1 Introduction

This is the eighth report in the series of annual publications on the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS–NMDS) since 2002. This report presents national, state and territory data about publicly funded alcohol and other drug treatment services, their clients, drugs of concern and the types of treatment received.

1.1 Purpose and structure

This report draws together data collected under the umbrella of the AODTS–NMDS which was originally implemented to help monitor and evaluate key objectives of the National Drug Strategic Framework 1998–99 to 2003–04 and to help plan, manage and improve the quality of alcohol and other drug treatment services in Australia (see AIHW: Grant & Petrie 2001 for historical development of the AODTS–NMDS). The AODTS–NMDS continues to support key treatment-related objectives of the National Drug Strategy 2004–09, particularly as trend data are becoming available.

The structure of the AODTS–NMDS report for 2007–08 has changed slightly from previous years. Separate sections are presented on each of the main drugs of concern (Chapter 4) and each of the main treatment types received (Chapter 5). This report also contains an additional chapter (Chapter 7) discussing future considerations for the NMDS including potential data development to answer key policy questions. This report is structured as follows:

- Chapter 2 provides a profile of the alcohol and other drug treatment agencies that supplied data for the 2007–08 collection.
- Chapter 3 reports on the demographic profile of clients who received treatment services.
- Chapter 4 focuses on the drugs of concern reported by clients, including the main drug that led them to seek treatment and additional drugs of concern. It also examines each of the main drugs of concern in relation to client, drug and treatment profiles.
- Chapter 5 focuses on main treatment types received by clients as well as additional treatments, and examines each main treatment type in relation to client, treatment and main drug profiles. It also presents information from the National Opioid Pharmacotherapy Statistics Annual Data Collection (NOPSAD) as the AODTS–NMDS does not capture most information about pharmacotherapy in Australia.
- Chapter 6 describes the comprehensiveness and quality of data.
- Chapter 7 examines data development issues, including the limitations of the current collection and the potential to improve information for policy makers and program planners.

1.2 Scope of the AODTS–NMDS

The scope of the AODTS–NMDS has remained the same since the collection's inception. The agencies and clients both included and excluded are outlined below.

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 the period 1 July 2007 to 30 June 2008.

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. Specifically, 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 solely receiving support from (the majority of) Australian Government-funded Indigenous substance use services or Aboriginal primary health care services that also provide treatment for alcohol and other drug problems
- people who seek advice or information but who are not formally assessed and 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.

1.3 Collection count

Since 2001–02, the unit of measurement for the AODTS–NMDS collection has been closed (or completed) treatment episodes. The 'closed treatment episode' concept is included in the national collection because it best reflects clinical practice within the alcohol and other drug treatment sector.

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

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

- the treatment delivery setting
- the main treatment type.

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

It is important to note that 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. Using the current collection methodology, it is not possible to identify when a client attends a number of different agencies throughout the collection period or returns for further treatment to the same agency in some jurisdictions.

1.4 Data issues

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 and services funded by states and territories. The data simply show where treatment occurred.
- Many drug treatment services used by Indigenous people do not report to the AODTS–NMDS. Interested readers can find more data about these services in other collections detailed in Appendix 6.
- Implementation of the AODTS–NMDS has been done in stages. Comparisons across years need to be made with caution.

Lastly, 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 Appendix 2. Footnotes throughout the report also highlight jurisdictional differences.

1.5 Other information from the AODTS–NMDS collection

Apart from this national annual report on the data from the collection, a national AODTS–NMDS summary bulletin is also produced each year. Briefings specific to each state and territory (except Queensland) are published shortly after the national publications. All publications released by the AIHW are available free of charge on the AIHW website <www.aihw.gov.au>.

In addition, the AIHW has released public-access data subsets from the AODTS–NMDS in the form of interactive data cubes. The data cubes can be used to perform simple analyses and present figures in a way suitable to individual needs. Cubes are presently available for the 2001–02 to 2006–07 collections. Data cubes for the 2007–08 collection period will be available at <www.aihw.gov.au/drugs/datacubes/index.cfm> from October 2009.

2 Treatment agency profile

This chapter profiles the alcohol and other drug treatment agencies that supplied data about their treatment episodes for the 2007–08 AODTS–NMDS collection. The number of treatment agencies reported in this chapter may not necessarily correspond to the total number of service delivery outlets in Australia. There are a variety of service delivery outlets including outreach locations or in the homes of clients. Some agencies may also have more than one service outlet but only report under the main administrative centre of the service.

- A total of 658 alcohol and other drug treatment agencies provided data for the period 2007–08 (Table 2.1). This represents an increase of 25 agencies since 2006–07. All jurisdictions apart from the Australian Capital Territory have reported small increases in the number of agencies.
- Several factors contribute to changes in the reported number of agencies between years. These factors include changing from collecting data at an administrative or management level to a service outlet level; and changes in the actual number of agencies on the ground. Changes in the number of agencies do not always reflect changes in service delivery capacity.
- In 2007–08, as in previous years, treatment agencies were most likely to be located in the most populous states of New South Wales (41%), followed by Victoria (21%) and Queensland (16%).

2.1 Treatment agency sector

Agencies were asked to identify whether they were run by the government or non-government sector.

- In 2007–08 the number of agencies in the non-government sector and government sector was almost equal (328 and 330 respectively) (Table 2.1). This balance may be exaggerated, however, as not all in-scope agencies in Queensland reported in 2007–08.
- Government sector agencies were more prominent in South Australia (84%) and New South Wales (75%), whereas in Victoria all 138 agencies were in the non-government sector.
- In Western Australia, service developments have led to the co-location of government and non-government agencies in some locations. In the 2007–08 collection there were eight integrated services reporting as government sector services.

Table 2.1: Treatment agencies by sector of service[a] and jurisdiction, 2007–08

Sector of service	NSW	Vic[b]	Qld	WA[c]	SA	Tas	ACT	NT	Australia
					(number)				
Government	201	—	59	19	41	6	1	3	330
Non-government[b]	67	138	47	32	8	10	9	17	328
Total	**268**	**138**	**106**	**51**	**49**	**16**	**10**	**20**	**658**
					(per cent)				
Government	75.0	—	55.7	37.3	83.7	37.5	10.0	15.0	50.2
Non-government	25.0	100.0	44.3	62.7	16.3	62.5	90.0	85.0	49.8
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent of total treatment agencies	**40.7**	**21.0**	**16.1**	**7.8**	**7.4**	**2.4**	**1.5**	**3.0**	**100**

(a) Sector of service refers to the public (government) and private (non-government) sectors. Agencies funded by the Australian Government Department of Health and Ageing under the Non-Government Organisation Treatment Grants Program are included in the government sector.

(b) Includes only those non-government agencies that receive public funding.

(c) Integrated government and non-government services are included in the government sector.

2.2 Location of treatment agencies

Treatment agencies were located in a range of geographically diverse areas, from large cities to remote regions. The Australian Standard Geographical Classification classifies areas into *Major cities*, *Inner regional* areas, *Outer regional* areas, *Remote* and *Very remote* areas. The classification uses road distance to different-sized urban areas to designate regions into these 'remoteness areas'.

- In 2007–08 treatment agencies were again mostly located in *Major cities* (57%) and *Inner regional* areas (26%) (Table 2.2). The number of agencies in *Major cities* may be over-represented because of agencies reporting small, non-metropolitan outlets or outreach activities against the central agency location.
- As expected because of its geographical profile, a large proportion of services in the Northern Territory (55%) continued to be located in *Remote* or *Very remote* areas. Similarly, Tasmania's agencies are all located in *Inner* and *Outer regional* areas because Tasmania does not have areas that meet the definition of 'Major cities'.

Table 2.2: Treatment agencies by geographical location[(a)] and jurisdiction, 2007–08

Location	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					(number)				
Major cities	161	90	45	38	32	—	10	—	376
Inner regional	86	38	26	4	8	11	—	—	173
Outer regional	21	10	26	4	7	5	—	9	82
Remote	—	—	6	5	1	—	—	9	21
Very remote	—	—	3	—	1	—	—	2	6
Total	**268**	**138**	**106**	**51**	**49**	**16**	**10**	**20**	**658**
					(per cent)				
Major cities	60.1	65.2	42.5	74.5	65.3	—	100.0	—	57.1
Inner regional	32.1	27.5	24.5	7.8	16.3	68.8	—	—	26.3
Outer regional	7.8	7.2	24.5	7.8	14.3	31.3	—	45.0	12.5
Remote	—	—	5.7	9.8	2.0	—	—	45.0	3.2
Very remote	—	—	2.8	—	2.0	—	—	10.0	0.9
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

(a) The geographical location of treatment agencies in the 2007–08 AODTS–NMDS has been analysed using the Remoteness Areas of the Australian Bureau of Statistics Australian Standard Geographical Classification (see Appendix 4 for information on how these categories are derived).

2.3 Location of treatment agencies and treatment types

The main treatment types provided by agencies varied somewhat depending on the geographical location of the agency (Table 2.3). The reasons for variations are not clear from the data collected and numerous factors may affect the results.

- Overall, counselling has remained the most common treatment type in all regions across Australia apart from *Very remote* areas, ranging from 36% of episodes in *Major cities* to 44% in *Remote* areas.
- In *Very remote* areas, 'other' treatment was the most common treatment provided (those treatments that do not meet the definitions listed in Table 2.2). For the whole of Australia, pharmacotherapy accounts for a substantial proportion of 'other' treatment. In *Very remote* areas, very little of 'other' treatment was pharmacotherapy (1%). Unfortunately, no additional information is currently available about 'other' treatment in *Very remote* areas.
- There was a decrease in withdrawal management treatment episodes as agencies became more remote. In *Major cities*, 18% of treatment episodes were withdrawal management. In *Very remote* areas, only 3% of treatment was withdrawal management. As was the case in 2006–07, *Outer regional* areas provided proportionately more information and education only (27%) than the other geographical locations.

Table 2.3: Main treatment type by geographical location[a], 2007–08 (per cent)

Main treatment type[b]	Major Cities	Inner Regional	Outer Regional	Remote	Very Remote	Australia
Withdrawal management (detoxification)	18.1	12.7	10.4	10.7	3.0	16.2
Counselling	35.7	42.9	38.2	43.7	16.6	37.3
Rehabilitation	7.3	7.3	5.9	6.2	12.2	7.2
Support and case management only	7.8	10.0	5.6	7.0	6.4	8.0
Information and education only	6.7	13.8	26.6	10.6	7.4	9.8
Assessment only	15.8	9.7	9.7	20.2	16.2	14.3
Other	8.5	3.6	3.6	1.5	38.1	7.2
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 residential address of the person receiving treatment).

(b) Additional information about main treatment types, including definitions, is provided in Chapter 5 of this report.

3 Client profile

This chapter provides a demographic profile of clients who received alcohol and other drug treatment services in 2007–08.

A typical client of an Australian alcohol and other drug treatment service is a male who has sought treatment for his own drug use. He is 32 years of age, Australian born and is not an Indigenous Australian. He sought treatment for his alcohol consumption at a service in a *Major City* and received counselling.

The analyses present the characteristics of people who received 'closed treatment episodes' from agencies that report to the AODTS–NMDS, with one exception: Section 3.3 about Indigenous status includes some data from another collection.

Box 3.1: Key definition and counts for closed treatment episodes, 2007–08

Closed treatment episode *refers to a period of contact, with defined dates of commencement and cessation, between a client and a treatment agency. In 2007–08 there were* ***153,998*** *closed treatment episodes, of which* ***147,721*** *were for clients seeking treatment for their own substance use.*

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 NMDS. It is likely that many people would approach other services for assistance, such as relationship counsellors.

3.1 Client type

Clients in the collection are categorised as those seeking treatment for their own drug use and those seeking treatment because of the drug use of another person. As in previous reporting periods, clients in 2007–08 most often sought treatment for their own drug use. A small proportion of clients sought treatment related to someone else's drug use.

- There were 147,721 episodes for clients seeking treatment for their own drug use reported in 2007–08 (Table 3.1); 6,277 treatment episodes were provided to people seeking assistance related to another person's drug use.
- Of the people seeking assistance related to someone else's drug use, 76% received counselling, 12% received support and case management and 7% received information and education only. These data suggest that most people seeking assistance because of someone else's drug use require more personal support or counselling than information and education.
- States and territories varied in the proportion of treatments they provided to people seeking assistance for their own drug use and those they provided to people seeking

assistance related to another person's drug use. All states and territories provided less than 10% of treatment to the latter group. The reason for the variation between jurisdictions is not known. Appendix tables A3.2 and A3.5 provide additional data on the geographic profile of agencies and the treatment episodes.

Table 3.1: Client type by jurisdiction, 2007–08 (per cent)

Client type	NSW	Vic[(a)]	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia	Total (no.)
Own drug use	98.1	94.9	97.9	91.0	96.5	92.3	98.0	94.2	95.9	147,721
Other's drug use	1.9	5.1	2.1	9.0	3.5	7.7	2.0	5.8	4.1	6,277
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**42,078**	**47,538**	**26,895**	**18,705**	**9,030**	**2,302**	**3,738**	**3,712**	**. .**	**153,998**
State/territory Per cent	**27.3**	**30.9**	**17.5**	**12.1**	**5.9**	**1.5**	**2.4**	**2.4**	**100.0**	**. .**

(a) Victoria does not report data for 'Other treatment type'. All treatment provided is recorded as 'Main treatment'. Additional information regarding this issue can be found in Box 5.1.

(b) The total number of episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

(c) The total number of episodes for Tasmania may be under-counted because two agencies supplied drug diversion data only.

3.2 Age and sex

The median age of clients was 32 years and a large majority were male (Table 3.2).

