Australian Government
Australian Institute of Health and Welfare

BULLETIN 128 • JUNE 2015

bulletin 128

National opioid pharmacotherapy statistics

2014

Summary

Dependence on opioid drugs is associated with a range of health and social problems that affect individual drug users, their family and friends, and the wider public. This bulletin presents information on the clients receiving opioid pharmacotherapy treatment, the doctors prescribing opioid pharmacotherapy drugs, and the dosing points that clients attend to receive their medication.

Over 48,000 Australians received pharmacotherapy treatment for their opioid dependence on a snapshot day in June 2014.

The number of people receiving opioid pharmacotherapy treatment almost doubled between 1998 (from around 25,000) and 2014, but growth in client numbers slowed in recent years (growing by 0.5–2% a year between 2011 and 2014).

Heroin is the most common opioid drug leading people to pharmacotherapy treatment.

Clients were nearly twice as likely to report heroin as an opioid drug of dependence as they were for all opioid pharmaceuticals combined, however this varied by jurisdiction.

Methadone continued to be the drug most commonly prescribed; the form in which buprenorphine is prescribed is changing.

Around two-thirds (67%) of clients received methadone in 2014, and this has been relatively stable since 2006. The remaining third (33%) received 1 of 2 forms of buprenorphine. Of these, the proportion receiving buprenorphine only has fallen (from 24% to 13%) while the proportion receiving buprenorphine combined with naloxone has risen (from 5% to 20%) over the same period. Naloxone is added to buprenorphine to deter its injection.

Opioid pharmacotherapy clients are getting older on average.

In 2014, around two-thirds (69%) of clients were aged 30–49, and this has been fairly consistent since 2006. However, from 2006 to 2014 the proportion of clients aged less than 30 more than halved (from 28% to 10%), and the proportion of clients aged 50 and over more than doubled (from 8% to 21%). These trends indicate an ageing population of clients in pharmacotherapy treatment.

Males and Indigenous Australians are over-represented in pharmacotherapy treatment.

Around two-thirds (65%) of clients receiving pharmacotherapy in June 2014 were male. Where reported, 1 in 10 (10%) clients identified as Indigenous and Indigenous Australians were around 3 times as likely to have received pharmacotherapy treatment as non-Indigenous Australians.

Prescriber numbers have increased, and most work in the private sector.

The number of prescribers of opioid pharmacotherapy rose by 31% since 2012 (from 1,768 to 2,319). In 2014, most prescribers treated 1–5 clients (39%), worked in the private sector (82%) and were authorised to prescribe more than 1 type of pharmacotherapy drug (74%).

Most dosing points were located in pharmacies.

Most clients need to attend a dosing point regularly to take their opioid pharmacotherapy drug under supervision. In 2013–14 there were 2,432 dosing point sites in Australia, and 9 in 10 (89%) were located in pharmacies.

Contents

Introduction

Opioid drug dependence

Dependence on opioid drugs is associated with a range of health and social problems that affect individual drug users, their family and friends, and the wider public. Opioid dependence can lead to many problems such as overdose, medical and psychological complications, social and family disruption, harms to child welfare, violence and drug-related crime, and the spread of bloodborne diseases. It is considered a serious public health issue (WHO 2013).

In 2013, about 3% of Australians had used opioids for non-medical reasons over their lifetime, while 1.2% had used heroin (AIHW 2014b). Among those Australians seeking treatment for drug and alcohol problems in 2012–13, opioids were a drug of concern in about 1 in 8 (13%) treatment episodes (AIHW 2014a).

What are opioid drugs?

Opioids are chemical substances that have a morphine-type action in the body. Opioid drugs depress the central nervous system and are widely used to treat pain due to their analgesic effect. Other effects include sedation and euphoria, however repeated use of opioids can lead to drug dependence—a chronic, relapsing condition (NSW Health 2006).

Opioid drugs include:

- illicit opioids, predominantly heroin (WHO 2013)
- prescription opioids (whether prescribed for the person or obtained illicitly) such as morphine and oxycodone (Roxburgh et al. 2011)
- over-the-counter opioids in which the opioid drug codeine is combined with a non-opioid analgesic such as paracetamol or ibuprofen (Nielsen et al. 2010).

Opioid pharmacotherapy treatment

Opioid dependence is a condition requiring long-term treatment. Opioid pharmacotherapy treatment is one of the main treatment types used for opioid drug dependence and involves replacing the opioid drug of dependence with a legally obtained, longer-lasting opioid that is taken orally. It reduces or eliminates withdrawal symptoms and drug cravings (NDARC 2004). Research suggests that pharmacotherapy treatment reduces heroin use, other opioid substance misuse and associated criminal behaviour. It also improves physical and mental health and social functioning (Ritter & Chalmers 2009).

In Australia, 3 medications are registered for long-term maintenance treatment for opioid-dependent people:

- methadone oral liquid (available since 1969)
- buprenorphine tablet (available since 2000)
- buprenorphine-naloxone tablet (available since 2005) or film (available since 2011) (DoHA 2007; DoHA 2012) (see Glossary for further details).

How is opioid pharmacotherapy provided in Australia?

The current Australian opioid pharmacotherapy system seeks to strike a balance between maximising accessibility of treatment and minimising the risks associated with non-compliance (injecting medication) and diversion (selling or swapping medication) (Ritter & Chalmers 2009). Methadone and buprenorphine are Schedule 8 (controlled) drugs, which means there are strict regulations associated with their use (Ritter & Chalmers 2009).

Clients seek or are referred to treatment for their opioid dependence. A health professional who is authorised to provide opioid pharmacotherapy (a prescriber) prescribes methadone, buprenorphine or buprenorphine-naloxone as part of the client's treatment plan. Clients are not usually given a whole course of their medication for use at home. Rather, the client attends a dosing point regularly and takes 1 dose of their prescribed medication under the supervision of a pharmacist or other health professional. Some takeaway doses may be given to eligible clients. Where takeaway dosing is permitted, it is recommended (for clients on buprenorphine) that buprenorphine-naloxone is prescribed (DoHA 2007). For more information on dosing, see the 'Dosing points' section of this bulletin.

Each state and territory has rules about how prescribers are authorised to prescribe methadone, buprenorphine and buprenorphine-naloxone. For more information, see the 'Prescribers' section of this bulletin and Appendix A (online).

