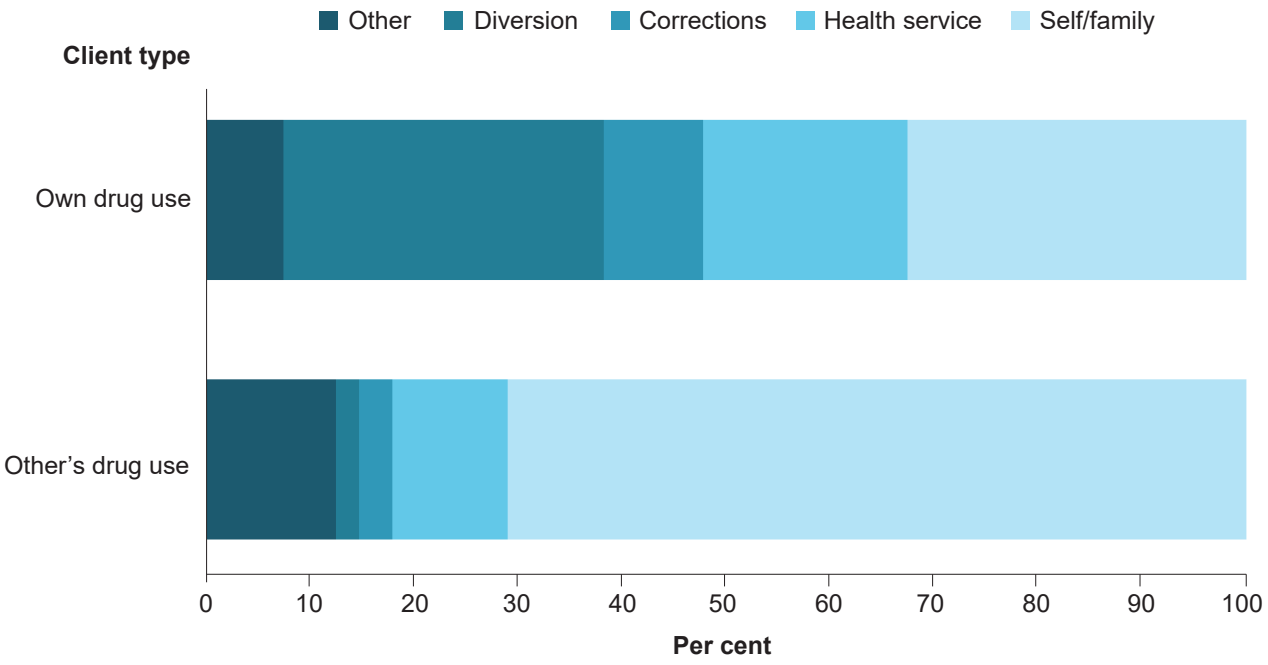
Source: Table SC.16.

Source of referral

Over 1 in 3 (34%) transitory service users were referred to their initial treatment episode in 2014–15 by self/family, followed by diversion (31%), health service (18%), and corrections (9.4%) (Table SE.7).

Among transitory service users who received treatment for their own drug use, the most common source of referral across all treatment episodes in 2014–15 to 2017–18 was self/family (32%), followed by diversion (31%), a health service (20%), and corrections (9.6%). About 71% of transitory service users who received treatment for someone else's drug use were referred via self/family (Figure 5.2).

Figure 5.2: Closed treatment episodes provided to transitory service users, by client type and source of referral, 2014–15 to 2017–18 (%)



Source: Table SE 6.

5.4 Where did transitory service users live and access treatment?

Among transitory service users:

- the majority (59%) of closed treatment episodes were provided by non-government agencies (Table SE.5)
- almost 7 in 10 (68%) closed episodes were provided in *Major cities*, followed by *Inner regional* areas (16%), and *Outer regional* areas (11.8%) (Table RA.1)
- while the proportion of male (68%) and female (32%) transitory service users followed the distribution of all service users, a higher proportion of female transitory service users living in *Remote and very remote* areas (36%) received treatment than those living in *Major cities* (31%), *Inner regional* areas (31%), and *Outer regional* areas (32%) (Table RA.4)
- age distribution varied between remoteness areas, with:
  - the majority of transitory service users living in all remoteness areas being aged 20–29 (29%), followed by 30–39 in *Major cities* (22%), *Inner regional* areas (23%), and *Outer regional* areas (23%)
  - *Remote and very remote* areas having the highest proportion of transitory service users aged 10–19 (25%) (Table RA.5)
- the proportion of transitory service users who identified as Indigenous was highest for those living in *Remote and very remote* areas (56%), followed by *Outer regional* areas (22%), *Inner regional* areas (11%), and *Major cities* (7.8%) (Table RA.6).

