Australian Government
Australian Institute of Health and Welfare

Alcohol and other drug treatment services in Australia 2010–11

Report on the National Minimum Data Set

DRUG TREATMENT SERIES NO. 18

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Authoritative information and statistics to promote better health and wellbeing

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

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Abbreviations

ABS	Australian Bureau of Statistics
AIHW	Australian Institute of Health and Welfare
AODTS–NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
DoHA	(Australian Government) Department of Health and Ageing
NDSHS	National Drug Strategy Household Survey
NGOTGP	Non-Government Organisation Treatment Grants Program
NMDS	National Minimum Data Set
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
OATSIH	Office for Aboriginal and Torres Strait Islander Health
OPT	opioid pharmacotherapy treatment
OSR	OATSIH Services Reporting

Symbols

–	nil or rounded to zero
. .	not applicable
n.a.	not available
n.e.c.	not elsewhere classified

Summary

The use of alcohol and other drugs is among the leading causes of illness and disability in Australia. In 2003, drug and alcohol use accounted for 12% of the total burden of disease. In 2010, 15% of Australians aged 14 or more had recently used illicit drugs, 15% were daily smokers and 80% used alcohol.

This report presents data about alcohol and other drug treatment agencies, their clients, drugs of concern and the type of treatment received.

The total number of treatment episodes provided to clients has increased

In 2010–11, around 150,500 closed treatment episodes were recorded, of which 144,000 (96%) were for clients seeking treatment for their own substance use. This is an increase from approximately 145,600 treatment episodes in 2009–10. Clients seeking treatment for their own drug use tended to be younger (median age of 33) than those seeking assistance for someone else's drug use (median age of 41). Two in 3 episodes where clients were seeking treatment for their own drug use involved males (97,800 episodes, 68%).

Around 1 in 8 (19,600 episodes, 13%) of the total closed treatment episodes involved clients who identified as being of Aboriginal or Torres Strait Islander origin, while they represent approximately 2.2% of the Australian population aged 10 and over. Most episodes involved clients who were born in Australia (130,300 episodes, 87%).

Alcohol continues to be the most common principal drug of concern

Alcohol continued to be identified as clients' principal drug of concern most commonly, representing almost half of the total closed treatment episodes (68,200 episodes, 47%) in all jurisdictions, except Tasmania, where cannabis was equally common. Cannabis (31,800 episodes, 22%), heroin (13,400 episodes, 9%) and amphetamines (12,600 episodes, 9%) were the next most common principal drugs of concern reported consistently across the years. There was a steady decline in treatment episodes with heroin identified as the principal drug of concern, from a peak of 2 in 10 (23,300 episodes, 18%) in 2003–04 to 1 in 10 (13,400 episodes, 9%) in 2010–11. Just under half of treatment episodes (70,900 episodes, 49%) involved multiple drugs of concern.

Counselling continues to be the most common treatment type

Counselling was the most common main treatment type (61,900 episodes, 41%) followed by withdrawal management (23,800 episodes, 16%) and assessment only (20,500 episodes, 14%). Counselling was nearly twice as common for those seeking treatment for someone else's drug use (75%) than for those seeking treatment for their own drug use (40%). Counselling treatment episodes had the longest median duration (57 days). Seven in 10 (102,300 episodes, 68%) episodes were closed due to an 'expected/compliant completion'.

The number of treatment agencies has remained relatively stable

In 2010–11, 666 alcohol and other drug treatment agencies provided data for the AODTS-NMDS. This is the second highest number of reporting treatment agencies since reporting began in 2001–02. The proportion of government and non-government sector agencies remained relatively stable between 2009–10 and 2010–11 (54% non–government sector and 46% government sector). Half of the treatment agencies (344 agencies, 52%) were located in major cities and almost 3 in 10 (182 agencies, 27%) were in inner regional areas.

1 Introduction

This is the eleventh report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) since 2002. It presents data about alcohol and other drug treatment services, their clients, drugs of concern and the types of treatment received. It contains a chapter exploring the relationship between alcohol and other drug use and specialist services, including housing assistance, and mental health treatment. The report also includes relevant information from other collections relating to alcohol and other drug treatment and use.

Definitions of terms used in this report

Some key terms used throughout this report are briefly defined below. More detailed and additional definitions are in the relevant chapters.

Treatment episode—a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency.

Main treatment type—the principal activity, as judged by the provider, that is necessary for the completion of the treatment plan for the principal drug of concern.

Other treatment type—depending on the context, can be either a main treatment type that does not fit into the categories provided for the collection, or additional treatments provided to the client as well as the main treatment type.

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

Other drugs of concern—any other drugs reported by the client, in addition to the principal drug of concern.

1.1 How are the data collected?

The AODTS–NMDS is a collection of data from publicly funded treatment services in all states and territories, including those directly funded by the Australian Government Department of Health and Ageing (DoHA). Publicly funded alcohol and other drug treatment agencies collect the agreed data items and forward this information to the appropriate health authority. Agencies ensure that the required information is accurately recorded. They are also responsible for ensuring that their clients are generally aware of the purpose for which the information is being collected and that their data collection and storage methods comply with existing privacy principles. In particular, they are responsible for maintaining the confidentiality of their clients' data and/or ensuring that their procedures comply with relevant state, territory and Australian Government legislation.

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

Government health authorities also ensure that appropriate information security and privacy procedures are in place. In particular, data custodians are responsible for ensuring that their data holdings are protected from unauthorised access, alteration or loss. For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning at that level. Figure 1.1 demonstrates the processes involved in constructing the national data.

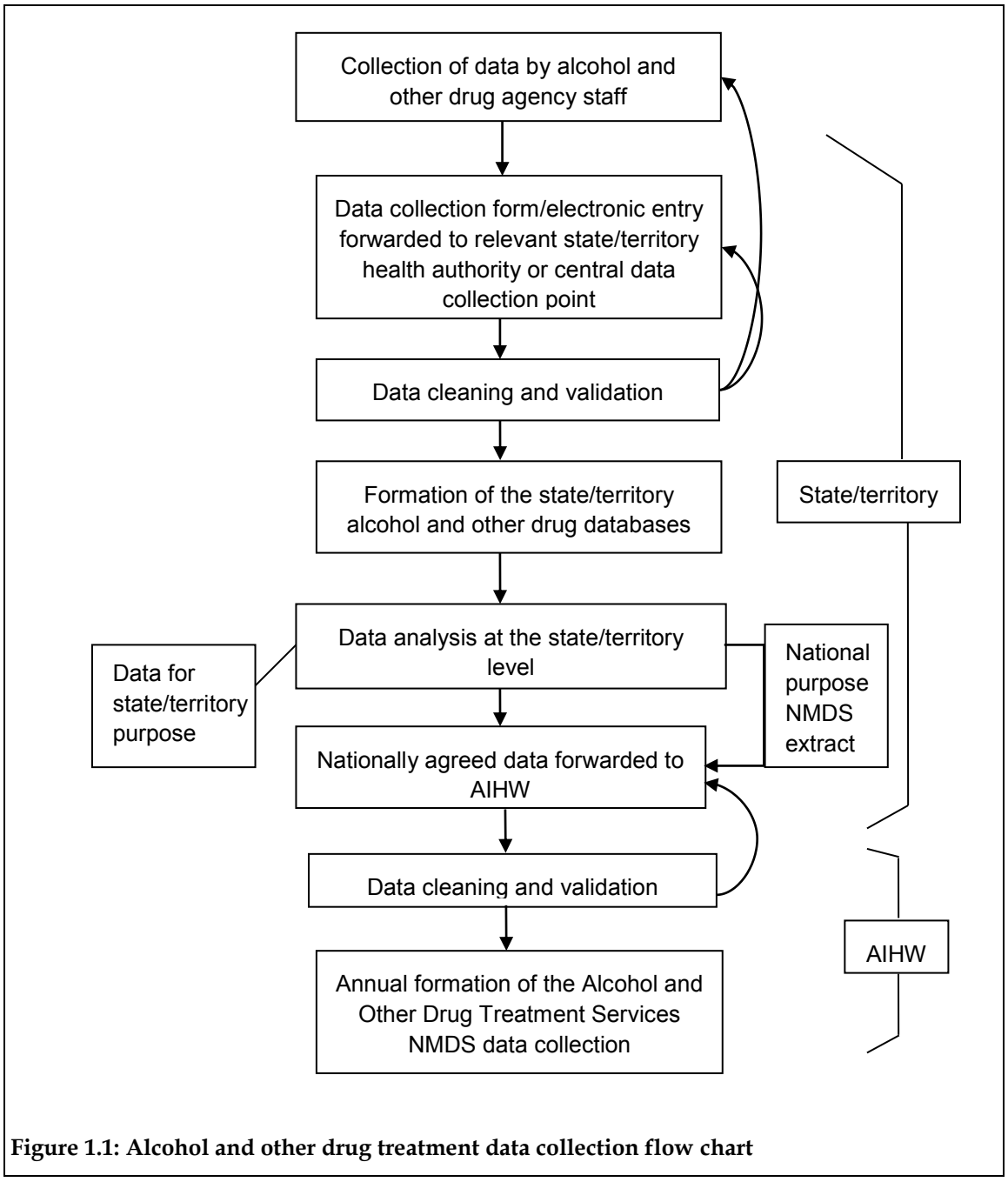


Figure 1.1: Alcohol and other drug treatment data collection flow chart

1.2 What's included?

The AODTS–NMDS counts treatment episodes completed during the collection period. For this report, the period was 1 July 2010 to 30 June 2011. More detail about the circumstances in which episodes are considered to be completed is in *Alcohol and Other Drug Treatment Services National Minimum Data Set specifications and collection manual 2010–11* (AIHW 2010a).

The agencies and clients agreed for inclusion—that is, the scope of the collection—has remained the same across all years of the collection.

1.2.1 Agencies and clients included

- All publicly funded (at state, territory and/or Australian Government level) government and non-government agencies that provide one or more specialist alcohol and/or other drug treatment services.
- All clients who had completed one or more treatment episodes at an alcohol and other drug treatment service that was in scope during 1 July 2010 to 30 June 2011.

1.2.2 Agencies and clients excluded

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

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

1.3 Important issues that explain the data

As an NMDS, there are collection, reporting and analysis characteristics of the collection that should be considered when reading and interpreting the data. These characteristics limit the application of some analyses and inferences should be drawn with caution.

Table 1.1 provides some explanatory notes to accompany the data in the tables and figures. There are further data quality issues to be aware of when interpreting results from the separate jurisdictions; these are outlined in Chapter 7. Appendix A consists of a data quality statement that discusses the quality of the AODTS–NMDS data in more detail.

1.3.1 Clients are not counted

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

Jurisdictions have implemented a collection methodology to allow for the counting of clients, not just episodes, in the 2012–13 collection.

1.3.2 Funding source cannot be differentiated

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

1.3.3 Coverage of Indigenous substance use services is limited

Data relating to Indigenous substance use services in the AODTS–NMDS collection are drawn primarily from treatment episodes where clients identifying as Indigenous have accessed services that are available to all people in Australia (mainstream services) and/or services that receive funding from state and territory governments.

Indigenous substance use–specific services that are funded solely by the DoHA's OATSIH generally do not report to the AODTS–NMDS because they have an alternative reporting mechanism, OATSIH Services Reporting (OSR). Data from services drawn from the OSR collection are included where possible in this report to provide a more complete picture of alcohol and other drug treatment for Aboriginal and Torres Strait Islander people in Australia. More details are provided in Chapter 3 and Appendix F.

1.3.4 Implementation makes a difference

National data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between them. The AODTS–NMDS has been implemented in stages, so comparisons across years, particularly the collection's first few years, need to be made with caution. Not all jurisdictions were able to provide data from the beginning of the collection and

not all elements have been reported from the same time. These differences are described as data quality features and administrative features in Table 7.3, in Chapter 7, and as footnotes in tables where appropriate.

1.4 Data issues specific to the 2010–11 year

Each year there are events and issues that have an impact on the collection and these differ between collection periods. These issues are discussed in more detail in Chapter 7.

- In 2010–11, New South Wales submitted data from 262 agencies, approximately the same number of agencies as that submitted in 2009–10 (258). However, the number of agencies was still lower than in 2007–08 (268) and so comparison over years with New South Wales data should be made with caution. These data include Non-Government Organisation Treatment Grants Program (NGOTGP) agencies located in New South Wales.
- In 2010–11, the DoHA conducted a review of the processes used to collate and provide data from NGOTGP agencies. The review resulted in an additional 14 agencies submitting data to the 2010–11 collection compared with 2009–10. The number of NGOTGP episodes also increased between 2009–10 (4,136 episodes) and 2010–11 (7,625 episodes).

  Approximately 8% (around 2,000) of Queensland's episodes have an 'inadequately described' principal drug of concern. This is due to data entry issues. These episodes are coded as 'all other drugs' for the purpose of analysis through this report. More information about Queensland-specific data quality features is provided in Table 7.3.
- Due to data quality and system issues, Tasmania provided revised AODTS–NMDS 2009–10 data after the release of the 2009–10 annual report. Online materials such as data cubes and supplementary tables were updated to include this revised data submission. However, the 2009–10 annual report (AIHW 2011c) does not include revised Tasmanian data. All 2009–10 data included in the 2010–11 annual report has been updated to include correct Tasmanian data. As a result, 2009–10 data presented in this annual report may differ from that presented in the 2009–10 annual report.

1.5 Explanatory notes

Table 1.1 provides some data quality considerations and explanatory notes that apply to many of the tables and figures in this report.

Table 1.1: Overall data quality considerations and explanatory notes for the AODTS–NMDS collection

Component	Data quality considerations/explanatory notes
Data completeness	• Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) numbers are affected by fluctuations in data completeness, and different jurisdictions experience different issues with collection and submission of data. This means that careful consideration needs to be given to changes in data quality over time when considering trend data to ensure that all caveats are taken into account.
Agencies	• Geographical location reported from the AODTS–NMDS collection is that of the treatment agency (not the residential address of the person receiving treatment). The geographical location of treatment agencies in the 2010–11 AODTS–NMDS has been analysed using the Remoteness Areas of the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix D for information on how these categories are derived). • Sector of service refers to the public ('government') and voluntary/private ('non-government') sectors. • An issue was identified in previous years with the interpretation of the 'government' and 'non-government' classification being reported differently between some states and territories. In most cases for previous years, Non-Government Organisation Treatment Grants Program (NGOTGP) agencies had been reported as public agencies (referred to as 'government agencies'). The approach was clarified and a determination was made to classify NGOTGP agencies as 'non-government' or private, because the establishments are not controlled by 'government'. This determination may have contributed to an overall increase in the number of 'non-government' agencies for collection periods from 2008–09 onwards. The change in categorisation for NGOTGP agencies means that any time series analysis of this statistic should be interpreted with caution. • In 2010–11, the Department of Health and Ageing conducted a review of the processes used to collate and provide NGOTGP agencies to the AODTS–NMDS collection. The review resulted in an additional 14 agencies submitting data to the 2010–11 collection from what was observed in 2009–10.
Clients	• The term 'Indigenous' refers to clients who identified as being Aboriginal and Torres Strait Islander people; 'non-Indigenous' refers to clients who said they were not 'Aboriginal and Torres Strait Islander people'. Alcohol and other drug treatment agencies are encouraged to use the National Best Practice Guidelines for collecting Indigenous status information. • This publication reports the number of episodes and not the number of clients because some information about clients may have been collected from the same individuals more than once. The number of clients, in addition to the number of episodes, will be collected in future, beginning with the 2012–13 collection period.
Drugs	• Principal drug of concern data are only provided for episodes where clients were seeking treatment for their own drug use. A principal drug of concern is not reported for episodes where the client is seeking assistance for someone else's drug use. • Throughout this report, the term 'amphetamines' includes drugs that are referred to as methamphetamines. • Principal and additional drugs of concern are coded according to the Australian Standard Classification of Drugs of Concern. See Appendix E for more information.
Treatment	• The category 'other' in main treatment type includes 2,685 (24%) closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia because agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see Section 5.5 for more information about pharmacotherapy treatment). • Jurisdictions map their treatment data into the treatment types presented here. For example, a state's treatment agencies may report specific types of counselling to the state's health authority but these are then amalgamated into 'counselling' for reporting to the AIHW. • 'Ceased to participate at expiation' is an expected/compliant completion in the sense that legally mandated treatment is completed. It is not possible to exclude episodes reported as 'ceased to participate at expiation' where clients finished enough treatment to expiate their offence but did not return for further treatment as expected.

2 In what sector and where are the treatment agencies?

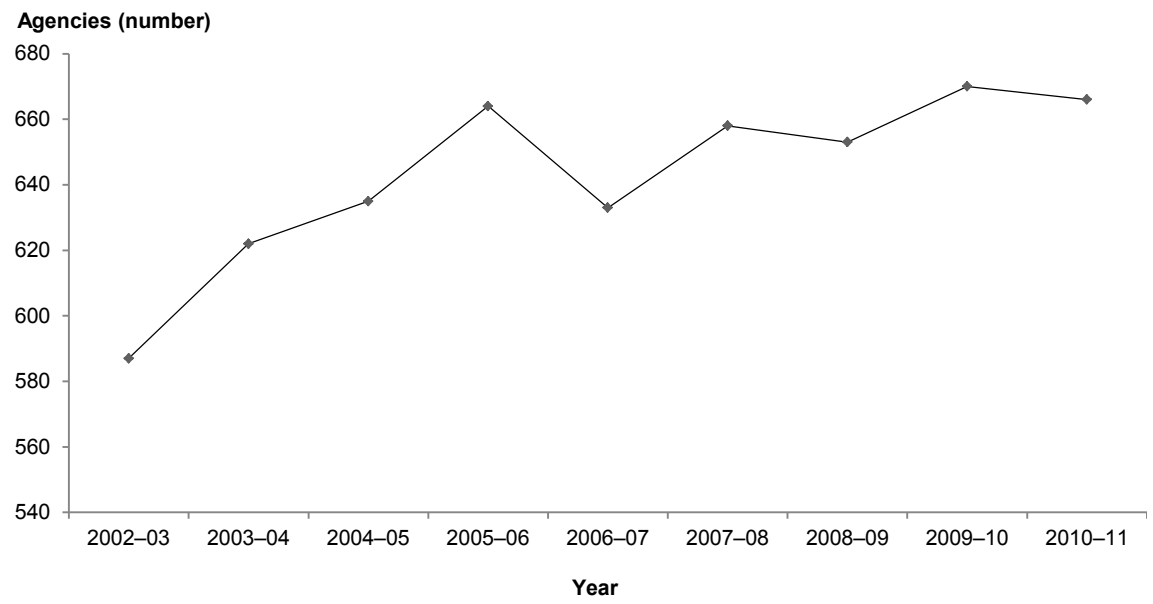
Key findings

- In 2010–11, 666 alcohol and other drug treatment agencies provided data to the AODTS–NMDS, a small decrease from 670 agencies in 2009–10.
- The proportion of non-government and government agencies remained relatively stable between 2009–10 and 2010–11.
- Nationally, 61% (91,700) of treatment episodes were provided by non-government agencies, which represent 54% (357) of agencies.
- As in previous years, most treatment agencies were located in *Major cities* (52%) and *Inner regional* areas (27%) in 2010–11.

Treatment agencies collect and supply data on treatment episodes for the AODTS–NMDS collection annually. The number of agencies reported in this chapter may not necessarily correspond with the total number of service delivery outlets in Australia, as some services are out of the scope of the collection. Please see Chapter 1 for more details on the collection's scope.

Agencies may deliver treatment through a variety of service delivery settings, including outreach locations or clients' homes. Some agencies may also have more than one service outlet but only report under the main administrative centre of the service.

- In 2010–11, 666 alcohol and other drug treatment agencies provided data, a small decrease from 670 agencies in 2009–10, but still the second highest number of agencies since reporting began in 2001–02 (Table C1).
- The number of agencies providing data for reporting remained stable in the Australian Capital Territory and South Australia (Table C1). The number of agencies providing data decreased in Victoria, Queensland and the Northern Territory and increased in New South Wales, Western Australia and Tasmania.
- Several factors can contribute to changes in the number of agencies reporting between years. As well as changes in the actual numbers of agencies, some may change from collecting data at an administrative/management level to a service outlet level, while others may experience technical issues submitting data correctly. Agencies may also move in and out of scope between collections (see Section 1.2).



Source: Table C1.

Figure 2.1: Number of agencies reporting to the AODTS–NMDS over time, 2002–03 to 2010–11

2.1 Service sectors

In many data collections, including the AODTS–NMDS, a distinction is made between 'government' and 'non-government' agencies. Agencies are asked to identify whether they are managed by the government or non-government sector. In the AODTS–NMDS, the term 'private' refers to the 'non-government' sector (see Box 2.1).

Box 2.1: Defining a Non-Government Organisation Treatment Grants Program (NGOTGP) agency

An issue was identified in previous years with the interpretation of the 'government' and 'non-government' classification being reported differently between some states and territories. In most cases for previous years, NGOTGP agencies had been reported as public agencies (referred to as 'government' agencies). The approach was clarified and a determination was made to classify NGOTGP agencies as 'non-government' or 'private', because the establishments are not controlled by government. This determination contributed to an overall increase in the number of 'non-government' agencies for the 2008–09 and 2009–10 collections.

The change in categorisation for NGOTGP agencies means that any time-series analysis of this statistic should be conducted with caution.

- The proportion of non-government (54%) and government (46%) agencies was the same in 2009–10 and 2010–11 (Table 2.1).
- In most jurisdictions, there were more non-government than government agencies. However, New South Wales and South Australia both had more government agencies (75% and 68%, respectively).

- Of the states and territories that had both government and non-government services, the Australian Capital Territory had the highest proportion of non-government agencies (90%) while New South Wales had the lowest (25%).
- Queensland had a similar proportion of government and non-government agencies, with 47% government agencies and 53% non-government.

Table 2.1: Treatment agencies reporting to the AODTS–NMDS, by sector of service[(a)] and jurisdiction, 2010–11

Sector of service	NSW	Vic	Qld	WA[(b)]	SA	Tas	ACT	NT	Australia
					Number				
Government	196	—	51	12	40	4	1	5	309
Non-government	66	136	58	44	19	12	9	13	357
Total	**262**	**136**	**109**	**56**	**59**	**16**	**10**	**18**	**666**
					Per cent				
Government	74.8	—	46.8	21.4	67.8	25.0	10.0	27.8	46.4
Non-government	25.2	100.0	53.2	78.6	32.2	75.0	90.0	72.2	53.6
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent total treatment agencies	**39.3**	**20.4**	**16.4**	**8.4**	**8.9**	**2.4**	**1.5**	**2.7**	**100.0**

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

(b) Services in Western Australia are not directly comparable with other states because of the growth of integrated services that include 'government' and 'non-government' service providers.

The proportion of agencies in each sector does not necessarily reflect the proportion of episodes completed across each sector. This is likely due to the size of the agencies as well as the type of treatment they provide.

- Nationally, 61% (91,700) of episodes were completed by non-government agencies (Table 2.2), which represent 54% (357) of agencies (Table 2.1).
- In New South Wales and South Australia, the proportion of government to non-government episodes was similar.
- Victoria only had non-government agencies and thus only had treatment episodes completed in non-government agencies.
- In Queensland, the Australian Capital Territory, Northern Territory and Tasmania, the proportion of episodes completed in non-government treatment agencies was greater than the proportion in government agencies.

Table 2.2: Treatment episodes by sector of service[(a)] and jurisdiction, 2010–11

Sector of service	NSW	Vic	Qld	WA[(b)]	SA	Tas	ACT	NT	Australia
					Number				
Government	27,817	—	18,218	2,092	6,722	1,207	1,575	1,146	58,777
Non-government	8,223	52,885	8,323	15,019	2,708	531	1,581	2,441	91,711
Total	**36,040**	**52,885**	**26,541**	**17,111**	**9,430**	**1,738**	**3,156**	**3,587**	**150,488**
					Per cent				
Government	77.2	—	68.6	12.2	71.3	69.4	49.9	31.9	39.1
Non-government	22.8	100.0	31.4	87.8	28.7	30.6	50.1	68.1	60.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Percentage of total episodes	**23.9**	**35.1**	**17.6**	**11.4**	**6.3**	**1.2**	**2.1**	**2.4**	**100.0**

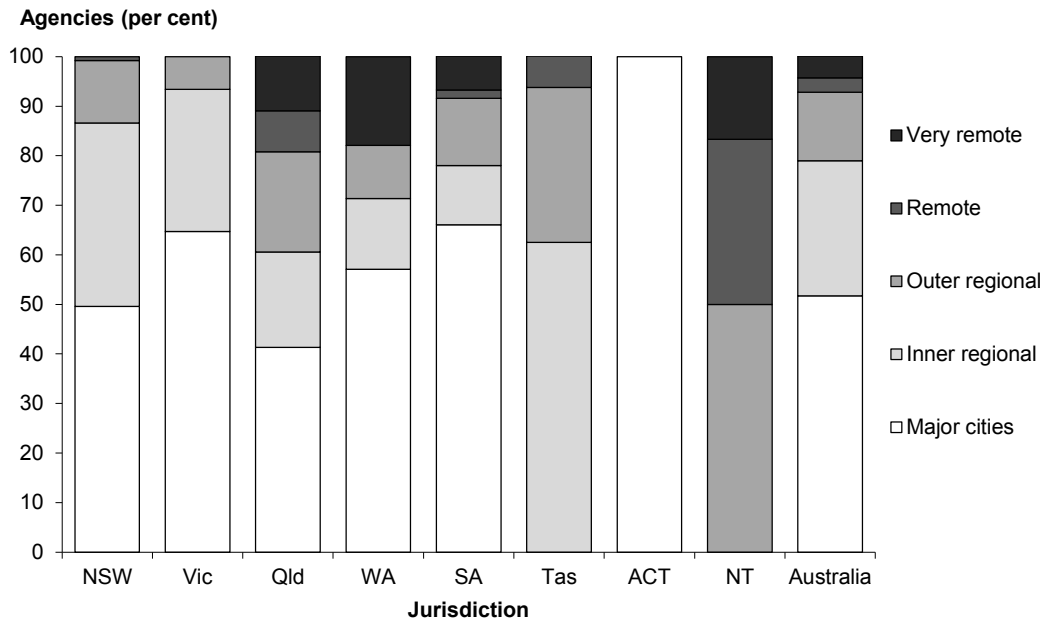
(a) Sector of service refers to the public ('government') and voluntary/private ('non-government') sectors. Agencies funded by the DoHA under the Non-Government Organisation Treatment Grants Program are now included in the 'non-government' sector, following clarification by the AODTS–NMDS Working Group.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

(b) Services in Western Australia are not directly comparable with other states because of the growth of integrated services that include 'government' and 'non-government' service providers.

2.2 Locations

There are treatment agencies in all states and territories of Australia. The Australian Standard Geographical Classification (ASGC) classifies areas as *Major cities, Inner regional*, *Outer regional*, *Remote* and *Very remote*. Annual revisions of geographical boundaries can cause an agency to move from one remoteness category to another, without physically moving premises. The same is not true for state and territory classifications, as these borders are not subject to annual revisions. The only way for an agency to be classified as part of a different state or territory is for that agency to physically move premises across a jurisdictional border.

- As in previous years, in 2010–11 most treatment agencies were in *Major cities* (52%, 344 agencies) and *Inner regional* areas (27%, 182 agencies) (Figure 2.2).
- The Australian Capital Territory had the highest proportion of agencies in *Major cities* (100%) but this was because all treatment agencies in the Australian Capital Territory fell within the *Major cities* classification. Likewise, Tasmania and the Northern Territory had no treatment agencies in *Major cities* as there were no areas in these jurisdictions that were classified as *Major cities*.
- Nationally, 7% of treatment agencies were in *Remote* and *Very remote* areas, while in the Northern Territory, half (50%) of agencies were in these areas.
- Western Australia had the highest proportion of agencies in *Very remote* areas, with almost 1 in 5 agencies in these locations (18%).



Source: Table C2.

Figure 2.2: Treatment agencies by geographical location, 2010–11

2.3 Treatment types delivered in different geographical locations

Agencies in different geographical locations tended to offer a different mix of treatment types (Table 2.3). This may stem from a range of factors and the data collected do not offer clear reasons for the differences.

- Counselling was the most common treatment type in 2010–11, accounting for 41% of treatment episodes in Australia. By geographical region, counselling was the most common treatment type in all but *Remote* areas, where assessment only was most common.
- The proportion of episodes where counselling was the reported main treatment type in *Very remote* areas decreased from 62% in 2009–10 to 56% in 2010–11. The proportion of 'other' treatment rose slightly in *Very remote* areas, from 2% in 2009–10 to 6% in 2010–11.
- Withdrawal management (detoxification) was more common in *Major cities*, *Inner Regional* and *Outer Regional* areas than in *Remote* or *Very remote* regions. This treatment type accounted for almost 1 in 5 (17%) episodes in *Major cities* but 1 in 20 (5%) episodes in *Remote areas* and 1 in 100 (1%) episodes in *Very remote* areas.
- Information and education only and assessment only treatment types were more common in *Remote* and *Very remote* areas, together making up 41% and 31% of all episodes in these areas, respectively. In comparison, they made up 21% of episodes in *Major cities* and 20% in *Inner regional* areas.

Table 2.3: Episodes by main treatment type and geographical location[(a)], 2010–11 (per cent)

Main treatment type	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Withdrawal management (detoxification)	17.3	13.2	16.5	5.1	1.1	15.8
Counselling	39.6	44.8	43.6	23.1	55.8	41.2
Rehabilitation	4.8	5.7	6.0	12.2	4.2	5.2
Support and case management only	9.1	11.9	4.9	3.0	2.7	9.1
Information and education only	6.6	8.7	10.0	14.5	13.3	7.7
Assessment only	14.2	11.1	12.7	26.1	17.2	13.6
Other	8.4	4.6	6.2	16.1	5.8	7.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

3 Who uses alcohol and other drug treatment services?

Key findings

- In 2010–11, around 150,500 closed treatment episodes were recorded, of which 144,000 (96%) were for clients seeking treatment for their own substance use.
- About 1 in 8 (19,600 episodes, 13%) episodes involved clients who identified as being of Aboriginal and Torres Strait Islander origin. To put this proportion into context, approximately 2.2% of the Australian population is of Aboriginal or Torres Strait Islander origin aged 10 and older.
- The majority of episodes involved clients who were born in Australia (130,300 episodes, 87%) and this proportion was higher than that found in the general population (70%).
- The majority of episodes where clients were seeking treatment for their own drug use involved males (97,800 episodes, 68%).
- Clients seeking treatment for their own drug use tended to be younger (median age of 33) than those seeking treatment for another's drug use (median age of 41).
- When episodes involved assistance being sought for someone else's drug use, they were more likely to be for female clients (63%) and these female clients had a median age of 44.
- The Northern Territory had the greatest proportion of episodes where people were seeking treatment for someone else's drug use (11%).

This chapter presents information about the characteristics of people who received treatment (closed treatment episodes) from agencies that report to the AODTS–NMDS (Box 3.1). Section 3.2.2 includes data on treatment provided through Indigenous programs from the OATSIH Services Reporting database.

Box 3.1: Key definition and counts for closed treatment episodes, 2010–11

A closed treatment episode refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency.

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

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

An example of an AODTS client*

Keith never thought of himself as the kind of person who would receive a drug or alcohol treatment. But when he decided to do something about his drinking in early 2011, he found that he was a fairly typical AODTS client. He was in his early thirties, was born in Australia and lived in a big city. He was primarily seeking treatment for his alcohol use, although he was also concerned about his cannabis habit.

He had always imagined alcohol and other drug treatment to be like the residential rehabilitation clinics that celebrities seemed to frequent but his counsellor told him that rehabilitation represented the smallest proportion of government-funded treatment in Australia. Keith received counselling in a non-residential treatment facility. His treatment lasted about 3 weeks and ended because he completed the treatment.

Now, Keith feels like he has more control over his drinking and is proud of what he achieved during his time in treatment.

*This is a hypothetical example constructed from common demographic and treatment characteristics and is not based on any one treatment episode.

3.1 Own or other's drug use

Clients in the collection are categorised either as those seeking treatment for their own drug use or those seeking assistance because of the drug use of another person. As in previous reporting periods, clients in 2010–11 most often sought treatment for their own drug use.

Clients receiving assistance related to someone else's drug use represented a small proportion (4%) of episodes.

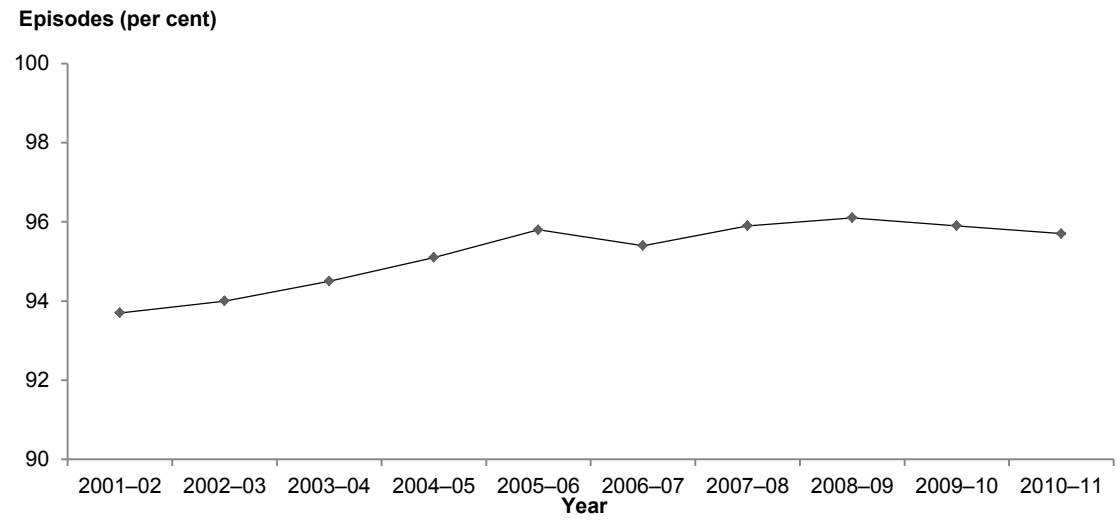
- In 2010–11 there were approximately 150,500 closed treatment episodes of which around 144,000 (96%) were for clients seeking treatment for their own drug use and around 6,500 (4%) for people seeking assistance related to another person's drug use (Table 3.1).

- Of the episodes for people seeking assistance related to someone else's drug use, 75% received counselling, 13% received support and case management only and 6% received information and education only.

The proportion of episodes where clients sought treatment for their own drug use has gradually increased over time from less than 94% of episodes in 2001–02 to almost 96% of episodes in 2010–11 (Figure 3.1).

Table 3.1: Client type by jurisdiction, 2010–11

Client type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Own drug use	35,365	49,974	25,580	15,971	9,143	1,653	3,108	3,208	144,002
Other's drug use	675	2,911	961	1,140	287	85	48	379	6,486
Total	**36,040**	**52,885**	**26,541**	**17,111**	**9,430**	**1,738**	**3,156**	**3,587**	**150,488**
					Per cent				
Own drug use	98.1	94.5	96.4	93.3	97.0	95.1	98.5	89.4	95.7
Other's drug use	1.9	5.5	3.6	6.7	3.0	4.9	1.5	10.6	4.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Jurisdiction (per cent)	**23.9**	**35.1**	**17.6**	**11.4**	**6.3**	**1.2**	**2.1**	**2.4**	**. .**



Source: Table C3.