Table 3.2: Sex by age group, 2007–08 (per cent)

	Age group (years)								
Sex/client type	10–19	20–29	30–39	40–49	50–59	60+	Total[(a)]	Total (no.)	Median age
Males									
Own drug use	10.9	32.6	29.1	17.6	7.1	2.5	100.0	100,022	32
Other's drug use	26.7	14.0	13.5	16.0	18.5	9.5	100.0	2,130	36
Total males	11.2	32.2	28.8	17.6	7.3	2.7	100.0	. .	32
Total males (number)	*11,430*	*32,875*	*29,435*	*17,947*	*7,490*	*2,710*	. .	*102,152*	. .
Females									
Own drug use	11.8	30.6	29.1	18.5	7.0	2.6	100.0	47,574	32
Other's drug use	13.2	11.7	16.5	22.6	23.2	11.5	100.0	4,128	44
Total females	11.9	29.1	28.1	18.8	8.3	3.3	100.0	. .	33
Total females (number)	*6,166*	*15,020*	*14,540*	*9,741*	*4,287*	*1,728*	. .	*51,702*	. .
Persons[(b)]									
Own drug use	11.2	31.9	29.1	17.9	7.1	2.5	100.0	147,721	32
Other's drug use	17.9	12.5	15.5	20.4	21.6	10.8	100.0	6,277	42
Total persons	**11.4**	**31.1**	**28.6**	**18.0**	**7.7**	**2.9**	**100.0**	**. .**	**32**
Total (number)	**17,618**	**47,936**	**44,007**	**27,722**	**11,788**	**4,440**	**. .**	**153,998**	**. .**

(a) Includes 'not stated' for age.

(b) Includes 'not stated' for sex.

- More episodes were provided to male clients (66%). Males have accounted for the majority of episodes since 2001–02.
- People in their twenties and thirties again dominated the age distribution of treatment clients.
- In 2007–08, people who received treatment for their own drug use were younger by 10 years than those who sought treatment in relation to someone else's drug use.

3.3 Indigenous status

- Just over one in ten (11%) episodes involved clients that identified as being of Aboriginal and/or Torres Strait Islander origin (Table 3.3).

Table 3.3: Age group by Indigenous[a] status and sex, 2007–08

Age group (years)	Indigenous			Non-Indigenous			Not stated			Total persons[c]
	Males	Females	Total[b]	Males	Females	Total[b]	Males	Females	Total[b]	
					(number)					
10–19	1,895	1,080	2,975	8,916	4,688	13,616	619	398	1,027	17,618
20–29	3,515	2,014	5,536	27,812	12,324	40,160	1,548	682	2,240	47,936
30–39	2,814	1,763	4,582	25,195	12,115	37,330	1,426	662	2,095	44,007
40–49	1,547	871	2,418	15,461	8,460	23,949	939	410	1,355	27,722
50–59	393	216	609	6,722	3,886	10,617	375	185	562	11,788
60+	115	59	174	2,467	1,587	4,056	128	82	210	4,440
Not stated	82	64	146	163	122	287	20	34	54	487
Total	**10,361**	**6,067**	**16,440**	**86,736**	**43,182**	**130,015**	**5,055**	**2,453**	**7,543**	**153,998**
					(per cent)					
10–19	18.3	17.8	18.1	10.3	10.9	10.5	12.2	16.2	13.6	11.4
20–29	33.9	33.2	33.7	32.1	28.5	30.9	30.6	27.8	29.7	31.1
30–39	27.2	29.1	27.9	29.0	28.1	28.7	28.2	27.0	27.8	28.6
40–49	14.9	14.4	14.7	17.8	19.6	18.4	18.6	16.7	18.0	18.0
50–59	3.8	3.6	3.7	7.7	9.0	8.2	7.4	7.5	7.5	7.7
60+	1.1	1.0	1.1	2.8	3.7	3.1	2.5	3.3	2.8	2.9
Not stated	0.8	1.1	0.9	0.2	0.3	0.2	0.4	1.4	0.7	0.3
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**
Per cent of treatment population	**6.7**	**3.9**	**10.7**	**56.3**	**28.0**	**84.4**	**3.3**	**1.6**	**4.9**	**100**

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

(b) There were 12 episodes for Indigenous people where sex was not stated, 97 episodes for non-Indigenous people where sex was not stated and 35 episodes where Indigenous status and sex were not stated.

(c) Includes 'not stated' for sex.

- Episodes were most common among those aged 20–29 years for both Indigenous and non-Indigenous clients.
- Similar to all episodes reported in the collection, some of the episodes involving Indigenous clients may have been provided to the same individuals. The current collection methodology does not allow analysis of this issue. Therefore, direct comparisons with the overall Indigenous/non-Indigenous composition of the Australian population are not appropriate.
- Indigenous status was 'not stated' for 5% of episodes nationally (the same proportion as in the previous 3 years).
- Episodes were relatively more common among Indigenous clients aged 10–19 years (18%) than among non-Indigenous clients aged 10–19 years (11%). These differences may reflect the age structures of the two populations, as Indigenous peoples have a younger age profile than non-Indigenous Australians.

Most Australian Government-funded alcohol and other drug services for Indigenous people are out of scope for the AODTS–NMDS. The Drug and Alcohol Service Report (DASR) details the activity of Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services. Additional information on the definitions used in the DASR report including the definition of 'episodes of care' is available in Appendix 6.

Care provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services

Residential treatment and rehabilitation refers to residential programs where clients receive formal rehabilitation for substance use. In 2007–08, an estimated 3,500 episodes of care were provided to clients in residential treatment/rehabilitation services (Table 3.4). Of these episodes of care, 74% were for male clients.

In 2007–08, an estimated 17,300 episodes of care were provided to clients accessing sobering-up or residential respite services. Sobering-up clients are in residential care overnight to sober up and do not receive formal rehabilitation, whereas residential respite clients spend 1–7 days in residential care for the purpose of respite and do not receive formal rehabilitation. Approximately three in five (62%) of episodes of care were for male clients.

'Other care' refers to a diverse range of non-residential programs, including preventative care, after-care follow-up and mobile assistance/night patrol. In 2007–08, there were an estimated 72,000 episodes for other care, up from 57,900 episodes in 2006–07. The high number of episodes of other care, compared with residential or sobering-up episodes of care, is due to the short-term nature of other care, with some clients receiving multiple episodes of care over the course of the year (see Appendix 6). Three in five (60%) episodes for other care were for male clients.

Table 3.4: Estimated number of 'episodes of care'[(a)] provided by Australian Government-funded Aboriginal and Torres Strait Islander substance use-specific services (DASR) by sex, and treatment type, 2007–08

	Estimated number of 'episodes of care'					
	Male		Female		Total	
Treatment type	No.	%	No.	%	No.	%
Residential treatment/rehabilitation[(b)]	2,600	74	900	26	3,500	100
Sobering-up/residential respite[(c)]	10,700	62	6,600	38	17,300	100
Other care[(d)]	43,300	60	28,800	40	72,000	100

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

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

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

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

Note: Figures have been rounded to the nearest hundred.

Source: Australian Government Department of Health and Ageing analysis of the 2007–08 Drug and Alcohol Service Report.

3.4 Country of birth and preferred language

Country of birth

- The majority (86%) of AODTS–NMDS episodes in 2007–08 involved clients born in Australia (Table A3.1).
- Clients born in other countries were represented in only a small proportion of episodes, with England (2%) and New Zealand (2%) being the next most common countries of birth. Similar to the issues outlined above for Indigenous peoples, treatment episodes for people born outside Australia are not directly comparable to population proportions.

Preferred language

- As in previous reporting periods, English was the most frequently reported preferred language in 2007–08 (96% of episodes).
- Other preferred languages were relatively uncommon, with the second most preferred language being Australian Indigenous languages, albeit at less than 1% of treatment episodes.

4 Drugs of concern

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 reported by clients of alcohol and other drug treatment services, including the main drug that led them to seek treatment, called the *principal drug of concern* (Section 4.2), and all drugs reported to be of concern (Section 4.3). This chapter also examines each of the most common drugs of concern in relation to client, drug and treatment profiles (Sections 4.4 to 4.10).

4.1 Context

Alcohol, tobacco and illicit drug use are responsible, directly and indirectly, for a considerable number of accidents, injuries, illnesses and deaths.

Mortality

In the most recent Burden of Disease and Injury in Australia study (Begg et al. 2007) it was estimated that 20,600 deaths were attributable to the use of tobacco, alcohol or illicit drugs in 2003.

Hospital treatment (morbidity)

There were 84,889 drug-related hospital 'separations' reported in 2007–08 (Table 4.1). 'Separations' refer to completed episodes 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 principal diagnoses of substance use disorder or harm (accidental, intended or self-inflicted) due to selected substances (See Appendix 7 for technical details). As well as alcohol and tobacco, some of the drugs of concern discussed here are available by prescription or can be legally purchased over the counter. Therefore, a proportion of the separations reported here may result from harm arising from the therapeutic use of drugs. The 84,889 drug-related separations in 2007–08 represented 1.1% of all hospital separations, the same proportion as the previous year (AIHW 2009).

Table 4.1: Same-day and overnight separations[a][b] with a principal diagnosis of drug-related harm or disorder, by drug of concern, Australia, 2007–08

Drug of concern identified in principal diagnosis[c]	Same-day separations	Overnight separations	Total separations[d]
Analgesics			
Opioids (includes heroin, opium, morphine & methadone)	2,031	4,961	6,992
Non-opioid analgesics (includes paracetamol)	1,242	3,629	4,871
Total analgesics	*3,273*	*8,590*	*11,863*
Sedatives & hypnotics			
Alcohol	21,578	22,481	44,059
Other sedatives & hypnotics (includes barbiturates & benzodiazepines; excludes alcohol)	3,507	6,801	10,308
Total sedatives & hypnotics	*25,085*	*29,282*	*54,367*
Stimulants & hallucinogens			
Cannabinoids (includes cannabis)	758	2,289	3,047
Hallucinogens (includes LSD & ecstasy)	231	218	449
Cocaine	128	106	234
Tobacco & nicotine	269	32	301
Other stimulants (includes amphetamines, volatile nitrates & caffeine)	1,003	2,744	3,747
Total stimulants & hallucinogens	*2,389*	*5,389*	*7,778*
Antidepressants & antipsychotics	1,820	4,930	6,750
Volatile solvents	293	392	685
Other & unspecified drugs of concern			
Multiple drug use	1,099	2,208	3,307
Unspecified drug use & other drugs not elsewhere classified[e]	34	105	139
Total other & unspecified drugs of concern	*1,133*	*2,313*	*3,446*
Total	**33,993**	**50,896**	**84,889**

(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) The code set used for this analysis is being reviewed. Technical details are included in Appendix 7.

(c) Drug of concern codes based on Australian Standard Classification of Drugs of Concern (ASCDC) which are mapped to ICD-10-AM 5th edition codes.

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

(e) See Appendix 7 for technical details.

Source: AIHW analysis of the National Hospitals Morbidity Database 2007–08.

In 2007–08, sedatives and hypnotics continued to account for the highest number of drug-related hospital separations, (or 64% of all drug-related separations), with alcohol making up 81% of separations for sedatives and hypnotics. On its own, alcohol accounted for 52% of drug-related hospital separations (Table 4.1). Of all drug-related separations reported, 14% were for analgesics, with opioids (heroin, opium, morphine and methadone) accounting for more than half of this group (or 8% of all drug-related separations). Stimulants and hallucinogens, including cannabis and cocaine, accounted for 9% of all drug-related separations.

Separations can be either same-day (where the patient is admitted and separated on the same day) or overnight (where the patient spends at least one night in hospital). In 2007–08, overnight separations continued to be more common for drug-related treatment than same-day separations, accounting for 60% of all drug-related separations (Table 4.1). Separations were most likely to be overnight for cannabis (75%) out of all the drugs reported. For alcohol, there were similar numbers of same-day and overnight separations.

Alcohol consumption guidelines

The National Health and Medical Research Council (NHMRC) released the *Australian guidelines to reduce health risks from drinking alcohol* in February 2009. These guidelines take a very different approach from the previous *Australian alcohol guidelines* (2001) in that they identify a progressively increasing risk of harm with increasing amounts of alcohol consumed rather than specifying 'risky' or 'high risk' levels of consumption. The guidelines suggest that Australians drink no more than two standard drinks on any day (Guideline 1) (NHMRC 2009).

Key definitions

The following data relates to those 147,721 episodes where clients were seeking treatment for their own drug use. There is more information about treatment episodes where clients were seeking treatment for someone else's substance use in Chapter 5.

Box 4.1: Key definitions and counts for closed treatment episodes and drugs, 2007–08

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 as it is assumed that only substance users themselves can accurately report on the principal drug of concern to them. In 2007–08, the principal drug of concern was reported for* ***147,721*** *closed treatment episodes.*

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. In 2007–08, over half of the closed treatment episodes included at least one other drug of concern (54% or* ***79,594****), in which* ***138,014*** *instances of other drugs of concern were reported (apart from principal drug of concern). This is an average of* ***1.1*** *other drugs of concern per treatment episode.*

All drugs of concern *refers to all drugs reported by clients, including the principal drug of concern and all other drugs of concern. In 2007–08, there were a total of* ***285,735*** *drugs of concern reported, either as a principal or other drug of concern.*

4.2 Principal drug of concern

Trends in principal drug of concern

Alcohol has been the most common principal drug of concern in all years since the start of the collection (Table 4.2). Further, the proportion of treatment episodes with alcohol as the principal drug of concern has grown over the last 3 years. Cannabis has consistently accounted for one-fifth to one-quarter of treatment episodes. Heroin has been the focus of proportionately fewer episodes since 2005–06.

It is important to understand that many factors may potentially contribute to changes in the pattern of drugs for which treatment is sought over time. These factors include but are not limited to changes in the:

- availability, purity and cost of substances
- perception of substance use
- availability of treatment services
- development of policies that target specific substances, groups or treatment types.

For example, the small proportion of nicotine-related episodes (included in 'all other drugs' in Table 4.2) may reflect the proportion of people who choose to access treatment for smoking through their GP, pharmacy or other support service such as state and territory Quit resources, rather than through the alcohol and drug treatment agencies that are reported in this collection.

