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Alcohol and other drug treatment services in Australia 2017–18

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Contents

Summary

Alcohol and other drug (AOD) treatment services across Australia provide a broad range of treatment services and support to people using drugs, and to their families and friends. This report presents information for 2017–18 about publicly funded AOD treatment service agencies, the people they treat and the treatment provided.

Around 130,000 clients sought AOD treatment in 2017–18

In 2017–18:

- around 130,000 clients aged 10 and over (a rate of 601 clients per 100,000 people) received treatment, a 9% rise since 2013–14 (119,000)
- around two-thirds of clients were male (66%), and just over half were aged 20–39 (54%)
- 1 in 6 (16%) clients aged 10 and over, identified as Indigenous Australians representing a rate of 3,597 clients per 100,000, compared with 495 clients per 100,000 non-Indigenous Australians
- treatment agencies provided about 208,900 closed treatment episodes—an average of 1.6 episodes per client
- around 4 in 5 (80%) episodes ended within 3 months
- less than 1% (2,838) of clients received treatment in every collection year from 2013–14.

In over 2 in 5 treatment episodes, clients reported more than 1 drug of concern: usually nicotine or cannabis

Alcohol, cannabis, amphetamines and heroin have remained the most common principal drugs of concern for clients since 2008–09.

In 2017–18:

- alcohol was the most common principal drug of concern, accounting for 35% of episodes, followed by amphetamines 27%, cannabis 22% and heroin 6%
- for clients aged 30 and over, alcohol was the most common principal drug of concern, while for clients aged 10–29, cannabis was the most common
- heroin as a principal drug of concern was most common among clients aged 30–49
- in over 2 in 5 (41%) treatment episodes, the client also reported additional drugs of concern—nicotine and cannabis were the most common.

Treatment episodes for amphetamines rose by over 300% over 10 years

Over the 10-year period to 2017–18:

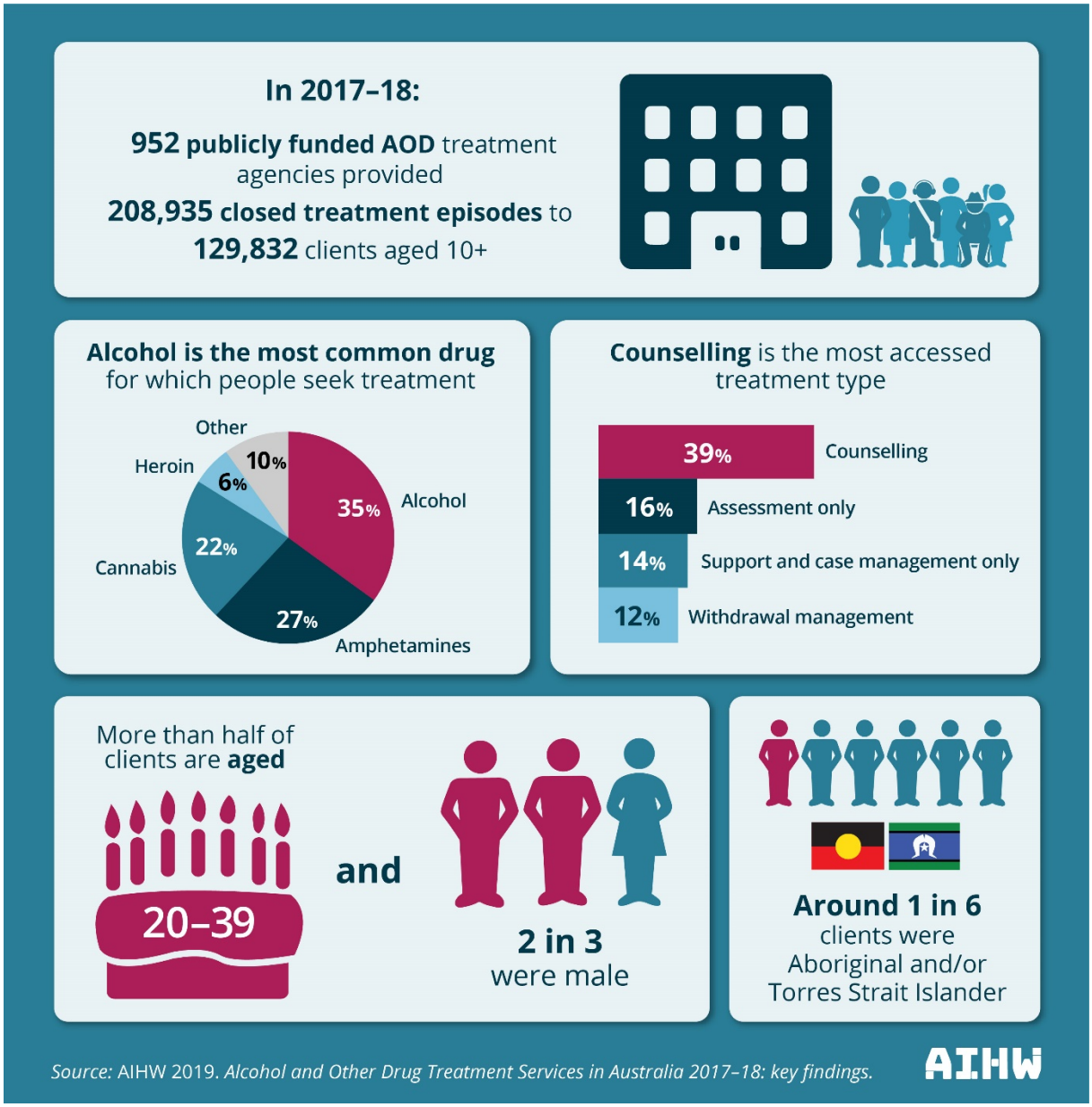
- the proportion of episodes where alcohol was the most common principal drug of concern decreased from 46% in 2008–09 to 35%
- the number of heroin treatment episodes fell by 22% (from 14,222 to 11,071 treatment episodes)
- where amphetamines were the principal drug of concern, the number of episodes for the clients method of drug use for injecting, smoking or inhaling increased almost 5-fold from 10,400 episodes in 2008–09 to 48,000 episodes in 2017–18.

Counselling continues to be the most common type of treatment

- Since 2008–09, the proportion of episodes for each main treatment type has remained stable, with counselling, support and case management and withdrawal management being the most common types of treatment. Counselling continues to be the most common main treatment type provided for all clients (ranging from 37% to 43% since 2008–09).

Independent residential accommodation was the most common accommodation for clients prior to the start of the service episode

- In 2017–18, data with valid response rates (over 90%) for usual accommodation type for the client prior to AOD service were reported by New South Wales, Queensland, Western Australia, South Australia and Northern Territory. Data are presented for these jurisdictions only.



1 Introduction

Alcohol and other drug (AOD) treatment services assist people to tackle their problematic drug use through a range of treatments. Many types of treatment are available in Australia. Most aim to reduce the harm of drug use, while some use a structured drug-free setting with abstinence-oriented interventions to help prevent relapse and develop skills and attitudes that assist clients to make changes leading to drug-free lifestyles (AIHW 2011).

This report presents national information for 2017–18 about publicly funded AOD treatment service agencies, the people they treat and the treatment provided. Between 2013–14 and 2017–18, the estimated number of clients who received treatment increased by 9% (from 118,760 clients to 129,832). Of those clients who received treatment in 2017–18, under 1% (2,838) of clients also received treatment in every collection year, from 2013–14 to 2017–18.

1.1 Drug use in Australia

Drug use can be either licit or illicit (see Glossary). Licit and illicit use of drugs is a significant issue in Australia and has a substantial societal cost: in 2004–05, it cost an estimated $56 billion, of which $8 billion was for illicit drug use (Collins & Lapsley 2008). In 2011, treatment for illicit drug use—including amphetamines, cannabis, cocaine, ecstasy or opioids—cost an estimated at $298 million (Smith et al. 2014). According to the 2015 Australian Burden of Disease Study, tobacco, alcohol and illicit drug use contributed to 9.3%, 4.5% and 2.7% of the total disease burden in Australia, respectively (AIHW 2019).

The 2016 National Drug Strategy Household Survey found alcohol and tobacco to be the most common drugs used in Australia, with 77% of Australians aged 14 and over drinking alcohol in the previous 12 months and 12% smoking tobacco daily (AIHW 2017). Nearly 1 in 5 (17%) people drank at levels that put them at increased risk of harm over their lifetime (more than 2 standard drinks per day on average), while one-quarter (26%) of people drank at least once a month at levels that put them at risk of accident or injury (more than 4 standard drinks in a session).

Although less prevalent than the use of licit drugs, illicit drug use is still relatively common. In 2016, about 2 in 5 people (43%) aged 14 and over reported using illicit drugs in their lifetime, while 1 in 7 (16%) reported using illicit drugs within the previous 12 months (AIHW 2017). Cannabis was the most commonly used illicit drug: more than 1 in 3 (35%) Australians aged 14 and over had used cannabis in their lifetime, while 1 in 10 (10%) had used it in the previous 12 months. Ecstasy and hallucinogens were the second and third most common (11% and 9.4%, respectively) for lifetime use, while pain-killers (analgesics) for non-medical purposes and ecstasy were the second and third most common for recent use (3.6% and 2.2%, respectively).

1.2 National Drug Strategy

Australia has had a coordinated approach to dealing with alcohol and other drugs since 1985. The National Drug Strategy (NDS) 2017–2026 is the 7th and latest iteration of the cooperative strategy between the Australian Government, state and territory governments and the non-government sector. It provides a framework that identifies national priorities relating to alcohol, tobacco and other drugs, guides action by governments—in partnership with service providers and the community—and outlines a national commitment to harm minimisation through balanced adoption of effective demand, supply and harm reduction strategies.

The NDS has an overarching approach of harm minimisation and encompasses 3 pillars, each with specific objectives (NDSC 2017):

- **demand reduction:** to prevent the uptake and/or delay the onset of use of alcohol, tobacco and other drugs; reduce the misuse of alcohol, tobacco and other drugs in the community; and support people to recover from dependence through evidence-informed treatment
- **supply reduction:** to prevent, stop, disrupt or otherwise reduce the production and supply of illegal drugs; and to control, manage and/or regulate the availability of illegal drugs
- **harm reduction:** to reduce the adverse health, social and economic consequences of the use of drugs, for the user, their families and the wider community.

Harm reduction actions in the strategy include (NDSC 2017):

- increasing access to pharmacotherapy treatment to reduce drug dependence and reduce the health, social and economic harms to individuals and the community that arise from unsanctioned opioid use
- monitoring emerging drug issues to provide advice to the health, law enforcement, education and social services sectors to inform individuals and the community regarding risky behaviours
- developing and promoting culturally appropriate alcohol, tobacco and other drug information and support resources for individuals, families, communities and professionals coming into contact with people at increased risk of harm from alcohol, tobacco and other drugs
- providing opportunities for intervention among high-prevalence or high-risk groups and locations, including the implementation of settings-based approaches to modify risk behaviours
- enhancing systems to facilitate greater diversion into health interventions from the criminal justice system, particularly for Aboriginal and Torres Strait Islander people, young people and other at risk populations who may be experiencing disproportionate harm.

1.3 Alcohol and other drug treatment services

AOD treatment services assist people to tackle their drug use through a range of treatments. Treatment objectives can include reduction or cessation of drug use, as well as improving social and personal functioning. Treatment and assistance may also be provided to support the family and friends of people using drugs. Treatment services include detoxification and rehabilitation, counselling and pharmacotherapy and are delivered in residential and non-residential settings.

In Australia, publicly funded treatment services for AOD use are available in all states and territories. Most of these services are funded by state and territory governments, while some are funded by the Australian Government. Information on publicly funded AOD treatment services in Australia, and the people and drugs treated, are collected through the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS). The AODTS NMDS is one of several NMDSs that collect data under the 2012 National Healthcare Agreement to inform policy and help improve service delivery (COAG 2012).

Other available data sources that support a more complete picture of AOD treatment in Australia include:

- the National Opioid Pharmacotherapy Statistics Annual Data collection www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/nopsad-2018
- the National Hospital Morbidity Database https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/drug-related-hospitalisations
- the Online Services Report Database https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/indigenous-health-organisations-aodt-services
- the Specialist Homelessness Services collection https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/shs-drug-and-alcohol-related-issues
- the National Prisoner Health Data collection www.aihw.gov.au/prisoner-health.

1.4 The AODTS NMDS

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government organisations. Information on clients and treatment services are included in the AODTS NMDS when a treatment episode provided to a client is closed (see Glossary).

This report provides information on the following types of treatment:

- assessment only
- counselling
- information and education only
- pharmacotherapy
- rehabilitation
- support and case management only
- withdrawal management (see Glossary).

The AODTS NMDS collects data about services provided to people who are seeking assistance for their own drug use and those seeking assistance for someone else's drug use.

Client information is collected at the episode level in the AODTS NMDS. The collection does not contain a unique identifier for clients, but from 2012–13, a statistical linkage key (SLK) was introduced, which enables the number of clients receiving treatment to be estimated. From 2012–13, SLK data were not available for all clients, so an imputation strategy was developed to estimate the number of clients and enable more complete reporting at the client level. Imputation was applied for the 2012–13, 2013–14 and 2015–16 collection years, because SLKs were missing for a high proportion of treatment episodes. The SLK reporting for 2012–13 contained a number of quality issues and is considered pilot analysis: this data is not included in trend analysis for client data. Further details on the imputation methodology are in Appendix B.

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

Coverage and data quality

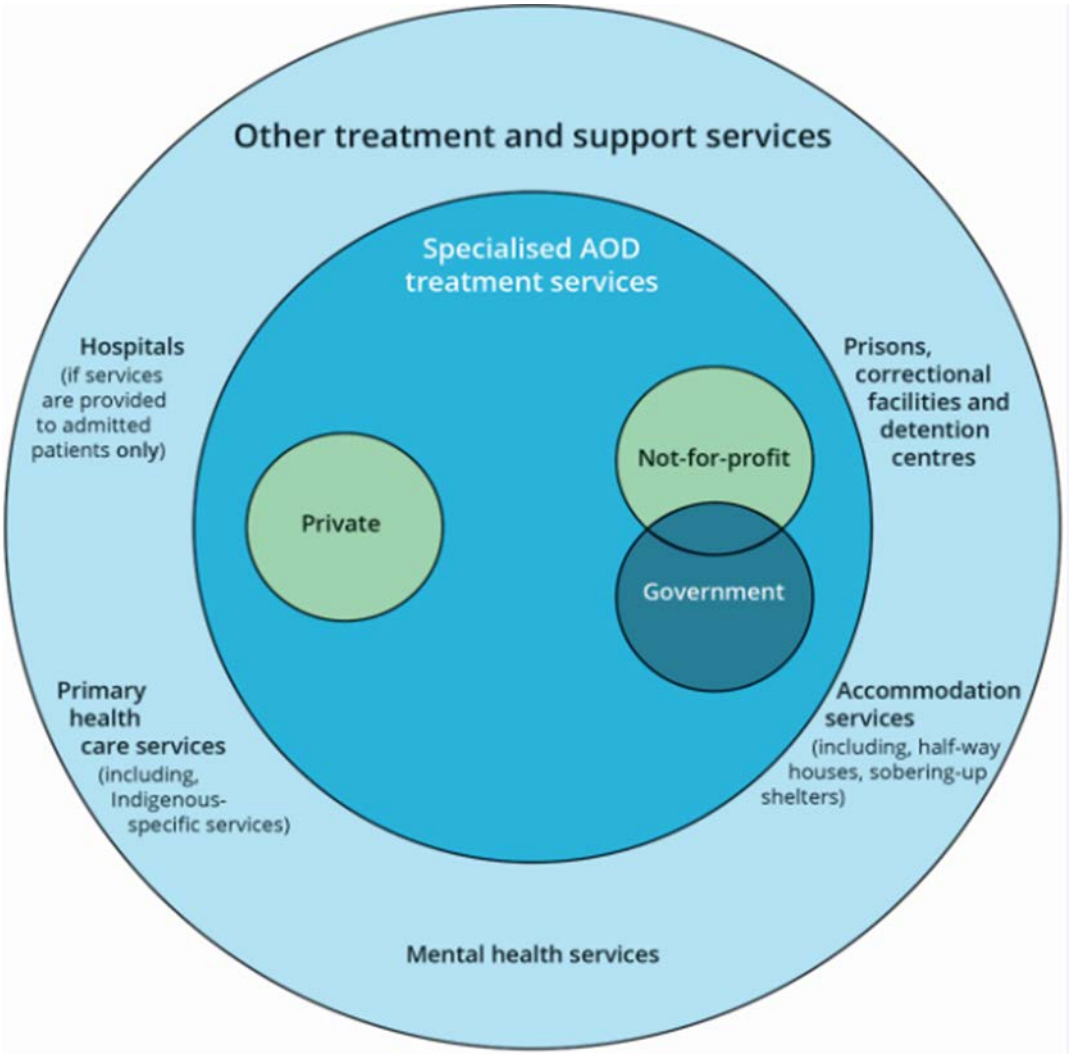
Although the AODTS NMDS collection covers the majority of publicly funded AOD treatment services, including government and non-government organisations, it is difficult to quantify fully the scope of AOD services in Australia.

People receive treatment for alcohol and other drug-related issues in a variety of settings not in scope for the AODTS NMDS. These include:

- services provided by other not-for-profit organisations and private treatment agencies that do not receive public funding
- alcohol and other drug treatment units in acute care or psychiatric hospitals that provide treatment only to admitted patients
- prisons, correctional facilities and detention centres
- primary health-care services, including general practitioner settings, community-based care, Indigenous-specific primary health-care services and dedicated substance use services
- health promotion services (for example, needle and syringe programs)
- accommodation services (for example, halfway houses and sobering-up shelters) (Figure 1.1).

In addition, agencies whose sole function is prescribing or providing dosing services for opioid pharmacotherapy are excluded from the AODTS NMDS. These data are captured in the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection available at www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/nopsad-2018/.

Figure 1.1: Alcohol and other drug treatment and support services in Australia



Note: Those in scope for the AODTS NMDS are shaded darker blue.

Australian Government-funded primary health-care services and substance-use services aimed at adversity experienced by Indigenous Australians may be in scope for the AODTS NMDS. However, most of these agencies do not contribute to the collection, because they currently provide data to the Online Services Report collection. For the latest data, see https://www.aihw.gov.au/reports/indigenous-health-welfare-services/health-organisations-osr-key-results-2016-17.

In 2017–18, 94% (952) of in-scope agencies submitted data to the AODTS NMDS. Overall, from 2016–17 to 2017–18, there was a decrease of 4 percentage points in the proportion of in-scope agencies that reported to the collection. For the 2014–15 and 2015–16 reporting periods, sector reforms and system issues in some jurisdictions affected the number of in-scope agencies that reported. This led to an under-count of the number of closed treatment episodes reported for these years, so results, especially across reporting years, should be interpreted with caution.

Further details on scope, coverage and data quality is available from the AODTS NMDS Data Quality Statement at http://meteor.aihw.gov.au/content/index.phtml/itemId/713818.

1.5 Accompanying material

The following online information accompanies this report:

- Scope, coverage and data quality at www.aihw.gov.au/about-our-data/our-data-collections/alcohol-other-drug-treatment-services
- Data quality statement at http://meteor.aihw.gov.au/content/index.phtml/itemId/713818
- State and territory summaries at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2016-17-state-territory-summaries/contents/summary
- Supplementary data tables (those with a prefix of 'S' referenced throughout the report) at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2016-17/data.
- Interactive data displays at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2017-18-key-findings/contents/data-visualisations

2 Agencies

The Australian Government and state and territory governments fund both government and non-government organisations to provide a range of AOD treatment services (see Glossary). Services are delivered in residential and non-residential settings, and include treatment such as detoxification, rehabilitation, counselling and pharmacotherapy.

The AODTS NMDS contains information on a subset of publicly funded AOD treatment services (see Section 1.4 for details of agencies that are excluded).

Box 2.1: Agencies key facts

In 2017–18:

- a total of 952 publicly funded agencies provided data about their treatment services to the AODTS NMDS
- more than 3 in 5 (61%) agencies were non-government
- more than half (58%) of agencies were located in *Major cities.*

Over the 10-year period to 2017–18:

- the number of publicly funded agencies providing AOD treatment increased by 46%.

2.1 Number of agencies

In 2017–18, 952 publicly funded AOD treatment agencies reported to the AODTS NMDS: an increase of 14% since 2016–17 (Box 2.1). This increase is in part attributable to the increase in Australian Government-funded services commissioned by Primary Health Networks (PHN) reporting data. The number of agencies per state and territory ranged from 16 in the Australian Capital Territory to 390 in New South Wales (Table SA.1).

Over the 10-year period to 2017–18, there has been a 46% increase in the number of reporting agencies (from 653 to 952). The increase has largely been driven by increases in reporting agencies in New South Wales (from 250 to 390), Queensland (122 to 176) and Western Australia (44 to 96) (Table SA.1).

A number of issues can affect agency reporting within jurisdictions either increasing or decreasing numbers, and these include:

- new client management systems improving data provision
- technical issues with new or old reporting systems
- overburden of reporting on small agencies.

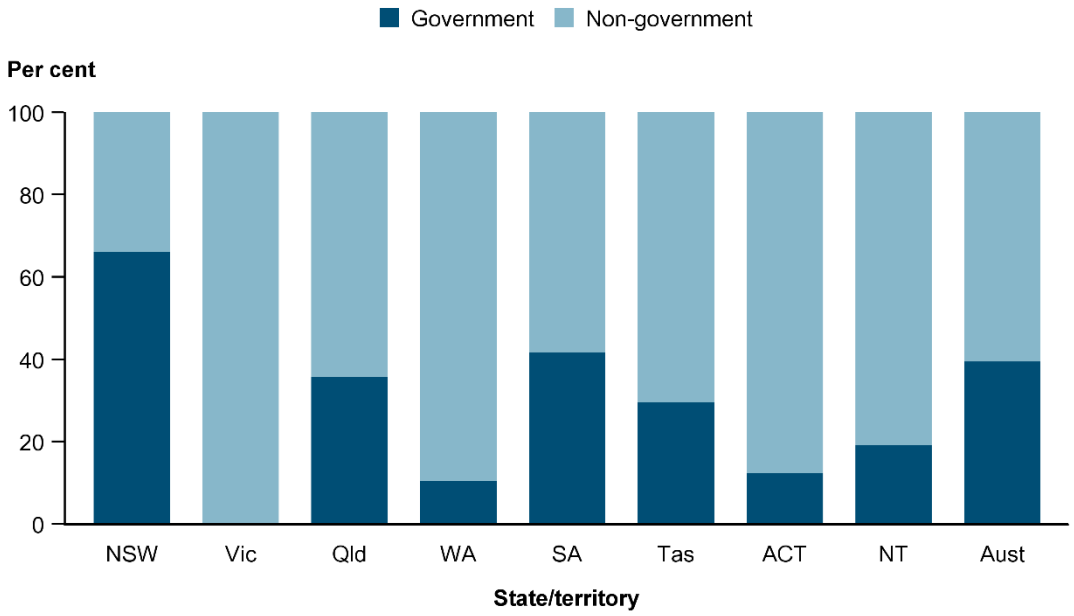
Another impact over reporting years includes the change in reporting from the head-office level to the service outlet level, which increases the number of agencies within 1 organisation. Most jurisdictions report that they are continuing to work to improve the coverage and quality of data supplied by agencies.

2.2 Service sector

Nationally, in 2017–18, over 3 in 5 (61% or 576) AOD treatment agencies were non-government, and these agencies provided over two-thirds (70% or 145,939) of closed treatment episodes (Figure 2.1). Over the 10-year period to 2017–18, the proportion of non-government agencies has increased (from 55% to 61%), along with the proportion of closed treatment episodes also provided by non-government agencies (from 59% to 70%) (tables SA.1–2).

In New South Wales, the majority of treatment agencies were in the government sector (66%). In the remaining states and territories, most treatment agencies were in the non-government sector, ranging from 58% in South Australia to 100% in Victoria.

Figure 2.1: Publicly funded AOD treatment agencies by service sector, states and territories, 2017–18



Source: Table SA.1.

2.3 Remoteness area

Nationally, in 2017–18, over half (58% or 556) of the treatment agencies were located in *Major cities* and over one-fifth (22%) were in *Inner regional* areas.

These agencies provided 71% and 17% of all treatment episodes, respectively (Table SA.4). Relatively few agencies were located in *Remote* and *Very remote* areas (6% in total). This pattern was similar across most states and territories, except for Northern Territory where 31% of agencies were located in *Remote* and 19% in *Very remote* areas (Table SA.3).

3 Clients

Client information is collected at the episode level in the AODTS NMDS. From 2012–13, a statistical linkage key (SLK) was introduced, which enables the number of clients receiving treatment to be estimated.

Box 3.1: Client key facts

In 2017–18:

- around 129,800 clients aged 10 and over received treatment from publicly funded AOD treatment agencies across Australia
- clients received an average of 1.6 treatment episodes for their own drug use
- more than half of all clients (54%) were aged 20–39
- independent residential accommodation was the most common usual accommodation type prior to the start of the service episode.

