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Patterns of intensive alcohol and other drug treatment service use in Australia

1 July 2014 to
30 June 2019

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Contents

Summary

Alcohol and other drug (AOD) treatment services aim to support people to reduce harmful AOD use. Clients accessing these services often receive multiple episodes of treatment, with some clients requiring more intensive treatment (for example, more episodes of treatment) to achieve their goals.

Using the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS), this report examines the treatment patterns of clients who received treatment from publicly funded specialist AOD services in the study period 1 July 2014 to 30 June 2019 (that is, 5 collection periods) for 3 client cohorts.

The 3 cohorts were those undertaking:

- intensive treatment (6,695 clients, or 3.2%)—clients who received 7 or more closed treatment episodes across at least 3 collection periods (that is, financial years)
- recurring treatment (14,292 clients, or 6.8%)—clients who received fewer than 7 closed treatment episodes across at least 3 collection periods
- non-recurring treatment (190,062 clients, or 90%)—clients who received treatment in fewer than 3 collection periods.

Clients who received intensive treatment were more likely to be female and less likely to live in disadvantaged or remote areas than clients who received recurring and non-recurring treatment

The cohort of clients that received intensive treatment had the highest percentage of females (41%) and clients residing in the least disadvantaged socioeconomic areas (18%). They were also less likely to live in *Outer regional*, *Remote* and *Very remote* areas (15%) than other clients.

Clients who received intensive treatment were more likely than clients who received recurring and non-recurring treatment to report multiple principal drugs of concern

Among all AOD clients, irrespective of their treatment cohort, alcohol was the most common principal drug of concern (PDOC) and counselling was the most common main treatment type.

Almost 2 in 3 (61%) clients who received intensive treatment reported multiple PDOC across episodes, compared with 53% for recurring and 11% for non-recurring treatment.

7 in 10 (70%) clients who received intensive treatment received at least 3 different main treatment types, compared with 25% for recurring and 3.1% for non-recurring treatment.

Clients who received either intensive or recurring treatment were more likely to end their last reported treatment episode in the study period with an unplanned cessation compared with previous treatment episodes

Clients who received intensive treatment were more likely to record an unplanned cessation for their last reported episode in the study period (26%) compared with all episodes (18%). This was also true for clients who received recurring treatment (31% for the last reported episode and 26% across all episodes).

Clients who received intensive treatment did not follow a dominant treatment pattern

Clients who received intensive treatment received many different combinations of treatment with no dominant pattern. For example, clients who received treatment for the most common PDOC—alcohol—followed over 500 different patterns of treatment.

Further development of the AODTS NMDS data collection could provide more comprehensive information about why people cease treatment

This analysis does not include information about treatment outcomes or severity of dependence. Outcomes and severity of dependence may be associated with the number of episodes clients receive, but it is not clear what that relationship is. For example, non-recurring clients may leave treatment because they met their treatment goals or, conversely, due to difficulties with treatment access. Inclusion of outcome data items in the AODTS NMDS could provide more information about why clients cease or return to treatment.

1 Introduction

The use of alcohol and other drugs (AOD) is an ongoing public health concern in Australia. At the population level, substance use poses a significant health, social and economic challenge (see Box 1.1). This is because AOD use is associated with person-level harms, including physical injury, psychological distress and mental health conditions, involvement in criminal activity, risky behaviours, preventable disease and mortality (ABS 2019; AIHW 2017, 2019a).

Box 1.1: Health, social and economic impacts of AOD use in Australia

Health impacts

- The health impacts associated with AOD use include hospitalisation, mental health conditions, physical injury, overdose and mortality.
- Tobacco, alcohol and illicit drug use together account for 16.5% of the burden of disease in Australia (AIHW 2019a).

Social impacts

- The social impacts of AOD use in Australia include involvement in criminal activity, engagement in risky behaviours, victimisation and road trauma.
- In 2016, 1 in 10 (9.9%) recent drinkers and 15.1% of people who had recently used illicit drugs had driven while intoxicated (AIHW 2017).
- In 2019, 1 in 5 (21%) Australians aged 14 and over were victims of an alcohol-related incident and 10.5% were victims of an illicit drug-related incident (AIHW 2020a).

Economic impacts

- Most of the economic impacts associated with AOD use relate to health care, criminal justice system expenditure and mortality.
- In 2015–16, the estimated cost of tobacco use was $136.9 billion (Whetton et al. 2019).
- Use of opioids ($15.8 billion) and cannabis ($4.5 billion) also presented substantial economic costs in 2015–16 (Whetton et al. 2020a, 2020b).
- In 2013–14, the estimated cost of methamphetamine use was more than $5 billion (Whetton et al. 2016).

1.1 Policy context

An individual's AOD use is dependent on a range of factors, including social, environmental and economic circumstances (Spooner 2009). Therefore, the implementation of evidence-based policies that are targeted at reducing AOD-related harms are increasingly important for shaping the patterns of AOD treatment service use in Australia.

National Drug Strategy 2017–2026

The National Drug Strategy (NDS) 2017–2026 provides a framework for a coordinated approach to minimising harm related to AOD use in Australia. The purpose of the NDS 2017–2026 is to build 'safe, healthy and resilient Australian communities through preventing and minimising alcohol, tobacco and other drug-related health, social and economic harms' (DoH 2017). The NDS is guided by 3 pillars of harm minimisation—demand reduction, supply reduction and harm reduction (DoH 2017). Together, these pillars aim to prevent, manage and reduce the:

- uptake and misuse of AOD
- supply and production of AOD
- social, health and economic costs of AOD.

The NDS recognises that maintaining access to high-quality treatment and support services is effective in reducing harms associated with AOD use. Accordingly, research that supports evidence-informed approaches has been identified as a priority action under the NDS 2017–2026 (DoH 2017).

National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029

The National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 aims to ensure that all Australians can 'access high quality treatment appropriate to their needs' (DoH 2019). The framework focuses on treatment interventions for AOD use, and provides an overview of effective treatment principles.

The framework describes intensive treatment interventions as those with a key focus on 'changing behaviour, enhancing physical and mental health, and social and emotional wellbeing' (DoH 2019).

The framework identifies 4 types of intensive intervention. These include:

- withdrawal management (detoxification)
- counselling
- rehabilitation
- pharmacotherapy.

As such, intensive interventions can be broadly characterised as those that are likely to require ongoing support and continued contact with a client (DoH 2019).

1.2 Alcohol and other drug treatment

AOD treatment services aim to provide support to people to reduce substance use, facilitate lifestyle change and improve overall health and wellbeing (AIHW 2020b). While treatment objectives vary, successful AOD treatment often involves multiple episodes of care (Kelly et al. 2019; Lubman et al. 2014). For example, a treatment pattern might include assessment, supervised withdrawal or rehabilitation, and multiple episodes of follow-up counselling (Lubman et al. 2014).

Notably, some clients receive more intensive treatment (that is, more episodes) than others. Factors such as principal drug of concern (PDOC) and treatment type are associated with treatment success and, potentially, number of treatment episodes (Lubman et al. 2014). However, the characteristics of clients who receive intensive treatment are relatively poorly understood. Additionally, it is not clear whether clients who receive intensive treatment follow similar patterns through treatment (for example, similar sequences of treatment types).

Previous research

Previous AIHW analysis examined treatment patterns using data from the Alcohol and Other Drug Treatment Services National Minimum Data Set (AODTS NMDS) (AIHW 2019b). This analysis revealed that a small proportion of clients (3%) treated in publicly funded AOD agencies received 'continuous treatment'; that is, at least 1 treatment episode in each collection period between 1 July 2014 and 30 June 2018 (AIHW 2019b). These clients however, accounted for 13% of total treatment episodes.

1.3 Purpose

The purpose of this report is to strengthen the evidence base for clients who have received multiple episodes of specialist AOD treatment over an extended period of time. Understanding these treatment patterns will help to inform the provision of policies and programs that reduce AOD-related harm, and better support client needs. This is important because people receiving AOD treatment often require ongoing support to implement lasting change and achieve their treatment goals (DoH 2019).

Therefore, this report aims to answer the research question:

What are the patterns of service use for clients who received intensive AOD treatment?

In doing so, this report seeks to identify clients who received intensive treatment from a publicly funded AOD treatment service, and characterise their service use patterns to inform policy and service planning. The report also seeks to compare characteristics of clients in this cohort with those who received less intensive treatment (that is, recurring or non-recurring treatment).

This report addresses a gap in knowledge about the patterns of AOD treatment service use in Australia by:

- establishing criteria for clients receiving intensive AOD treatment
- identifying the characteristics of clients who received intensive AOD treatment
- investigating whether common patterns of treatment service use were evident among clients who received intensive AOD treatment and, if so, how these compare with other client cohorts.