Figure 3.1: Proportion of episodes where clients sought treatment for their own drug use, 2001–02 to 2010–11

3.1.1 Across Australia

The proportion of treatments provided to people seeking assistance for their own drug use and those seeking assistance related to another person's drug use varied between jurisdictions, as in previous years.

The proportion of episodes where clients were seeking treatment for their own drug use ranged from 89% in the Northern Territory to 99% in the Australian Capital Territory (Table 3.1). There was a slight drop of 2.5 percentage points from 2009–10 (98.9%) to 2010–11 (96.4%) for Queensland.

3.1.2 Age and sex

As in previous years, the majority of episodes in 2010–11 involved male clients (67%). The median age of all clients was 33, with almost 3 in 5 episodes involving clients aged 20–39 (55%). However, the age and sex profile of clients changed according to whether they were seeking treatment for their own or someone else's drug use (Table 3.2).

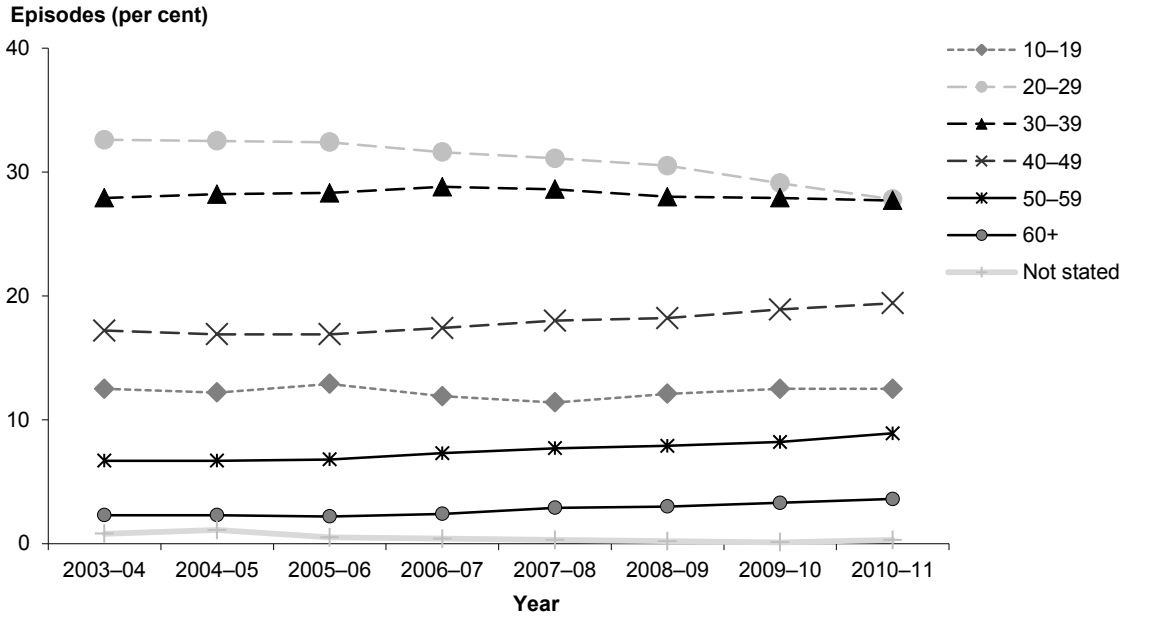
- The majority of episodes where clients were seeking treatment for their own drug use involved males (68%).
- When episodes involved assistance being sought for someone else's drug use, the client was more likely to be female (63%) and these female clients had a median age of 44. The proportion of assistance being sought for someone else's drug use was much lower for males at 37%, and they had a median age of 37.
- Clients seeking treatment for their own drug use tended to be younger (median age of 33) than those seeking assistance for someone else's drug use (median age of 41).

Table 3.2: Client type by sex by age group, 2010–11 (per cent)

	Age group (years)							Total (number)	Median age
	10–19	20–29	30–39	40–49	50–59	60+	Not stated		
					Males				
Own drug use	12.6	29.2	27.9	18.7	8.2	3.0	0.3	97,762	32
Other's drug use	22.5	13.7	18.7	19.4	13.7	11.6	0.3	2,379	37
Total males	*12.8*	*28.8*	*27.7*	*18.8*	*8.3*	*3.2*	*0.3*	. .	*32*
Total males (number)	*12,808*	*28,872*	*27,767*	*18,785*	*8,329*	*3,252*	*328*	*100,141*	. .
					Females				
Own drug use	11.8	27.0	28.4	20.3	9.1	3.2	0.3	46,132	33
Other's drug use	11.8	10.7	18.0	23.9	20.4	14.9	0.4	4,103	44
Total females	*11.8*	*25.7*	*27.5*	*20.6*	*10*	*4.2*	*0.3*	. .	*34*
Total females (number)	*5,920*	*12,890*	*13,834*	*10,325*	*5,011*	*2,104*	*151*	*50,235*	. .
					Persons[(a)]				
Own drug use	12.3	28.5	28.1	19.2	8.5	3.1	0.3	144,002	33
Other's drug use	15.7	11.8	18.3	22.3	17.9	13.7	0.3	6,486	41
Total persons	**12.5**	**27.8**	**27.7**	**19.4**	**8.9**	**3.6**	**0.3**	**. .**	**33**
Total (number)	**18,736**	**41,791**	**41,639**	**29,131**	**13,345**	**5,365**	**481**	***150,488***	**. .**

(a) Includes 'not stated' for sex.

As shown in Figure 3.2, the age range of clients has remained relatively stable over time. The proportion of clients aged 20–29 has decreased slightly over time from 33% in 2003–04 to 28% in 2010–11. This has been accompanied by a slight increase in the proportion of clients aged 40–49, increasing from 17% in 2003–04 to 19% in 2010–11 and an increase in the proportion of 50–59 year olds (increasing from 7% in 2003–04 to 9% in 2010–11). The proportion of 10–19 and 30–39 year olds has remained relatively constant.



Source: Table C6.

Figure 3.2: Treatment episodes by age group, 2003–04 to 2010–11

3.2 Indigenous Australians

3.2.1 Indigenous clients in the AODTS–NMDS collection

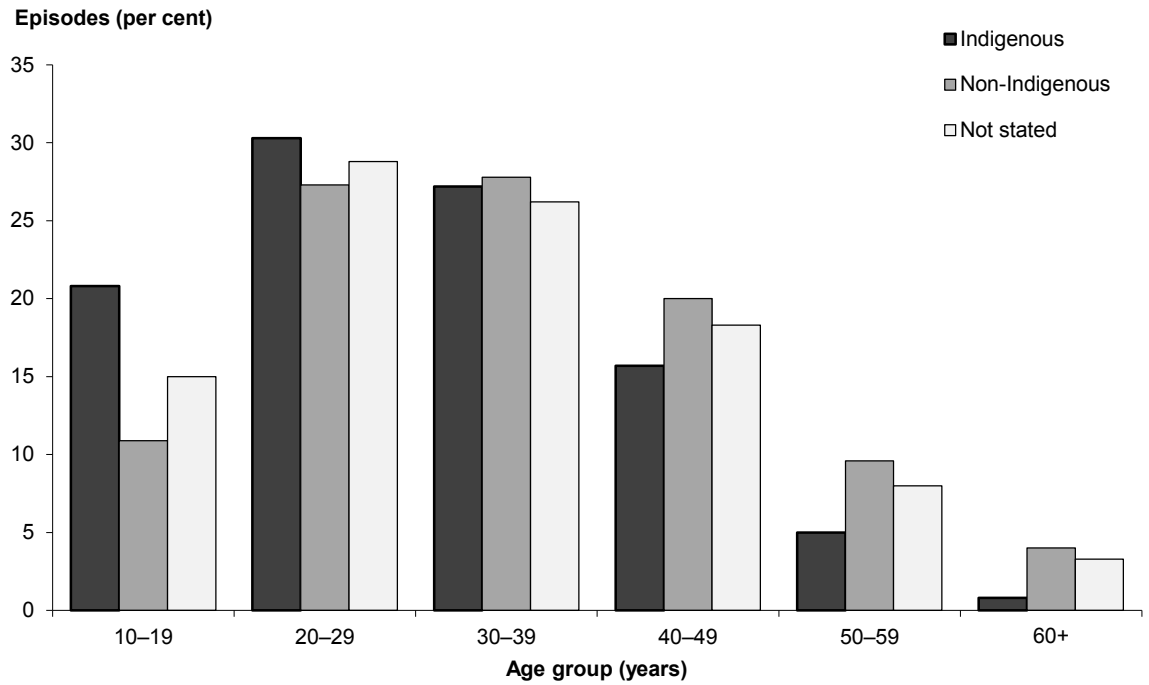
- In 2010–11, about 1 in 8 episodes (19,600 episodes, 13%) involved clients who identified as being of Aboriginal and Torres Strait Islander origin (Table 3.3). When compared with their proportions in the general population aged ten and older (2.2%) (ABS 2012a), Aboriginal and Torres Strait Islander people were over-represented in this collection. The proportion of clients seeking treatment in the 10–19 and 20–29 age groups (Figure 3.3) was also higher for Indigenous clients than for the general population.
- Among Indigenous clients, those aged 20–29 received the highest proportion of treatment episodes. However, this proportion decreased to 30% in 2010–11 from 32% in the previous year.
- On average, Indigenous clients tended to be younger than non-Indigenous clients. The proportion of episodes in the 10–19 and 20–29 age groups was greater among Indigenous clients (21% and 30%, respectively) than non-Indigenous clients (11% and 27%, respectively) (Figure 3.3). In contrast, the proportions of episodes among older age groups (30 and over) was higher for non-Indigenous than Indigenous clients. These differences may reflect the age structures of the two populations, as Indigenous Australians have a younger age profile than non-Indigenous Australians (ABS 2012a).
- Indigenous status was 'not stated' for 6% of episodes nationally, a similar proportion to that observed in previous years. However, this varied substantially by age group, ranging from 3% for those aged 60 and over, to 29% for those aged 20–29.

Table 3.3: Treatment episodes by age group by Indigenous status and sex, 2010–11

Age group (years)	Indigenous			Non-Indigenous			Not stated			Total episodes[(b)]
	Males	Females	Total[(a)]	Males	Females	Total[(a)]	Males	Females	Total[(a)]	
					Number					
10–19	2,744	1,339	4,084	9,246	4,151	13,403	818	430	1,249	18,736
20–29	3,807	2,127	5,939	23,399	10,031	33,451	1,666	732	2,401	41,791
30–39	3,304	2,026	5,331	22,957	11,134	34,116	1,506	674	2,192	41,639
40–49	2,046	1,040	3,086	15,685	8,810	24,513	1,054	475	1,532	29,131
50–59	661	312	973	7,209	4,490	11,703	459	209	669	13,345
60+	93	64	157	2,985	1,941	4,935	174	99	273	5,365
Not stated	41	17	58	265	123	388	22	11	35	481
Total	**12,696**	**6,925**	**19,628**	**81,746**	**40,680**	**122,509**	**5,699**	**2,630**	**8,351**	**150,488**
					Per cent					
10–19	21.6	19.3	20.8	11.3	10.2	10.9	14.4	16.3	15.0	12.5
20–29	30.0	30.7	30.3	28.6	24.7	27.3	29.2	27.8	28.8	27.8
30–39	26.0	29.3	27.2	28.1	27.4	27.8	26.4	25.6	26.2	27.7
40–49	16.1	15.0	15.7	19.2	21.7	20.0	18.5	18.1	18.3	19.4
50–59	5.2	4.5	5.0	8.8	11.0	9.6	8.1	7.9	8.0	8.9
60+	0.7	0.9	0.8	3.7	4.8	4.0	3.1	3.8	3.3	3.6
Not stated	0.3	0.2	0.3	0.3	0.3	0.3	0.4	0.4	0.4	0.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Proportion of treatment episodes	**8.4**	**4.6**	**13.0**	**54.3**	**27.0**	**81.4**	**3.8**	**1.7**	**5.5**	**100.0**

(a) There were 7 episodes for Indigenous Australians where sex was 'not stated', 83 episodes for non-Indigenous people where sex was 'not stated' and 22 episodes where Indigenous status and sex were 'not stated'.

(b) Includes 'not stated' for sex.



Source: Table 3.3.

Figure 3.3: Treatment episodes by age group by Indigenous status, 2010–11

3.2.2 Care provided by OATSIH-funded substance use–specific services

Information on drug services specifically aimed at Indigenous Australians (funded solely by OATSIH) is included in the OATSIH Services Reporting (OSR) data collection, managed by the AIHW. Key information is provided below and additional information on the definitions used in the OSR, including the definition of 'episodes of care', is in Appendix F.

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2010–11, around 3,600 episodes of care were provided to clients in Australian Government–funded Indigenous residential treatment/rehabilitation services (Table 3.4). Of these episodes of care, 74% were for male clients. It is important to note that these data are not directly comparable with AODTS–NMDS data, since definitions of treatment episodes differ between the two collections.

In 2010–11, around 14,600 episodes of care were provided to clients accessing Australian Government–funded Indigenous sobering-up or residential respite services. Sobering-up clients are in residential care overnight and do not receive formal rehabilitation, whereas residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. More than half (58%) of these episodes were for male clients.

'Other care' refers to a diverse range of non-residential programs, including preventive care, after-care follow-up and mobile assistance/night patrol. In 2010–11, there were approximately 71,900 episodes of 'other care', up from about 56,000 in 2009–10. The high number of 'other care' episodes, compared with residential or sobering-up episodes, is due to their short-term nature, with some clients receiving multiple episodes of care over the

course of the year (see Appendix F). Over half (55%) of the episodes of 'other care' were for males.

Table 3.4: Estimated number of episodes of care provided by Australian Government–funded Indigenous substance use–specific services, by sex and treatment type, 2010–11

	Male		Female		Total	
Treatment type	**No.**	**Per cent**	**No.**	**Per cent**	**No.**	**Per cent**
Residential treatment/rehabilitation	2,699	74.0	946	26.0	3,645	100.0
Sobering-up/residential respite	8,472	58.0	6,134	42.0	14,606	100.0
Other care[(a)]	39,206	54.5	32,698	45.5	71,904	100.0

(a) Sex was reported as 'unknown' in 4,052 (5%) episodes of care and these have been excluded for analysis purposes.

Source: AIHW OATSIH Services Reporting database 2010–11.

3.3 Country of birth and preferred language

As in previous years, the majority (around 130,300 episodes, 87%) of AODTS–NMDS episodes in 2010–11 involved clients born in Australia. This proportion is higher than that found in the general population (70%) in the 2011 Census (ABS 2012b).

Clients born in other countries were represented in only a small proportion of episodes, with United Kingdom (3%) and New Zealand (2%) being the next most common countries of birth. In comparison, in the 2011 Census, 5% of people in Australia were born in the United Kingdom and 2% in New Zealand (ABS 2012c).

As in previous reporting periods, English was the most frequently reported preferred language (96%). Less than 1% of episodes involved clients who reported an Australian Indigenous language as their preferred language (see Table C4 for more information).

4 What drugs do people seek treatment for?

Alcohol, tobacco and illicit drug use is responsible, directly and indirectly, for a considerable number of accidents, injuries, illnesses and deaths in Australia. The use of these substances caused an estimated 20,600 deaths in Australia in 2003, as reported by the most recent Burden of Disease and Injury study (Begg et al. 2007). The study reported that alcohol and illicit drugs were the leading cause of burden in males in those aged 0–44, and tobacco, in addition to high body mass, were the leading causes in those aged 45–64 across both sexes.

The 2010 National Drug Strategy Household Survey report showed significant reductions in daily tobacco smoking since 2007 and a small overall rise in illicit drug use. It indicated mixed findings on alcohol consumption and risk (AIHW 2011a).

This chapter presents contextual information on mortality, morbidity and behaviours associated with licit and illicit drug use in Australia. It also focuses on the drugs of concern (Box 4.1) reported by clients of alcohol and other drug treatment services. This includes the main drug that led them to seek treatment, called the principal drug of concern (Section 4.1), and all drugs reported to be of concern (Section 4.3). This chapter also briefly examines the relationships between most common drugs of concern, client and treatment profiles and how this relationship has changed over time (Section 4.2).

More detailed data on drugs of concern are in Appendix C (tables C7 to C21).

Box 4.1: Key definitions and counts for closed treatment episodes and drugs, 2010–11

'Principal drug of concern' refers to the main substance that the client stated led them to seek treatment from the alcohol and other drug treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses involving principal drug of concern because it is assumed that only substance users themselves can accurately report their own principal drug of concern.

'Other drugs of concern' refers to any other drugs reported by the client, in addition to the principal drug of concern. Clients can nominate up to five other drugs of concern.

'All drugs of concern' refers to all drugs reported by clients, including the principal drug of concern as well as any other drugs of concern reported.

4.1 Principal drug of concern

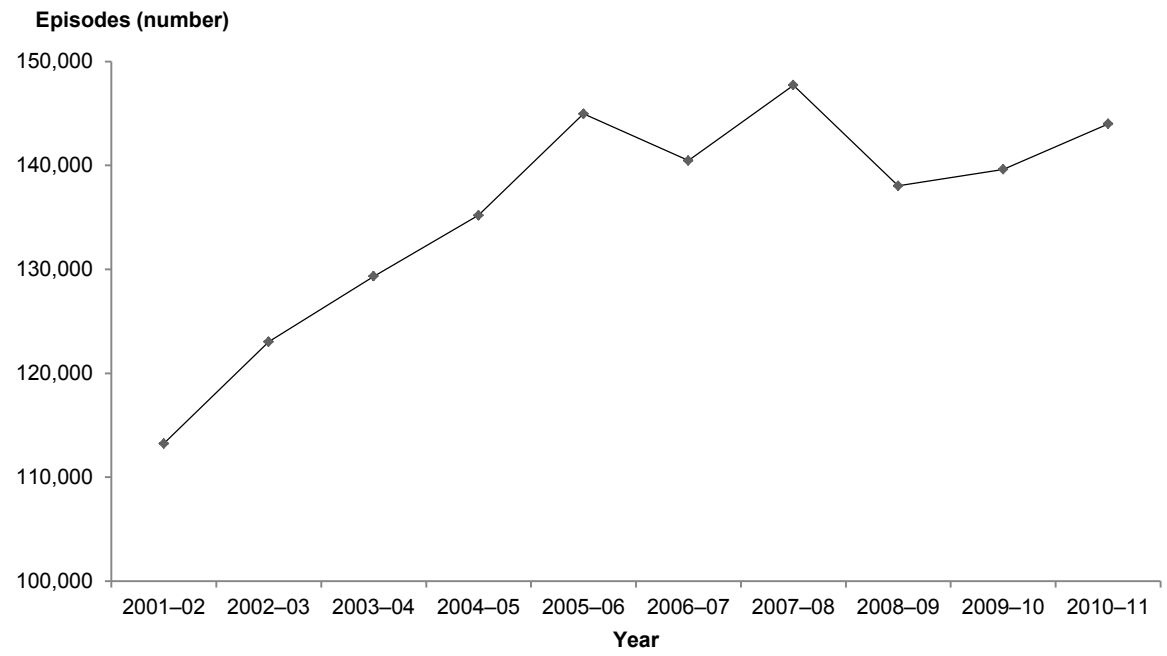
Key findings

- In 2010–11, around 144,000 episodes of treatment were delivered to clients seeking treatment for their own substance use in 2010–11. This was an increase of about 4,400 episodes from 2009–10.
- Alcohol was the most common principal drug of concern both nationally (68,200 of episodes, 47%) and in all jurisdictions, except Tasmania, where cannabis was equally common.
- There has been a steady decline in episodes with heroin as the principal drug of concern, from a peak of 23,300 of episodes (18%) in 2003–04 to 13,400 episodes (9%) in 2010–11.
- The older a client, the more likely they were to seek treatment for alcohol use and the less likely they were to seek treatment for cannabis use.
- About two-thirds of episodes of treatment for 'own drug use' were for males (97,800 of episodes, 68%). Episodes for male clients outnumbered those for females across all drug types.
- When compared with non-Indigenous Australians, episodes for Indigenous Australians were more likely to have alcohol as the principal drug of concern and less likely to have amphetamines or heroin.

The following data provide information about the principal drug of concern relating to episodes where clients were seeking treatment for their own substance use. A principal drug of concern is not collected where clients were seeking assistance for someone else's drug use.

4.1.1 Principal drugs of concern over time

Approximately 144,000 episodes of treatment were delivered to clients seeking treatment for their own substance use in 2010–11 (Figure 4.1). This was an increase of about 30,800 episodes from the collection's inception in 2001–02. From the start of collection, the number of episodes increased until 2005–06. It then declined slightly in 2006–07 before reaching a peak of 147,700 episodes in 2007–08. The number of episodes in 2010–11 was below this peak. This trend is similar to that of the number of agencies providing treatment (see Table 2.1).

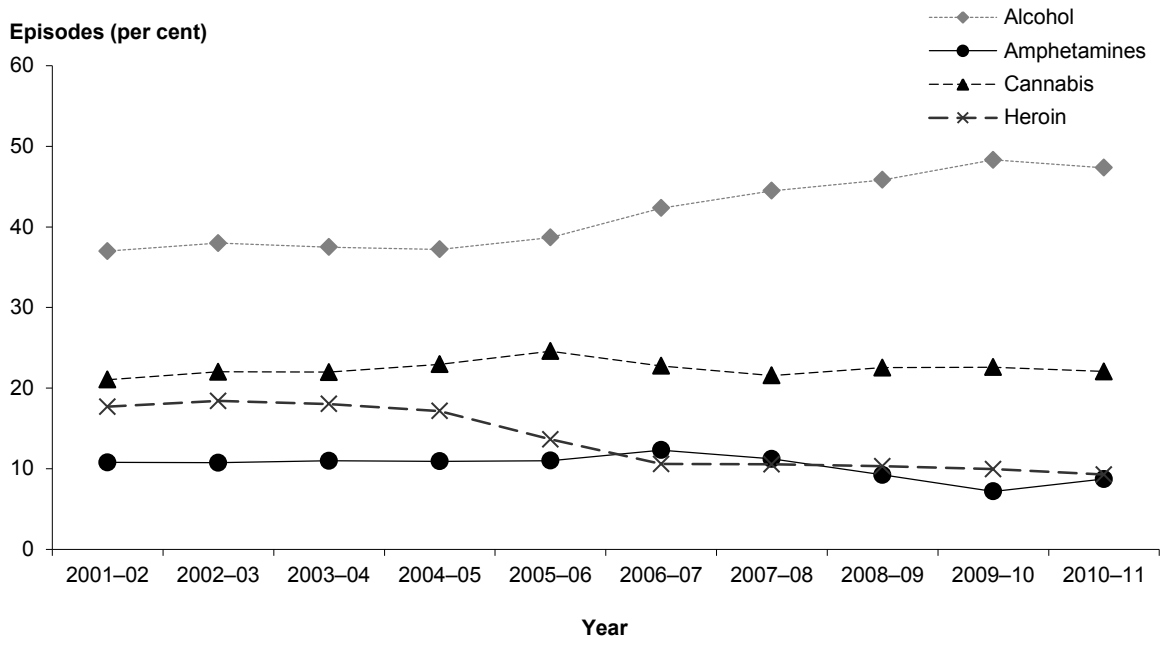


Source: Table C19.

Figure 4.1: Treatment episodes for client's own drug use, all principal drugs of concern, 2001–02 to 2010–11

- The proportion of alcohol episodes out of all episodes where clients sought treatment for their own drug use fell by 1 percentage point from 2009–10 to 2010–11, from 48% to 47%, respectively (Figure 4.2).
- Figure 4.2 shows that, since the collection's inception in 2001–02, the proportion of alcohol episodes has risen by 10 percentage points.
- The proportion of episodes with cannabis as the principal drug of concern has been relatively stable though the life of the collection, varying between 21% and 25% of episodes where clients sought treatment for their own drug use.
- In 2010–11, the proportion of heroin episodes continued to decline. This was a continuation of an 8-year trend that has shown a steady decline in heroin episodes, from a peak of 18% of episodes in 2002–03 to 9% in 2010–11.
- The number of amphetamine episodes increased between 2009–10 and 2010–11, from 7% to 9%, respectively.

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



Source: Table C19.

Figure 4.2: Treatment episodes for client's own drug use by the four most common principal drugs of concern, 2001–02 to 2010–11

4.1.2 Principal drugs of concern across Australia

As observed in previous years, alcohol and cannabis were the most common principal drugs of concern nationally (accounting for 47% and 22% of treatment episodes, respectively). These were followed by heroin and amphetamines (both 9%). Opioids other than heroin accounted for about 5% of episodes, with methadone and morphine each representing about 1% of total episodes. Benzodiazepines were the principal drug of concern for about 2% of episodes and nicotine for about 1% of episodes. Less than 1% of episodes reported ecstasy as the principal drug of concern (Table 4.1). Additional data on drug-related items are in tables C7 to C21.

- Alcohol was the most common principal drug of concern in all jurisdictions, except Tasmania, where cannabis was equally common (Table 4.1).
- Queensland had the lowest proportion of episodes where alcohol was the principal drug of concern (38%), while the Northern Territory had the highest (64%).
- Alcohol and cannabis both accounted for 39% of episodes in Tasmania. This was lower than the national proportion for alcohol (47%) and higher than the national proportion for cannabis (22%).
- The Australian Capital Territory had the largest proportion of treatment episodes where heroin was the principal drug of concern (16% compared with 9% nationally).
- Tasmania and the Northern Territory had a lower proportion of episodes where heroin was the principal drug of concern (both around 1% compared with the national average of 9%) but a higher proportion of episodes where morphine was the principal drug of concern (7% for the Northern Territory and 5% for Tasmania, compared with 1% nationally).

- The Northern Territory reported a higher-than-average proportion of episodes where volatile solvents were the principal drug of concern (9% compared with less than 1% nationally).

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

Table 4.1: Treatment episodes for client's own drug use by principal drug of concern and jurisdiction, 2010–11 (per cent)

	Jurisdiction								
	NSW	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**
Analgesics									
Heroin	8.9	12.7	5.6	7.4	7.4	0.5	15.7	1.2	9.3
Methadone	2.1	1.0	0.7	1.7	2.1	1.2	1.4	0.7	1.4
Morphine	1.1	0.7	1.5	1.0	2.0	5.1	0.4	6.6	1.2
Other opioids	2.9	0.8	2.9	0.8	3.3	2.2	3.4	1.0	1.9
Total analgesics	*15.1*	*16.1*	*10.7*	*14.0*	*14.9*	*9.7*	*20.8*	*9.5*	*14.5*
Sedatives and hypnotics									
Alcohol	50.6	47.0	38.2	47.7	54.7	38.8	53.8	64.2	47.3
Benzodiazepines	2.2	1.9	1.5	1.1	1.6	1.9	1.0	0.3	1.7
Total sedatives and hypnotics	*52.9*	*49.3*	*39.7*	*48.9*	*56.3*	*40.8*	*54.7*	*64.9*	*49.2*
Stimulants and hallucinogens									
Amphetamines	8.3	6.9	8.1	15.7	12.8	8.6	6.4	3.1	8.7
Cannabis	19.6	23.4	29.1	18.8	13.2	38.9	16.9	10.6	22.1
Ecstasy	0.2	0.3	1.2	0.3	0.6	0.6	0.4	0.3	0.5
Cocaine	0.7	0.2	0.4	0.2	0.1	0.1	0.3	0.1	0.3
Nicotine	1.4	1.0	2.4	0.5	1.0	0.4	0.2	1.6	1.3
Total stimulants and hallucinogens	*30.3*	*32.1*	*41.5*	*35.7*	*27.8*	*49.2*	*24.4*	*15.7*	*33.1*
Volatile solvents	0.1	0.3	0.1	0.5	0.1	0.1	0.0	8.7	0.4
All other drugs	1.6	2.3	8.0	1.0	0.8	0.2	0.0	1.1	2.8
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**35,365**	**49,974**	**25,580**	**15,971**	**9,143**	**1,653**	**3,108**	**3,208**	**144,002**

Note: See Table 7.3 for further state-specific data quality features.

With the exception of agencies in *Very remote* areas, the more remote an agency's location, the more episodes it reported where alcohol was the principal drug of concern (Table 4.2). Agencies in *Remote* and *Very remote* areas had the highest proportions of alcohol episodes (65% and 58%, respectively) while agencies in *Major cities* had the lowest (46%).

The proportion of episodes in *Very remote* areas where alcohol was the principal drug of concern (58%) continued to decrease from 68% in 2009–10 and 81% in 2008–09.

The proportion of episodes with heroin or amphetamines as principal drugs of concern were highest in *Major cities* (12% and 10%, respectively) and decreased as remoteness increased,

except in *Very remote* areas where these proportions were slightly higher than in *Remote* areas.

Cannabis was the second most common principal drug of concern and continued to be most common in agencies in *Inner regional* (27%) and *Outer regional* (23%) areas.

Table 4.2: Treatment episodes for client's own drug use by principal drug of concern and geographical location[(a)], 2010–11 (per cent)

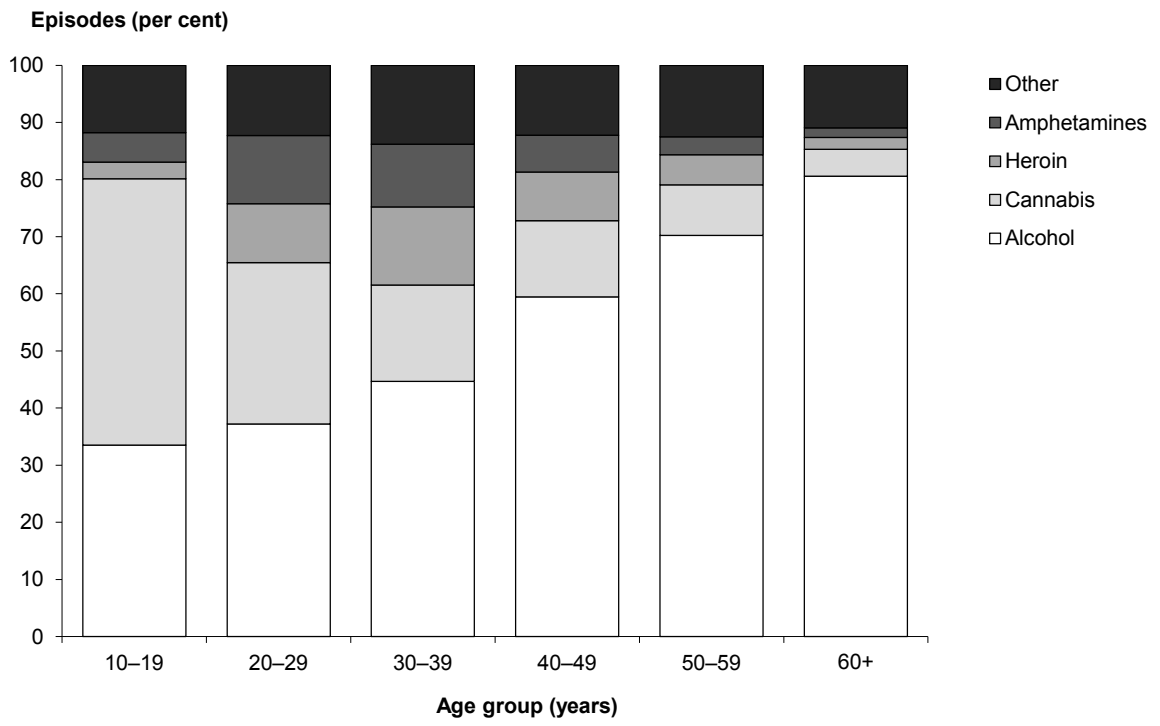
	Geographical area				
	Major cities	**Inner regional**	**Outer regional**	**Remote**	**Very remote**
Analgesics					
Heroin	12.1	4.6	3.0	2.9	3.2
Methadone	1.5	1.2	1.1	0.3	0.6
Morphine	0.9	1.4	3.3	1.0	1.2
Other opioids	2.0	1.8	2.2	1.1	2.7
Total analgesics	*17.1*	*9.9*	*10.2*	*5.4*	*8.1*
Sedatives and hypnotics					
Alcohol	45.8	48.9	49.6	65.1	57.5
Benzodiazepines	1.9	1.5	1.0	0.9	1.2
Total sedatives and hypnotics	*47.8*	*50.5*	*51.4*	*66.0*	*58.7*
Stimulants and hallucinogens					
Amphetamines	9.9	7.3	5.5	3.0	6.6
Cannabis	20.5	26.5	23.0	17.0	20.6
Ecstasy	0.6	0.3	0.4	0.3	0.6
Cocaine	0.4	0.2	0.2	0.1	0.0
Nicotine	0.8	1.8	2.9	1.5	1.2
Total stimulants and hallucinogens	*32.5*	*36.4*	*32.2*	*22.1*	*29.3*
Volatile solvents	0.2	0.1	1.6	3.0	1.7
All other drugs	2.4	3.1	4.7	3.5	2.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Geographical location is based on the geographical location of the treatment agency.

4.1.3 Age and principal drug of concern

Older clients were generally more likely to seek treatment for alcohol use and less likely to seek treatment for cannabis use (Figure 4.3).

- Alcohol was the most frequently reported principal drug of concern for all age groups, except 10–19 year olds, where cannabis was more common. The proportion of episodes where alcohol was the principal drug of concern ranged from less than 2 in 5 for 10–19 year olds (34%) to more than 4 in 5 clients aged 60 and over (81%).
- Cannabis was the most common principal drug of concern for 10–19 year olds (47%). It was second most common for all other age groups and the proportion decreased as the age group increased, ranging from 28% for 20–29 years olds to 5% for those ages 60 and over.
- Alcohol, cannabis, heroin and amphetamines accounted for between 85% and 90% of treatment episodes in all age groups.
- Heroin and amphetamine episodes were most common among the 20–29 and 30–39 age groups.



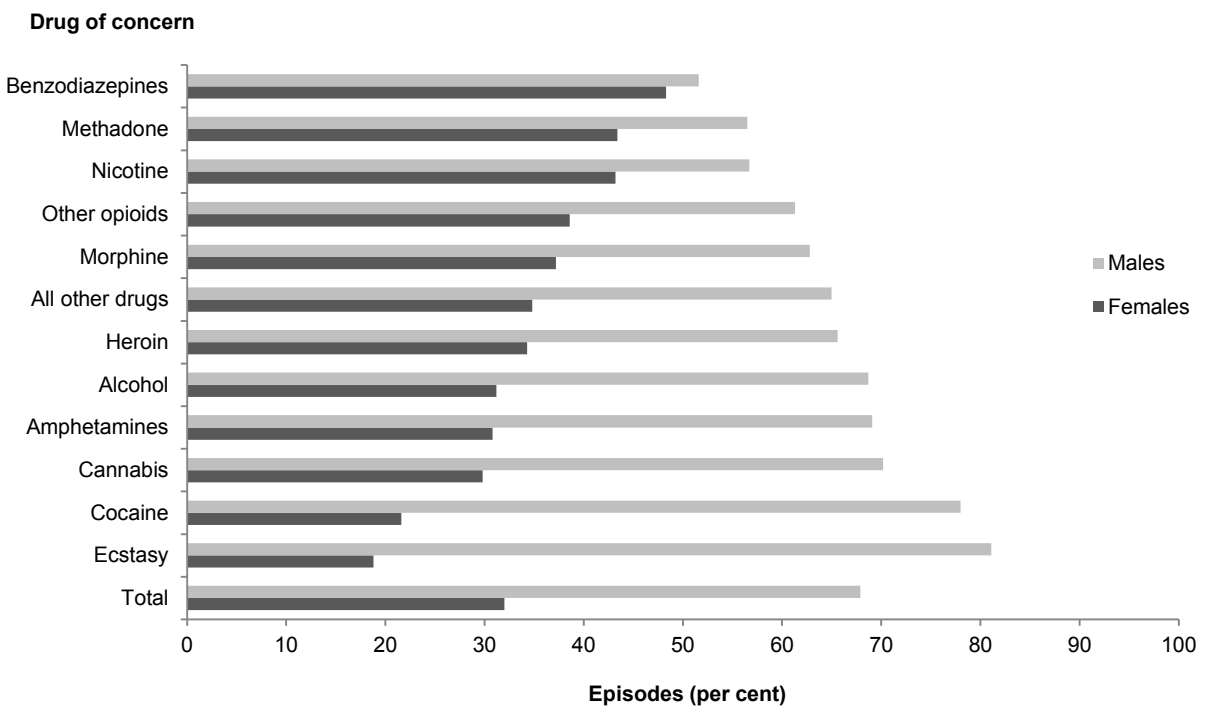
Source: Table C9.