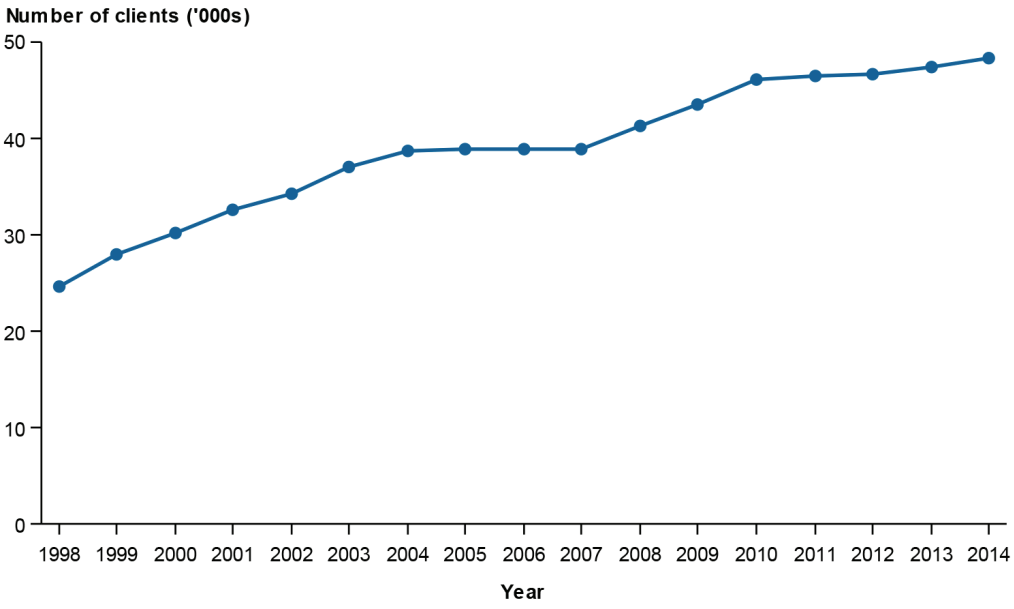
About the NOPSAD collection

The National Opioid Pharmacotherapy Statistics Annual Data (NOPSAD) collection is a set of jurisdictional data that includes information about clients accessing pharmacotherapy for the treatment of opioid dependence; prescribers participating in the delivery of pharmacotherapy treatment; and dosing sites that clients attend to receive their medication. Data are reported on a snapshot day in June each year.

The information about the provision of opioid pharmacotherapy treatment in this bulletin is based on the data from the NOPSAD collection. The bulletin is part of the *National opioid pharmacotherapy statistics 2014* release which includes supplementary tables (those with a prefix of S) and web pages which are available from the Australian Institute of Health and Welfare (AIHW) website at: <http://www.aihw.gov.au/national-opioid-pharmacotherapy-statistics-annual-data-collection/>.

Clients

On a snapshot day in June 2014, 48,393 clients were receiving pharmacotherapy treatment in Australia, a rise of 951 (or 2%) between 2013 and 2014 (Figure 1). In contrast, between 1998 and 2004, and again between 2007 and 2010, client numbers grew by 5–13% a year.



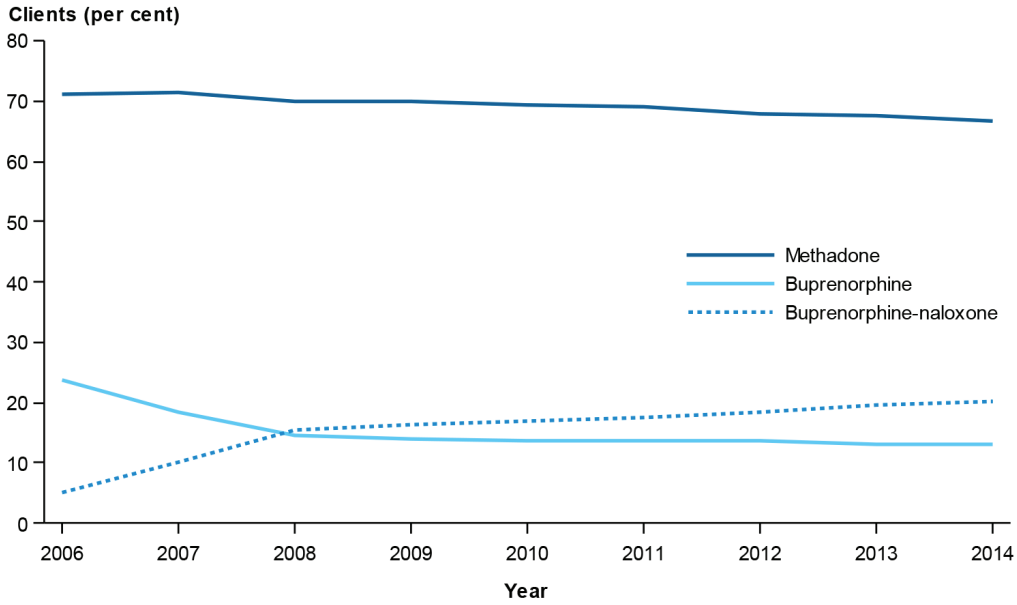
Source: Table S1.

Figure 1: Clients receiving pharmacotherapy treatment on a snapshot day, 1998 to 2014

Nationally, the number of clients per 10,000 people in the population increased from 15 in 1998 to 24 in 2010, but has since remained stable at 24 (Table S1). In 2014, New South Wales had the highest rate of clients (26 per 10,000 population), followed by Victoria (24 per 10,000) and the Australian Capital Territory (24 per 10,000). The Northern Territory had the lowest rate of clients (6 per 10,000 population). The low rate of clients in the Northern Territory may be partially attributable to the limited availability of heroin (Moon 2014), the impact of remote locations on treatment delivery, and a highly mobile population. Rates for all states and territories have remained relatively stable over the last 4 collection years (Table S2).

On a snapshot day in June 2014, 67% of clients received methadone, 13% received buprenorphine, and 20% received buprenorphine-naloxone (Table S4). However, it should be noted that New South Wales does not report clients receiving buprenorphine-naloxone separately—these clients are included in the number of clients receiving buprenorphine. When New South Wales data are excluded, in the rest of Australia 61% of clients received methadone, 5% received buprenorphine, and 34% received buprenorphine-naloxone.

Nationally, from 2008 to 2014, the proportion of clients receiving methadone fell slightly from 70% to 67% (Figure 2). Over the same period, the proportion of clients receiving buprenorphine fell from 15% to 13%, while the proportion receiving buprenorphine-naloxone rose from 16% to 20%. These data indicate that buprenorphine-naloxone prescription is replacing buprenorphine prescription to some extent. This is in keeping with national guidelines (DoHA 2007), which recommend that buprenorphine-naloxone should be preferred over buprenorphine for most clients receiving takeaway doses.