1.4 Alcohol and other drug treatment services in Australia

The AODTS NMDS is collected annually by the Australian Institute of Health and Welfare (AIHW) to monitor treatment episodes and contribute to the development of policy and service planning (AIHW 2020b). See Box 1.2 for information about the AODTS NMDS.

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

The AODTS NMDS contains information on treatment provided to clients by publicly funded AOD treatment services, including government and non-government agencies. Clients include people who are seeking assistance for their own drug use, and those seeking assistance for someone else's drug use. Information on clients is included in the AODTS NMDS when a treatment episode is closed (see Glossary).

Client information is collected at the episode level in the AODTS NMDS. A statistical linkage key (SLK) was introduced in 2012–13, which enables the number of individual clients receiving treatment to be estimated. The SLK is constructed from information about the client's date of birth, sex and selected letters of their name.

Imputation was applied for selected AODTS NMDS data items in instances where the response rate fell below an agreed cut-off in the states and territories. Imputation was undertaken for the 2012–13, 2013–14 and 2015–16 collections (see the relevant Data Quality Statements for previous collection years for more detail). Analysis of the SLK data showed that approximately 99% of national data contained a valid SLK in 2018–19, reflecting high response rates and improved SLK quality for all jurisdictions. The analysis in this report is based on AODTS NMDS data from 2013–14 to 2018–19. This is because, as a pilot collection, the 2012–13 SLK has data quality issues.

Coverage and data quality

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

Further details on scope, coverage and data quality is available from the AODTS NMDS Data Quality Statement. This report includes cross-references to supplementary tables (denoted as 'SC' or 'SE'), which are available at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/patterns-of-intensive-aod-treatment-2014-to-2019/data.

2 Defining intensive AOD treatment

For the purposes of this report, a set of criteria for defining intensive AOD treatment was established. The criteria were based on both the number of collection periods and number of treatment episodes that a client received within the study period. See Appendix A for further information on intensive treatment definitions and Appendix B for information on logistic modelling methodology and jurisdictional results.

2.1 What is intensive AOD treatment?

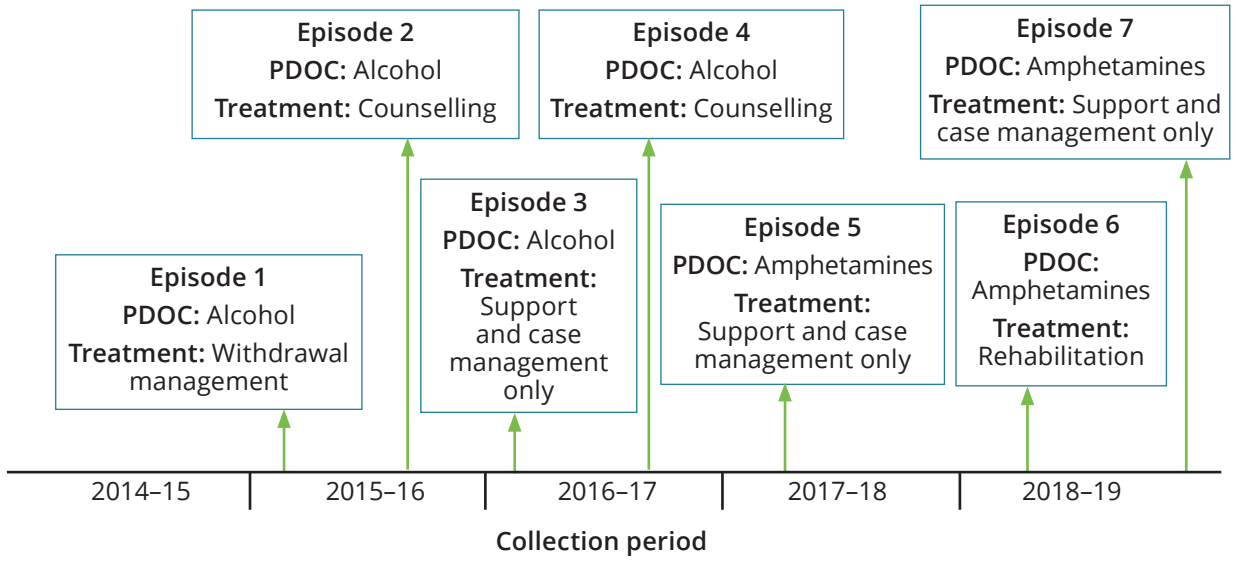
Clients receiving intensive treatment—clients who received 7 or more closed treatment episodes across at least 3 collection periods (see Figure 2.1).

This definition can be broken down into 2 key criteria:

Criterion 1: the client received AOD treatment in at least 3 collection periods.

Criterion 2: the client received an overall total of at least 7 closed treatment episodes.

Figure 2.1 Example of intensive treatment



2.2 What is recurring AOD treatment?

Clients receiving intensive treatment—clients who received fewer than 7 closed treatment episodes across at least 3 collection periods (see Figure 2.2).

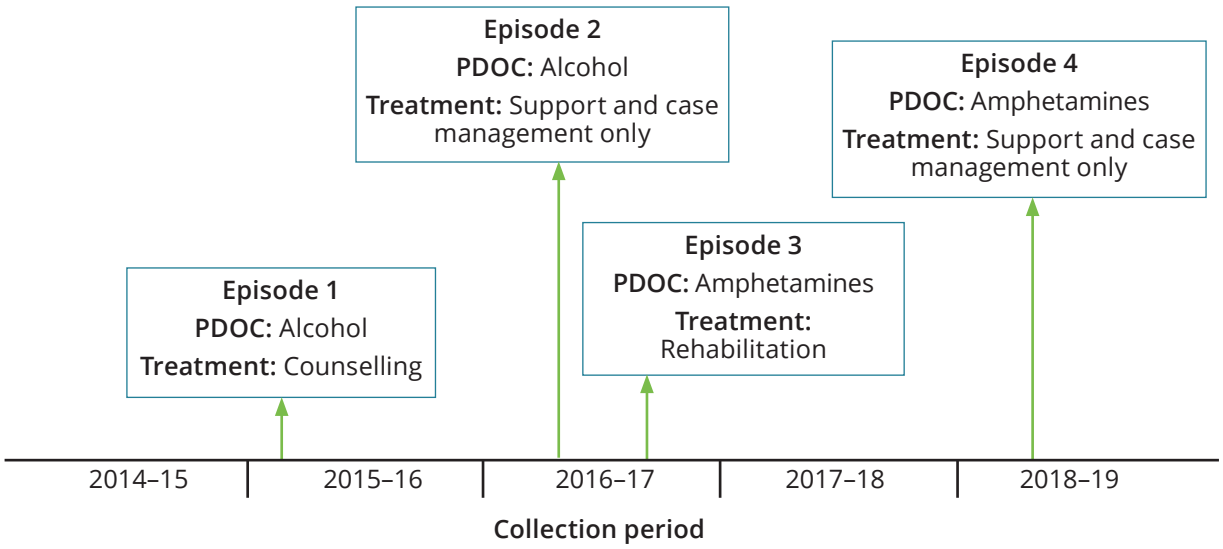
This definition can be broken down into 2 key criteria:

Criterion 1: the client received AOD treatment in at least 3 collection periods.

Criterion 2: the client received fewer than 7 closed treatment episodes total.

Please note: clients must have received a minimum of 3 episodes to appear in 3 collection periods.

Figure 2.2 Example of recurring treatment



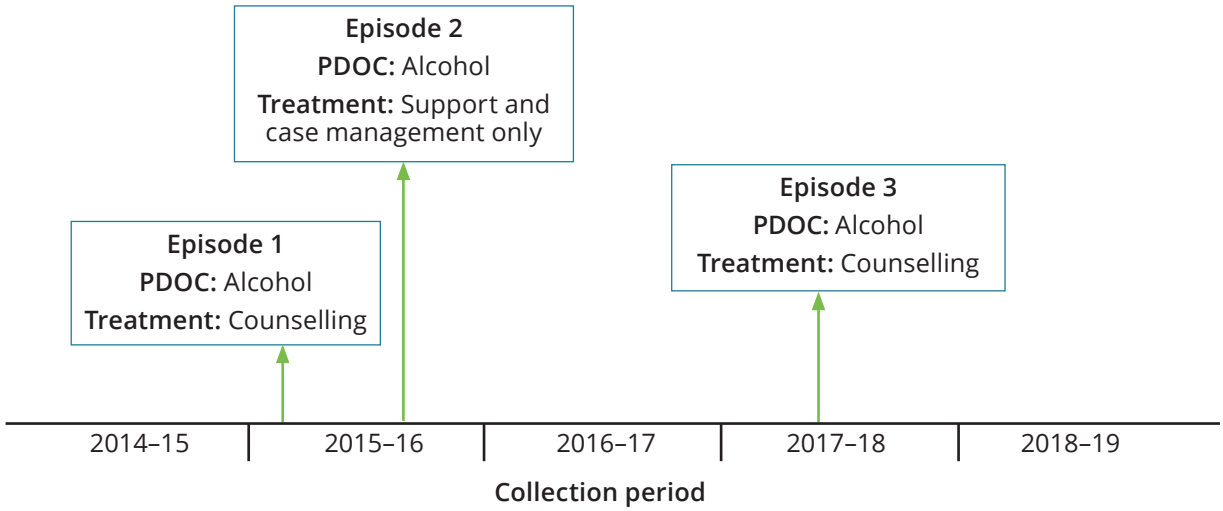
2.3 What is non-recurring AOD treatment?