Figure 4.3: Treatment episodes for client's own drug use by top four principal drugs of concern and age group, 2010–11

4.1.4 Sex and principal drug of concern

As in all previous years, about two-thirds of all treatment episodes where clients were seeking treatment for their own drug use were for males (68%) (Figure 4.4). Episodes for male clients outnumbered those for females across all drug types. Episodes for benzodiazepines had the most even gender split, with females accounting for almost half (48%) of episodes. Ecstasy and cocaine showed the greatest difference by gender, with about 4 in 5 clients seeking treatment being male (81% and 78%, respectively).

Two in 3 episodes (69%) for alcohol, the most common principal drug of concern, were delivered to male clients.



Source: Table C10.

Figure 4.4: Treatment episodes for client's own drug use by principal drug of concern and sex, 2010–11

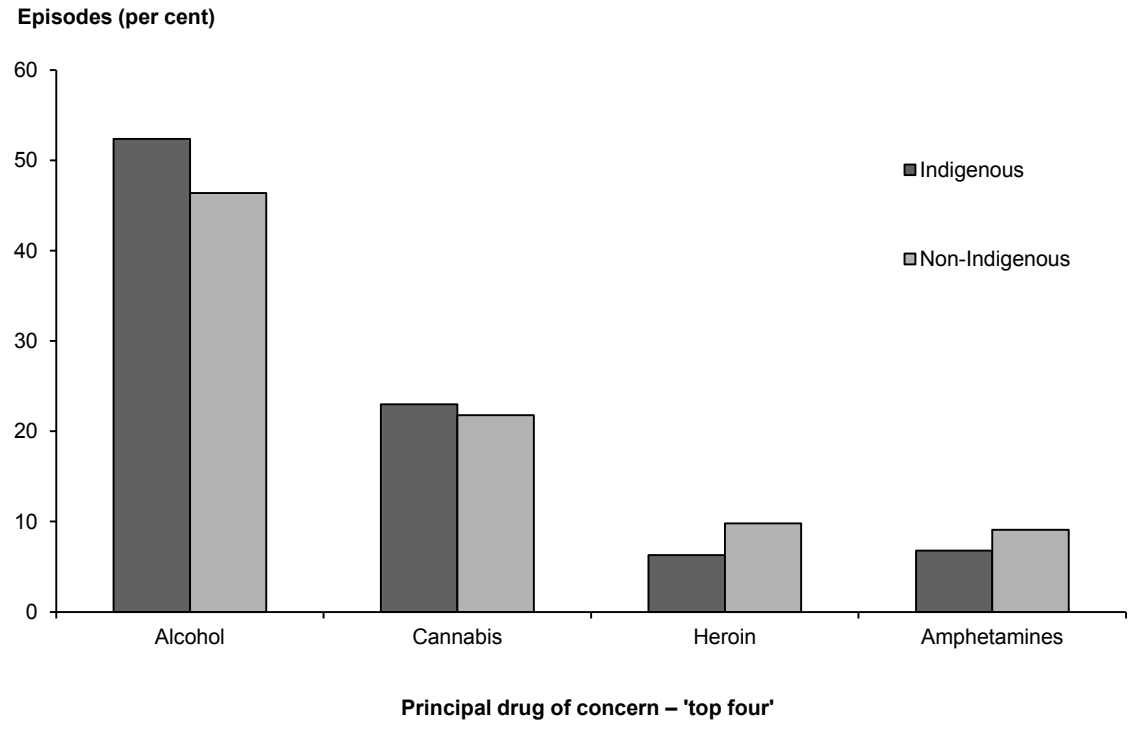
4.1.5 Indigenous Australians and principal drug of concern

Indigenous Australian clients reported the same top four principal drugs of concern as the population overall—alcohol (52% of episodes), cannabis (23%), amphetamines (7%) and heroin (6%).

Indigenous Australians were more likely to report alcohol as the principal drug of concern (52% of episodes) than non-Indigenous clients (46% of episodes) and less likely to report amphetamines (7% compared with 9%, respectively) or heroin (6% compared with 10%, respectively). Cannabis was reported in similar proportions by the two population groups (Figure 4.5).

Episodes for Indigenous clients were much more likely to have volatile solvents as the principal drug of concern than episodes for non-Indigenous clients (2% compared with 0.1%, respectively) (Table C11).

Trends in the proportion of principal drugs of concern among Indigenous clients remained relatively stable between 2009–10 and 2010–11 (Table C20).



Source: Table C11.

Figure 4.5: Treatment episodes for client's own drug use by selected top four principal drug of concern and Indigenous status, 2010–11

4.2 Individual principal drug of concern profiles

Key findings

- In 2010–11, around half of episodes (around 70,900 episodes, 49%) had more than one drug of concern.
- As in previous years, alcohol was the most common principal drug of concern for which treatment was sought, accounting for almost half of episodes (68,200 episodes, 47%).
- Episodes where alcohol was the principal drug of concern were less likely to have an additional drug of concern than episodes with any other principal drug of concern (42% compared with 49% for all drugs).
- Clients seeking treatment for cannabis tended to be younger, with a median age of 25 compared with 33 for all drug types.
- Although ecstasy was not a very common principal drug of concern, ecstasy episodes had the youngest clients, the highest proportion of male clients and the lowest proportion of Indigenous clients, compared with other drugs of concern.
- In 2010–11, for the first time since the collection's inception, more episodes with benzodiazepines as their principal drug of concern were completed by males (52%) than females.

The following section provides more detailed information on each of the key substances profiled in the AODTS–NMDS. Information about the drug, client and treatment profile is outlined for each of the individual principal drugs of concern. Some information about the use of the drug in Australia obtained from various other data sources is also provided.

For further information on data used in this section, see tables C7 to C21.

4.2.1 Alcohol

Box 4.2: Alcohol consumption guidelines

The National Health and Medical Research Council (NHMRC) released the Australian guidelines to reduce health risks from drinking alcohol in 2009. These take a different approach from the previous Australian alcohol guidelines by identifying a progressively increasing risk of harm with increasing amounts of alcohol consumed rather than specifying 'risky' or 'high risk' levels of consumption.

According to the NHMRC 2009 guidelines, the lifetime risk of harm from drinking alcohol increases with the amount consumed. For healthy men and women, drinking no more than two standard drinks on any day reduces the lifetime risk of harm from alcohol-related disease or injury. On a single occasion of drinking, the risk of alcohol-related injury increases with the amount consumed. For healthy men and women, drinking no more than four standard drinks on a single occasion reduces the risk of alcohol-related injury arising from that occasion (NHMRC 2009).

Pattern of use in Australia

Alcohol is the most widely used drug in Australia. Analysis of the 2010 National Drug Strategy Household Survey (NDSHS) (AIHW 2011a) describes various behaviours, characteristics and attitudes of those who consume alcohol.

In the 12 months before the survey, almost half of the population aged 14 and over (47%) drank alcohol on a daily or weekly basis, and about a third (34%) drank less than once a week. Older people were more likely to be daily drinkers than younger people, and males were more likely to be daily drinkers than females.

The proportion of people drinking alcohol at levels that put them at risk of harm over their lifetime remained relatively stable at 1 in 5 (20%) between 2007 and 2010.

However, more than 3.7 million people in Australia aged 14 and over were at risk of an alcohol-related disease or injury over their lifetime based on their pattern of drinking in 2010 (up from 3.5 million in 2007) and people aged 18–29 were more likely than any other age group to drink alcohol in a way that put them at risk of alcohol-related harm over their lifetime (32% for those aged 18–19 and 27% for those aged 20–29). In 2010, males were twice as likely as females to drink alcohol in quantities that put them at risk of incurring an alcohol-related chronic disease or injury over their lifetime (29% and 11%, respectively) (AIHW 2011a).

Drug profile

- Alcohol was the most common principal drug of concern for which treatment was sought in 2010–11, accounting for almost half of episodes (47%), almost unchanged from 48% in 2009–10.
- Alcohol has been the most common principal drug of concern reported since the collection began in 2001–02. The proportion of alcohol episodes out of all episodes where clients sought treatment for their own drug use has risen by 10 percentage points since 2001–02.
- Episodes where alcohol was the principal drug of concern were less likely to have an additional drug of concern than episodes with any other principal drug of concern (42% compared with 49% for all drugs).
- Where alcohol was the principal drug of concern, cannabis was most likely to be an 'other drug of concern' (36%).

Client profile

- Clients seeking treatment for alcohol were older than those seeking treatment for any other principal drug of concern; the median age for alcohol clients was 37 compared with 33 for all principal drugs of concern.
- The age distribution of clients seeking treatment for alcohol as the principal drug of concern remained stable compared with 2009–10, with clients aged 30–39 accounting for the greatest proportion of episodes (27%), and followed by those aged 40–49 (24%).
- Seven in 10 episodes (69%) where alcohol was the principal drug of concern were for male clients. This remained unchanged from 2009–10.
- About 15% of all episodes with alcohol as the principal drug of concern in 2010–11 were for Indigenous Australians and this is similar to 2009–10.

Treatment profile

- The most common main treatment type for alcohol was counselling (42%) and this was similar to the proportion of counselling episodes for all drugs of concern (40%).
- Treatment episodes where alcohol was the principal drug of concern had a median of 22 days.
- Treatment was most likely to take place in a non-residential treatment facility (62% of episodes) or a residential treatment facility (21%), consistent with 2009–10 findings. The most common reason for cessation of treatment was that it was completed (63%).
- As in 2009–10, self-referral was the most common source of referral for alcohol treatment (38% of episodes).

4.2.2 Cannabis

Pattern of use in Australia

According to the 2010 NDSHS (AIHW 2011a), 1 in 10 people in Australia aged 14 and over (10%) had used cannabis at least once in the last 12 months and 1 in 3 (35%) had used cannabis at some stage in their lifetime. The average age of first use was 19 and males were more likely to have ever used, or recently used, cannabis than females. There was an increase in cannabis use between 2007 and 2010.

Drug profile

- Cannabis was the second most common principal drug of concern in 2010–11, accounting for over 1 in 5 treatment episodes (22% or 31,800 episodes).
- Smoking was the most common method of using cannabis (78%). While this was a substantial decrease from 2009–10 (89%), it coincides with an increase in 'not stated' responses for method of use (11% for 2010–11 compared with 4% for 2009–10). More information on 'not stated' responses for this item is in Section 7.2.2.
- When 'other drugs of concern' are also considered, 42% of episodes included cannabis as a drug of concern.
- About 3 in 5 episodes with cannabis as the principal drug of concern (57%) included at least one other drug of concern. This other drug of concern was most likely to be alcohol (37%) although nicotine and amphetamines were also relatively common (21% and 18%, respectively).

Client profile

- Seven in 10 episodes (70%) where cannabis was reported as the principal drug of concern were for males. This remained unchanged from the previous year.
- Clients seeking treatment for cannabis tended to be younger; the median age for clients seeking treatment for cannabis was 25, which was younger than the median age for all drugs (33). This was consistent with the median age observed in 2009–10.
- Clients aged 20–29 accounted for the largest proportion of treatment episodes (37%), followed by those aged 10–19 (26%).
- Around 1 in 7 episodes (14%) for cannabis treatment involved clients who identified as Indigenous.

Treatment profile

- Self-referral was the most common source of referral for episodes with cannabis as the principal drug of concern (29% of episodes). This was less than the proportion of self-referral for all episodes (36%). Referrals from court diversion were also relatively common for episodes with cannabis as the principal drug of concern (20% of episodes compared with 13% for all drugs of concern).
- Counselling was the most common main treatment type received (39% of episodes) and this was similar to the proportion for all drugs (40%).
- Treatment was most likely to take place in a non-residential treatment facility (62% of episodes). Treatment episodes most often ended because the treatment was completed (52%) or because the client ceased to participate at expiation (16%).

4.2.3 Heroin

Pattern of use in Australia

According to the 2010 NDSHS, fewer than 2% of Australians aged 14 and over have used heroin in their lifetime, with less than 1% having used heroin in the 12 months before the survey (AIHW 2011a). Those aged 30–39 were most likely to have used heroin in their lifetime (3%) compared with other age groups, with males twice as likely as females to have ever used heroin (2% compared with 1%, respectively). Of the 15 illicit drugs included in the 2010 NDSHS, heroin was the eleventh most commonly used (jointly with ketamine and methadone/buprenorphine). The average age at which Australians first used heroin was 21.

Drug profile

- Heroin was the third most common principal drug of concern for which treatment was sought in 2010–11 (9% of episodes).
- The proportion of episodes reporting heroin as their principal drug of concern in 2010–11 was lower than any other year of the collection (9%) and this was part of a continued decline from a high of 18% in 2002–03.
- Heroin is rarely reported as an 'other drug of concern' (4% of episodes). In total, 13% of episodes included heroin as a drug of concern, as either the principal drug of concern or as another drug of concern.
- Nearly two-thirds (63%) of episodes with heroin as their principal drug of concern included at least one other drug of concern. This other drug was most likely to be cannabis.
- Injecting was the most common method of use among those reporting heroin as their principal drug of concern (78% of episodes). This was a decline from 86% observed in 2009–10. However, this decline is accompanied by an increase in the proportion of 'not stated' responses for method of use (see Section 7.2.2 for more details). Clients reported that they most often smoked heroin in 5% of episodes.

Client profile

- Male clients accounted for two-thirds of episodes (66%) reporting heroin as the principal drug of concern. This was slightly below the proportion for all drugs (68%) and slightly below the proportion for males reporting heroin as their principal drug of concern in 2009–10 (67%).

- Three-quarters of all episodes (73%) were for clients aged 20–39.
- The median age of clients receiving treatment for heroin was 32, similar to 2009–10.
- About 1 in 10 (9%) episodes for heroin treatment involved clients who identified as Indigenous; lower than the proportion for all drugs (13%). Of all episodes involving Indigenous Australian clients, the overall proportion for heroin has gradually decreased from 10% in 2005–06 to 6% in 2010–11. This decrease has also been observed among non-Indigenous clients (from 14% in 2005–06 to 10% in 2010–11).

Treatment profile

- Counselling was the most common main treatment type for those with heroin as the principal drug of concern (36%). Withdrawal management (detoxification) was the second most common treatment type (18%).
- In 2010–11, more than 3 in 5 episodes (62%) with heroin as the principal drug of concern were delivered in non-residential treatment facilities.
- Self-referral was the most common source of referral in 2010–11 (42%, down from 44% in 2009–10). This was higher than the proportion of all episodes with this source of referral (36%). Referrals from court diversion and correctional services were next most common (15% and 14%, respectively).
- Three in 5 treatment episodes for heroin ended because the treatment was completed (57%). The next most common reason for treatment ending was that the client ceased to participate without notifying the service (14%).

4.2.4 Amphetamines

Pattern of use in Australia

According to the 2010 NDSHS, 7% of Australians aged 14 and over had used amphetamines for non-medical purposes at some stage in their lifetime, and 2% had used them in the past 12 months (AIHW 2011a).

People aged 30–39 were most likely to have ever used amphetamines (15%). Males were more likely than females to have used amphetamines in the past 12 months (3% compared with 2%, respectively). The average age of first use was 21. Between 1998 and 2010, there was a decrease from 4% to 2% in the recent use of amphetamines among people in Australia aged 14 and over.

Drug profile

- Amphetamines were the fourth most common principal drug of concern for which treatment was sought in 2010–11 (9% of episodes), a slight increase compared with 2009–10 (7%).
- When other drugs of concern were also considered, 20% of all treatment episodes included amphetamines as a drug of concern, and this finding was similar to 2009–10.
- Three in 5 (61%) episodes included at least one other drug of concern in addition to amphetamines, a decrease from 64% in 2009–10. In both 2009–10 and 2010–11, this other drug was most commonly cannabis.

- Almost half (49%) of episodes reported injecting as their method of use, a decrease from 61% of episodes in 2009–10. This decrease corresponded with an increased proportion of 'not stated' responses to this item in 2010–11 (see Section 7.2.2 for more details).

Client profile

- Remaining stable from 2009–10, 69% of episodes with amphetamines as their principal drug of concern involved male clients. This was only slightly above the proportion for all drugs (68%).
- The median age of clients receiving treatment for amphetamine use was 30, with clients aged 20–29 accounting for the greatest proportion of episodes (39%), followed by those aged 30–39 (36%). This is similar to 2009–10 where the age group of 20–29 was also the most common (42%).
- The proportion of episodes with amphetamines as their principal drug of concern involving clients who identified as Indigenous Australians (10%) was lower than the proportion for all drugs (13%).

Treatment profile

- Similar to previous years, counselling was the most common main treatment type, with about half (48%) of episodes where amphetamines were the principal drug of concern reporting this treatment. This proportion was higher than the proportion for all principal drugs of concern (40%). Assessment only was the second most common treatment type in 2010–11 (17% of episodes).
- One in 3 episodes for amphetamine treatment involved clients who referred themselves (36%).
- The most common treatment delivery setting for clients receiving treatment for amphetamine use was non-residential (64%), followed by residential (17%).
- Over half (57%) of episodes with amphetamines recorded as the principal drug of concern ended because treatment was completed. The second most common reason for cessation was that the client ceased to participate without notifying the service provider (17% of episodes). Proportionally more treatment episodes for amphetamines ended this way, compared with any other principal drug of concern (14% for all drugs of concern).

4.2.5 Benzodiazepines

Pattern of use in Australia

Benzodiazepines include tranquillisers and sleeping pills. According to the 2010 NDSHS (AIHW 2011a), of people in Australia aged 14 and over, fewer than 2% reported using benzodiazepines (identified as tranquillisers or sleeping pills in the survey) in the previous 12 months for non-medical purposes. People aged 20–29 were most likely to use tranquillisers or sleeping pills (3%) compared with other age groups. There was very little overall difference in the prevalence of recent use of tranquillisers or sleeping pills between males and females. Of those who had ever used tranquillisers or sleeping pills, the average age of first use was 27.

Drug profile

- Benzodiazepines were the principal drug of concern in fewer than 2% of episodes in 2010–11; this proportion has remained stable since 2001–02.

- When other drugs of concern were considered, almost 1 in 10 treatment episodes (8%) included benzodiazepines.
- Almost 2 in 3 episodes (64%) included at least one other drug of concern in addition to benzodiazepines, most commonly alcohol or cannabis (both 20%). This is similar to proportions observed in 2009–10.

Client profile

- Treatment episodes for benzodiazepines had a higher proportion of female clients than any other principal drug of concern, with just under half (48%) of episodes delivered to female clients.
- Historically, benzodiazepines were the only drug group where more episodes were completed by female clients than male clients. Figure 4.6 shows that between 2002–03 and 2007–08 more females than males received treatment for benzodiazepine use. The gap between females and males narrowed from 2004–05 and in 2008–09 this ratio was even (50% for both males and females). In 2009–10 females again accounted for slightly more episodes (52%) than males. In 2010–11, for the first time since the collection's inception, more episodes with benzodiazepines as their principal drug of concern were completed by males (52%) than females.
- Clients aged 30–39 accounted for the greatest proportion of episodes (36%), followed by those aged 20–29 (24%).
- Clients identified as Indigenous Australians in 7% of episodes where benzodiazepines were the principal drug of concern; this was lower than the proportion for all drugs (13%).

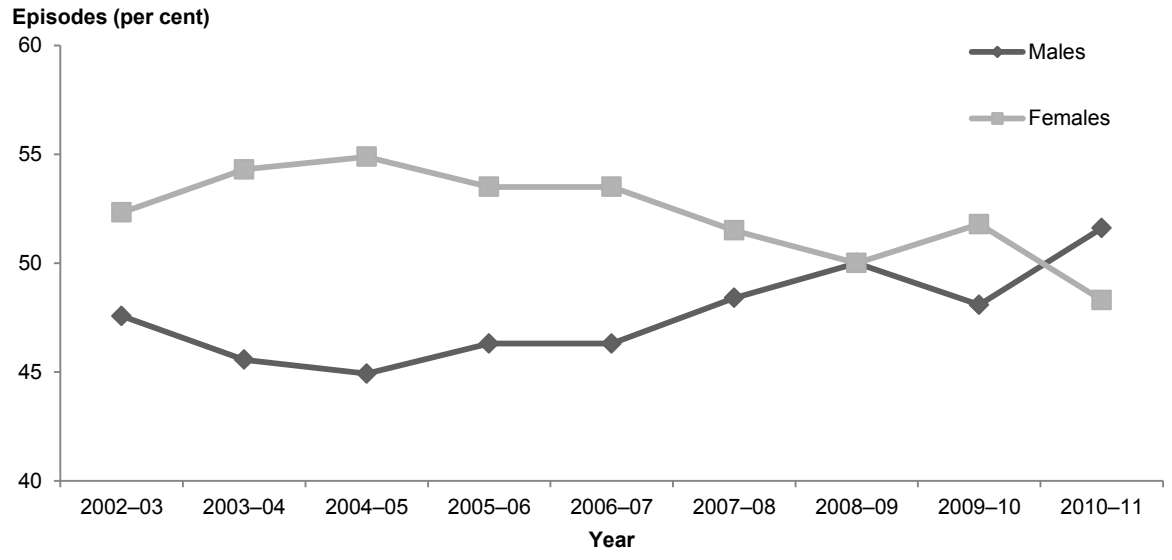


Figure 4.6: Treatment episodes with benzodiazepines as their principal drug of concern by sex, 2002–03 to 2010–11

Treatment profile

- Counselling and withdrawal management (detoxification) were the most common main treatment types received (36% and 27%, respectively).

- Self-referral was the most common source of referral, accounting for 2 in 5 episodes (38%). Referrals by medical practitioners or by alcohol and other drug treatment services were the next most common (both 12%).
- Three in 5 treatment episodes (63%) with benzodiazepine as the principal drug of concern took place in non-residential facilities.
- Most treatment episodes ceased because the treatment had been completed (59%).

4.2.6 Ecstasy

Pattern of use in Australia

According to the 2010 NDSHS, 1 in 10 (10%) people in Australia aged 14 and over have used ecstasy at some stage in their lifetime, with 3% reporting use in the last 12 months (AIHW 2011a). Of those who had ever used ecstasy, the average age of first use was 22. Those aged 20–29 were more likely than others to have used ecstasy, either recently or at least once in their lifetime (10% and 24%, respectively). Overall, males were more likely than females to have recently used ecstasy (4% compared with 2%, respectively). For the first time since 1995, ecstasy use declined between 2007 and 2010. A significant decline was seen among males aged 14 and over (from 4.4% in 2007 to 3.6% in 2010) and in the 14–19 age group (from 5.0% in 2007 to 2.8% in 2010).

Drug profile

- Ecstasy as the principal drug of concern accounted for less than 1% (around 700) of treatment episodes in 2010–11.
- Ecstasy episodes remained steady as a proportion of all episodes between 2009–10 and 2010–11 (both less than 1%) but decreased substantially in terms of total number of episodes where ecstasy was the principal drug of concern (around 700 episodes in 2010–11 down 400 episodes from around 1,100 in 2009–10).
- When all drugs of concern are considered, 4% of treatment episodes included ecstasy as a drug of concern, down from 6% in 2009–10.
- Just under half of episodes with ecstasy as their principal drug of concern (48%) included at least one other drug of concern and this drug was most commonly alcohol.

Client profile

- Episodes where ecstasy was the principal drug of concern had a higher proportion of male clients than any other drug type (81% compared with 68% for all drug types).
- The median age for clients seeking treatment for ecstasy was 23, the lowest of all drug types. Three-quarters of episodes (76%) involved clients under 30.
- Only 6% of episodes involved clients who identified as Indigenous Australian, the lowest proportion of all principal drugs of concern. However, this proportion is still higher than the proportion of Indigenous Australians in the total Australian population aged 10 and older (approximately 2.2%).

Treatment profile

- Counselling was the most common main treatment type for episodes with ecstasy as the principal drug of concern (43% of episodes). The second most common main treatment type was information and education only (25%).

- Ecstasy-related episodes had a relatively low rate of self-referral (18%), an increase from 15% in 2009–10. Court diversion was the most common source of referral for ecstasy episodes (36%). Police diversion was also a common source of referral (16%).
- The proportion of episodes with ecstasy as the principal drug of concern that took place in a non-residential treatment facility decreased from 81% in 2009–10 to 65% in 2010–11. This decrease corresponded with an increase in episodes that took place in home or outreach settings which each accounted for 13% in 2010–11, up from 2% for home and 8% for outreach in 2009–10.
- Accounting for almost half of episodes (49%), the most common reason for cessation was that treatment was completed. This was followed by ceasing to participate when the client fulfilled their obligation to receive treatment (29%).

4.2.7 Cocaine

Pattern of use in Australia

According to the 2010 NDSHS (AIHW 2011a), 7% of people in Australia aged 14 and over have used cocaine at some stage in their lifetime, and 2% reported using cocaine in the previous 12 months. The average age at which cocaine was first used was 23. The 30–39 age group had the highest proportion (14%) of persons ever using cocaine, with the 20–29 age group having the highest proportion of persons who had recently used cocaine (7%). Overall, males were more likely than females to have recently used cocaine (3% compared with 2%, respectively). Recent cocaine use has been increasing since 2004, and this trend continued in 2010 with an increase in recent use, from 1.6% in 2007 to 2.1% in 2010.

Drug profile

- Cocaine was the principal drug of concern in a small proportion of episodes in 2010–11 (less than 1%, or around 500 episodes). This is a small decrease from around 600 episodes in 2009–10.
- When other drugs of concern are also considered, 2% of treatment episodes included cocaine in 2010–11.
- Three in 5 (61%) episodes included at least one other drug of concern in addition to cocaine, a decrease from 64% in 2009–10. Alcohol was most commonly this other drug (27%).
- The most common method of use was sniffing, accounting for 54% of episodes. Injecting (15%) and smoking (11%) were also common methods of use (see Section 7.2.2 for more details on the quality of method of use data in the 2010–11 collection).

Client profile

- Nearly 4 in 5 episodes (78%) were for males.
- The median age of clients receiving treatment was 30 in 2010–11, with clients aged 20–29 and 30–39 accounting for the greatest proportions of episodes. These findings are similar to those observed in 2009–10.
- About 9% of cocaine-related episodes were for clients that identified as Indigenous Australians. While this was an increase compared with 2009–10 (4%), the number of episodes for Indigenous clients with cocaine as the principal drug of concern is quite small and is therefore more subject to change.

Treatment profile

- Counselling was the most common main treatment received by those reporting cocaine as the principal drug of concern, increasing from 44% of episodes in 2009–10 to 51% in 2010–11. This was followed by assessment only (16%).
- Self-referral was the most common source of referral for episodes with cocaine as the principal drug of concern (38%). This was an increase from 34% observed in 2009–10.
- Treatment was most likely to take place in a non-residential treatment facility (73% of episodes) or a residential treatment facility (11%).

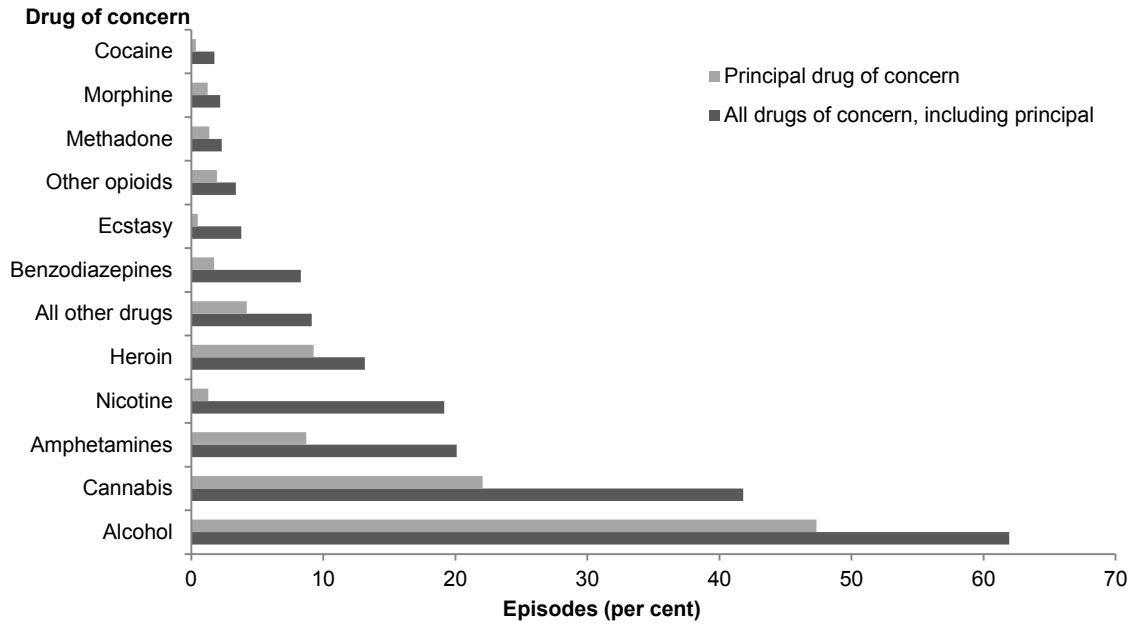
4.3 All drugs of concern

Key findings

- Just under half of episodes (around 70,900 episodes, 49%) had at least one other drug of concern in addition to their principal drug of concern.
- Alcohol was both the most commonly reported principal drug of concern (47%) and the most common drug of concern when all drugs were considered (62%).
- Despite being reported as the principal drug of concern in only 1% of treatment episodes, nicotine was the fourth most common drug reported overall, reported in 19% of all episodes.
- Heroin was rarely reported as an additional drug of concern.

Clients may nominate up to five other drugs of concern for each episode in addition to the principal drug of concern. This means that a particular drug type has a certain proportion of episodes where it is the principal drug of concern and a certain proportion of episodes where it is an additional drug of concern. The sum of these is the proportion of episodes where that drug type is a drug of concern, when all drugs of concern are considered.

- Alcohol was both the most commonly reported principal drug of concern (47%) and the most common drug of concern when all drugs were considered (62%) (Figure 4.7).
- Cannabis was recorded as the second most common drug of concern, both as the principal drug of concern and where all drugs were considered (22% and 42%, respectively).
- Although amphetamines were slightly less common than heroin as principal drugs of concern (both about 9%), when all drugs were considered, amphetamines were a drug of concern in 20% of episodes and heroin in 13%. This was because heroin was rarely reported as an additional drug of concern (4% of episodes).
- Despite being reported as the principal drug of concern in only 1% of treatment episodes, nicotine was the fourth most common drug reported overall, reported in 19% of all episodes.



Source: Table C13.

Figure 4.7: Treatment episodes for client's own drug use by principal drug of concern and all drugs of concern, 2010–11

5 What treatments do people receive?

Key findings

- The total number of treatment episodes has increased from around 113,700 in 2001–02 to approximately 150,500 in 2010–11.
- Most treatment episodes (102,300 episodes, 68%) were closed due to an 'expected/compliant completion'.
- Counselling was the most common main treatment type nationally (61,900 episodes, 41%).
- Counselling had the longest median duration (57 days) of all treatment types, a change from 2009–10 where the longest median duration was for support and case management (53 days).
- In 2010–11, there were 13,800 closed treatment episodes that included at least one additional treatment type (14% of all episodes), an increase from 2009–10 (8,800 or 9%).

When attending an alcohol and other drug treatment agency, a client will receive a main treatment and sometimes additional or 'other' treatments (Box 5.1).

There are two types of clients who seek treatment: those who seek treatment for their own drug use and those who seek assistance in relation to someone else's drug use. Data in this chapter explore main treatment and other treatment for both these client groups. However, data relating to a principal drug of concern for a treatment episode are only reported for those who sought treatment for their own drug use.

The treatment types reported to the AODTS–NMDS are broad categories. They are intended to group similar treatments rather than represent in detail the large variety of treatment programs around Australia. It is important to note that there is no consensus about the 'right' mix of treatments or the volume of treatment services needed to meet the needs of people with drug-use issues in Australia.

Box 5.1: Key definitions and counts for treatment programs, 2010–11

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

'Other treatment type' refers to two separate concepts in the technical specifications for the AODTS–NMDS collection. First, it refers to main treatment types that do not fit into the categories of withdrawal management (detoxification), counselling, rehabilitation, support and case management only, information and education only or assessment only. In this context, 'other treatment types' might include living skills classes or relapse prevention.

Second, 'other treatment type' refers to additional treatments provided to clients as well as the main treatment type. These are referred to as 'additional treatment types' in this report. Additional treatment types most often include treatments from the categories used for main treatment type. For example, a client may receive withdrawal management (detoxification) as their main treatment and counselling as an additional treatment. Up to four additional treatment types can be recorded for each client.

'All treatment types' refer to all treatments reported by agencies as taking place during the collection period, including the main and additional treatments.

5.1 Main treatment types

Key findings

- Counselling was the most common main treatment type nationally (61,900 episodes, 41%) followed by withdrawal management (23,800 episodes, 16%) and assessment only (20,500 episodes, 14%).
- Counselling was most common in most states and territories. The exceptions were the Northern Territory and the Australian Capital Territory, where assessment only was the most common (39% and 20%, respectively), and Queensland, where information and education only was the most frequent main treatment type (33%).
- The total number of treatment episodes has increased from around 113,000 in 2001–02 to approximately 150,500 in 2010–11.
- Most (102,300 episodes, 68%) treatment episodes were closed due to an 'expected/compliant completion'.

5.1.1 Variation between jurisdictions

Overall, in Australia, counselling was the most common treatment, with 41% of episodes having this as the main treatment type. As seen in Table 5.1, for the main treatment of counselling, there was a marked variation between the states and territories, with Tasmania reporting the highest rate at 66%, and the Australian Capital Territory reporting the lowest, at 17%. The proportion of counselling episodes in the Australian Capital Territory (17%) was 13 percentage points lower than in 2009–10 (30%) and the proportion of assessment only episode increased from 13% in 2009–10 to 20% in 2010–11. For further information on these changes, see Table 7.3.

Variation was observed for all treatment types across the jurisdictions, most notably, information and education only varied from 1 in 100 (1%) of all treatment types in New South Wales, Victoria and the Northern Territory to 1 in 3 (33%) in Queensland.