5.5 Case study: Transitory service user

Jack, 15, has a dysfunctional family life in a small rural town. Jack is regularly in conflict with his mum's boyfriend, and has often witnessed domestic and family violence and drug use at home. Trauma from the domestic and family violence, coupled with Jack's own cannabis use, make it difficult for Jack to concentrate at school.

Jack struggles to make satisfactory grades, and to maintain relationships with peers and teachers, though he attends regularly. He has a few close friends and some supportive teachers, and feels like school is his safe place.

Anger and boredom are the main triggers for Jack's cannabis use, which he uses to help calm his intense, confusing emotional world. He has been caught smoking cannabis at school and has received suspensions for this in the past. Jack has learned to solve interpersonal problems with violence. An assault on a fellow student results in a community order that includes alcohol and other drug counselling.

The male counsellor assigned to Jack's case is able to offer an outreach service. He arranges to conduct the counselling sessions at Jack's school, because it is a familiar and safe place. Jack is initially uncommunicative during the first counselling session, and is uncomfortable with the attention. The counsellor uses various techniques to shift Jack's focus, and engage him in conversation. It takes Jack some time to relax, but over subsequent sessions, this approach helps develop a level of trust. Jack has few positive male figures in his life, and the connection with the counsellor starts to build his sense of self-worth.

Throughout the therapy, the counsellor uses motivational interviewing to support Jack in determining what function cannabis has in his life. Jack expresses that he is angry about the situation at home and that cannabis use temporarily removes it.

Together, Jack and his counsellor explore Jack's strengths, interests, and values, such as school, his friends and living free from violence. Jack begins to understand how cannabis use is affecting his life. With his counsellor, he looks at alternative coping mechanisms and strategies—he learns refusal skills, and how to use the delayed distraction technique. Jack and his counsellor maintain a strong rapport.

After regularly attending 10 sessions, at the age of 16, he moves in with a friends' family. He says that he feels ready to focus on his future without cannabis.

* This case story is not based on an actual person. It is based on de-identified data collated from the patterns of AOD treatment service use cohort analyses. It is intended to present an example of a 'typical' transitory service user to demonstrate common patterns of service use for this cohort. The experience of each individual client is different.

6 Conclusion

This report provides insight into how clients use AOD treatment services, highlighting their sociodemographic characteristics, the substances they received treatment for, and where they live. It makes comparisons across service user cohorts, and provides narrative examples of the patterns of treatment.

Alcohol was the top principal drug of concern for all service user groups. Continual service users were more likely than transitory and episodic service users to have amphetamines and heroin as their principal drugs of concern. Transitory service users had the highest proportion of episodes where cannabis was their principal drug of concern, and the lowest proportion with amphetamines and heroin.

Continual service users were more likely than other service user groups to access treatment through multiple agencies, and remain in treatment for longer. While this service user group makes up a small proportion of all AOD clients, this report shows the high level of contact this group has with the sector.

The main limitation of this report is that the analysis can provide insights only into the pattern of alcohol and other drug treatment service use for those clients who accessed AOD services that report to the AODTS NMDS. Further research is required to gain a more comprehensive understanding of the patterns of AOD treatment service use in Australia, including those services outside of the scope of the AODTS NMDS.

While this report demonstrates differences in principal drugs of concern between service user groups, analysis into detailed patterns of service use for specific drugs, or remoteness areas would provide further insights for the sector. This could include differences in patterns of service use for specific principal drug of concern compared with all clients, consistency of clients' principal drug of concern from first treatment episode, or the relationship to the source of referral. Similarly, looking at why repeat service users leave a service would provide further understanding of the factors affecting clients' repeat service use.

Current research highlights the chronic and relapsing nature of substance use. However, a number of additional factors—including homelessness, socioeconomic status, disability, contact with the criminal justice system, and mental health—can play a role in how a client engages with AOD treatment services over time.