Clients receiving non-recurring treatment—clients who received treatment in fewer than 3 collection periods (see Figure 2.3).

This definition has 1 key criterion:

Criterion 1: clients received only closed episodes of treatment in 1 or 2 collection periods.

Figure 2.3 Example of non-recurring AOD treatment



2.4 Analysis criteria

Clients were excluded from the analysis if they:

- received a closed treatment episode between 1 July 2013 and 30 June 2014
- received their first recorded closed treatment episode between 1 July 2017 and 30 June 2019
- were referred from another AOD treatment service for their initial episode in the 2014–15 collection period
- received treatment only for another person's AOD use
- reported 'assessment only' as their main treatment type for all episodes.

These criteria provided a proxy start date by ensuring that the initial cohort received treatment for their own drug use, and did not receive AOD treatment in the 12 months before 1 July 2014. They also ensured that there was enough time for clients to have received treatment in 3 or more collection periods. However, it is important to note that clients may have received treatment before 1 July 2013, and/or continued to receive treatment beyond 30 June 2019. Services accessed in these periods are outside the scope of this report. Episodes with 'assessment only' as the main treatment type were also out of scope of the criteria of this analysis. This is because assessment-only treatment episodes focus primarily on identifying harmful AOD use and assessing clients' needs, and are not considered intensive interventions.

2.5 Rationale

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

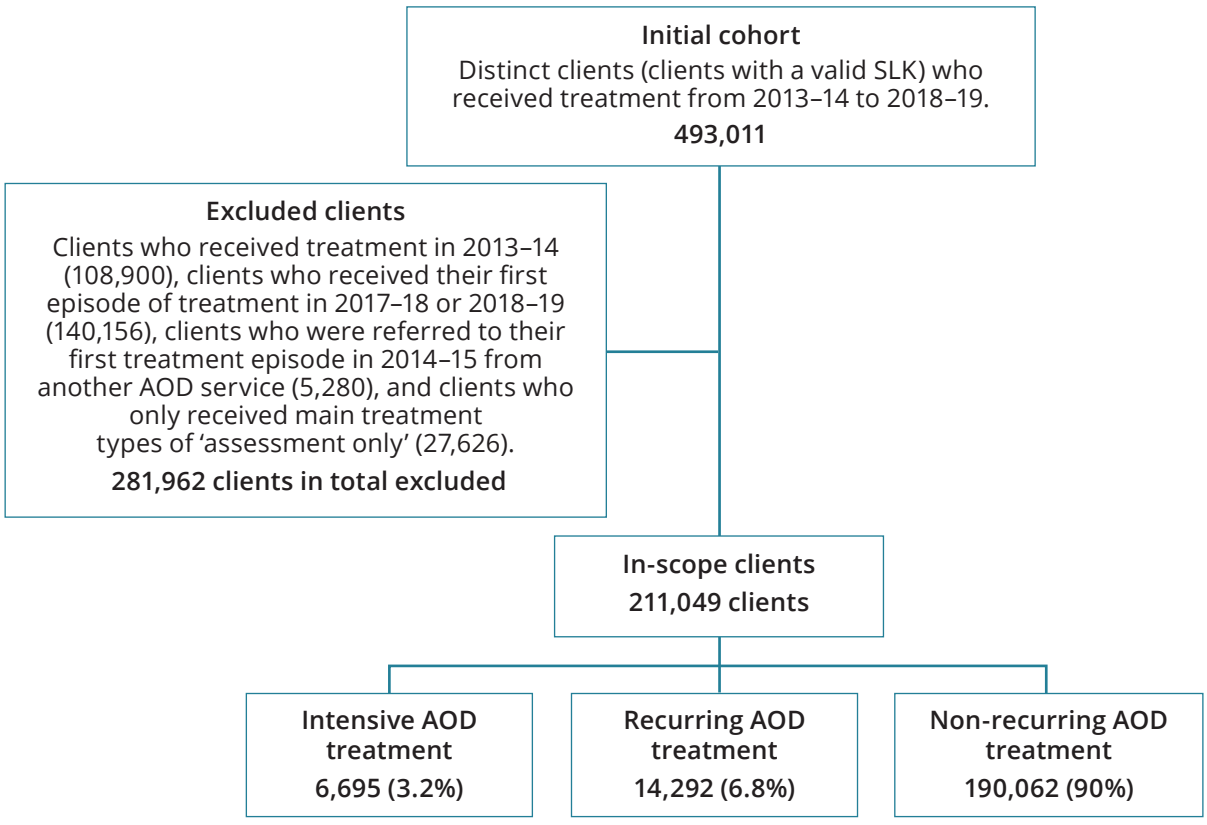
- treatment experiences vary among individuals
- there is a subset of clients which engages with AOD treatment services more regularly than others, and therefore has a higher level of contact with the sector over time (AIHW 2019b; Kelly & White 2011).

This report focuses on the 211,049 clients who received AOD treatment between 1 July 2014 and 30 June 2019 (Figure 2.4). Three cohorts of clients were then identified based on the patterns of treatment received:

- intensive AOD treatment
- recurring AOD treatment
- non-recurring AOD treatment.

Please refer to Appendix A for more information about the criteria for intensive treatment.

Figure 2.4: Overview of clients receiving AOD treatment for their own AOD use



3 Characteristics of clients who received intensive AOD treatment

3.1 Who received intensive AOD treatment?

A total of 6,695 clients received intensive AOD treatment (Table SC.1). This accounts for 3.2% of all clients, but 16% of all closed treatment episodes.

Of the 6,695 clients who received intensive treatment:

Nearly 3 in 5 (**59%**) were male.

20–39 yrs

More than half (**57%**) were aged 20–39.

Almost 1 in 7 (**13%** or 859 clients) identified as Indigenous Australians.

More than half (**56%**) lived in *Major cities*.

Almost 1 in 5 (**18%**) lived in the most socioeconomically disadvantaged areas.

3.2 Who received recurring AOD treatment?

A total of 14,292 clients received recurring AOD treatment (Table SC.1). This accounts for 6.8% of all clients, but 14% of all closed treatment episodes.

Of the 14,292 clients who received recurring treatment:

Around 2 in 3 (**67%**) were male.

20–39 yrs

Around 3 in 5 (**61%**) were aged 20–39.

Almost 1 in 6 (**17%** or 2,426 clients) identified as Indigenous Australians.

Close to half (**47%**) lived in *Major cities*.

More than 1 in 5 (**22%**) lived in the most socioeconomically disadvantaged areas.

3.3 Who received non-recurring AOD treatment?

A total of 190,062 clients received non-recurring AOD treatment (Table SC.1). This accounts for 90% of all clients, but 70% of all closed treatment episodes.

Of the 190,062 clients who received non-recurring treatment:

More than 2 in 3 (**69%**) were male.

More than half (**54%**) were aged 20–39.

Around 1 in 7 (**14%** or 26,335 clients) identified as Indigenous Australians.

Close to half (**47%**) lived in *Major cities*.

More than 1 in 5 (**22%**) lived in the most socioeconomically disadvantaged areas.

3.4 Key comparative findings

While the social and demographic characteristics of clients remained relatively consistent across all 3 cohorts, there were notable differences between groups (Table 3.1).

Key findings

Intensive AOD treatment

Compared with clients who received either recurring or non-recurring AOD treatment, clients who received intensive AOD treatment had:

- the highest proportion of females (41%)
- the highest proportion residing in the least socioeconomically disadvantaged areas (18%).

Recurring AOD treatment

Compared with clients who received either intensive or non-recurring AOD treatment, clients who received recurring AOD treatment had:

- the highest proportion aged 20–29 and 30–39 (31% and 30%, respectively)
- the highest proportion who identified as Indigenous Australians (17%).

Non-recurring AOD treatment

Compared with clients who received either intensive or recurring AOD treatment, clients who received non-recurring AOD treatment had:

- the highest proportion of males (69%)
- the highest proportion aged 10–19 (16%).

Sex and age

Across all cohorts receiving AOD treatment, the majority of clients were male. However, proportions differed depending on whether these clients received intensive, recurring or non-recurring AOD treatment:

- Clients who received intensive AOD treatment were more likely to be female (41%) compared with those who received recurring (33%) or non-recurring (31%) AOD treatment (Table 3.1).
- Clients receiving recurring AOD treatment had the highest proportion of clients aged 20–29 and 30–39 (31% and 30%, respectively) (Table 3.1).
- Male clients who received intensive AOD treatment were most commonly aged 30–39 (30%), whereas females who received intensive AOD treatment were most commonly aged 20–29 (32%) (Table SC.7).