Table 5.1: Treatment episodes by main treatment type and jurisdiction, 2010–11 (per cent)

	Jurisdiction									
Main treatment type	**NSW**	**Vic**	**Qld**	**WA**	**SA**	**Tas**	**ACT**	**NT**	**Australia**	**Total (number)**
Withdrawal management (detoxification)	20.6	19.5	7.7	8.4	18.5	1.3	16.1	9.5	15.8	23,843
Counselling	31.4	51.2	28.8	64.1	26.6	65.9	17.4	21.1	41.2	61,935
Rehabilitation	7.0	3.5	1.9	5.9	9.5	10.1	10.4	15.7	5.2	7,844
Support and case management only	9.8	13.1	5.9	4.9	3.4	1.2	12.0	2.0	9.1	13,678
Information and education only	1.2	0.5	32.6	3.4	9.6	11.3	14.5	0.9	7.7	11,532
Assessment only	14.7	9.5	17.5	5.8	25.4	8.3	19.9	38.5	13.6	20,511
Other	15.3	2.8	5.5	7.5	7.0	2.0	9.7	12.4	7.4	11,145
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**36,040**	**52,885**	**26,541**	**17,111**	**9,430**	**1,738**	**3,156**	**3,587**	**. .**	**150,488**

5.1.2 Client type

Table 5.2 describes what main treatments were delivered to clients who sought treatment for their own drug use or for someone else's drug use. Rehabilitation and withdrawal management (detoxification) were only provided to clients concerning their own drug use. Three in 4 episodes (75%) where clients were seeking treatment for someone else's drug use involved counselling as the main treatment type, compared with 2 in 5 (40%) where a client's own drug use was treated.

Table 5.2: Treatment types by client type, 2010–11 (per cent)

	Client type	
Treatment type	**Own drug use**	**Other's drug use**
Withdrawal management (detoxification)	16.6	—
Counselling	39.6	74.7
Rehabilitation	5.4	—
Support and case management only	8.9	12.8
Information and education only	7.7	5.8
Assessment only	14.1	2.9
Other, including pharmacotherapy[(a)]	7.6	3.7
Total	**100.0**	**100.0**

(a) Pharmacotherapy was not provided to clients seeking treatment for other's drug use.

5.1.3 Variation over time

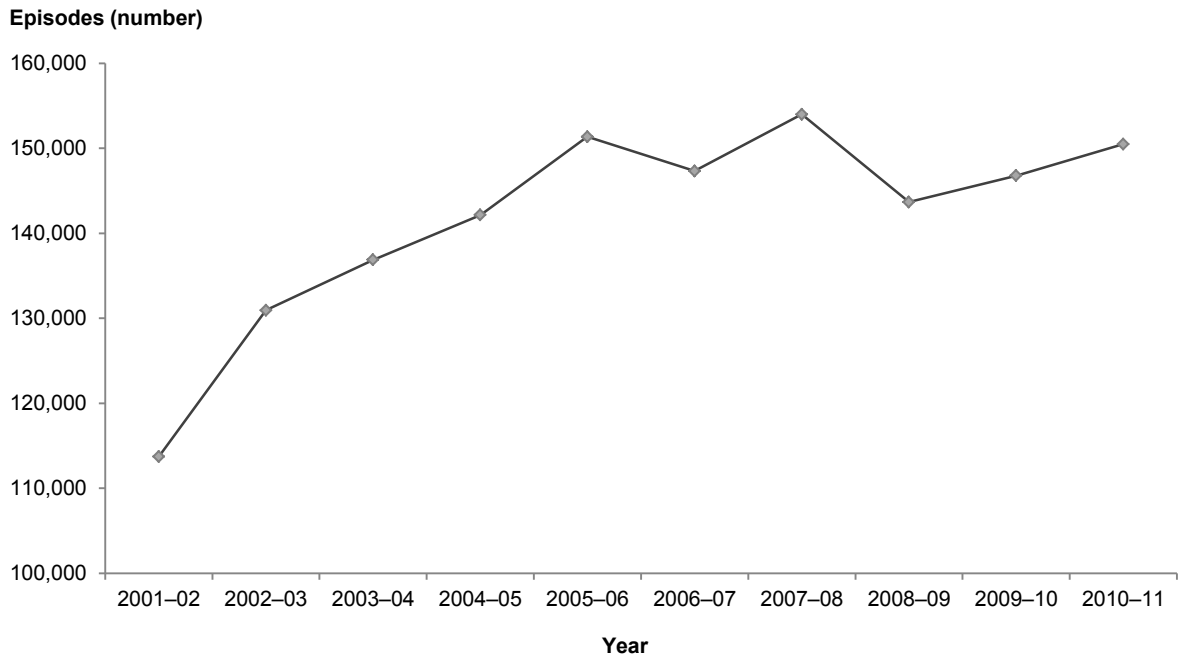
An increase in the total number of treatment episodes has been observed from 2001–02 to 2010–11 (Figure 5.1 and Table 5.3). In 2001–02, there were approximately 113,700 episodes, this has increased to around 150,500 in 2010–11. However, the number of episodes peaked in 2007–08 and remains slightly lower in 2010–11. This trend closely mirrors the number of agencies providing treatment (see Table C1).

Over the last 2 years (2009–10 and 2010–11) the number of all treatment types has increased, except for information and education only, which saw a slight decline from approximately 13,100 to 11,500 (Table 5.3). This may be attributable to a revision in coding practices for information and education only (see Table 7.3 for further detail).

The most common main treatment type offered continues to be counselling, at 41% of the total number of main treatment types. This proportion has remained stable over the last 10 years, despite a rise in the number of episodes. The second most common treatment, withdrawal management (detoxification), has seen a decline over time, from 19% in 2001–02 to 16% in 2010–11.

As can be seen in Figure 5.2, the types of treatments that are delivered is changing over time. The year-to-year changes observed in Table 5.3 and Figure 5.2 may be attributable to major shifts in the national treatment focus. For example, over the period of the collection (2001–02 to 2010–11) there has been a decrease in the proportion of episodes with withdrawal management (detoxification) or rehabilitation as their main treatment type, accompanied by an increase in interventions such as support and case management only.

Another interesting trend identified over the collection period is that the proportion of interventions involving counselling appeared to increase as the proportion of interventions involving assessment only decreased.



Source: Table C3.

Figure 5.1: Treatment episodes reported in the AODTS–NMDS, 2001–02 to 2010–11

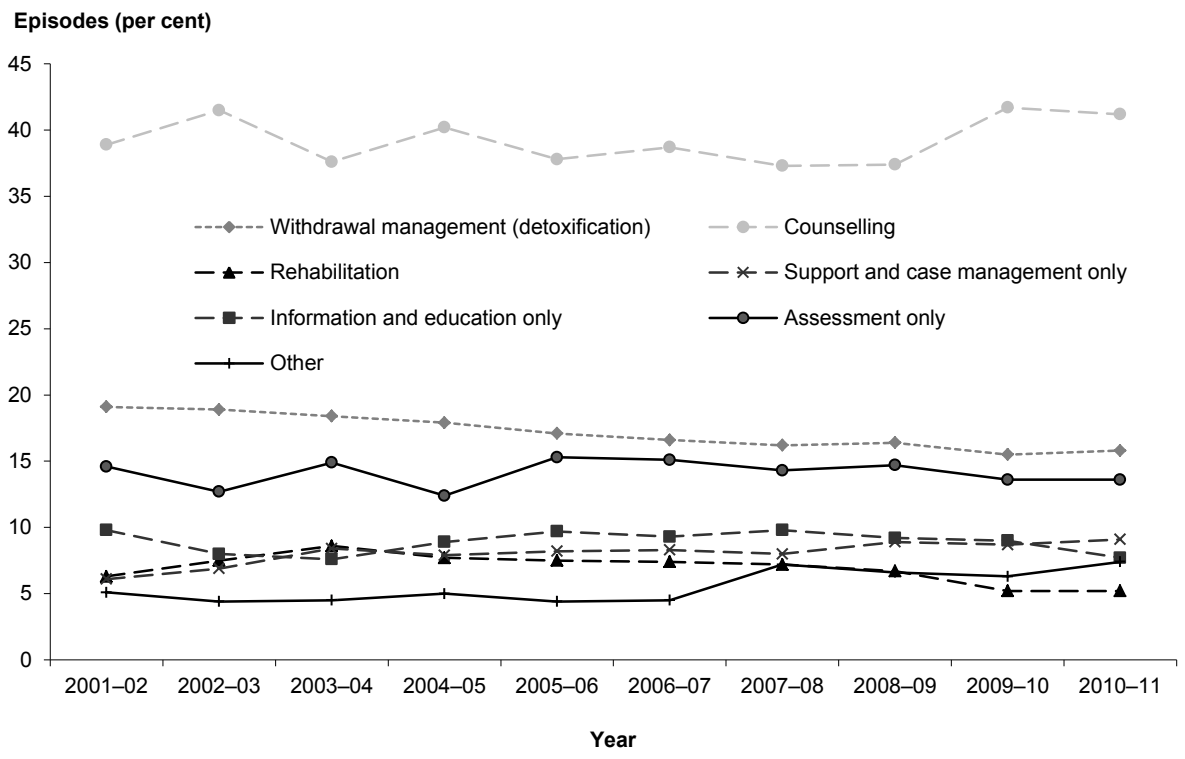
It is important to note that Figure 5.2 includes episodes of treatment delivered to clients for their own drug use, along with treatment for someone else's drug use. These two different client types have a different treatment profile; for example, counselling is delivered to three-quarters (75%) of clients seeking treatment for someone else's drug use, compared with two-fifths (40%) of clients treating their own drug use (see Table 5.2).

Table 5.3: Treatment episodes by main treatment type, 2001–02 to 2010–11

	Year									
Main treatment type	**2001–02**	**2002–03**	**2003–04**	**2004–05**	**2005–06**	**2006–07**	**2007–08**	**2008–09**	**2009–10[a]**	**2010–11**
					Number					
Withdrawal management (detoxification)	21,744	24,767	25,123	25,458	25,828	24,467	24,999	23,599	22,534	23,843
Counselling	44,184	54,395	51,514	57,076	57,277	57,017	57,470	53,787	60,792	61,935
Rehabilitation	7,195	9,865	11,717	10,959	11,331	10,950	11,099	9,667	7,521	7,844
Support and case management only	6,951	9,097	11,494	11,240	12,417	12,290	12,279	12,740	12,718	13,678
Information and education only	11,197	10,478	10,465	12,609	14,655	13,723	15,086	13,283	13,077	11,532
Assessment only	16,647	16,632	20,414	17,663	23,125	22,295	21,976	21,172	19,803	20,511
Other[b]	5,787	5,696	6,142	7,139	6,729	6,583	11,089	9,424	9,186	11,145
Total	**113,705**	**130,930**	**136,869**	**142,144**	**151,362**	**147,325**	**153,998**	**143,672**	**145,631**	**150,488**
					Per cent					
Withdrawal management (detoxification)	19.1	18.9	18.4	17.9	17.1	16.6	16.2	16.4	15.5	15.8
Counselling	38.9	41.5	37.6	40.2	37.8	38.7	37.3	37.4	41.7	41.2
Rehabilitation	6.3	7.5	8.6	7.7	7.5	7.4	7.2	6.7	5.2	5.2
Support and case management only	6.1	6.9	8.4	7.9	8.2	8.3	8.0	8.9	8.7	9.1
Information and education only	9.8	8.0	7.6	8.9	9.7	9.3	9.8	9.2	9.0	7.7
Assessment only	14.6	12.7	14.9	12.4	15.3	15.1	14.3	14.7	13.6	13.6
Other[b]	5.1	4.4	4.5	5.0	4.4	4.5	7.2	6.6	6.3	7.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

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

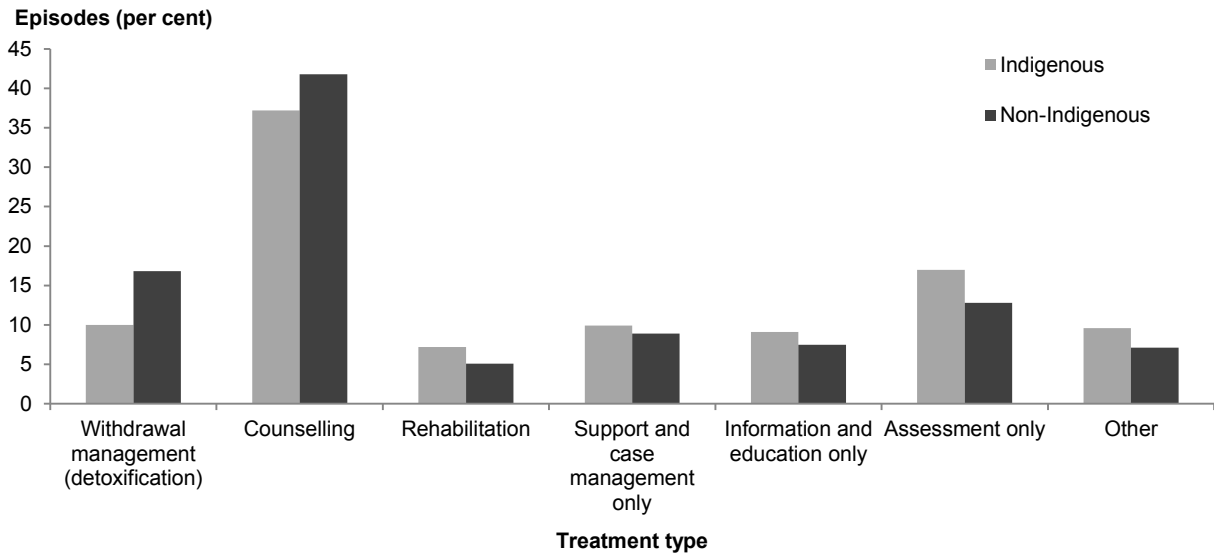


Source: Table C26.

Figure 5.2: Treatment episodes by main treatment type, 2001–02 to 2010–11

5.1.4 Indigenous Australians and treatment programs

Closed treatment episodes where the client identified as Indigenous represented 13% of all episodes, while Indigenous people comprise only 2.2% of the Australian population aged 10 or older (ABS 2012a). As can be seen in Figure 5.3, differences can be observed in the type of treatment that Indigenous people received. Indigenous clients were less likely to receive withdrawal management (detoxification) (10% compared with 17% for non-Indigenous clients) or counselling (37% compared with 42%, respectively), and more likely to receive all other treatments when compared with non-Indigenous people. However, the proportion of episodes where Indigenous status was not recorded or not stated was considerable in 2010–11, with 1 in 20 (6%) episodes not having Indigenous status recorded. Some treatment services that primarily provide treatments for Indigenous people are not included in this collection—see Appendix F and Table 3.4 for more information about treatments not within the scope of the AODTS–NMDS.



Source: Table C31.

Figure 5.3: Treatment episodes by main treatment type and Indigenous status, 2010–11

5.1.5 Reasons for ceasing treatment

The AODTS–NMDS does not contain an indicator of treatment outcomes, however it is possible to group cessation reasons into broader categories. These can be defined as 'expected/compliant' completions, 'unexpected/non-compliant' completions and completions where there was a change in the treatment mode (or administrative completions). This method has been used historically to collate and report data (AIHW 2010b, 2011c).

In 2010–11, around 7 in 10 (around 102,300 episodes, 68%) completions recorded a reason for cessation in the 'expected or compliant' category. 'Unexpected/non-compliant' cessations accounted for 1 in 5 (21%) completions, and 'changes to treatment mode' (6%) and the 'other/not stated' (5%) category made up the remaining 11% (Table 5.4).

Table 5.4: Cessation reasons grouped by indicative outcome type in 2010–11[(a)]

Expected/compliant completions (68%)	Unexpected/non-compliant cessations (21%)	Changes to treatment mode (6%)
Treatment completed	Ceased to participate against advice	Change in treatment type
Ceased to participate at expiation[(b)]	Ceased to participate without notice	Change in delivery setting
Ceased to participate by mutual agreement	Ceased to participate involuntary (non-compliance)	Change in principal drug of concern
	Drug court/and or sanctioned by court diversion service	Transferred to another service provider
	Imprisoned, other than drug court sanctioned	
	Died	

(a) 'Other' and 'not stated' totalled 5%.

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

Since the beginning of this collection in 2001–02, the five most commonly reported reasons for cessation have remained quite consistent. 'Treatment completed' has always been the most common reason, with 3 in 5 (58%) episodes reporting this reason for cessation in 2010–11, followed by treatments where the client ceased to participate without notice (14%) (Table 5.5). 'Ceased to participate at expiation' was reported in 7% of cases in 2010–11, and 'transferred to another service provider' was the next most common cessation reason.

For the first time over the life of the collection, the fifth most common reason has changed: 'other' has become more common than 'ceased to participate against advice', at 4.0% and 3.9%, respectively, although both have increased since 2009–10. Seven of the remaining 9 cessation reasons were reported in less than 1% of episodes.

Table 5.5: Reason for completion of treatment episodes 2010–11

Reason for completion	Per cent of total
Treatment completed	58.0
Ceased to participate without notice	14.0
Ceased to participate at expiation	7.1
Transferred to another service provider	4.5
Other	4.0
Ceased to participate against advice	3.9
Ceased to participate by mutual agreement	2.9
Ceased to participate involuntary (non-compliance)	1.9
Imprisoned, other than drug court sanctioned	0.9
Change in delivery setting	0.7
Change in main treatment type	0.6
Drug court and/or sanctioned by court diversion service	0.2
Died	0.2
Change in principal drug of concern	<0.1
Not stated	1.0
Total	**100.0**

Table 5.6 reports the reason for cessation for each principal drug of concern. In 2010–11, clients whose principal drug of concern was ecstasy were the most likely to have an expectant/compliant completion, with 4 in 5 (80%) falling into this category. The lowest rate of expected completions was for episodes with morphine as the primary drug of concern (53%). Morphine also had the highest rate of unexpected/non-compliant completions (28%), and the lowest rate was observed for nicotine as the principal drug of concern (13%).

Table 5.6: Cessation reason grouped by indicative outcome type, by principal drug of concern (per cent)

Principal drug of concern	Expected/compliant completions	Changes to treatment mode	Unexpected/non-compliant cessation	Other/not stated	Total
Analgesics					
Heroin	61.7	7.2	25.0	6.1	**100.0**
Methadone	57.4	12.3	23.8	6.5	**100.0**
Morphine	52.7	12.9	27.9	6.4	**100.0**
Other opioids	59.7	11.4	24.7	4.3	**100.0**
Total analgesics	*55.9*	*10.3*	*27.3*	*6.5*	***100.0***
Sedatives and hypnotics					
Alcohol	68.6	6.0	20.4	5.1	**100.0**
Benzodiazepines	66.3	7.5	20.7	5.6	**100.0**
Total sedatives and hypnotics	*67.4*	*9.1*	*16.5*	*7.0*	***100.0***
Stimulants and hallucinogens					
Amphetamines	63.9	5.8	26.7	3.7	**100.0**
Cannabis	70.8	4.4	20.5	4.3	**100.0**
Ecstasy	79.7	2.0	15.4	3.0	**100.0**
Cocaine	67.9	4.2	23.6	4.4	**100.0**
Nicotine	78.4	4.1	12.7	4.8	**100.0**
Total stimulants and hallucinogens	*68.1*	*7.9*	*18.2*	*5.8*	***100.0***
Volatile solvents	70.5	7.8	15.7	6.0	**100.0**
All other drugs	79.0	5.3	11.9	3.8	**100.0**

5.2 Specific main treatment types

Key findings

- Counselling was the most common treatment provided, with around 61,900 episodes. The treatment delivered least was rehabilitation, with about 7,800 episodes delivered.
- Counselling had the longest median duration (57 days) of all treatment types, a change from 2009–10 where the longest median duration was for support and case management (53 days).
- In 2010–11, support and case management had the second longest median duration of treatment, at 52 days, followed by rehabilitation, at 44 days.
- Episodes with cannabis as the principal drug of concern were most likely to be for information and education only, with 2 in 5 cases (43%) associated with this treatment.
- Alcohol was the most common principal drug of concern associated with all other treatment types.
- The median age was lowest for clients provided with information and education only, with a median age of 24. This was closely followed by support and case management only, with a median age of 26. Withdrawal management (detoxification) was associated with the highest median age (37).

Appendix tables C22 to C31 provide more detailed data on main treatment types.

5.2.1 Counselling

In the context of the AODTS–NMDS, counselling is defined as any method of individual or group counselling directed towards identified problems with alcohol and/or other drug use or dependency (AIHW 2010a). 'Counselling is a joint approach between the counsellor and the client with treatment plans negotiated and agreed upon by both parties' (NCETA 2004).

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

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

Principal drug profile

There were around 61,900 episodes in 2010–11 where counselling was recorded as the main treatment type delivered to clients. Half (50%) of the episodes that reported counselling as the main treatment type were associated with alcohol as the principal drug of concern.

Cannabis, amphetamines and heroin were also common principal drugs of concern among clients receiving counselling as the main treatment type (22%, 11% and 8%, respectively).

Client profile

- Counselling was the most common main treatment for episodes where clients were seeking treatment for their own drug use and clients seeking treatment for another person's drug use.
- Counselling was most likely to be provided to people aged 30–39 (29%). The median age for clients receiving counselling was 33.
- The majority (65%) of episodes where counselling was the main treatment type were for male clients.
- Clients identified as Indigenous in 12% of episodes.
- Self-referral was the most common source of referral (42%), followed by court diversions (13%) and referral from alcohol and other drug treatment services (10%).

Treatment profile

- Counselling has remained the most common treatment provided since 2002–03, and this proportion has remained relatively stable at around 2 in 5 episodes (41% in 2010–11).
- Nine in 10 (91%) episodes where counselling was the main treatment type occurred in non-residential treatment facilities.
- Completing treatment was the most common reason that counselling episodes were ceased (56%).
- Counselling had the longest median treatment duration, at 57 days.

5.2.2 Withdrawal management (detoxification)

What is withdrawal management (detoxification)?

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

Principal drug profile

Withdrawal management (detoxification) was provided as the main treatment type for around 23,800 closed treatment episodes in 2010–11. For just over half of these closed treatment episodes (54%), alcohol was the principal drug of concern. Cannabis accounted for the next greatest proportion of principal drugs of concern (18%), followed by heroin (10%). Ecstasy, cocaine and nicotine each represented less that 1% of principal drugs of concern.

Client profile

- All episodes with withdrawal management as the main treatment type were for clients seeking treatment for their own drug use.
- Two-thirds of episodes where withdrawal management was the main treatment were for male clients (65%), similar to the proportion for all treatment types (66%).
- The median age of both female and male clients was 37.
- The greatest proportion of episodes where withdrawal management was the main treatment were for clients aged 30–39 (29%), followed by those aged 40–49 (25%).
- The majority of referrals for this type of treatment were self-referrals (52%), followed by referrals from alcohol and other drug treatment services (18%).
- Approximately 8% of these episodes were for clients who identified as Indigenous Australians.

Treatment profile

- Episodes with withdrawal management (detoxification) as the main treatment type accounted for 16% of all episodes. This proportion has been declining gradually since 2002–03, when 19% of episodes received withdrawal management as the main treatment.
- Most treatments involving withdrawal management were provided in a residential treatment facility (59%). Three in 10 (31%) were provided in a non-residential treatment facility. Home-based treatments were provided in 7% of cases.
- Two-thirds (67%) of treatment episodes were closed because treatment was completed. One in 10 (10%) were closed because the client ceased to participate against advice.
- The median duration of a treatment episode was unchanged from previous years at 8 days.

5.2.3 Assessment only

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

The process of assessment identifies the nature of the drug issue, including the extent and associated health implications, the client's needs (which form the basis of the treatment plan) and which treatment would be most appropriate for the client (NCETA 2004). Assessment may be done by a central agency whose sole purpose is to make assessments and refer to appropriate treatment agencies, or completed in-house at an alcohol and other drug treatment agency as the first part or session in a course of treatment.

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

Information from states and territories indicates that some episodes reported as 'assessment only' are those where clients did not return for further treatment. The AODTS–NMDS does not collect information about clients' reasons for not returning to treatment as expected.

There are a variety of reasons that clients may not return after undergoing assessment. For example, a client may have felt that they received enough assistance, may not have found the contact useful or may not have been motivated to continue.

Sometimes the coding practices of treatment agencies can affect the number of assessment only episodes that are recorded. Coding practices are influenced by the service delivery processes within the agency. Therefore, the method of counting assessment only episodes may differ between states and territories, and comparison of data nationally and across jurisdictions should be made with caution. For more information about jurisdictional differences in coding of treatment types, see Table 7.3.

Principal drug profile

In 2010–11, there were approximately 20,500 episodes where assessment only was the main treatment type. Half of these episodes (50%) involved alcohol as the principal drug of concern, and 1 in 5 (18%) involved cannabis as the principal drug of concern. For episodes with volatile solvents as the principal drug of concern, assessment only was the most common treatment type (49%) (Table C29).

Client profile

- Where assessment only was nominated as the main treatment, 99% were for clients receiving treatment for their own drug use.
- The median age was 32 for males and 34 for females. These ages are the same as the median age for all treatment types.
- The most common age group for this treatment type was 20–29 (33%), followed by 30–39 (30%).
- Three in 4 (75%) were male, the highest proportion of all treatment types.
- One in 6 (16%) episodes had a client who identified as Indigenous.
- The most common source of referral, correctional services, referred one-third (33%) of episodes, the highest proportion of all treatment types. The second most common source of referral was self-referral (24%).

Treatment profile

- More than half of treatment episodes took place in a non-residential treatment facility (55%). More than one-quarter (28%) were delivered in a treatment delivery setting in the 'other' category. This was the highest proportion for all treatment types.
- The most common reason for finishing an assessment only episode was that the treatment was completed (79%).
- The median number of days for an assessment only episode was 2.

5.2.4 Support and case management only

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

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

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

Principal drug profile

In 2010–11, there were approximately 13,700 episodes where support and case management only was identified as the main treatment type. The most common drug that clients sought treatment for was alcohol, which was the principal drug of concern in 38% of cases. Cannabis was the next most common drug of concern (31%), followed by heroin, at 12%.

Client profile

- In 2010–11, included in the around 13,700 episodes where support and case management was identified as the main treatment type are around 800 clients who sought treatment for someone else's drug use (6%).
- In more than 3 in 5 episodes, clients receiving this treatment type were male (64%).
- The median age for episodes receiving this type of treatment was 26, up from 24 in the 2009–10 collection.
- In 1 in 7 episodes (14%) the client identified as Indigenous.
- The largest source of referral was self-referral (37%), and 2 in 10 episodes were referred as part of a court diversion (19%).

Treatment profile

- Support and case management only had the second longest median duration of treatment, at 52 days.
- Of all treatment types, support and case management only had the highest proportion of treatment episodes delivered in an outreach setting (51%).
- Of all the treatment types, support and case management only episodes were most likely to cease because of a reason of 'other' (9%).
- The most common reason for closing a support and case management only treatment episode, however, was completion of treatment (59%).

5.2.5 Information and education only

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

for around 8 weeks, drop-in programs, which run for a number of weeks, and programs for prisoners, which can run for up to 12 weeks.

Principal drug profile

There were around 11,500 episodes in the 2010–11 collection where information and education only was reported as the main treatment type. Episodes where the main treatment type was information and education only had the lowest proportion of alcohol as the principal drug of concern out of all treatment types (26%). Cannabis was the most common drug of concern, with 2 in 5 (43%) information and education only episodes reporting cannabis as the principal drug of concern, the highest proportion out of all treatment types.

Client profile

- Most episodes where the main treatment type was information and education only were for clients seeking treatment for their own drug use (97%).
- Episodes where information and education only was the main treatment type had younger clients than episodes for other forms of treatment (a median age of 24 as compared with 33).
- One-third (34%) of episodes were for clients in the 20–29 age group. The next most common was 10–19, with 3 in 10 (29%) clients in this age group.
- Episodes for males accounted for three-quarters (74%) of the total.
- One in 6 (16%) episodes involved clients who identified as Indigenous.
- For half of all episodes, clients were referred to this form of treatment by a court diversion (52%), and 1 in 4 (23%) were referred through police diversion. Both of these proportions are the highest of all treatment types.
- Information and education only was less likely than any other treatment type to be accessed via self-referral (7%).

Treatment profile

- Out of all treatment types, information and education only had the highest proportion of treatments being delivered at home, at 10%.
- Seven in 10 (70%) episodes were closed because the client ceased to participate at expiation; that is, the client had completed enough of the treatment to satisfy the requirements of a police or court diversion.
- The second most common reason for closing an information and education only episode was that the client completed the treatment (23%).
- Information and education sessions tended to be delivered on a single day.

5.2.6 Rehabilitation

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

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

Principal drug profile

In 2010–11, there were around 7,800 episodes in which rehabilitation was nominated as the main treatment type.

The most common principal drug of concern that clients sought rehabilitation treatment for was alcohol (51%), followed by cannabis (16%), amphetamines and heroin (each 13%).

Client profile

- All episodes where clients received rehabilitation as the main treatment type were for treatment of their own drug use.
- The median age was 33—this was the same for males and females.
- Two in 3 episodes were for males (64%).
- Clients identified as Indigenous in 1 in 5 episodes (18%).
- The most common source of referral for episodes where rehabilitation was the main treatment type was self-referral (37%), followed by referral from an alcohol and other drug treatment service (22%).

Treatment profile

- The proportion of episodes where rehabilitation was the main form of treatment has been steadily declining since the start of the collection, from 8% in 2002–03 to 5% in 2010–11.
- The median length of an episode of rehabilitation was 44 days.
- Rehabilitation treatment was most likely to be completed in a residential treatment facility—this occurred in 81% of cases in 2010–11; a small increase from 78% in 2009–10.
- The most common reason for closing a treatment episode where rehabilitation was the main treatment type was that the treatment was completed (41%). Ceasing to participate against advice (20%), ceasing to participate involuntarily (13%) and ceasing to participate without notice (10%) were the next most common reasons for cessation.

5.2.7 Other main treatment types

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

About one-third of the episodes reported here as providing an 'other main treatment type' actually involved pharmacotherapy. However, it is important to understand that AODTS–NMDS pharmacotherapy data do not tell the whole story about pharmacotherapy in Australia. Agencies that only provide pharmacotherapy are not required to report to the AODTS–NMDS. Those agencies that are required to report are asked to do so only when they provide pharmacotherapy and another drug treatment to the same person. Information specific to opioid pharmacotherapy treatment can be found in the National Opioid Pharmacotherapy Statistical Annual Data (NOPSAD) collection (see Section 5.5).

Principal drug profile

There were around 11,100 episodes in 2010–11 with the main treatment type classified as 'other'. Alcohol was the most common principal drug of concern involved with this treatment type (46%) followed by heroin (13%) and cannabis (11%).

Client profile

- The majority of episodes (98%) were for the client's own drug use.
- Six in 10 (62%) episodes were for males.
- The median age for treatment was 36 (37 for males and 35 for females).
- People aged 30–39 years accounted for the greatest proportion of episodes (26%) followed by those aged 40–49 (21%) and those aged 20–29 (20%).
- About 17% of episodes were for clients who identified as Indigenous Australians.
- Medical practitioners and self-referral were the most common referral sources (26% and 23%, respectively), followed by hospitals (16%) and alcohol and other drug treatment services (9%).

Treatment profile

- Other main treatments were most likely to occur in a non-residential treatment setting, with half of episodes (52%) occurring in this setting. Treatment in a residential treatment facility was the next most common, with 2 in 5 (40%) episodes occurring in this setting. These treatments were least likely to be provided in the home of the client (less than 1%).
- The median number of days for other main treatments, regardless of the setting, was 7 in 2010–11. The median treatment duration has decreased from 48 days in 2006–07. This change was related to the larger proportion of non-pharmacotherapy treatments included in the past 3 collection years.
- The majority of episodes ended because treatment had been completed (60%), followed by clients being transferred to another service provider (16%).

5.3 Additional treatments

Key findings

- In 2010–11, there were around 13,800 closed treatment episodes that included at least one additional treatment type (14% of all episodes), an increase from 2009–10 (8,800 or 9%).
- Almost half of episodes receiving rehabilitation as the main treatment type also received an additional treatment in 2010–11 (47%). This was the highest proportion of all treatment types.
- One-third (33%) of episodes with withdrawal management (detoxification) as the main treatment type received an additional treatment in 2010–11, an increase from 2009–10 (20%).
- One-third (33%) of episodes with 'other' as the main treatment type received additional treatment in 2010–11, doubling from 2009–10 (16%).

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

The provision of more than one type of treatment during an episode may occur because treatment agencies provide multiple treatments that can be (but are not required to be) part of a single treatment plan. Other treatment agencies provide only one type of treatment and, therefore, do not report other treatment types.

An additional treatment type is not reported where it may be regarded as a core component of the main treatment type. For example, counselling that is required as part of a rehabilitation episode is not reported in addition to rehabilitation as the main treatment type.

As shown in Table 5.7, 1 in 7 episodes (14%) in 2010–11 reported at least one additional treatment type, an increase from 10% in 2009–10 (Figure 5.4). The most common main treatment type accompanied by an additional treatment was rehabilitation, with almost half of episodes (47%) involving rehabilitation also receiving an additional treatment. This was a marked increase from 2009–10 (37%). The next most common main treatment types accompanied by an additional treatment were withdrawal management (detoxification) (33%) and 'other' (33%) treatments. The proportion of episodes receiving withdrawal management accompanied by an additional treatment was almost double that observed in 2009–10 (20%), however it should be noted that this proportion has fluctuated over time (38% in 2008–09).

The proportion of episodes receiving additional treatment with main treatment type 'other' has fluctuated over the past few years. In 2008–09, 43% of such episodes had an additional treatment, followed by 16% in 2009–10, and 33% in 2010–11 (Figure 5.4).

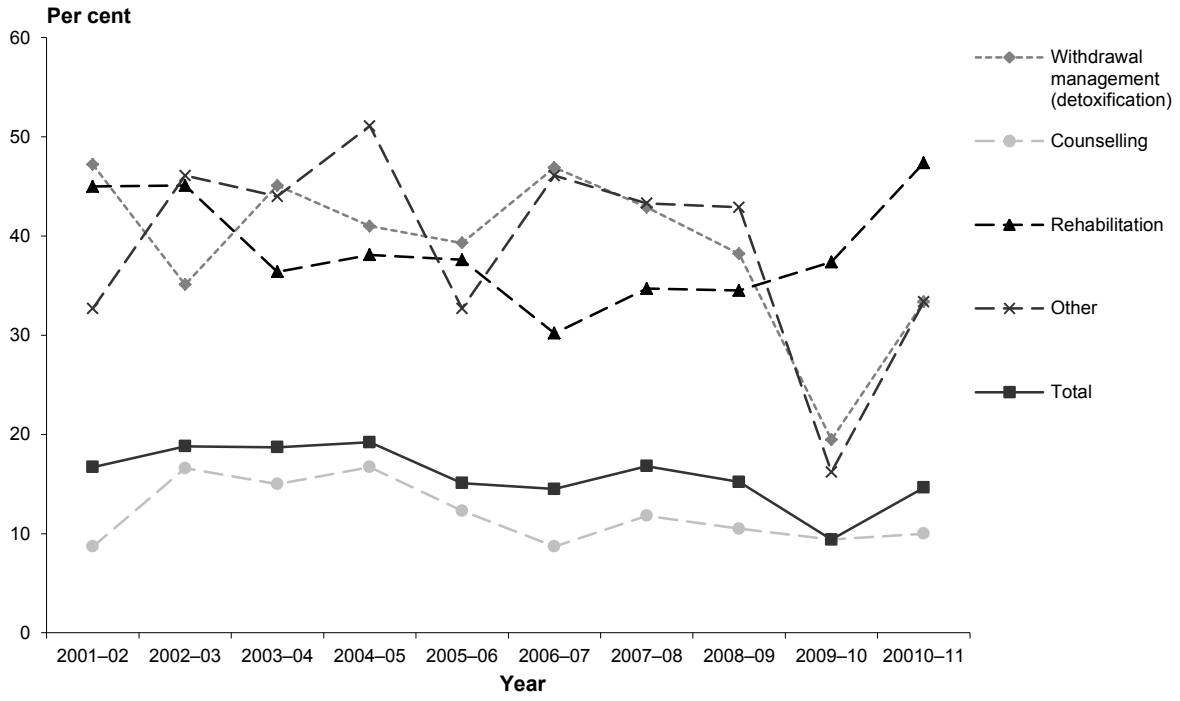
Table 5.7: Treatment episodes, with or without additional treatment types, by main treatment type, 2010–11

Main treatment	With additional treatment	With no additional treatment	Total episodes	Proportion of episodes with additional treatment
	Number			Per cent
Withdrawal management (detoxification)	4,520	9,010	13,530	33.4
Counselling	3,284	31,588	34,872	9.4
Rehabilitation	2,850	3,161	6,011	47.4
Support and case management only	—	6,749	6,749	—
Information and education only	—	11,269	11,269	—
Assessment only	—	15,482	15,482	—
Other, including pharmacotherapy	3,165	6,525	9,690	32.7
Total	**13,819**	**83,784**	**97,603**	**14.2**

Note: Victorian data are excluded from this analysis because Victoria counts each treatment as an individual episode.