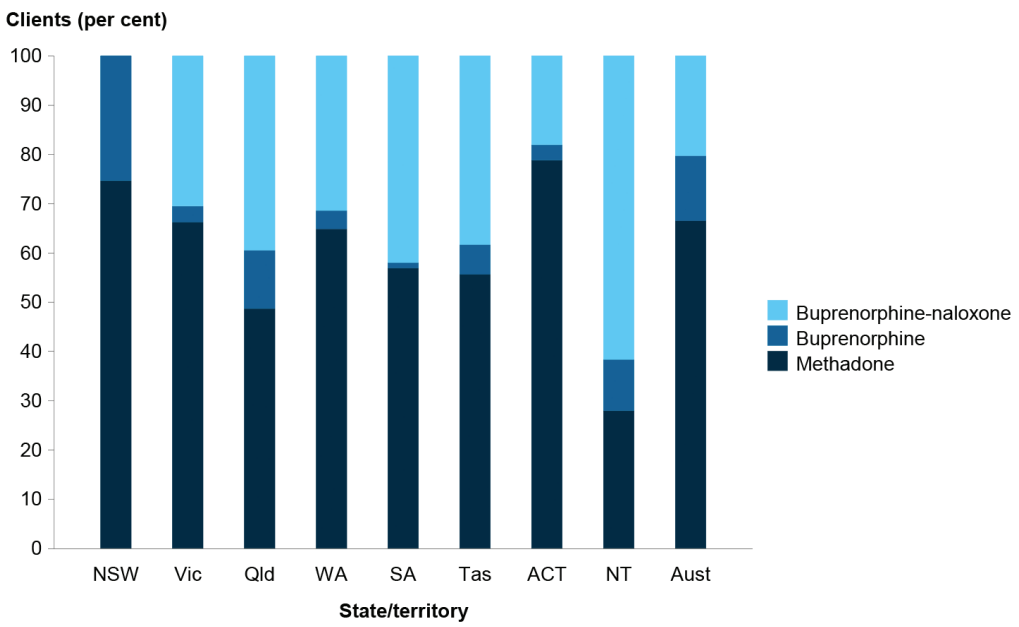
Notes

1. Data prior to 2008 should be interpreted with caution, as separate data collection of buprenorphine-naloxone started at different times: 2006 for Vic, WA, SA, NT; 2007 for Tas and the ACT; and 2008 for Qld.
2. NSW counts 'buprenorphine-naloxone' as 'buprenorphine'. See Appendix A (online).

Source: Table S4.

Figure 2: Clients receiving pharmacotherapy treatment on a snapshot day, by pharmacotherapy type, 2006 to 2014

The proportion of clients receiving each of the 3 pharmacotherapies varies across states and territories (Figure 3). In 2014, methadone was the most common pharmacotherapy in all jurisdictions except for the Northern Territory. The Australian Capital Territory and New South Wales had the highest proportion of clients receiving methadone (79% and 75% respectively). In contrast, only 28% of clients in the Northern Territory were prescribed methadone. The Northern Territory had the highest proportion of clients receiving buprenorphine-naloxone (62%). Buprenorphine-naloxone is the default treatment drug for the main pharmacotherapy program in the Northern Territory.



Note: NSW counts 'buprenorphine-naloxone' as 'buprenorphine'. See Appendix A (online) for further details.

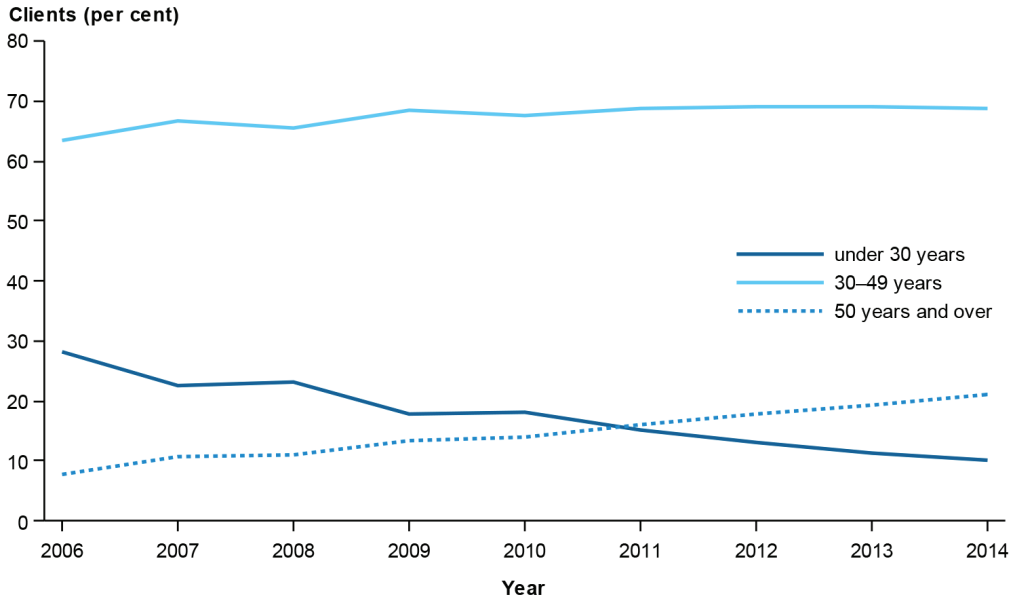
Source: Table S4.

Figure 3: Clients receiving pharmacotherapy treatment on a snapshot day, by pharmacotherapy type, states and territories, 2014

Age and sex

In 2014, around two-thirds (69%) of clients were aged 30–49, and this proportion has been fairly consistent since 2006 (Figure 4). However, from 2006 to 2013 the proportion of clients aged less than 30 more than halved (from 28% to 10%), and the proportion of clients aged 50 and over more than doubled (from 8% to 21%). This trend indicates an ageing cohort of people receiving opioid pharmacotherapy treatment. This trend towards pharmacotherapy clients being older has also been observed overseas (see, for example, Doukas 2011 and Dürsteler-MacFarland et al. 2011) and may be due to:

- methadone treatment having been available for more than 40 years
- pharmacotherapy treatment reducing the risk of premature death, resulting in some clients remaining in treatment for decades
- clients seeking treatment for the first time at an older age.



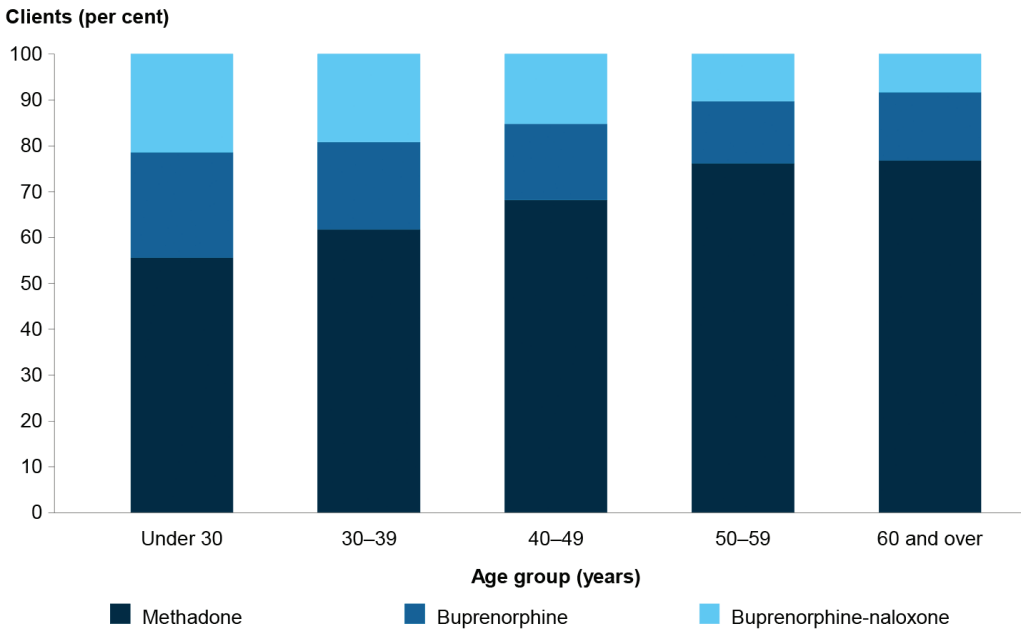
Note: Collection of age began in 2006.