Indigenous status

Overall, the majority of clients receiving AOD treatment identified as non-Indigenous. However, there was variation across the cohorts. For example, clients who received recurring AOD treatment were more likely to identify as Indigenous Australians (17%, or 2,426 clients) compared with clients who received either non-recurring (14%, or 26,335 clients) or intensive (13%, or 859 clients) AOD treatment (Table 3.1).

Socioeconomic disadvantage

Socioeconomic disadvantage is defined in this report using the Australian Bureau of Statistics' Index of Relative Socio-economic Disadvantage (IRSD). The IRSD was derived from the postcode of the client's last known home address at the start of the first treatment episode. Proportions were relatively consistent across socioeconomic groups. There were some variations depending on whether clients received intensive, recurring or non-recurring AOD treatment. For example, clents who received intensive AOD treatment were more likely to reside in the least socioeconomically disadvantaged areas (18%) compared with clients who received recurring and non-recurring AOD treatment (both 14%) (Table 3.1).

Remoteness area

Remoteness area was derived from the postcode of the client's last known home address at the start of the first treatment episode. Across all cohorts receiving AOD treatment, the majority of clients lived in *Major cities*. However, proportions differed depending on whether the clients received intensive, recurring or non-recurring AOD treatment. For example:

- Clients who received intensive AOD treatment were more likely to live in *Major cities* (56%) than clients who received either recurring or non-recurring AOD treatment (both 47%) (Table 3.1).
- Clients who received intensive AOD treatment were less likely to live in *Outer regional*, *Remote* and *Very remote* areas (15% combined) than clients who received either recurring or non-recurring AOD treatment (both 26%). However, this could be due to a range of factors, including accessibility of treatment services and travel time.

Table 3.1: AOD treatment service client profile (%)

Characteristics		Intensive	Recurring	Non-recurring
Sex	Male	58.5	67.2	69.1
	Female	41.4	32.8	30.8
	Total	***100.0***	***100.0***	***100.0***
Age	10–19	13.2	12.2	16.2
	20–29	28.1	30.6	29.8
	30–39	29.3	30.1	24.5
	40–49	19.3	18.5	17.6
	50–59	7.8	6.8	8.1
	60 and over	2.2	1.7	3.8
	Total	***100.0***	***100.0***	***100.0***
Indigenous status	Indigenous	12.8	17.0	13.9
	Non-Indigenous	83.5	79.3	82.2
	Not stated	3.6	3.7	4.0
	Total	***100.0***	***100.0***	***100.0***
Socioeconomic disadvantage	1 (most disadvantaged)	18.3	22.0	22.2
	2	19.6	21.5	21.4
	3	20.4	20.1	21.0
	4	19.3	17.9	18.1
	5 (least disadvantaged)	18.2	14.3	14.2
	Unknown socioeconomic area	4.3	4.2	3.2
	Total	***100.0***	***100.0***	***100.0***
Remoteness area	Major cities	55.5	46.5	46.9
	Inner regional	25.6	24.4	24.4
	Outer regional	11.0	15.6	16.3
	Remote	2.3	5.5	5.8
	Very remote	2.1	4.9	4.1
	Unknown remoteness area	3.5	3.2	2.4
	Total	***100.0***	***100.0***	***100.0***

Notes

1. Percentage distributions may not sum to 100 due to rounding.
2. Quintile 1 (most disadvantaged) – Quintile 5 (least disadvantaged) refers to area based quintiles classified according to the Socioeconomic Index for Areas 2016, specifically the Index of Relative Socio-economic Disadvantage (IRSD).
3. The IRSD was derived from the postcode of the client's last known home address at the start of the first treatment episode.
4. Remoteness area was derived from the postcode of the client's last known home address at the start of the first treatment episode.

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

4 Patterns of service use among clients who received intensive AOD treatment

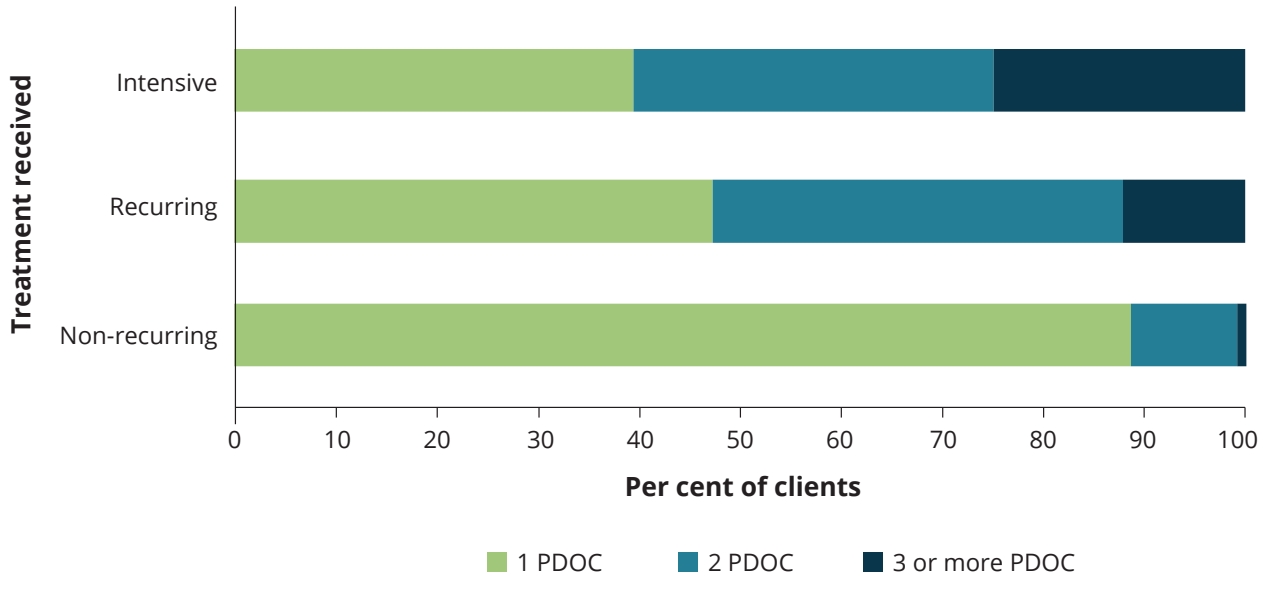
4.1 Principal drug of concern

For how many principal drugs of concern did clients receive treatment?

Clients receiving either recurring or intensive treatment were more likely to report multiple PDOC than clients receiving non-recurring treatment. Clients receiving intensive treatment were the most likely cohort to receive treatment for 3 or more PDOC (Figure 4.1; Table 4.1). In particular:

- One-quarter (25%) of clients receiving intensive treatment reported 3 or more PDOC across their treatment episodes, compared with 12% of clients receiving recurring treatment and 0.9% of those receiving non-recurring treatment.
- Clients receiving recurring (41%) or intensive (36%) treatment were more likely to report 2 PDOC than clients with non-recurring treatment (10%).
- Almost 9 in 10 (89%) clients receiving non-recurring treatment reported a single PDOC, compared with 47% and 40% for clients receiving recurring and intensive treatments, respectively.

Figure 4.1: Proportion of clients with 1, 2, or 3 or more PDOC, by treatment received



Source: Table SC.8.

What drugs of concern did clients receive treatment for?

Alcohol was the most common PDOC reported in each of the cohorts. Among clients with a single PDOC, amphetamines and cannabis were the second and third most common PDOC in each of the 3 cohorts. Clients receiving either recurring or intensive treatment were more likely to receive treatment for amphetamines than cannabis, while for clients receiving non-recurring treatment, the opposite was found (Table 4.1).

Among clients who received intensive treatment and reported a single PDOC across all episodes, the most common was alcohol (58% of clients), followed by amphetamines (26%) and cannabis (8.9%) (Table 4.1). These 3 PDOC were also the most common PDOC for clients who received treatment for multiple PDOC across treatment episodes. More specifically:

- Almost one-quarter (23%) of clients who received intensive treatment for 2 PDOC reported cannabis and amphetamines as their PDOC, and 17% reported amphetamines and other drugs (Table 4.1).
- Among clients who received intensive treatment for 3 or more PDOC, the top 3 drug combinations were: alcohol, amphetamines and cannabis (17%); amphetamines, cannabis and other drugs (16%); and alcohol, amphetamines and other drugs (13%).