The proportion of 'other' main treatment types that had an additional treatment recorded showed the most variation over time, ranging from 51% in 2004–05 to 33% in 2010–11 (excluding 2009–10 data).

The proportion of episodes with withdrawal management (detoxification) as the main treatment type that also recorded an additional treatment has fluctuated over the life of the collection. The proportion decreased between 2001–02 (47%) and 2005–06 (39%), followed by an increase to 47% in 2006–07. A low point of 20% was observed in 2009–10, before increasing to 33% in 2010–11.



Source: Table C30.

Figure 5.4: Proportion of treatment episodes with additional treatments by main treatment type, 2001–02 to 2010–11

5.4 Alcohol and other drug treatment in prison health services 2010

Key findings

- In 2010, alcohol and other drug related issues represented 7% of all problems managed during the National Prisoner Health Census period.
- Alcohol and other drug issues represented 21% of problems managed for female prisoners compared with 4% for male prisoners.
- Medications used in opioid dependence represented 4% of the total medications administered.
- Medications used in nicotine dependence represented less than 1% of medications administered.
- In 2010, methadone was the most commonly available treatment for opioid dependence in Australian prisons.
- Methadone maintenance treatment programs were offered to all detainees in all jurisdictions.
- One in 8 (13%) entrants reported having ever received an opioid pharmacotherapy treatment.

This section describes data on alcohol and other drug treatment in prison clinics during the 2010 National Prisoner Health Census. The 2010 Census was conducted during 11–24 October 2010 in the Australian Capital Territory and the Northern Territory and during 8–21 November 2010 in Queensland, South Australia, Tasmania and Western Australia. One prison in Queensland completed the Census during February 2011. New South Wales and Victoria did not participate in the 2010 Census (AIHW 2011b).

Sections 5.4.1 and 5.4.2 describe problems managed in prison clinics during the census period, as well as medications administered to prisoners. Section 5.4.3 reports details on the availability of pharmacotherapy in the prisons and prison entrants' opioid pharmacotherapy treatment histories. While these data were collected as part of the 2010 National Prisoner Health Census, they do not relate to the data on medications administered because they were collected through separate mechanisms.

5.4.1 Problems managed

Over the 2-week Census period, 5,800 prisoners visited prison health clinics and over 16,800 problems were managed.

Alcohol and other drug related issues represented 7% (1,141) of all problems managed during the census period and involved 501 prisoners (9% of prisoners who visited prison clinics) (Table 5.8). Tasmania had the highest proportion, with 20% of prisoners who visited the prison clinic for their alcohol and other drug problems. Queensland had the highest proportion of alcohol and other drug problems managed (9% of all problems managed).

The majority of alcohol and other drug problems managed involved male prisoners (572 problems managed for males compared with 557 for females). However, when the proportions of all visits for both sexes were considered, alcohol and other drug issues represented a much larger proportion of all problems managed for female prisoners (21% of problems managed for female prisoners compared with 4% for male prisoners). Additionally, female prisoners had more alcohol and other drug problems managed per prisoner than their male counterparts—86 female prisoners had 557 clinic visits with alcohol and other drug problems managed while 405 male prisoners had 572 similar visits.

Prisoners aged 25–34 had the most alcohol and other drug problems managed (607 problems, representing 12% of all problems managed for this age group). Prisoners aged 45 and over had the fewest alcohol and other drug problems managed (74 problems representing 2% of all problems managed for this age group).

Indigenous and non-Indigenous prisoners had the same proportion of alcohol and other drug problems managed (7%).

Table 5.8: Alcohol and other drug problems managed in prison clinics during the 2010 National Prisoner Health Census[a][b][c]

	Alcohol and other drug problems managed		Prisoners who visited prison clinics to manage alcohol and other drug problems	
	Number	Total problems managed (per cent)	Number	Total prisoners who visited prison clinics (per cent)
State or territory				
NSW[a]	n.a.	n.a.	n.a.	n.a.
Vic[a]	n.a.	n.a.	n.a.	n.a.
Qld	529	8.9	71	5.0
WA	391	5.7	269	10.0
SA	139	5.2	97	11.1
Tas	75	6.3	58	20.3
ACT	7	3.2	6	5.4
NT[c]	n.a.	n.a.	n.a.	n.a.
Sex				
Male	572	4.1	405	8.9
Female	557	21.0	86	13.9
Age group (years)				
18–24	123	4.8	75	8.4
25–34	607	11.6	236	13.1
35–44	316	7.1	128	9.4
45+	74	1.9	46	4.6
Indigenous status				
Indigenous	347	7.3	165	10.5
Non-Indigenous	775	6.7	323	9.2
Total[d]	**1,141**	**6.8**	**501**	**9.3**

(a) New South Wales and Victoria did not participate in the 2010 Census.

(b) Analysis based on prisoners who used the prison clinic during the Census period; not all prisoners in custody.

(c) Northern Territory data not available as the method of data collection does not reflect the service availability to prisoners.

(d) Total includes people of unknown sex, age and Indigenous status.

Source: Unpublished analysis of 2010 National Prisoner Health Census.

5.4.2 Medications administered

During the 2-week Prisoner Health Census, about 12,900 prescribed medications were administered (Table 5.9). This section focuses on those medications that were administered to assist with opioid or nicotine dependence. For the purposes of this census, the medications in opioid dependence include methadone, naltrexone, buprenorphine and buprenorphine–naloxone (see Box 5.9); and medication used in nicotine dependence includes, for example, QuitX.

Medications used in opioid dependence represented 4% of the total medications administered in the prisons surveyed (Table 5.9).

Males and females received medications for opioid dependence at similar rates.

Medications used in opioid dependence were most often administered to prisoners aged 25–34. This was in contrast with the total number of medications across all medication types, where the number of medications administered increased as age group increased. Medications used in opioid dependence accounted for 6% of medications administered to 25–34 year olds and 1% of medications administered to prisoners over 45 years.

Medications used in opioid dependence represented 4% of medications for non-Indigenous prisoners and 2% for Indigenous prisoners.

Medications used in nicotine dependence represented less than 1% of medications administered both nationally and in all states and territories, except the Australian Capital Territory where these medications accounted for 3% of medications and Queensland (2%) (Table 5.9).

Table 5.9: Medications used in opioid and nicotine dependence administered during the 2010 National Prisoner Health Census

	NSW[(a)]	Vic[(a)]	Qld	WA	SA	Tas	ACT	NT	Total
					Number				
Medications used in opioid dependence	n.a.	n.a.	21	163	220	10	60	3	477
Medications used in nicotine dependence	n.a.	n.a.	61	17	22	3	9	—	112
All prescribed medications	**n.a.**	**n.a.**	**4,079**	**4,573**	**2,429**	**717**	**271**	**785**	**12,854**
					Per cent				
Medications used in opioid dependence	n.a.	n.a.	<1.0	3.6	9.1	1.4	22.1	<1.0	3.7
Medications used in nicotine dependence	n.a.	n.a.	1.5	<1.0	<1.0	<1.0	3.3	—	<1.0
All prescribed medications	**n.a.**	**n.a.**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) New South Wales and Victoria did not participate in the 2010 Census.

Source: Unpublished analysis of 2010 National Prisoner Health Census.

5.4.3 Opioid pharmacotherapy treatment in prison health services

As of January 2008, Australia was one of 29 countries following the World Health Organization's 1993 guidelines to offer opioid pharmacotherapy in prisons (Larney & Dolan 2009). In some jurisdictions, however, this was restricted to prisoners who were receiving pharmacotherapy in the community before entering prison.

In 2010, methadone was the most commonly available treatment in Australian prisons, with maintenance treatment programs offered to all detainees in all jurisdictions. The use of buprenorphine was less common, with New South Wales, Victoria and South Australia the only jurisdictions providing this treatment in prisons. Buprenorphine–naloxone was only provided in Victoria and Western Australia and only for prisoners who were receiving this treatment before entering prison (Table 5.10).

Table 5.10: Availability of opioid substitution treatment in Australian prisons, states and territories, 2010

	Methadone		Buprenorphine		Buprenorphine/naloxone	
	Maintenance	Initiation	Maintenance	Initiation	Maintenance	Initiation
NSW	✓	✓	✓	✓	×	×
Vic	✓	✓	✓	×	✓	×
Qld	✓	×	×	×	×	×
WA	✓	✓	×	×	✓	×
SA	✓	✓	✓	✓	×	×
Tas	✓	×	×	×	×	×
ACT	✓	✓	×	×	×	×
NT	✓	×	×	×	×	×

Source: Unpublished analysis of 2010 National Prisoner Health Census.

In the National Prisoner Health Census 2010, prison entrants were asked whether they were currently receiving an opioid pharmacotherapy treatment (OPT) or had in the past. About 1 in 8 (13%) entrants reported having ever received an OPT. A small proportion of entrants indicated that they were currently receiving methadone treatment (3%) or other opiate-replacement program (2%). Just over 1 in 17 entrants (6%) had received methadone treatment at some time in the past, and a similar proportion (7%) had received another OPT in the past (Table 5.11).

Table 5.11: Prison entrants, opioid pharmacotherapy treatment history, 2010 (a)

Opioid pharmacotherapy treatment	Currently		In the past	
	Number	Per cent	Number	Per cent
Methadone	20	3.3	37	6.1
Other opiate replacement program	10	1.6	43	7.0
Total prison entrants	**610**	**100.0**	**610**	**100.0**

(a) Excludes New South Wales and Victoria, as they did not participate in the 2010 Census.

Source: Unpublished analysis of 2010 National Prisoner Health Census.

5.5 Pharmacotherapy treatments—findings from the National Opioid Pharmacotherapy Statistics Annual Data collection 2011

Key findings

- In 2011, on the snapshot day, there were 46,446 clients who received pharmacotherapy for opioid dependence. There were 1,444 prescribers, and medication was delivered to clients at 2,264 dosing points.
- Methadone continued to be the most commonly prescribed drug, with 69% of clients receiving methadone for their opioid dependence. The proportion of clients taking buprenorphine–naloxone was 17%, which has increased from 5% in 2006.

As most services whose main activity is to prescribe or supply clients with pharmacotherapy for opioid dependence are outside the scope of the AODTS–NMDS, this section of the report draws on data from the collection where data from these services is captured, the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection.

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

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

The data in this section are from the *National Opioid Pharmacotherapy Statistics Annual Data collection: 2011 report* (AIHW 2012a).

The NOPSAD collection provides national data on the provision of opioid pharmacotherapy treatment (see Box 5.9). More specifically, it provides data on the practitioners who prescribe treatment, the dosing sites where pharmacotherapy drugs are dispensed, and the clients receiving opioid pharmacotherapy treatment.

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

Box 5.9: Pharmacotherapy types

The NOPSAD collection captures information about three pharmacotherapy types currently recommended for the treatment of opioid dependency: methadone, buprenorphine and buprenorphine–naloxone (DoHA 2007).

Methadone

Methadone is a synthetic opioid used to treat heroin and other opioid dependence. It reduces opioid withdrawal symptoms, the desire to take opioids and the euphoric effect when opioids are used. It is taken orally on a daily basis (DoHA 2007).

Buprenorphine

Buprenorphine acts in a similar way to methadone, but is longer lasting and may be taken daily or every second or third day. Two buprenorphine preparations are registered in Australia for the treatment of opioid dependence: a product containing only buprenorphine and a combined product containing buprenorphine and naloxone. The buprenorphine-only product is available as a tablet containing buprenorphine hydrochloride that is administered orally (DoHA 2007).

Buprenorphine–naloxone

The combination buprenorphine–naloxone product is a sublingual tablet or film (as of 1 September 2011) containing buprenorphine hydrochloride and naloxone hydrochloride (DoHA 2012). Buprenorphine–naloxone is often the preferred pharmacotherapy takeaway product (Chapleo & Walter 1997; DoHA 2007; Dunlop 2007).This is because, when taken as intended by dissolving the tablet or film under the tongue, the combined product acts as if it was buprenorphine alone. However, if the combined product is injected, naloxone blocks the effects of buprenorphine and increases opioid withdrawal symptoms. This reduces the risk that those receiving buprenorphine–naloxone as a takeaway dose inject it or sell it to others to inject (Chapleo & Walter 1997; DoHA 2007; Dunlop 2007).

5.5.1 Client characteristics

On the snapshot day in June 2011, 46,446 clients were receiving pharmacotherapy treatment nationally (Table 5.12). While this was similar to 2010 (46,078 clients), in the preceding 3 years (2007–10) client numbers grew by 5–6% annually (AIHW 2012a). Since 1998, client rates have almost doubled, increasing from 1.3 clients per 1,000 people to 2.1 clients per 1,000 people.

Clients receiving opioid treatment are getting older, with the proportion of clients aged 30 years and over increasing from 72% in 2006 to 85% in 2011. The median age of clients in 2011 across all drug types was 38.

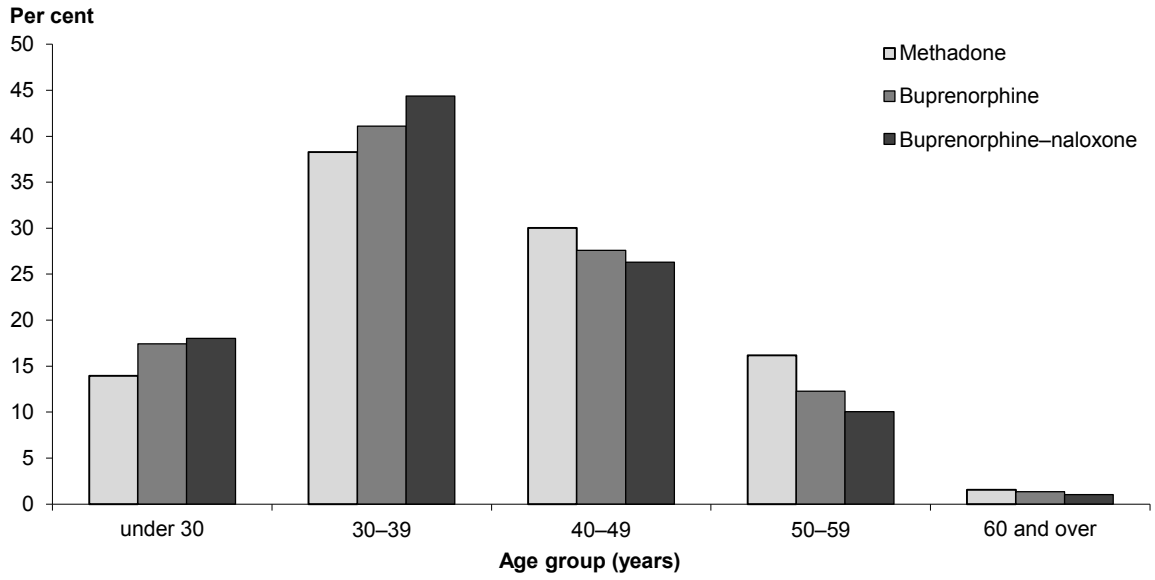
Methadone was the most common pharmacotherapy drug, however the proportion of clients taking buprenorphine–naloxone has increased from 5% in 2006 to 17% in 2011.

- In 2011, 69% of clients received methadone, 14% received buprenorphine and 18% received the combination product buprenorphine–naloxone (Table 5.12).
- The proportion of clients receiving buprenorphine–naloxone increased from 5% in 2006 to 18% in 2011.
- The combined product buprenorphine–naloxone was used more among younger clients, with methadone more likely to be used among clients age 40 years and over (Figure 5.5).

Table 5.12: Clients, by pharmacotherapy type, and state and territory, on a snapshot day, 2011

Pharmacotherapy type	NSW[(a)]	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Methadone	14,659	9,033	2,993	2,269	1,959	419	659	31	32,022
Buprenorphine	4,172	652	878	136	351	56	45	19	6,309
Buprenorphine–naloxone	n.a.	4,070	1,831	977	873	170	121	73	8,115
Total	**18,831**	**13,755**	**5,702**	**3,382**	**3,183**	**645**	**825**	**123**	**46,446**
					Per cent				
Methadone	77.8	65.7	52.5	67.1	61.5	65.0	79.9	25.2	68.9
Buprenorphine	22.2	4.7	15.4	4.0	11.0	8.7	5.5	15.4	13.6
Buprenorphine–naloxone	n.a.	29.6	32.1	28.9	27.4	26.4	14.7	59.3	17.5
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent of all clients	**40.5**	**29.6**	**12.3**	**7.3**	**6.9**	**1.4**	**1.8**	**0.3**	**100.0**

(a) In NSW, clients prescribed buprenorphine–naloxone are counted under 'buprenorphine'.



Note: In New South Wales, clients receiving buprenorphine–naloxone are reported as receiving buprenorphine.

Source: AIHW 2012a.

Figure 5.5: Clients by age group and pharmacotherapy type, on a snapshot day, 2011

5.5.2 Prescribers

The total number of prescribers (1,444) remained relatively stable between 2010 and 2011 despite fluctuations among jurisdictions (AIHW 2012a).

- Private prescribers were the most common prescriber type (79%).
- Public prescribers were most prevalent in New South Wales, where 23% were public prescribers. Victoria did not have any public prescribers, all were private prescribers.
- The majority of clients (65%) were prescribed their pharmacotherapy through private prescribers.
- The proportion of prescribers authorised to prescribe more than one pharmacotherapy type has increased every year since 2006.
- Three in 4 prescribers (77%) were authorised to prescribe more than one drug type, up from half (51%) in 2006.

5.5.3 Dosing points

In 2010–2011, there were 2,264 pharmacotherapy dosing point sites, an increase of 64 sites from 2009–10.

- Among the states and territories, the most notable change was an increase of 69 sites in Victoria.
- As has been observed in previous years, the majority of sites were pharmacies (88%).

5.6 Hospitalisations associated with drug use

There were around 91,600 hospital separations reported with a drug-related principal diagnosis in 2010–11 (Table 5.13). A hospital separation refers to a completed episode of hospital care ending with discharge, death, transfer or a change to another type of care. Drug-related separations refer to hospital care with selected diagnoses of substance use disorder or harm (accidental, intended or self-inflicted) due to selected substances (see Appendix G for technical details). Drugs described in this section include legal, accessible drugs such as alcohol and tobacco, drugs that are available by prescription or over-the-counter, such as analgesics and antidepressants, and drugs that are generally not sourced through legal means, such as heroin and ecstasy. Therefore, a proportion of the separations reported here may result from harm arising from the therapeutic use of drugs, and the inclusion of therapeutic use may mean the burden of drugs and alcohol on the hospital system appears larger than expected.

The 91,600 separations with a drug-related principal diagnosis in 2010–11 represented 1.0% of all hospital separations, a similar proportion to previous years (AIHW 2011c).

In 2010–11, sedatives and hypnotics continued to account for the highest proportion of hospital separations with a drug-related principal diagnosis (63% of all such separations), with alcohol making up 87% of separations for sedatives and hypnotics. On its own, alcohol accounted for 55% of these hospital separations (Table 5.13). Of all separations with a drug-related principal diagnosis, 14% were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for more than half of this group (8% of all drug-related separations). Stimulants and hallucinogens, including cannabis and cocaine, accounted for 9% of all separations where the principal diagnosis was drug-related.

Table 5.13: Same-day and overnight separations[a][b] with a principal diagnosis of drug-related harm or substance use disorder, by drug of concern, Australia, 2010–11

Drug of concern	Same-day separations		Overnight separations		Total separations[c]	
	Number	Per cent	Number	Per cent	Number	Per cent
Analgesics						
Opioids (includes heroin, opium, morphine and methadone)	2,394	6.1	5,123	9.8	7,517	8.2
Non-opioid analgesics (includes paracetamol)	1,452	3.7	4,233	8.1	5,685	6.2
Total analgesics	*3,846*	*9.8*	*9,356*	*17.9*	*13,202*	*14.4*
Sedatives and hypnotics						
Alcohol	26,008	66.2	24,018	45.9	50,026	54.6
Other sedatives and hypnotics (includes barbiturates and benzodiazepines)	2,284	5.8	5,478	10.5	7,762	8.5
Total sedatives and hypnotics	*28,292*	*72.0*	*29,496*	*56.4*	*57,788*	*63.1*
Stimulants and hallucinogens						
Cannabinoids (includes cannabis)	1,076	2.7	2,669	5.1	3,745	4.1
Hallucinogens (includes LSD and ecstasy)	25	0.1	19	0.0	44	0.0
Cocaine	76	0.2	103	0.2	179	0.2
Tobacco and nicotine	18	0.0	25	0.0	43	0.0
Other stimulants (includes amphetamines, volatile nitrates and caffeine)	1,354	3.4	2,521	4.8	3,875	4.2
Total stimulants and hallucinogens	*2,549*	*6.5*	*5,337*	*10.2*	*7,886*	*8.6*
Antidepressants and antipsychotics	2,034	5.2	5,609	10.7	7,643	8.3
Volatile solvents	313	0.8	422	0.8	735	0.8
Other and unspecified drugs of concern						
Multiple drug use	2,195	5.6	1,990	3.8	4,185	4.6
Unspecified drug use and other drugs not elsewhere classified[b]	56	0.1	91	0.2	147	0.2
Total other and unspecified drugs of concern	*2,251*	*5.7*	*2,081*	*4.0*	*4,332*	*4.7*
Total	**39,285**	**100.0**	**52,301**	**100.0**	**91,586**	**100.0**

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

(b) See Appendix G for technical details. Please note that some codes included in previous AODTS–NMDS reports are now excluded.

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

Source: AIHW analysis of the National Hospital Morbidity Database 2010–11.

Separations can be either same-day (where the patient is admitted and separated on the same day) or overnight (where the patient is admitted to hospital and separates on different dates). In 2010–11, overnight separations continued to be more common for drug-related treatment than same-day separations, accounting for 57% of all drug-related separations. Separations were most likely to be overnight for non-opioid analgesics (74%) out of all the drugs reported. Separations were most likely to be same day where the associated drug reported was a hallucinogen (including LSD and ecstasy), where 57% were same-day separations.

Table 5.14 reports separations with additional diagnoses where these drugs of concern were implicated; for example, where the principal diagnosis is an injury due to a fall, and an additional diagnosis is acute alcohol intoxication. Separations with a principal diagnosis as already presented in Table 5.13 are excluded from data presented in Table 5.14.

In 2010–11, there were around 128,600 occasions where a drug of concern was identified as an additional diagnosis during hospital treatment. This excludes those episodes where a drug of concern was identified in the principal diagnosis. However, separations can include more than one (and sometimes many) additional diagnoses. This figure counts some separations more than once.

Excluding separations where the principal diagnosis was drug-related, in 2010–11:

- There were 1,769 separations with a tobacco and nicotine additional diagnosis, and 93% of these resulted in an overnight separation, the highest for any drug.
- The majority of separations with a drug-related additional diagnosis (66%) included sedatives and hypnotics.
- Following alcohol (62%), the next most prevalent additional diagnosis was for a cannabis-related disorder or harm (12%).

As mentioned previously, 1% of all hospital separations were for a drug-related principal diagnosis. When additional diagnosis is also considered, a drug-related harm or substance use disorder was indicated in around 2% of all hospital separations.

Table 5.14: Same-day and overnight separations[a][b] with an additional (but not principal) diagnosis of drug-related harm or substance use disorder, by drug of concern, Australia, 2010–11

Drug of concern	Same-day separations		Overnight separations		Total separations[c]	
	Number	Per cent	Number	Per cent	Number	Per cent
Analgesics						
Opioids (includes heroin, opium, morphine and methadone)	1,438	5.3	9,738	9.6	11,181	8.7
Non-opioid analgesics (includes paracetamol)	250	0.9	1,097	1.1	1,348	1.0
Total analgesics	*1,688*	*6.2*	*10,835*	*10.7*	*12,529*	*9.7*
Sedatives and hypnotics						
Alcohol	19,802	72.7	59,455	58.6	79,330	61.6
Other sedatives and hypnotics (includes barbiturates and benzodiazepines)	871	3.2	4,301	4.2	5,175	4.0
Total sedatives and hypnotics	*20,673*	*75.9*	*63,756*	*62.9*	*84,505*	*65.6*
Stimulants and hallucinogens						
Cannabinoids (includes cannabis)	2,241	8.2	13,148	13.0	15,397	12.0
Hallucinogens (includes LSD and ecstasy)	109	0.4	171	0.2	280	0.2
Cocaine	143	0.5	345	0.3	489	0.4
Tobacco and nicotine	121	0.4	1,648	1.6	1,769	1.4
Other stimulants (includes amphetamines, volatile nitrates and caffeine)	746	2.7	4,553	4.5	5,302	4.1
Total stimulants and hallucinogens	*3,360*	*12.3*	*19,865*	*19.6*	*23,237*	*18.0*
Antidepressants and antipsychotics	236	0.9	1,409	1.4	1,646	1.3
Volatile solvents	86	0.3	363	0.4	449	0.3
Other and unspecified drugs of concern						
Multiple drug use	1,187	4.4	4,992	4.9	6,183	4.8
Unspecified drug use and other drugs not elsewhere classified[b]	23	0.1	186	0.2	209	0.2
Total other and unspecified drugs of concern	*1,210*	*4.4*	*5,178*	*5.1*	*6,392*	*5.0*
Total	**27,253**	**100.0**	**101,406**	**100.0**	**128,759**	**100.0**

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

(b) See Appendix G for technical details. Please note that some codes included in previous AODTS–NMDS reports are now excluded.

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

Source: AIHW analysis of the National Hospital Morbidity Database 2010–11.

6 Relationship between the AODTS–NMDS and associated data sets

6.1 Introduction

This chapter supplements the 2010–11 AODTS–NMDS collection by presenting information on some associated data sets and exploring the relationship between alcohol and other drug use and specialist services, such as housing assistance and access to mental health services and treatment. The chapter aims to describe these collections and identify data elements relevant to the AODTS–NMDS. It also describes gaps in data collection and identifies areas where further improvements could be made.

Use of alcohol and other drugs is among the leading causes of illness and disability in Australia, accounting for 12% of the total burden of disease in 2003 (AIHW 2012b). In that year, alcohol use was the tenth leading cause of years of life lost due to disability, and heroin or poly-drug use was ranked nineteenth (Begg et al. 2007). The economic cost of drug use is estimated to be around $56 billion annually, with tobacco accounting for the majority of this (56%) (AIHW 2011a). Drug use is fairly common in Australia. In 2010, 15% of Australians had recently used illicit drugs, and 15% were daily smokers. The use of some substances is widespread, such as alcohol, which is used by 80%of the population (AIHW 2011a).

Most Australians who use substances do so for relaxation, enjoyment and sociability, and this use causes few adverse effects (NHMRC 2009). For some, however, their substance use can become problematic and cause significant illness and hardship: drug use has links to cancers, mental illness, liver diseases and dependence, among others (NHMRC 2012). When drug use damages health or wellbeing, it becomes known as 'harmful use' (NCCH 2009).

Research has shown that particular groups in the population have a higher risk of developing harmful drug use. Drug use is much more prevalent among the homeless, prisoners and those accessing mental health services. A study conducted among the homeless population in Melbourne during 2007 estimated that 43% of the sample met criteria for harmful substance use (Chamberlain et al. 2007). Similarly, in prisoner populations, 3 in 4 prisoners (74%) reported being current daily tobacco smokers, 3 in 5 (58%) reported use of alcohol at hazardous levels and two-thirds (66%) reported having used illicit drugs in the 12 months before incarceration (AIHW 2011b). Comorbidity of mental illness and harmful substance use is also common: depending on the population sampled, it has been estimated that between 30% and 80% of people with a mental illness fall into this class (NSWDH 2000).

The relationship between homelessness, contact with the criminal justice system, harmful drug use and mental illness is complex; for example, drug use and mental illness are both a cause of and a result of homelessness and criminal justice system contact (SVMHS & CLS 2005). There are limited data available to indicate to what extent each factor is causal to, and resultant of, the others, however some correlations can be identified in the literature that imply that each factor has influence on the others:

- In 2011, the AIHW Specialist Homelessness Services report indicated that over 1 in 10 clients (12%) seeking housing assistance were doing so mainly, or in part, because of problematic drug, substance and/or alcohol use (AIHW 2012c). Chamberlain et al. (2007) stated that two-thirds (66%) of homeless people with substance use problems developed these problems after becoming homeless. Their study also estimated that 1 in 3 (30%) of

those homeless had mental illness, with half of these developing mental illness after becoming homeless.

- No direct data are available detailing the number of homeless people who have a mental illness across Australia. However, there are some indicative data available: the previously mentioned study conducted in Melbourne in 2007 estimated 34% (SVMHS & CLS 2005).Willis (2004) stated that rates of mental illness are around twice as high in homeless youth compared with youth in the general population.
- Homeless people with a mental illness are more likely to come into contact with the criminal justice system: they are 40 times more likely to be arrested and 20 times as likely to be imprisoned as those with stable accommodation (Willis 2004).
- In prisoner populations, it is estimated that 3 in 10 people (31%) have a mental illness (AIHW 2011b). In contrast, the Australian Bureau of Statistics (ABS) estimated in 2007 that 1 in 5 (20%) of the general Australian population had recently (in the previous 12 months) suffered from a mental illness (ABS 2007).

Because of the complex relationships between homelessness, contact with the criminal justice system, harmful drug use and mental illness, good-quality and comprehensive data need to be collected in order to establish and accurately quantify the relationship between them. It is important that client characteristics can be accurately captured and described when accessing mental health, alcohol and drug services and correctional facilities. Consistency in information collected is also important, to facilitate comparisons between these data sets. Currently, there is some overlap between the data collected by the services, such as drug and alcohol use among prisoners, and the reason for accessing housing assistance. However, due to the design and other limitations of the collections, insufficient overlap exists to enable detailed research into client behaviour, and the characteristics of clients accessing these services. Improved data collection by these services could enable more detailed research to be conducted, better care planning and resource allocation, resulting in improvements to service provision.

This chapter explores the relationship between alcohol and other drug use and specialist services, such as housing assistance and access to mental health services and treatment. The collections that will be considered are: the Specialist Homelessness Services NMDS, the Residential Mental Health Care NMDS, the Community Mental Health Care NMDS, the Prison Entrants Data Set Specifications (DSS), the Prisoners in Custody Repeat Medications DSS, and the Prison Clinic Contact DSS.

6.2 The data sets

6.2.1 Specialist Homelessness Services National Minimum Data Set

The Specialist Homelessness Services (SHS) NMDS is a collection intended to enable the counting and description of people who are either homeless or at risk of becoming homeless, and who seek assistance from specialist homelessness agencies. Clients, including children, are included in the collection regardless of whether support is provided or not. Data are collected by the agencies, and include basic sociodemographic information and the services required by, and provided to, each client. Information relevant to client circumstances before, during and after the support period is collected.

The SHS NMDS includes some information that could be used as an alternative to indicate alcohol and other drug use among clients. It includes a variety of questions relating to drug

and alcohol services. These include the client's referral source, which includes 'drug and alcohol service' as a response category; the reasons for seeking assistance, which has 'problematic drug or substance abuse' and 'problematic alcohol use', among other options, as response categories; and type of assistance provided, which includes 'drug/alcohol counselling' as a response category.

Additionally, the SHS NMDS includes a question about 'Person—type of institution recently left' that collects data about the types of agencies or facilities which a person may have resided in within a designated time period previously (and has now left). Clients can indicate if they have recently left a psychiatric facility, rehabilitation (not exclusively drug and alcohol rehabilitation) or a youth or adult correctional facility. This information gives an indication of the proportion of SHS clients who have accessed alcohol and other drug treatment agencies or have been imprisoned. However, because the collection only captures this information for clients who were in these facilities in the last 12 months, an accurate indication cannot be established from this information.

6.2.2 Mental health–care service collections

The Admitted Patient Mental Health Care NMDS collects data from designated psychiatric units within acute hospitals and psychiatric hospitals. The collection is restricted to patients who are admitted to a facility, and does not currently collect information from patients who are treated for psychiatric illness in hospitals or units that are not designated psychiatric facilities. The collection comprises patient demographics such as date of birth, Indigenous status, and living arrangements, as well as information about the episode of care, the facility and the illness that is being treated.

No alcohol or other drug–specific information is collected. However, the principal diagnosis, or the main reason the client was receiving treatment, is collected for the episode of care. A client can receive a principal diagnosis of 'mental and behavioural disorders due to psychoactive substance use' that can indicate that the person was admitted principally due to problematic substance use.

Principal diagnosis is of limited use to indicate comorbidity of mental illness and substance use disorders as only information about the principal diagnosis (and not secondary diagnosis) is captured. Clients who receive treatment primarily because of a mental illness will not have a secondary diagnosis of a substance use disorder recorded, and those who are primarily treated for a substance use disorder will not have a secondary diagnosis of another mental illness recorded.

The Admitted Patient Mental Health Care NMDS also collects information about whether the patient was homeless. There currently is no information collected to indicate if the patient had contact with the criminal justice system.

Another collection is the Community Mental Health Care NMDS. It collects information about services provided by specialised mental health agencies that treat patients on an out-client basis; that is, they are not admitted to a psychiatric hospital, a designated psychiatric unit or a residential mental health–care service. This collection is similar to the Admitted Patient Mental Health Care NMDS, in that it collects patient demographics, establishment items, and details of the episode of care. The collection also includes the principal diagnosis of the patient. No additional diagnoses are recorded, and because of this, the collection is unable to determine the extent of comorbidity in patients. Again, as with the Admitted

Patient Mental Health Care NMDS, there also is no information collected to determine if a person is experiencing homelessness or contact with the criminal justice system.

A third collection, the Residential Mental Health Care NMDS obtains data from government-funded residential mental health–care facilities where they employ staff trained in mental health. Designated psychiatric hospitals and psychiatric units are excluded. This collection includes information about the patients, the mental health–care facilities, and the type of care provided. Principal diagnosis is collected, along with information about additional diagnoses. The inclusion of additional diagnoses in this collection makes it more useful in detecting comorbidity; however, as with the other mental health collections, no specific information about a patient's alcohol or other drug use is collected. Information about the patient's accommodation status or criminal justice contact is also not captured.

6.2.3 Prisoner Health Data Set Specifications

Data are collected from all public and private prisons throughout Australia through three data set specifications that comprise the Prisoner Health DSS:

- Prison Entrants DSS describe data on all prisoners who enter prison during the National Prisoner Health Census period. Data are collected on demographics, mental health, chronic diseases, drug and alcohol use, the use of health services and pregnancy. The alcohol and drug use sections cover smoking status, drug use (including prescription medications used for non-medical purposes) and quantities of alcohol consumed. The prisoner is able to indicate if they have a mental health condition, including drug and alcohol abuse, however no further details are recorded. The assessing health professional is able to indicate if the prisoner has been referred to a prison mental health service or is currently at risk of suicide or self-harm.
- Prison Clinic Contact DSS describe data from all visits to prison clinics by prisoners during the census period. Information is collected about whether a prisoner or prison staff initiated the visit, what type of health professional saw the prisoner, and the problems that were managed during the visit. The treating health professional is able to indicate if the problem related to 'alcohol or drug use', or a 'psychological/mental health condition'.
- The Prisoners in Custody—Repeat Medications DSS collect data on the number of prisoners who are taking repeat medications (that largely remain the same from day to day) during the census period. It collects prisoner Indigenous status, and the medication that is being administered. The health professional is able to indicate if the medication that was dispensed was medication used to treat opioid dependence, or if the medication was used to treat nicotine dependence.