Over the 5–year period to 2017–18:

- 17% (74,500) of clients received treatment in 2017–18 only
- 0.6% (2,800) of clients received treatment in all five collection years (from 2013–14 to 2017–18).

In 2017–18, around 129,800 clients aged 10 and over received 208,900 closed treatment episodes from publicly funded AOD treatment agencies across Australia (Box 3.1; Table 3.1). This equates to a rate of 601 clients per 100,000 people in 2017–18, compared with 585 clients per 100,000 in 2013–14 (Table SC.21). Between 2013–14 and 2017–18, the estimated number of clients rose from around 118,700 to 129,800, an overall increase of 9%.

Around 1 in 6 (16%) clients were Aboriginal or Torres Strait Islander, this is a rate of 3,597 clients per 100,000, compared with 495 clients per 100,000 non-Indigenous Australians (Table SC.26).

3.1 Characteristics of clients

Clients can receive treatment for their own or someone else's drug use (see Glossary). In 2017–18, around 125,000 clients received treatment for their own drug use and around 6,000 received treatment in relation to someone else's drug use (Table 3.1).

A small proportion (less than 1%) of clients received treatment for their own drug use and received treatment for someone else's drug use in 2017–18.

In 2017–18, clients seeking treatment for their own drug use received an average of 1.6 treatment episodes, while those receiving treatment for someone else's drug use received an average of 1.3 episodes.

Table 3.1: Clients[a], treatment episodes and rates, by client type and state and territory, 2017–18

	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Australia
					Own drug use				
Number of episodes	44,922	64,082	42,576	22,862	10,344	3,570	6,826	5,571	200,753
Number of clients	26,734	31,158	33,254	16,990	7,371	2,585	4,020	3,442	124,619
Episodes per client	1.7	2.1	1.3	1.3	1.4	1.4	1.7	1.6	1.6
Rate of episodes[b] (number per 100,000 population)	650	1,149	987	1,020	680	771	1,896	2,658	929
Rate of clients[b] (number per 100,000 population)	387	559	771	758	484	559	1,117	1,642	577
					Other's drug use				
Number of episodes	902	3,862	894	1,786	197	166	105	270	8,182
Number of clients	777	2,611	555	1,650	179	151	97	206	6,226
Episodes per client	1.2	1.5	1.6	1.1	1.1	1.1	1.1	1.3	1.3
Rate of episodes[b] (number per 100,000 population)	13	69	21	80	13	36	29	129	38
Rate of clients[b] (number per 100,000 population)	11	47	13	74	12	33	27	98	29
					Total				
Number of episodes	45,824	67,944	43,470	24,648	10,541	3,736	6,931	5,841	208,935
Number of clients	27,407	33,006	33,762	18,589	7,544	2,725	4,109	3,628	129,832
Episodes per client	1.7	2.1	1.3	1.3	1.4	1.4	1.7	1.6	1.6
Rate of episodes[b] (number per 100,000 population)	663	1,218	1,008	1,100	693	807	1,925	2,787	967
Rate of clients[b] (number per 100,000 population)	396	592	783	830	496	589	1,141	1,731	601

(a) Client numbers based on client records with a valid SLK. No imputation applied for 2017–18.

(b) The crude rate is based on the preliminary Australian estimated resident population as at 31 December 2018.

Sources: Tables SC.21 and SC.27.

Client profile

In 2017–18, of the 129,800 clients aged 10 and over, most were seeking treatment for their own drug use—over 124,600 clients (or 96% of episodes)—and were more likely to be male (66% of clients). Conversely, clients seeking treatment for someone else's drug use were more likely to be female (64%) (tables SC.1–2).

Age

Clients receiving treatment for their own drug use tended to be younger, on average, than those receiving treatment for someone else's drug use.

In 2017–18:

- more than half (54%) of clients seeking treatment were aged 20–39

- clients seeking support for someone else's drug use were older —over half (58%) were aged 40 and over
- one-third (33%) of clients aged 40 and over received treatment for their own drug use (Table SC.3)
- clients aged 20–39 represented over half (55%) of clients receiving treatment for their own drug use, but only about one-quarter (26%) of clients receiving treatment for someone else's drug use
- clients aged 40 and over represented one-third (33%) of clients receiving treatment for their own drug use, compared with over half (58%) of clients receiving treatment for someone else's drug use (tables SC.2–3).

Over the 10-year period to 2017–18:

- the proportion of closed treatment episodes for clients who were aged 20–29 fell from 31% to 26%, while the proportion for those aged 40 and over rose from 29% to 34% (Table SE.5)
- the median (midpoint) age for all closed treatment episodes rose from 32 to 34 years
- for treatment episodes for clients seeking treatment for their own use, the median age also rose from 32 in 2008–09 to 34 in the same period
- for treatment episodes related to another's drug use, clients were generally older over the 10-year period, with the median age fluctuating from 41 in 2007–08 down to 39 in 2014–15 and up to 44 in 2016–17 and 2017–18 (Table SE.8).

Clients mostly received treatment in a *Major city* via a single AOD agency service.

In 2017–18:

- over 7 out of 10 (71%) closed treatment episodes were provided in *Major cities,* 17% in *Inner regional* areas and 9% in *Outer regional* areas
- relatively few treatment episodes were provided in *Remote* (3%) or *Very remote* areas (1%) (Table SA.4)
- most (82%) clients received treatment at a single agency,13% at 2 agencies, and 5% of clients received treatment at 3 or more agencies (Table SC.23)
- the number of clients receiving treatment via publicly funded AOD services increased slightly between 2016–17 and 2017–18 (from around 127,400 to 129,800).

Indigenous status

Despite comprising only 2.7% (ABS 2016) of the Australian population aged 10 and over in 2017–18, 16% of all clients were Aboriginal or Torres Strait Islander people. This varied by client type: about 1 in 6 (16%) clients receiving treatment for their own drug use and 12% of clients receiving treatment for someone else's drug use, were Indigenous (Table SC.4).

The main drugs that led Indigenous clients to seek treatment were alcohol, amphetamines, cannabis, heroin and volatile solvents (Table SC.8).

Country of birth and preferred language

The majority (86%) of closed treatment episodes were for clients born in Australia, while 72% of the general population was born in Australia (ABS 2017).

In 2017–18:

- 86% of episodes were provided to clients who were born in Australia

- clients receiving treatment that were born in countries other than Australia represented only a small proportion of all treatment episodes, with New Zealand and the United Kingdom being the next most common countries of birth (both 2%) (Table SE.9)
- comparatively, as at 30 June 2016, 5% of the Australian population were born in the United Kingdom and 2.5% in New Zealand (ABS 2017)
- English was the most frequently reported preferred language (96% of treatment episodes) among clients (Table SE.10).

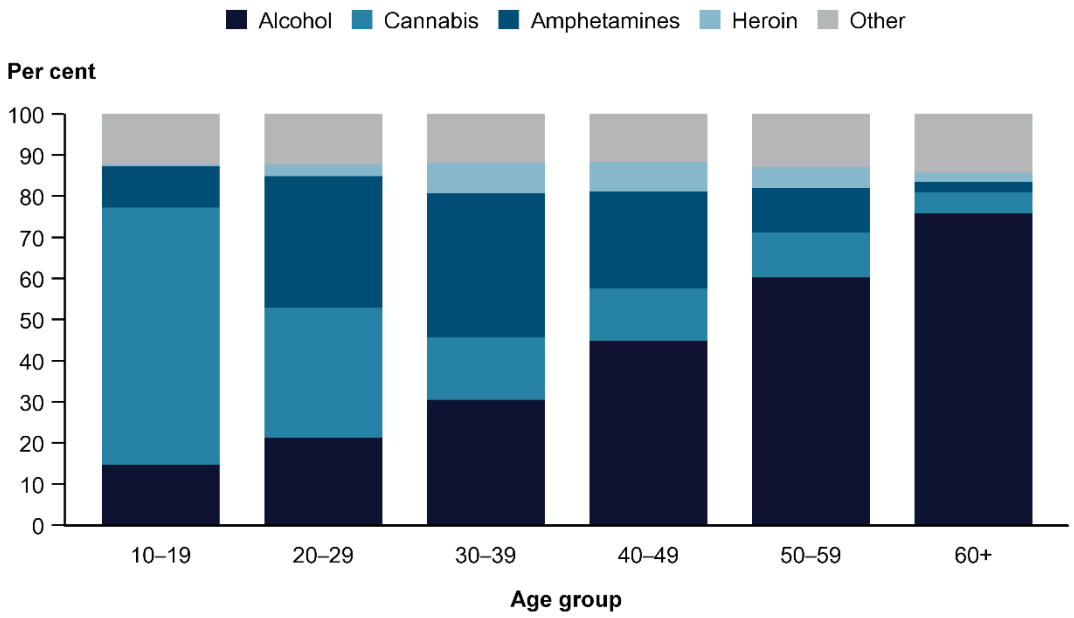
3.2 Clients and drugs of concern

At the client level, in 2017–18, alcohol was the most common principal drug of concern (34% of clients), followed by amphetamines (25%), cannabis (24%) and heroin (5%) (Table SC.9).

The proportion of clients receiving treatment where alcohol was the principal drug of concern increases substantially with age. Alcohol as a principal drug of concern was more common in the older age groups: 61% of those aged 50–59 and 76% of clients aged 60 and over, whereas it was a principal drug of concern for about 1 in 6 (15%) clients aged 10–19 (Figure 3.1; Table SC.7).

For clients receiving treatment for cannabis, the opposite was true. Those aged 10–19 were most likely to be receiving treatment for cannabis (62%), which was the principal drug of concern for almost two-thirds of clients in this age group, compared with 15% of those aged 30–39.

Figure 3.1: Clients principal drug of concern, by age group (years), 2017–18



Note: Based on client records with a valid SLK.

Source: Table SC.7.

For clients receiving treatment in 2017–18:

- where amphetamines and heroin were the principal drugs of concern, clients were most likely to be aged 20–49
- amphetamines were most likely to be the principal drug of concern for clients aged 20–39 (34% of those aged 20–29 and 38% of those aged 30–39)
- only 5% of those aged 10–19, and 4% of clients aged 50+ were receiving treatment for amphetamines
- heroin was most common among clients aged 30–49 (ranging from 43% of clients aged 30–39 and 29% of those aged 40–49), compared with 1% of clients aged 10–19 and 11% of clients aged 50+ (Table SC.7)
- alcohol was the most common principal drug of concern in treatment episodes reported across all agency remoteness areas except for *Very remote* areas
- agencies located in *Major cities* provided the highest proportion of treatment episodes for all principal drugs of concern
- where volatile solvents were the principal drug of concern, the highest proportion of treatment episodes reported were provided in *Outer regional*, *Very remote* and *Remote* areas, and the lowest proportion in *Inner regional* areas (30%)
- where amphetamines were the principal drug of concern, treatment episodes were mostly provided in *Major cities* (74%) followed by *Inner regional* (17%).

Client patterns of service use over multiple years

Nationally, around 622,000 closed treatment episodes were provided to over 445,200 clients in the 5 most recent collection years (2013–14, 2014–15, 2015–16, 2016–17 and 2017–18). Of these closed episodes, varying proportions of clients received some form of treatment across multiple collection years (tables SC.28 and 3.2):

- 17% (74,519) of clients received treatment in 2017–18 only
- 3.5% (15,513) of clients received treatment in both 2016–17 and 2017–18
- 1.4% (6,182) of clients received treatment in each year from 2015–16 to 2017–18
- 0.6% (2,712) of clients received treatment in each year from 2014–15 to 2017–18
- 0.6% (2,838) of clients received treatment in all years; from 2013–14 to 2017–18.

Over the period 2013–14 to 2017–18, nationally a total of nearly 445,500 clients received treatment. Of those:

- 73% (327,271) of clients received treatment in only a single year
- 18% (78,996) of clients received treatment in any 2 of the 5 years
- 6% (26,855) of clients received treatment in any 3 of the 5 years
- 2% (9,336) of clients received treatment in any 4 of the 5 years
- 0.6% (2,838) received treatment in all 5 collection years.

Table 3.2: Summary characteristics of clients[a] receiving treatment in multiple years (%)

	Clients 2016–17 and 2017–18	Clients 2015–16 to 2017–18	Clients 2014–15 to 2017–18	Clients in all five years up to 2017–18
Total proportion of clients	**3.5%**	**1.4%**	**0.6%**	**0.6%**
Sex				
Male	64.8	64.0	62.5	61.7
Female	35.1	36.3	37.6	38.3
Client type				
Own drug use	97.6	98.3	98.3	98.5
Others drug use	2.4	1.8	1.7	1.6
Indigenous status [b]				
Indigenous	14.9	14.1	13.2	12.0
Non-Indigenous	81.1	81.8	82.2	83.9
Age				
10–19	12.1	10.7	10.1	9.6
20–29	28.4	28.8	26.7	25.4
30–39	30.0	31.3	32.5	33.4
40–49	19.3	19.6	20.8	21.3
50+	10.3	9.5	9.8	10.3
Principal drugs of concern				
Alcohol	33.3	34.6	41.0	43.9
Amphetamines	25.7	25.4	21.9	18.8
Cannabis	19.5	17.5	16.6	14.8
Heroin	5.8	7.2	8.8	10.6
Referral to treatment				
Self/family	38.3	41.4	46.2	50.7
Health service	26.7	27.7	27.9	28.0
Corrections	12.4	11.0	6.9	5.1
Diversion	15.0	12.1	11.0	9.0
Other	7.7	7.8	7.9	7.2
Main treatment type				
Counselling	39.9	39.2	40.7	41.4
Information and education only	5.7	4.3	3.7	3.2
Support and case management only	13.8	12.8	8.5	9.2
Assessment only	17.4	16.6	15.5	12.6
Withdrawal management	14.1	17.0	21.4	23.1
Other[c] [d]	9.0	10.1	10.2	10.6
Treatment setting				
Non-residential treatment facility	66.0	64.1	63.2	63.7
Residential treatment facility	13.0	16.5	21.1	22.4
Other[d]	21.1	19.5	14.1	13.8
Treatment completion				
Expected/planned completion	58.4	57.6	58.7	60.6
Ended due to unplanned completion	21.0	20.9	22.1	21.7
Other[e]	20.5	21.5	19.2	17.7

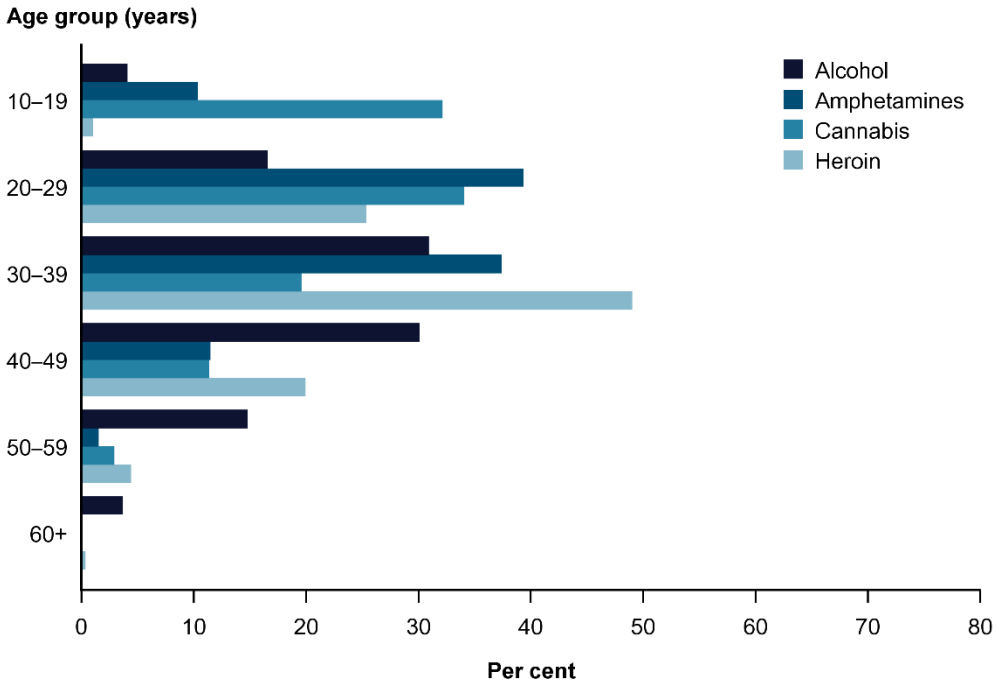
(continued)

(a) Based on valid SLK client data—no imputation applied to data.
(b) The proportion of clients for Indigenous status may not sum to the total, due to missing or not reported data.
(c) Includes pharmacotherapy, other and rehabilitation.
(d) Includes where treatment is delivered in the client's own home or usual place of residence or in an outreach setting.
(e) Includes where client is referred to another service/change treatment mode and other.
Sources: Tables SCY_2yr.1–.19, SCY_3yr.1–.19, SCY_4yr.1–.19, SCY_5yr.1–.19.

Clients receiving treatment in all 5 years from 2013–14 to 2017–18 were:

- more likely to be older where heroin was the principal drug of concern: 49% were aged 30–39 and 20% aged 40–49
- more likely to be younger where cannabis was the principal drug of concern: 34% were aged 20–29 and 32% aged 10–19
- most likely to be aged 20–39 where amphetamines were the principal drug of concern (77%)
- more likely to be older where alcohol was the principal drug of concern: only 4% were aged 10–19 but 48% aged 40 or over. Alcohol was the most common principal drug of concern for 2 in 5 clients (44%) (Figure 3.2; Table SCY.29).

Figure 3.2: Clients who received treatment in all 5 years, 2013–14, 2014–15, 2015–16, 2016–17 and 2017–18 by age group (years) and selected drugs of concern (%)

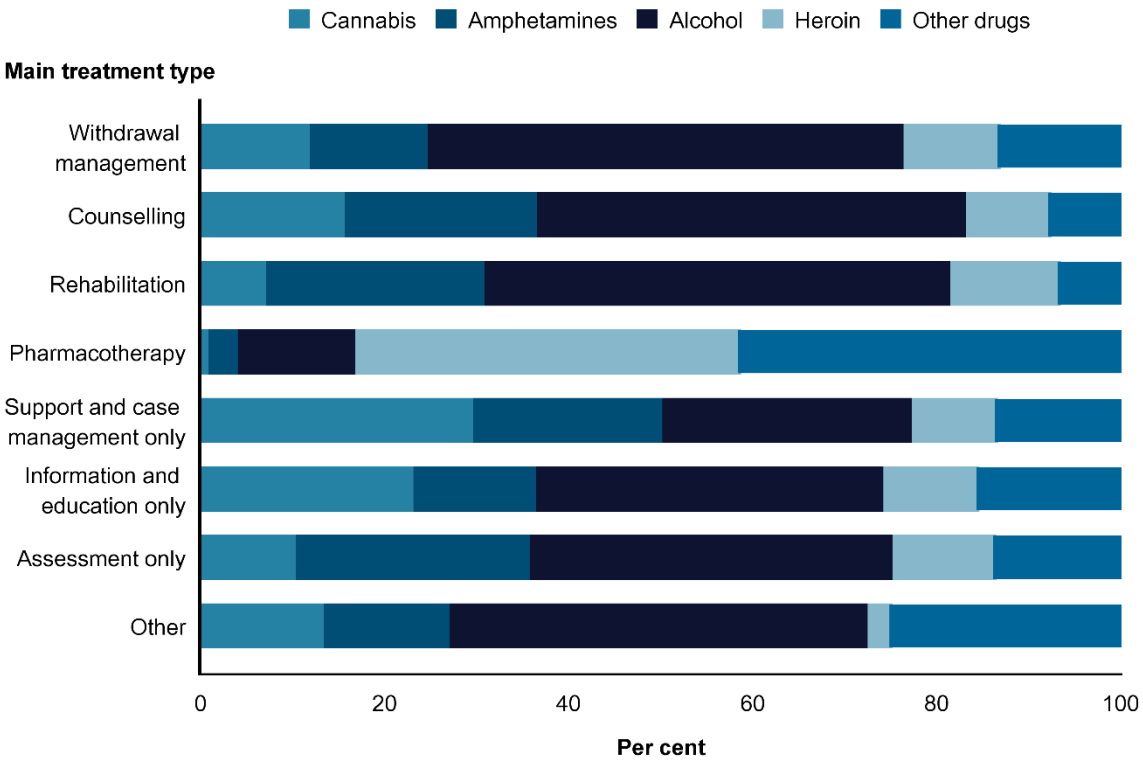


Source: Table SCY.29.

For clients receiving treatment in all 5 years from 2013–14 to 2017–18:

- counselling was the most common treatment type for alcohol (47%), followed by amphetamines (21%) and cannabis (16%)
- support and case management only was more commonly provided to clients with a principal drug of concern of cannabis (30%) or alcohol (27%)
- pharmacotherapy was the most common main treatment for over 2 in 5 clients (41%) where heroin was a principal drug of concern and 16% of clients where morphine was a principal drug of concern (morphine is a proportion of 'other' drugs in Figure 3.3).

Figure 3.3: Clients who received treatment in all five years, 2013–14, 2014–15, 2015–16, 2016–17 and 2017–18, by main treatment and selected drugs of concern (%)



Note: Pharmacotherapy treatment is undercounted. It is also reported in the NOPSAD report.

Source: Table SCY.36.

3.3 Usual accommodation type for client

For the 2015–16 collection year, the AODTS NMDS implemented the data element 'usual accommodation type' for the client prior to service. The data element enables analysis of the usual type of physical accommodation the person lived in prior to the start of the alcohol and other drug treatment service episode.

Preliminary analysis of the newly collected data for both the 2015–16, 2016–17 and 2017–18 collection years for usual accommodation type, resulted in high 'not stated' rates across some jurisdictions. It was recommended that the data not be published due to gaps in reporting and incomplete representation of client numbers receiving treatment services within jurisdictions and nationally.

For the 2017–18 collection year, data with valid response rates (over 90%) for usual accommodation type for the client prior to service for selected jurisdictions are reported, but not national totals.

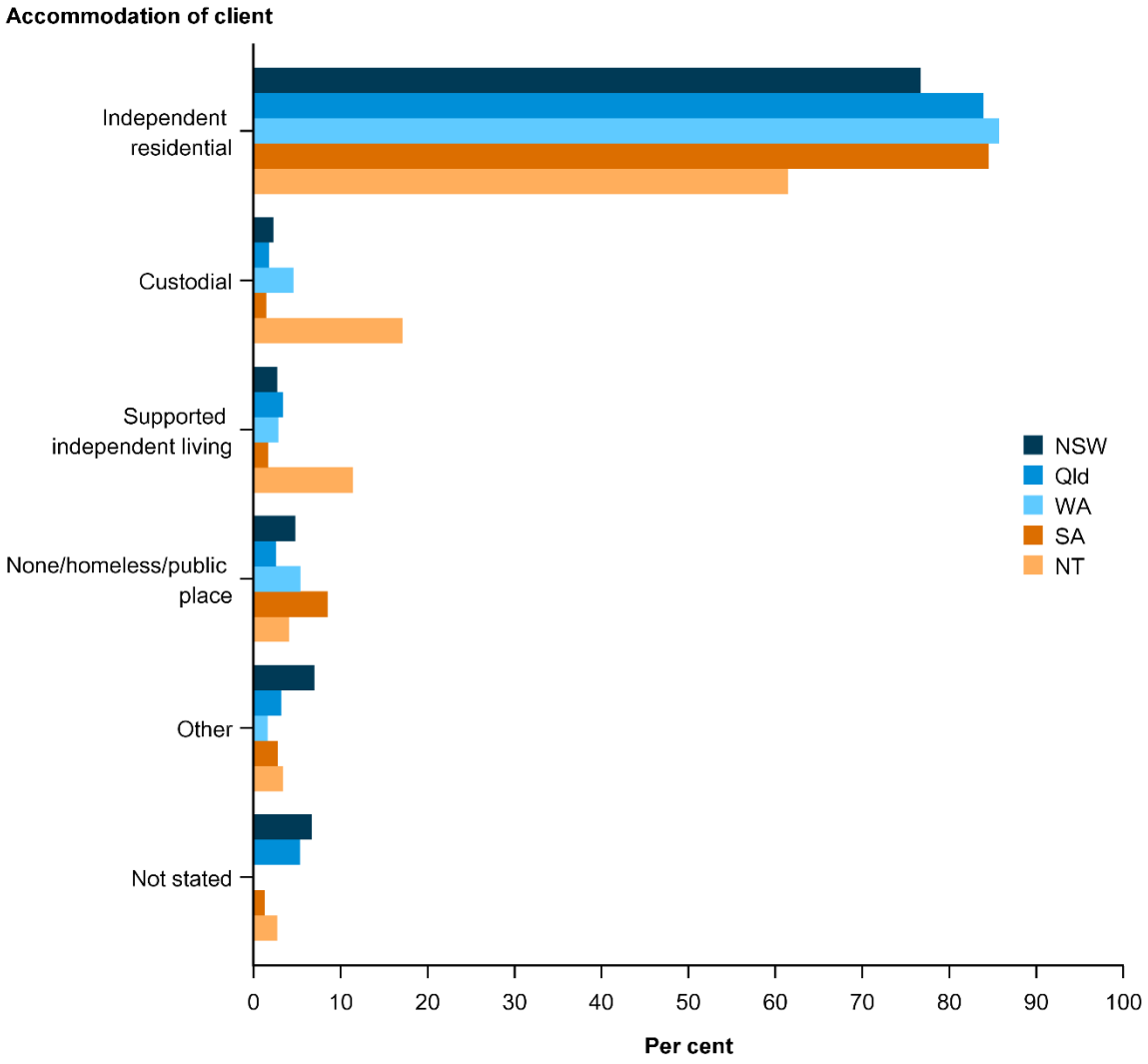
In 2017–18, the data quality for reporting of usual accommodation type for the client prior to service was considered suitable for release for New South Wales, Queensland, Western Australia, South Australia and Northern Territory. Data are presented for these jurisdictions only.