Table 4.1: Proportion of clients by number of PDOC and drug type, clients with intensive, recurring, and non-recurring treatment

Characteristics		Intensive	Recurring	Non-recurring
Number of PDOC	1	39.5	47.3	88.7
	2	35.6	40.6	10.4
	3 or more PDOC	24.9	12.1	0.9
	Total	***100***	***100***	***100***
Clients with 1 PDOC	Alcohol	57.8	44.0	32.8
	Amphetamines	26.0	31.3	18.0
	Cannabis	8.9	14.8	31.9
	Heroin	3.8	4.2	3.1
	Other	3.4	5.7	14.1
	Total	***100***	***100***	***100***
Clients with 2 PDOC	Alcohol and amphetamines	13.9	12.5	10.6
	Alcohol and cannabis	13.5	14.7	15.1
	Alcohol and heroin	1.9	1.3	1.2
	Alcohol and other	14.7	10.1	14.4
	Amphetamines and cannabis	23.2	22.1	18.9
	Amphetamines and heroin	4.1	4.4	3.1
	Amphetamines and other	17.4	19.7	17.1
	Cannabis and other	5.5	7.7	12.4
	Cannabis and heroin	0.9	1.0	1.2
	Heroin and other	4.9	6.6	6.0
	Total	***100***	***100***	***100***
Clients with 3 or more PDOC	Alcohol, amphetamines, cannabis	17.4	18.3	15.6
	Alcohol, amphetamines, heroin	3.2	2.0	2.0
	Alcohol, amphetamines, other	12.8	16.6	17.8
	Alcohol, cannabis, heroin	0.6	0.8	1.0
	Alcohol, cannabis, other	10.0	10.8	14.0
	Alcohol, heroin, other	4.1	3.7	5.3
	Amphetamines, cannabis, heroin	2.8	3.5	2.4
	Amphetamines, cannabis, other	16.1	21.2	22.9
	Amphetamines, heroin, other	8.2	10.9	9.9
	Cannabis, heroin, other	2.9	4.2	3.9
	Alcohol, amphetamines, cannabis, heroin	1.1	0.7	0.2
	Alcohol, amphetamines, cannabis, other	10.7	4.1	3.6
	Alcohol, amphetamines, heroin, other	3.4	0.9	0.5
	Alcohol, cannabis, heroin, other	1.4	0.8	0.3
	Amphetamines, cannabis, heroin, other	3.8	1.3	0.6
	5 PDOC	1.5	0.2	0.0
	Total	***100***	***100***	***100***

Note: Percentage distributions may not sum to 100 due to rounding.

Sources: Tables SC.8 and SC.9.

4.2 Main treatment type

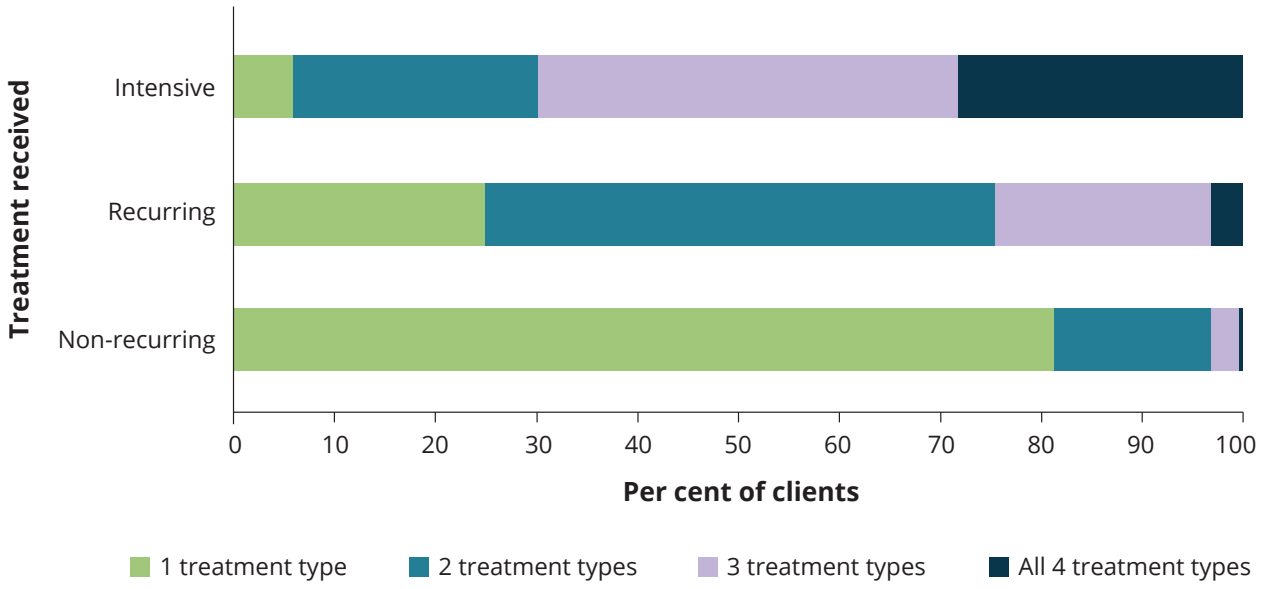
The National Framework for Alcohol, Tobacco and Other Drug Treatment 2019–2029 identifies 4 treatment types that are considered intensive: counselling, withdrawal management, rehabilitation and pharmacotherapy (DoH 2019). In this report, pharmacotherapy was included in the 'other' category because of small numbers. This is because most pharmacotherapy services are outside the scope of the AODTS NMDS. Therefore, the data presented here are a substantial under-representation. More information on opioid pharmacotherapy in Australia is available from the AIHW's National Opioid Pharmacotherapy Statistics Annual Data collection. Given this, the following sections focus on counselling, withdrawal management, rehabilitation and 'other' (pharmacotherapy and support and case management).

How many main treatment types did clients receive?

The number of treatment types that clients received across treatment episodes was higher for clients who received intensive treatment than for those who received either recurring or non-recurring treatment. Over 9 in 10 (94%) clients receiving intensive treatment received more than 1 of the 4 treatment types (counselling, withdrawal management, rehabilitation and 'other') across episodes (Figure 4.2; Table 4.2):

- Clients receiving non-recurring treatment were the most likely to report receiving 1 treatment type (81%), while clients receiving recurring treatment were the most likely to receive 2 treatment types (50%) and clients receiving intensive treatment were the most likely to receive 3 (42%).
- Over one-quarter (28%) of clients receiving intensive treatment received all 4 treatment types examined. This was a much larger proportion than for clients receiving either recurring (3.2%) or non-recurring (0.4%) treatment.

Figure 4.2: Proportion of clients with 1, 2, 3 or all 4 treatment types, by treatment received



Source: Table SC.10.

What main treatment types did clients receive?

Among clients who received intensive treatment, combinations of treatment including counselling and/or withdrawal management were the most common. For example, 2 in 5 (44%) clients with 2 treatment types received counselling and 'other' treatment, 25% received counselling and withdrawal management, and 18% received withdrawal management and 'other' treatment (Table 4.2).

The most common treatment types were similar across all cohorts (Table 4.2):

- Among clients with 1 treatment type, counselling was the most common treatment for those receiving intensive (58%), recurring (76%) or non-recurring (50%) treatment.
- For clients with 2 treatment types, counselling and 'other' treatment was the most common combination for clients receiving intensive (44%), recurring (61%) or non-recurring (52%) treatment.
- Among clients receiving 3 treatment types, the most common treatment combination was counselling, withdrawal management and 'other' treatment for clients receiving intensive (57%), recurring (50%) or non-recurring (50%) treatment.

Table 4.2: Proportion of clients by number of main treatment types and main treatment type, clients with intensive, recurring or non-recurring treatment

Characteristics		Intensive	Recurring	Non-recurring
Number of treatment types	1	5.9	25.0	81.2
	2	24.3	50.4	15.6
	3	41.6	21.4	2.7
	All 4 treatment types	28.2	3.2	0.4
	Total	***100.0***	***100.0***	***100.0***
Clients with 1 treatment type	Counselling	58.3	75.5	50.4
	Withdrawal management	4.8	4.0	6.8
	Rehabilitation	1.3	1.6	3.6
	Other treatment	35.7	18.9	39.2
	Total	***100.0***	***100.0***	***100.0***
Clients with 2 treatment types	Counselling and withdrawal management	24.8	17.3	20.0
	Counselling and rehabilitation	7.3	9.0	7.7
	Counselling and other	44.0	60.6	51.8
	Withdrawal management and rehabilitation	3.8	2.5	4.9
	Withdrawal management and other	18.1	7.4	11.0
	Rehabilitation and other	2.0	3.3	4.7
	Total	***100.0***	***100.0***	***100.0***
Clients with 3 treatment types	Counselling, withdrawal management, rehabilitation	16.3	17.2	20.4
	Counselling, withdrawal management, other	56.9	50.0	49.5
	Counselling, rehabilitation, other	16.5	25.0	17.0
	Withdrawal management, rehabilitation, other	10.3	7.8	13.1
	Total	***100.0***	***100.0***	***100.0***

Notes

1. Pharmacotherapy, support and case management only, and information and education only were included in the 'other' category.
2. Percentage distributions may not sum to 100 due to rounding.