None of the data sets collected in prisons currently collect data describing the previous accommodation status of prisoners.

6.3 Relationships between these data sets

There is some overlap between the data sets that have been presented here. Most data sets do collect data to enable description of the clients of the services, including alcohol and drug use. This overlap, however, is insufficient to enable detailed research into the health outcomes and behaviours of clients, particularly the potential overlap of clients' access to these services. Currently, the data sets are collected, analysed and reported individually,

independently of the content and output of the other data sets. Moving to an approach where collections are more integrated would be beneficial in that it would allow further analysis and enhance the value of each data set individually and in common.

There are two methods of adding to the collections to enable more in-depth research to be performed. Firstly, a standard set of additional data elements could be added to each collection capturing information about a client's interaction with other treatment services. While this would not allow tracking of individual clients between services, it would allow further and more in-depth analysis to be performed, giving an indication of the number of clients that are accessing multiple services and which services are more likely to be accessed by clients who are accessing certain other services. Inclusion of other elements, such as if the client had ever been diagnosed with a mental health disorder, would allow estimates of clients' comorbidities to be determined.

One issue with the above approach is agreement on definitions of standard questions and classifications of standard responses. This is not such an issue for clients who had been in prison, or had been homeless, as these situations are defined clearly in their respective collection specifications. The definition of a mental health disorder, however, varies across the collections. Some collections, for example, include drug and alcohol items in mental health status while others do not. A similar situation is seen in data collected about drug use, where some collections include all drug use, and others contain some measure of harmful use, with differing definitions of this term, particularly when applied to alcohol.

Another method to enable greater analysis in the collections described above could be achieved through data linkage. Data linkage brings together information about people, places and events from different data collections based on common features. It is one of the most powerful means for adding value to data and there is substantial benefit to be gained from research using linked data to gain a greater understanding of a situation. It enables two or more records belonging to the same individual to be brought together, creating a single record with information from each of the linked collections. This technique allows analysis of movement of people between services and also people's use of numerous different services concurrently. Data linkage could provide:

- a better understanding of clients' movements between services
- a more complete picture of clients' use of various services
- further insight into each of the various services described in this chapter.

In conclusion, evidence exists that suggests that among the homeless, prisoners and those accessing mental health services, drug use is much more prevalent than in the general population. The relationship between these factors is complex, and it has been proposed that clients who access one service are more likely to access one or more of the others. More research needs to be conducted into the relationships between clients accessing drug and alcohol treatment, specialist homelessness services, mental health services and those who come into contact with the criminal justice system, to build an evidence base around use of these services. Further data collection and research is important to help describe the relationships between problematic drug and alcohol use, homelessness, incarceration and mental illness. This would allow for more targeted program delivery and could help enhance evidence-based policy development.

Currently, the AIHW administers a number of collections that capture data from services that provide these functions, and also conducts a survey on Australia's prisoners. While there is some overlap of data included in these collections, there is little conformity between

the collections. Two approaches were presented here that could be adopted to add value and the ability to perform analysis across the collections. Firstly, a set of standard data elements could be added to each collection's specifications. Alternatively, data could be linked between collections, allowing for clients' use of various services over time to be analysed. There is the potential for much more powerful and useful analysis to be performed if these collections could be standardised and/or linked.

7 Quality and collection methods of the data

7.1 Collection method and data included

The data in this report are administrative data; that is, they have been collected as part of the process of providing treatment, rather than by survey. Some items, such as principal drug of concern, will be based on information collected from the client. Other data items, such as main treatment type, will be supplied by agencies from their records.

The NMDS is effectively a subset of a larger collection of jurisdictional data sets. Although all states and territories have agreed to report the data items that make up this NMDS, most jurisdictions collect more data for their own planning and monitoring purposes. The policy and administrative features of the AODTS–NMDS collection within each jurisdiction are outlined in Table 7.3.

Features of the national collection include:

- Data are reported by each state and territory regardless of funding source. For example, this report does not distinguish between services funded by the Australian Government's Non-Government Organisation Treatment Grants Program (NGOTGP) and services funded by states and territories. The data simply show where treatment occurred.
- National data are affected by variations in service structures and collection practices between states and territories. Care should be taken when making comparisons between states and territories. The administrative and policy features of each jurisdiction are outlined in Table 7.3.

7.2 Comprehensiveness of the data

In 2010–11, data were provided from 666 (86%) of the 771 agencies that were in scope for this collection. This is equal to the percentage of agencies that were in scope and submitted in 2009–10 (86%).

In 2010–11, New South Wales submitted data from 260 agencies, approximately the same number of agencies that submitted in 2009–10. However, the number of agencies was still lower (by 12) than in 2008–09 and so comparison over years with New South Wales data should be made with caution.

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

The AIHW is working with jurisdictions to improve the per cent of in-scope agencies submitting data to the collection.

As in previous years, the majority of Indigenous substance use–specific services and Aboriginal primary health–care services funded directly by the OATSIH that provide alcohol and other drug treatment are not included in the 2010–11 collection. Key information about these services can be found in Appendix F. The AIHW are working with the DoHA to include these agencies in future AODTS–NMDS collections.

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

Agency NMDS status	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	DoHA[(a)]	Australia
						Number				
Submitted	260	136	89	49	48	16	10	18	40	666
In-scope	321	139	116	54	49	16	11	24	41	771
Difference	61	3	27	5	1	0	1	6	1	105
						Per cent				
In-scope agencies submitting	81.0	97.8	76.7	90.7	98.0	100.0	90.9	75.0	97.6	86.4

(a) Refers to NGOTGP programs only.

7.2.1 Australian Government data

Data reported for each state and territory in 2010–11 include services provided under the National Illicit Drug Strategy NGOTGP. Since the 2002–03 AODTS–NMDS report, Australian Government data have not been analysed separately, but as part of the jurisdiction in which the NGOTGP agency was located.

In 2010–11, the DoHA conducted a review of the processes used to collate and provide NGOTGP agencies. The review resulted in an additional 14 agencies submitting data to the 2010–11 collection from what was observed in 2009–10. The number of NGOTGP episodes also increased between 2009–10 (4,136 episodes) and 2010–11 (7,625 episodes).

7.2.2 Data quality

One indication of data quality is the number of unknown or 'not stated' responses in a data set. The proportions of 'not stated' responses in the 2010–11 AODTS–NMDS are largely similar to those seen in 2009–10.

The proportion of 'not stated' responses for injecting drug use historically has been high. This proportion increased to 14% in 2009–10 and continued to increase to 21% in 2010–11 (Table 7.2). This increase was driven by a large 'not stated' increase in Queensland (increasing from 14% to 59%) due a one-off anomaly with the introduction of a new collection database and a high number of issues relating to data entry, staff training and compliance. A similar pattern of 'not stated' responses was observed for method of use, where the proportion of 'not stated' responses increased from 5% in 2009–10 to 15% in 2010–11, also driven by a large increase in 'not stated' responses in Queensland for reasons mentioned above (increasing from 4% in 2009–10 to 58% in 2010–11).

Approximately 8% of Queensland's episodes have a missing principal drug of concern. This is due to data entry issues related again to the introduction of a new collection database, staff training and compliance. These episodes are coded as 'all other drugs' for the purpose of analysis throughout this report. More information about Queensland-specific data quality features can be found in Table 7.3.

The proportion of 'not stated' responses for Indigenous status has historically remained around 5% or 6% nationally. As in previous years, there was variation in the rates of 'not stated' for Indigenous status across the states and territories, with Western Australia

reporting the lowest rate of less than 1% and Tasmania the highest of 18%. See Table 7.3 for more details on jurisdictional data quality initiatives.

Table 7.2 : Not stated, missing and unknown responses for select data items, by jurisdiction, 2010–11 (per cent)

Data item[(a)]	NSW	Vic	Qld[(b)]	WA	SA	Tas	ACT	NT	Australia[(c)]
Client data items									
Country of birth	0.7	3.6	2.0	0.2	2.1	—	0.8	7.9	2.1
Date of birth/age	0.1	0.1	1.4	0.1	—	—	0.4	0.1	0.3
Indigenous status	2.3	9.2	6.1	0.2	4.4	°18.0	6.8	1.7	5.5
Preferred language	0.5	4.8	1.3	0.1	2.2	—	0.3	19.5	2.7
Sex	0.1	0.1	0.1	<0.1	—	—	—	0.1	0.1
Source of referral	0.4	1.1	0.1	—	1.4	0.5	0.6	1.0	0.7
Drug data items									
Method of use	3.7	9.2	°58.3	0.9	1.9	1.0	0.3	1.1	°14.7
Injecting drug use	11.3	17.6	°59.2	#0.6	8.8	#16.8	14.0	13.4	°20.8
Treatment data items									
Reason for cessation	0.4	1.7	1.1	0.1	0.2	1.2	1.8	3.3	1.0

Notes

° Those cells marked with a circle increased between 2009–10 and 2010–11 by more than 4 percentage points.

Those cells marked with a hash decreased between 2009–10 and 2010–11 by more than 4 percentage points.

(a) This table only included items where a 'not stated' response is valid. For example, client type must be provided for the episode to be included in the collection and so is not included in this table.

(b) Approximately 8% of Queensland's episodes have a missing principal drug of concern. These episodes are coded as 'all other drugs' for the purpose of analysis through this report.

(c) 'Australia' represents the total value of the state data that have been provided.

7.3 Policy and administrative features in each jurisdiction

Table 7.3 outlines the policy and administrative features of each jurisdiction that have an impact on data completeness and quality.

Table 7.3: Policy, administrative and data quality features by jurisdiction for the AODTS–NMDS collection

Jurisdiction	Policy, administrative and data quality features
New South Wales	New South Wales Health collects data from all Australian Government/state government-funded agencies as part of requirements stipulated in a signed service agreement at the commencement/renewal of each funding agreement. Data are provided monthly by agencies to their respective Local Health Districts (LHD).There are a number of data collection systems in use and development. The New South Wales Minimum Data Set is collected by these systems from which the collection of the AODTS–NMDS is provided. New South Wales is developing a State Baseline Build related to alcohol and other drugs which will roll out through New South Wales through the CHIME and Cerner systems over the next few years. The majority of non-government organisation data is collected via the Network of Alcohol and Other Drugs Agencies (NADA) online system. The NADA is the peak organisation for the non-government drug and alcohol sector in New South Wales. The total number of agencies and episodes for New South Wales was under-reported because of system issues for the reporting period of 2008–09. This should be kept in mind when analysing time series data. The number of agencies submitted by New South Wales in 2010–11 was still lower than would be expected (eight agencies less than was recorded in 2007–08). This under-reporting should be kept in mind when interpreting New South Wales agency and episode data. Comparisons over time with New South Wales data should also be made with caution. • The proportion of episodes for amphetamine use will be under-reported because other sources indicate a relatively high incidence of methamphetamine clients in the agencies affected by under-reporting because of system issues.
Victoria	The Victorian Drug Treatment Service Program provides a range of services to cover the needs of clients experiencing substance abuse issues. The Victorian Government purchases these drug treatment services from independent agencies (non-government organisations) on behalf of the community, and has developed the concept of an 'episode of care' as the fundamental unit for service funding. An episode of care is a particular course of treatment in which the client achieves at least one significant treatment goal under the care of an alcohol and other drug worker. The episode of care is a measure of successful client outcomes. It aims to develop performance measurement beyond activities, throughputs and outputs, to measure what the client gets out of treatment. Agencies funded to provide drug treatment services in Victoria have service provision targets, which are defined in terms of number of episodes of care to be provided by service type and by target group (for example, youth or adult). As a requirement of their funding agreement with the Victorian Department of Health, agencies are required to submit data on a quarterly basis, detailing their provision of drug treatment services and achievement of episodes of care. A subset of these data is contributed to the AODTS–NMDS annually. The majority of Victorian alcohol and other drug service providers continue to use the SWITCH or FullADIS information systems to report quarterly activity. However, hospitals and community health centres have since 2007–08 used the HealthSMART client management systems to report on alcohol and other drug treatment activity. • In 2010–11, as in previous years, Victoria did not differentiate between main and other treatment types. As such, Victoria is not directly comparable with other jurisdictions because every treatment type provided is reported as a separate episode. • Victoria only provides information about non-government agencies that receive public funding. • In Victoria, assessment only episodes include brokerage services wherein clients with drug conditions who have received sentences are assessed, a treatment plan developed, and the necessary treatment purchased from community-based alcohol and other drug treatment agencies. The very nature of these types of episodes results in durations that may exceed 90 days.

(continued)

Table 7.3 (continued): Policy, administrative and data quality features by jurisdiction for the AODTS–NMDS collection

Queensland	Queensland Health collects data from all Queensland Government alcohol and other drug treatment service providers and from all Queensland Illicit Drug Diversion Initiative—Police and Court Diversion clients. The Australian Government currently collects data from the Australian Government–funded agencies operating in Queensland. Queensland Health has a state-wide web-based clinical information management system supporting the collection of AODTS–NMDS items for all Queensland Government alcohol and other drug treatment services. Queensland Health will shortly be the sole data custodian of all alcohol and other drug treatment services in Queensland. In 2007, Queensland Health funded the establishment of the Queensland Network of Alcohol and Drug Agencies (QNADA), the peak body for non-government organisations that provide alcohol and other drug treatment services. One of the key objectives for the QNADA was the establishment of a database to collect information for the AODTS–NMDS. It is expected that this will enable a more comprehensive data set to be submitted to the AIHW in future. • Care should be taken when interpreting principal drug of concern over time for Queensland, as Queensland did not provide data consistent with the AODTS–NMDS specifications in 2001–02. • Approximately 8% of Queensland's episodes have a missing principal drug of concern. This is due to data entry issues related to staff training and compliance. These episodes are coded as 'all other drugs' for the purpose of analysis through this report. • The proportion of 'not stated' responses for injecting drug use and method of use in Queensland in 2010–11 was high (59% and 58%, respectively). This high 'not stated' rate was due to a one off anomaly with the introduction of a new collection database and data entry issues related to staff training and compliance. An ongoing strategy of re-engagement with alcohol and other drug treatment services Queensland staff commenced in November 2011 to mitigate this low response rate for the 2011–12 and future collection periods. The AIHW is also working with Queensland to improve staff training and compliance for future collection periods. • There are a number of episodes in Queensland where the main treatment type is 'police and court diversion'. This number will continue to increase in the 2011–12 period. For these episodes, the main treatment type will be recorded in the AODTS–NMDS as 'information and education only' and the reason for cessation will be 'ceased to participate at expiation'. All police and court diversion treatments are one service contact (date of commencement = date of cessation). • Although police and court diversion client treatment is administratively recorded for the AODTS–NMDS as 'information and education only', it should be noted that the actual treatment session for all police and court diversion clients consists of a 2-hour treatment session that includes extensive alcohol and drug assessment to determine dependence, assessment of risk-taking behaviours, provision of advice and information on reducing/ceasing drug use and harm minimisation, motivational intervention, provision of resources and referral. • The high proportion of episodes with cannabis as the principal drug of concern (29%) is due to the inclusion of episodes from the Queensland police and court diversion program.
Western Australia	Data are provided by both government and non-government sectors. Non-government services are contracted by the Drug and Alcohol Office (DAO) to provide alcohol and drug services. They have contractual obligations to incorporate the data elements of the AODTS–NMDS in their collections. They are also obliged to provide data in a regular and timely manner to the DAO. These data are collated and checked by the DAO before submission to the AIHW annually. • Services in Western Australia are not directly comparable with other states, or previous years, because of the growth of integrated services that include government and non-government service providers. • In Western Australia, a reform in the way non-residential treatment services are provided in the Perth metropolitan area has resulted in the co-location and integration of some government and non-government services. Time series data do not adequately illustrate these changes. • Western Australia reviews the geographical demographics of their clients regularly throughout the year and adjusts the locations of their service delivery outlets accordingly to meet the demands of the population. Therefore, variation between remote and very remote locations exists between years.

(continued)

Table 7.3 (continued): Policy, administrative and data quality features by jurisdiction for the AODTS–NMDS collection

Western Australia *(continued)*	• Clients are generally able to access the agencies from multiple sites within any one episode depending on the client's need and the availability of appointments within the alcohol and other drug treatment services. Examples of where these situations occur are when clients: – follow a specific worker from one service delivery outlet to another – change workers during an episode, where the new workers are located at different service delivery outlets – attend one service delivery outlet for the initial service contact (commencement of episode) due to availability of appointment times and move to a more convenient service delivery outlet during the episode – move between service delivery outlets to fit service contacts within clients' other personal needs.
South Australia	Data are provided by government (Drug and Alcohol Services South Australia—DASSA) and non-government alcohol and other drug treatment services. Non-government alcohol and other drug treatment services in South Australia are subject to service agreements with the South Australian Minister for Mental Health and Substance Abuse. As part of these service agreements, non-government organisations are required to provide timely client data in accordance with the AODTS–NMDS guidelines. Data are forwarded to DASSA for collation and checking. DASSA then forwards cleaned data to the AIHW annually. DASSA does not collect information directly from those services funded by the NGOTGP. Data are provided directly to the DoHA. • Care should be taken when interpreting principal drugs of concern over time for South Australia, as South Australia did not provide data consistent with the AODTS–NMDS specifications in 2001–02. South Australia was excluded from analysis of main treatment type in 2001–02.
Tasmania	Data are provided by both government (Alcohol and Drug Services—ADS) and non-government organisations (NGOs). NGOs funded by the Tasmanian Government provide AODTS–NMDS and key performance indicator data under the provisions of a service agreement. AODTS–NMDS data are submitted to ADS State Office on either a six-monthly or yearly basis. Data quality reports are fed back to the NGOs and training/information on data-capture practices are provided as required. ADS utilises iPM patient administration system as its key business system. This state-wide system is in use across the three Tasmanian Health Organisations (THOs), which includes inpatient, residential, outpatient and community service settings. It has been modified in order to capture the AODTS–NMDS data items. A range of online self-service reporting is used to monitor performance activity and data quality. Tasmania's illicit drug diversion treatment data are managed and extracted from the Drug Offence Reporting System (DORS). This system resides with Tasmania Police. A high proportion of treatment episodes in Tasmania with the principal drug of cannabis can largely be attributed to the inclusion of these data. Tasmania resubmitted the 2009–10 data after the release of the 2009–10 annual report due to the retrospective identification of a data quality anomaly affecting only that financial year. Online materials such as data cubes and supplementary tables were updated to include this updated data submission. However, the 2009–10 annual report does not include updated Tasmanian data. All 2009–10 data included in the 2010–11 annual report has been updated to include correct Tasmanian data. As a result, time series data are not directly comparable with the 2009–10 annual report. Training in culturally sensitive practice has been provided for service providers across the Tasmanian alcohol and other drug service sector. Despite this, Tasmanian data reporting for Indigenous status still remains low.
Australian Capital Territory	Australian Capital Territory alcohol and other drug treatment service providers supply the Health Directorate with their complete data collection for the AODTS–NMDS by 31 August each financial year, as specified in their Service Funding Agreement. Since 1 July 2007, the treatment service providers have been encouraged to use a standardised reporting system developed by the Health Directorate to enhance uniformity and reliability of data. The observed increase in assessment only episodes between 2009–10 and 2010–11 was related to one agency's increased assessment activity that resulted in increased numbers being assessed as unsuitable or not attending treatment. The number of counselling treatment services in the Australian Capital Territory has decreased between 2009–10 and 2010–11. The Australian Capital Territory noted two agencies that provide the majority of counselling treatment in the Australian Capital Territory both reported a reduced number of closed treatment episodes since 2009–10. One agency advised that there were a number of variables that contributed to the low number of occasions of service, such as significant staff shortages for the counselling team and a high number of vacancies for allotted counselling sessions.

(continued)

Table 7.3 (continued): Policy, administrative and data quality features by jurisdiction for the AODTS–NMDS collection

Northern Territory	Alcohol and other drug treatment services in the Northern Territory are provided by government and non-government agencies. The bulk of services provided through non-government agencies are funded via service-level agreements with the Northern Territory Department of Health. All funded agencies are required to provide the AODTS–NMDS data items to the department on a regular and timely basis as part of a larger data collection. Summary statistical reports are sent to all agencies every 6 months detailing client activity for the previous 12 months.
Australian Government Department of Health and Ageing (DoHA)	The DoHA funds a number of alcohol and other drug treatment services under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program (NGOTGP). These agencies are required to collect data (according to the AODTS–NMDS specifications) to facilitate the monitoring of their activities and to provide quantitative information to the Australian Government on these activities. Data from these agencies are generally submitted to the relevant state/territory health authority, except for a number of agencies in Western Australia, South Australia, New South Wales and Queensland, which submit data annually to the DoHA. Reported numbers for each state and territory in the AODTS–NMDS annual report include services provided under the National Illicit Drug Strategy NGOTGP. To ensure consistency with previous years' data, when collating the 2010–11 AODTS–NMDS information, where an organisation's sub-agencies have been given more than one establishment identifier, those identifiers were used, so that sub-agencies were counted as separate agencies. When an organisation's subprojects have been given one establishment identifier, only this establishment identifier was used, and so counted as one agency. In 2010–11, the DoHA conducted a review of the processes used to collate and provide NGOTGP agencies' data. The review resulted in an additional 14 agencies submitting data to the 2010–11 collection from that observed in 2009–10. The number of NGOTGP episodes also increased between 2009–10 (4,136 episodes) and 2010–11 (7,625 episodes).

7.4 Data quality considerations for other collections

Table 7.4 outlines data quality considerations relating to the additional data collections used in this report.

Table 7.4: Data quality considerations for additional data collections included in this report

Data collection	Data quality considerations
National Drug Strategy Household Survey (NDSHS)	The introduction of the 2009 guidelines has implications for the interpretation of NDSHS alcohol data that were collected before 2009. In this report, results from the 2010 NDSHS were analysed using the 2009 guidelines, as these were current during the collection period. Results from the NDSHS 2007, originally collected using the 2001 guidelines, have been re-analysed according to the 2009 guidelines, to enable time series comparisons (for more information on the guidelines and NDSHS data, see AIHW 2011a).
National Hospital Morbidity Data Base collection	The National Hospital Morbidity Database (NHMD) is a compilation of episode-level records from admitted patient morbidity data collection systems in Australian hospitals. It is a comprehensive data set that has records for all episodes of admitted patient care from essentially all public and private hospitals in Australia. The purpose of the NHMD is to collect information about care provided to admitted patients in Australian hospitals. The scope of the NHMD is episodes of care for admitted patients in all public and private acute and psychiatric hospitals, free-standing day hospital facilities and alcohol and drug treatment centres in Australia. Hospitals operated by the Australian Defence Force, corrections authorities and in Australia's offshore territories are not in scope but some are included. The data supplied are based on the National Minimum Data Set (NMDS) for Admitted Patient Care and include demographic, administrative and length of stay data, as well as data on the diagnoses of the patients, the procedures they underwent in hospital and external causes of injury and poisoning. In 2010–11, diagnoses and external causes of injury and poisoning were recorded using the seventh edition of the *International statistical classification of diseases and related health problems, 10th revision, Australian Modification* (ICD-10-AM) 7th edition (NCCH 2009). Changes in the ICD-10-AM/ Australian Classification of Health Interventions (ACHI) classifications and the associated Australian Coding Standards may affect the comparability of the data over time The counting unit for the NHMD is the 'separation'. Separation is the term used to refer to the episode of admitted patient care, which can be a total hospital stay (from admission to discharge, transfer or death) or a portion of a hospital stay beginning or ending in a change of type of care (for example, from acute care to rehabilitation). Separations for which the care type was reported as newborn (without qualified days) and records for 'hospital boarders' and 'posthumous organ procurement' have been excluded from analysis of data in Tables 5.13 and 5.14. A record is included for each separation, not for each patient, so patients who separated more than once in the year have more than one record in the NHMD. The hospital separations data do not include episodes of non-admitted patient care provided in outpatient clinics or emergency departments. Patients in these settings may be admitted subsequently, with the care provided to them as admitted patients being included in the NHMD.
National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection	While states and territories strive to report data consistent with agreed standards, the NOPSAD collection is not a national minimum data set and some discrepancies exist between the ways in which data are reported. Please refer to the *National Opioid Pharmacotherapy Statistics Annual Data collection: 2011 report* (AIHW 2012a) for more information. The number of clients reported reflects the number of clients in the program on a 'snapshot/specified' day in June, except for Western Australia, where the number of clients treated through the month of June is reported. In New South Wales, clients prescribed buprenorphine–naloxone are counted under buprenorphine.
National Prisoner Health Census	Prison entrants exclude New South Wales and Victoria, as they did not participate in the 2010 National Prisoner Health Census.

Appendix A: Data quality statement

Summary of key data quality issues of the AODTS–NMDS 2010–11

- Each jurisdiction has differing policy and administrative features that have an impact on the quality of data collected. These features are outlined in Table 7.3.
- There is a diverse range of alcohol and other drug treatment services in Australia and not all of these are in the scope of the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS). See Section 1.2.2 for more information about agencies and clients excluded from the AODTS–NMDS collection.
- Data are reported by each state and territory regardless of funding type. Because all services are publicly funded, they receive at least some of their funding through a state, territory or Australian government program. The actual funding program cannot be differentiated, however services are categorised according to their sector, with government funded and operated services reported as public services and those operated by non-government organisations reported as private services.
- National data are affected by variations in service structures and collection practices between states and territories and care should be taken when making comparisons between them. Also, the AODTS–NMDS has been implemented in stages, so comparisons across years, particularly the earlier years of the collection, need to be made with caution. Not all jurisdictions were able to provide data from the beginning of the collection and not all elements have been reported from the same time. These differences are described as data quality features and administrative features in Table 7.3, in Chapter 7, and as footnotes in tables where appropriate.
- As a unit of measurement, the 'closed treatment episode' used in the AODTS–NMDS cannot provide information on the number of clients who access publicly funded alcohol and other drug treatment, nor can it provide information on the extent of concurrent, sequential or recurrent service use. This is because it is possible for a single individual to access more than one service at a time, for different treatments and for different substance use problems. A new data element called a statistical linkage key will be included in the 2012–13 collection. This new element will allow the number of clients accessing treatment to be estimated. A statistical linkage key would also facilitate a greater range of analysis to provide information on patterns of service use, treatment pathways and the characteristics of groups of clients and agencies.
- Clients receiving services that are funded solely by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) as Indigenous Substance Use Services, Aboriginal primary health–care services, Aboriginal medical services and community-controlled health services are not included in the AODTS–NMDS (these services contribute to an alternative reporting mechanism).
- Improving the timeliness of data submissions continues to be a priority for the AIHW. It is hoped that the introduction of the Validata™ tool for the 2011–12 collection will allow jurisdictions to clean and submit data to the AIHW in a more timely fashion.
- Each year there are events and issues that have an impact on the collection and these differ between collection periods. These issues are discussed in more detail in Chapter 7.

Description

The AODTS–NMDS presents data about alcohol and other drug treatment services, their clients, drugs of concern and the types of treatment received.

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

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning at that level. Figure 1.1 (Chapter 1) demonstrates the processes involved in constructing the national data.

Institutional environment

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

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

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

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

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

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

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

Timeliness

The AIHW and jurisdictions are working towards improving the timeliness of the AODTS–NMDS submission. Due to system and staffing issues in some jurisdictions, the 2010–11 AODTS–NMDS was finalised in June 2012, 5 months after the anticipated data finalisation date. The AIHW is continuing to work with jurisdictions to improve the timeliness of data submissions.

Most notably, the AIHW will be utilising the Validata™ tool for the 2011–12 collection period. The Validata™ tool will allow jurisdictions to identify any issues with their own data and fix them, with a goal of submitting final data to the AIHW earlier than has occurred in previous years.

Accessibility

Results from the collection are published in an annual report that can be accessed via the AIHW website. An accompanying AODTS–NMDS specifications and collection manual is also produced annually.

In addition to the annual report, the AIHW publishes a profile summarising the main findings from the AODTS–NMDS.

To complement this national report and provide greater detail, state and territory bulletins are also produced annually and are available free of charge on the AIHW website, <www.aihw.gov.au>. In addition, public-access data subsets from the AODTS–NMDS are also available on the AIHW website, in the form of interactive data cubes, <http://www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data-cubes/>.

Additional data requests can also be made on an ad hoc basis.

Interpretability

Information on alcohol and other drug treatment services is available in the outputs mentioned above. Definitions of terms used are in the report to assist with interpretability. Detailed definitions of items collected can also be found in the AODTS–NMDS specifications and collection manual (AIHW 2010a).

Relevance

The AODTS–NMDS was created to assist in the monitoring and evaluation of key objectives of the National Drug Strategy and will continue to provide an important source of information for monitoring the National Drug Strategy.

It is one of a number of data sources that provide a picture of alcohol and other drug treatment services in Australia. Data from the collection can also be considered with information from other sources; for instance, the National Drug Strategy Household Survey, to inform debate, policy decisions and planning processes that occur within the broader alcohol and other drug treatment sector.

Accuracy

The AODTS–NMDS is a collection of data from publicly funded treatment services in all states and territories, including those directly funded by the DoHA.

The AODTS–NMDS counts treatment episodes completed during the collection period. For this report, the period was 1 July 2010 to 30 June 2011. More detail about the circumstances in which episodes are considered to be completed is in AODTS–NMDS specifications and collection manual 2010–11 (AIHW 2010a).

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

Table 1.1 provides some explanatory notes to accompany the data in the tables and figures. There are further data quality issues relevant to the interpretation of results from the separate jurisdictions; these are outlined in Chapter 7.

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

Coherence

The AODTS–NMDS collection is reported annually. The method of data collection and elements collected is consistent between years allowing for meaningful comparisons over time.

Appendix B: Data elements in the AODTS–NMDS for 2010–11

The detailed data definitions for the data elements in the AODTS–NMDS for 2010–11 are published in the *National health data dictionary*, version 15 (NHISSC 2010) and are available on the AIHW's Metadata Online Registry (METeOR) at <meteor.aihw.gov.au/content/index.phtml/itemId/374211>.

Table B1: Data elements for the AODTS–NMDS, 2010–11

Data element	METeOR identifier
Establishment-level data elements	
Establishment identifier (comprising)	269973
state identifier	269941
establishment sector	269977
region code	269940
establishment number	269975
Geographical location of establishment	341802
Client-level data elements	
Client type	270083
Country of birth	270277
Date of birth	287007
Date of cessation of treatment episode for alcohol and other drugs	270067
Date of commencement of treatment episode for alcohol and other drugs	270069
Establishment identifier	269973
Indigenous status	291036
Injecting drug use	270113
Main treatment type for alcohol and other drugs	270056
Method of use for principal drug of concern	270111
Other drugs of concern	270110
Other treatment type for alcohol and other drugs	270076
Person identifier	290046
Preferred language	304128
Principal drug of concern	270109
Reason for cessation of treatment episode for alcohol and other drugs	270011
Sex	287316
Source of referral to alcohol and other drug treatment services	269946
Treatment delivery setting for alcohol and other drugs	270068
Supporting items	
Cessation of treatment episode for alcohol and other drugs	327302
Commencement of treatment episode for alcohol and other drugs	327216
Treatment episode for alcohol and other drugs	268961
Service delivery outlet	268970

Appendix C: Detailed tables

Agency tables

Table C1: Treatment agencies by jurisdiction, 2002–03 to 2010–11[(a)]

Year	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
2002–03	229	148	96	28	50	11	6	19	587
2003–04	259	143	94	34	53	12	8	19	622
2004–05	287	136	87	40	46	12	9	18	635
2005–06	282	138	114	44	44	10	10	22	664
2006–07	262	136	105	44	44	13	10	19	633
2007–08	268	138	106	51	49	16	10	20	658
2008–09	250	136	122	44	55	15	10	21	653
2009–10	258	138	118	52	59	15	10	20	670
2010–11	262	136	109	56	59	16	10	18	666

(a) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

Table C2: Treatment agencies by geographical location, 2010–11

Location	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Major cities	130	88	45	32	39	—	10	—	344
Inner regional	97	39	21	8	7	10	—	—	182
Outer regional	33	9	22	6	8	5	—	9	92
Remote	2	—	9	—	1	1	—	6	19
Very remote	—	—	12	10	4	—	—	3	29
Total	**262**	**136**	**109**	**56**	**59**	**16**	**10**	**18**	**666**

Table C3: Episodes by clients seeking treatment for their own drug use, 2002–03 to 2010–11

Year	Clients seeking treatment for their own drug use (number of episodes)	Per cent	All treatment episodes (number)
2002–03	123,032	94.0	130,930
2003–04	129,331	94.5	136,869
2004–05	135,202	95.1	142,144
2005–06	144,963	95.8	151,362
2006–07	140,475	95.4	147,325
2007–08	147,721	95.9	153,998
2008–09	138,027	96.1	143,672
2009–10[(a)]	139,614	95.9	145,631
2010–11	144,002	95.7	150,488

(a) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

Client profile tables

Table C4: Treatment episodes by selected client data items and jurisdiction, 2010–11

Client item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Number				
Own drug use	35,365	49,974	25,580	15,971	9,143	1,653	3,108	3,208	144,002
Others drug use	675	2,911	961	1,140	287	85	48	379	6,486
Sex									
Males	24,302	33,873	18,842	10,915	6,475	1,215	2,093	2,426	100,141
Females	11,719	18,943	7,680	6,195	2,955	523	1,063	1,157	50,235
Not stated	19	69	19	1	—	—	—	4	112
Age group (years)									
10–19	2,363	7,279	3,754	2,974	822	307	571	666	18,736
20–29	9,009	15,113	8,447	4,651	2,290	505	793	983	41,791
30–39	10,606	14,185	6,966	4,814	2,771	457	843	997	41,639
40–49	8,160	10,188	4,407	2,816	2,068	272	576	644	29,131
50–59	4,024	4,402	1,899	1,336	1,050	134	257	243	13,345
60+	1,849	1,673	697	502	425	63	105	51	5,365
Not stated	29	45	371	18	4	—	11	3	481
Indigenous status									
Indigenous	4,266	3,366	4,030	3,805	1,462	189	358	2,152	19,628
Non-Indigenous	30,945	44,663	20,884	13,273	7,553	1,236	2,582	1,373	122,509
Not stated	829	4,856	1,627	33	415	313	216	62	8,351
Country of birth									
Australia	31,983	45,265	23,055	14,156	8,185	1,683	2,813	3,171	130,311
United Kingdom	928	938	567	1,225	348	12	79	29	4,126
New Zealand	704	926	1,111	553	82	15	36	30	3,457
Vietnam	110	543	40	58	178	—	6	1	936
Not stated	233	1,871	544	28	195	—	24	282	3,177
All other countries	2,082	3,342	1,224	1,091	442	28	198	74	8,481
Preferred language									
English	35,482	49,537	26,095	17,006	8,994	1,736	3,129	2,044	144,023
Australian Indigenous languages	21	19	18	20	58	—	—	763	899
Vietnamese	61	258	7	16	111	—	3	1	457
Not stated	171	2,538	343	13	208	—	10	699	3,982
All other languages	305	533	78	56	59	2	14	80	1,127
Source of referral									
Self	14,699	20,026	7,254	6,429	2,688	911	1,500	1,224	54,731
Family member/friend	1,318	1,517	852	1,005	414	38	164	185	5,493
Medical practitioner	4,077	2,431	1,035	687	463	97	16	83	8,889
Hospital	2,402	574	1,680	324	993	21	215	157	6,366
Mental health care service	1,367	1,011	866	521	178	25	64	42	4,074
Alcohol and other drug treatment service	3,427	6,304	726	4,212	1,174	27	240	186	16,296
Other community/health-care service	750	2,650	249	261	281	101	118	304	4,714
Correctional service	2,466	6,237	3,627	696	581	119	209	352	14,287
Police diversion	63	798	2,268	862	620	320	235	159	5,325
Court diversion	3,117	7,517	6,567	1,685	96	23	245	333	19,583
Other	2,198	3,231	1,385	429	1,810	47	132	527	9,759
Not stated	156	589	32	—	132	9	18	35	971
Total	**36,040**	**52,885**	**26,541**	**17,111**	**9,430**	**1,738**	**3,156**	**3,587**	**150,488**

Table C5: Treatment episodes by demographic data items and geographical location, 2010–11

Data items	Major cities	Inner regional	Outer regional	Remote	Very remote	Australia
Sector			**Number**			
Government	33,961	14,450	7,079	1,056	2,231	58,777
Non-government	63,742	18,655	7,654	1,319	341	91,711
			Per cent			
Government	34.8	43.6	48.0	44.5	86.7	39.1
Non-government	65.2	56.4	52.0	55.5	13.3	60.9
Sex			**Number**			
Male	65,083	21,821	9,868	1,612	1,757	100,141
Female	32,558	11,268	4,835	759	815	50,235
Not stated	62	16	30	4	—	112
			Per cent			
Male	66.6	65.9	67.0	67.9	68.3	66.5
Female	33.3	34.0	32.8	32	31.7	33.4
Not stated	0.1	—	0.2	0.2	—	—
Age group (years)			**Number**			
10–19	12,176	3,749	1,937	566	308	18,736
20–29	27,166	9,171	3,979	681	794	41,791
30–39	27,146	9,255	3,879	579	780	41,639
40–49	18,894	6,646	2,743	367	481	29,131
50–59	8,723	3,033	1,303	132	154	13,345
60+	3,509	1,193	572	46	45	5,365
Not stated	89	58	320	4	10	481
			Per cent			
10–19	12.5	11.3	13.1	23.8	12.0	12.5
20–29	27.8	27.7	27.0	28.7	30.9	27.8
30–39	27.8	28.0	26.3	24.4	30.3	27.7
40–49	19.3	20.1	18.6	15.5	18.7	19.4
50–59	8.9	9.2	8.8	5.6	6.0	8.9
60+	3.6	3.6	3.9	1.9	1.7	3.6
Not stated	0.1	0.2	2.2	0.2	0.4	0.3
Indigenous status			**Number**			
Indigenous	8,637	4,478	3,400	1,379	1,734	19,628
Non-Indigenous	83,158	26,962	10,840	938	611	122,509
Not stated	5,908	1,665	493	58	227	8,351
			Per cent			
Indigenous	8.8	13.5	23.1	58.1	67.4	13.0
Non-Indigenous	85.1	81.4	73.6	39.5	23.8	81.4
Not stated	6.0	5.0	3.3	2.4	8.8	5.5
Total	**97,703**	**33,105**	**14,733**	**2,375**	**2,572**	**150,488**

Table C6: Treatment episodes by age group, 2003–04 to 2010–11[a]

Age group (years)	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10[b]	2010–11
					Number			
10–19	12.5	12.2	12.8	11.7	11.2	11.9	12.5	12.5
20–29	32.6	33.6	33.3	32.6	31.9	31.2	29.1	27.8
30–39	27.9	28.8	28.9	29.4	29.1	28.5	27.9	27.7
40–49	17.2	16.5	16.6	17.3	17.9	18.2	18.9	19.4
50–59	6.7	6.0	6.0	6.6	7.1	7.4	8.2	8.9
60+	2.3	2.0	1.9	2.1	2.5	2.7	3.3	3.6
Not stated	0.8	1.0	0.4	0.3	0.3	0.2	0.1	0.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Includes data for all clients.