Source: Table S6.

Figure 4: Clients receiving pharmacotherapy treatment on a snapshot day, by age group, 2006 to 2014

In 2014, clients ranged in age from their late-teens to 90. The median age of clients across all pharmacotherapy types was 40 years in 2013 and 2014, compared with 39 in 2012 and 38 in 2011 (the first year single-year age data were collected). At a state and territory level, clients in Victoria had the youngest median age (38 years) and clients in New South Wales had the oldest median age (42 years) (Table S5).

In 2014, methadone was the most commonly dispensed pharmacotherapy across all age groups (Figure 5). For older clients, the proportion receiving methadone was higher than for younger clients. Conversely, younger clients were more likely to receive buprenorphine or buprenorphine-naloxone than older clients. As buprenorphine was registered in Australia for opioid pharmacotherapy in 2000, and buprenorphine-naloxone was only registered in 2005 (DoHA 2007), one explanation for the observed trend might be that some older, long-term clients first entered treatment when methadone was the only available pharmacotherapy for opioid dependence and they have remained on this regime.



Notes
1. Data for Victoria were not available for age by pharmacotherapy type.
2. New South Wales count 'buprenorphine-naloxone' as 'buprenorphine'. As a result, the proportion of clients receiving buprenorphine-naloxone nationally is likely to be higher than reported in this figure. See Appendix A (online) for further details.

Source: Table S6.

Figure 5: Clients receiving pharmacotherapy treatment on a snapshot day, by age group and pharmacotherapy type, 2014

On a snapshot day in June 2014, around two-thirds (65%) of clients receiving pharmacotherapy were male. This proportion was consistent across states and territories (ranging from 60% in Tasmania to 67% in the Northern Territory), and by pharmacotherapy type—64% of clients receiving methadone, 65% of clients receiving buprenorphine and 67% of clients receiving buprenorphine-naloxone (Table S7).

There was little difference in age of male and female pharmacotherapy clients; however, females tended to be slightly younger. Clients aged 25-34 were more likely to be female, while those aged 50 and over were more likely to be male (Table S22).

The rate of people receiving pharmacotherapy was highest between ages spanning early 30s to mid-50s for both males and females (Figure 6). The rate peaked at the age of 37 for males and 36 for females (with 81 clients for every 10,000 males aged 37 in the population, and 46 clients for every 10,000 females aged 36). Males were generally more likely—and in some cases about twice as likely—to be receiving pharmacotherapy when compared to females of the same age.

Notes

1. Unit record data were used to produce this figure. Records were available for 58% of total clients receiving pharmacotherapy on a snapshot day in 2014. Vic and Qld data were not available.
2. Australian population estimates for June 2014 were used to produce this figure.

Source: Table S21.

Figure 6: Clients receiving pharmacotherapy treatment on a snapshot day, by age and sex, 2014

Aboriginal and Torres Strait Islander people

In 2014, 6 states and territories were able to provide information about the Indigenous status of clients receiving pharmacotherapy treatment. Victoria and Western Australia did not report the Indigenous status of their clients, with the result that Indigenous status was only reported for around two-thirds (30,749 or 64%) of clients in the collection. The analysis of the 2014 data that follows should be treated with caution due to the high proportion of clients (42%) for whom Indigenous status is either not reported or not stated.

In 2014, 2,994 (10%) of clients identified as being of Aboriginal and/or Torres Strait Islander origin (hereafter referred to as Indigenous Australians) (Table S9). The proportion of clients who were Indigenous Australians ranged from 5% in Queensland to 12% in the Northern Territory.

Overall, the rate of Indigenous clients receiving pharmacotherapy treatment was 53 per 10,000 Indigenous Australians. When compared to the rate for non-Indigenous clients (17 clients per 10,000 non-Indigenous Australians), Indigenous Australians are over-represented in pharmacotherapy treatment for opioid dependence. Among the states and territories for which data were available, the Australian Capital Territory and New South Wales had the highest rates of Indigenous clients (136 clients per 10,000 Indigenous Australians, and 100 per 10,000 respectively), and Queensland and the Northern Territory the lowest, consistent with their low overall rate of pharmacotherapy (17 clients per 10,000 Indigenous Australians and 2 per 10,000 respectively). (*Note*: The high rate in the Australian Capital Territory should be interpreted with caution as it has a small Indigenous Australian population.)

Seven in 10 (70%) Indigenous clients received methadone (Table S9).

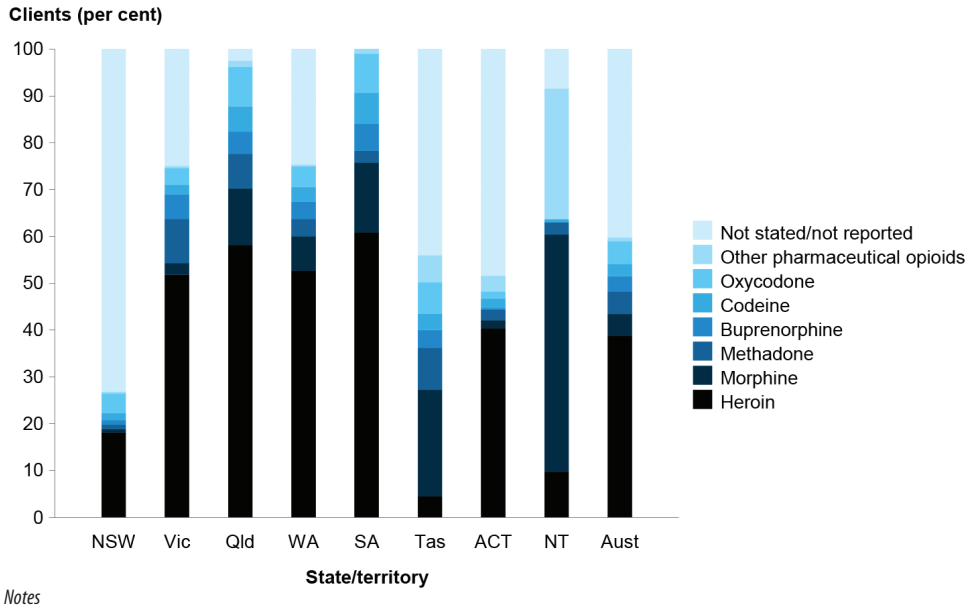
Opioid drug of dependence and client status

In 2013, two new data items were collected and reported—clients' opioid drugs of dependence (the drugs leading people to seek opioid pharmacotherapy treatment), and client status (new, ongoing or re-admitting client, and client transferring from another state/territory jurisdiction). Over the 2 years these data items have been collected, high rates of 'not stated' and 'not reported' responses were received (40% and 49% respectively), therefore the following information should be interpreted with caution, as there is no information on the extent to which those reporting and those not reporting differ on these issues.

Opioid pharmacotherapy clients receive treatment for a range of drugs of dependence, including illicit opioids (such as heroin) and pharmaceutical opioids, which are available illicitly, by prescription (such as morphine and oxycodone) or over the counter (such as codeine-paracetamol combinations).