Almost two-thirds (62%) of all closed treatment episodes (130,324) are included in the following analysis: not stated responses account for approximately 4% of these episodes. There were minor levels of variation across states and territories for usual accommodation type prior to service in 2017–18 (Figure 3.4).

Of these closed treatment episodes:

- the most common usual accommodation prior to the start of the service episode was Independent residential accommodation. This category includes private residences, boarding houses, private hotels and informal housing
- Independent residential accommodation was most common in Western Australia (86%) followed by South Australia and Queensland (both 84%)
- the Northern Territory reported 17% of accommodation type episodes as custodial (Prison/remand centre/youth training centre) and 11% of closed episodes for domestic-scale supported living facilities
- Accommodation type episodes reported as none/homeless/public place were most common in South Australia (8%) followed by Western Australia and New South Wales (both 5%).

Figure 3.4: Closed episodes by clients accommodation type prior to treatment service, selected states and territories, 2017–18



Note: 'Other' includes where accommodation type prior to treatment service was hospital, residential aged care, residential AOD/MH/Other and other.

Source: Table SE. 28.

4 Drugs of concern

People may seek AOD treatment services due to problematic use of one or more drugs. For most people, however, there is one drug that is of most concern for them, and therefore the focus of the treatment they receive. This is referred to as their principal drug of concern. Clients can also report other drugs of concern (referred to as additional drugs of concern). Information on clients and treatment agencies are included in the AODTS NMDS when a treatment episode provided to a client is closed (Box 4.2).

Box 4.1: Key facts

In 2017–18:

- over 200,700 of closed treatment episodes provided were for clients receiving treatment for their own drug use
- nationally, alcohol was the most common principal drug of concern (35% of episodes) followed by amphetamines (27%), cannabis (22%), and heroin (6%)—together, these 4 drugs accounted for 89% of all treatment episodes
- alcohol was the most common principal drug of concern in all remoteness areas, with the highest proportion of episodes located in *Very remote* areas (71%), and the lowest proportion in *Major cities* (33%)
- clients whose principal drug of concern was volatile solvents generally spent longer in treatment—the median duration of episodes was 63 days compared with 19 days for all treatment episodes.

Over the 10-year period to 2017–18:

- the top 4 principal drugs of concern have remained consistent, although from 2015–16, amphetamines replaced cannabis as the second most common principal drug of concern
- the number of closed treatment episodes where amphetamines were the principal drug of concern increased by 323% (rising from around 12,700 episodes up to 53,900)
- treatment episodes for cannabis rose by 39%
- the number of episodes for clients injecting, smoking or inhaling amphetamines increased almost 5-fold from 10,400 episodes in 2008–09 to 48,000 episodes in 2017–18.

Box 4.2: Key terminology

Closed treatment episode

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

A treatment episode is considered closed where any of the following occurs: treatment is completed or has ceased; there has been no contact between the client and treatment provider for 3 months; or there is a change in the main treatment type, principal drug of concern or delivery setting.

(continued)

Box 4.2 (continued): Key terminology

Treatment episodes are excluded from the AODTS NMDS for a reporting year if they:

- are not closed in the relevant financial year
- are for clients who are receiving pharmacotherapy (through an opioid substitution therapy program) and not receiving any other form of treatment that falls within the scope of the collection include only activities relating to needle and syringe exchange, or
- are for a client aged under 10.

Drugs of concern

The **principal drug of concern** is the main substance that the client stated led them to seek treatment from the AOD treatment agency. In this report, only clients seeking treatment for their own substance use are included in analyses of principal drug of concern. It is assumed that only substance users themselves can accurately report principal drug of concern; therefore these data are not collected from those who seek treatment for someone else's drug use.

Additional drugs of concern refers to any other drugs the client reports using in addition to the principal drug of concern. Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode.

All drugs of concern refers to all drugs reported by clients, including the principal drug of concern and any additional drugs of concern.

Reasons for cessation

The reasons for a client ceasing to receive a treatment episode from an AOD treatment service include:

- expected/planned completion: episodes where the treatment was completed, or where the client ceased to participate at expiation or by mutual agreement
- ended due to unplanned completion: episodes where the client ceased to participate against advice, without notice or due to non-compliance
- referred to another service/change in treatment mode: episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider.

Treatment types

Treatment type refers to the type of activity used to treat the client's alcohol or other drug problem. Rehabilitation, withdrawal management (detoxification) and pharmacotherapy are not available for clients seeking treatment for someone else's drug use.

The **main treatment type** is the principal activity that is determined at assessment by the treatment provider to be necessary for the completion of the treatment plan for the client's alcohol or other drug problem for their principal drug of concern. One main treatment type is reported for each treatment episode. 'Assessment only', 'support and case management only' and 'information and education only' can be reported only as main treatment types.

Other treatment types refer to other treatment types provided to the client, in addition to their main treatment type. Up to 4 additional treatment types can be reported.

Note that Victoria and Western Australia do not supply data on additional treatment types. In these jurisdictions, each type of treatment (main or additional) results in a separate episode.

Although there are many different drugs for which people receive treatment, the most common principal drugs of concern—alcohol, amphetamines, cannabis and heroin—have accounted for the large majority of services over time (Figure 4.1). Nationally, alcohol has been the most common principal drug of concern up to 2017–18, followed by cannabis until 2014–15, when amphetamines became the second most common principal drug of concern. Heroin has maintained its place as the fourth most common principal drug of concern. Due to this consistent trend, the focus of this chapter is on these drugs.

Where a person receives treatment or support for someone else's drug use, the principal drug of concern for that person is not collected. As a result, no information is presented in this chapter on treatment received by people for someone else's drug use.

Drugs of concern and treatment provided

In 2017–18, over 200,700 (96%) of closed treatment episodes provided were for clients receiving treatment for their own drug use (Table SE.1; Box 4.1).

Clients own drug use

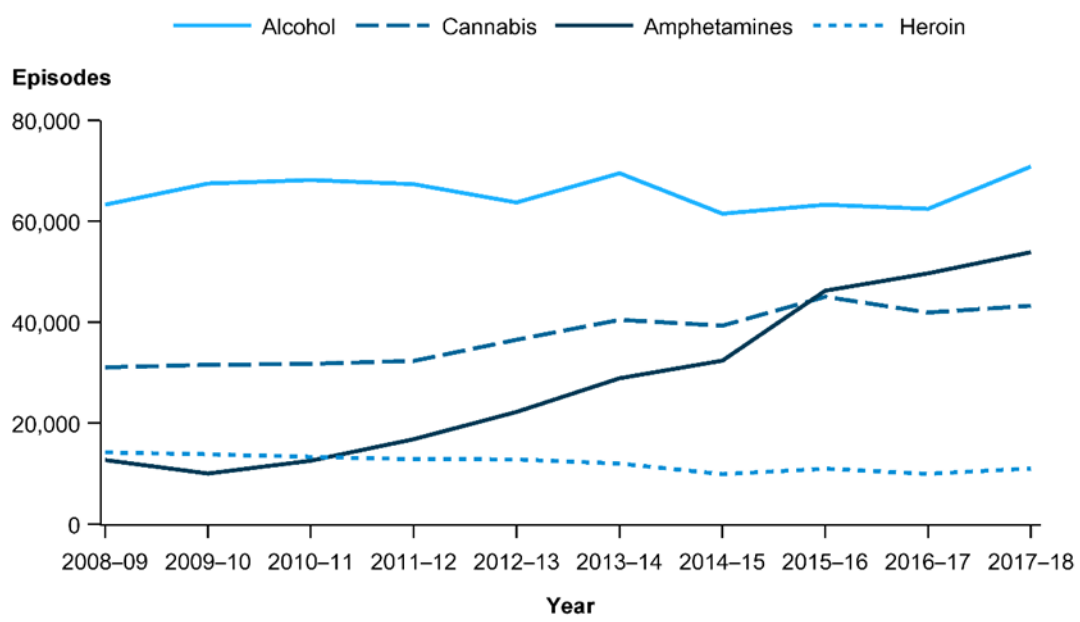
In 2017–18:

- the most common principal drugs of concern (the primary drug leading someone to seek treatment; Box 4.2) were alcohol (35% of episodes), amphetamines (27%), cannabis (22%) and heroin (6%)
- clients reported an additional drug of concern in over 2 in 5 (41%) episodes
- almost one-quarter (23%) of episodes had 1 additional drug of concern, 11% had 2 drugs and 1% had 5 drugs
- nicotine and cannabis (both 16%) were the most common additional drugs of concern (tables SD.6 and SD.8).
- the majority of closed treatment episodes for clients receiving treatment for their own drug use were provided by non-residential treatment facilities (63%), followed by residential treatment facilities (16%) and outreach settings (13%) (outreach includes any public or private location where services are provided away from the main service location, or a mobile service)
- episodes provided for the most common principal drugs of concern (alcohol, amphetamines, cannabis, and heroin) were most likely to be provided by non-residential treatment facilities (89%) (Table SD.12)
- nearly 4 in 5 (80%) episodes ended within 3 months. Almost one-third (30%) of episodes ended within 1 day and over half (56%) ended within 1 month. Only 7% of episodes lasted 6 months or longer
- the median duration of closed treatment episodes was 19 days (tables SE.21–22).

Since 2008–09:

- the proportion of episodes where alcohol was the principal drug of concern decreased from 46% to 35%
- the proportion of episodes where amphetamines were the principal drug of concern increased (from 9% to 27%) (Table SD.9)
- counselling continues to be the most common main treatment type provided to clients for their own drug use, comprising over one-third of episodes since 2008–09. However, since 2012–13, assessment only replaced withdrawal management, and support and case management only as the next most common main treatment type (Table ST.4).

Figure 4.1: Closed treatment episodes for own drug use, by selected principal drug of concern, 2008–09 to 2017–18



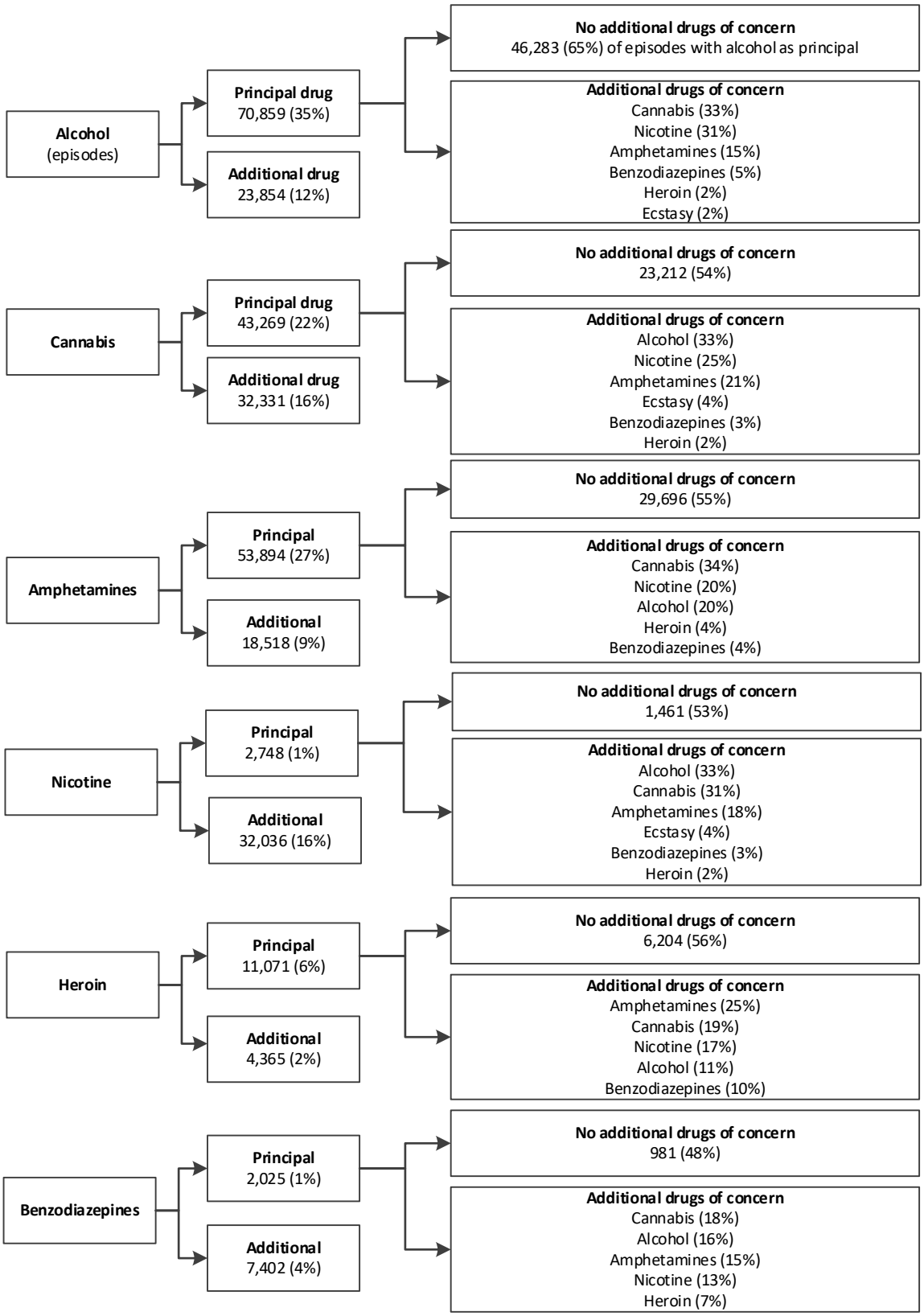
Source: Table SD.2.

Over the 10-year period to 2017–18, substantial shifts in treatment activity were reported (Figure 4.1). For example:

- the number of closed treatment episodes provided to clients receiving treatment for their own drug use increased by 45% (from around 138,000 to over 200,700)
- the number of episodes provided for amphetamines as a principal drug of concern increased substantially—rising over 300% (from around 12,700 up to 53,900 episodes)
- treatment episodes provided for cannabis as a principal drug of concern increased by 39% (from 31,100 to 43,200 episodes)
- the number of episodes for heroin fell by 22% (from around 14,200 to 11,000)
- the number of treatment episodes for alcohol fluctuated during this time, but it still remained the top drug of concern nationally (Table SD.2).

Decreases or increases in certain principal drug episodes in particular years can be subject to administrative anomalies in the data. For example, the drop in all treatment episodes in the 2014–15 and 2016–17 collection years may be partly related to system changes resulting in under-reporting or partial reporting of the number of episodes in some jurisdictions.

Figure 4.2: Closed treatment episodes for own drug use, by principal drug of concern and additional drugs of concern, 2017–18



Note: Totals might not add to 100% due to rounding.

Sources: Tables SD.6, SD.7 and SD.8.

4.1 Alcohol

In 2017–18, alcohol was a drug of concern (principal or additional) in 47% of closed episodes for a client's own drug use and was the most common principal drug of concern (70,859 or 35% of all closed treatment episodes) (Figure 4.2; Table SD.8). At the client level, alcohol was the most common principal drug of concern (34%).

Clients can nominate up to 5 additional drugs of concern: these drugs are not necessarily the subject of any treatment within the episode. In 12% of treatment episodes where alcohol was the principal drug of concern, the client reported additional drugs of concern. This was most commonly cannabis or nicotine (33% and 31%, respectively) (Figure 4.2; tables SD.6–7).

Box 4.3: Alcohol

Alcohol is a central nervous system depressant that inhibits brain functions, dampens the motor and sensory centres, and makes judgment, coordination and balance more difficult (NDARC 2010). According to the 2009 Australian guidelines to reduce health risks from drinking alcohol (NHMRC 2009), people who drink more than 2 standard drinks per day on average have an increased lifetime risk of harm from alcohol-related disease or injury, while those who drink more than 4 standard drinks on a single occasion are at risk of harm on that occasion.

Results from the 2016 National Drug Strategy Household Survey (AIHW 2017) showed that:

- about 77% of Australians aged 14 and over drank alcohol in the previous 12 months
- a significant proportion of the Australian population drank at risky levels—1 in 5 (17%) aged 14 and over drank at a level that put them at risk of alcohol-related harm over their lifetime, while 1 in 4 (26%) drank at levels that put them at risk of harm from a single drinking occasion at least once in the previous 12 months
- males were more likely than females to drink at levels—1 in 5 (17%) aged 14 and over drank at a level that put them at risk of alcohol-related harm over their lifetime, while 1 in 4 (26%) drank at levels that put them at risk of harm from a single drinking occasion at least once in the previous 12 months
- males were more likely than females to drink at levels that placed them at risk of harm over their lifetime as well as on a single occasion.

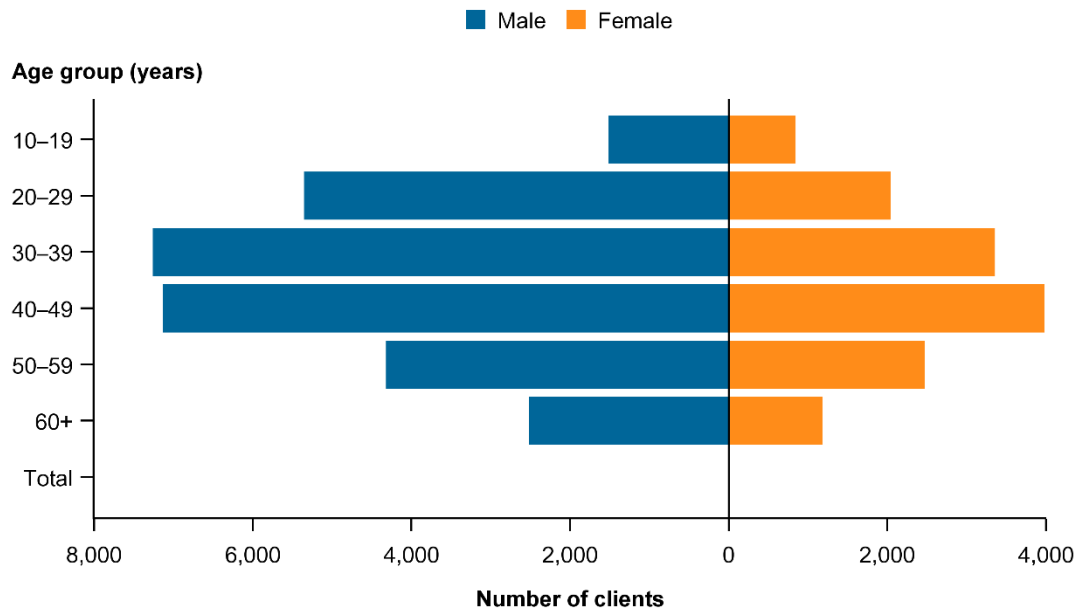
Client demographics

In 2017–18, around two-thirds of clients whose principal drug of concern was alcohol were male (67%) and 1 in 6 were Indigenous (17%) (tables SC.6 and SC.8).

For clients whose principal drug of concern was alcohol:

- the rate for Indigenous Australian clients receiving treatment for alcohol as a principal drug of concern decreased over the years from 2014–15 (1,434 per 100,000 population) to 2017–18 (1,303 per 100,000 population) (Table SC.26)
- the clients were most likely to be aged 40–49 (27% of clients), followed by 30–39 (25%) (Table SC.7)
- clients were most likely to be female and most likely to be older (aged 40+) (56%, compared with 51% for males) (Figure 4.3).

Figure 4.3: Closed episodes provided for own drug use where alcohol was a principal drug of concern, by sex and age group, 2017–18



Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for alcohol as a main drug of concern (tables SCY.1–36):

- In both years, 2016–17 and 2017–18, around one-third (33%) of clients received treatment for alcohol.
- In all years from 2015–16 to 2017–18, over one-third (35%) of clients received treatment for alcohol.
- In all years from 2014–15 to 2017–18, over 2 in 5 clients (41%) received treatment for alcohol.
- In all years from 2013–14 to 2017–18, over 2 in 5 clients (44%) received treatment for alcohol.

Treatment

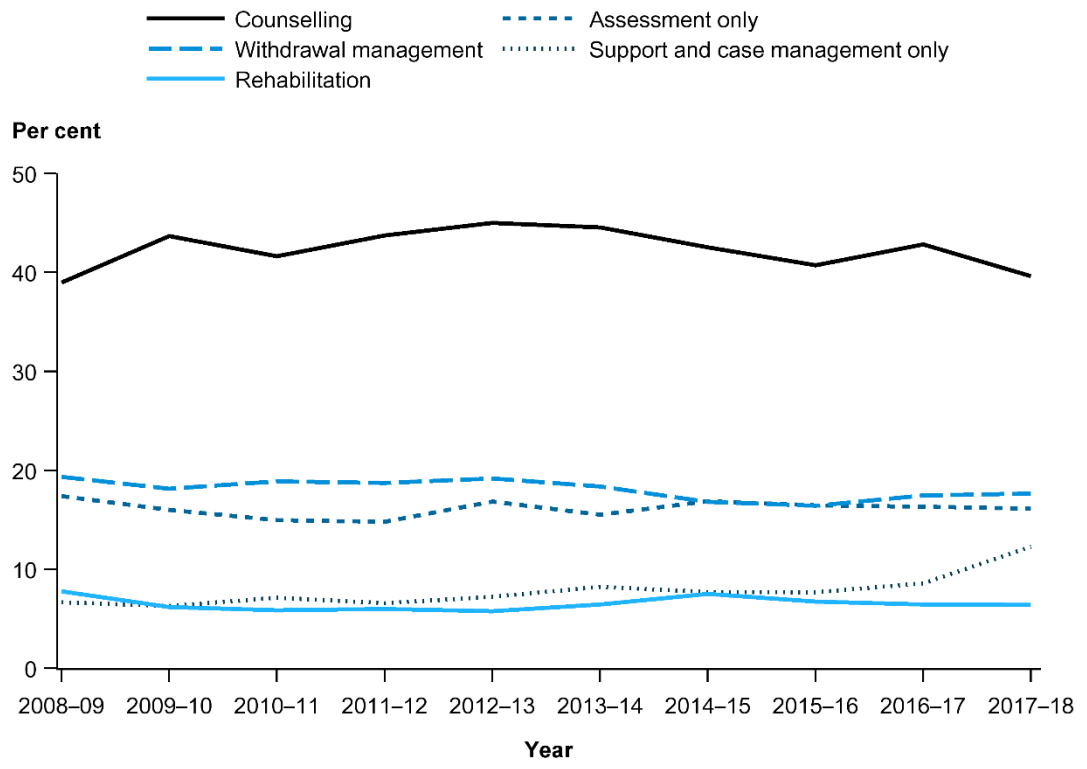
In 2017–18, for closed treatment episodes where alcohol was the principal drug of concern:

- the most common source of referral was self/family (43%), followed by a health service (36%) (Table SD.21)
- the most common main treatment type was counselling (40%), followed by withdrawal management (18%) and assessment only (16%)
- almost 2 in 3 treatment episodes for withdrawal management were for clients aged 40+ (64%) (Table SD.27).

Over the 10-year period to 2017–18, counselling, withdrawal management and assessment only have remained the most common main treatment types for episodes where alcohol was the principal drug of concern (Figure 4.4).

More than half (54%) of closed treatment episodes with alcohol as the principal drug lasted less than 1 month (23% ended within 1 day) (Table SE.25). The median duration of episodes with alcohol as the principal drug of concern was over 3 weeks (23 days) (Table SD.33).

Figure 4.4: Closed treatment episodes with alcohol as the principal drug of concern, by the top 5 treatment types received, 2008–09 to 2017–18



Source: Table SD.26.

For alcohol-related treatment episodes in 2017–18:

- most were likely to take place in a non-residential treatment facility (62%), with almost 1 in 5 (20%) occurring in a residential treatment facility
- where counselling was the main treatment type, most episodes (89%) took place in a non-residential treatment facility
- where withdrawal management was the main treatment type episodes were most likely to take place in a residential treatment facility (60%) (Table SD.28)
- almost two–thirds (63%) of episodes ended with a planned cessation, while 19% ended unexpectedly (that is, the client ceased to participate against advice, without notice or due to non-compliance)
- planned cessations were most common where the referral source was self/family (45%)
- unexpected cessations were also most common where the referral source was self/family (49%) (Table SD.29).