(b) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

Drugs of concern tables

Table C7: Treatment episodes by drug-related data items and jurisdiction, 2010–11[a][b]

Drug-related item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Injecting drug use					Number				
Current injector	6,494	7,140	1,482	3,285	1,630	245	667	336	21,279
Injected 3–12 months ago	1,528	4,590	417	1,176	449	63	171	70	8,464
Injected 12+ months ago	4,117	5,538	889	2,447	1,178	161	265	212	14,807
Never injected	19,229	23,879	7,654	8,972	5,084	906	1,570	2,159	69,453
Not stated	3,997	8,827	15,138	91	802	278	435	431	29,999
Method of use									
Ingests	20,037	24,321	3,501	8,759	6,303	782	1,845	2,159	67,707
Smokes	8,355	10,469	5,871	3,393	1,257	641	558	385	30,929
Injects	5,310	7,580	1,124	3,436	1,297	198	651	304	19,900
Sniffs (powder)	222	381	68	87	28	6	14	12	818
Inhales (vapour)	59	2,198	68	104	21	5	25	305	2,785
Other	77	447	29	52	64	4	6	3	682
Not stated	1,305	4,578	14,919	140	173	17	9	40	21,181
Principal drug of concern									
Analgesics									
Heroin	3,157	6,371	1,428	1,186	678	8	487	39	13,354
Methadone	728	505	188	268	189	20	42	21	1,961
Morphine	406	353	390	152	185	84	11	213	1,794
Other opioids	1,039	423	733	132	298	37	107	32	2,801
Total analgesics	*5,354*	*8,026*	*2,748*	*2,232*	*1,365*	*161*	*648*	*305*	*20,839*
Sedatives and hypnotics									
Alcohol	17,904	23,491	9,778	7,617	5,003	642	1,671	2,061	68,167
Benzodiazepines	766	970	372	168	142	31	30	9	2,488
Total sedatives and hypnotics	*18,696*	*24,618*	*10,160*	*7,802*	*5,152*	*674*	*1,701*	*2,082*	*70,885*

(continued)

Table C7 (continued): Treatment episodes by drug-related data items and jurisdiction, 2010–11[(a)(b)]

Drug-related item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Stimulants and hallucinogens					**Number**				
Amphetamines	2,945	3,429	2,076	2,503	1,171	142	198	99	12,563
Cannabis	6,933	11,681	7,437	3,000	1,204	643	525	339	31,762
Ecstasy	86	169	315	47	59	10	13	9	708
Cocaine	233	115	94	32	11	2	10	4	501
Nicotine	498	502	620	73	91	7	6	52	1,849
Total stimulants and hallucinogens	*10,726*	*16,049*	*10,617*	*5,701*	*2,543*	*814*	*757*	*505*	*47,712*
Volatile solvents	21	139	21	80	10	1	1	280	553
All other drugs	568	1,142	2,034	156	73	3	1	36	4,013
Total	**35,365**	**49,974**	**25,580**	**15,971**	**9,143**	**1,653**	**3,108**	**3,208**	**144,002**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C8: Treatment episodes by other drugs of concern and jurisdiction, 2010–11[(a)(b)]

Other drugs of concern	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Analgesics					**Number**				
Heroin	1,105	3,363	257	489	226	6	102	26	5,574
Methadone	563	548	76	121	45	2	19	9	1,383
Morphine	322	511	120	188	128	28	9	49	1,355
Other opioids	773	727	147	160	176	11	82	7	2,083
Total analgesics	*2,794*	*5,350*	*610*	*1,406*	*586*	*53*	*218*	*91*	*11,108*
Sedatives and hypnotics									
Alcohol	3,709	10,394	2,441	2,808	842	172	426	238	21,030
Benzodiazepines	2,057	5,369	323	946	481	51	141	85	9,453
Total sedatives and hypnotics	*5,848*	*16,193*	*2,779*	*3,782*	*1,332*	*227*	*570*	*335*	*31,066*
Stimulants and hallucinogens									
Amphetamines	2,986	9,070	804	2,175	749	110	353	153	16,400
Cannabis	5,982	14,139	1,371	3,686	1,749	222	609	652	28,410
Ecstasy	781	2,741	326	519	177	29	115	66	4,754
Cocaine	696	810	113	262	66	4	44	16	2,011
Nicotine	6,285	10,985	1,522	3,467	2,311	177	365	633	25,745
Total stimulants and hallucinogens	*17,011*	*39,702*	*4,315*	*10,511*	*5,084*	*561*	*1,528*	*1,537*	*80,249*
Volatile solvents	23	332	21	56	11	3	4	57	507
All other drugs	357	1,752	73	81	32	3	12	52	2,362
Total	**26,033**	**63,329**	**7,798**	**15,836**	**7,045**	**847**	**2,332**	**2,072**	**125,292**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C9: Treatment episodes by principal drug of concern and age group (years), 2010–11[(a)(b)]

Principal drug of concern	10–19	20–29	30–39	40–49	50–59	60+	Not stated	Total
Analgesics				**Per cent**				
Heroin	2.9	10.3	13.6	8.5	5.3	2.1	1.3	9.3
Methadone	0.2	1.1	2	1.6	1.6	0.6	—	1.4
Morphine	0.3	1.1	1.6	1.6	1.4	0.6	0.7	1.2
Other opioids	0.5	1.6	2.5	2.4	2.1	1.3	8.0	1.9
Total analgesics	*4.0*	*14.7*	*20.8*	*14.8*	*11*	*4.8*	*10*	*14.5*
Sedatives and hypnotics								
Alcohol	33.5	37.2	44.7	59.5	70.2	80.6	59.3	47.3
Benzodiazepines	0.5	1.5	2.2	1.9	2.0	2.2	2.4	1.7
Total sedatives and hypnotics	*34.3*	*38.8*	*47.0*	*61.5*	*72.5*	*82.8*	*61.7*	*49.2*
Stimulants and hallucinogens								
Amphetamines	5.2	12	11	6.5	3.1	1.7	7.6	8.7
Cannabis	46.6	28.3	16.9	13.3	8.9	4.7	17.4	22.1
Ecstasy	0.6	1.0	0.3	0.1	0.1	0.1	0.2	0.5
Cocaine	0.2	0.5	0.4	0.3	0.2	0.1	—	0.3
Nicotine	1.8	1.0	1.0	1.1	2.1	3.5	2.2	1.3
Total stimulants and hallucinogens	*54.9*	*43*	*29.8*	*21.4*	*14.5*	*10.2*	*27.6*	*33.1*
Volatile solvents	1.8	0.4	0.1	—	0.1	0.1	0.2	0.4
All other drugs	5.1	3.0	2.3	2.3	1.9	2.1	0.4	2.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C10: Treatment episodes by selected data items and principal drug of concern, 2010–11[(a)]

	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens						
Client data item	Heroin	Metha-done	Morphine	Other opioids	Alcohol	Benzodi-azepines	Amphe-tamines	Cannabis	Ecstasy	Cocaine	Nicotine	All other drugs	Total
Median age						Years							
Males	33	37	36	35	36	34	31	25	23	31	33	28	32
Females	31	33	33	35	38	37	29	26	24	30	36	31	34
All persons	32	35	35	35	37	35	30	25	23	30	34	29	33
Age group (years)						Per cent							
10–19	3.8	1.7	3.0	3.5	8.7	3.7	7.3	26.0	16.2	7.8	17.5	22.0	12.3
20–29	31.6	23.0	25.1	23.9	22.4	24.2	39.0	36.5	59.9	37.9	21.3	30.6	28.5
30–39	41.3	42.0	35.7	36.8	26.5	36.5	35.5	21.5	15.5	34.7	22.2	24.4	28.1
40–49	17.6	22.3	25.0	23.4	24.2	21.2	14.2	11.6	5.5	14.8	16.5	14.9	19.2
50–59	4.8	9.6	9.5	9.1	12.6	10.0	3.0	3.4	2.1	3.8	13.6	6.2	8.5
60+	0.7	1.4	1.5	2.1	5.3	4.0	0.6	0.7	0.6	1.0	8.4	1.9	3.1
Not stated	—	—	0.2	1.3	0.4	0.4	0.3	0.3	0.1	—	0.5	0.1	0.3
Sex													
Male	65.6	56.5	62.8	61.3	68.7	51.6	69.1	70.2	81.1	78.0	56.7	65.0	67.9
Female	34.3	43.4	37.2	38.6	31.2	48.3	30.8	29.8	18.8	21.6	43.2	34.8	32.0
Not stated	—	0.1	—	—	0.1	0.1	0.1	0.1	0.1	0.4	0.1	0.2	0.1
Indigenous status													
Indigenous	9.0	11.1	11.1	11.2	14.7	7.2	10.3	13.8	6.2	9.2	12.1	16.1	13.3
Non-Indigenous	85.9	84.9	83.4	83.5	79.7	87.0	84.6	80.2	88.7	86.8	82.5	79.4	81.2
Not stated	5.1	4.0	5.5	5.3	5.6	5.8	5.1	6.0	5.1	4.0	5.4	4.5	5.5

(continued)

Table C10 (continued): Treatment episodes by selected data items and principal drug of concern, 2010–11[(a)]

	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens						
Client data item	Heroin	Metha-done	Morphine	Other opioids	Alcohol	Benzodi-azepines	Amphe-tamines	Cannabis	Ecstasy	Cocaine	Nicotine	All other drugs	Total
Source of referral						Per cent							
Self	41.5	39.4	47.8	45.3	38.4	38.3	35.9	29.2	18.2	38.3	29.5	26.4	36.0
Family member/friend	3.1	3.4	3.3	2.8	2.8	2.7	4.8	3.2	3.5	4.0	1.9	2.4	3.1
Medical practitioner	3.5	13.4	10.4	11.2	7.2	12.3	3.6	3.8	2.5	6.6	10.7	6.0	6.0
Hospital	2.7	10.2	4.6	8.1	5.6	6.2	2.9	2.3	2.4	2.0	9.3	2.6	4.4
Mental health care service	1.3	1.5	2.1	2.7	3.0	4.2	2.9	3.3	1.0	1.4	2.8	1.4	2.8
Alcohol and other drug treatment service	10.9	14.8	10.3	10.0	11.7	11.7	10.6	10.8	4.0	7.8	3.6	7.1	11.0
Other community/health-care service	2.9	1.8	2.6	1.6	3.0	3.0	2.3	3.5	0.8	2.2	4.5	2.8	3.0
Correctional service	14.0	5.2	7.8	6.5	9.8	7.1	12.8	9.5	11.4	10.0	3.6	3.6	9.9
Police diversion	1.0	0.7	1.5	1.3	2.1	0.5	5.4	7.4	15.5	3.2	7.4	5.5	3.7
Court diversion	14.7	4.5	6.3	2.4	8.6	8.3	13.3	20.2	36.2	21.0	19.9	35.0	13.4
Other	4.1	5.0	3.3	7.3	7.1	5.3	5.0	6.5	4.1	3.4	5.6	5.7	6.3
Not stated	0.3	0.1	0.1	0.7	0.7	0.3	0.5	0.3	0.3	0.2	1.1	1.7	0.6
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**13,354**	**1,961**	**1,794**	**2,801**	**68,167**	**2,488**	**12,563**	**31,762**	**708**	**501**	**1,849**	**6,054**	**144,002**

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

Table C11: Treatment episodes by Indigenous status and principal drug of concern, 2010–11[(a)(b)]

	Indigenous		Non-Indigenous		Not stated		Total	
Principal drug of concern	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Analgesics								
Heroin	1,203	6.3	11,469	9.8	682	8.6	13,354	9.3
Methadone	217	1.1	1,665	1.4	79	1.0	1,961	1.4
Morphine	199	1.0	1,497	1.3	98	1.2	1,794	1.2
Other opioids	314	1.6	2,339	2.0	148	1.9	2,801	1.9
Total analgesics	2,004	10.5	17,789	15.2	1,046	13.2	20,839	14.5
Sedatives and hypnotics								
Alcohol	9,998	52.4	54,323	46.4	3,846	48.4	68,167	47.3
Benzodiazepines	180	0.9	2,164	1.9	144	1.8	2,488	1.7
Total sedatives and hypnotics	*10,194*	*53.4*	*56,693*	*48.5*	*3,998*	*50.3*	*70,885*	*49.2*
Stimulants and hallucinogens								
Amphetamines	1,300	6.8	10,628	9.1	635	8.0	12,563	8.7
Cannabis	4,397	23.0	25,474	21.8	1,891	23.8	31,762	22.1
Ecstasy	44	0.2	628	0.5	36	0.5	708	0.5
Cocaine	46	0.2	435	0.4	20	0.3	501	0.3
Nicotine	224	1.2	1,526	1.3	99	1.2	1,849	1.3
Total stimulants and hallucinogens	*6,031*	*31.6*	*38,974*	*33.3*	*2,707*	*34.0*	*47,712*	*33.1*
Volatile solvents	362	1.9	172	0.1	19	0.2	553	0.4
All other drugs	503	2.6	3,327	2.8	183	2.3	4,013	2.8
Total	**19,094**	**100.0**	**116,955**	**100.0**	**7,953**	**100.0**	**144,002**	**100.0**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C12: Treatment episodes by drug-related data items and principal drug of concern, 2010–11[(a)]

	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens						
Drug-related data item	**Heroin**	**Methadone**	**Morphine**	**Other opioids**	**Alcohol**	**Benzodi-azepines**	**Amphe-tamines**	**Cannabis**	**Ecstasy**	**Cocaine**	**Nicotine**	**All other drugs**	**Total**
Method of use						**Per cent**							
Ingests	2.0	76.2	20.0	49.4	84.5	79.9	10.4	4.1	74.2	3.0	6.9	22.0	47.0
Smokes	5.4	0.9	2.0	2.1	1.3	1.2	20.9	78.1	1.4	10.8	79.1	3.6	21.5
Injects	78.2	11.1	59.7	21.6	0.4	4.9	48.8	0.4	2.0	14.6	0.4	14.0	13.8
Sniffs (powder)	0.2	—	0.2	0.1	—	—	3.6	0.1	1.0	53.7	—	0.4	0.6
Inhales (vapour)	0.7	0.1	0.1	0.3	0.1	0.2	1.4	5.8	0.1	0.8	3.6	8.3	1.9
Other	0.2	0.4	0.1	3.5	0.1	0.4	0.7	0.6	—	0.6	0.4	3.2	0.5
Not stated	13.3	11.3	18.0	22.9	13.6	13.3	14.2	11.0	21.3	16.6	9.5	48.5	14.7
Injecting drug use													
Current injector	55.2	30.9	54.8	27.3	4.6	20.7	38.1	7.0	3.2	13.4	2.3	12.9	14.8
Injected 3–12 months ago	17.0	16.4	7.6	6.9	3.2	8.5	10.0	4.9	2.3	6.2	2.5	4.5	5.9
Injected 12+ months ago	10.6	31.4	7.2	11.4	10.0	16.3	9.6	10.4	3.2	4.6	7.8	6.3	10.3
Never injected	5.1	5.2	10.8	27.0	61.0	33.8	26.3	58.3	68.4	53.3	63.2	26.1	48.2
Not stated	12.1	16.1	19.6	27.4	21.3	20.7	16.1	19.4	22.9	22.6	24.2	50.3	20.8
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**13,354**	**1,961**	**1,794**	**2,801**	**68,167**	**2,488**	**12,563**	**31,762**	**708**	**501**	**1,849**	**6,054**	**144,002**

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

Table C13: Treatment episodes by principal drug of concern and all drugs of concern, 2010–11[(a)]

Drug of concern	Principal drug of concern reported	Proportion of all closed treatment episodes (per cent)	All drugs of concern reported, including principal	Proportion of all closed treatment episodes[(b)] (per cent)
Analgesics				
Heroin	13,354	9.3	18,928	13.1
Methadone	1,961	1.4	3,344	2.3
Morphine	1,794	1.2	3,149	2.2
Other opioids	2,801	1.9	4,884	3.4
Sedatives and hypnotics				
Alcohol	68,167	47.3	89,197	61.9
Benzodiazepines	2,488	1.7	11,941	8.3
Stimulants and hallucinogens				
Amphetamines	12,563	8.7	28,963	20.1
Cannabis	31,762	22.1	60,172	41.8
Ecstasy	708	0.5	5,462	3.8
Cocaine	501	0.3	2,512	1.7
Nicotine	1,849	1.3	27,594	19.2
All other drugs	6,054	4.2	13,148	9.1
Total	**144,002**	**100.0**	**269,294**	**—**

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

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

Table C14: Treatment episodes by principal drug of concern, with or without other drugs of concern, 2010–11[(a)]

Principal drug of concern	With other drugs	With no other drugs	Total closed treatment episodes	Proportion of episodes with 'other drugs' of concern (per cent)
Analgesics		**Number**		
Heroin	8,387	4,967	13,354	62.8
Methadone	1,138	823	1,961	58.0
Morphine	1,039	755	1,794	57.9
Other opioids	1,228	1,573	2,801	43.8
Sedatives and hypnotics				
Alcohol	28,696	39,471	68,167	42.1
Benzodiazepines	1,586	902	2,488	63.7
Stimulants and hallucinogens				
Amphetamines	7,684	4,879	12,563	61.2
Cannabis	18,040	13,722	31,762	56.8
Ecstasy	342	366	708	48.3
Cocaine	307	194	501	61.3
Nicotine	783	1,066	1,849	42.3
All other drugs	1,681	4,373	6,054	27.8
Total	**70,911**	**73,091**	**144,002**	**49.2**

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

Table C15: Treatment episodes with other drugs of concern by selected principal drugs of concern, 2010–11[(a)(b)]

Other drugs of concern	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens					All other drugs	Total
	Heroin	Methadone	Morphine	Other opioids	Alcohol	Benzod-i-azepines	Amphet-amines	Cannabis	Ecstasy	Cocaine	Nicotine		
							Number						
Analgesics													
Heroin	—	314	206	179	1,935	354	950	1,397	8	32	35	164	5,574
Methadone	511	—	64	38	276	150	107	202	—	10	11	14	1,383
Morphine	402	72	—	63	322	48	151	262	—	2	6	27	1,355
Other opioids	489	43	81	66	714	151	182	270	2	10	20	55	2,083
Total analgesics	*1,523*	*455*	*368*	*374*	*3,492*	*752*	*1,484*	*2,237*	*10*	*54*	*75*	*284*	*11,108*
Sedatives and hypnotics													
Alcohol	2,626	227	315	301	7	635	3,613	11,766	210	146	474	710	21,030
Benzodiazepines	2,380	354	311	356	3,008	40	1,000	1,558	13	33	32	368	9,453
Total sedatives and hypnotics	*5,069*	*593*	*635*	*663*	*3,232*	*703*	*4,712*	*13,431*	*227*	*182*	*508*	*1,111*	*31,066*
Stimulants and hallucinogens													
Amphetamines	2,774	184	263	231	6,149	363	119	5,608	108	103	85	413	16,400
Cannabis	4,250	441	484	412	16,414	624	4,450	—	106	85	343	801	28,410
Ecstasy	319	8	22	16	1,558	38	1,043	1,607	—	54	15	74	4,754
Cocaine	325	16	6	10	625	29	531	407	30	—	6	26	2,011
Nicotine	2,271	410	315	371	12,659	444	2,069	6,614	53	45	—	494	25,745
Total stimulants and hallucinogens	*10,218*	*1,073*	*1,125*	*1,064*	*38,400*	*1,530*	*8,678*	*15,209*	*328*	*292*	*474*	*1,858*	*80,249*
Volatile solvents	36	3	—	4	220	10	29	183	—	1	5	16	507
All other drugs	297	53	82	32	921	135	195	539	15	16	12	65	2,362
Total	**17,143**	**2,177**	**2,210**	**2,137**	**46,265**	**3,130**	**15,098**	**31,599**	**580**	**545**	**1,074**	**3,334**	**125,292**

(continued)

Table C15 (continued): Treatment episodes with other drugs of concern by selected principal drugs of concern, 2010–11[a][b]

Other drugs of concern	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens					All other drugs	Total
	Heroin	Methadone	Morphine	Other opioids	Alcohol	Benzodi-azepines	Amphet-amines	Cannabis	Ecstasy	Cocaine	Nicotine		
							Per cent						
Analgesics													
Heroin	—	14.4	9.3	8.4	4.2	11.3	6.3	4.4	1.4	5.9	3.3	4.9	4.4
Methadone	3.0	—	2.9	1.8	0.6	4.8	0.7	0.6	—	1.8	1.0	0.4	1.1
Morphine	2.3	3.3	—	2.9	0.7	1.5	1.0	0.8	—	0.4	0.6	0.8	1.1
Other opioids	2.9	2.0	3.7	3.1	1.5	4.8	1.2	0.9	0.3	1.8	1.9	1.6	1.7
Total analgesics	*8.9*	*20.9*	*16.7*	*17.5*	*7.5*	*24*	*9.8*	*7.1*	*1.7*	*9.9*	*7.0*	*8.5*	*8.9*
Sedatives and hypnotics													
Alcohol	15.3	10.4	14.3	14.1	—	20.3	23.9	37.2	36.2	26.8	44.1	21.3	16.8
Benzodiazepines	13.9	16.3	14.1	16.7	6.5	1.3	6.6	4.9	2.2	6.1	3.0	11.0	7.5
Total sedatives and hypnotics	*29.6*	*27.2*	*28.7*	*31.0*	*7.0*	*22.5*	*31.2*	*42.5*	*39.1*	*33.4*	*47.3*	*33.3*	*24.8*
Stimulants and hallucinogens													
Amphetamines	16.2	8.5	11.9	10.8	13.3	11.6	0.8	17.7	18.6	18.9	7.9	12.4	13.1
Cannabis	24.8	20.3	21.9	19.3	35.5	19.9	29.5	—	18.3	15.6	31.9	24.0	22.7
Ecstasy	1.9	0.4	1.0	0.7	3.4	1.2	6.9	5.1	—	9.9	1.4	2.2	3.8
Cocaine	1.9	0.7	0.3	0.5	1.4	0.9	3.5	1.3	5.2	—	0.6	0.8	1.6
Nicotine	13.2	18.8	14.3	17.4	27.4	14.2	13.7	20.9	9.1	8.3	—	14.8	20.5
Total stimulants and hallucinogens	*59.6*	*49.3*	*50.9*	*49.8*	*83*	*48.9*	*57.5*	*48.1*	*56.6*	*53.6*	*44.1*	*55.7*	*64*
Volatile solvents	0.2	0.1	—	0.2	0.5	0.3	0.2	0.6	—	0.2	0.5	0.5	0.4
All other drugs	1.7	2.4	3.7	1.5	2.0	4.3	1.3	1.7	2.6	2.9	1.1	1.9	1.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C16: Treatment episodes by selected treatment data items and principal drug of concern, 2010–11[(a)]

	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens						
Data item	Heroin	Methadone	Morphine	Other opioids	Alcohol	Benzodi-azepines	Amphe-tamines	Cannabis	Ecstasy	Cocaine	Nicotine	All other drugs	Total
Main treatment type						Per cent							
Withdrawal management (detoxification)	18.1	17.6	20.5	25.4	18.7	26.6	10.8	13.4	2.3	8.0	10.9	11.5	16.6
Counselling	35.6	23.2	28.9	25.8	41.6	36.1	48.0	39.4	42.5	50.7	35.6	26.6	39.6
Rehabilitation	7.6	3.9	4.2	2.6	5.9	3.9	8.2	4.0	3.8	5.8	0.9	2.3	5.4
Support and case management only	11.3	9.7	6.9	5.8	7.1	8.6	8.5	12.5	8.3	9.0	6.8	8.5	8.9
Information and education only	1.3	1.9	3.9	3.4	4.3	1.8	3.5	15.2	24.9	5.2	22.5	31.9	7.7
Assessment only	15.4	9.3	18.1	16.1	15.0	13.9	17.0	11.6	15.0	16.0	9.4	9.6	14.1
Other	10.7	34.4	17.5	21.0	7.4	9.0	3.9	3.9	3.2	5.4	13.8	9.5	7.6
Treatment delivery setting													
Non-residential treatment facility	61.7	64.4	68.2	63.9	61.7	63.0	64.2	61.5	64.5	72.5	59.8	75.5	62.7
Residential treatment facility	21.3	26.3	16.4	25.6	20.9	23.2	16.5	13.4	7.5	11.4	12.3	7.7	18.3
Home	1.2	2.1	2.1	1.7	2.0	2.7	1.9	4.6	12.9	3.6	5.5	3.6	2.7
Outreach setting	7.5	5.0	9.4	7.7	10.3	7.4	10.9	16.1	12.9	8.0	17.1	11.2	11.3
Other	8.3	2.1	4.0	1.1	5.1	3.7	6.5	4.4	2.3	4.6	5.4	2.0	5.1
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**13,354**	**1,961**	**1,794**	**2,801**	**68,167**	**2,488**	**12,563**	**31,762**	**708**	**501**	**1,849**	**6,054**	**144,002**

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

Table C17: Treatment episodes by selected treatment data items and principal drug of concern, 2010–11[(a)]

	Analgesics				Sedatives and hypnotics		Stimulants and hallucinogens						
	Heroin	Methadone	Morphine	Other opioids	Alcohol	Benzodi-azepines	Amphet-amines	Cannabis	Ecstasy	Cocaine	Nicotine	All other drugs	Total
Reason for cessation						Per cent							
Treatment completed	57.3	54.2	47.4	54.3	62.6	59.0	57.0	52.4	49.2	59.1	51.8	40.4	57.7
Change in main treatment type	0.4	1.3	5.2	1.4	0.6	0.8	0.7	0.5	0.1	0.4	0.5	0.7	0.6
Change in delivery setting	0.7	1.1	1.8	1.4	0.7	0.8	1.4	0.5	0.4	0.8	0.8	0.5	0.7
Change in principal drug of concern	—	—	—	—	—	—	—	—	—	—	0.1	—	—
Transferred to another service provider	6.0	9.9	5.9	8.6	4.7	5.8	3.7	3.4	1.4	3.0	2.6	5.4	4.6
Ceased to participate against advice	5.1	4.7	6.2	5.7	3.9	5.2	4.7	3.3	1.4	3.6	1.1	2.0	3.9
Ceased to participate without notice	14.0	13.9	16.7	15.6	13.9	11.6	17.4	13.8	11.2	16.2	10.5	10.7	14.0
Ceased to participate involuntary (non-compliance)	2.8	1.8	2.4	2.1	1.6	2.3	2.4	2.5	1.4	1.4	0.4	1.0	2.0
Ceased to participate at expiation	2.0	1.7	2.5	2.4	2.9	3.1	3.7	15.7	28.5	7.0	23.5	31.4	7.3
Ceased to participate by mutual agreement	2.5	1.5	2.8	3.0	3.0	4.1	3.2	2.7	2.0	1.8	3.1	1.8	2.8
Drug court and/or sanctioned by court diversion service	0.4	0.1	0.1	0.1	0.1	0.3	0.5	0.2	0.1	0.6	0.1	0.1	0.2
Imprisoned, other than drug court sanctioned	2.4	2.9	1.9	1.0	0.7	1.0	1.6	0.7	1.1	1.8	0.5	1.0	1.0
Died	0.3	0.5	0.6	0.2	0.2	0.3	0.1	0.1	0.1	—	0.1	0.2	0.2
Other	5.1	6.0	5.7	3.7	4.1	4.8	3.2	3.7	2.3	3.6	2.6	3.8	4.0
Not stated	1.0	0.5	0.7	0.5	0.9	0.8	0.5	0.6	0.7	0.8	2.2	0.8	0.8
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**13,354**	**1,961**	**1,794**	**2,801**	**68,167**	**2,488**	**12,563**	**31,762**	**708**	**501**	**1,849**	**6,054**	**144,002**

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

Table C18: Median duration in days of closed treatment episodes by principal drugs of concern, 2010–11[(a)(b)]

Principal drug of concern	Median number of days	Total number of treatment episodes
Analgesics		
Heroin	36	13,354
Methadone	25	1,961
Morphine	21	1,794
Other opioids	13	2,801
Total analgesics	*30*	*20,839*
Sedatives and hypnotics		
Alcohol	22	68,167
Benzodiazepines	22	2,488
Total sedatives and hypnotics	*22*	*70,885*
Stimulants and hallucinogens		
Amphetamines	29	12,563
Cannabis	22	31,762
Ecstasy	10	708
Cocaine	36	501
Nicotine	14	1,849
Total stimulants and hallucinogens	*23*	*47,712*
All other drugs	1	4,013
Total	**23**	**144,002**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C19: Treatment episodes for client's own drug use by principal drug of concern, 2001–02 to 2010–11[a]

Principal drug of concern	2001–02[b]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10[c]	2010–11
					Number					
Analgesics										
Heroin	20,027	22,642	23,326	23,193	19,776	14,870	15,571	14,222	13,882	13,354
Methadone	2,570	2,173	2,404	2,454	2,462	2,268	2,296	2,136	1,907	1,961
Other opioids	2,209	2,273	2,408	2,661	2,920	3,058	3,513	4,532	4,920	4,595
Sedatives and hypnotics										
Alcohol	41,886	46,747	48,500	50,324	56,076	59,480	65,702	63,272	67,450	68,167
Benzodiazepines	2,745	2,609	2,711	2,538	2,583	2,298	2,487	2,080	2,238	2,488
Stimulants and hallucinogens										
Amphetamines	12,211	13,213	14,208	14,780	15,935	17,292	16,588	12,739	10,027	12,563
Cannabis	23,826	27,106	28,427	31,044	35,636	31,980	31,864	31,100	31,559	31,762
Ecstasy	253	416	508	580	897	1,010	1,321	1,397	1,105	708
Cocaine	804	323	272	400	434	448	457	479	595	501
All other drugs	5,875	4,854	5,935	7,228	8,244	7,771	7,922	6,070	5,955	7,903
Not stated	825	676	632	—	—	—	—	—	—	—
Total	**113,231**	**123,032**	**129,331**	**135,202**	**144,963**	**140,475**	**147,721**	**138,027**	**139,614**	**144,002**

(continued)

Table C19 (continued): Treatment episodes for client's own drug use by principal drug of concern, 2001–02 to 2010–11[a]

Principal drug of concern	2001–02[b]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10[c]	2010–11
					Per cent					
Analgesics										
Heroin	17.7	18.4	18.0	17.2	13.6	10.6	10.5	10.3	9.9	9.3
Methadone	2.3	1.8	1.9	1.8	1.7	1.6	1.6	1.5	1.4	1.4
Other opioids	2.0	1.8	1.9	2.0	2.0	2.2	2.4	3.3	3.5	3.1
Sedatives and hypnotics										
Alcohol	37.0	38.0	37.5	37.2	38.7	42.3	44.5	45.8	48.3	47.3
Benzodiazepines	2.4	2.1	2.1	1.9	1.8	1.6	1.7	1.5	1.6	1.7
Stimulants and hallucinogens										
Amphetamines	10.8	10.7	11.0	10.9	11.0	12.3	11.2	9.2	7.2	8.7
Cannabis	21.0	22.0	22.0	23.0	24.6	22.8	21.6	22.5	22.6	22.1
Ecstasy	0.2	0.3	0.4	0.4	0.6	0.7	0.9	1.0	0.8	0.5
Cocaine	0.7	0.3	0.2	0.3	0.3	0.3	0.3	0.3	0.4	0.3
All other drugs	5.2	3.9	4.6	5.3	5.7	5.5	5.4	4.4	4.2	5.6
Not stated	0.7	0.5	0.5	—	—	—	—	—	—	—
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Queensland supplied data for police diversion clients only.