Table 4.2: Trends in principal drug of concern[a], 2001–02 to 2007–08

Principal drug of concern	2001–02[b]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
				(per cent)			
Alcohol	37.0	38.0	37.5	37.2	38.7	42.3	44.5
Amphetamines	10.8	10.7	11.0	10.9	11.0	12.3	11.2
Benzodiazepines	2.4	2.1	2.1	1.9	1.8	1.6	1.7
Cannabis	21.0	22.0	22.0	23.0	24.6	22.8	21.6
Cocaine	0.7	0.3	0.2	0.3	0.3	0.3	0.3
Ecstasy	0.2	0.3	0.4	0.4	0.6	0.7	0.9
Heroin	17.7	18.4	18.0	17.2	13.6	10.6	10.5
Methadone	2.3	1.8	1.9	1.8	1.7	1.6	1.6
Other opioids	2.0	1.8	1.9	2.0	2.0	2.2	2.4
All other drugs[C]	5.2	3.9	4.6	5.3	5.7	5.5	5.4
Not stated	0.7	0.5	0.5	—	—	—	—
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

continued

Table 4.2 (continued): Trends in principal drug of concern[a], 2001–02 to 2007–08

Principal drug of concern	2001–02[b]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
				(number)			
Alcohol	41,886	46,747	48,500	50,324	56,076	59,480	65,702
Amphetamines	12,211	13,213	14,208	14,780	15,935	17,292	16,588
Benzodiazepines	2,745	2,609	2,711	2,538	2,583	2,298	2,487
Cannabis	23,826	27,106	28,427	31,044	35,636	31,980	31,864
Cocaine	804	323	272	400	434	448	457
Ecstasy	253	416	508	580	897	1,010	1,321
Heroin	20,027	22,642	23,326	23,193	19,776	14,870	15,571
Methadone	2,570	2,173	2,404	2,454	2,462	2,268	2,296
Other opioids	2,209	2,273	2,408	2,661	2,920	3,058	3,513
All other drugs[c]	5,875	4,854	5,935	7,228	8,244	7,771	7,922
Not stated	825	676	632	—	—	—	—
Total	**113,231**	**123,032**	**129,331**	**135,202**	**144,963**	**140,475**	**147,721**

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

(b) Queensland supplied data for police diversion clients only and South Australia supplied client registration data rather than treatment episode data.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

In 2007–08, alcohol and cannabis were again the most common principal drugs of concern in episodes nationally (44% and 22% respectively). These were followed by opioids (14%, with heroin accounting for 11%)[1] and amphetamines (11%). Benzodiazepines and nicotine each accounted for 2% of episodes and less than 1% of episodes were for ecstasy and cocaine. (Table 4.3).

Principal drug of concern across Australia

Apart from Tasmania and the Australian Capital Territory, all jurisdictions reported a rise in the number of treatment episodes for alcohol use. The smallest increase was in Queensland (0.1 percentage points) and the largest increase was in the Northern Territory (9.7 percentage points). These increases may be attributed to increased attention to problematic alcohol consumption, service availability, alcohol availability or improvements to data collection.

The large populations in New South Wales and Victoria heavily influenced national results and this should be considered when interpreting the data below:

- The ACT continued to have the greatest proportion of treatment episodes where heroin was the principal drug of concern (20%) and remained greater than the larger states of New South Wales and Victoria (12% and 15% respectively).

1 The AODTS–NMDS collection excludes agencies whose sole purpose is to prescribe and/or dose for methadone or other opioid pharmacotherapies. Therefore, the collection excludes many clients receiving treatment for opioid use.

- The proportion of episodes where heroin was the principal drug of concern increased in Victoria (14% in 2006–07 and 15% in 2007–08). It continued to be greater than the national proportion (11%).
- The Northern Territory continued to report the highest proportion of episodes where morphine is the principal drug of concern (7% compared with the national proportion of 1%). This may reflect the unavailability of heroin in the NT or be indicative of preference.
- Alcohol-related treatment continued to dominate service delivery in *Very remote* areas (87% of episodes compared with 80% in 2006–07). Episodes where heroin was the principal drug of concern were more common in *Major cities* (45% of all heroin treatment episodes occurred in *Major cities*) and episodes for cannabis use dominated service delivery in *Inner regional* areas.

Table 4.3: Principal drug of concern[(a)] by jurisdiction, 2007–08 (per cent)

Principal drug	NSW	Vic	Qld[(b)]	WA	SA	Tas[(c)]	ACT	NT	Australia	Total (no.)
Alcohol	49.3	44.2	33.8	40.6	52.8	32.1	48.9	73.1	44.5	65,702
Amphetamines	10.8	7.5	8.8	25.6	15.8	11.3	9.6	2.4	11.2	16,588
Benzodiazepines	2.0	2.1	1.0	1.2	2.0	1.3	0.8	0.6	1.7	2,487
Cannabis	17.1	22.2	36.8	14.2	10.3	45.3	14.3	9.7	21.6	31,864
Cocaine	0.6	0.2	0.2	0.2	0.2	0.0	0.3	0.0	0.3	457
Ecstasy	0.4	0.8	2.2	0.6	1.0	1.7	0.7	0.3	0.9	1,321
Nicotine	1.1	0.6	6.1	0.8	0.7	0.5	0.2	0.4	1.7	2,548
Opioids										
Heroin	12.0	14.6	4.1	8.3	8.9	0.3	19.6	1.2	10.5	15,571
Methadone	2.5	1.0	0.7	2.3	1.5	1.1	1.4	0.4	1.6	2,296
Morphine	1.0	0.0	1.6	0.1	2.4	4.6	0.4	7.1	0.9	1,390
Total opioids[(d)]	17.6	16.5	8.0	10.9	16.1	6.6	23.6	8.7	14.5	21,380
All other drugs[(e)]	1.1	6.0	3.1	6.1	1.1	1.2	1.6	4.8	3.6	5,374
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**. .**
Total (number)	**41,277**	**45,104**	**26,332**	**17,014**	**8,712**	**2,124**	**3,662**	**3,496**	**. .**	**147,721**

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

(b) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

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

(d) 'Total opioids' includes the balance of opioid drugs coded according to ASCDC. See Appendix 5 and Table A3.3.

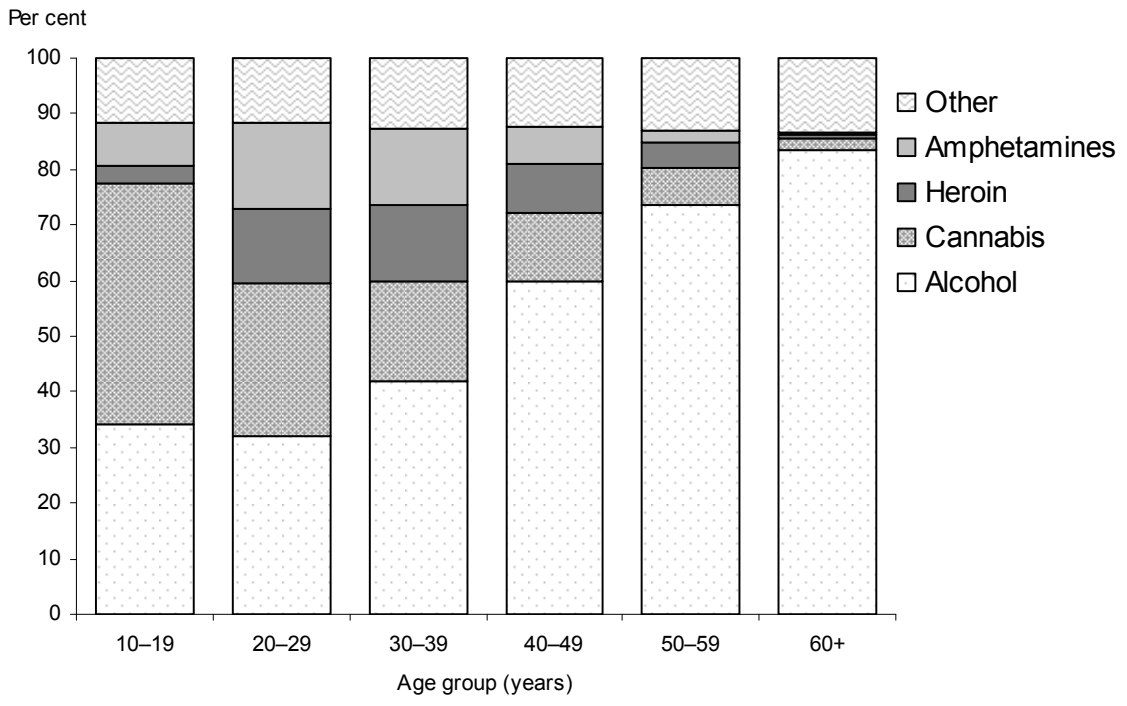
(e) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5 and Table A3.3.

Appendix tables A3.3 to A3.16 provide additional data on drug-related items.

Age and principal drug of concern

There was considerable variation in the principal drugs of concern reported by age groups. Figure 4.1 shows the increasing proportion of treatment episodes for alcohol use and the decreasing proportion of episodes for cannabis use as well as stable proportions for the treatment of 'other drug' use, across age groups.

- Clients aged 10–19 years most frequently reported cannabis as their principal drug of concern (43%). Alcohol was the second most frequently reported principal drug of concern (34%).
- Although 20–29 year olds reported alcohol as their principal drug of concern less frequently than 10–19 year olds (32%), this was still the most frequently reported for that group, followed by cannabis (28%) and amphetamines (16%).
- After alcohol, cannabis and heroin were the most frequently reported principal drugs of concern for those aged 40–49 and 50–59 years.
- Those aged 60+ years reported benzodiazepines as their principal drug of concern more often than cannabis (2.2% and 2.1% respectively), although benzodiazepines are reported as a principal drug of concern in similar proportions from ages 30–60+ (2.1%–2.4%).



Source: Table A3.6.

Figure 4.1: Selected principal drug of concern by age group, 2007–08

Indigenous status and principal drug of concern

- Indigenous clients were most likely to report the same four principal drugs of concern as the population overall—alcohol (53% of episodes), cannabis (22%), opioids (10% with heroin accounting for 7%) and amphetamines (9%) (Table 4.4).
- Alcohol was more likely to be nominated by Indigenous clients (53% of episodes, compared with 43% for non-Indigenous Australians) and opioids less so (10%, compared with 15%).
- There are similar treatment patterns for Indigenous and non-Indigenous Australians across most principal drugs of concern. For example, treatment episodes where ecstasy and benzodiazepines are the principal drugs of concern have increased slightly for both groups and fallen for amphetamines and cannabis from last year's collection. This pattern has not been shared in treatment episodes for opioids; it has risen slightly for non-Indigenous Australians and fallen slightly for Indigenous Australians (Table 4.5).

As previously noted, these data relating to Indigenous status do not tell the whole story about substance use services provided to Aboriginal and Torres Strait Islander peoples in Australia. A substantial number of agencies providing treatment to Indigenous people for substance use report to different data collections (see Section 1.5 for further details and Appendix 6 for data on these services).

Table 4.4: Principal drug of concern[(a)] by Indigenous status, 2007–08

Principal drug of concern	Indigenous		Non-Indigenous		Not stated		Total	
	No.	Per cent	No.	Per cent	No.	Per cent	No.	Per cent
Alcohol	8,484	52.8	54,113	43.5	3,105	42.9	65,702	44.5
Amphetamines	1,480	9.2	14,416	11.6	692	9.6	16,588	11.2
Benzodiazepines	131	0.8	2,241	1.8	115	1.6	2,487	1.7
Cannabis	3,471	21.6	26,842	21.6	1,551	21.4	31,864	21.6
Cocaine	27	0.2	411	0.3	19	0.3	457	0.3
Ecstasy	58	0.4	1,215	1.0	48	0.7	1,321	0.9
Nicotine	237	1.5	2,214	1.8	97	1.3	2,548	1.7
Opioids								
Heroin	1,097	6.8	13,655	11.0	819	11.3	15,571	10.5
Methadone	180	1.1	2,010	1.6	106	1.5	2,296	1.6
Morphine	172	1.1	1,139	0.9	79	1.1	1,390	0.9
Total opioids[(b)]	*1,587*	*9.9*	*18,634*	*15.0*	*1,159*	*16.0*	*21,380*	*14.5*
All other drugs[(c)]	583	3.6	4,344	3.5	447	6.2	5,374	3.6
Total	**16,058**	**100.0**	**124,430**	**100.0**	**7,233**	**100.0**	**147,721**	**100.0**
Per cent of Indigenous status	**10.9**	**. .**	**84.2**	**. .**	**4.9**	**. .**	**100.0**	**. .**

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

(b) 'Total opioids' includes the balance of opioid drugs coded according to ASCDC. See Appendix 5.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

Table 4.5: Trends in principal drug of concern[a] by Indigenous status, 2005–06 to 2007–08 (per cent)

Principal drug of concern	2005–06		2006–07		2007–08	
	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous	Indigenous	Non-Indigenous
Alcohol	44.9	37.8	49.0	41.4	52.8	43.5
Amphetamines	9.9	11.2	10.9	12.6	9.2	11.6
Benzodiazepines	0.9	1.9	0.7	1.7	0.8	1.8
Cannabis	24.9	24.7	22.0	22.9	21.6	21.6
Cocaine	0.1	0.3	0.2	0.3	0.2	0.3
Ecstasy	0.1	0.7	0.3	0.8	0.4	1.0
Nicotine	1.1	1.8	1.7	1.7	1.5	1.8
Opioids						
Heroin	9.6	14.3	7.6	11.0	6.8	11.0
Methadone	1.3	1.7	1.5	1.6	1.1	1.6
Morphine	0.9	0.9	1.1	0.9	1.1	0.9
Total opioids[b]	*12.5*	*18.0*	*10.9*	*14.8*	*9.9*	*15.0*
All other drugs[c]	5.5	3.6	4.3	3.6	3.6	3.5
Total	**100**	**100**	**100**	**100**	**100.0**	**100.0**

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

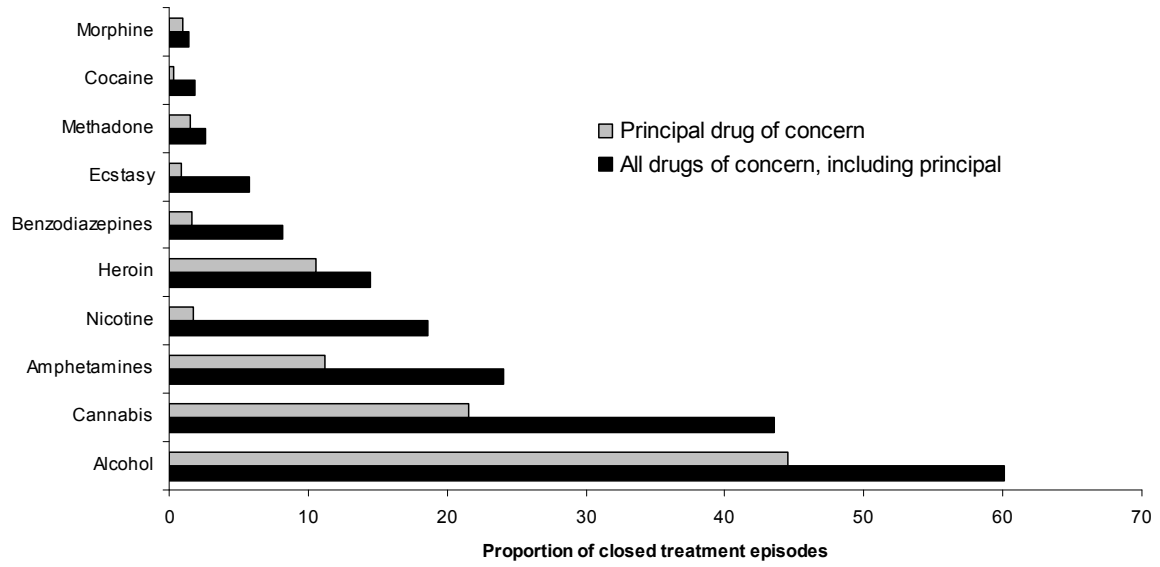
(b) 'Total opioids' includes the balance of opioid drugs coded according to ASCDC. See Appendix 5.