Sources: Tables SC.10 and SC.11.

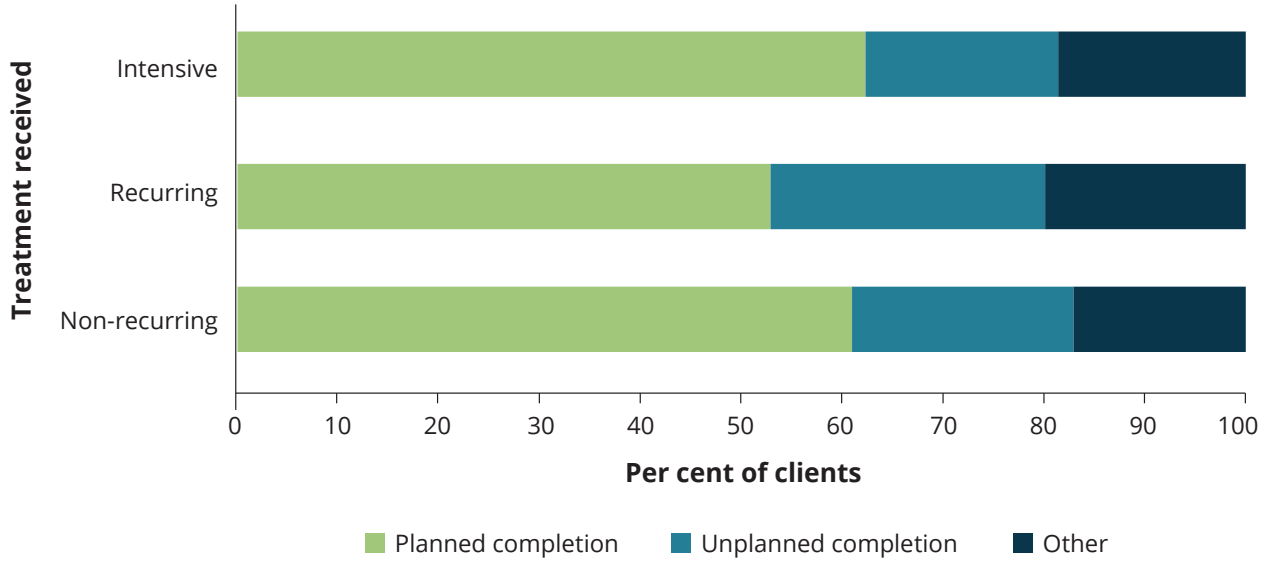
4.3 Reason for cessation: planned or unplanned

What were the reasons for cessation by clients?

Among clients who received intensive treatment, just under two-thirds (62%) of treatment episodes ended with a planned completion. This was a higher proportion than for clients who received recurring treatment (53% of episodes), but was similar to those who received non-recurring treatment (61%) (Figure 4.3; Table 4.3).

Among clients who received intensive treatment, almost 1 in 5 (19%) treatment episodes ended with an unplanned cessation. This was lower than for clients receiving recurring (27%) or non-recurring treatment (22%).

Figure 4.3: Proportion of episodes by reason for cessation, by treatment received by clients



Note: 'Other' includes referral to another service, change in treatment mode, and other.

Source: Table SE.1

Did unplanned completion become more common in the last reported treatment episode compared with previous episodes?

Clients receiving intensive treatment were more likely to end their last reported treatment episode in the study period with an unplanned cessation (26% of episodes) than their previous episodes (18%) (Table 4.3). Clients receiving recurring treatment also followed this pattern, being more likely to record an unplanned cessation reason in their last reported episode (31%) than all previous episodes (26%).

Table 4.3: Proportion of episodes ending in planned or unplanned cessation by clients receiving intensive, recurring or non-recurring treatment

Characteristics		Intensive	Recurring	Non-recurring
% of all episodes by cessation reason	Planned completion	62.3	52.9	61.0
	Unplanned completion	19.1	27.3	21.9
	Other	18.6	19.8	17.1
	Total	100.0	100.0	100.0
	Total	***100.0***	***100.0***	***100.0***
% of last reported and previous episodes by cessation reason				
% of last reported treatment episodes in the study period	Planned completion	59.2	53.9	62.6
	Unplanned completion	26.3	31.1	22.9
	Other	14.5	15.0	14.5
	Total	***100.0***	***100.0***	***100.0***
% of previous episodes	Planned completion	62.6	52.5	58.4
	Unplanned completion	18.3	26.1	20.2
	Other	19.1	21.3	21.4
	Total	***100.0***	***100.0***	***100.0***

Notes

1. 'Other' includes referral to another service, change in treatment mode, and other.
2. Percentage distributions may not sum to 100 due to rounding.

Sources: Tables SE.1 and SE.2.

4.4 Were there patterns of service use among clients who received intensive AOD treatment?

What is a pattern of service use?

A pattern of service use refers to a sequence of treatment across time. This includes patterns of characteristics across treatment episodes, such as PDOC, main treatment type and cessation reason. For example, a simple pattern might involve an episode of withdrawal management for alcohol as the PDOC, followed by an episode of counselling for alcohol (Lubman et al. 2014).

The AODTS NMDS captures a range of information about AOD treatment episodes, including PDOC, main treatment type, reason for cessation, source of referral and treatment duration. If all of these treatment variables were considered across all treatment episodes, identification of patterns may be difficult. For example, in a given episode, clients may share a common PDOC and treatment type but have been referred by a different source.

To simplify analysis (or reporting) of patterns of service use, this report assessed 3 key variables and examined only the initial stages of treatment. Specifically, the analysis included PDOC, main treatment type and cessation reason across clients' first 3 treatment episodes.

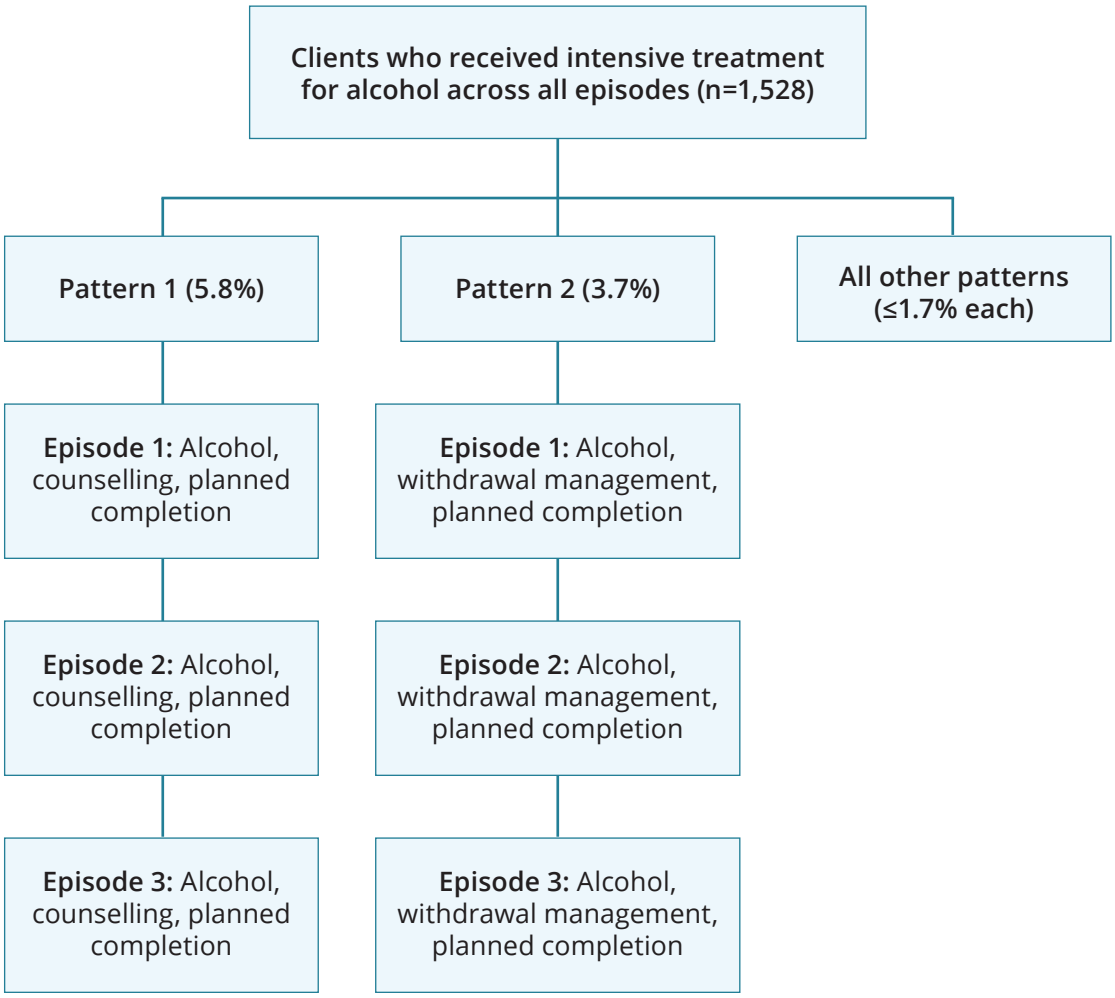
Were there patterns of service use?