At the national level, in 2014, clients were nearly twice as likely to report heroin as an opioid drug of dependence (18,806 clients) than they were for opioid pharmaceuticals (10,161 clients) (Figure 7). Oxycodone (2,357 clients), methadone (2,314 clients) and morphine (2,249) were the next most commonly reported drugs of dependence; however, pharmacotherapy drugs may be subject to misreporting if a client's treatment drug is reported in place of the opioid drug of dependence leading a client to seek treatment. In addition, differences in reporting for Victoria mean that data on opioid drug of dependence should be interpreted with caution (see footnote in Figure 7 for more information).

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.



Notes

1. All jurisdictions except Victoria reported 1 opioid drug of dependence per client. Victoria reported multiple opioid drugs of dependence (up to 5) for a maximum of 1% of clients—these data have been included without amendment.
2. 'Not stated/not reported' also includes 'inadequately described' responses.

Source: Table S10.

Figure 7: Clients receiving pharmacotherapy treatment on a snapshot day, by opioid drug of dependence, states and territories, 2014

Clients interact with the pharmacotherapy treatment system in a number of ways. A client's status may differ according to whether they are: receiving treatment for the first time (new); re-entering treatment after a lapse (re-admission); continuing treatment (ongoing); or transferring from another state/territory jurisdiction (interstate transfer).

On a snapshot day in June 2014, client status data were provided for Victoria, Queensland, Western Australia and Tasmania (Table S11). In these 4 jurisdictions, the majority of clients were classed as ongoing. This was highest in Tasmania (99%), followed by Western Australia (95%), Victoria (78%) and Queensland (70%). The proportion of re-admitting clients ranged from 24% in Queensland to less than 1% in Tasmania. New clients comprised only a small proportion of clients in all 4 jurisdictions (no greater than 10%).

Prescribers

Medical personnel, such as general practitioners and medical specialists, prescribe opioid pharmacotherapies. Each state and territory has a registration process through which prescribers can undergo training and become registered or authorised to prescribe opioid pharmacotherapies to clients. Data on all registered or authorised prescribers are included in this report, except for New South Wales, Western Australia and South Australia, where prescribers are included only if they are actively prescribing for at least 1 client on the snapshot day (see Table A2 of online Appendix A for further details). New South Wales (9), Western Australia (3) and South Australia (3) have prescribers who prescribe in more than 1 location, and as such are counted twice. This will lead to slightly deflated client to prescriber ratios.

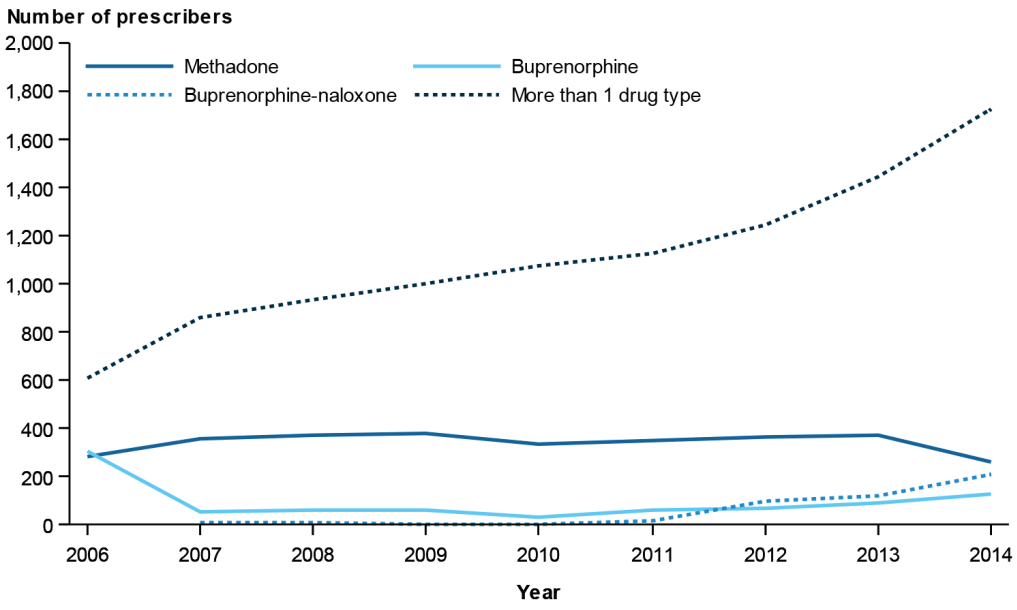
Being authorised or registered to prescribe pharmacotherapy for opioid dependence does not necessarily mean that the prescriber will prescribe this medication during any given year. Prescribers who have prescribed pharmacotherapy for a client with opioid dependence in a given financial year are referred to as 'active prescribers' (see Glossary for more information).

Nationally, there were 2,319 prescribers authorised to prescribe 1 or more pharmacotherapy drugs in 2014 (Table S15). This was a rise of 294 prescribers (15%) from 2013 and (31%) since 2012. Of these 2,319 prescribers, 74% (1,726) were authorised to prescribe more than one pharmacotherapy type, 11% (262) were authorised to prescribe methadone only, and 9% (207) were authorised to prescribe buprenorphine-naloxone only. The remaining 5% (124) were located in New South Wales and were authorised to prescribe buprenorphine and/or buprenorphine-naloxone, but reported as 'buprenorphine only' (Table S15).

Over the period 2006 to 2014, the proportion of prescribers authorised to prescribe more than 1 pharmacotherapy type rose from 51% to 74% (Figure 8). The rise in the proportion of prescribers authorised to prescribe buprenorphine-naloxone only (from 1% in 2011 to 9% in 2014) occurred mainly in South Australia, and is due to the introduction of the Suboxone® Opioid Substitution Program (see Table A1 of online Appendix A for more information). In Victoria, as of 2013, general practitioners could prescribe buprenorphine-naloxone for up to

5 patients without the need to attend training (Vic Health 2013). This also had an impact on the increased proportion of buprenorphine-naloxone-only prescribers.

All prescribers in Queensland, Western Australia, the Australian Capital Territory and the Northern Territory were registered to prescribe more than 1 drug type in 2014 (Table S15).



Note: NSW counts 'buprenorphine-naloxone' as 'buprenorphine'. See Appendix A (online) for further details.

Source: Table S15.

Figure 8: Prescribers, by pharmacotherapy type, 2006 to 2014

Where do prescribers work and how many clients do they treat?

Prescribers are classified according to the sector in which they are working when prescribing pharmacotherapy drugs to clients, that is, private, public or correctional facility. Of the 2,319 prescribers authorised to prescribe pharmacotherapy drugs in 2014, 82% (1,898) were private prescribers, 13% (296) were public prescribers, and 4% (83) were prescribers working in a correctional facility (Table 1).

Table 1: Prescribers, by prescriber type, states and territories, 2014

Prescriber type	NSW	Vic	Qld	WA	SA	Tas	ACT	NT	Aust
Public prescriber	152	—	83	23	16	12	5	5	296
Private prescriber	502	977	126	68	164	19	42	—	1,898
Public/private prescriber[(a)]	36	—	5	—	—	—	1	—	42
Correctional facility	26	18	7	23	5	2	1	1	83
Total	**716**	**995**	**221**	**114**	**185**	**33**	**49**	**6**	**2,319**

(a) In NSW, Qld and the ACT, these numbers relate to prescribing that cannot be separated into a single prescriber type.