(c) Includes balance of principal drugs of concern coded according to ASCDC. See Appendix 5.

4.3 All drugs of concern

When all drugs of concern are considered (that is, the principal and all other drugs of concern nominated by the client):

- Alcohol and cannabis remained the two most commonly reported drugs of concern in 2007–08 (Figure 4.2).
- There was a slight increase in the number of treatment episodes where benzodiazepines are recorded as a drug of concern, from 7.8% in 2006–07 to 8.2% in 2007–08.
- Despite being reported as a principal drug of concern in only 2% of treatment episodes, nicotine was the fourth most common drug of concern reported overall, reported in 19% of all episodes.



Source: Table A3.7.

Figure 4.2: Principal drug of concern and all drugs of concern, 2007–08

4.4 Alcohol

Patterns of use in Australia

Alcohol is the most widely used drug in the Australian community. Based on data from the 2007 National Drug Strategy Household Survey (NDSHS) (AIHW 2008b, 2008c):

- In the 12 months before the survey, 8% of Australians aged 14 years and over drank alcohol on a daily basis, 41% on a weekly basis and 34% drank less regularly than once a week.
- Older people were more likely to be daily drinkers than younger people (16% of those aged 60 years and over compared with 1% of those aged 14–19 years).
- Males were twice as likely to be daily drinkers (11%) compared with females (6%), and males were also more likely to drink weekly (47%) than females (36%).
- According to the 2001 NHMRC Australian alcohol guidelines[2] (NHMRC 2001), in the 12 months before the survey, one in ten (10%) Australians aged 14 years and over consumed alcohol at levels that are considered risky or high risk to health in the long term, with persons in the 20–29 years age group most likely to consume alcohol in a way that put them at risk of long-term alcohol-related harm.

[2] According to the NHMRC 2001 guidelines, the consumption of 29 or more (if male) or 15 or more (if female) standard drinks per week is considered risky or high risk to health in the long term. The consumption of 7 or more (if male) or 5 or more (if female) standard drinks on any one day is considered risky or high risk to health in the short term.

- Almost one-quarter of recent drinkers[3] reported being 'unable to remember afterwards what happened' while they were drinking (24%) or reported having 'a feeling of guilt or remorse after drinking' (23%) at least once in the previous 12 months.
- Almost one in five people who reported drinking in the previous 12 months also reported that they 'were not able to stop drinking' once they had started (19%) or 'failed to do what was normally expected' of them because of drinking (18%) at least once in the previous year.

Alcohol as a principal drug of concern

- Alcohol was the most common principal drug of concern for which treatment was sought in 2007–08, accounting for 44% of episodes (Table 4.3).
- When all drugs of concern are considered (that is, the principal drug of concern and all other drugs of concern nominated by the client), 60% of treatment episodes included alcohol in 2007–08 (Figure 4.2).
- Alcohol has been the most common principal drug of concern reported since the inception of collection in 2001–02 (Table 4.2).

Of the 65,702 closed treatment episodes where alcohol was nominated as the principal drug of concern:

Client profile (Table A3.8)

- The majority (69%) of episodes were for male clients.
- The median age of persons receiving treatment was 36 years (males 36 years; females 37 years).
- Clients aged 30–39 years accounted for the greatest proportion of episodes (28%), followed by clients aged 40–49 years (24%) and those aged 20–29 years (23%). These proportions are almost unchanged from the previous year.
- 13% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (38%) followed by referral from a correctional service and 'other' source (11% each). 'Correctional services' generally include prisons and community services, such as parole services. Alcohol and other drug treatment services (AODTS) were the referral source for 10% of episodes.

Drug profile (tables A3.9, A3.10 and A3.11)

- 45% of episodes for alcohol included at least one other drug of concern. From these episodes, 45,607 instances of other drugs of concern were recorded (each episode can have up to five other drugs of concern recorded). Of the 45,607 instances of other drugs of concern, 36% were cannabis, 25% nicotine, 14% amphetamines and 6% benzodiazepines.

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[3] A recent drinker is defined as a person who consumed a full serve of alcohol in the last 12 months.

- For those episodes where alcohol was the principal drug of concern, 67% of episodes were for clients who had never injected a substance and 6% identified as current injectors. The 'not stated' proportion was 14% which is similar to the proportion of 'not stated' in the last collection.

Treatment profile (tables A3.12 and A3.14)

- Counselling was the most common main treatment type received (39% of episodes) followed by withdrawal management (19%).
- Treatment was most likely to take place in a non-residential treatment facility (65% of episodes), followed by a residential treatment facility (22%). Treatment was less frequently provided in an outreach setting (9%) or at the home of the client (2%).
- Treatment episodes most often ended because the treatment was completed (61%). The next most common reason for treatment episodes to end was that the client ceased to participate without notifying the service provider (16% of episodes ended this way). For a full list of cessation reasons see Table A3.12.
- Treatment generally lasted around 16 days (median).

Alcohol and young people

Patterns of alcohol use by young people (AIHW 2008b)

Estimates of alcohol use by younger people should be interpreted with caution because of the low prevalence and smaller sample sizes for these age groups.

- In 2007, over two-thirds of those aged 12–15 years (67%) had never consumed a full serve of alcohol.
- Rates of abstinence from drinking alcohol (never had a full serve of alcohol) fell sharply from two-thirds (67%) for those aged 12–15 years to 9% for those aged 18–19 years. The abstinence rate for all Australians aged 12 years and over was 13%.
- In the age group 12–15 years, higher proportions of females than males consumed alcohol daily and weekly. In the age groups 16–17 and 18–19 years, higher proportions of females than males consumed alcohol less than weekly. For all other combinations of age group and rate of alcohol consumption, the proportion of males was higher than that for females.

Young people in treatment for alcohol use (tables A3.6, A3.13, A3.15, A3.21)

- The proportion of closed treatment episodes for young people aged 10–19 years of age, where alcohol was nominated as the principal drug of concern, was 34% in 2007–08 compared with 44% for across all ages.
- Around 8% of main treatments for alcohol were provided to young people under 20 years, with 18–19 year olds accounting for half of the treatment for young people. Of 14–15 year olds in treatment, 41% nominated alcohol and 39% nominated cannabis as their principal drug of concern. In contrast, 16-17 year olds nominated cannabis (46%) then alcohol (34%) as their principal drugs of concern.

- Counselling was the most common treatment type for young people in treatment for alcohol use (34%), which is slightly lower than the national proportion for all ages for this treatment type (39%).
- Young people were least likely to receive rehabilitation as treatment for alcohol use (5%) compared with 8% of the total treatment population. Young people were more likely to receive information and education only for alcohol use (19% of main treatments) compared with other age groups (6%).

4.5 Cannabis

Patterns of use in Australia

Cannabis is the most widely used illicit drug in Australia. According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over:

- One in 11 (9%) had used cannabis at least once in the last 12 months and one in three (34%) had used cannabis at some stage in their lifetime,
- The age group 20–29 years was most likely to have used cannabis in the last 12 months (21%). The age group 30–39 years was more likely to have ever used cannabis (55%) than any other age group.
- Males aged 30–39 years were most likely to have ever used cannabis (57%) and males aged 20–29 years were most likely to have recently used cannabis (26%).
- Males were more likely than females to have used cannabis in the last 12 months (12% and 7% respectively).
- Of those who have ever used cannabis, the average age at which Australians first used cannabis was 19 years.
- 12% of recent cannabis users reported attempting to stop or cut down their use in the previous 12 months.

Cannabis as a principal drug of concern

- Cannabis was the second most common principal drug of concern for which treatment was sought in 2007–08, accounting for 22% of closed treatment episodes (Table 4.3). The proportion of episodes where cannabis was nominated as the principal drug of concern continued to decline in 2007–08 (23% in 2006–07).
- When all drugs of concern are considered (that is, the principal drug of concern and all other drugs of concern nominated by the client), 44% of episodes included cannabis as a drug of concern (Figure 4.2).

Of the 31,864 closed treatment episodes where cannabis was nominated as the principal drug of concern:

Client profile (Table A3.8)

- The majority (70%) of episodes were for male clients. This is the same as for the last collection period.
- The median age of those in treatment for cannabis use was 26 years (25 years for males and 26 years for females).
- Clients aged 20–29 years continued to account for the greatest proportion of episodes (41%). Clients aged 10–19 years and 30–39 years each accounted for more than one in five treatment episodes.
- 11% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (26% of episodes). Referrals from police diversion and court diversion rose from 17 %to 19% and 11% to 14% respectively.

Drug profile (tables A3.9, A3.10 and A3.11)

- Smoking was the most common method of use (91% of episodes), followed by inhaling vapour (4%). Around 2% of episodes were for people who ingested cannabis.
- 60% of episodes included at least one other drug of concern in addition to cannabis. From these episodes, 32,566 instances of other drugs of concern were recorded (clients can report up to five other drugs of concern).
- Of the 32,566 instances of other drugs of concern, most were for alcohol (36%). Nicotine was the next most common (21%), then amphetamines (19%) and ecstasy (8%).
- As in the previous reporting period, the majority of episodes involved clients who reported never injecting drugs (61%). Eight per cent of episodes involved clients who reported being current injectors, and 18% involved clients who reported they had injected drugs in the past. Caution should be used, however, when interpreting data for 'injecting drug use' because of the high 'not stated' response for this item (13% of treatment episodes).

Treatment profile (tables A3.12 and A3.14)

- Counselling was the most common main treatment type received (33% of episodes). Information and education only made up 26% of episodes followed by withdrawal management (12%).
- Treatment was most likely to take place in a non-residential treatment facility (70% of episodes), followed by an outreach setting (13%) and residential treatment facility (12%).
- Almost half (47%) of treatment episodes ended because the treatment was completed. The next most common reason for treatment episodes to end was that the client ceased to participate at expiation—that is, where the client had completed a treatment program as a requirement of police/court diversion (23% of episodes ended this way). About 14% of episodes ended because the client ceased to participate in treatment without notifying the treatment provider.
- The median number of days for a treatment episode decreased from 13 days in 2006–07 to 12 days in 2007–08.

4.6 Amphetamines

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over:

- 6% had used amphetamines[4] for non-medical purposes at some stage in their lifetime, and less than 3% had used them in the previous 12 months.
- The age group most likely to have ever used amphetamines was 20–29 years (16%). This same group was also most likely to have used amphetamines in the previous 12 months (7%).
- Males were more likely than females to have used amphetamines in the 12 months before the survey. About half of males aged 20–29 years of age who had ever used amphetamines (18%) had used them in the previous year (10%).
- Of those who had ever used amphetamines, the average age of first use was 20.9 years.
- 13% of recent amphetamine users reported attempting to stop or cut down their use in the previous year.

Amphetamines as the principal drug of concern

- Amphetamines were the third most common principal drug of concern for which treatment was sought in 2007–08, accounting for 11% of episodes (Table 4.3).
- When all types of opioids are combined (methadone, morphine, heroin and other opioids) they account for more episodes than amphetamines. However, no single opioid outnumbered amphetamines.
- When all drugs of concern are considered (that is, the principal drug of concern and all other drugs of concern nominated by the client), 24% of treatment episodes included amphetamines as a drug of concern in 2007–08 (Figure 4.2).
- There was a sharp fall in heroin as the principal drug of concern between 2004–05 and 2005–06 and a corresponding rise in treatment for amphetamine use (Table A4.2).

In 2007–08, of the 16,588 closed treatment episodes where amphetamines were nominated as the principal drug of concern:

Client profile (Table A3.8)

- Over two-thirds of episodes were for male clients (68%).
- The median age of persons receiving treatment was 29 years (males 29 years; females 28 years).
- Persons aged 20–29 years accounted for the greatest proportion of episodes (44%), followed by persons aged 30–39 years (35%).

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4 The 2007 NDSHS refers to this group of drugs as meth/amphetamines. Similarly, within this report, the term 'amphetamines' includes those drugs that are referred to as methamphetamines, such as ice, crystal and speed.

- 9% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Most people referred themselves to treatment (35%). About 26% of episodes were initiated by a court diversion program or correctional service (13% each), and referrals from other alcohol and drug treatment services fell two percentage points to just over 8% compared with the previous collection period.

Drug profile (tables A3.9, A3.10 and A3.11)

- Though injecting was the most commonly reported method of use, this behaviour fell three percentage points to 66% of episodes. Smoking was the next most common method of use and increased three percentage points to 17% whereas ingestion remained stable at 11% of episodes. There has also been a small increase in inhaling vapour as the method of use for amphetamines, which indicates a shift to methods of use with a lower degree of associated risk (0.8% to 1.0%).
- 66% of episodes included at least one other drug of concern in addition to amphetamines. From these episodes, 21,028 instances of other drugs of concern were recorded (clients can report up to five other drugs of concern).
- Of the 21,028 instances of other drugs of concern, 33% were for cannabis, 22% alcohol, and 10% for nicotine.
- Over half of episodes involved clients who reported being current injectors (51%). This is a decline of seven percentage points from 2006–07. There was an increase of three percentage points in treatment episodes for clients who reported they had injected drugs in the past (21%) and a two percentage point increase for clients who had never injected drugs (21%).