For more information on the groupings for reasons for cessation of treatment, see Appendix A (Table A3).

4.2 Cannabis

In 2017–18, cannabis was a drug of concern (principal or additional) in 38% of episodes and was the third most common principal drug of concern (over 43,200 closed treatment episodes for a client's own drug use or 24% of clients) (Figure 4.2; tables SD.6 and SD.8).

In almost half (46%) of episodes with cannabis as the principal drug of concern, the client reported additional drugs of concern (Table SD.6). This was most commonly alcohol (33%), nicotine (25%) or amphetamines (21%) (Figure 4.2; Table SD.7). Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode.

Box 4.4: Cannabis

Cannabis (also called marijuana or gunja) is derived from the cannabis plant (usually *Cannabis sativa*) and is used in whole plant (typically the flowering heads), resin or oil forms. Cannabis has a range of stimulant, depressant and hallucinogenic effects. The risks associated with long-term or regular use of cannabis include addiction, damage to lungs and lung functioning, effects on memory and learning, and psychosis and other mental health conditions. Cannabis withdrawal is now listed as a discrete syndrome in the Diagnostic and Statistical Manual of Mental Disorders (NCPIC 2011). According to the 2016 National Drug Strategy Household Survey (AIHW 2017), 1 in 3 Australians aged 14 and over have used cannabis at some point in their lifetime, while 1 in 10 have used it in the previous 12 months.

Diversion treatment programs

Among diversion clients, diversion episodes are most likely to be for cannabis, followed by alcohol, amphetamines or heroin (Figure 4.6). Throughout Australia, there are programs that divert people who were apprehended or sentenced for a minor drug offence from the criminal justice system. Many of these diversions result in people receiving drug treatment services. Services vary widely, ranging from short-term assessment, information or education sessions to longer term treatments such as counselling and withdrawal management, which are supported by Australian Government funding and a national framework. Diversion programs in the states and territories have led to the development of systematic approaches to diversion. Some states and territories have also incorporated their own additional drug diversion programs that have different priorities and target groups, including cannabis expiation notice schemes, youth programs and alcohol-related offenders, which have changed over time due to legislative, regulatory and policy frameworks related to drugs and drug use.

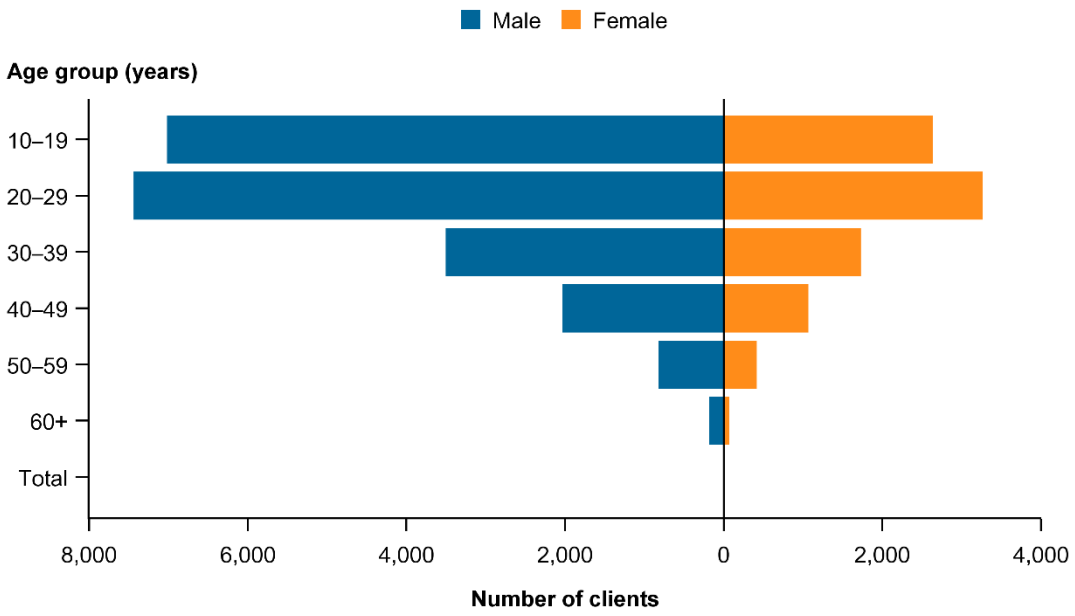
Client demographics

In 2017–18, where cannabis was the principal drug of concern, over two-thirds of clients were males (70%) and around 1 in 6 were Indigenous (17%) (tables SC.6 and SC.8).

For clients whose principal drug of concern was cannabis:

- the rate for Indigenous Australian clients receiving treatment for cannabis as a principal drug of concern increased over the years from 2014–15 (832 per 100,000 population) to 2017–18 (970 per 100,000 population) (Table SC.26)
- for over two-thirds (67%) of clients aged 10–29, cannabis was most likely to be the principal drug of concern (Table SC.7)
- male (68%) and female (64%) clients with cannabis as their principal drug of concern were most likely to be aged 10–29 (Figure 4.5).

Figure 4.5: Closed treatment episodes provided for own drug use where cannabis was a principal drug of concern, by sex and age group, 2017–18



Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for cannabis as a main drug of concern (tables SCY.1–36):

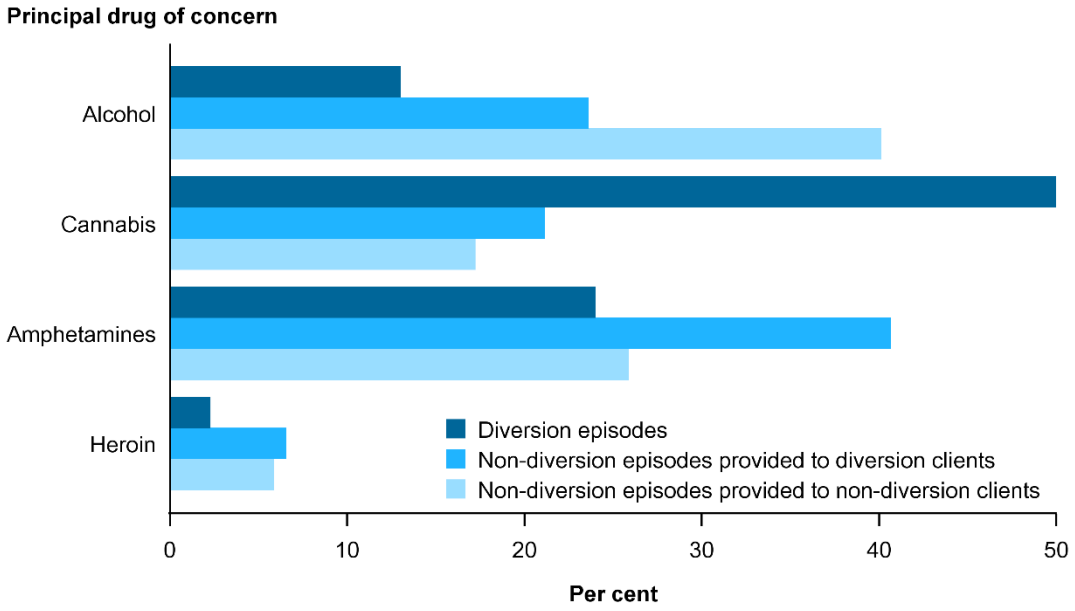
- In both years, 2016–17 and 2017–18, around 1 in 5 clients (20%) received treatment for cannabis.
- In all years from 2015–16 to 2017–18, almost 1 in 5 clients (18%) received treatment for cannabis.
- In all years from 2014–15 to 2017–18, around 1 in 6 clients (17%) received treatment for cannabis.
- In all years from 2013–14 to 2017–18, more than 1 in 7 clients (15%) received treatment for cannabis.

Treatment

In 2017–18, for episodes where cannabis was the principal drug of concern:

- the most common source of referral was diversion (that is, referred from the criminal justice system into AOD treatment for drug or drug-related offences) (32%), followed by self/family (28%) (Table SD.37)
- diversion clients receiving treatment for cannabis, represented over half (51%) of all episodes related to treatment referrals diverted from the criminal justice system (Figure 4.6)
- some diversion clients also received treatment episodes where the source of referral was not related to diversion within the same year, such as amphetamines (24% of episodes for diversion only and 41% receiving diversion and non-diversion treatment episodes) (see Glossary and Appendix A) (Figure 4.6; Table SE.27).

Figure 4.6: Closed treatment episodes, by selected principal drug of concern and diversion client type, 2017–18



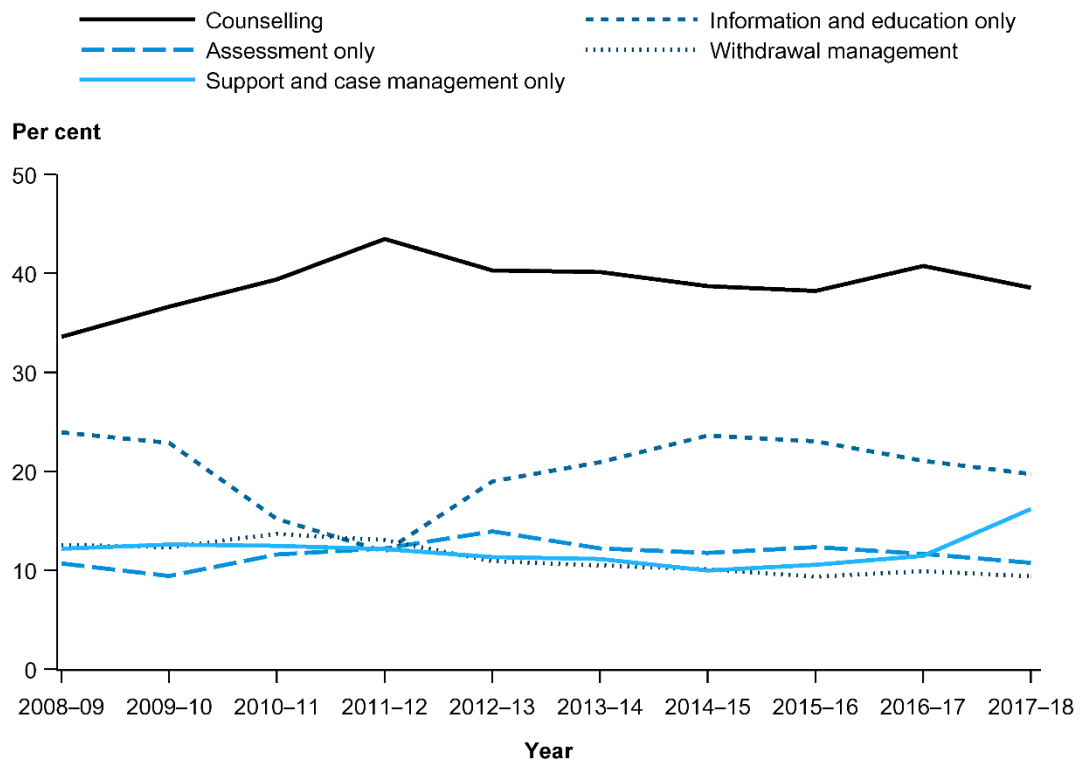
Source: Table SE.27.

For treatment episodes where cannabis was the principal drug of concern in 2017–18:

- counselling was the most common main treatment type (39%), followed by information and education only (20%) (Table SD.42)
- most (84%) episodes where counselling was the main treatment type took place in a non–residential treatment facility (Table SD.44)
- treatment was most likely to take place in a non-residential treatment facility (67%)
- almost 3 in 5 (61%) episodes lasted less than 1 month (40% ended within 1 day) (Table SE.25)
- the median duration of a treatment episode was 11 days (Table SD.47)
- support and case management as the main treatment type had a median duration of about 5 weeks (34 days), rehabilitation lasted around 6 weeks (44 days) and counselling median duration was 7 weeks (49 days)
- information and education only/assessment only had the shortest duration, 1 day only
- almost three–quarters (69%) of closed episodes ended with an expected cessation and two-fifths where the client was diverted from the criminal justice system (42%)
- around 1 in 6 (17%) episodes ended unexpectedly (Table SD.45).

Since 2008–09, counselling has remained the most common form of treatment, accounting for around 40% of treatment episodes annually, followed by information and education only increasing as a result of diversion programs (Figure 4.7; Table SD.42).

Figure 4.7: Closed treatment episodes with cannabis as the principal drug of concern, by the top 5 treatment types received, 2008–09 to 2017–18



Source: Table SD.42.

4.3 Amphetamines

In 2017–18, amphetamines were a drug of concern (principal or additional) in 36% of closed treatment episodes (Figure 4.2; Table SD.8). Amphetamines were the second most common principal drug of concern for the third consecutive year (27% of treatment episodes and 25% of clients), having surpassed cannabis for the first time in 2015–16 (over 49,600 episodes) and increasing to 53,900 episodes in 2017–18 (Figure 4.2; Table SD.8).

Box 4.5: Amphetamines

Amphetamines stimulate the central nervous system and can result in euphoria, increased energy, decreased appetite, paranoia and increased blood pressure (ADCA 2013). Long-term effects include high blood pressure, extreme mood swings, depression, anxiety, psychosis and seizures. There is no approved pharmacotherapy for the management of amphetamine withdrawal or replacement therapy (Lee et al. 2007). According to the 2016 National Drug Strategy Household Survey (AIHW 2017), 1 in 16 (6.3%) Australians aged 14 and over have used meth/amphetamines for non-medical purposes at some point in their lifetime, while 1 in 70 (1.4%) have used them in the previous 12 months.

The AODTS NMDS data available for amphetamines correspond to the Australian Standard Classification of Drugs of Concern (ASCDC) for the general 'amphetamines' classification, in which methylamphetamine is a sub-classification. Data on different forms of amphetamines—methylamphetamine specifically—are not separately reported due to the nature of the classification structure used in this collection.

A client's usual method of administering their principal drug of concern can provide an indication of the form a client used, particularly for amphetamines. For example, those smoking (clients who report either smoking or inhaling amphetamines) will be using the crystal form, and those ingesting or snorting are most likely to be using the powder form.

According to the 2016 National Drug Strategy Household Survey (AIHW 2017), the proportion of the adult population using methamphetamine fell from 2.1% in 2010 to 1.4% in 2016. However, among recent methamphetamine users, there was a change in the main form used, with a significant increase in the use of crystal methamphetamine or 'ice' (from 22% to 57% over the same period).

In 2017–18, for closed treatment episodes where amphetamines were the principal drug of concern:

- clients reported additional drugs of concern in almost half (45%) of episodes
- additional drugs of concern were most commonly cannabis (34%), nicotine and alcohol (both 20%) (Figure 4.2; tables SD.6–SD.7)
- smoking/inhaling was the most common usual method of use (51% of episodes), followed by injecting (38%) (Table SD.55).

Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode.

Over the 10-year period to 2017–18:

- the proportion of episodes with amphetamines as the principal drug of concern rose from 9% to 27%
- AOD treatment services provided up to 53,900 closed treatment episodes where amphetamines were the principal drug of concern (Table SD.2)

- between 2008–09 and 2017–18 the number of closed treatment episodes with amphetamines as the principal drug of concern increased substantially, rising over 300% (from around 12,700 episodes up to 53,900).

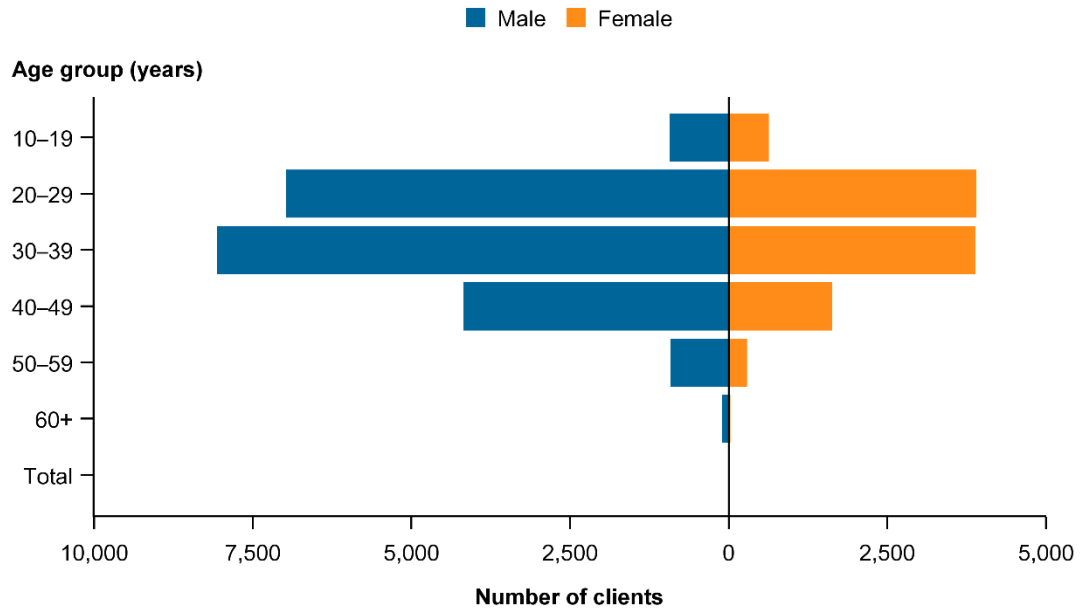
Client demographics

In 2017–18, two-thirds of clients receiving treatment for amphetamines as a principal drug of concern were male (67%) and about 1 in 6 clients were Indigenous (16%) (tables SC.6 and SC.8).

For clients whose principal drug of concern was amphetamines:

- the rate of Indigenous Australians increased over the years from 2014–15 (530 per 100,000 population) to 2017–18 (952 per 100,000 population)
- while a small number of episodes (4,984 episodes) where amphetamines were a principal drug of concern were reported nationally for Indigenous clients, this represents a larger proportion of the Indigenous population across Australia (Table SC.8)
- clients were most likely to be aged 20–39 (72%), followed by those aged 40–49 (18%) (Tables SC.5–7)
- male (71%) and female (76%) clients with amphetamines as their principal drug of concern were most likely to be aged 20–39 (Figure 4.8).

Figure 4.8: Number of clients with amphetamines as the principal drug of concern, by age group (years) and sex, 2017–18



Note: Based on client records with a valid SLK.

Sources: Tables SC.6 and SC.7.

Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for amphetamines as a principal drug of concern (tables SCY.1–36):

- In both years, 2016–17 and 2017–18, over 1 in 5 (26%) clients received treatment for amphetamines.
- In all years from 2015–16 to 2017–18, 1 in 4 (25%) clients received treatment for amphetamines.
- In all years from 2014–15 to 2017–18, over 1 in 4 (22%) clients received treatment for amphetamines.
- In all years from 2013–14 to 2017–18, almost 1 in 5 (19%) clients received treatment.

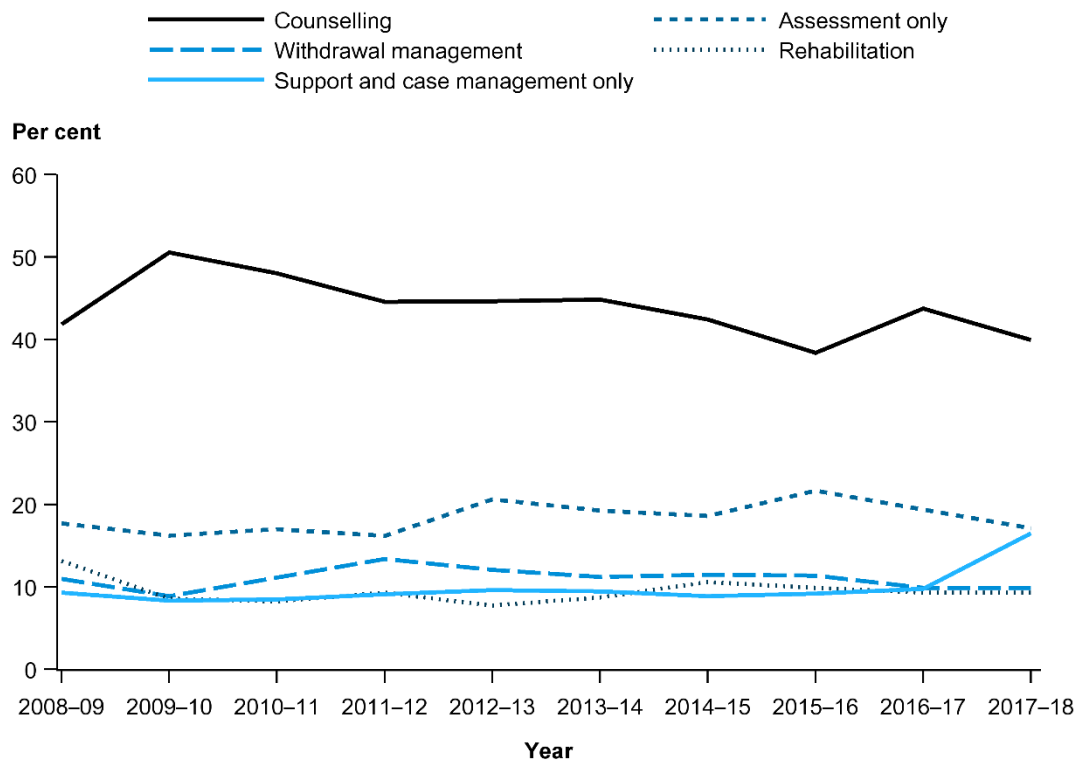
Treatment

In 2017–18, for treatment episodes where amphetamines was the principal drug of concern:

- the most common main treatment type was counselling (40% of episodes), followed by assessment only (17%), and support and case management (16%)
- treatment was most likely to take place in a non-residential treatment facility (61% of episodes) (Tables SD.58 and SD.60)
- the most common source of referral was self/family (39%), followed by health services (23%), and diversion (16%) (Table SD.53).

Over the 10-year period to 2017–18, the proportion of episodes where counselling was the main treatment type for amphetamines as the principal drug of concern peaked at 51% in 2009–10 falling to 40% in 2017–18 (Figure 4.9; Table SD.58).

Figure 4.9: Closed treatment episodes with amphetamines as the principal drug of concern, by the top 5 treatment types received, 2008–09 to 2017–18



Source: Table SD.58.

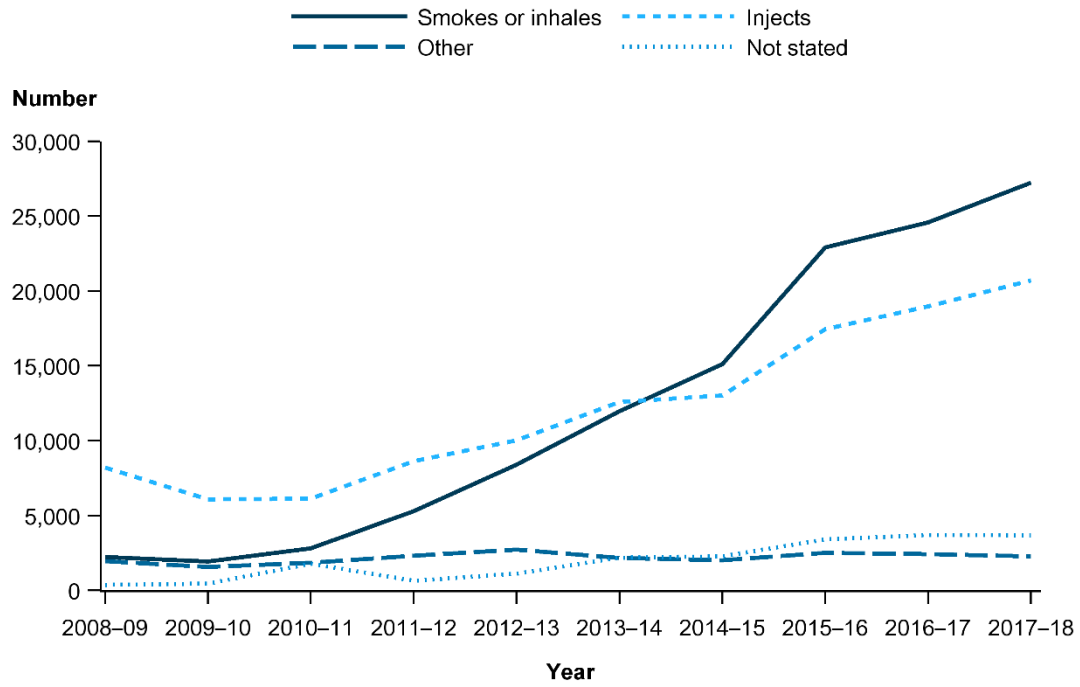
For treatment episodes where amphetamines were the principal drug of concern in 2017–18:

- over half (54%) of the episodes lasted less than 1 month (28% ended within 1 day) (Table SE.25)
- the median duration of episodes was just over 3 weeks (23 days) (Table SE.23)
- episode duration varied widely depending on the main treatment type—episodes with a main treatment type of counselling had a median duration of just over 8 weeks (60 days), rehabilitation had median duration of 7 weeks (45 days) and withdrawal management ended within 1 week (7 days) (Table SD.64)
- almost 3 in 5 (57%) episodes ended with an expected cessation
- expected cessations were most common for episodes where self/family was the referral source (39%). Slightly less than one-quarter (24%) of episodes ended unexpectedly (Table SD.61).