Note: The states and territories have different guidelines and policies regarding training and registration to prescribe opioid pharmacotherapy types. In South Australia, for example, 109 out of 185 prescribers treat a total of 157 clients (under the SOSP). See Appendix A (online) for more information.

In 2014, Victoria had no public prescribers, and so had the highest proportion of private prescribers (98%). It was followed by South Australia and the Australian Capital Territory (89% and 86% private prescribers respectively). The Northern Territory had the highest proportion of public prescribers (83%), followed by Queensland (38%) and Tasmania (36%).

Of the 48,393 clients receiving treatment in Australia on the snapshot day in June 2014, 63% (30,550) received treatment from a private prescriber, 24% (11,479) received treatment from a public prescriber, and 7% (3,285) received treatment from a correctional facility prescriber (Table S3). These proportions have remained stable since 2006 (Table S12).

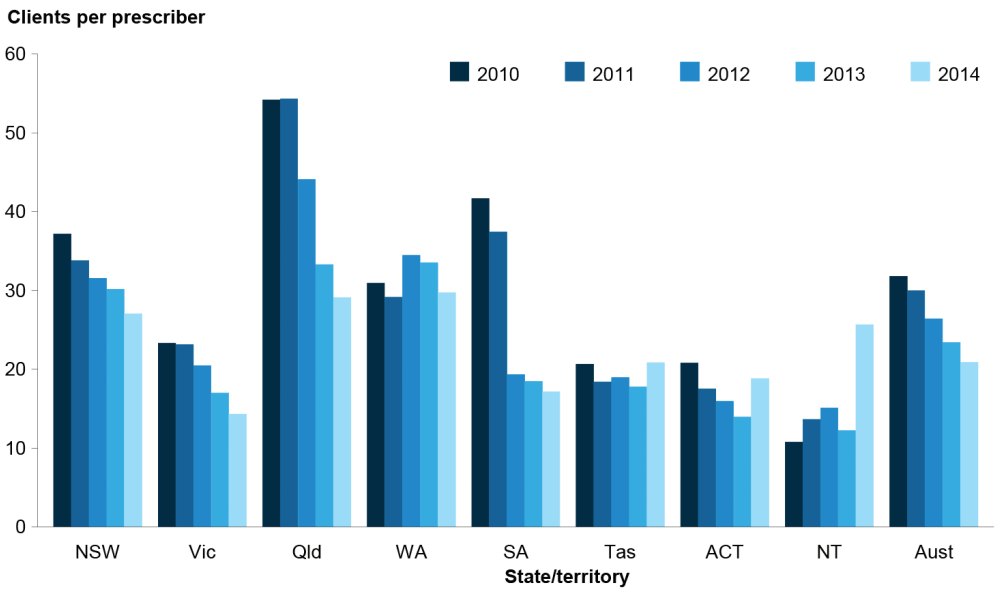
Private prescribers treated the majority of clients in New South Wales, Victoria, Western Australia, South Australia and Tasmania. Public prescribers treated the majority of clients in Queensland, the Australian Capital Territory and the Northern Territory (Table S3). This pattern is similar to that observed in 2013 for all jurisdictions.

Clients per prescriber

Data on the number of clients receiving pharmacotherapy treatment per prescriber were collected for the first time in 2014. Prescribers most commonly treated 1–5 clients. Nationally, on a snapshot day in June 2014, 39% of pharmacotherapy prescribers were treating 1–5 clients and 25% of prescribers were not treating any clients. Across states and territories, the proportion of pharmacotherapy prescribers treating 1–5 clients ranged between 16% in Queensland and 68% in South Australia (Table S17).

On a snapshot day in 2014, 2,319 prescribers were treating an average of 21 clients each. Over the 5-year period from 2010, there has been a steady decline in ratio of clients to prescribers (from 32 clients) (Figure 9). Low growth in client numbers (2% between 2013 and 2014) coupled with relatively high growth in prescriber numbers (15% between 2013 and 2014) has meant that the client-per-prescriber ratio fell in 2014. This continues a recent trend, with the client-per-prescriber ratio falling over the last 4 collection years.

Between 2013 and 2014, the number of clients per prescriber fell in the larger jurisdictions, but rose in Tasmania (from 18 to 21), the Australian Capital Territory (from 14 to 19), and the Northern Territory (from 12 to 26). In relative terms, Queensland had a notable drop (from 33 to 29), as did Western Australia (from 34 to 30).



Note: In South Australia, the decline in clients per prescriber is attributed to the introduction of the SOSP. On a snapshot day in 2014, 109 prescribers registered under the SOSP treated a total of 157 clients, while the remaining 76 prescribers treated a total of 3,016 clients.

Source: Table S19.

Figure 9: Average number of clients per prescriber, states and territories, 2010 to 2014

In 2014, prescribers working in the public sector had, on average, nearly 2.5 times as many clients as prescribers working in the private sector (39 clients per prescriber compared with 16) (Table S20). However, both sectors saw decreases in client ratios from 2013, with ratios for public prescribers dropping from 49 to 39 and private prescribers from 19 to 16. Public prescribers in the Australian Capital Territory (105 clients) and South Australia (70 clients) had a relatively high average number of clients. Private prescribers had a lower average number of clients than public prescribers in all states and territories except Victoria, which had no public prescribers.

Prescribers working in correctional facilities had an average of 40 clients nationally, but at a state and territory level this varied widely, from 2 clients per prescriber in Tasmania to 107 clients per prescriber in the Australian Capital Territory (Table S20).

Does treatment vary between sectors?

In 2014, methadone was the most commonly prescribed drug across all sectors (Table S12). However, prescribers in correctional facilities were far more likely to prescribe methadone (87% of clients) when compared with private (66%) or public prescribers (61%). Private prescribers were the most likely to prescribe buprenorphine-naloxone (23%) compared with public (22%) or correctional facility (6%) prescribers. Given that clients prescribed buprenorphine-naloxone in New South Wales are reported as receiving buprenorphine, the proportion of clients actually receiving buprenorphine-naloxone nationally is likely to be an underestimate.

The client group that particular prescriber types treat can vary depending on the demographic features of the clients. Based on 2014 unit record data from 6 states and territories, correctional facility prescribers were more likely to treat younger clients (Table S25)—correctional facilities treated clients aged under 30 at over twice the rate seen for all prescribers. Public, private and public/private prescribers served similar client groups.

Public, private and public/private prescriber types were generally similar in terms of the proportion of male and female clients treated, each treating about twice as many males as females (Table S24). Correctional facilities were different, with about 9 in 10 clients being male.

Dosing points

At the start of treatment, clients need to attend the clinic or pharmacy to take their dose under supervision. However, the requirement to travel regularly to the dosing point can be a barrier to both ongoing participation in treatment and social reintegration. To overcome these issues, there is a provision for takeaway doses for stable clients in some circumstances (DoHA 2007). Policies on takeaway dosing vary by state or territory. For more information, refer to the individual state and territory guidelines for treating opioid dependence in Table A3 of Appendix A (online). Where takeaway dosing is allowed, it is preferred that clients on buprenorphine are given the combination buprenorphine-naloxone product as the 'properties of the combination product are intended to limit the abuse potential of buprenorphine' (DoHA 2007).