Treatment profile (tables A3.12 and A3.14)

- Counselling was the most common main treatment type received (42% of episodes), followed by assessment only (17%) and rehabilitation (14%). This is similar to the previous year where assessment constituted 18% of treatments provided for amphetamine use.
- Treatment was most likely to take place in a non-residential treatment facility (70% of episodes), followed by a residential treatment facility (18%).
- Around half of all episodes ended because treatment was completed. The next most common reason treatment ended (21%) was because the client ceased to participate without notifying the service provider.
- There was an increase of 5 days in the median number of days in treatment from 18 in 2006–07 to 23 in 2007–08.

4.7 Heroin

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over:

- Less than 2% (0.3 million) had used heroin in their lifetime. Less than 1% had used heroin in the 12 months before the survey.
- More males than females had used heroin in their lifetime (2% compared with 1%).
- Persons in the 30–39 years age group were most likely to have used heroin in their lifetime (less than 3% each), and persons in the 20–29 years age group were most likely to have used heroin in the previous 12 months (less than 1%).
- The average age at which Australians first used heroin was 21.9 years of age.
- 61% of recent heroin users reported attempting to stop or cut down their use in the previous 12 months.

Heroin as a principal drug of concern

- Heroin was the fourth most common principal drug of concern for which treatment was sought in 2007–08, accounting for 11% of closed treatment episodes (Table 4.3).
- When all drugs of concern are considered (that is, the principal drug of concern and all other drugs of concern nominated by the clients), 14% of treatment episodes included heroin as a drug of concern (Figure 4.2).

Of the 15,571 closed treatment episodes where heroin was nominated as the principal drug of concern:

Client profile (Table A3.8)

- The majority (66%) of episodes were for male clients.
- The median age of persons receiving treatment was 31 years (males 32 years; females 29 years).
- Clients aged 20–29 years accounted for the greatest proportion of episodes (40%), followed by those aged 30–39 years (38%) and those aged 40–49 years (15%).
- 7% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (43% of episodes), as it was for most drug types. About 13% of referrals were from alcohol and other drug treatment services and 12% from correctional services.

Drug profile (Tables A3.9, A3.10 and A3.11)

- Injecting was the most common method of use (91% of episodes). In 5% of episodes, people reported that they most often smoked their heroin.

- 10,366 episodes (or 67%) included at least one other drug of concern. From these episodes, 20,653 instances of other drugs of concern were recorded (clients can report up to five other drugs of concern).
- Of the 20,653 instances of other drugs of concern, 25% were for cannabis and 19% for amphetamines.
- The majority (62%) of episodes involved clients who reported being current injectors, and 28% involved clients who reported they had injected drugs in the past.
- Only 4% of episodes involved clients who reported never having injected drugs, which is similar to the proportion in the last reporting period.

Treatment profile (Tables A3.12 and A3.14)

- Counselling was the most common main treatment type received (29% of episodes); 23% of episodes were withdrawal management (detoxification), and 16% were assessment only.
- Most treatment took place in either non-residential treatment facilities (69%) followed by residential treatment facilities (22%).
- About 53% of episodes ended because the treatment was completed. The next most common reason treatment ended was because the client ceased to participate without notifying the service provider (17%).
- Heroin continues to have the longest treatment duration with a median number of 29 treatment days.

4.8 Benzodiazepines

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over:

- Less than 2% reported using benzodiazepines such as tranquillisers or sleeping pills in the previous 12 months for non-medical purposes. People aged 20–29 years were most likely to use benzodiazepines (3%).
- There was very little overall difference in the prevalence of recent use of tranquillisers or sleeping pills between males and females.

Benzodiazepines as a principal drug of concern

- Benzodiazepines as a principal drug of concern accounted for relatively few treatment episodes at less than 2% of closed treatment episodes in 2007–08 (Table 4.3).
- When all drugs of concern are considered (that is, the principal drug of concern and all other drugs of concern nominated by the client), 8% of treatment episodes included benzodiazepines as a drug of concern (Figure 4.2).

- The proportion of treatment episodes where benzodiazepines were reported as the principal drug of concern has remained stable since 2001–02 at approximately 2% (Table 4.2).

Of the 2,487 closed treatment episodes where benzodiazepines where nominated as the principal drug of concern:

Client profile (Table A3.8)

- Unlike the majority of other drug types, the majority (52%) of episodes were for female clients.
- The median age of persons receiving treatment was 35 years (males 35 years; females 36 years).
- Clients aged 30–39 years accounted for the greatest proportion of episodes (37%). Clients aged 20–29 years and 40–49 years accounted for 25% and 22% respectively.
- 5% of episodes were for clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (41% of episodes), followed by referrals from a medical practitioner (13%). Alcohol and other drug treatment services made up 12% of referrals. Medical practitioners were the referral source for a greater proportion of benzodiazepine episodes than any other drug type (apart from 'other' opioids and methadone).

Drug profile (tables A3.9, A3.10 and A3.11)

- Most clients (94%) reported ingesting benzodiazepines; however, 4% said they injected them.
- 66% included at least one other drug of concern in addition to benzodiazepines. From these episodes, 2,926 instances of other drugs of concern were recorded (clients can report up to five other drugs of concern).
- Where other drugs of concern were reported (2,926 instances), 21% of records were for alcohol, 19% cannabis, and 12% each for amphetamines and nicotine.
- Given that most people reported ingesting benzodiazepines, it is interesting that 49% stated that they were current or former injectors of drugs. Care should be taken, however, when interpreting data for 'injecting drug use' because of the high 'not stated' response for this item (14% of episodes).

Treatment profile (tables A3.12 and A3.14)

- Withdrawal management (detoxification) was the most common main treatment type received (32% of episodes), the highest proportion of this treatment type for all drug types. Counselling (30%) was the next most common treatment provided, followed by assessment only (14%).
- Treatment was most likely to take place in a non-residential treatment facility (63% of episodes). Treatment in a residential treatment facility rose six percentage points to 26% in this reporting period.

- The majority (59%) of episodes ended because treatment was completed. The next most common reason for treatment episodes to end was ceasing to participate without notice (12%).
- The median number of days for a treatment episode fell by 2 days to 18 days in 2007–08.

4.9 Ecstasy

Patterns of use in Australia

Following cannabis, ecstasy is the second most widely used illicit drug in Australia. According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over:

- 9% had used ecstasy at some stage in their lifetime, and less than 4% had used it in the previous 12 months.
- The age group most likely to have ever used ecstasy was the 20–29 years age group (24%). Persons aged 20–29 years were also most likely to have used ecstasy within the previous 12 months (11%). One in seven (14%) males aged 20–29 years had used ecstasy in the previous 12 months.
- Overall, males were more likely than females to have used ecstasy in the previous 12 months.
- Of those who had ever used ecstasy, the average age of first use was 22.6 years.
- Less than 1% of recent ecstasy users reported attempting to stop or cut down their use in the previous 12 months.

Ecstasy as a principal drug of concern

- Ecstasy as a principal drug of concern accounted for less than 1% of closed treatment episodes in 2007–08 (Table 4.3).
- When all drugs of concern are considered (that is, the principal drug of concern and all other drugs of concern nominated by the client), 6% of treatment episodes included ecstasy as a drug of concern (Figure 4.2).
- The proportion of episodes where ecstasy was reported as the principal drug of concern has increased since 2001–02, but remained relatively minor at less than 1% of treatment episodes (Table 4.2).

Of the 1,321 closed treatment episodes where ecstasy was nominated as the principal drug of concern:

Client profile (Table A3.8)

- The majority (76%) of episodes were for male clients.
- People seeking treatment for ecstasy tended to be younger than those seeking treatment for other drugs. The median age for ecstasy-related episodes was 21 years (males 22 years; females 21 years).

- Not surprisingly then, people aged 20–29 years accounted for the greatest proportion of episodes (60%), followed by people aged 10–19 years (27%).
- 4% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Ecstasy-related episodes had a relatively low rate of self-referrals (17%) compared with other drug types. More episodes were initiated by a referral from a diversion program (56%), including police and court-based diversion. This is a six percentage point increase from the previous year.

Drug profile (tables A3.9, A3.10 and A3.11)

- Ingestion was the most common method of use (91% of episodes). Other methods reported were injecting (3%), smoking (2%) and sniffing (1%) ecstasy. (Note that in 3% of episodes method of use was not stated.)
- 63% of episodes included at least one other drug of concern in addition to ecstasy. From these episodes, 1,558 instances of other drugs of concern were recorded (clients can report up to five other drugs of concern).
- Of the 1,558 instances of other drugs of concern, 33% were alcohol, 24% cannabis and 20% amphetamines.
- The majority (79%) of episodes involved clients who reported never having injected drugs; 12% of episodes involved current or former injectors; 9% of episodes did not record an 'injecting drug use status' for the client.

Treatment profile (tables A3.12 and A3.14)

- Counselling was the most common main treatment type received (37% of episodes). Information and education only rose to 35% (27% 2006–07) and assessment only accounted for 10%.
- Treatment was most likely to take place in a non-residential treatment facility (80% of episodes), followed by an outreach setting (13%).
- Around 43% of episodes ended because the treatment was completed. The next most common reason for treatment episodes to end was that the client ceased to participate at expiation (35%) —that is, where the client had completed a treatment program as a requirement of a diversion program.
- Ecstasy-related treatment episodes remained the shortest and the median duration halved in this collection period to 4 days.

4.10 Cocaine

Patterns of use in Australia

According to the 2007 NDSHS (AIHW 2008b, 2008c), of Australians aged 14 years and over:

- 6% had used cocaine at some stage in their lifetime, and less than 2% reported using cocaine in the previous 12 months.

- The 20–29 years age group had the highest proportion (12%) of persons ever using cocaine compared with all other age groups. Similarly, the 20–29 years age group had the highest proportion (5%) of persons who had recently used cocaine.
- Overall, males were more likely than females to have recently used cocaine.
- The average age at which Australians used cocaine for the first time was 23.1 years.
- Few cocaine users reported attempting to stop or cut down their use in the previous 12 months (3%).

Cocaine as a principal drug of concern

- Cocaine as a principal drug of concern again accounted for a very small proportion of episodes in 2007–08 (less than 1% or 457 of 147,721 episodes) (Table 4.3).
- When all drugs of concern are considered, around 2% of treatment episodes included cocaine as a drug of concern (Figure 4.2).

Of the 457 episodes where cocaine was nominated as the principal drug of concern:

Client profile (Table A3.8)

- The majority (71%) of episodes were for male clients.
- The median age of persons receiving treatment was 30 years (males 30 years; females 28 years).
- Clients aged 20–29 years accounted for 42% of treatment episodes and clients aged 30–39 years accounted for 38%.
- 6% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (42% of episodes). Court diversion was the referral source for 12% of episodes and correctional services 10%. Referrals from family and friends fell from being the second most common in 2006–07 (12%) to 7% in this collection period.

Drug profile (tables A3.9, A3.10 and A3.11)

- Sniffing cocaine as a powder was the most common method of use (46% of episodes), followed by injecting (29%) and smoking (15%).
- 69% of episodes included at least one other drug of concern in addition to cocaine. From these episodes, 602 instances of other drugs of concern were recorded (clients can report up to five other drugs of concern).
- Of the 602 instances of other drugs of concern, 20% were for alcohol, 18% each for amphetamines and cannabis.
- Just under one-third (29%) of episodes involved clients who were current injectors; 46% involved clients who reported never injecting drugs. There was a 10% 'not stated' response for injecting drug use.

Treatment profile (Tables A3.12 and A3.14)

- Counselling was the most common main treatment received (44% of episodes), followed by assessment only (15%) and withdrawal management (detoxification) (13%).
- Treatment was most likely to take place in a non-residential treatment facility (75% of episodes), or a residential treatment facility (20%).
- The majority (58%) of episodes ended because the treatment was completed. The next most common reason for episodes to end (20%) was that the client ceased to participate without notifying the service provider.
- The median number of days for an episode rose to 22 days from 17 in 2006–07.

5 Treatment programs

Treatment programs consist of the main treatment type received by a client together with any additional treatments received from the same service.

Data presented in this chapter generally relate to all episodes, including those for people seeking treatment in relation to someone else's drug use. The one exception is in relation to data about principal drug of concern. As people seeking treatment in relation to someone else's drug use are not asked to identify the other person's drug of concern, these clients are not included in those data relating to drugs of concern.

Box 5.1: Key definitions and counts for treatment programs, 2007–08

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. In 2007–08 the main treatment type was reported for all* ***153,998*** *episodes.*

Some caution should be used when comparing main treatment types over time and between jurisdictions. For example, caution is required when comparing the number of closed treatment episodes for main treatment type from the collection periods 2002–03 to 2007–08 with those of 2001–02. In 2001–02, records from South Australia were excluded from tables using main treatment type because South Australia did not provide this data item. In 2007–08, as in previous years, Victoria did not differentiate between main and other treatment types. Victoria is not directly comparable with other jurisdictions because every treatment type provided to a client is reported as a separate episode.

Other treatment type *refers to two separate things 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. In 2007–08 there were 11,089 treatment episodes featuring 'other treatment types' as the main treatment provided. 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. In 2007–08, there were 17,893 closed treatment episodes that included at least one additional treatment type. (Note that Victoria is excluded from analyses of additional treatment types.)*

All treatment types *refers to all treatments reported by agencies as taking place during the collection period, including the main and additional treatments. In 2007–08, there were a total of* ***174,856*** *treatments reported.*

5.1 Main treatment

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 useful to keep in mind that several 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. It is also 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.

Trends in main treatment

Nationally, counselling has been the most common main treatment type in each year of the collection, accounting for more than 37% of episodes each year (Table 5.1). Furthermore, the same treatment types tend to be reported in similar proportions each year. Withdrawal management (detoxification) has consistently been reported as around 16–19% of main treatments; assessment only as 12–15% of main treatments. The remaining treatment types each made up less than 10% of treatments provided each year.