Over the 10-year period to 2017–18, the number of episodes for clients smoking/inhaling amphetamines increased almost 5-fold from 10,400 episodes in 2008–09 to 48,000 episodes in 2017–18 (Table SD.55, Figure 4.10).

Injecting as a method of use for amphetamines has been rising since 2011–12, which may be attributed to patterns arising from an increase in the availability of crystal methamphetamines, as well as an increase in treatment episodes, and for injecting clients who might have been using amphetamines and heroin interchangeably (AIHW 2015).

Figure 4.10: Closed treatment episodes for own drug use with amphetamines as the principal drug of concern, by method of use, 2008–09 to 2017–18



Note: 'Other' includes 'ingests', 'sniffs' and 'other'.

Source: Table SD.55.

4.4 Heroin

In 2017–18, heroin was a drug of concern (principal or additional) in 8% of closed treatment episodes and was reported in 6% of episodes as a principal drug of concern, making it the 4th most common principal drug of concern (around 11,000 closed treatment episodes and 5% of clients) (Figure 4.2; tables SC.6 and SD.8).

Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode. In less than half (44%) of episodes with heroin as the principal drug of concern, the client reported additional drugs of concern. This was most commonly amphetamines (25%) and cannabis (19%) (tables SD.6–7).

Box 4.6: Heroin

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

Heroin users seeking treatment can take part in a withdrawal program (also called detoxification), an abstinence-based treatment (for example, residential rehabilitation in a therapeutic community) or attend an opioid maintenance substitution program (O'Brien 2004).

Results from the 2016 National Drug Strategy Household Survey showed that:

- 1.3% of people in Australia aged 14 and over had used heroin in their lifetime and 0.2% had used it in the previous 12 months.
- there was no significant change in the proportion of people using heroin between 2013 and 2016 (AIHW 2017).

Results from the 2018 National opioid pharmacotherapy statistics annual data (NOPSAD) collection reported that clients receive pharmacotherapy treatment for a range of opioid drugs. These include illicit opioids (such as heroin) and pharmaceutical opioids available by prescription (such as oxycodone) or through illicit means. From 1 February 2018, all formerly over-the-counter (non-prescription) codeine-containing medicines for pain relief, cough and colds became available by prescription only.

Data for opioid drug of dependence has a high proportion of clients with 'Not stated/not reported' as their opioid drug of dependence (39% of clients in 2018). High rates of 'Not stated/not reported' were shown in New South Wales (65%), Victoria (32%) and the Australian Capital Territory (31%).

For the 61% of clients with a reported opioid drug of dependence, heroin was the most commonly reported drug of dependence (60%) followed by oxycodone (9%) and codeine (8%).

Heroin was the most common drug of dependence in all states and territories, except Tasmania and the Northern Territory, where morphine was the most common (AIHW 2018).

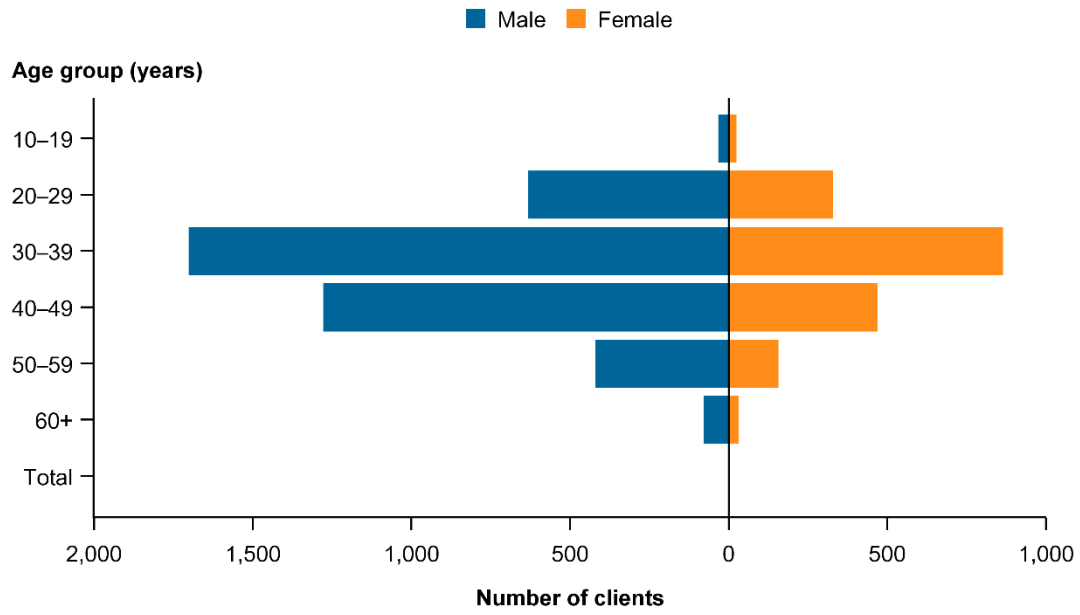
Client demographics

Where heroin was the principal drug of concern, 69% of clients were male and 14% were Indigenous (tables SC.6 and SC.8).

For clients whose principal drug of concern was heroin:

- the rate for Indigenous Australian clients receiving treatment for heroin as a principal drug of concern increased slightly over the years from 2014–15 (133 per 100,000 population) to 2017–18 (164 per 100,000 population)
- clients with heroin as their principal drug of concern were most likely to be aged 30–39 (43%), followed by those aged 40–49 (29%) and those aged 20–29 (16%) (Table SC.7)
- male (72%) and female (71%) clients with heroin as their principal drug of concern were most likely to be aged 30–49 (Figure 4.11).

Figure 4.11: Number of clients with heroin as the principal drug of concern, by age group (years) and sex, 2017–18



Note: Based on client records with a valid SLK.

Sources: Tables SC.6 and SC.7.

Client patterns of service use

Of the clients receiving treatment in multiple collection years, a similar proportion of clients received treatment for heroin as a main drug of concern (tables SCY.1–36):

- In both years, 2016–17 and 2017–18, 6% of clients received treatment for heroin.
- In all years from 2015–16 to 2017–18, 7% of clients received treatment for heroin.
- In all years from 2014–15 to 2017–18, almost 1 in 10 (9%) clients received treatment for heroin.
- In all years from 2013–14 to 2017–18, over 1 in 10 (11%) clients received treatment for heroin.

Treatment

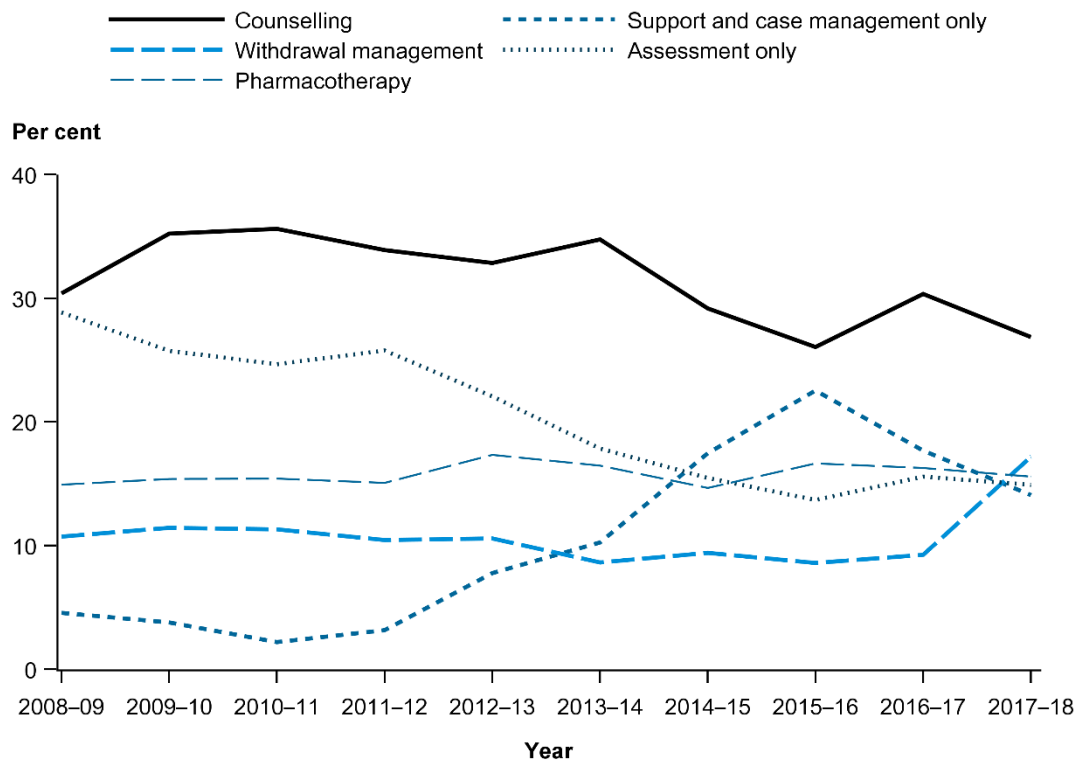
In 2017–18, for treatment episodes where heroin was the principal drug of concern:

- the most common source of referral was self/family (49%), followed by a health service (24%), and correction programs (12%) (Table SD.85)
- the most common main treatment types were counselling (27%), followed by support and case management only (17%), and assessment only (16%) (Table SD.90)
- treatment episodes were most likely to take place in a non-residential treatment facility (65%) (Table SD.92).

Over the 10-year period to 2017–18, the proportion of episodes with withdrawal management as the main treatment type for the principal drug of concern of heroin fell from 29% to 15%, with pharmacotherapy treatment episodes increasing from 5% to 14% (Figure 4.12; Table SD.90). The decrease in 2015–16 for pharmacotherapy treatment can be attributed to jurisdictional coding practices/system changes resulting in under-reporting at the national level for pharmacotherapy as a treatment type.

The increase in the proportions for pharmacotherapy is mostly due to changes in the AODTS NMDS reporting specifications introduced for the first time in 2011–12 to allow pharmacotherapy to be reported as a primary treatment, in combination with some other form of treatment.

Figure 4.12: Closed treatment episodes with heroin as the principal drug of concern, by the top 5 treatment types received, 2008–09 to 2017–18



Source: Table SD.90.

For treatment episodes where heroin was the principal drug of concern in 2017–18:

- injecting was the most common method of use (81% of episodes) (Table SD.87)
- in almost 2 in 3 (61%) episodes, the client reported they had injected drugs in the previous 3 months, while 10% reported they last injected 3–12 months ago (injecting status was not reported for 10% of episodes) (Table SD.88)
- about half (56%) of the episodes lasted less than 1 month (28% ended within 1 day), and were mostly for the main treatment types of assessment only, support and case management only, and withdrawal management (Table SE.25)
- the median duration of episodes was just under 3 weeks (18 days)
- Episodes with counselling as the main treatment lasted about 9 weeks (66 days), while episodes with support and case management lasted just over 2 weeks (15 days), and episodes with withdrawal management treatment lasted about 1 week (6 days) (Table SD.96)
- more than half (59%) of the episodes ended with an expected cessation (Table SD.93).

Over the 10-year period to 2017–18, the proportion of episodes where heroin was the principal drug of concern fell from 10% to 6% (Table SD.2).

4.5 Pharmaceuticals

In 2017–18, pharmaceutical drugs were the principal drug of concern in 5% of all episodes for a client's own use (around 9,600 of closed treatment episodes) (Figure 4.2; Table SD.9). Pharmaceuticals were more likely to be reported as an additional drug of concern in closed treatment episodes (8%).

Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode. Over half (54%) of episodes with pharmaceutical drugs as the principal drug of concern, the client reported additional drugs of concern. This was most commonly cannabis (17%), amphetamines (16%) and nicotine (14%) (tables SD.6–7).

Box 4.7: Pharmaceuticals

Pharmaceuticals are drugs that are available from a pharmacy—over the counter or by prescription—which may be subject to misuse (MCDS 2011).

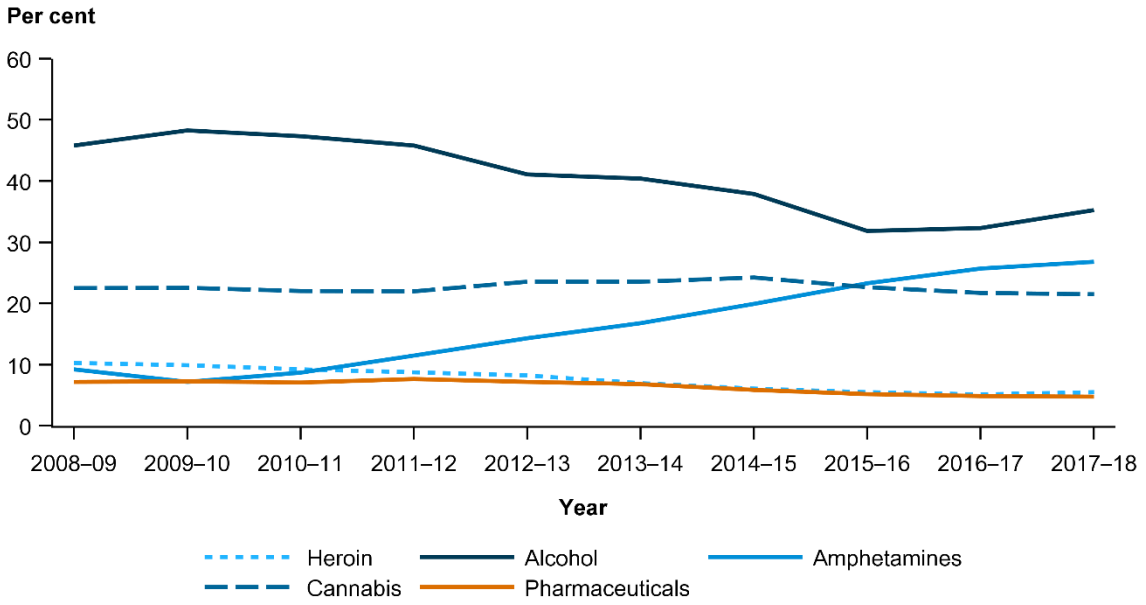
Pharmaceuticals are not listed as a broad drug group in the ASCDC classification. In the AODTS NMDS report, 10 drug types were identified as making up the group 'pharmaceuticals' for the purposes of this analysis: codeine, morphine, buprenorphine, oxycodone, methadone, benzodiazepines, steroids, other opioids, other analgesics, and other sedatives and hypnotics.

Further information corresponding to the Australian Standard Classification of Drugs of Concern (ASCDC) codes and classifications is in Appendix A

Results from the National Drug Strategy Household Survey showed that in 2016 just under 1 in 20 (4.8%) Australians had misused a pharmaceutical in the last 12 months (pain-killers/opiates, tranquillisers, steroids, or methadone/buprenorphine) (AIHW 2017).

Over the 10-year period to 2017–18, the proportion of treatment episodes with a pharmaceutical drug as the principal drug of concern increased from 7% in 2008–09 to 8% in 2011–12 and then fell to 5% in 2017–18 (Figure 4.13).

Figure 4.13: Proportion of closed treatment episodes for the top 5 principal drugs of concern, 2008–09 to 2017–18 (%)

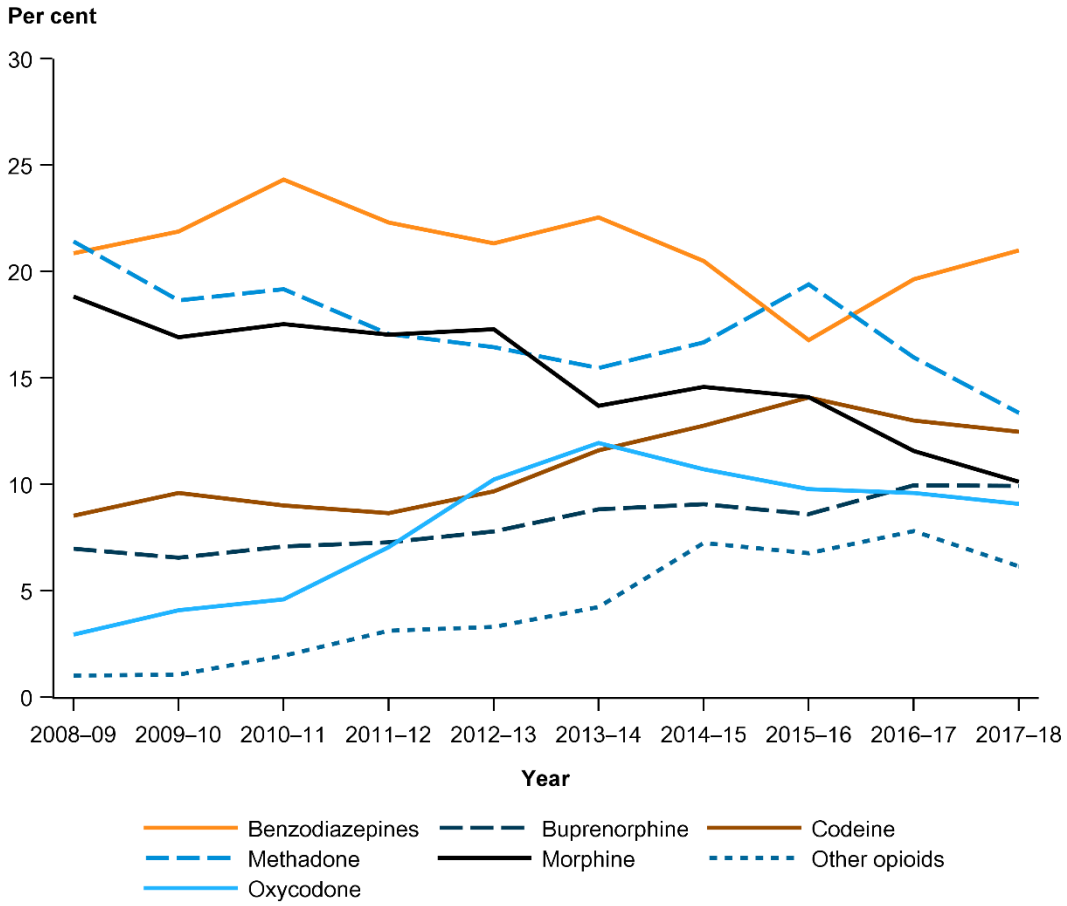


Source: Table SD.9

In 2017–18, benzodiazepines represented the largest proportion of closed episodes for a single drug type within the pharmaceutical group (21%) followed by methadone (13%), codeine (12%) and morphine (10%) (Figure 4.14; Table SD.146).

The proportions of treatment episodes for morphine and methadone have decreased over the 10-year period, while the proportions for codeine, oxycodone and buprenorphine have increased. Treatment episodes for codeine as a principal drug of concern almost doubled (from 851 episodes in 2008–09 to 1,448 in in 2015–16) and oxycodone treatment episodes tripled (from 3% in 2008–09 to 9% in 2017–18), despite a fall since 2013–14 when it was 12%. Over the same period, treatment episodes for methadone as a principal drug of concern fell by 8 percentage points (from 21% to 13%) and morphine fell by 9 percentage points (from 19% to 10%) (Figure 4.14; Table SD.146).

Figure 4.14: Proportion of closed treatment episodes for selected pharmaceutical drugs of concern, 2008–09 to 2017–18 (%)



Source: Table SD.9.

Client demographics

Where pharmaceuticals were the principal drug of concern in 2017–18, over half (58%) of the clients were male and around 1 in 8 were Indigenous (12%).

For clients whose principal drug of concern was a pharmaceutical drug:

- female clients were more likely to report specific pharmaceutical drug types; for example, a higher proportion of female clients (53%) received treatment for codeine as their principal drug of concern (Table SC.6)
- the most common age group for clients seeking treatment for pharmaceuticals as a principal drug of concern were aged 30–39 (34%), followed by clients aged 40–49 (26%) and 20–29 (20%) (Table SC.7).

Treatment

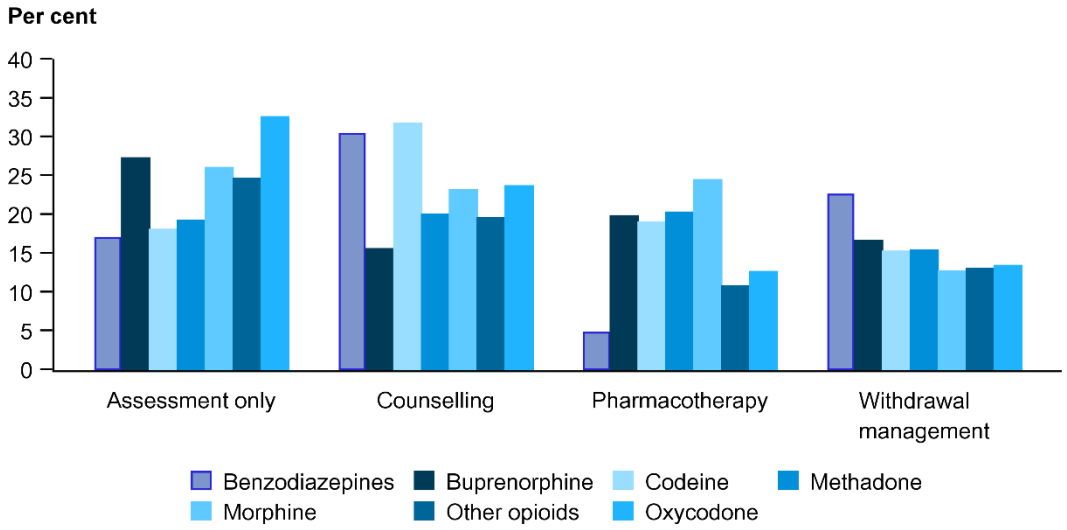
In 2017–18, for treatment episodes where pharmaceuticals were the principal drug of concern:

- almost half of the referrals for treatment episodes were for self/family (39%), followed by a health service (28%) (Table SD.149)
- the most common main treatment type was counselling (25%), assessment only (21%) and withdrawal management (17%), followed by pharmacotherapy (13%) (Table SD.148).

The relative proportions of treatment episodes for each main treatment type by individual pharmaceuticals varied substantially. For example:

- where counselling was the main treatment, there was a higher proportion of treatment for benzodiazepines (30%) and codeine (32%) as principal drugs of concern
- where the main treatment was withdrawal management, the most common principal drug of concern was benzodiazepines (23%), followed by buprenorphine (16%)
- differences for pharmacotherapy as a main treatment were substantial, ranging from 4% for benzodiazepines to 24% for morphine as principal drugs of concern
- oxycodone had the highest proportion of episodes for assessment only (32%) (Figure 4.15; Table SD.148).

Figure 4.15: Proportion of main treatment type for selected pharmaceuticals as the principal drug of concern, 2017–18 (%)



Source: Table SD.148

For treatment episodes where pharmaceuticals were the principal drug of concern in 2017–18:

- clients were more likely to have ever injected a pharmaceutical drug (21%) than for treatment episodes for most other drugs of concern (16%) (Table SD.10)
- in almost one-third of treatment episodes (27%), clients reported injecting within the last 3 months and 14% repoted injectingover 12 months ago (Table SD.11)

- over half (57%) of treatment episodes ended with an expected cessation, while 1 in 5 (18%) ended unexpectedly.

Of the principal drugs of concern identified as pharmaceuticals, steroids had the highest proportion (74%) of treatment episodes ending with an expected cessation, followed by benzodiazepines (63%) and methadone (59%). The proportion of treatment episodes ending with an unexpected cessation was highest for morphine (25%), followed by codeine and oxycodone (both 22%), and lowest for methadone (14%) (SD.150).

4.6 Selected other drugs

A number of drugs make up a smaller proportion of overall treatment services. These drugs may be less prominent in treatment services because they are less common, or users may be less likely to seek treatment. Information about nicotine, ecstasy and benzodiazepines is included in this section, not just as a result of prevalence among the population, but also the increased harms that these substances bring to an individual and/or the community (see Box 4.8).

Box 4.8: Drug descriptions

Nicotine

Nicotine is the stimulant drug in tobacco smoke. It is highly addictive and causes dependency (ADCA 2013). Tobacco use (9%) was the highest risk factor contributing to the total burden of disease and injury in Australia in 2011 (AIHW 2016). The health effects of smoking include premature death and tobacco-related illnesses such as cancer, chronic obstructive pulmonary disease and heart disease.

Ecstasy

Ecstasy is the popular street name for a range of drugs said to contain the substance 3, 4 methylenedioxymethamphetamine (MDMA): an entactogenic stimulant with hallucinogenic properties. Ecstasy is usually sold in tablet or pill form, but is sometimes found in capsule or powder form. The short-term effects of ecstasy include euphoria, feelings of wellbeing and closeness to others, and increased energy. Harms include psychosis, heart attack and stroke. Little is known about the long-term effects of ecstasy use, but there is some research linking regular and heavy use of ecstasy to memory problems and depression (ADCA 2013).