In 2013–14 there were 2,432 dosing points in Australia, a rise of 77 (3%) from 2012–13 (Table S16). In the same period the number of dosing points rose in all states and territories (with the exception of the Australian Capital Territory, which stayed the same). Nationally, in 2013–14 the majority of dosing points were pharmacies (89%), which were the most common dosing point sites in all states and territories (Table 2). These proportions are very similar to those observed in previous years.

Table 2: Dosing point sites, states and territories, 2013–14

Dosing point sites	NSW[a]	Vic	Qld	WA	SA	Tas	ACT	NT	Aust	Aust (%)
Public clinic	36	—	10	1	2	2	1	2	54	2.2
Private clinic	12	—	10	—	—	—	—	—	22	0.9
Pharmacy	700	478	436	242	197	60	32	9	2,154	88.6
Correctional facility	2	11	4	2	8	1	1	1	30	1.2
Other[b]	75	15	77	3	1	1	—	—	172	7.1
Total (number)	825	504	537	248	208	64	34	12	2,432	100.0
Total (%)	**33.9**	**20.7**	**22.1**	**10.2**	**8.6**	**2.6**	**1.4**	**0.5**	**100.0**	. .

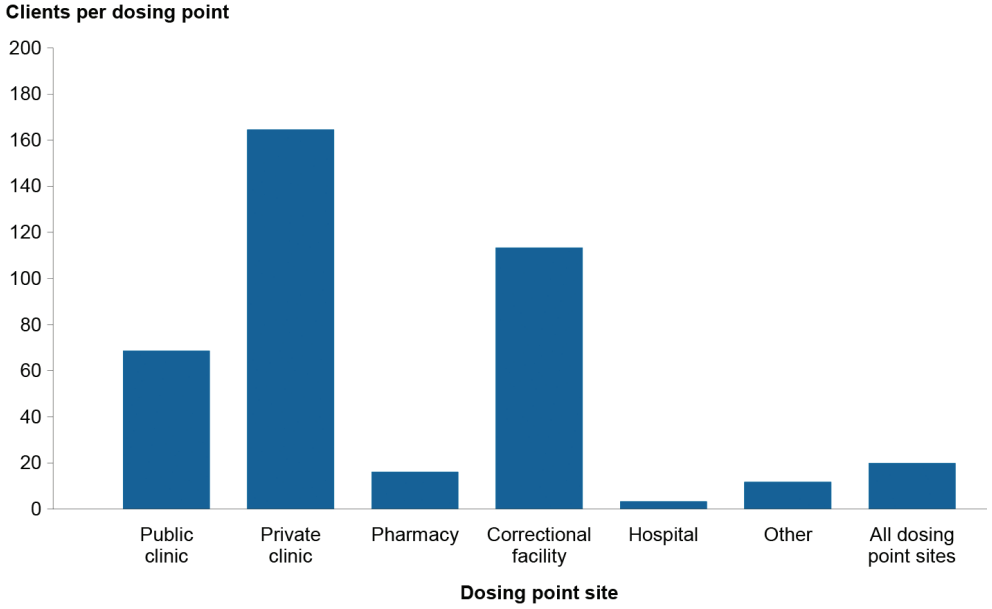
(a) See Appendix A (online) for more information about NSW. NSW and WA correctional dosing points are reported as 2 sites.

(b) The category 'other' includes hospitals, mobile dosing sites, community health clinics, non-government organisations, doctors' surgeries and dosing points 'not stated'.

What is the relationship between clients and dosing points?

Of the 48,393 clients receiving treatment on the snapshot day in June 2014, the majority (71%) dosed at a pharmacy. Other common sites for dosing were public clinics (8% of clients), private clinics and correctional facilities (7% each) (Table S13). Data on the number of clients receiving pharmacotherapy treatment per dosing point were collected for the first time in 2014. The most common number of clients per dosing point was 1–5 clients. Nationally, on a snapshot day in June 2014, 31% of dosing points treated 1–5 clients, 20% treated 21–50, and 18% 11–20. The pattern of client numbers per dosing point varied greatly across states and territories (Table S18).

On average, 20 clients were dosed at each dosing point site (Figure 10). However, this varied significantly by the type of dosing point. Private clinics dosed, on average, more than 10 times as many clients as each pharmacy (165 clients per dosing point compared to 16). Correctional facilities dosed an average of 113 clients, but this number is inflated as New South Wales and Western Australia report all correctional dosing point sites under 2 sites. When New South Wales and Western Australian data are excluded, correctional facilities dosed an average of 55 clients (tables 2 and S13).

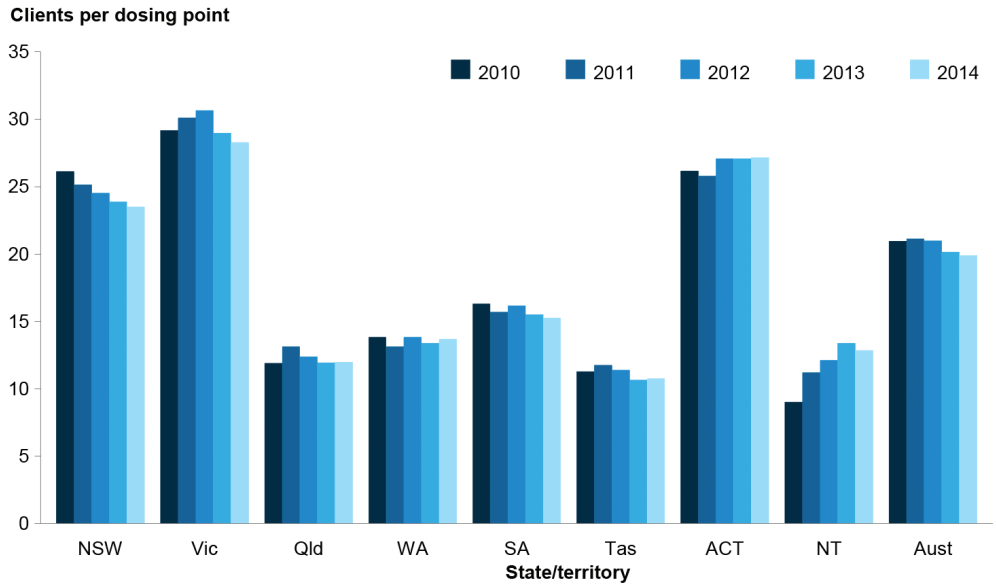


Note: NSW and WA correctional dosing points are reported as 2 sites.

Source: Tables 2 and S13.

Figure 10: Average number of clients per dosing point, 2014

Nationally, the average number of clients per dosing point rose from around 19 in 2006, peaking at around 21 between 2010 and 2012 (Figure 11). In 2014, the ratio fell back slightly to 20. At a state and territory level, the ratio of clients per dosing point rose or remained relatively stable between 2006 and 2012. In 2014, Victoria (28) had the highest ratio of clients per dosing point followed by the Australian Capital Territory (27) and New South Wales (23) (Figure 11).