(c) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

Table C20: Treatment episodes by principal drug of concern and Indigenous status, 2006–07 to 2010–11[a][b]

Principal drug of concern	2006–07		2007–08		2008–09		2009–10[c]		2010–11	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Analgesics						Per cent				
Heroin	7.6	11.0	6.8	11.0	6.1	10.9	5.9	10.6	6.3	9.8
Methadone	1.5	1.6	1.1	1.6	1.3	1.6	1.3	1.4	1.1	1.4
Morphine	1.1	0.9	1.1	0.9	1.1	1.4	1.4	1.2	1.0	1.3
Total opioids	*10.9*	*14.8*	*9.9*	*15.0*	*9.5*	*16*	*9.9*	*15.6*	*10.1*	*14.5*
Sedatives and hypnotics										
Alcohol	49.0	41.4	52.8	43.5	53.7	44.8	55.4	47.2	52.4	46.4
Benzodiazepines	0.7	1.7	0.8	1.8	0.6	1.6	0.8	1.7	0.9	1.9
Stimulants and hallucinogens										
Amphetamines	10.9	12.6	9.2	11.6	7.5	9.6	5.5	7.5	6.8	9.1
Cannabis	22.0	22.9	21.6	21.6	23.4	22.3	22.4	22.5	23	21.8
Ecstasy	0.3	0.8	0.4	1.0	0.3	1.1	0.2	0.9	0.2	0.5
Cocaine	0.2	0.3	0.2	0.3	0.2	0.4	0.1	0.5	0.2	0.4
All other drugs	6.0	5.3	5.1	5.3	4.8	4.2	5.5	4.0	6.3	5.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

(c) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

Table C21: Treatment episodes where amphetamines were the principal drug of concern by usual method of use, 2002–03 to 2010–11[a]

Usual method of use	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10[b]	2010–11
					Number				
Ingests	1,271	1,558	1,671	1,788	1,907	1,778	1,466	1,178	1,306
Smokes	173	420	718	1,437	2,377	2,784	2,091	1,792	2,625
Injects	10,915	11,241	11,309	11,670	11,926	10,900	8,203	6,074	6,127
Sniffs (powder)	511	630	665	645	622	554	437	369	451
Inhales (vapour)	27	65	59	97	133	168	147	131	172
Other	20	26	23	24	31	33	38	26	94
Not stated	296	268	335	274	296	371	357	457	1,788
Total	**13,213**	**14,208**	**14,780**	**15,935**	**17,292**	**16,588**	**12,739**	**10,027**	**12,563**
					Per cent				
Ingests	9.6	11.0	11.3	11.2	11.0	10.3	11.5	11.7	10.4
Smokes	1.3	3.0	4.9	9.0	13.7	16.1	16.4	17.9	20.9
Injects	82.6	79.1	76.5	73.2	69.0	63.0	64.4	60.6	48.8
Sniffs (powder)	3.9	4.4	4.5	4.0	3.6	3.2	3.4	3.7	3.6
Inhales (vapour)	0.2	0.5	0.4	0.6	0.8	1.0	1.2	1.3	1.4
Other	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.7
Not stated	2.2	1.9	2.3	1.7	1.7	2.1	2.8	4.6	14.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

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

(b) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

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Treatment program tables

Table C22: Treatment episodes by selected treatment data items and jurisdiction, 2010–11[(a)]

Treatment item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Main treatment type					**Number**				
Withdrawal management (detoxification)	7,425	10,313	2,048	1,438	1,748	22	509	340	23,843
Counselling	11,303	27,063	7,653	10,960	2,506	1,145	549	756	61,935
Rehabilitation	2,531	1,833	497	1,017	900	175	327	564	7,844
Support and case management only	3,544	6,929	1,579	839	316	21	380	70	13,678
Information and education only	431	263	8,659	584	908	197	457	33	11,532
Assessment only	5,294	5,029	4,655	988	2,393	144	628	1,380	20,511
Other	5,512	1,455	1,450	1,285	659	34	306	444	11,145
Cessation reason									
Treatment completed	23,731	38,033	6,982	8,614	5,763	557	1,629	1,941	87,250
Change in main treatment type	4	—	327	48	124	18	42	389	952
Change in delivery setting	5	—	602	180	113	49	67	53	1,069
Change in principal drug of concern	—	—	5	3	7	2	1	1	19
Transferred to another service provider	2,263	1,851	756	1,252	403	71	159	70	6,825
Ceased to participate against advice	2,178	936	945	648	598	132	220	168	5,825
Ceased to participate without notice	4,882	4,532	5,150	3,641	1,539	344	484	443	21,015
Ceased to participate involuntary (non-compliance)	1,128	467	140	470	159	131	271	91	2,857
Ceased to participate at expiation	1	909	8,645	893	37	231	2	18	10,736
Ceased to participate by mutual agreement	2	1,570	1,070	1,060	305	140	89	119	4,355
Drug court and/ or sanctioned by court diversion service	101	76	30	34	23	1	9	14	288
Imprisoned, other than drug court sanctioned	288	356	356	192	155	16	22	34	1,419
Died	62	64	53	35	28	9	12	1	264
Other	1,239	3,195	1,196	31	161	16	93	126	6,057
Not stated	156	896	284	10	15	21	56	119	1,557

(continued)

Table C22 (continued): Treatment episodes by selected treatment data items and jurisdiction, 2010–11[(a)]

Treatment item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Treatment delivery setting					**Number**				
Non-residential treatment facility	22,583	33,619	15,938	12,075	6,877	1,319	1,661	1,200	95,272
Residential treatment facility	12,378	6,806	1,694	1,891	1,285	163	1,223	1,018	26,458
Home	132	1,532	1,655	336	119	9	105	50	3,938
Outreach setting	610	5,899	6,581	2,342	965	229	110	691	17,427
Other	337	5,029	673	467	184	18	57	628	7,393
Total	**36,040**	**52,885**	**26,541**	**17,111**	**9,430**	**1,738**	**3,156**	**3,587**	**150,488**

(a) Includes treatment data for all clients.

Table C23: Treatment episodes by other treatment type and jurisdiction, 2010–11[(a)(b)]

Other treatment type	NSW	Qld	WA	SA	Tas	ACT	NT	Australia
				Number				
Withdrawal management	803	121	—	277	18	21	92	1,332
Counselling	4,953	702	121	897	87	114	559	7,433
Other	3,872	1,668	108	1,670	13	74	323	7,728
All other treatments	**9,628**	**2,491**	**229**	**2,844**	**118**	**209**	**974**	**16,493**

(a) Includes treatment data for all clients.

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

Table C24: Treatment episodes by selected client data items and main treatment type, 2010–11[(a)]

Client item	Withdrawal management (detoxification)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other	Total
Median age				**Years**				
Male	37	33	33	25	24	32	37	32
Female	37	35	33	26	27	34	35	34
All persons	37	33	33	26	24	32	36	33
Age group (years)				**Per cent**				
10–19	6.6	9.7	9.1	28.7	28.8	7.7	14.1	12.5
20–29	21.9	28.1	27.5	29.7	34.3	33.1	19.7	27.8
30–39	29.1	28.8	33.7	21.6	18.6	30.4	25.8	27.7
40–49	24.6	20.0	20.4	13.3	11.7	18.6	20.5	19.4
50–59	12.2	9.3	7.2	5.2	5.0	7.5	11.6	8.9
60+	4.2	3.9	2.1	1.5	1.3	2.6	8.1	3.6
Not stated	1.3	0.1	—	0.1	0.2	—	0.2	0.3
Client type								
Own drug use	100.0	92.2	100.0	93.9	96.7	99.1	97.8	95.7
Others drug use	—	7.8	—	6.1	3.3	0.9	2.2	4.3
Sex								
Male	65.2	64.6	63.7	63.5	73.6	75.4	62.2	66.5
Female	34.7	35.3	36.2	36.4	26.4	24.5	37.7	33.4
Not stated	0.1	0.1	0.1	—	0.1	0.1	0.1	0.1
Indigenous status								
Indigenous	8.2	11.8	17.9	14.2	15.5	16.3	17.0	13.0
Non-Indigenous	86.5	82.6	79.8	79.4	79.5	76.5	78.2	81.4
Not stated	5.3	5.6	2.3	6.4	5.0	7.2	4.8	5.5

(continued)

Table C24 (continued): Treatment episodes by selected client data items and main treatment type, 2010–11[(a)]

Client item	Withdrawal management (detoxification)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other	Total
Source of referral				**Per cent**				
Self	51.7	42.3	36.7	36.9	7.3	23.9	22.9	36.4
Family member/friend	2.9	4.5	5.1	4.5	1.3	3.0	1.9	3.7
Medical practitioner	7.7	4.5	2.8	2.5	0.7	3.6	25.6	5.9
Hospital	5.9	2.0	3.7	1.4	2.0	6.2	15.6	4.2
Mental health care service	2.5	3.1	2.2	1.9	0.7	2.6	4.5	2.7
Alcohol and other drug treatment service	18.2	9.7	22.0	10.9	6.4	5.2	8.5	10.8
Other community/health-care service	3.4	3.5	6.3	4.2	0.7	1.6	2.2	3.1
Correctional service	1.2	7.7	5.7	7.9	2.5	33.4	4.7	9.5
Police diversion	0.2	1.6	1.4	1.6	23.2	2.8	6.2	3.5
Court diversion	2.5	13.4	7.5	19.0	52.0	6.7	0.8	13.0
Other	3.4	6.8	6.0	8.0	2.6	10.5	6.7	6.5
Not stated	0.4	0.8	0.4	1.0	0.6	0.4	0.4	0.6
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**23,843**	**61,935**	**7,844**	**13,678**	**11,532**	**20,511**	**11,145**	**150,488**

(a) Includes treatment data for all clients.

Table C25: Treatment episodes by selected treatment items and main treatment type, 2010–11[(a)]

Treatment item	Withdrawal management (detoxification)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other	Total
Treatment delivery setting				**Per cent**				
Non-residential treatment facility	30.8	90.9	15.1	45.3	61.3	55.4	52.1	63.3
Residential treatment facility	59.1	0.4	80.7	2.0	2.9	3.5	39.9	17.6
Home	7.3	0.8	1.6	1.0	9.5	1.5	0.4	2.6
Outreach setting	2.6	6.8	2.1	50.7	22.7	11.3	5.1	11.6
Other	0.2	1.1	0.5	1.1	3.7	28.2	2.5	4.9
Reason for cessation								
Treatment completed	66.5	55.9	40.5	59.2	23.1	78.5	60.2	58
Change in main treatment type	0.7	0.5	0.2	0.5	0.1	1.5	0.9	0.6
Change in delivery setting	0.6	0.7	0.5	0.5	0.4	1.1	0.7	0.7
Change in principal drug of concern	—	—	—	—	—	—	—	—
Transferred to another service provider	4.9	3.9	4.1	5.9	0.5	1.7	15.6	4.5
Ceased to participate against advice	9.7	1.7	20.1	2.8	0.3	0.9	2.2	3.9
Ceased to participate without notice	8.2	21.8	9.7	13.5	2.4	7.1	10.9	14.0
Ceased to participate involuntary (non-compliance)	2.8	1.0	12.6	1.8	1.4	0.4	0.6	1.9
Ceased to participate at expiation	0.8	2.8	0.6	1.1	69.8	2.6	0.5	7.1
Ceased to participate by mutual agreement	2.8	3.8	4.6	2.4	0.8	2.1	0.9	2.9
Drug court and/ or sanctioned by court diversion service	—	0.2	0.2	0.5	0.1	0.1	0.1	0.2
Imprisoned, other than drug court sanctioned	0.6	1.0	0.7	1.8	—	0.7	1.9	0.9
Died	0.1	0.2	0.2	0.2	—	0.1	0.4	0.2
Other	1.9	4.8	4.6	9.0	0.9	2.5	4.0	4.0
Not stated	0.4	1.6	1.3	0.7	0.2	0.7	1.1	1.0
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**23,843**	**61,935**	**7,844**	**13,678**	**11,532**	**20,511**	**11,145**	**150,488**

(a) Includes treatment data for all clients.

Table C26: Treatment episodes by main treatment type, 2002–03 to 2010–11 (per cent)

Main treatment type	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10[(a)]	2010–11
Withdrawal management (detoxification)	18.9	18.4	17.9	17.1	16.6	16.2	16.4	15.5	15.8
Counselling	41.5	37.6	40.2	37.8	38.7	37.3	37.4	41.7	41.2
Rehabilitation	7.5	8.6	7.7	7.5	7.4	7.2	6.7	5.2	5.2
Support and case management only	6.9	8.4	7.9	8.2	8.3	8.0	8.9	8.7	9.1
Information and education only	8.0	7.6	8.9	9.7	9.3	9.8	9.2	9.0	7.7
Assessment only	12.7	14.9	12.4	15.3	15.1	14.3	14.7	13.6	13.6
Other	4.4	4.5	5.0	4.4	4.5	7.2	6.6	6.3	7.4
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differs from data published in the 2009–10 annual report.

Table C27: Treatment episodes by selected age groups and main treatment type, 2010–11

Age group (years)	Withdrawal management (detoxification)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other	Total
				Column per cent				
10–13	0.1	0.4	0.2	2.9	1.5	0.6	0.3	0.6
14–15	0.7	1.8	1.4	4.9	6.2	4.3	0.8	2.3
16–17	2.4	3.2	3.9	2.9	10.0	11.4	2.1	4.2
18–19	3.5	4.3	3.6	3.4	11.0	12.5	4.6	5.4
20+	92.1	90.1	90.9	85.7	71.2	71.0	92.2	87.2
Not stated	1.3	0.1	<0.1	0.2	0.1	0.2	<0.1	0.3
Total (column per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
				Row per cent				
10–13	1.7	27.4	1.6	34.0	21.5	7.5	6.3	100.0
14–15	4.8	32.5	3.1	15.9	24.6	14.5	4.6	100.0
16–17	9.0	31.4	4.9	5.2	21.7	20.9	6.9	100.0
18–19	10.3	33.3	3.5	4.7	18.7	17.9	11.6	100.0
20+	16.7	42.5	5.4	7.3	7.4	6.2	14.4	100.0
Not stated	65.5	19.1	0.4	3.7	4.0	5.2	2.1	100.0
Total (row per cent)	**15.8**	**41.2**	**5.2**	**7.4**	**9.1**	**7.7**	**13.6**	**100.0**
Total number	**23,843**	**61,935**	**7,844**	**13,678**	**11,532**	**20,511**	**11,145**	**150,488**

Table C28: Median duration in days of closed treatment episodes by main treatment type, 2010–11[(a)]

Main treatment type	Median number of days	Total number of treatment episodes
Withdrawal management (detoxification)	8	23,843
Counselling	57	57,090
Rehabilitation	44	7,844
Support and case management only	52	12,847
Information and education only	1	11,156
Assessment only	2	20,320
Other	7	10,902
Total	**23**	**144,002**

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

Table C29: Treatment episodes by principal drug of concern and main treatment type, 2010–11[(a)(b)]

Principal drug of concern	Withdrawal management (detoxification)	Counselling	Rehabilitation	Support and case management only	Information and education only	Assessment only	Other	Total
Analgesics				**Per cent**				
Heroin	10.1	8.3	12.9	11.8	1.6	10.1	13.1	9.3
Methadone	1.5	0.8	1.0	1.5	0.3	0.9	6.2	1.4
Morphine	1.5	0.9	1.0	1.0	0.6	1.6	2.9	1.2
Other opioids	3.0	1.3	0.9	1.3	0.9	2.2	5.4	1.9
Total analgesics	*17.0*	*11.8*	*15.9*	*16.9*	*3.4*	*15.1*	*29*	*14.5*
Sedatives and hypnotics								
Alcohol	53.5	49.7	51.1	37.9	26.0	50.2	46.4	47.3
Benzodiazepines	2.8	1.6	1.2	1.7	0.4	1.7	2.1	1.7
Total sedatives and hypnotics	*56.5*	*51.5*	*52.4*	*39.8*	*26.5*	*52*	*48.5*	*49.2*
Stimulants and hallucinogens								
Amphetamines	5.7	10.6	13.2	8.3	4.0	10.5	4.5	8.7
Cannabis	17.9	21.9	16.0	30.9	43.3	18.2	11.4	22.1
Ecstasy	0.1	0.5	0.3	0.5	1.6	0.5	0.2	0.5
Cocaine	0.2	0.4	0.4	0.4	0.2	0.4	0.2	0.3
Nicotine	0.8	1.2	0.2	1.0	3.7	0.9	2.3	1.3
Total stimulants and hallucinogens	*24.8*	*34.9*	*30.3*	*41.3*	*53.1*	*30.6*	*18.9*	*33.1*
Volatile solvents	0.2	0.2	0.4	0.4	0.1	1.3	0.2	0.4
All other drugs	1.4	1.6	1.0	1.6	16.9	0.9	3.4	2.8
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Total (number)	**23,843**	**57,090**	**7,844**	**12,847**	**11,156**	**20,320**	**10,902**	**144,002**

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

(b) Drug types may not sum to presented totals because only large drug groups are displayed.

Table C30: Treatment episodes with an additional treatment type, 2002–03 to 2010–11[a]

Other treatment Type	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08	2008–09	2009–10[b]	2010–11
					Per cent				
Withdrawal management (detoxification)	35.1	45.1	41.0	39.3	46.9	42.9	38.2	19.5	33.4
Counselling	16.6	15.0	16.7	12.3	8.7	11.8	10.5	9.4	9.4
Rehabilitation	45.1	36.4	38.1	37.6	30.2	34.7	34.5	37.4	47.4
Other	46.1	44.0	51.1	32.7	46.1	43.3	42.9	16.2	32.7
Total	**18.8**	**18.7**	**19.2**	**15.1**	**14.5**	**16.8**	**15.2**	**9.4**	**14.2**

(a) Tasmania resubmitted data for the 2009–10 collection in December 2011. Because of this, 2009–10 data presented in this report differ from data published in the 2009–10 annual report.

(b) The increase in withdrawal management and other treatment types between 2009–10 and 2010–11 is primarily due to a change of coding practices in New South Wales. Please see Table 7.3 for more information.

Table C31: Treatment episodes by main treatment type and Indigenous status, 2010–11

	Indigenous		Non-Indigenous		Not stated		Total	
Main treatment type	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Withdrawal management (detoxification)	1,954	10.0	20,625	16.8	1,264	15.1	23,843	15.8
Counselling	7,308	37.2	51,184	41.8	3,443	41.2	61,935	41.2
Rehabilitation	1,405	7.2	6,259	5.1	180	2.2	7,844	5.2
Support and case management only	1,945	9.9	10,859	8.9	874	10.5	13,678	9.1
Information and education only	1,782	9.1	9,169	7.5	581	7.0	11,532	7.7
Assessment only	3,341	17.0	15,697	12.8	1,473	17.6	20,511	13.6
Other	1,893	9.6	8,716	7.1	536	6.4	11,145	7.4
Total	**19,628**	**100.0**	**122,509**	**100.0**	**8,351**	**100.0**	**150,488**	**100.0**
Percentage of closed treatment episodes	**. .**	**13.0**	**. .**	**81.4**	**. .**	**5.6**	**. .**	**100.0**

Appendix D: Australian Standard Geographical Classification

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

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

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

Major cities of Australia

Inner regional Australia

Outer regional Australia

Remote Australia

Very remote Australia.

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

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

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

1 ANALGESICS

11 Organic Opiate Analgesics

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

12 Semisynthetic Opioid Analgesics

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

13 Synthetic Opioid Analgesics

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

14 Non Opioid Analgesics

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

2 SEDATIVES AND HYPNOTICS

21 Alcohols

2101	Ethanol
2102	Methanol
2199	Alcohols, n.e.c.

22		**Anaesthetics**
	2201	Gamma-hydroxybutyrate
	2202	Ketamine
	2203	Nitrous oxide
	2204	Phencyclidine
	2299	Anaesthetics, n.e.c.
23		**Barbiturates**
	2301	Amylobarbitone
	2302	Methylphenobarbitone
	2303	Phenobarbitone
	2399	Barbiturates, n.e.c.
24		**Benzodiazepines**
	2401	Alprazolam
	2402	Clonazepam
	2403	Diazepam
	2404	Flunitrazepam
	2405	Lorazepam
	2406	Nitrazepam
	2407	Oxazepam
	2408	Temazepam
	2499	Benzodiazepines, n.e.c.
29		**Other Sedatives and Hypnotics**
	2901	Chlormethiazole
	2902	Kava lactones
	2903	Zopiclone
	2999	Other Sedatives and Hypnotics, n.e.c.

3 STIMULANTS AND HALLUCINOGENS

31		**Amphetamines**
	3101	Amphetamine
	3102	Dexamphetamine
	3103	Methamphetamine
	3199	Amphetamines, n.e.c.
32		**Cannabinoids**
	3201	Cannabinoids

33		**Ephedra Alkaloids**
	3301	Ephedrine
	3302	Norephedrine
	3303	Pseudoephedrine
	3399	Ephedra alkaloids, n.e.c.
34		**Phenethylamines**
	3401	DOB
	3402	DOM
	3403	MDA
	3404	MDEA
	3405	MDMA
	3406	Mescaline
	3407	PMA
	3408	TMA
	3499	Phenethylamines, n.e.c.
35		**Tryptamines**
	3501	Atropinic alkaloids
	3502	Diethyltryptamine
	3503	Dimethyltryptamine
	3504	Lysergic acid diethylamide
	3505	Psilocybin
	3599	Tryptamines, n.e.c.
36		**Volatile Nitrates**
	3601	Amyl nitrate
	3602	Butyl nitrate
	3699	Volatile Nitrates, n.e.c.
39		**Other Stimulants and Hallucinogens**
	3901	Caffeine
	3902	Cathinone
	3903	Cocaine
	3904	Methcathinone
	3905	Methylphenidate
	3906	Nicotine
	3999	Other Stimulants and Hallucinogens, n.e.c.

4 ANABOLIC AGENTS AND SELECTED HORMONES

41 Anabolic Androgenic Steroids

4101	Boldenone
4102	Dehydroepiandrosterone
4103	Fluoxymesterone
4104	Mesterolone
4105	Methandriol
4106	Methenolone
4107	Nandrolone
4108	Oxandrolone
4111	Stanozolol
4112	Testosterone
4199	Anabolic Androgenic Steroids, n.e.c.

42 Beta Agonists

4201	Eformoterol
4202	Fenoterol
4203	Salbutamol
4299	Beta2 Agonists, n.e.c.

43 Peptide Hormones, Mimetics and Analogues

4301	Chorionic gonadotrophin
4302	Corticotrophin
4303	Erythropoietin
4304	Growth hormone
4305	Insulin
4399	Peptide Hormones, Mimetics and Analogues, n.e.c.

49 Other Anabolic Agents and Selected Hormones

4901	Sulfonylurea hypoglycaemic agents
4902	Tamoxifen
4903	Thyroxine
4999	Other Anabolic Agents and Selected Hormones, n.e.c.

5 ANTIDEPRESSANTS AND ANTIPSYCHOTICS

51 Monoamine Oxidase Inhibitors

5101	Moclobemide
5102	Phenelzine

	5103	Tranylcypromine
	5199	Monoamine Oxidase Inhibitors, n.e.c.
52		**Phenothiazines**
	5201	Chlorpromazine
	5202	Fluphenazine
	5203	Pericyazine
	5204	Thioridazine
	5205	Trifluoperazin
	5299	Phenothiazines, n.e.c.
53		**Serotonin Re-uptake Inhibitors**
	5301	Citalopram
	5302	Fluoxetine
	5303	Paroxetine
	5304	Sertraline
	5399	Serotonin Reuptake Inhibitors, n.e.c.
54		**Thioxanthenes**
	5401	Flupenthixol
	5402	Thiothixene
	5499	Thioxanthenes, n.e.c.
55		**Tricyclic Antidepressants**
	5501	Amitriptyline
	5502	Clomipramine
	5503	Dothiepin
	5504	Doxepin
	5505	Nortriptyline
	5599	Tricyclic Antidepressants, n.e.c.
59		**Other Antidepressants and Antipsychotics**
	5901	Butyrophenones
	5902	Lithium
	5903	Mianserin
	5999	Other Antidepressants and Antipsychotics, n.e.c.

6 VOLATILE SOLVENTS

61 Aliphatic Hydrocarbons

6101 Butane
6102 Petroleum
6103 Propane
6199 Aliphatic Hydrocarbons, n.e.c.

62 Aromatic Hydrocarbons

6201 Toluene
6202 Xylene
6299 Aromatic Hydrocarbons, n.e.c.

63 Halogenated Hydrocarbons

6301 Bromochlorodifluoromethane
6302 Chloroform
6303 Tetrachloroethylene
6304 Trichloroethane
6305 Trichloroethylene
6399 Halogenated Hydrocarbons, n.e.c.

69 Other Volatile Solvents

6901 Acetone
6902 Ethyl acetate
6999 Other Volatile Solvents, n.e.c.

9 MISCELLANEOUS DRUGS OF CONCERN

91 Diuretics

9101 Antikaliuretics
9102 Loop diuretics
9103 Thiazides
9199 Diuretics, n.e.c.

92 Opioid Antagonists

9201 Naloxone
9202 Naltrexone
9299 Opioid Antagonists, n.e.c.

99 Other Drugs of Concern

9999 Other Drugs of Concern

Appendix F: Alcohol and other drug treatment provided by services funded to assist Indigenous Australians

The number of treatment episodes reported through the AODTS–NMDS for Aboriginal and Torres Strait Islander people does not represent all alcohol and other drug treatments provided to Indigenous people in Australia for 2010–11. Data for the majority of Australian Government–funded Aboriginal and Torres Strait Islander substance use–specific services are available from the Office for Aboriginal and Torres Strait Islander Health (OATSIH) Services Reporting (OSR) data collection. In 2009–10, the OSR replaced the two previous data collections, Drug and Alcohol Service Report and Service Activity Reporting. In the 2010–11 OSR, 49 of the 51 substance use–specific services (96% of funded services) provided data.

This appendix presents a selection of data from the 2010–11 OSR. The OSR and AODTS–NMDS have different collection purposes, scope and counting rules. For example, the OSR collects service-level estimates for client numbers and episodes of care, whereas the AODTS–NMDS collects unit records for closed treatment episodes. The definitions of 'closed treatment episodes' (AODTS–NMDS) and 'episodes of care' (OSR) are not consistent (Box F1).

In 2010–11, 12 out of the 49 Australian Government–funded substance use–specific services reporting in the OSR also reported under the AODTS–NMDS.

Box F1: Comparison of treatment episode definitions in the OSR and AODTS–NMDS

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

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

Substance use–specific services

In 2010–11, an estimated 28,552 people were seen by Australian Government–funded Aboriginal and Torres Strait Islander substance use–specific services (Table F1).

Table F1: Estimated number of clients seen by Australian Government–funded Aboriginal and Torres Strait Islander substance use–specific services, by jurisdiction and Indigenous status, 2010–11

Indigenous status	NSW	Vic/Tas	Qld	WA	SA	NT	Total
Indigenous	814	1,144	6,569	3,992	4,425	4,666	21,610
Non-Indigenous	303	145	4,834	505	745	105	6,637
Unknown Indigenous status	—	—	—	103	202	—	305
Total clients (number)	**1,117**	**1,289**	**11,403**	**4,600**	**5,372**	**4,771**	**28,552**
Total clients (per cent)	**3.9**	**4.5**	**39.9**	**16.1**	**18.8**	**16.7**	**100.0**

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

Source: OATSIH Services Reporting Database, 2010–11.

Substance use treatment and assistance

Substances as a specifically targeted program

In addition to the number of clients seen, treatment agencies report on the drugs for which they provide treatment during the year (Table F2).

Table F2: Substances/drugs for which treatment/assistance provided as a targeted program by Australian Government–funded Aboriginal and Torres Strait Islander substance use–specific services, 2009–10 and 2010–11 (per cent)

Substance/drug	2009–10	2010–11
Alcohol	91.7	87.8
Cannabis/marijuana	77.1	75.5
Multiple drug use	54.2	53.1
Tobacco/nicotine	52.1	55.1
Amphetamines	45.8	30.6
Petrol	35.4	32.7
Other solvents/inhalants	43.8	34.7
Benzodiazepines	37.5	36.7
Heroin	29.2	28.6
Ecstasy/MDMA	25.0	24.5
Morphine	16.7	16.3
Cocaine	25.0	22.4
Methadone	18.8	14.3
Barbiturates	22.9	20.4
LSD	22.9	24.5
Other drugs	6.3	2.0
Kava	8.3	8.2
Steroids/anabolic agents	12.5	8.2
Total (number)	**48**	**49**

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

Source: OATSIH Services Reporting Database, 2010–11.

Substances on an individual client basis

Aboriginal and Torres Strait Islander primary health–care services provide a variety of health-care services, including extended care roles (for example, diagnosis and treatment of illness and disease, 24-hour emergency care, dental/hearing/optometry services), preventive health care (for example, health screening for children and adults), health-related community support (for example, school-based activities, transport to medical appointments) and support in relation to substance use issues.

The number of clients who attended Aboriginal and Torres Strait Islander primary health–care services and received alcohol or other drug treatment is not collected in the OSR. Similarly, the number of reported episodes of care that related solely or partially to alcohol or other drug treatment is not collected. However, the drug types for which treatment was provided are known. In 2010–11, most services covered issues relating to alcohol (98%), cannabis (98%) and tobacco/nicotine and multiple drug use (both 80%) which all increased over 5 percentage points from the previous year.

There was an overall increase in the percentage of services that provided treatment/assistance on an individual client basis for most substances in 2010–11. The largest increases were for multiple drug use (increase of 11 percentage points), cannabis/marijuana (11 points) alcohol, kava and cocaine (all 8 points) (Table F3).

Table F3: Substances/drugs for which treatment/assistance provided on an individual client basis by Australian Government–funded Aboriginal and Torres Strait Islander substance use specific services, 2008–09, 2009–10 and 2010–11

	2008–09		2009–10		2010–11	
Substance/drug	**Number**	**Per cent**	**Number**	**Per cent**	**Number**	**Per cent**
Alcohol	40	88.9	43	89.6	48	98.0
Cannabis/marijuana	39	86.7	42	87.5	48	98.0
Tobacco/nicotine	34	75.6	35	72.9	39	79.6
Multiple drug use	34	75.6	33	68.8	39	79.6
Amphetamines	27	60.0	27	56.3	28	57.1
Other solvents/inhalants	26	57.8	27	56.3	24	49.0
Benzodiazepines	25	55.6	28	58.3	31	63.3
Petrol	24	53.3	24	50.0	26	53.1
Heroin	21	46.7	22	45.8	19	38.8
Morphine	19	42.2	15	31.3	17	34.7
Barbiturates	19	42.2	12	25.0	13	26.5
Methadone	18	40.0	16	33.3	17	34.7
Ecstasy/MDMA	18	40.0	16	33.3	17	34.7
Cocaine	15	33.3	10	20.8	14	28.6
LSD	8	17.8	12	25.0	12	24.5
Steroids/anabolic agents	6	13.3	7	14.6	6	12.2
Kava	5	11.1	2	4.2	6	12.2
Other drugs	3	6.7	4	8.3	3	6.1
	***n* = 45**		***n* = 48**		***n* = 49**	

Note: Percentage of services that cover substance use issues on an individual client basis.

Source: OATSIH Services Reporting Database, 2010–11.

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

The following table (Table G1) provides technical details about the mapping process applied to produce the hospital separations data in Section 5.6. Please note that these codes are not a complete list of *International statistical classification of diseases and related health problems, 10th revision, Australian Modification* (ICD-10-AM) codes (NCCH 2009) for which a hospital separation may be attributed as (wholly or partially) drug-related.

Table G1: Mapping of ICD-10-AM codes to the Australian Standard Classification of Drugs of Concern (ASCDC) output categories to be used in the 2010–11 AODTS–NMDS annual report[(a)]

Drug of concern identified in principal diagnosis	ICD-10-AM codes used in the 2010–11 analysis
Analgesics	
Opioids (includes heroin, opium, morphine & methadone)	F11.0–11.9, T40.0–40.4
Non-opioid analgesics (includes paracetamol)	T39.0, T39.1, T39.3, T39.4, T39.8, T39.9, F55.2
Sedatives and hypnotics	
Alcohol (ethanol)	E52, F10.0–10.9, G31.2, I42.6, K29.2, K70.0–70.9, K85.2, K86.0, T51.0–51.9, Z71.4
Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes ethanol)	F13.0–13.9, T41.2, T42.3–42.8
Stimulants and hallucinogens	
Cannabinoids (includes cannabis)	F12.0–12.9, T40.7
Hallucinogens (includes LSD & ecstasy)	F16.0–16.9, T40.8, T40.9
Cocaine	F14.0–14.9, T40.5
Tobacco & nicotine	F17.0–17.9, T65.2, Z71.6
Other stimulants (includes amphetamines, pseudoephedrine, volatile nitrates & caffeine)	F15.0–15.9, T40.9,T43.6, T46.0, T46.3
Antidepressants and antipsychotics	
Antidepressants & antipsychotics	F55.0, T43.0–43.5
Volatile solvents	
Volatile solvents	F18.0–18.9, T52.0–52.9, T53.1, T53.2, T53.3, T53.4, T53.5, T53.6, T53.7, T53.9, T59.0, T59.8
Other and unspecified drugs of concern	
Multiple drug use	F19.0–19.9
Unspecified drug use & other drugs not elsewhere classified (includes psychotropic drugs not elsewhere classified; diuretics; anabolic and androgenic steroids & opiate antagonists)	Z71.5, T38.7, T43.8, T43.9, T50.1, T50.2, T50.3, T50.7, F55.1, F55.3, F55.4, F55.5, F55.6, F55.8, F55.9, N14.1–14.3
Foetal and perinatal related conditions	
Foetal and perinatal related conditions (include conditions from alcohol, tobacco & nicotine & drugs of addiction use of the mother)	Q86.0, P04.2–04.4

(a) This list of codes included in analyses of hospital data has changed from previous reports. Time series hospital data have been re-analysed using this list of codes, therefore some figures may differ from those previously published.

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Related publications

This report, *Alcohol and other drug treatment services in Australia 2010-11: report on the National Minimum Data Set*, is part of an annual series. The AIHW also publishes a report profile to accompany this report and an annual series of eight state and territory bulletins. These publications, as well as past and future reports in this series, can be downloaded for free online from the AIHW website, <www.aihw.gov.au/alcohol-and-other-drugs-publications/>. The website also includes information on ordering printed copies.

Data are also available online in interactive data cubes, <www.aihw.gov.au/alcohol-and-other-drug-treatment-services-data-cubes/> and in state and territory supplementary tables, <www.aihw.gov.au/aodts-nmds-supplementary-tables/>.

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

- AIHW 2012. National Opioid Pharmacotherapy Statistics Annual Data collection: 2011 report. Drug treatment series no. 15. Cat. no. HSE 121. Canberra: AIHW.
- AIHW 2011. 2010 National Drug Strategy Household Survey report. Drug statistics series no. 25. Cat. no. PHE 145. Canberra: AIHW.
- AIHW 2011. Drugs in Australia 2010: tobacco, alcohol and other drugs. Drug statistics series no. 27. Cat. no. PHE 154. Canberra: AIHW.

Around 150,500 closed treatment episodes for alcohol and other drug use were provided in Australia in 2010–11—almost 5,000 more than in 2009–10. For almost half of these episodes, the principal drug of concern was alcohol. Cannabis was the second most common principal drug of concern. Counselling was the most common type of treatment, followed by withdrawal management.