Benzodiazepines

Benzodiazepines are depressant drugs: they slow down the activity of the central nervous system and the speed of messages going between the brain and the body. Formerly known as ‘minor tranquillisers’, benzodiazepines are most commonly prescribed by doctors to relieve stress and anxiety, and to aid sleep. They are a drug of dependence, and are associated with fatal and non-fatal overdose among opioid users. Some people use benzodiazepines illegally to become intoxicated or to come down from the effects of stimulants, such as amphetamines or cocaine (ADF 2013)

Results from the National Drug Strategy Household Survey showed that in 2016:

- almost 1 in 7 Australians were current smokers and 1 in 8 were daily smokers
- although smoking rates have been on a long-term downward trend, for the first time in over 2 decades, the daily smoking rate among people aged 14 and older did not decline significantly between 2013 and 2016 (from 13% to 12%)
- 2% of Australians aged 14 and over used ecstasy in the previous 12 months
- ecstasy use did not significantly change from 2013 to 2016 (2.5% to 2.2%).

Clients can nominate up to 5 additional drugs of concern, but these drugs are not necessarily the subject of any treatment within the episode. The selected drugs of concern—nicotine, ecstasy and benzodiazepines—were more likely to be reported as an additional drug of concern rather than a principal drug of concern (tables 4.1 and SD.8).

Nicotine was reported as a principal drug of concern in only 1.3 % of treatment episodes, but in 16% of episodes as an additional drug of concern. Most clients seeking treatment for ecstasy were younger—aged 10–29 (88%)—and were more likely to be male (81%). Around 7 in 10 (70%) clients seeking treatment for benzodiazepines were aged over 30 and almost half were female (44%) (Table 4.1).

Table 4.1: Summary characteristics of other selected drugs of concern, 2017–18 (%)

	Nicotine	Ecstasy	Benzodiazepines
Client data			
Sex[(a)]			
Male	58.0	80.7	56.2
Female	41.9	19.3	43.7
Indigenous status[(a) (b)]			
Indigenous	16.4	4.0	7.7
Non-Indigenous	81.7	92.1	87.9
Age[(a)]			
10–19	20.3	32.8	8.1
20–29	24.5	58.0	21.6
30–39	20.4	8.3	27.6
40–49	15.1	3.3	22.5
50+	19.7	0.5	20.0
Closed treatment episodes			
Drugs of concern			
Principal drug of concern	1.3	0.6	1.0
Additional drug of concern	15.9	1.7	3.7
Referral to treatment			
Self/family	22.7	17.4	48.1
Health service	36.7	10.4	39.2
Corrections	3.8	6.4	2.9
Diversion	29.5	62.4	4.9
Other	7.3	3.5	5.0
Main treatment type			
Counselling	28.3	26.7	30.4
Information and education only	13.3	36.5	5.7
Assessment only	28.1	21.6	16.9
Withdrawal management	10.7	2.2	22.5
Other[(c)]	19.7	13.1	24.5
Treatment setting			
Non-residential treatment facility	64.1	80.1	60.0
Residential treatment facility	4.4	3.6	20.5
Other[(d)]	31.5	16.3	19.5
Treatment completion			
Expected cessation	79.1	85.5	63.3
Unexpected cessation	10.9	8.8	16.0
Other[(e)]	10.0	5.7	20.7
Median duration (episodes)	**2 days**	**1 day**	**14 days**

(a) Based on valid SLK client data.

(b) The proportion of clients for Indigenous status may not sum to the total, due to missing or not reported data.

(c) Includes support and case management only, pharmacotherapy, other and rehabilitation.

(d) Includes where treatment is delivered in the client's own home or usual place of residence or in an outreach setting.

(e) Includes administrative cessation.

Sources: Tables SC.5–7, SD.66, SD.69, SD.73, SD.76–79, SD.99, SD.106, SD.108–110, SD.114–117, SD.122, SD.124–126.

The proportion of episodes with either nicotine, ecstasy or benzodiazepines as the principal drug of concern has remained stable at around 1%–2% for each drug each year since 2013–14 (Table SD.9). Typically, these 3 principal drugs of concern have together contributed around 3%–4% of the total number of treatment episodes each year since 2013–14.

Over the 10-year period to 2017–18, the proportion of closed treatment episodes for these drugs listed as an additional drug of concern varied: ecstasy decreased from 6% to 2% and benzodiazepines fell from 7% to 4%. Nicotine increased from 18%, peaking in 2012–13 (23%) then falling to 16% in 2017–18 (Table SD.9).

Nicotine

In 2017–18, nicotine was a principal drug of concern in just 1.4% of treatment episodes (2,748), but listed as an additional drug of concern in 16% of treatment episodes (32,036) (tables 4.1 and SD.9); additional drugs of concern are not necessarily the subject of any treatment within the episode. Since 2008–09, the proportion of episodes with nicotine as the principal drug has remained stable at 1%–2% (Table SD.9).

Reasons for the low proportion of episodes in which nicotine was the principal drug include the wide availability of support and treatment for nicotine use in the community, such as through general practitioners, pharmacies, helplines or web services. People might also view AOD treatment services as most appropriate for drug use that is beyond the expertise of general practitioners. However, therapy to quit smoking is becoming an integral part of some AOD services as a parallel treatment with other drugs of concern.

Client demographics

Where nicotine was a principal drug of concern:

- 58% of clients were male and 16% were Indigenous Australians
- over 3 in 5 clients were aged under 30 years (42%) and 21% were aged over 50 (tables 4.1 and SC.5–7).

Nicotine was more commonly reported as an additional drug of concern (16%): the most commonly reported principal drugs of concern in combination with nicotine as an additional drug of concern were alcohol (33%) and cannabis (31%) (tables SD.7–8).

Treatment

For treatment episodes where nicotine was the principal drug of concern in 2017–18:

- the most common source of referral was a health service (37%), followed by police or court diversion programs (30%) and self/family (23%) (Table 4.1)
- assessment only (28%), counselling (28%), and support and case management only (15%) were the most common main treatment types (tables 4.1 and SD.74)
- treatment episodes were most likely to take place in a non-residential treatment facility (64%) (Table SD.76)
- almost two-thirds (66%) of episodes lasted less than 1 month (48% ended within 1 day and were mostly an assessment only) (Table SE.25)
- the median duration of episodes was 2 days (tables 4.1 and SD.79)
- almost three–quarters (79%) of episodes ended with an expected cessation, while 11% ended unexpectedly
- expected cessations were most common where the main treatment type was assessment only (33%) (Table SD.78).

Ecstasy

Ecstasy was a principal drug in less than 1% of episodes (1,185 closed episodes) and an additional drug of concern in 2% (3,484) of closed episodes in 2017–18.

The proportion of episodes with ecstasy as a principal drug has remained stable at up to 1% of all closed treatment episodes since 2008–09, but as an additional drug of concern it decreased from 6% of episodes in 2008–09 to 2% in 2017–18 (tables 4.1 and SD.7).

Client demographics

Where ecstasy was the principal drug of concern:

- over 8 in 10 (81%) clients were male and 4% were Indigenous
- over half of the clients (58%) were aged 20–29 and 33% were aged 10–19 (tables 4.1 and SD.115–116).

Ecstasy was more likely to be reported as an additional drug of concern: the most common principal drugs of concern that were reported in combination with ecstasy as an additional drug of concern were alcohol (34%) and cannabis (26%) (Figure 4.2; Table SD.7).

Treatment

For treatment episodes where ecstasy was the principal drug of concern in 2017–18:

- in almost three–quarters (62%) of treatment episodes, the client's source of referral was from police and court diversion (tables 4.1 and SD.125)
- the most common main treatment type was information and education only (36%), followed by counselling (27%), and assessment only (22%) (Table SD.121)
- treatment was most likely to take place in a non-residential treatment facility (80%) (Table SD.124)
- almost three–quarters (75%) of episodes lasted less than 1 month (61% ended within 1 day) (Table SE.25)
- the median duration of episodes was 1 day (tables 4.1 and SD.127).
- almost 9 in 10 (85%) episodes ended with an expected cessation, while 9% ended unexpectedly
- expected cessations were most common where the main treatment type was information and education only (42%) (Table SD.126).

Benzodiazepines

In 2017–18, benzodiazepines were a principal drug of concern in 1% of treatment episodes (2,025 episodes) and an additional drug of concern in 4% of treatment episodes (7,402 episodes) (Table 4.1).

In the 10-year period to 2017–18, the proportion of episodes with benzodiazepines as the principal drug changed by only 1 percentage point (Table SD.9).

Client demographics

Where benzodiazepines were the principal drug of concern:

- over half (56%) of the clients were male and 8% were Indigenous
- over 7 in 10 clients (70%) with benzodiazepines as a principal drug of concern were aged over 30 years (Table 4.1).

Benzodiazepines were more likely to be an additional drug of concern: the most common principal drugs of concern in combination with benzodiazepines as an additional drug of concern were cannabis (18%), alcohol (16%) and amphetamines (15%) (Table SD.7).

Treatment

For treatment episodes where benzodiazepines was the principal drug of concern in 2017–18:

- the most common source of referral was self/family (48%), followed by a health service (39%) (Table 4.1)
- the most common main treatment type was counselling (30%), followed by withdrawal management (23%) and assessment only (17%) (tables 4.1 and SD.106)
- treatment was most likely to take place in a non-residential treatment facility (60%)
- counselling was the main treatment provided (33% of episodes) in a non-residential treatment facility, followed by assessment only (21%) (Table SD.110)
- nearly 3 in 5 (62%) episodes lasted less than 1 month, and 84% of episodes lasted up to 3 months (Table SE.25)
- the median duration of episodes was 2 weeks (14 days) (tables 4.1 and SD.111).
- around 3 in 5 (63%) episodes ended with an expected cessation, while 16% ended unexpectedly
- expected cessations were more common for episodes where the main treatment type was counselling (25%) or withdrawal management (23%) (Table SD.110).

5 Treatment provided

There are a number of treatment types available to assist people with problematic drug use in Australia. Most aim to reduce the harm of drug use, while others use a structured drug-free setting with abstinence-oriented interventions.

This chapter presents information on the treatment types provided by publicly funded AOD treatment agencies in Australia. Information on clients and treatment agencies is included in the AODTS NMDS when a treatment episode provided to a client is closed (see Box 4.2). Treatment is available to help people tackle their own drug use, and to support the family and friends of people using drugs.

Box 5.1: Treatment provided key facts

In 2017–18, for closed treatment episodes for **all** clients:

- counselling was the most common treatment type nationally (44%)
- self/family was the most common source of referral (36%)
- around 4 in 5 (77%) episodes ended within 3 months
- around 3 in 5 (50%) episodes had an expected/planned completion.

With regard to treatment provided for own drug use and support for someone else's drug use:

- most clients for whom treatment was provided for a client's own drug use were male (67%), whereas most clients seeking support for someone else's drug use were female (64%)
- over two-thirds (67%) of clients aged 10–39 were seeking treatment for their own drug use, whereas over half (58%) of clients aged 40 and over were seeking support for someone else's drug use
- the median duration of episodes for a client's own drug use was 3 weeks (19 days).

Over the 10-year period to 2017–18:

- the proportion of episodes for each main treatment has remained stable, with counselling and assessment only being the most common types of treatment
- support and case management only has become the third most common treatment over the last 3 years
- the median duration of closed episodes for the client's own drug use increased from 18 days to 19 days
- the proportion of episodes with an expected cessation decreased from 66% to 63%.

5.1 Referral to treatment

In 2017–18, the most common source of referral for clients overall was self/family (36%). This was consistent for all treatment types, with the exception of support and case management only, where correctional service was the most common source of referral (37%) and information and education only, where police and court diversion was the most common source of referral (63%) (Table SC.18).

The most common source of referral treatment episodes was self/family for both clients receiving treatment for their own drug use (39%) and clients receiving treatment for someone else's drug use (58%).

Referral episodes from a health service were also common for both groups (28% and 18%, respectively), while referral episodes from police or court diversion programs accounted for 16% of episodes for clients receiving treatment for their own drug use. Clients referred by diversion programs were younger: with 22% of these episodes being for clients aged 10–19, 34% for clients aged 20–29 and 24% for clients aged 30–39 (Table SE.16).

In 2017–18, the source of referral varied according to clients' principal drugs of concern (Table 5.1). For example:

- Self/family were the most common source of referral for clients receiving treatment for the principal drugs heroin (49% of episodes), benzodiazepines (48%) and morphine (48%).
- Where cannabis was the principal drug of concern, diversion (32% of episodes) was the most common source of referral, followed by self/family referrals (28% of episodes).
- Clients receiving treatment for alcohol as their principal drug of concern were less likely to be referred through diversion (7% of episodes) when compared with clients receiving treatment episodes for heroin, amphetamines, or cannabis (9%, 16% and 32%, respectively).
- Around 6 in 10 (62%) treatment episodes for clients whose principal drug of concern was ecstasy were referred to treatment through police or court diversion programs (see Chapter 4 for further information regarding drugs of concern).

Table 5.1: Closed treatment episodes, by principal drug of concern and source of referral, 2017–18 (%)

Principal drug of concern	Self/family	Health service	Corrections	Diversion	Other	Total
Analgesics						
Codeine	45.1	45.6	1.0	1.3	7.1	100
Morphine	47.8	31.6	12.6	3.2	4.9	100
Buprenorphine	44.2	37.0	11.8	1.8	4.8	100
Heroin	49.2	23.6	12.3	9.3	5.6	100
Methadone	42.6	40.1	8.3	3.2	5.8	100
Total analgesics	*48.2*	*28.0*	*11.1*	*7.3*	*5.6*	*100*
Sedatives and hypnotics						
Alcohol	43.4	35.6	7.3	6.8	6.9	100
Benzodiazepines	48.1	39.2	2.9	4.9	5.0	100
Total sedatives and hypnotics	*43.6*	*35.7*	*7.1*	*6.7*	*6.8*	*100*
Stimulants and hallucinogens						
Amphetamines	38.9	23.5	15.1	16.4	6.2	100
Ecstasy	17.4	10.4	6.4	62.4	3.5	100
Cocaine	38.7	16.4	11.4	28.8	4.7	100
Nicotine	22.7	36.7	3.8	29.5	7.3	100
Total stimulants and hallucinogens	*37.7*	*23.6*	*14.1*	*18.5*	*6.1*	*100*
Cannabis	**28.1**	**23.4**	**9.4**	**32.0**	**7.1**	**100**
Volatile solvents	**16.6**	**29.5**	**3.2**	**16.6**	**34.1**	**100**

Source: Table SD.17.

Over the 10-year period to 2017–18:

- the proportion of treatment episodes with self/family referrals for clients' own drug use fluctuated from 38% in 2008–09, increasing to 42% in 2013–14 and decreasing to 39% in 2017–18
- self/family referrals for someone else's drug use followed a similar trend, increasing from 60% in 2008–09 to 64% in 2014–15, then falling to 58% in 2017–18
- the proportion of treatment episodes where the client was referred by health services increased for clients seeking treatment for their own drug use (from 27% to 28%) and decreased for someone else's drug use (from 23% to 18%) (Table SE.15)
- treatment episodes where alcohol was the principal drug of concern increased where self/family was the source of referral (from 40% to 43%) (Table SD.17)
- where cannabis was reported as the principal drug of concern, proportions slightly decreased for diversion referrals (34% in 2008–09 and 32% in 2017–18) (Table SD.17).

5.2 Duration of treatment

In 2017–18, around 4 in 5 closed treatment episodes ended within 3 months for both clients receiving treatment for their own drug use and for someone else's drug use (80% and 79%, respectively). The proportion of treatment episodes for a clients' own drug use that ended within 3 months remained fairly stable (80%) over the 5 years to 2017–18 (Table SE.21).

Nationally, the median duration of closed episodes was just under 3 weeks (19 days) for clients' own drug use and just under 5 weeks (31 days) for clients receiving support for someone else's drug use. The median duration of closed treatment episodes for a clients' own drug use fluctuated slightly over the 10 years: increasing from 18 days in 2008–09 to 23 days in 2013–14 and decreasing to 19 days in 2017–18 (Table SE.22).

5.3 Treatment completion

Reasons for clients no longer receiving treatment from an AOD treatment service include expected cessations (for example, treatment was completed), unplanned cessations (for example, non-compliance) and administrative cessation (for example, client transferred to another service provider) (see Glossary and Box 4.1).

In 2017–18, around 3 in 5 (63%) treatment episodes for a client's own drug use were expected (planned) completions. One-fifth (20%) of treatment episodes ended due to unplanned completion, 11% of cessations were for other reasons and 7% were referred to another service/change in treatment mode. This pattern differed slightly for clients who received support for someone else's drug use. For example, treatment episodes that ended due to unplanned completion were lower (11% compared with 20% for treatment episodes for own drug use) (Table 5.2).

Table 5.2: Closed treatment episodes, by reason for cessation and client type, 2017–18 (%)

Reason for cessation	Own drug use	Other's drug use
Expected (planned) completion	62.8	74.4
Ended due to unplanned completion	19.8	10.5
Referred to another service/change in treatment mode	6.6	3.3
Other	10.8	11.7
Total	**100.0**	**100.0**

Source: Table SE.18.

In 2017–18:

- treatment episodes with an expected cessation were highest where ecstasy was the principal drug of concern (86%), followed by nicotine (79%) and volatile solvents (76%)
- the lowest proportion of expected cessations were for episodes with morphine as the principal drug of concern (38%)
- about one-quarter (25%) of treatment episodes where morphine was the principal drug of concern had an unplanned cessation, followed by amphetamines (24%) and codeine (22%), while ecstasy had the lowest proportion (9%) (Table 5.3).

Table 5.3: Closed treatment episodes, by principal drug of concern and reason for cessation, 2017–18 (%)

Principal drug of concern	Expected (planned) completion	Ended due to unplanned completion	Referred to another service/change in treatment mode	Other	Total
Analgesics					
Codeine	57.4	22.0	13.5	7.1	100
Morphine	38.3	24.8	22.2	14.7	100
Buprenorphine	48.8	17.5	21.5	12.2	100
Heroin	58.8	18.7	7.2	45.3	100
Methadone	59.2	14.2	14.9	11.8	100
Total analgesics	*56.8*	*18.9*	*10.1*	*14.1*	*100*
Sedatives and hypnotics					
Alcohol	63.3	19.4	7.7	9.7	100
Benzodiazepines	63.3	16.0	10.4	10.3	100
Total sedatives and hypnotics	*63.3*	*19.3*	*7.8*	*9.7*	*100*
Stimulants and hallucinogens					
Amphetamines	57.4	24.1	5.9	12.6	100
Ecstasy	85.5	8.8	2.2	3.5	100
Cocaine	68.5	18.3	4.3	8.8	100
Nicotine	79.1	10.9	3.3	6.7	100
Total stimulants and hallucinogens	*59.4*	*22.9*	*5.6*	*12.1*	*100*
Cannabis	**69.4**	**17.5**	**4.2**	**8.9**	**100**
Volatile solvents	**75.9**	**13.7**	**3.1**	**7.3**	**100**

Source: Table SE.12.

During the 10 years to 2017–18:

- treatment episodes that ended in an expected cessation have remained relatively stable overall (falling by 3 percentage points) (Table SD.16)
- increases in expected cessation were greatest for episodes where volatile solvents (increased by 22 percentage points), buprenorphine and methadone were the principal drugs of concern (both increased by 4 percentage points)
- decreases in expected cessation were reported for treatment episodes where morphine (14 percentage points) or buprenorphine (8 percentage points) were the principal drug of concern
- unplanned cessations increased for episodes where morphine was the principal drug of concern (1 percentage points), and decreased by 7 percentage points for cocaine episodes and 10 percentage points for volatile solvents episodes (Table SD.16).

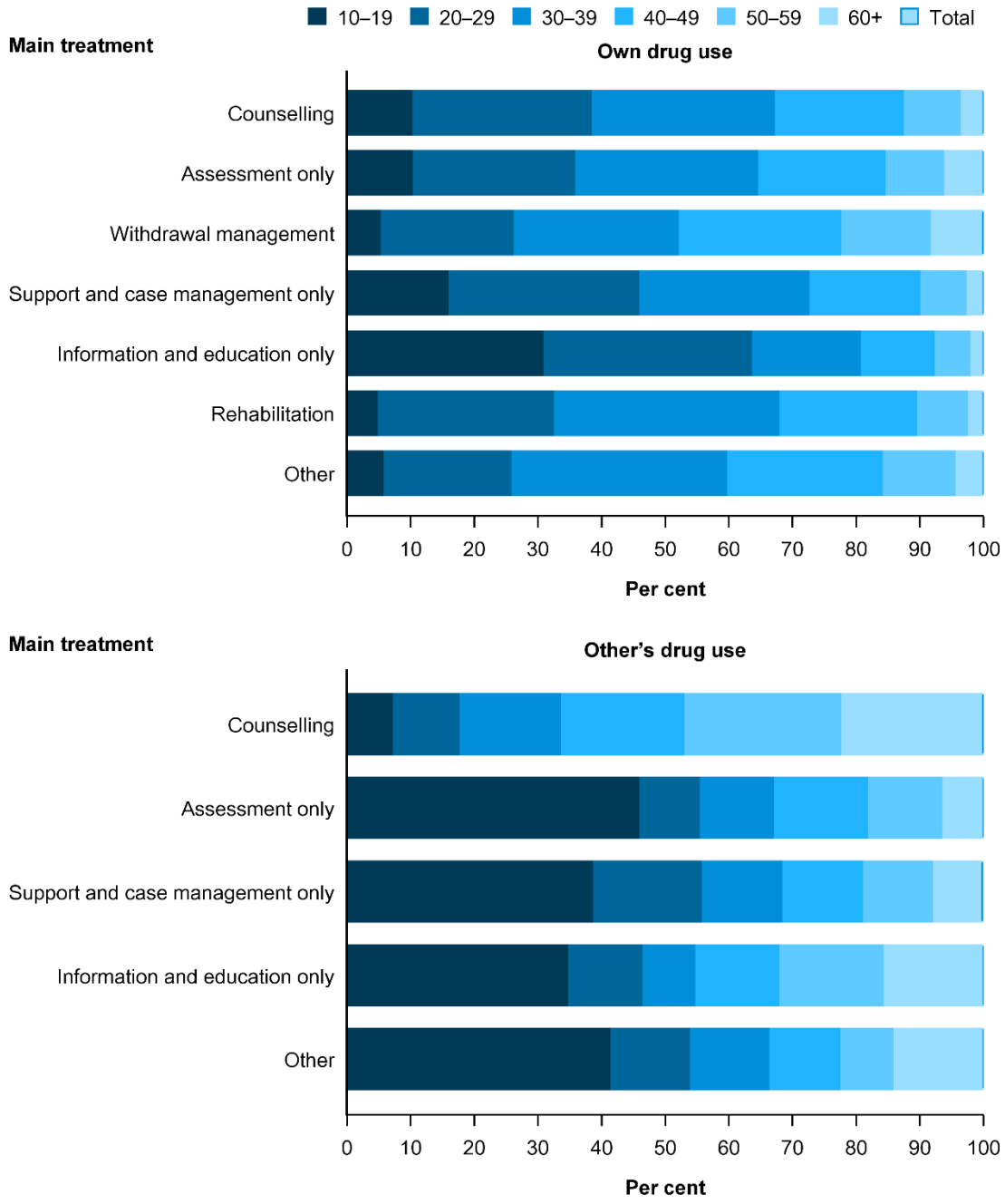
5.4 Treatment types

Counselling was the most common treatment type provided to all clients in 2017–18 (44%), followed by assessment only (15%), and support and case management only (12%). This pattern was consistent for clients receiving treatment for their own drug use, while for clients receiving treatment for someone else's drug use the most common treatment type was counselling (73%), followed by information and education only (11%), and support and case management only (8%) (Table SC.15).

In 2017–18, the majority of clients seeking treatment for their own drug use were aged 20–49 for all treatment types (ranging from 72% to 85%), with the exception of information and education only, where the majority of clients were aged 10–39 (81%) (Figure 5.1).

The age of clients varied by main treatment type for those seeking treatment for someone else's drug use. The majority of clients receiving counselling for someone else's drug use were aged 40 or older (66%), while the highest proportions of those receiving support and case management only and assessment only for someone else's drug use were aged 10–19 (39% and 46%, respectively) (Figure 5.1; Table SC.16).

Figure 5.1: Main treatment type, by client type and age group (years), 2017–18



Source: Table SC.16.

Generally, the total number of treatment episodes delivered each year has increased over the life of the AODTS NMDS collection. The proportion of closed treatment episodes have remained relatively constant for counselling, the most prevalent main treatment type reported for all clients. For clients own drug use, treatment types such as withdrawal management and counselling are most highly reported in the AODTS NMDS over time, excluding assessment only as a specific treatment service. Some changes in data can be influenced by system changes, coding practices or actual changes in treatment policies or capacity within jurisdictions, which may contribute to variation over time.