Even when patterns were simplified, clients who received intensive treatment followed a range of different combinations with no dominant pattern. For example, among the 1,528 clients who only sought treatment for their own alcohol use across all episodes, 532 different patterns of treatment in the first 3 episodes were identified. Among clients who received treatment for alcohol only as their PDOC (Figure 4.4), across the first 3 episodes:

- The most common pattern (5.8% of clients) involved 3 episodes of counselling, all with a planned completion.
- The second most common pattern (3.7%) involved 3 episodes of withdrawal management, all with a planned completion.
- Each of the remaining patterns was followed by less than or equal to 1.7% of clients.

Analysis of clients who received intensive treatment for a PDOC other than alcohol (for example, amphetamines) also revealed no dominant patterns across the first 3 episodes.

Figure 4.4: The most common initial patterns[(a)] of treatment among clients receiving intensive treatment for their own alcohol use across all episodes



(a) Initial patterns refer to patterns of service use in clients' first 3 treatment episodes, noting that these clients received at least 7 closed treatment episodes over the study period.

5 Limitations and priorities

We note that there are limitations in the AODTS NMDS. For example, differences in data collection and reporting by states and territories mean that clients from different jurisdictions may be more or less likely to have their treatment classified as intensive (see Appendix B).

A priority area for the AODTS NMDS is to examine the collection of treatment outcomes data. Outcome indicators may clarify why clients cease or continue treatment. For example, clients who receive non-recurring treatment may achieve their treatment goals after 1 or 2 episodes of treatment. Conversely, these clients may cease treatment prematurely due to barriers (for example, accessibility), despite experiencing ongoing symptoms of dependence.

Collecting information about severity of dependence may also be used as an outcome indicator (that is, whether assessed in each episode and/or after treatment cessation), but could also help to inform the nature of treatment (intensive, recurring or non-recurring). For example, clients with higher severity of dependence may require more intensive treatment.

Even though clients receiving intensive, recurring and non-recurring treatment do show differences in demographics and treatment characteristics, the outcomes for these different treatment cohorts are unclear.

AODTS NMDS data development activities could help to understand whether more treatment episodes are supporting clients to achieve their treatment goals. For example, the AODTS NMDS could seek to include treatment outcome data items in the data collection and monitor changes over time. This would enable future research to examine the reasons that clients cease or continue treatment, and how they differ across cohorts.

6 Conclusion

This report examined the characteristics of clients who received intensive AOD treatment in Australia over the 5-year period 2014–15 to 2018–19. It explored the sociodemographic and treatment characteristics of this cohort and compared it with cohorts that received either recurring or non-recurring treatment. This report also assessed patterns through treatment among clients who received intensive treatment, and identified common factors associated with receiving intensive treatment.

Across all 3 treatment cohorts, clients were more likely to be male and non-Indigenous. However, clients who received intensive treatment were more likely to be female, non-Indigenous and live in the least socioeconomically disadvantaged areas than both other cohorts.

There was no dominant pattern of treatment service use among clients who received intensive AOD treatment. Treatment patterns involved many combinations of PDOC, main treatment types and cessation reasons. However, there were key characteristics that distinguished these clients from those receiving either recurring or non-recurring treatment.

Alcohol was the most common PDOC across all clients, irrespective of the treatment cohort, and counselling was the most common main treatment type. Clients who received intensive treatment were more likely to report multiple PDOC and multiple main treatment types across their treatment episodes than both other cohorts. They were also more likely to report planned completion for most or all of their treatment episodes than were clients with recurring treatment.

These findings indicate that clients are willing to make repeated efforts to seek support to overcome problematic AOD use. Understanding these factors may help with treatment service planning.

Appendix A: How the intensive Alcohol and other Drug treatment cohort was defined

The goal of this study was to explore the treatment patterns of a subset of clients who had received 'intensive' treatment, conceptualised as treatment that took place across many episodes over a long period of time. This required the development of set criteria for how to classify any given series of treatment episodes.

From this goal, 2 broad criteria were developed: treatment across multiple years, and treatment across many episodes. Each of these criteria required specific values to determine the treatment cohort.

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

For the treatment across multiple years criterion, the goal was to choose the smallest possible number of collection periods in which treatment could occur for it to still be considered long term. As a result, 2 collection periods was not sufficient—a person may have received 2 episodes of treatment, 1 in May and 1 in August of the same year, and they would fall into 2 collection periods.

The choice of treatment in at least 3 collection periods ensures that a person has returned to treatment multiple times, in episodes ending more than a year apart.

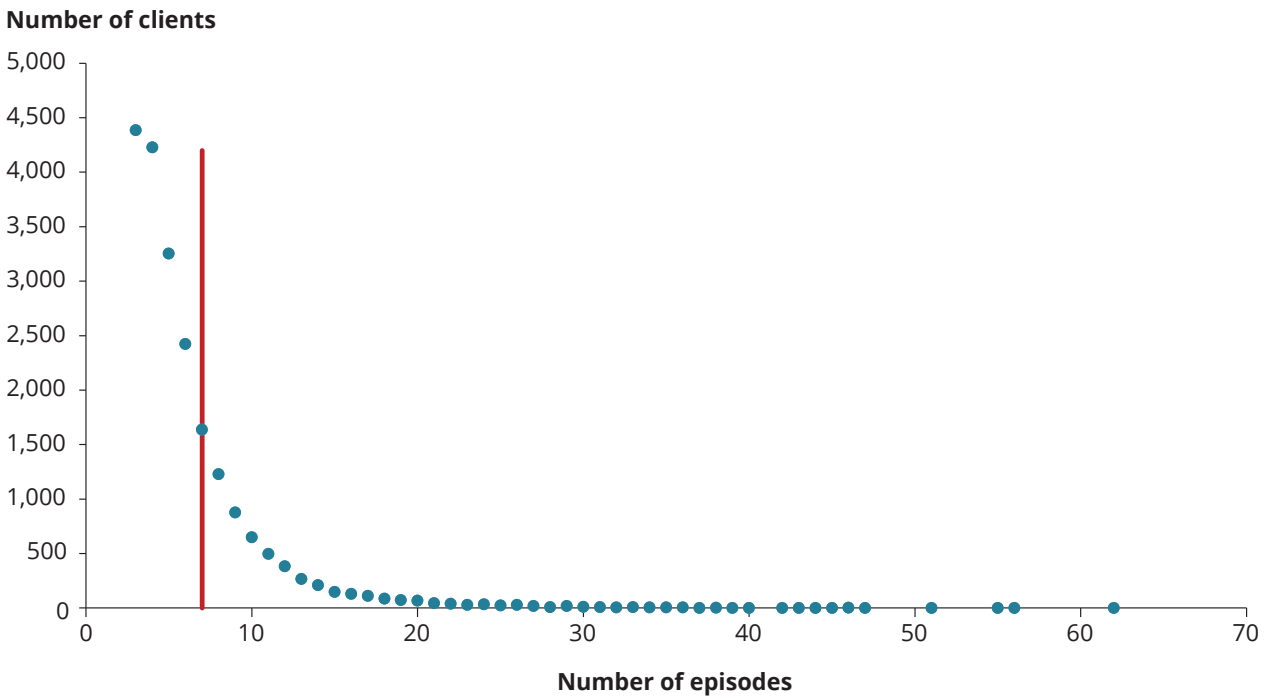
Criterion 1: The client received AOD treatment in at least 3 collection periods.

The non-recurring cohort was defined as clients who did not fit this criterion; that is, clients who received treatment in 1 or 2 collection periods. Following the establishment of criterion 1, clients who received their first episode of treatment in 2017–18 or 2018–19 were also removed, as it was not possible for them to appear in 3 collection periods.

The treatment across 'many' episodes criterion required a set number of episodes to be chosen as a cut-off. To address the question of what this cut-off should be, the number of episodes that provided to each client who met criterion 1 was modelled to assess whether any number of distinct cohorts could be identified.

The results in Figure A1 show that there were no distinct cohorts within the population of clients who met criterion 1—the choice of a cut-off number of episodes to define 'intensive' treatment was hence somewhat arbitrary.

Figure A1: Number of episodes that each client received, among clients who had received AOD treatment in at least 3 collection periods



After considering factors such as the overall number of clients, the Australian Institute of Health and Welfare chose the largest number of episodes which captures the top 25% of clients (in terms of total number of episodes). In Figure A1, this is the line at 7 episodes—slightly more than 25% of clients received 7 or more closed treatment episodes between 2013–14 and 2018–19.