In 2007–08, the most notable change in main treatments provided was in the 'other' treatment category. Other main treatment types are those that do not fall into the first six categories listed in Table 5.1 but are still within the scope of the collection (see section 1.3 for further information about the collection's scope).

Other types of treatment made up around 7% of main treatments provided in 2007–08 as compared with around 5% in 2006–07. The number of pharmacotherapy episodes included in 'other' has remained similar, so the increase in other episodes is due to an increase in non-pharmacotherapy treatments.

Table 5.1: Trends in main treatment type, 2001–02 to 2007–08

Main treatment type	2001–02[(a)]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
				(per cent)			
Withdrawal management (detoxification)	19.1	18.9	18.4	17.9	17.1	16.6	16.2
Counselling	38.9	41.5	37.6	40.2	37.8	38.7	37.3
Rehabilitation	6.3	7.5	8.6	7.7	7.5	7.4	7.2
Support and case management only	6.1	6.9	8.4	7.9	8.2	8.3	8.0
Information and education only	9.8	8.0	7.6	8.9	9.7	9.3	9.8
Assessment only	14.6	12.7	14.9	12.4	15.3	15.1	14.3
Other[(b)]	5.1	4.4	4.5	5.0	4.4	4.5	7.2
Total	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**

continued

Table 5.1 (continued): Trends in main treatment type, 2001–02 to 2007–08

Main treatment type	2001–02[a]	2002–03	2003–04	2004–05	2005–06	2006–07	2007–08
				(number)			
Withdrawal management (detoxification)	21,744	24,767	25,123	25,458	25,828	24,467	24,999
Counselling	44,184	54,395	51,514	57,076	57,277	57,017	57,470
Rehabilitation	7,195	9,865	11,717	10,959	11,331	10,950	11,099
Support and case management only	6,951	9,097	11,494	11,240	12,417	12,290	12,279
Information and education only	11,197	10,478	10,465	12,609	14,655	13,723	15,086
Assessment only	16,647	16,632	20,414	17,663	23,125	22,295	21,976
Other[b]	5,787	5,696	6,142	7,139	6,729	6,583	11,089
Total	**113,705**	**130,930**	**136,869**	**142,144**	**151,362**	**147,325**	**153,998**

(a) Excludes South Australia.

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

Main treatment types across Australia

Although there has not been much variation in the treatment types provided at the national level over time, there was some variation in the types of treatment provided in states and territories as shown in Table 5.2 relating to the 2007–08 year.

- Around half of treatment episodes in Victoria, Western Australia and Tasmania were for counselling.
- There was a large variation in the proportion of episodes provided as information and education only, from less than 1% in Victoria to 46% in Queensland.
- Most states and territories reported that 90% of their episodes met one of the defined treatment types in the NMDS. The Northern Territory and New South Wales had higher proportions of 'other' main treatments. In New South Wales, this was related to a growing number of outreach services to hospital in-patients.

Table 5.2: Main treatment type by jurisdiction, 2007–08

Main treatment type	NSW[(a)]	Vic[(b)]	Qld[(c)]	WA	SA	Tas[(d)]	ACT[(e)]	NT	Australia	Total (no.)
Withdrawal management (detoxification)	19.7	21.4	5.4	10.6	18.9	1.4	21.1	14.7	16.2	24,999
Counselling	29.1	46.8	27.1	54.6	26.4	53.6	28.5	20.7	37.3	57,470
Rehabilitation	8.8	3.9	2.2	14.5	16.2	4.3	6.2	11.5	7.2	11,099
Support and case management only	8.4	13.4	3.8	3.0	0.9	3.8	10.3	6.6	8.0	12,279
Information and education only	1.2	0.8	46.4	2.7	2.0	25.5	8.2	3.3	9.8	15,086
Assessment only	16.2	10.5	12.5	10.3	29.8	11.3	18.8	32.9	14.3	21,976
Other[(f)]	16.5	3.0	2.6	4.4	5.8	0.1	7.0	10.3	7.2	11,089
Total (per cent)	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**100.0**	**..**
Total (number)	**42,078**	**47,538**	**26,895**	**18,705**	**9,030**	**2,302**	**3,738**	**3,712**	**..**	**153,998**

(a) In NSW, the 'Other' category includes outreach services provided to hospital patients by community-based alcohol and other drug treatment agencies. These 'consultation liaison' activities were excluded from the data in 2006–07. Consultation liaison was included in earlier years of the collection but has increased substantially in 2007–08.

(b) The number of closed treatment episodes for Victoria may not be directly comparable to other jurisdictions because Victoria does not differentiate between main and other treatment types. All treatment provided is reported as a unique episode against main treatment type, regardless of whether it was judged to be the principal activity necessary for completion of a treatment plan.

(c) The total number of closed treatment episodes for Queensland may be under-counted because of the exclusion of a number of non-government agencies.

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

(e) The number of closed treatment episodes for assessment only in the Australian Capital Territory has decreased since 2006–07 because of a review of the reporting practices of one agency.

(f) 'Other' includes 3,178 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

Indigenous status and treatment programs

- Episodes involving Indigenous clients were most likely to involve counselling (35%), followed by assessment only (18%), withdrawal management (detoxification) (12%) and information and education only (11%) (Table 5.3).
- Similar to 2006–07, Indigenous clients received counselling at a similar rate to non-Indigenous clients, but were less likely to receive withdrawal management (detoxification) as a main treatment (12% of treatment episodes) compared with non-Indigenous people (17%).
- Treatment episodes involving Indigenous clients were more likely to involve assessment only (18%) as the main treatment type, compared with 14% of episodes for non-Indigenous clients.
- Overall, the differences in service patterns between Indigenous and non-Indigenous clients are similar to those found in the 2006–07 collection.
- For more information about alcohol and other drug treatment provided to Indigenous people in services not included in the AODTS–NMDS see Appendix 6.

Table 5.3: Main treatment type by Indigenous status, 2007–08

	Indigenous		Non-Indigenous		Not stated		Total	
Main treatment type	**No.**	**Per cent**	**No.**	**Per cent**	**No.**	**Per cent**	**No.**	**Per cent**
Withdrawal management (detoxification)	2,037	12.4	21,776	16.7	1,186	15.7	24,999	16.2
Counselling	5,758	35.0	48,633	37.4	3,079	40.8	57,470	37.3
Rehabilitation	1,451	8.8	9,433	7.3	215	2.9	11,099	7.2
Support and case management only	1,369	8.3	10,321	7.9	589	7.8	12,279	8.0
Information and education only	1,843	11.2	12,581	9.7	662	8.8	15,086	9.8
Assessment only	2,893	17.6	17,721	13.6	1,362	18.1	21,976	14.3
Other[(a)]	1,089	6.6	9,550	7.3	450	6.0	11,089	7.2
Total	**16,440**	**100.0**	**130,015**	**100.0**	**7,543**	**100.0**	**153,998**	**100.0**
Per cent of closed treatment episodes	**10.7**	**. .**	**84.4**	**. .**	**4.9**	**. .**	**100.0**	**. .**

(a) 'Other' includes 3,178 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.10).

5.2 Additional treatments

This section looks at the main treatment recorded for clients together with additional treatment types that were provided. As such it provides information about the provision of multiple treatment types, in the same episode, by the same agency. As in previous years, Victorian data have been excluded from these analyses as Victoria counts each treatment separately.

The provision of more than one type of treatment during an episode occurs for several reasons. Some agencies provide complementary treatments such as withdrawal management (detoxification) and counselling. In other agencies, participation in a variety of treatments may be a requirement for clients, for example, rehabilitation programs where individual, group or family counselling is part of the treatment. This may be reported as rehabilitation as the main treatment and counselling as the additional treatment.

- Of the 106,460 episodes in 2007–08 (excluding Victoria), 17,893 episodes (17%) reported at least one other treatment type—that is, a main treatment type and at least one additional treatment type (Table 5.4).
- Withdrawal management (detoxification) was the main treatment most likely to be provided together with another treatment type—43% of episodes included at least one additional treatment type
- Similarly 35% of rehabilitation episodes included at least one additional treatment type.
- Counselling was most often a stand-alone treatment, with only 12% of episodes including an additional treatment.

- By definition, 'support and case management only', 'information and education only' and 'assessment only' are all stand-alone treatments. Appropriately, then, no additional treatments were reported for these treatments.

Table 5.4: Main treatment type, with or without additional treatment types, Australia[(a)], 2007–08

Main treatment	With additional treatment	With no additional treatment	Total episodes	Proportion of episodes with additional treatment
Withdrawal management (detoxification)	6,344	8,461	14,805	42.9
Counselling	4,170	31,031	35,201	11.8
Rehabilitation	3,200	6,031	9,231	34.7
Support and case management only	—	5,914	5,914	—
Information and education only	—	14,684	14,684	—
Assessment only	—	16,984	16,984	—
Other[(b)]	4,179	5,462	9,641	43.3
Total	**17,893**	**88,567**	**106,460**	**16.8**

(a) Excludes 47,538 closed treatment episodes from Victoria as this jurisdiction does not provide data for 'other treatment types' separately, but instead reports each treatment provided as a main treatment type in unique episodes.

(b) 'Other' includes 3,178 closed treatment episodes where the main treatment was reported as pharmacotherapy. This represents a small proportion of pharmacotherapy treatment in Australia as agencies whose sole activity is to prescribe and/or dose for methadone or other opioid pharmacotherapies are currently excluded from the AODTS–NMDS (see also Section 5.9).

5.3 Counselling

What is counselling?

'Counselling' is one type of service that is provided by alcohol and other drug treatment agencies. There are many different types of counselling provided to individuals, groups or families—at an agency, at the client's home or over the phone. The number of counselling sessions provided can vary considerably among clients. Counselling can be provided by a doctor, social worker, psychologist, specialist drug and alcohol worker, generalist welfare worker or other worker.

There are many types of counselling but they can all be described as '… a joint endeavour between the counsellor and client involving the development of a therapeutic relationship with treatment plans and goals negotiated and agreed upon, by both parties' (Dale & Marsh 2000). Counselling approaches frequently used in the alcohol and other drug field include cognitive behavioural therapy which, among other things, builds skills to deal with lapses; and motivational interviewing, which aims to assist ambivalent clients by exploring both the 'good and not so good' aspects of their drug use. Other counselling approaches such as narrative therapy may also be used, particularly when they may be more appropriate for particular populations (Bacon 2007).

Counselling as a main treatment

- Counselling was the most common main treatment provided in 2007–08, accounting for 37% of episodes (Table 5.2).
- Since 2001–02, counselling has consistently been the most common main treatment type reported in the AODTS–NMDS. The proportion of treatment episodes where counselling was reported as the main treatment has fluctuated over this time between 37% and 42% of episodes (Table 5.1).

In 2007–08, of the 57,470 closed treatment episodes where counselling was nominated as the main treatment:

Client profile (Table A3.19)

- 92% of episodes were for clients seeking treatment for their own drug use. Counselling was the treatment most likely to be provided to people seeking treatment related to someone else's drug use.
- The majority (64%) of episodes were for male clients.
- The median age of persons receiving treatment was 33 years (males 32 years; females 34 years).
- People in their 20s and 30s accounted for the largest proportion of episodes (both 30%), followed by people aged 40–49 years (19%).
- 10% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (40% of episodes), followed by 'other' referral sources (14%), referrals from alcohol and other drug treatment services and from correctional services (8% each).

Treatment profile (tables A3.20 and A3.22)

- Counselling was most likely to occur in a non-residential treatment facility (94% of episodes), rather than at the client's home (1%), an outreach setting (4%) or a residential treatment facility (less than 1%).
- The majority (52%) of episodes were reported to have ended because the treatment was completed. The next most common reason for ending a treatment episode (26%) was that the client ceased to participate with notifying the service provider.
- Counselling episodes were longer than most other treatment types, at a median length of 47 days. Support and case management only was the only other treatment that took place over a longer period.

Principal drug profile (Table A3.23)

Of the 52,697 episodes in 2007–08 where counselling was nominated as the main treatment and the client was seeking treatment for their own drug use:

- Alcohol was the most common principal drug of concern reported (49% of episodes), followed by cannabis (20%), amphetamines (13%) and heroin (9%).

5.4 Withdrawal management (detoxification)

What is withdrawal management?

'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 substances 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.

Withdrawal management as a main treatment

- Withdrawal management was the second most common main treatment type provided in 2007–08, accounting for 16% of episodes (Table 5.2).
- Since 2001–02, withdrawal management has consistently been the second most common 'main' treatment reported in the AODTS–NMDS. Over this time, the proportion of treatment episodes where withdrawal management (detoxification) was reported as the main treatment has remained between 16% and 19% (Table 5.1).

In 2007–08, of the 24,999 episodes where withdrawal management was nominated as the main treatment received:

Client profile (Table A3.19)

- The majority (65%) of episodes were for male clients.
- The median age of clients receiving treatment was 35 years (males 36 years; females 35 years).
- People participating in withdrawal management were most likely to be aged in the 30–39 years age group (32%), followed by people aged 20–29 years (25%).
- 8% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Self-referral was the most common source of referral (53% of episodes);14%of withdrawal management referrals came from alcohol and other drug treatment services.

Treatment profile (tables A3.20 and A3.22)

- Treatment was most likely to occur in a residential treatment facility (60% of episodes). However, 29% of episodes were also provided via a non-residential setting, and over 8% at the home of the client.
- The majority (65%) of episodes were reported to have ended because the treatment was completed. The next most common reasons for ending a treatment episode were that the client ceased to participate against advice or without notice (around 11% each).
- The median duration of a treatment episode was the same as 2006–07 at 8 days.

Principal drug profile (Table A3.23)

Of the 24,999 closed treatment episodes in 2007–08 where withdrawal management was nominated as the main treatment type:

- Alcohol was the most common principal drug of concern reported (49% of episodes), followed by cannabis (15%) and heroin (14%).

5.5 Assessment only

What is assessment only?

Assessment forms part of most treatments in alcohol and other drug treatment services. The process of assessment identifies the nature of the drug issue, the client's needs (which form the basis of the treatment plan) and which treatment would be most appropriate for the client. 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 can be many parts to assessment including gathering a detailed history of the client's drug use, current and past medical and psychiatric treatments; family and social history; and screening of blood or urine (Kleber et al. 2007).