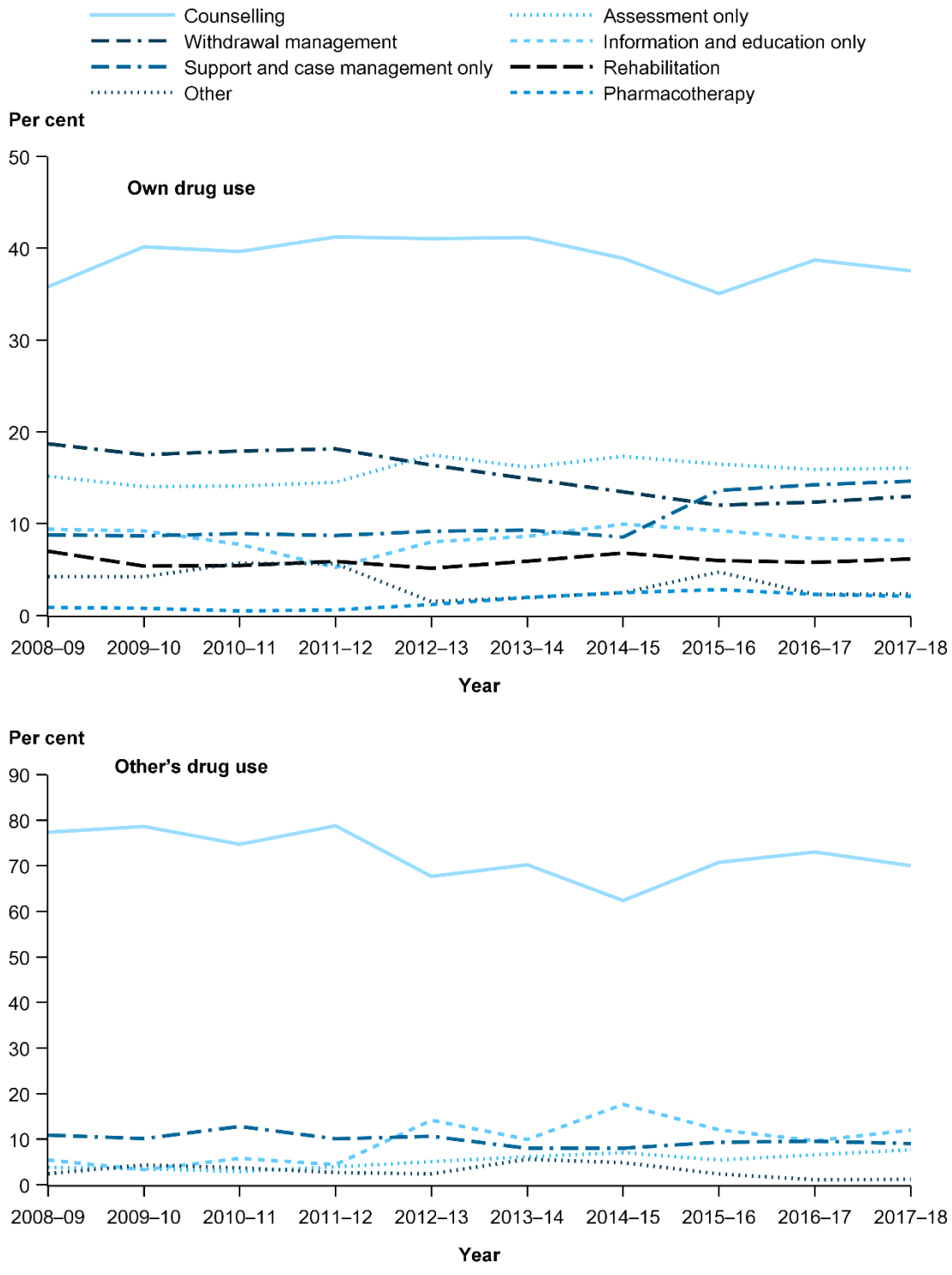
For treatment provided for a **client's own drug use** over the 10-year period:

- the proportion of episodes for each main treatment type has remained fairly stable since 2008–09
- counselling continues to be the most common main treatment type provided to clients, comprising about 2 in 5 episodes over this time
- the proportion of episodes with counselling as the main treatment type increased from 36% in 2008–09 to 41% in 2012–13, but decreased to 38% in 2017–18
- the number of treatment episodes with a main treatment of withdrawal management steadily declined (from 19% in 2008–09 to 13% in 2017–18).

For treatment provided for those **seeking support for someone else's drug use**:

- counselling, information and education only, support and case management only and assessment only have remained the most common main treatment types since 2008–09
- the majority of treatment episodes providing counselling as the main treatment type fell from 77% in 2008–09 to 70% in 2017–18
- episodes with information and education only as the main treatment type increased (from 5% in 2008–09 to 12% in 2017–18) (Figure 5.2; tables ST.4 and ST.7.2).

Figure 5.2: Closed treatment episodes, by client type and main treatment type, 2008–09 to 2017–18



Note: Withdrawal, rehabilitation and pharmacotherapy treatment is not available for clients seeking treatment for others drug use.

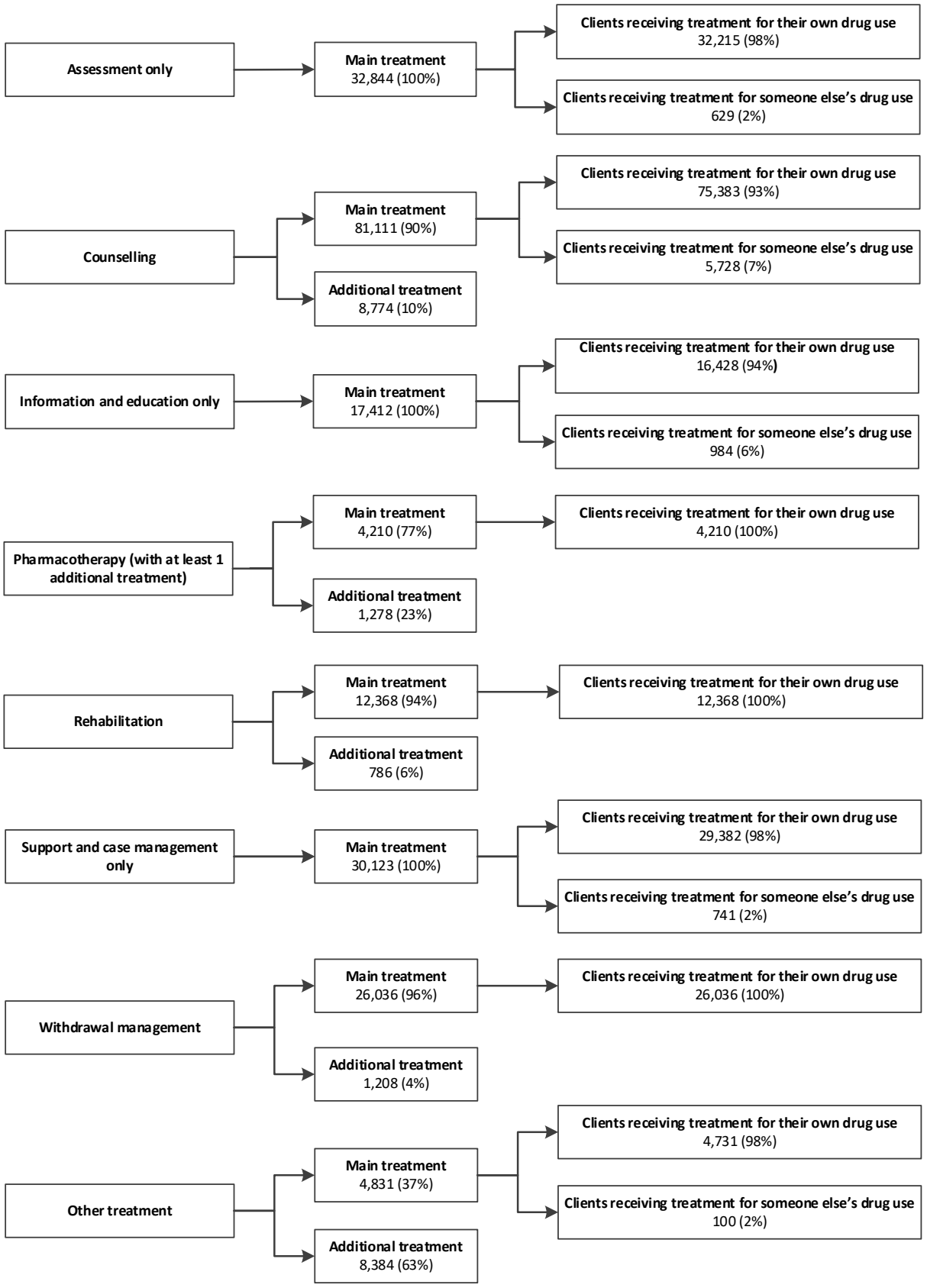
Source: Table ST.4.

In 2017–18, counselling was the most common treatment type across all remoteness areas. Withdrawal management (detoxification) as a main treatment type for own drug use was more common in *Major cities* (14%) than in other areas. The lowest number of treatment episodes for withdrawal management was in *Very remote* areas (3.1%). For support and case management only, the lowest proportion was in *Remote* areas (2.4%) (Table SA.9).

Clients can receive treatment for their own or someone else's drug use (see Glossary). In 2017–18, around 124,600 (96%) clients received treatment for their own drug use and around 6,200 (4%) received treatment in relation to someone else's drug use (Section 2.1; table SC.21).

A similar pattern was recorded across all treatment types, with the proportion of episodes provided for the client's own drug use ranging from 100% where the main treatment type was either withdrawal management, rehabilitation or pharmacotherapy, to 94% where counselling or information and education only was the main treatment type (Figure 5.3).

Figure 5.3: Summary treatment characteristics (main and additional) of closed episodes, 2017–18



Sources: Table ST.1.

Counselling

Counselling is the most common treatment type for problematic alcohol and/or other drug use and can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing (ADCA 2013).

In 2017–18, counselling was reported as a main treatment type in 39% (81,111) of all treatment episodes. Almost 2 in 5 (38%) treatment episodes for their own drug use received counselling as a main treatment; this proportion was 70% for clients seeking help for someone else's drug use (Table ST.4). Episodes of counselling as a main treatment type were most commonly provided to clients whose principal drug of concern was either alcohol (37%), amphetamines (29%) or cannabis (22%) (Table ST.22).

Client profile

For clients whose main treatment was counselling:

- younger males were more likely to receive counselling for their own drug use (66% of treatment episodes), with 57% of these episodes being provided to those aged 20–39
- clients receiving counselling for someone else's drug use were more likely to be female (66% of episodes) and aged over 40 (69%) (Table ST.19)
- for clients seeking treatment for their own drug use, around 1 in 6 (17%) closed treatment episodes with a main treatment type of counselling were for Indigenous clients
- for episodes where clients received counselling due to someone else's drug use, 8% of clients identified as Indigenous (Table ST.21).

Treatment profile

Counselling treatment for clients own drug use and for someone else's use:

- around 1 in 7 episodes with a main treatment type of counselling lasted 1 day (13% for own drug use and 15% for someone else's use), while over half lasted between 30 days and up to 6 months (56% and 50%, respectively) (Table ST.26)
- counselling episodes were longer than most other treatment types, with a median length of 57 days (Table SE.24).

Over the 10-year period to 2017–18:

- for clients receiving counselling for their own drug use, the proportion of episodes ending within 1 month fell from 39% to 32%
- the proportion of episodes lasting more than 1 month increased from 61% to 68% (Table ST.27)
- for clients receiving counselling for someone else's drug use, the proportion of closed episodes lasting 1 day decreased from 17% to 15%, while the proportion lasting 6 months or more fell from 13% to 10% (Table ST.27).

Assessment only

Although all service providers would normally include an assessment component in all treatment types, assessment only episodes are those for which only an assessment has been provided to the client.

In 2017–18, 16% (32,844) of all treatment episodes reported a main treatment type of assessment only. Around 1 in 6 (16%) treatment episodes for clients seeking help for their own drug use received an assessment only as a main treatment; this proportion was 8% for clients seeking help for someone else's drug use (Table ST.4). Assessment only treatment

episodes were most commonly provided to clients whose principal drug of concern was either alcohol (36%), amphetamines (29%) or cannabis (14%) (Table ST.44).

Client profile

For clients whose main treatment was assessment only:

- males aged 10–39 were more likely (64%) to receive assessment only as treatment for their own drug use, with over half (86%) of these episodes provided to those aged 20–39
- clients receiving assessment only for someone else's drug use were more likely to be male (53%), with 75% of those males aged 10–39 (Table ST.41)
- 17% of assessment only treatment episodes for clients' own drug use were for Indigenous clients and 35% of assessment only episodes for someone else's drug use were for Indigenous clients (Table ST.43).

Over the 10-year period to 2017–18:

- for clients seeking treatment for their own drug use, the proportion of treatment episodes for clients aged 20–29 decreased from 35% to 25%
- the proportion of assessment only episodes for those aged 60 and over increased steadily over the 10 years, rising from 2% in 2008–09 to 5% in 2017–18
- for clients seeking treatment for someone else's drug use, there was an increase in the proportion of assessment only treatment episodes for clients aged 10–19, from 15% to 43% (Table ST.42)
- over half (52%) of assessment only treatment episodes were provided to clients aged 40 and over in 2013–14, compared with 36% in 2017–18 (Table ST.42)
- more than two-thirds (68%) of all assessment only treatment episodes lasted just 1 day
- for clients seeking treatment for their own drug use, around two-thirds (68%) of assessment only episodes lasted just 1 day, compared to the majority of those seeking treatment for someone else's drug use (81%) (Table ST.45).

Over the 10-year period to 2017–18:

- for clients seeking treatment for their own drug use, the proportion of closed episodes lasting just 1 day rose from 49% to 68%
- the proportion of episodes lasting 2–29 days decreased from 31% to 21%
- for those clients seeking treatment for someone else's drug use, the proportion of closed assessment only episodes lasting just 1 day remained relatively stable over the same period (around 80% in 2008–09 and 2017–18)
- assessment only episodes lasting 2–29 days increased from 9% to 13% over the same period
- the proportion of all assessment only treatment episodes lasting between 3–6 months fell from 4% to 2%. (Table ST.46)
- it is important to note that these trends are influenced by differences in jurisdictional service delivery practices and data quality improvement over time.

Withdrawal management

Withdrawal management (detoxification) includes medicated and non-medicated treatment to help manage, reduce or stop the use of a drug of concern. This type of treatment is not available for clients seeking treatment for someone else's drug use.

In 2017–18, 12% (26,036) of closed treatment episodes with a main treatment type of withdrawal management were provided to clients for their own drug use (Table ST.4).

Withdrawal management treatment episodes as a main treatment type were most commonly provided to clients whose principal drug of concern was either alcohol (48%), amphetamines (20%) or cannabis (16%) (Table ST.33).

Client profile

For clients whose main treatment was withdrawal management:

- almost two-thirds (61%) of these episodes were provided to male clients and 1 in 10 (10%) were for Indigenous clients (tables ST.30 and ST.32)
- more than half (52%) of all withdrawal management treatment episodes were provided for those aged 30–39 (27%) or 40–49 (25%) (Table ST.31).

Treatment profile

Withdrawal management treatment for a client's own drug use:

- over 4 in 5 treatment episodes (85%) ended within 1 month (Table ST.38)
- the median duration of treatment episodes has remained unchanged since 2011–12, at 8 days (Table SE.24)
- the majority of episodes (69%) were reported to have ended due to an expected (planned) completion (Table ST.12).

Over the 10-year period to 2017–18:

- the proportion of closed withdrawal management episodes ending within 1 month rose from 77% to 85% (Table ST.38)
- the proportion of episodes lasting longer than 1 month fell from 22% to 15% (Table ST.38).

Support and case management only

Support includes activities such as providing emotional support to a client who occasionally calls an agency worker. Case management is usually more structured than support. It can assume a more holistic approach, taking into account all client needs (including general welfare needs) and it encompasses assessment, planning, linking, monitoring and advocacy (Vanderplaschen et al. 2007).

In 2017–18, around 14% (30,123) of all closed treatment episodes reported a main treatment type of support and case management only. Over 1 in 7 (15%) episodes for clients receiving treatment for their own drug use received support and case management only as a main treatment, with 9% receiving this treatment for someone else's drug use (Table ST.4).

Support and case management only episodes as a main treatment were mostly provided to clients whose principal drug of concern was either alcohol (30%), amphetamines (30%) or cannabis (24%) (Table ST.52).

Client profile

For clients whose main treatment was support and case management only:

- around two-thirds (66%) of treatment episodes provided to clients for their own drug use were for male clients, under half (48%) were for clients aged 10–29 and 12% of episodes were for Indigenous clients

- female clients seeking treatment for their own drug use were more likely to be Indigenous than were male clients (15% compared with 11%) (tables ST.49–51)
- for clients seeking treatment for someone else's drug use, 55% of support and case management only episodes were for females, 36% were for clients aged 10–19 and 1 in 14 (7%) were for Indigenous clients
- for clients seeking treatment for someone else's drug use, around 1 in 12 (8%) male clients and around 1 in 15 (6%) female clients were Indigenous (tables ST.49–51).

Over the 10-year period to 2017–18:

- there was a decrease in the proportion of support and case management only episodes provided to younger clients
- for both client types, the proportion provided to those aged 10–19 decreased (from 28% in 2008–19 to 17% of episodes for clients receiving treatment for their own drug use in 2017–18, and from 51% in 2008–09 to 36% in 2017–18 for clients seeking support for someone else's drug use) (Table ST.50)
- almost half (48%) of the treatment episodes provided to clients for their own drug use were provided to those aged 10–19 (17%) or 20–29 (31%).

Treatment profile

Support and case management treatment for clients own drug use and for someone else's use:

- the proportion of episodes lasting over 12 months were similar (2% for clients receiving treatment for their own drug use, compared with 3% for clients for someone else's drug use)
- the proportion of episodes lasting 1 day was higher for clients receiving treatment for their own drug use (33%, compared with 24% for someone else's use) (Table ST.54).

Over the 10-year period to 2017–18:

- the proportion of closed treatment episodes lasting 1 day for clients seeking treatment for their own drug use, where support and case management only was provided, rose substantially—from 6% to 33%
- for clients seeking treatment for someone else's drug use, the proportion of episodes rose from 20% to 24% (Table ST.54).

Information and education only

In 2017–18, 8% (17,412) of all treatment episodes reported a main treatment type of information and education only. Over 1 in 12 (8%) treatment episodes for clients seeking help for their own drug use received information and education only as a main treatment, compared with 12% for those seeking treatment for someone else's drug use (Table ST.4).

Client profile

For clients whose main treatment was information and education only:

- clients receiving information and education only for their own drug use were most likely to be male (69%) and younger (28% of episodes were for clients aged 10–19 and 31% for clients aged 20–29)
- for someone else's drug use, clients were more likely to be female (67%) and older (52% of episodes were for clients aged 30 and over)
- around 1 in 6 (17%) closed treatment episodes for clients seeking treatment for their own drug use were provided to clients who identified as Indigenous, compared with around

1 in 16 (16%) episodes where clients sought treatment for someone else's drug use (Table ST.59).

Over the 10-year period to 2017–18:

- the age profile of all clients receiving information and education only treatment for their own use remained relatively stable. However, for clients seeking support for someone else's drug use, the proportion of clients aged 10–19 fluctuated, from 14% in 2008–09 to 23% in 2017–18, following a peak of 57% in 2014–15 (tables ST.57–58)

Treatment profile

Information and education treatment for clients own drug use and for someone else's use:

- as expected for this type of treatment, almost 4 in 5 (77%) treatment episodes lasted just 1 day for clients seeking treatment for their own drug use; for those seeking treatment for someone else's drug use, this proportion was 49% (Table ST.62).

Over the 10-year period to 2017–18:

- for clients seeking treatment for their own drug use, the proportion of closed episodes that lasted just 1 day decreased from 89% to 77%
- the proportion of episodes lasting 30–90 days rose from 4% to 9%
- for those clients seeking support for someone else's drug use, the proportion of information and education only episodes that lasted just 1 day fluctuated from 51% in 2008–09, to 70% in 2013–14 and to 49% in 2017–18
- the proportion of episodes lasting 2–29 days fluctuated from 6% in 2008–09, to 9% in 2013–14 and 13% 2017–18 (Table ST.62).

It is important to note that these trends are influenced by differences in jurisdictional program practices over time.

Rehabilitation

Rehabilitation focuses on helping clients to cease their drug use, and to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in a number of ways including residential treatment services, therapeutic communities and community-based rehabilitation services (AIHW 2011). This type of treatment is not available for clients seeking treatment for someone else's drug use.

In 2017–18, 6% (12,368) of closed treatment episodes with a main treatment type of rehabilitation were provided to clients for their own drug use. Rehabilitation treatment episodes as a main treatment type were most commonly provided to clients whose principal drug of concern was either amphetamines (40%), alcohol (37%) or cannabis (11%) (Table ST.68).

Client profile

For clients whose main treatment was rehabilitation:

- almost two-thirds (64%) of the treatment episodes were provided to male clients and 21% were provided to Indigenous clients (tables ST.4, ST.65 and ST.67)
- almost two-thirds (63%) of the treatment episodes provided for rehabilitation were for clients aged 20–29 (29%) or 30–39 (34%).

Treatment profile

Rehabilitation treatment for a client's own drug use:

- more than one-third (37%) of the episodes lasted 1–3 months, while a further 29% lasted 2–29 days (tables ST.66 and ST.73)
- over the 10-year period to 2017–18, the duration of closed episodes of rehabilitation for those clients seeking treatment for their own drug use remained relatively stable (Table ST.73).

Pharmacotherapy

Pharmacotherapy is the replacement of a person's drug of choice with a legally prescribed and dispensed substitute. Pharmacotherapy programs are available for a range of drugs, including alcohol and opioids. Where a pharmacotherapy is used for withdrawal, it is included in the 'withdrawal' category.

Only episodes where pharmacotherapy was an additional treatment, or where it was the main treatment with an additional treatment provided, are included in the AODTS NMDS. Episodes where pharmacotherapy was the main treatment and no additional treatment was provided are excluded.

On a snapshot day in 2018, just over 50,000 clients received pharmacotherapy treatment for their opioid dependence as reported in the National Opioid Pharmacotherapy Statistics Annual Data report (NOPSAD). Pharmacotherapy is available only to clients receiving treatment for their own drug use. Because most pharmacotherapy services are outside the scope of the AODTS NMDS, the data presented on pharmacotherapy episodes are a significant under-representation. More information on opioid pharmacotherapy treatment provided in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/nopsad-2017/contents/summary.

For services that were in scope of the AODTS NMDS in 2017–18, 3% (4,210) of treatment episodes were provided with a treatment type of pharmacotherapy (main or additional). Around one-quarter (23% or 1,278) of these episodes reported pharmacotherapy as an additional treatment (tables ST.4 and ST.75).

Pharmacotherapy treatment episodes as a main treatment type were most commonly provided to clients whose principal drug of concern was either heroin (37%), amphetamines (13%) or alcohol (13%) (Table ST.79).

Client profile

For clients whose main treatment was pharmacotherapy:

- nearly two-thirds (65%) of pharmacotherapy treatment episodes were provided to male clients and 12% were for Indigenous clients
- over two-thirds (67%) of episodes were for those aged 30–39 (39%) or 40–49 (28%). A further 18% were for clients aged 20–29, while just 3% were for clients aged 60 and over (tables ST.76–78).

Treatment profile

Pharmacotherapy treatment for a client's own drug use:

- almost 1 in 5 (18%) of the closed episodes lasted over 12 months, while a further one-third (26%) lasted 3–12 months (Table ST.84)

- pharmacotherapy is commonly reported as an additional treatment in the AODTS NMDS
- the most common principal drugs of concern with additional treatment episodes of pharmacotherapy include alcohol (37%), followed by amphetamines (28%) and cannabis (11%) (Table ST.80).