Criterion 2: The client received an overall total of at least 7 closed treatment episodes.

Clients who met both criteria were considered to have received 'intensive treatment', while clients who only met criterion 1 (that is, who received 3–6 treatment episodes) were considered to have received 'recurring' treatment.

This outlines the method of defining an intensive treatment cohort. Future studies that may use a subset of the Alcohol and Other Drug Treatment Services National Minimum Data Set, or individual collections, may differ on the cut-off for criterion 2, and may define intensive treatment differently as a result.

Appendix B: Logistic modelling methodology and jurisdictional results

To ensure accurate representation of the alcohol and other drugs treatment service client population, logistic regression modelling was applied to collection period data between 2014–15 and 2018–19. In particular, modelling was undertaken to determine whether known treatment and reporting differences between states and territories were influencing the national results of clients receiving intensive, recurring and non-recurring treatment (chapters 3 and 4).

Alcohol and other drug (AOD) intensive treatment

Intensive AOD treatment was defined as clients who received 7 or more closed treatment episodes across at least 3 collection periods between 2014–15 and 2018–19. This category was determined at the national level, where it represents the 75th percentile for the number of closed treatment episodes that each client received.

State and territory differences

States and territories take different approaches to treatment, both in terms of the mix of treatment types offered across treatment services, and how episode data from treatment episodes are recorded. One potential consequence of these differences is that clients in some jurisdictions may, on average, record more or fewer distinct treatment episodes, which in turn means that treatment may be more likely to be categorised as intensive in some jurisdictions than in others. For example, while 23% of the clients in the Alcohol and Other Drug Treatment Services National Minimum Data Set recorded treatment in Victoria, 43% of clients receiving intensive treatment were based in Victoria (Table B1).

Table B.1: Proportion of clients with intensive AOD treatment and all clients, by state and territory, 2014–15 to 2018–19

State/territory	Clients receiving intensive treatment	All clients
New South Wales	23.8	20.9
Victoria	42.7	22.6
Queensland	12.3	31.0
Western Australia	11.8	14.5
South Australia	3.2	4.6
Tasmania	1.0	1.9
Australian Capital Territory	4.0	2.4
Northern Territory	1.3	2.0
Total	***100.0***	***100.0***

Note: Percentage distributions may not sum to 100 due to rounding.

Differences between jurisdictions may affect the generalisability of the results. For example, if clients receiving AOD treatment in 1 state tend to be older, and that state is more likely to have clients who received intensive treatment, then there may appear to be a relationship between age and intensive treatment that is purely caused by jurisdictional differences.

To ensure differences between states and territories are not causing the differences between clients receiving intensive, recurring and non-recurring treatment in chapters 3 and 4, a logistic model was applied. This model allows for exploration of the association between personal and treatment-level characteristics, while controlling for potential confounding effects between them. By controlling for state/territory in this model, it is possible to examine whether the other variables were still associated with intensive, recurring or non-recurring treatment.

The logistic regression modelling generally follows the results from the descriptive analyses reported in chapters 3 and 4. For example, after controlling for state/territory differences, clients who received intensive treatment were more likely to be female and to live in the least socioeconomically disadvantaged areas than clients who received recurring or non-recurring treatment.

The model did disagree with some of the descriptive analysis. Before running the logistic regression model, clients who received intensive treatment included the highest proportion of clients who identified as non-Indigenous. However, this was no longer the case after controlling for state/territory in the logistic model, although clients who received non-recurring treatment did still have the highest proportion of Indigenous clients.

Only differences found to be statistically significant after controlling for state/territory in the logistic regression model are described in this report, to prevent differences in states or territories from confounding the results.

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- South Australian Department of Health
- Tasmanian Department of Health
- Australian Capital Territory Health Directorate
- Northern Territory Department of Health.

Abbreviations

AIHW	Australian Institute of Health and Welfare
AOD	alcohol and other drug/s
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
IRSD	Index of Relative Socio-economic Disadvantage
NDS	National Drug Strategy
PDOC	principal drug of concern
SLK	statistical linkage key

Glossary

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

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

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

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

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

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

Illicit drug use: includes:

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

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

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

Remoteness area: The Australian Bureau of Statistics' Australian Statistical Geography Standard Remoteness Area classification allocates 1 of 5 remoteness categories to areas, based on their relative accessibility to goods and services (such as general practitioners, hospitals and specialist care) as measured by road distance. These classifications reflect the level of remoteness at the time of the 2011 Census. Areas are classified as *Major cities*, *Inner regional, Outer regional, Remote* and *Very remote*. The remoteness area of the treatment service was derived from its Statistical Area Level 2 (SA2) 2011, while the remoteness area of the client was derived from the postcode of the client's last known home address at the start of the treatment episode. When either the SA2 or the postcode covered multiple remoteness areas, the remoteness area allocation with the largest proportion was selected.

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

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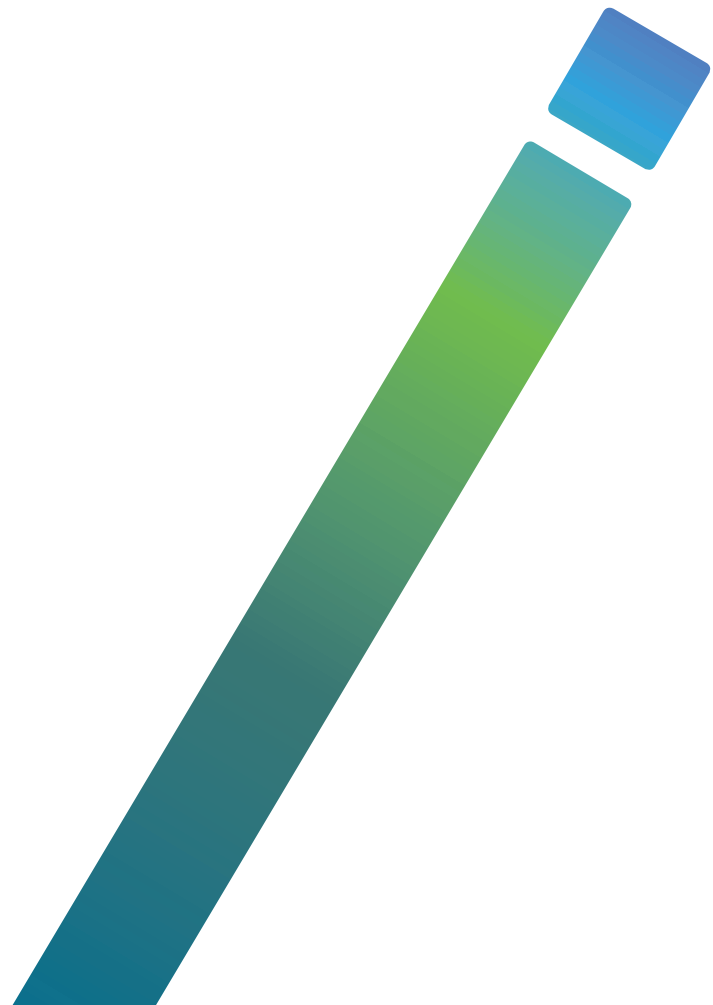
Related publications

This report, *Patterns of intensive alcohol and other drug treatment service use in Australia, 1 July 2014 to 30 June 2019*, is part of an annual drug treatment series. For those requiring further detail, complete data tables are available at https://www.aihw.gov.au/reports/alcohol-other-drug-treatment-services/patterns-of-intensive-aod-treatment-2014-to-2019/data. The 4 earlier editions and any published subsequently can be downloaded for free from the Australian Institute of Health and Welfare (AIHW) website, at https://www.aihw.gov.au/reports-data/health-welfare-services/alcohol-other-drug-treatment-services/reports. The website also includes information on ordering printed copies.

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

- AIHW 2019. Australian Burden of Disease Study: impact and causes of illness and death in Australia 2015. Australian Burden of Disease Study series no.19. Cat no. BOD 22. Canberra: AIHW.
- AIHW 2020. Alcohol and other drug treatment services in Australia, 2018–19. Drug treatment series no. 34. Cat. no. HSE 243. Canberra: AIHW.
- AIHW 2020. Alcohol, tobacco & other drugs in Australia. Cat. no. PHE 221. Canberra: AIHW.
- AIHW 2020. National Drug Strategy Household Survey 2019. Drug Statistics series no. 32. PHE 270. Canberra AIHW.

Clients accessing alcohol and other drug treatment services often receive multiple episodes of treatment, with some clients requiring more intensive treatment to achieve their goals. This report describes 3 distinct client cohorts based on their patterns of treatment service use between 1 July 2014 and 30 June 2019. Clients who received intensive treatment were more likely than other cohorts to report receiving treatment for multiple principal drugs of concern and for more main treatment types across episodes.



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