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

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/territories and comparison of data nationally and across jurisdictions should be made with caution.

Assessment only as a main treatment type

- Assessment only was the third most common main treatment provided in 2007–08, accounting for 14% of closed treatment episodes (Table 5.2).
- Since 2001–02, assessment only has consistently been the third most common main treatment reported in the AODTS–NMDS at between 12–15% of episodes (Table 5.1).

In 2007–08, of the 21,976 episodes where assessment only was nominated as the main treatment received:

Client profile (Table A3.19)

- Almost all (99%) episodes were for clients seeking treatment for their own drug use.
- The majority (74%) of episodes were for male clients.
- The median age of persons receiving treatment was 32 years (32 years for both males and females).
- Persons aged 20–29 years accounted for the greatest proportion of episodes (35%), followed by persons aged 30–39 years (32%).
- 13% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- People most often were referred by a correctional service (32%) or referred themselves (29%).

Treatment profile (tables A3.20 and A3.22)

- Treatment was most likely to occur in a non-residential treatment facility (84% of episodes), followed by an outreach setting (9%).
- The majority (82%) of episodes were reported to have ended because the treatment was completed. The next most common reason reported for ending an episode (8%) was that the client ceased to participate without notifying the service provider.
- Assessment only episodes usually took place over 2 days compared with 1 day in 2006–07.

Principal drug profile (Table 3.23)

Of the episodes in 2007–08 where assessment only was nominated as the main treatment and the client was seeking treatment for their own drug use:

- Alcohol was the most common principal drug of concern reported (50% of episodes), followed by cannabis (15%) and amphetamines (13%).

5.6 Information and education only

What is information and education only?

'Drug education is teaching and communicating to help people avoid harm caused by the abuse of various drugs' (Wilson & Kolander 2003). Often education focuses on preventing drug use by young people; however, it can be used in a variety of settings with a range of people.

An 'information and education only' episode in the AODTS–NMDS can be delivered to an individual or group. Group information and education is included in the AODTS–NMDS data if the individuals involved are registered clients of a treatment agency. An open information session for the general public is not included.

An example of group education is a workshop on the health and legal effects of cannabis use. Individual education may take the form of a brief face-to-face session with a counsellor incorporating verbal and written information about drug-related harms.

Information and education only as a main treatment

- Information and education only was the fourth most common main treatment provided in 2007–08, accounting for 10% of episodes (Table 5.2).
- Since 2001–02, information and education only has been the fourth most common main treatment reported in the AODTS–NMDS (with the exception of the 2003–04 collection period where it was the sixth most common main treatment). Over this time, the proportion of episodes where information and education only was reported as the main treatment has remained steady at between 8% and 10% (Table 5.1).

In 2007–08, of the 15,086 episodes where information and education only was nominated as the main treatment received:

Client profile (Table A3.19)

- 97% were for clients seeking treatment for their own drug use.
- The majority (72%) of episodes were for male clients.
- The median age of persons who received treatment was younger than the median age for all treatment types (25 years compared with 32 years). Males receiving information and education had a median age of 25 years; females 26 years.
- Persons aged 20–29 years accounted for the largest proportion of episodes (38%), followed by persons aged 10–19 years (25%).
- 12% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- Police and court diversion programs were the most common sources of referral (46% and 27% of episodes respectively). Information and education had the lowest rate of self-referral (14%).

Treatment profile (tables A3.20 and A3.22)

- Treatment was most likely to occur in a non-residential treatment facility (71% of episodes), followed by an outreach setting (24%).
- Two-thirds of episodes were reported to have ended because the client expiated their offence—that is, the client had completed an education or information program as a requirement of a diversion program. The next most common reason for episodes to end (19%) was because the treatment was completed.
- Information and education only was likely to be delivered on a single day, rather than over a period of time or a number of sessions (the median number of days for a treatment episode was 1).

Principal drug profile (Table A3.23)

For clients who received information or education only about their own drug use:

- Cannabis was the most common principal drug of concern reported (57% of episodes), followed by alcohol (22%).

5.7 Support and case management only

What is support and case management only?

'Support and case management only' 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. So, for example, supportive contact with a client that does not meet the definition of information and education 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'. The functions of case management 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 some counselling by the case manager (Vanderplasschen et al. 2007).

Support and case management only as a main treatment type

- Support and case management only as the main treatment accounted for 8% of closed treatment episodes in 2007–08 (Table 5.2).
- The proportion of episodes where support and case management only was reported as the main treatment increased from 6% in 2001–02 to 8% in 2003–04, and has since remained relatively stable at approximately 8% (Table 5.1).

In 2007–08, of the 12,279 episodes where support and case management only was nominated as the main treatment provided:

Client profile (Table A3.19)

- 94% were for clients seeking treatment for their own drug use; 6% for people seeking treatment related to someone else's drug use.
- The majority (63%) of episodes were for male clients.

- The median age of persons receiving support and case management only was the youngest of all treatment types: 24 years (males 24 years; females 23 years).
- Clients aged 20–29 years accounted for the greatest proportion of episodes (34%), followed by those aged 10–19 years (30%).
- 11% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin.
- One third of referrals were self-referrals (34%), and court diversion (16%) was the next most common source of referral.

Treatment profile (tables A3.20 and A3.22)

- Treatment was most likely to occur in an outreach setting (50% of episodes). This is a very large proportion of episodes provided by outreach (the proportion across all treatment types was 10%). Non-residential treatment facilities provided 46% of support and case management only.
- Around two-thirds (62%) of episodes were reported to have ended because the treatment was completed. The next most common reason reported for ending an episode (14%) was that the client ceased to participate without notifying the service provider.
- Support and case management only episodes were the longest with a median number of treatment days of 52 (up from 47 in 2006–07).

Principal drug profile (Table A3.23)

Where support and case management only was the main treatment and the client was seeking treatment for their own drug use:

- Alcohol was the most common principal drug of concern reported (32% of episodes), followed by cannabis (29%) and heroin (13%). Heroin accounted for proportionately more support and case management episodes than it did for any other treatment type (apart from withdrawal management and 'other' main treatment types).

5.8 Rehabilitation

What is rehabilitation?

There are a number of ways rehabilitation can be provided to clients. The main purpose of rehabilitation is to support clients in stopping their substance abuse, in order to prevent any future psychological, legal, financial, social and physical consequences of problematic substance use. 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 (NSW Department of Health 2007).

Rehabilitation programs offered in therapeutic communities are multidimensional. They may include psychological therapies, education, peer support and skills development to empower clients to make positive changes in their lives. Residents stay in the community for

varying periods of time, depending on their individual needs (NSW Department of Health 2007).

Community-based rehabilitation programs are also available in some areas. These programs may begin with home-based detoxification and continue with both individual and group counselling over a period of time.

Rehabilitation as a main treatment

- Rehabilitation as the main treatment accounted for 7% of episodes in 2007–08 (Table 5.2).
- The proportion of episodes where rehabilitation was reported as the main treatment has remained between 6% and 9% since data collection started (Table 5.1).

In 2007–08, of the 11,099 episodes where rehabilitation was nominated as the main treatment received:

Client profile (Table A3.19)

- Two-thirds of episodes were for male clients.
- The median age of persons receiving treatment was 32 years (males and females both 32 years).
- Persons aged 20–29 years and 30–39 years together accounted for 67% of episodes.
- 13% of episodes involved clients who identified as being of Aboriginal and/or Torres Strait Islander origin. (There were also 3,100 residential treatment/rehabilitation episodes of care provided to Indigenous people in DASR agencies in 2007–08. See Appendix 6 for more information.)
- Self-referral was the most common source of referral (33% of episodes), followed by referrals from alcohol and other drug treatment services (20%).

Treatment profile (tables A3.20 and A3.22)

- Treatment was most likely to occur in a residential treatment facility (65% of episodes). 29% per cent of episodes were provided in a non-residential treatment facility.
- The most common reason reported for the cessation of episodes was treatment completion (37%). Almost half ended because the client ceased to participate against advice (16%), or without notice (16%) or because of non-compliance with the expectations of the rehabilitation provider (11%). Treatment provider expectations may include the person not bringing drugs on the premises and refraining from harassing other clients.
- The median number of days for an episode was 37.

Principal drug profile (Table A3.23)

Where rehabilitation was nominated as the main treatment type:

- Alcohol was the most common principal drug of concern reported (47% of episodes), followed by amphetamines (21%), cannabis (15%) and heroin (11%).

5.9 Other main treatment types

'Other' main treatment types are modes of treatment that do not fit the descriptions of the main treatment discussed previously. Examples of other main treatment types may be 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.

Around 29% 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 report 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 5.10).

Other main treatment reported

- There were 11,089 episodes (7%) where 'other' was the main treatment (Table 5.2). Of these episodes, 29% were pharmacotherapy.
- The proportion of 'other' episodes increased in 2007–08 from the previously stable proportion of about 4–5% of treatment episodes each year (Table 5.1). This increase is largely due to the inclusion of consultation liaison services in New South Wales.

Client profile (Table A3.19)

- 99% of episodes were for the client's own drug use.
- 62% of episodes were for males.
- The median age for treatment was 35 years (36 years for males and 34 years for females).
- 30–39 year olds account for the greatest proportion of episodes (28%) followed by 20–29 year olds (26%).
- Around 10% of episodes were for clients who identified as being of Aboriginal and/or Torres Strait Islander origin. This figure may under-represent the total number of services provided to Aboriginal and Torres Strait Islander peoples because they receive treatment from Indigenous-specific services. One type of 'other' treatment provided in those agencies is 'sobering up/residential respite'. There were an estimated 10,700 episodes of sobering up/respite care provided by Aboriginal and Torres Strait Islander substance use-specific agencies in 2007–08. See Appendix 6 for more details.
- Medical practitioners were the main referral source (31%) followed by self-referral (26%) and hospitals (13%).

Treatment profile (tables A3.20 and A3.22)

- Other main treatments were most likely to occur in a non-residential treatment setting (49%) followed by a residential treatment facility (43%). Other 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 8. In 2006–07 the median treatment duration was 48 days. This change is related to the larger proportion of non-pharmacotherapy treatments included in 2007–08.
- The majority of episodes ended because treatment had been completed (59%) followed by clients being transferred to another service provider (16%).

Principal drug profile (Table 3.23)

Of the 11,089 episodes where other main treatment types were reported (including pharmacotherapy):

- Alcohol was the most common principal drug of concern reported (42%) followed by heroin (19%) and cannabis (9%).

5.10 National Opioid Pharmacotherapy Statistics Annual Data Collection 2008

This section is included to provide a fuller picture about pharmacotherapy treatment in Australia than is available through the AODTS–NMDS collection. The data here are sourced from the National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) Collection.

In Australia, people with opioid dependence have been treated using opioid pharmacotherapy for several decades (methadone since 1969 and buprenorphine since 2000). The Australian Government funds the provision of pharmacotherapy drugs via pharmaceutical benefits arrangements, through clinics and pharmacies approved by state and territory governments. Treatment of opioid dependence is administered according to the law of the relevant state or territory, and within a framework which includes not only medical treatment but also social and psychological treatment.

Although jurisdictions strive to report data consistent with agreed standards, the NOPSAD Collection is not a national minimum data set and some discrepancies do exist between the ways various jurisdictions report data.

Number of clients receiving pharmacotherapy treatment

Nationally, an estimated 41,347 clients were receiving pharmacotherapy treatment on the 'snapshot/specified' day in June 2008 (Table 5.5). The distribution of clients by pharmacotherapy drug type was:

- 70% (28,930) of clients were receiving methadone
- 15% (6,005) of clients were receiving buprenorphine
- 15% (6,412) of clients were receiving buprenorphine/naloxone (Table 5.5).

It is important to note that the number of clients receiving buprenorphine/naloxone is an underestimate since New South Wales was not able to separately identify the number of clients receiving buprenorphine/naloxone. In New South Wales, clients receiving buprenorphine/naloxone are reported under the category 'buprenorphine'.

Since 2006, the uptake of buprenorphine/naloxone as a pharmacotherapy treatment has been increasing. Of the jurisdictions able to identify clients receiving buprenorphine/naloxone, the largest increases in proportions of clients receiving this treatment were seen in the Northern Territory, South Australia, Victoria and Western Australia.

The largest proportion of clients was seen in New South Wales (42%), followed by Victoria (29%) and Queensland (12%). Western Australia and South Australia each provided services to approximately 7% of clients receiving pharmacotherapy treatment in 2008, but the figure reported for Western Australia was for the number of clients who received treatment in the entire month of June.

The proportion of clients prescribed methadone, buprenorphine or buprenorphine/naloxone varied across jurisdictions, although over 60% of clients in most jurisdictions were prescribed methadone.

Table 5.5: Estimated number of pharmacotherapy clients by pharmacotherapy drug type and jurisdiction, on a 'snapshot/specified' day[(a)], 2008

Pharmacotherapy drug type	NSW	Vic	Qld	WA[(a)]	SA	Tas	ACT	NT	Australia
Methadone	13,973	7,161	2,746	1,995	1,929	480	597	49	28,930
Buprenorphine	3,195	1,209	689	181	565	54	89	23	6,005
Buprenorphine/naloxone[(b)]	—	3,451	1,464	732	558	54	100	53	6,412
Total	**17,168**	**11,821**	**4,899**	**2,908**	**3,052**	**588**	**786**	**125**	**41,347**

(a) The number of clients on 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.

(b) In New South Wales, clients prescribed buprenorphine/naloxone are counted under buprenorphine.

Note: Each state and territory uses a different method to collect data on pharmacotherapy prescription and dosing. These differences may result in minor discrepancies if directly comparing one jurisdiction with another jurisdiction.

Clients receiving pharmacotherapy treatment on a snapshot day in June 2008 were predominately male (64% of clients). Of the 41,221 clients whose age group could be identified, 38% of clients were aged 30–39 years, 27% aged 40–49 years and 23% aged 20–29 years (AIHW 2009b).

In 2008, clients were most likely to receive pharmacotherapy doses at a pharmacy (69%). Services were also provided by public clinics (10%), private clinics (8%), correctional settings (7%) and other settings (6%), including hospitals.

6 Collection methods and data quality

6.1 Collection method and data included

While reading this report, it is important to keep in mind that the data reported are administrative by-product data. This means that the data have been collected as part of the process of providing treatment to people at agencies, rather than being collected directly from people by administering a questionnaire. 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.