Despite this, the available data in the AODTS NMDS are currently unable to measure all these factors. Data development and linkage projects could be done to look at these factors interact, and further asses a client's pathway through AOD treatment services. In addition, it would be useful if future analyses could encapsulate a client's contact with AOD treatment over a longer period, to gain a more complete picture of treatment patterns.

Acknowledgments

The authors of this report were Ms Elyse Kambisios, Mr Lachlan Facchini, and Ms Emily Ross from the Tobacco, Alcohol and Other Drugs Unit of the Australian Institute of Health and Welfare.

Ms Kristina Da Silva, Ms Kristy Raithel, Mr David Whitelaw, Mr Jeffrey Pullin, Ms Moira Hewitt, Mr Matthew James, and Ms 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 and Mr Jeff Buckley are gratefully acknowledged.

The AIHW acknowledges the assistance of the Western Australian Network of Alcohol and other Drug Agencies in the authoring of case studies for this report.

The Department of Health provided funding for this report.

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

- Australian Government Department of Health
- New South Wales Ministry of Health
- Victorian Department of Health and Human Services
- Queensland Department of Health
- Western Australian Mental Health Commission
- South Australian Department of Health
- Tasmanian Department of Health
- Australian Capital Territory Health Directorate
- Northern Territory Department of Health.

Abbreviations

AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drug/s
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
SLK	statistical linkage key

Glossary

Aboriginal or Torres Strait Islander: A person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander person. See also **Indigenous**.

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.

Amphetamines: Stimulants that include methamphetamine, also known as methylamphetamine. Amphetamines speed up the messages going between the brain and the body.

Australian Statistical Geography Standard Remoteness Area: The Australian Bureau of Statistics' Australian Statistical Geography Standard Remoteness Area classification allocates 1 of 5 remoteness categories to areas, based on their relative accessibility to goods and services

(such as general practitioners, hospitals, and specialist care) as measured by road distance. These classifications reflect the level of remoteness at the time of the 2011 Census. Areas are classified as *Major cities, Inner regional, Outer regional, Remote,* and *Very remote*. For analysis, *Remote* and *Very remote* are often grouped together. The remoteness area of the treatment service was derived from its Statistical Area Level 2 (SA2) 2011, while the remoteness area of the client was derived from the postcode of the client's last known home address at the start of the treatment episode. When either the SA2 or the postcode covered multiple remoteness areas, the remoteness area allocation with the largest proportion was selected.

Cannabis: Derivative from the cannabis plant (usually *Cannabis sativa*), which is used in whole plant (typically the flowering heads), resin, or oil forms. Cannabis has stimulant, depressant, and hallucinogenic effects.

Client type: The status of a person in terms of whether the treatment episode concerns their own alcohol and/or other drug use, or that of another person. Clients may seek treatment or assistance for their own alcohol and/or other drug use, or treatment and/or assistance for the alcohol and/or other drug use of another person.

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

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

Heroin: One of a group of drugs known as opioids, which are strong painkillers with addictive properties. Heroin and other opioids are classified as depressant drugs.

Illicit drug use: Includes:

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

Indigenous: Person of Aboriginal or Torres Strait Islander descent who identifies as an Aboriginal or Torres Strait Islander. See also **Aboriginal or Torres Strait Islander**.

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

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

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

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

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List of tables

List of figures

Related publications

This report is part of the drug treatment series. Earlier editions and any published subsequently can be downloaded from www.aihw.gov.au/reports-data/health-welfare-services/alcohol-other-drug-treatment-services/reports. The website also includes information on ordering printed copies.

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

- AIHW 2017. National Drug Strategy Household Survey 2016: detailed findings. Drug statistics series no. 31. Cat. no. PHE 214. Canberra: AIHW.
- AIHW 2018. Alcohol and other drug treatment services in Australia 2017–18. Drug treatment services series no. 33. Cat. no. HSE 230. Canberra: AIHW.
- AIHW 2018. Alcohol, tobacco, and other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW.
- AIHW 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease Study series no.19. Cat. no. BOD 22. Canberra: AIHW.

Clients accessing alcohol and other drug treatment services across Australia commonly have multiple episodes of treatment spanning several years. This report categorises 3 client groups based on their patterns of service use between 1 July 2014 and 30 June 2018. While there were subtle differences in principal drug of concern and some aspects of service use between the 3 groups, overall there were many similarities. This highlights the complexities of characterising alcohol and other drug service users.

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