Appendix A: Data and methods

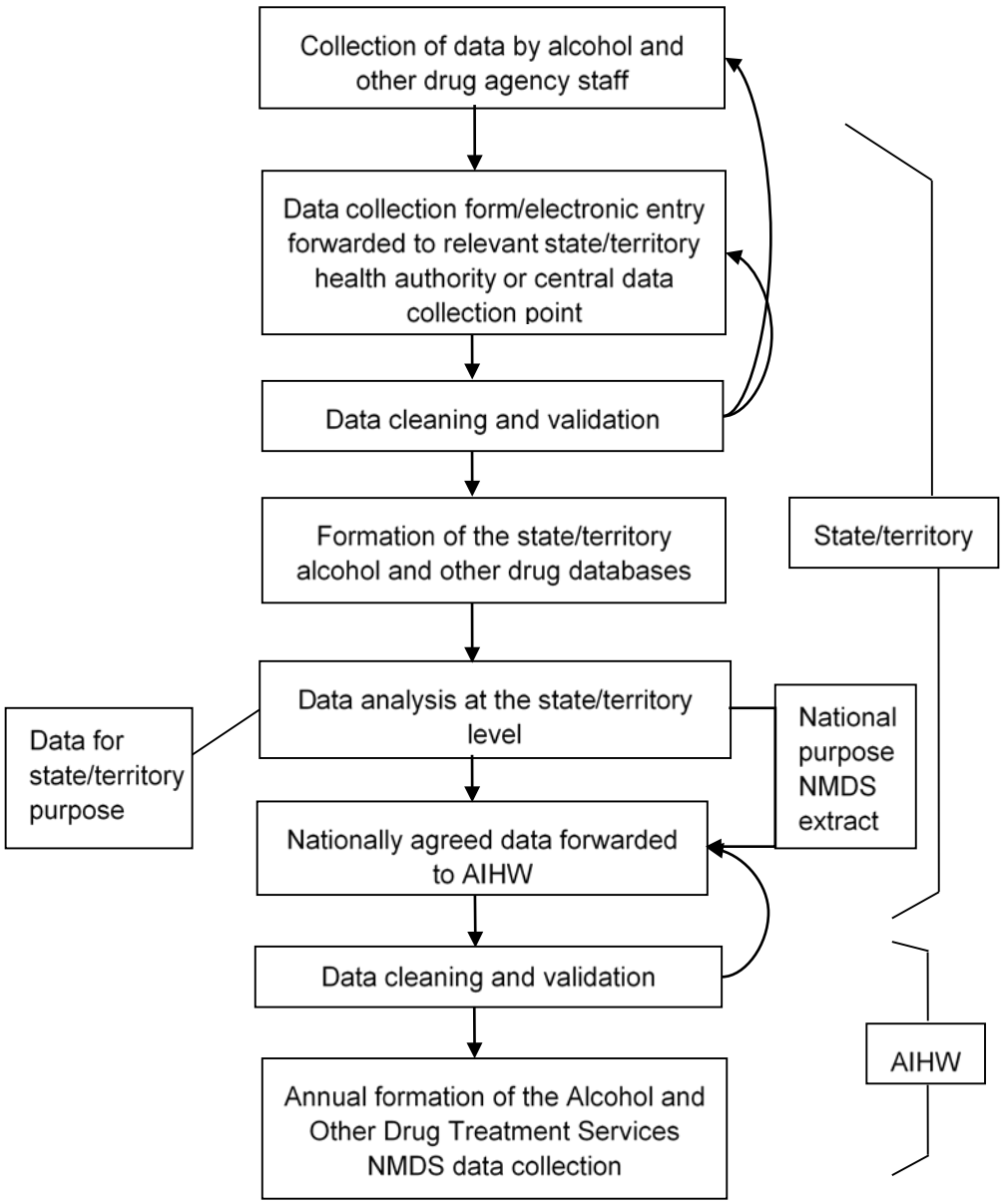
Age

Age is calculated as at the start of the episode.

Data collection process

For most states and territories, the data provided for the national collection are a subset of a more detailed jurisdictional data set used for planning and policy. Figure A1 shows the processes involved in constructing the national data.

Figure A1: Alcohol and other drug treatment data collection flowchart



Drugs of concern

The AODTS NMDS contains data on drugs of concern that are coded using the ABS's Australian Standard Classification of Drugs of Concern (ASCDC) (ABS 2011a). In this report, these drugs are grouped (Table A1).

Table A1: Groupings of drugs of concern

Group	ASCDC codes	Category	Includes
Analgesics	1000–1999	Codeine	
		Morphine	
		Buprenorphine	
		Heroin	
		Methadone	
		Other opioids	Oxycodone, fentanyl, pethidine
		Other analgesics	Paracetamol
Sedatives and hypnotics	2000–2999	Alcohol	Ethanol, methanol and other alcohols
		Benzodiazepines	Clonazepam, diazepam and temazepam
		Other sedatives and hypnotics	Ketamine, nitrous oxide, barbiturates and kava
Stimulants and hallucinogens	3000–3999	Amphetamines	Amphetamine, dexamphetamine and methamphetamine
		Ecstasy (MDMA)	
		Cocaine	
		Nicotine	
		Other stimulants and hallucinogens	Volatile nitrates, ephedra alkaloids, phenethylamines, tryptamines and caffeine
Cannabinoids	7000–7199	Cannabis	
Other	4000–6999 9000–9999	Other	Anabolic agents and selected hormones, antidepressants and antipsychotics, volatile solvents, diuretics and opioid antagonists
Not stated	0000–0002	Not stated	

In this report, pharmaceutical drugs were grouped using 10 drug types, making up the pharmaceuticals group for the purposes of the analysis. These drugs correspond to the ASCDC codes and classifications (Table A2).

Table A2: Pharmaceutical drugs of concern, ASCDC codes and classifications

Drug category	ASCDC code	ASCDC classification (broad group and narrow group/s)	Drug description (ASCDC base level unit/s)
Codeine	1101	**Analgesics** Organic opiate analgesics	Codeine
Morphine	1102	**Analgesics** Organic opiate analgesics	Morphine
Buprenorphine	1201	**Analgesics** Semisynthetic opioid analgesics	Buprenorphine
Oxycodone	1203	**Analgesics** Semisynthetic opioid analgesics	Oxycodone
Methadone	1305	**Analgesics** Synthetic opioid analgesics	Methadone
Benzodiazepines	2400–2499	**Sedatives and hypnotics** Benzodiazepines	Benzodiazepines n.f.d., alprazolam, clonazepam, diazepam, flunitrazepam, lorazepam, nitrazepam, oxazepam, temazepam, benzodiazepines n.e.c.
Steroids	4000–4999	**Anabolic agents and selected hormones** Anabolic androgenic steroids Beta2 agonists Peptide hormones, mimetics and analogues Other anabolic agents and selected hormones Not further defined	Anabolic agents and selected hormones n.f.d., anabolic androgenic steroids n.f.d., boldene, dehydroepiandrosterone, fluoxymesterone, mesterolone, methandriol, methenolone, nandrolone, oxandrolone, stanozolol, testosterone, anabolic androgenic steroids n.e.c., beta2 agonists n.f.d., eformoterol, fenoterol, salbutamol, beta2 agonists n.e.c., peptide hormones, mimetics and analogues n.f.d., chorionic gonadotrophin, corticotrophin, erythropoietin, growth hormone, insulin, peptide hormones, mimetics and analogues n.e.c., other anabolic agents and selected hormones n.f.d., sulfonylurea hypoglycaemic agents, tamoxifen, thyroxine, other anabolic agents and selected hormones n.e.c.
Other opioids	1100, 1199, 1200, 1299, 1300–1304, 1306–1399	**Analgesics** Organic opiate analgesics Semisynthetic opioid analgesics Synthetic opioid analgesics Not further defined	Organic opiate analgesics n.f.d., organic opiate analgesics n.e.c., semisynthetic opioid analgesics n.f.d., semisynthetic opioid analgesics n.e.c., synthetic opioid analgesics n.f.d., fentanyl, fentanyl analogues, levomethadyl acetate hydrochloride, meperidine analogues, pethidine, tramadol, synthetic opioid analgesics n.e.c.
Other analgesics	0005, 1000, 1400–1499	**Analgesics** Non-opioid analgesics Not further defined	Analgesics n.f.d., non-opioid analgesics n.f.d., acetylsalicylic acid, paracetamol, ibuprofen, non-opioid analgesics n.e.c.
Other sedatives and hypnotics	2000, 2200–2299, 2300–2399, 2500–2599, 2900–2999	**Sedatives and hypnotics** Anaesthetics Barbiturates Gamma-hydroxybutyrate (GHB) type drugs and analogues Other sedatives and hypnotics	Sedatives and hypnotics n.f.d., anaesthetics n.f.d., ketamine, nitrous oxide, phencyclidine, propofol, anaesthetics n.e.c., barbiturates n.f.d., amylobarbitone, methylphenobarbitone, phenobarbitone, barbiturates n.e.c., GHB-type drugs and analogues n.f.d., GHB, gamma-butyrolactone, 1,4-butanediol, GHB-type drugs and analogues n.e.c., other sedatives and hypnotics n.f.d., chlormethiazole, kava lactones, zopclone, doxylamine, promethazine, zolpidem, other sedatives and hypnotics n.e.c.

n.f.d—not further defined; n.e.c—not elsewhere classified.

Duration

Duration is calculated in whole days, and only for closed episodes.

Population rates

In this publication, crude rates were calculated using the ABS's estimated resident population at the midpoint of the data range: that is, rates for 2017–18 data were calculated using the estimated resident population at 31 December 2017.

Reason for cessation

The AODTS NMDS contains data on the reason an episode ended (reason for cessation). In this report, these reasons are grouped (Table A3), but data for the individual end reasons are available in the online supplementary tables.

A different method was used for grouping end reasons in reports released before 2014, so trend comparisons across reports should be made with caution. It is possible to compare data at the individual end reasons using the supplementary tables.

Table A3: Grouping of cessation reasons, by indicative outcome type

Outcome type	Reason for cessation
Expected/planned completion	Treatment completed
	Ceased to participate at expiation
	Ceased to participate by mutual agreement
Ended due to unplanned completion	Ceased to participate against advice
	Ceased to participate without notice
	Ceased to participate due to non-compliance
Referred to another service/change in treatment mode	Change in main treatment type
	Change in delivery setting
	Change in principal drug of concern
	Transferred to another service provider
Other	Drug court or sanctioned by court diversion service
	Imprisoned (other than drug court sanctioned)
	Died
	Other
	Not stated

Remoteness area

This report uses the ABS's Australian Statistical Geography Standard (ASGS) Remoteness Structure 2011 (ABS 2011b) to analyse the proportion of AOD treatment agencies by remoteness area. This structure allows areas that share common characteristics of remoteness to be classified into broad geographic regions of Australia. These areas are:

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

The remoteness structure divides each state and territory into several regions based on their relative access to services.

Examples of urban centres in each remoteness area are:

- *Major cities* Canberra, Newcastle
- *Inner regional* Hobart, Bendigo
- *Outer regional* Cairns, Darwin
- *Remote* Katherine, Mount Isa
- *Very remote* Tennant Creek, Meekatharra.

For this report, the remoteness area of the agency was determined using the Statistical Area Level 2 (SA2) of the agency. Some statistical areas are split between multiple remoteness areas. Where this was the case, the data were weighted according to the proportion of the population of the statistical areas in each remoteness area.

The Australian Statistical Geography Standard ASGS has replaced the Australian Standard Geographical Classification 2006 (ABS 2006), which was used in previous reports to calculate remoteness areas. Therefore, remoteness data for 2011–12 and previous years are not comparable with those for 2012–13 and subsequent years.

Service sectors

From 2008–09, agencies funded by the Department of Health under the Non-Government Organisation Treatment Grants Program (NGOTGP) were classified as non-government agencies. Before this, many of these agencies were classified as government agencies. As a result, trends in service sectors of agencies should be interpreted with caution.

Source of referral: diversion

Throughout Australia, there are programs that divert people who have been apprehended or sentenced for a minor drugs offence from the criminal justice system. Many of these diversions result in clients receiving drug treatment services, who have been referred to treatment agencies as part of a drug diversion program. Since the 1980s, Australian governments have supported programs aimed at diverting from the criminal justice system people who have been apprehended or sentenced with a minor drugs offence.

In Australia, drug diversion program come in two main forms:

- **Police diversion** occurs when an offence is first detected by a law enforcement officer. It usually applies for minor use or possession offences, often relating to cannabis, and can involve the offender being cautioned, receiving a fine and/or having to attend education or assessment sessions.
- **Court diversion** occurs after a charge is laid. It usually applies for offences where criminal behaviour was related to drug use (for example, burglary or public order offence). Bail-based programs generally involve assessment and treatment, while pre- and post-sentence programs (including drug courts) tend to involve intensive treatment and are aimed at repeat offenders.

Trends

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

Appendix B: Imputation methodology for AOD clients

From the inception of the AODTS NMDS, data have been collected only about treatment episodes provided by AOD treatment services. Data about the clients those episodes relate to have not been available at a national level. An SLK was introduced into the AODTS NMDS for the 2012–13 collection to enable the number of clients receiving treatment to be counted, while continuing to ensure the privacy of these individuals receiving treatment.

An imputation strategy for the collection was developed to correct for the impact of invalid or missing SLKs on the total number of clients. This strategy takes into account several factors relating to the number of episodes per client and makes assumptions relating to spread across agencies. It also takes into consideration the likelihood that an episode with a missing SLK relates to a client that has already been counted through other episodes with a valid SLK.

To ensure an accurate representation of the AODTS client population, imputation was applied to the 2012–13, 2013–14 and 2015–16 AODTS NMDS to account for the proportion of valid SLKs being less than 95% for these years. The national rate of valid SLKs for these years was largely affected by low proportions of valid SLKs in New South Wales.

Attributing the number of clients to a set of missing SLK records

The AODTS NMDS collects information at the service record level. Service records are associated with individual clients through an SLK. There are a number of records that have missing or invalid SLK data that cannot be attributed to a client. This leads to an under-reporting of the total number of clients using the services, because some (but not all) of the records will belong to clients who are not observed via a valid SLK.

This document describes the method of using the available data—after making several assumptions about the behaviour of the whole population—to estimate the total number of clients.

Imputation groups

Imputation groups are formed to improve the performance of the estimates. The service records were grouped according to properties that are thought to influence the behaviour of clients and the quality of SLK data, and then the imputation was performed at this imputation group level.

Possible properties used to develop groups include location, provider size (measured by number of service records) and service type. The data are also grouped according to any subpopulations that are going to be reported upon, such as jurisdiction.

The final imputation groups were formed by balancing the often-competing priorities of having homogenous groups and the need to have groups large enough to ensure that the imputation is robust.

Assumptions and approximations

Assumption 1: randomness and independence

This imputation method assumes that whichever service provider a client attends for each incidence of service is random and independent of any other incidents of service the client may have. It is further assumed that the validity or otherwise of the SLK recorded on each service record is random, and independent of both the client and the service provider with which the record is associated.

Assumption 2: distribution of the number of service records per client

This method also assumes that the distribution of the number of records per client for all clients is similar to that observed using the subset of records with valid SLKs.

Approximation 1: no client has more than 10 service records

This imputation method uses the approximation that no client has more than 10 service records.

In order to implement this approximation, any clients observed to have more than 10 service records were treated as if they had only 10, and the proportion of clients with 10 service records calculated accordingly.

Notation

The definition of the notation used in this document is as follows:

N_t: the (unknown) total number of clients

N_t': the imputed total number of clients

N_{SLK1}: the number of clients observed using the records with a valid SLK

P_{SLK1}: the proportion of clients with at least 1 service record with a valid SLK

P_{Ni}: the (unknown) proportion of clients with i service records

P_{Ni}': the imputed proportion of clients with i service records

$P_{Ni,SLK1}$: the proportion of clients with i service records as observed using records with valid SLKs

n_t: the total number of service records

$n_t|N_t, P_{Ni}$: the number of service records given the total number of clients and the proportions of clients with i service records, $i = 1,2, \ldots 10$

n_{SLK1}: the number of service records with a valid SLK

n_{SLK0}: the number of service records with an invalid SLK

p_{SLK0}: the proportion of service records with an invalid SLK.

Methodology

Given Assumption 1 and Approximation 1, the proportion of clients who have at least 1 service record with a valid SLK is:

$$P_{SLK1} = \sum_{i=1}^{10} P_{Ni}\left(1 - p_{SLK0}^{i}\right)$$

Now:

$$N_{SLK1} = P_{SLK1} \times N_t$$

so it follows that the total number of clients is:

$$N_t = \frac{N_{SLK1}}{P_{SLK1}}$$

To resolve this equation for N_t the values of the P_{Ni} is required. These are unknown, given it is not possible to observe the whole population due to the records with invalid SLK values. This method imputes the unknown P_{Ni} using numerical methods, then uses these values to impute N_t.

The process starts with the distribution of number of records per client that were observed using the records with valid SLKs $\left(P_{Ni,SLK1}\right)$. These values are then adjusted so that the following conditions are met.

Constraint 1

The sum of the imputed proportions is equal to 1. That is:

$$\sum_{i=1}^{10} P'_{Ni} = 1$$

Constraint 2

The imputed proportion of clients with 1 service record is less than or equal to the observed equivalent proportion among clients with records with valid SLKs. That is:

$$P'_{N1} \leq P_{N1,SLK1}$$

This constraint is used because some of the clients observed to have only 1 record will, in fact, have additional records with invalid SLKs. It is unlikely that the true proportion of clients with 1 service record is higher than that observed using records with valid SLKs.

Constraint 3

The total number of service records that the imputed total number of clients and the imputed distribution of records per client imply is equal to the observed number of service records.

That is:

$$n_t | N'_t, P'_{Ni} = N'_t \sum_{i=1}^{10} (i \times P'_{Ni}) = n_t.$$

This constraint is used to ensure that the imputed values are consistent with the observed number of records.

Penalty function

Under Assumption 2 we want to limit how much the imputed proportions differ from the proportions observed via the records with valid SLK data. To achieve this we use a penalty function that increases as the distance between the imputed and observed proportions increases. This function is defined to be:

$$f\left(P_{N1,SLK1}, P_{N2,SLK1}, \ldots, P_{N10,SLK1}, P'_{N1}, P'_{N2}, \ldots, P'_{N10}\right) = \sum_{i=1}^{10} \frac{\left(P'_{Ni} - P_{Ni,SLK1}\right)^2}{P_{Ni,SLK1}}$$

Using numerical methods, the $P'_{N1}, P'_{N2}, \ldots P'_{N10}$ are chosen such that the penalty function is minimised, subject to the 3 constraints.

The final step is to use the imputed proportions to calculate the imputed total number of clients:

$$N'_t = \frac{N_{SLK1}}{\sum_{i=1}^{10} P'_{Ni}\left(1 - p^i_{SLK0}\right)}$$

The resulting number is then rounded to the nearest integer.

Discussion

This imputation technique uses available information to impute the total number of clients. The methodology takes into account the proportion of records with invalid SLK data and the distribution of the number of service records per client, as observed via the records with valid SLK data. It is apparent that the assumptions made do not hold for every client or service record. It is reasonable to expect that a client's attendance at a service provider will be affected by location and any prior contact they had with a provider. It should also be noted that some service providers failed to collect SLK for any service record during the reference period.

Despite the known cases where Assumption 1 does not hold, it is reasonable to hope that, across the population as a whole, the assumption is a reasonable representation of the populations of clients and service records.

It is believed that the impact of Approximation 1 will be small because, given Assumption 1, the chance that a client with more than 10 service records is not observed via a record with a valid SLK is extremely small. The chance diminishes as the proportion of records with an invalid SLK decreases and across jurisdictions the highest proportion observed is about 0.3. It should also be noted that the largest proportion of clients with 10 or more service records observed in the data at the jurisdiction level was only 0.007.

There are many different penalty functions that could be used in this imputation. The function used was chosen because, compared with the other penalty functions investigated, it produced imputed proportions that were generally as close or closer to the observed proportions. It also most consistently resulted in a distribution that was similar in shape to the observed distribution of the number of records per client.

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- Department of Health and Wellbeing, South Australia
- Department of Health and Human Services, Tasmania
- Health Directorate, Australian Capital Territory
- Department of Health, Northern Territory.

Abbreviations

ACT	Australian Capital Territory
AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drugs
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
ASCDC	Australian Standard Classification of Drugs of Concern
ASGC	Australian Standard Geographical Classification
ASGS	Australian Statistical Geography Standard
GHB	gamma hydroxybutyrate
MDMA	3, 4-methylenedioxymethamphetamine
NDS	National Drug Strategy
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
SLK	statistical linkage key
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Symbols

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

Notes: Components of tables may not sum to totals due to rounding. Trend data may differ from data published in previous versions of *Alcohol and other drug treatment services in Australia* due to data revisions.

Supplementary tables referred to in this report (tables with the prefix 'S') are available for download from https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/aodts-2016-17/data

Glossary

additional drugs: Clients receiving treatment for their own drug use nominate a principal drug of concern that has led them to seek treatment and additional drugs of concern, of which up to 5 are recorded in the AODTS NMDS. Clients receiving treatment for someone else's drug use do not nominate drugs of concern.

additional treatment type: Clients receive 1 main treatment type in each episode and additional treatment types as appropriate, of which up to 4 are recorded in the AODTS NMDS.

alcohol: A central nervous system depressant made from fermented starches. Alcohol inhibits brain functions, dampens the motor and sensory centres and makes judgement, coordination and balance more difficult.

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

Australian Standard Geographical Classification (ASGC): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGC was implemented in 1984 and the final release was in 2011. It has been replaced by the Australian Statistical Geography Standard (ASGS).

Australian Statistical Geography Standard (ASGS): Common framework defined by the Australian Bureau of Statistics for collection and dissemination of geographically classified statistics. The ASGS replaced the ASGC in July 2011.

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

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

client counts: Includes:

- distinct clients—where the total number refers to the actual number of clients counted
- estimated clients—where the number of clients is estimated using imputed numbers (see imputation methodology).

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

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

diversion client type: Clients who received at least 1 AOD treatment episode during a collection year resulting from a referral by a police or court diversion program. The 2 subtypes in this group are:

- diversion only clients—received treatment as a result of diversion referrals only
- diversion client with non-diversion episodes—received at least 1 treatment episode resulting from a diversion referral, but also received at least 1 treatment episode resulting from a non-diversion referral in a collection year.

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

GHB: stands for gamma hydroxybutyrate, which is a central nervous system depressant. Common names for GHB include, G, Grievous Bodily Harm, fantasy, liquid E, liquid ecstasy and blue nitro.

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

heroin: One of a group of drugs known as opioids, which are strong pain-killers with addictive properties. Heroin and other opioids are classified as depressant drugs. Common names for heroin include smack, skag, dope, H, junk, hammer, slow, gear, harry, big harry, horse, black tar, China white, Chinese H, white dynamite, dragon, elephant, boy, home-bake or poison.

illicit drug use: Includes:

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

licit drug use: The use of legal drugs in a legal manner, including tobacco smoking and alcohol consumption.

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

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

method of use for principal drug of concern: The client's usual method of administering the principal drug of concern as stated by the client. Includes: ingests, smokes, injects, sniffs (powder), inhales (vapour), other and not stated.

nicotine: The highly addictive stimulant drug in tobacco.

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

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

reason for cessation: The reason the client ceased to receive a treatment episode from an alcohol and other drug treatment service. The client can have:

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

The grouped categories used in the report for **reason for cessation:**

- referred to another service/change in treatment mode: includes episodes that ended due to a change in main treatment type, delivery setting or principal drug of concern, or where the client was transferred to another service provider
- ended due to planned completion: Includes episodes where the client completed treatment—ceased to participate at expiation or by mutual agreement
- ended due to unplanned completion: Includes episodes where the client ceased to participate against advice, without notice, or due to non-compliance.

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

standard drink: Contains 10 grams of alcohol (equivalent to 12.5 millilitres of alcohol). Also referred to as a full serve.

tobacco: A plant, *Nicotiana tabacum*, whose leaves are dried and used for smoking and chewing and in snuff. Its major pharmacologically active substance is the alkaloid nicotine (see **nicotine**).

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

treatment type: The type of activity that is used to treat the client's alcohol or other drug problem, which includes:

- assessment only—where only assessment is provided to the client (service providers would normally include an assessment component in all treatment types)
- counselling—can include cognitive behaviour therapy, brief intervention, relapse intervention and motivational interviewing
- information and education only—where only information and education is provided to the client (service providers would normally include an information and education component in all treatment types)
- pharmacotherapy—where the client receives another type of treatment in the same treatment episode and includes drugs such as naltrexone, buprenorphine and methadone used as maintenance therapies or relapse prevention for people who are addicted to certain types of opioids. Where a pharmacotherapy is used for withdrawal, it is included in the withdrawal category. Due to the complexity of the pharmacotherapy sector, this report provides only limited information on agencies whose sole function is to provide pharmacotherapy
- rehabilitation—focuses on supporting clients in stopping their drug use, and to prevent psychological, legal, financial, social and physical consequences of problematic drug use. Rehabilitation can be delivered in several ways, including residential treatment services, therapeutic communities and community-based rehabilitation services
- support and case management only—support includes helping a client who occasionally calls an agency worker for emotional support, while case management is usually more structured than 'support'. It can assume a more holistic approach, taking into account all client needs (including general welfare needs) and it includes assessment, planning, linking, monitoring and advocacy
- withdrawal management (detoxification)—includes medicated and non-medicated treatment to help manage, reduce or stop the use of a drug of concern.

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List of tables

List of figures

List of boxes

In 2017–18, 952 publicly-funded alcohol and other drug treatment services provided just under 210,000 treatment episodes to an estimated 130,000 clients. The four most common drugs that led clients to seek treatment were alcohol (35% of all treatment episodes), amphetamines (27%), cannabis (22%) and heroin (6%). Two-thirds (66%) of all clients receiving treatment were male and the median age of clients was 34.

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