While all states and territories have agreed to report the data items that make up this national minimum data set, most jurisdictions collect more data for their own planning and monitoring purposes. The national minimum data set is effectively a subset of a larger collection of jurisdictional data sets. The policy and administrative features of the AODTS–NMDS collection within each jurisdiction are outlined in Appendix 2.

Responsibility for the collection

The AODTS–NMDS was developed and implemented under the terms of the National Health Information Agreement (NHIA). Under the NHIA, the Australian Government and state and territory government health authorities are committed to working with the Australian Institute of Health and Welfare (AIHW), the Australian Bureau of Statistics (ABS) and others to develop, collate and report national health information.

The AODTS–NMDS is a nationally agreed set of data items collected by all in-scope service providers, collated by relevant health authorities and compiled into a national data set by the AIHW. The AIHW is the data custodian for the national data set and performs a coordinating role as national secretariat to the collection. The Intergovernmental Committee on Drugs (IGCD) AODTS–NMDS Working Group is responsible for the ongoing development and maintenance of the national collection. The Working Group has representatives from the Australian Government, each state and territory government, the AIHW, the ABS and the National Drug and Alcohol Research Centre.

Key responsibilities of each authority in regard to the AODTS–NMDS collection follow.

Government health authorities

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

The Australian Government and state and territory government departments have custodianship of their own data collections under the NHIA. The AIHW is custodian of the national collection.

Alcohol and other drug treatment agencies

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. 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 federal government legislation.

AIHW

Under a memorandum of understanding with the Australian Government Department of Health and Ageing (DoHA), the AIHW is responsible for the management of the AODTS–NMDS. The AIHW maintains a coordinating role in the collection, including providing secretariat duties to the IGCD 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).

6.2 Comprehensiveness of the data

In 2007–08, data were provided from 552 (91%) of the 608 agencies that were in scope for this collection (this excludes Queensland agencies).

As in previous years, the majority of Australian Government-funded Indigenous substance use services and Aboriginal primary health care services that provide alcohol and other drug treatment are not included in the 2007–08 collection. More detailed information on the under-count of services provided to Aboriginal and Torres Strait Islander peoples, as well as other data caveats, are available in Section 1.3.

Presentation of Australian Government data

Data reported for each state and territory in 2007–08 include services provided under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program (NGOTGP). Since the 2002–03 AODTS–NMDS report, Australian Government data have not been analysed separately; rather they have been analysed as part of the jurisdiction in which the NGOTGP agency was located.

6.3 Data quality

Overall, the quality of the 2007–08 AODTS–NMDS data has continued the trend of improvement across collection periods with a few exceptions. The proportions of 'not stated' are largely similar to those seen in 2006–07 with some exceptions. In particular, the proportion of 'not stated' responses for *Country of birth* and *Reason for cessation* increased in the Northern Territory. 'Not stated' rates also increased in the ACT for *Injecting drug use* and in Tasmania for *Method of use* (Table 6.1).

The proportion of 'not stated' responses for *Indigenous status* has not improved or worsened since 2005–06. 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 about 2% and Tasmania, Victoria and the ACT reporting the highest rates of about 8%.

The proportion of 'not stated' responses for *Injecting drug use* continues to remain high. In 2007–08, the proportion of 'not stated' episodes was around 12%, which is slightly higher than 2006–07.

Table 6.1: Not stated /missing/unknown responses for data items, by jurisdiction, 2007–08[(a)] (per cent)

Data Item	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
Client data items									
Client type	—	—	—	—	—	—	—	—	—
Country of birth	1.7	3.2	1.7	0.2	1.1	0.1	1.2	6.9[(b)]	2.0
Date of birth/age	—	0.5	0.3	0.3	0.2	0.1	0.2	2.1	0.3
Indigenous status	2.8	7.6	5.7	1.5	4.3	7.6	7.6	1.8	4.9
Preferred language	1.1	—	0.9	0.1	1.1	—	1.1	9.5	0.8
Sex	—	0.2	—	—	—	—	—	0.3	0.1
Source of referral	0.2	0.8	0.3	—	2.6	—	0.5	2.9	0.6
Drug data items[(c)]									
Principal drug of concern	—	—	—	—	—	—	—	—	—
Method of use	1.0	2.1	3.3	0.2	1.5	7.9[(b)]	0.6	0.6	1.8
Injecting drug use	7.2	15.7	18.1	7.5	5.6	16.3	14.0[(c)]	12.3	12.1
Treatment data items									
Main treatment type	—	—	—	—	—	—	—	—	—
Reason for cessation	0.2	0.5	1.0	0.3	—	—	0.1	7.3[(c)]	0.6
Treatment delivery setting	—	—	—	—	—	—	—	—	—

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

(b) These categories saw an increase of more than 4 percentage points since 2006–07.

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

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

7 Data development—enhancing policy and planning relevance

The AODTS–NMDS is a rich source of information about alcohol and other drug treatment provided in Australia. It provides information about treatment agencies including where they are located and in which sector (public or private) they operate. The AODTS–NMDS also provides demographic data about clients who have received treatment, information about the types of treatment provided and drugs of concern.

In the spirit of the National Drug Strategy's commitment to seek opportunities to improve data collections, this chapter considers how further development of the collection could enhance the information available to policy makers and program planners. Any changes to the collection would require further consideration, discussion and development, particularly by the AODTS–NMDS Working Group. This chapter is intended to highlight potential enhancements only.

7.1 How much treatment is being provided?

An accurate picture of how much treatment is provided is important so that trends can be monitored over time.

What does the NMDS tell us?

In the 2007–08 collection period, 153,998 episodes were provided by agencies reporting to the NMDS.

Over the time that the AODTS–NMDS collection has been operating, there has been a steady increase in the number of treatment episodes reported by agencies, apart from the 2006–07 year (Table 7.1).

Table 7.1: Age group trends, 2001–02 to 2007–08

Age group	2001–02[a]	2002–03	2003–04	2004–05	2005–06	2006–07[c]	2007–08
10–19 years	15,816	15,968	17,059	17,406	19,508	17,598	17,618
20–29 years	41,377	43,529	44,684	46,244	49,006	46,599	47,936
30–39 years	32,057	35,634	38,166	40,123	42,825	42,407	44,007
40–49 years	19,241	21,910	23,564	23,956	25,625	25,708	27,722
50–59 years	7,987	8,656	9,107	9,593	10,221	10,804	11,788
60+ years	2,739	2,958	3,140	3,328	3,389	3,581	4,440
Total[b]	**113,705**	**130,930**	**136,869**	**142,144**	**151,362**	**147,325**	**153,998**

(a) Excludes South Australia.

(b) Includes 'not stated'.

(c) In 2006–07, systems issues in New South Wales contributed to a decline in the total number of treatment episodes.

Information is also available about the treatment types provided in each year of the collection (Table 5.1). For example, the number of counselling episodes has increased over time but has remained at around 39–42% of treatment episodes provided each year.

The number of treatment agencies reporting to the collection has also increased over time from 553 in 2001–02 to 658 in 2007–08.

What else could the NMDS tell us?

There are a number of questions raised about the potential use of this data collection:

- How many individuals receive treatment?
- Is treatment available in a greater number of physical locations?

The AODTS–NMDS counts episodes rather than clients or people receiving services. As a result, the number of individuals receiving treatment is unclear.

Another issue related to interpreting the amount of treatment provided is that the reported increase in treatment agencies may not simply reflect that there are more agencies for clients to choose from. Improvements have been made to the collection over time by moving to reporting agencies at the service outlet level, rather than just the central or administrative centre of each agency. As a result, some agencies that were reported as a single agency in past years will now appear as several agencies. Although this needs to be taken into account when interpreting time series data, the 'service outlet' approach provides a clearer picture of the number of locations where treatment service agencies are operating.

It is also important for users of NMDS data to be aware that the number of in-scope agencies that do not report their data is difficult to determine in some jurisdictions. Therefore, some of the increase in agencies may represent the inclusion of agencies that were operating, but not reporting, in previous years.

Potential enhancements

Statistical linkage provides the ability to link records without identifying an individual. Linkage for the purposes of statistical analysis, research and informing policy is designed to provide information on the patterns of service usage, by groups of individuals. For example, by linking records, we could determine the average number of assessments provided to groups of clients with a specific profile before they move on to another treatment. Information of this kind is important to plan service delivery and gain a better understanding of the health issues faced by this population.

The introduction of a statistical linkage key (SLK), for the purposes of probabilistic record linkage, would allow an estimation of the number of clients accessing treatment (AIHW 2009c). An SLK would also facilitate more powerful analysis to provide information on patterns of service usage, treatment pathways and the characteristics of groups of clients and agencies.

The number of treatment agency locations will become clearer as service outlets are more reliably used as the basis for reporting 'agencies' to the NMDS. Jurisdictions are also engaged in ongoing efforts to ensure that all in-scope agencies report.

7.2 Is treatment accessible?

The National Drug Strategy 2004–2009 identifies 'improved access to quality treatment' as a priority area, including 'minimising barriers to treatment'.

What does the NMDS tell us?

Treatment agencies are located in all states and territories with the more populous states hosting a greater proportion of agencies. Treatment agencies are also located in a mix of geographical areas, from *Major cities* through to *Very remote* areas (see Chapter 2 for more information).

The AODTS-NMDS provides information regarding access to treatment for population subgroups through country of birth, preferred language of clients, age, sex, Indigenous status and other demographic information. It is possible to use these data to analyse the proportion of treatment episodes for certain groups. For example, in 2007–08 people born outside of Australia accounted for 14% of treatment episodes.

What else could the NMDS tell us?

Other questions the NMDS could answer include:

- Do some groups need to travel further than others to access treatment?
- Are some groups over-represented in alcohol and drug treatment?

Although the location of treatment agencies is reported to the NMDS, the geographic location of clients or the distance they need to travel to access services is not. The information available related to accessibility could be supplemented by incorporating data about the broad residential location of clients.

The current counting rules (the 'treatment episode' concept) and the inability to count the number of clients in the AODTS–NMDS make it inappropriate to compare groups in treatment with groups in the general population. For example, the proportion of people born outside Australia who received alcohol and drug treatment cannot be compared with the proportion of people born outside Australia in the general population.

In addition, the NMDS could provide information about access-related issues such as client mental health status or family situation. This would allow analyses of clients with comorbidity, parental responsibilities and/or without family support to identify whether these groups are under- or over-represented in the treatment population.

Potential enhancements

The distance client groups travel to treatment services could be captured with a new data element in the collection. The new data element could be in the form of residential postcode or statistical area from an ABS classification. Alternatively, the data element could capture the distance or time travelled to reach an agency. These data, used in conjunction with other data sources, could be used to inform policy and research on the accessibility of treatment.

The introduction of an SLK, identified earlier as useful for understanding the amount of treatment provided, would also be useful in establishing the number of clients from population subgroups, some of which may be under- or over-represented in treatment.

In addition, new data elements could be introduced to allow the identification of groups of interest. These groups may include clients with a co-existing mental health problem and those in different family situations, such as those with dependent children or living alone. These new data elements, together with the SLK, would allow analysis of these groups compared with those in the general population.

7.3 Is treatment effective?

Another area identified in the National Drug Strategy is the need to 'evaluate the impact of existing activities and determine consequential impacts on patterns of drug supply, use and associated harm'. The NMDS contributes to this priority by providing information about the reasons that people cease treatment. There is potential to increase the amount of information about treatment effectiveness, and to make data available for program evaluators through improvements to the collection.

What does the NMDS tell us?

The AODTS–NMDS captures 'cessation reason'. Cessation reason is defined as the reason for the client ceasing to receive a treatment episode from an alcohol and other drug treatment service. Cessation reasons can be grouped into expected/compliant completions, unexpected/non-compliant completions and changes to treatment mode (Table 7.2). These groupings provide some indication of whether treatment was completed or ended for another reason.

Table 7.2: Cessation reasons grouped by indicative outcome type[(a)]

Expected/compliant completions	Unexpected/non-compliant cessations	Changes to treatment mode
Treatment completed [(b)]	Ceased to participate against advice	Change in treatment type
Ceased to participate at expiation[(c)]	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' cessation reasons not detailed.

(b) 'Treatment completed' can be reported in a range of circumstances (see "What else could the NMDS tell us?" section).

(c) '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.

In 2007–08, two-thirds of treatment episodes were expected or compliant completions, 23% were unexpected or non-compliant cessations and 7% ended because of a change in treatment mode. Over the time the collection has been operating (since 2001–02), the

proportion of expected/compliant completions has gradually increased from 61% to 66%. The proportion of unexpected/non-compliant completions has declined slightly from 24% to 23% and changes to treatment mode have fluctuated while remaining below 7% since 2005–06.

What else could the NMDS tell us?

There is some scope for the NMDS to tell us more about effectiveness such as whether the goals of treatment were met.

Although completed treatments are more likely to be effective because there was more *opportunity* to meet initial treatment goals, the completion or unexpected cessation of a treatment episode does not provide an indication of *how well* treatment goals were met.

The interpretation of cessation reason data requires awareness of varying coding practices for some of the response categories. For example, when 'treatment completed' is coded, this may mean that only *immediate* treatment goals were met or that contact has ceased in a treatment type that does not require any particular treatment duration, such as support and case management. It is also possible that some treatment episodes where a client has not returned as expected after an initial contact, rather than being coded 'ceased to participate without notice', were actually coded 'assessment only' and 'treatment completed'.

The AODTS–NMDS does not provide any information about the effectiveness of specific treatment programs that report their data for the national picture.

Potential enhancements

More information about treatment effectiveness could be collected if an outcome measure was introduced into the collection. The administrative (as opposed to research-focused) nature of the AODTS–NMDS collection means that the outcome measure would need to be captured within the period of the treatment episode. It would be most logical to capture outcomes at the end of treatment episodes. This timing would focus the choice of outcome measures on *immediate* outcomes, such as the degree to which treatment goals were met as measured by the client and/or service provider. An example of such an outcome measure can be found in the Northern Territory's drug treatment collection, which includes a tick box question on treatment discharge forms: 'Treatment goals achieved?' with possible responses of 'all', 'some' or 'none'.