Source: Table S19.

Figure 11: Average number of clients per dosing point, states and territories, 2010 to 2014

While the majority of clients were dosed at pharmacies, a larger proportion of clients who received buprenorphine-naloxone were dosed at a pharmacy (86%) than those receiving methadone (71%) or the buprenorphine-only product (57%). A larger proportion of clients who received methadone were dosed in a correctional facility (9%) than those who received buprenorphine only (4%) or buprenorphine-naloxone (2%). These proportions have remained similar for about the last 5 years (Table S14). The proportion of clients dosed with buprenorphine-naloxone may be higher than reported, as clients receiving this treatment in New South Wales are reported as receiving buprenorphine. (Refer to Table S13 for a further breakdown of clients by pharmacotherapy type, dosing points, and state and territory.)

As with prescriber types, the characteristics of the client group treated at particular dosing point types are not uniform. For those states and territories for which data were available, more pharmacy dosing points treated an older client group (those aged 50 and over) in 2014 than other dosing point types (Table S27). Correctional facility dosing points, on the other hand, dosed a much younger client group than other dosing point types. The client groups dosed at public clinics, private clinics and hospitals were similar.

All dosing point types treated more males than females, reflecting the overall proportion of males and females receiving pharmacotherapy treatment. The proportion of male clients ranged from 61% for pharmacy dosing points to 88% for correctional facility dosing points (Table S26). Correctional facility dosing points dosed 7 male clients for every female client.

There are a number of different pathways that clients take from where they are prescribed pharmacotherapy to where they are given their treatment dose. On a snapshot day in June 2014, the large majority of clients dosed at public clinics were prescribed by public prescribers (Table 3). Likewise, almost all clients dosed at private clinics were dosed by private prescribers. For clients treated at pharmacies, about 3 in 10 were prescribed by public prescribers and about 6 in 10 by private prescribers.

Table 3: Clients receiving pharmacotherapy treatment on a snapshot day, by prescriber type and dosing point type, 2014 (per cent)

	Dosing point type							
Prescriber type	Public clinic	Private clinic	Pharmacy	Correctional facility	Hospital	Other	Not stated	All dosing points
Public prescriber	7.7	0.4	15.4	0.3	0.3	—	4.7	28.8
Private prescriber	2.0	9.2	31.1	0.3	0.2	0.1	9.2	52.1
Public/private prescriber	3.0	0.8	5.6	0.5	0.5	—	0.7	11.1
Correctional facility	0.1	—	0.2	6.6	—	0.2	1.0	8.0
Total	**12.8**	**10.4**	**52.3**	**7.6**	**1.0**	**0.3**	**15.6**	**100.0**

Note: Unit record data were used to produce this table. Records were available for 57% of total clients receiving pharmacotherapy on a snapshot day in 2014. Vic and Qld data were not available.

Glossary

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

Buprenorphine-naloxone (Suboxone®): The combination buprenorphine-naloxone product is a sublingual tablet or film containing buprenorphine hydrochloride and naloxone hydrochloride (DoHA 2012). It is recommended that buprenorphine-naloxone should be prescribed in preference to buprenorphine for most clients receiving takeaway doses (DoHA 2007). This is because, when taken as intended by dissolving the tablet or film under the tongue, the combined product acts as if it was buprenorphine alone. However, if the combined product is injected, naloxone can block the effects of buprenorphine and increases opioid withdrawal symptoms. This reduces the risk that those receiving buprenorphine-naloxone as a takeaway dose will inject it or sell it to others to inject (Chapleo & Walter 1997; DoHA 2007; Dunlop 2007).

client: a person registered as receiving opioid pharmacotherapy treatment on the snapshot day.

correctional facility prescribers: prescribers who work in prisons or other correctional services.

dosing point site: a place at which at least 1 client is provided a pharmacotherapy drug on the snapshot day. Sites include public and private clinics (such as methadone clinics), pharmacies, correctional facilities, hospitals (admitted patients and outpatients) and other locations such as community health centres and doctors' surgeries.

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

prescriber: a registered prescriber who is accredited and/or authorised to prescribe a pharmacotherapy drug and who has not been recorded as ceasing this registration before the snapshot day. More specifically, prescribers are included in the count if they are registered or active prescribers, that is, prescribers who are scripting at least 1 client during the reporting period (that is, each financial year).

prescriber type: the sector (public or private) in which the prescriber is practising when prescribing pharmacotherapy drugs.

private prescribers: prescribers who work in organisations that are not controlled by government, such as private general practice clinics.

public prescribers: prescribers who work in organisations that are part of government or are government-controlled, such as public drug and alcohol clinics and public hospitals.

specified/snapshot day or snapshot day: a particular day, usually in June each year, on which clients are counted for the NOPSAD collection. The snapshot day varies between states and territories, but allows the number of clients to be estimated at a single point in time. See Appendix A (online) for information about the use of the snapshot day for each state and territory.

Acknowledgments

The authors of this bulletin were Rachelle Graham, Melinda Petrie and Karen Webber from the Tobacco, Alcohol and Other Drugs Unit of the AIHW. Moira Hewitt provided valuable support.

The contributions, comments and advice of the NOPSAD Collection Working Group are gratefully acknowledged.

The Australian Government Department of Health provided funding for this bulletin.

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

- Department of Health, Australian Government
- Ministry of Health, New South Wales
- Department of Health and Human Services, Victoria
- Department of Health, Queensland
- Department of Health, Western Australia
- Department for Health and Ageing, 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
AODTS NMDS	Alcohol and Other Drug Treatment Services National Minimum Data Set
DoH	(Australian Government) Department of Health
NOPSAD	National Opioid Pharmacotherapy Statistics Annual Data
NSW	New South Wales
NT	Northern Territory
Qld	Queensland
SA	South Australia
Tas	Tasmania
Vic	Victoria
WA	Western Australia

Symbols

—	nil or rounded to zero
. .	not applicable

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More information and related publications

Supplementary data tables (those with a prefix of S) containing the information referred to in this bulletin are part of this release and can be downloaded free of charge from <http://www.aihw.gov.au/publication-detail/?id=60129551121>. Additional material, including explanatory notes and a data quality statement, are also available in online appendixes A and B.

For more information on alcohol and other drug use and treatment services in Australia, see the AIHW website <http://www.aihw.gov.au/alcohol-and-other-drugs/>.

The following AIHW publications also contain information on drug use and treatment:

- *National Drugs Strategy Household Surveys (NDSHS)* <http://www.aihw.gov.au/alcohol-and-other-drugs/ndshs/>
- *Alcohol and other drug treatment services in Australia* <http://www.aihw.gov.au/alcohol-and-other-drugs/aodts/>
- *Prisoner health services in Australia 2012* <http://www.aihw.gov.au/publication-detail/?id=60129548273>.

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ISSN 1446-9820

ISBN 978-1-74249-737-2 (PDF)
ISBN 978-1-74249-738-9 (Print)

Suggested citation
Australian Institute of Health and Welfare 2015. National opioid pharmacotherapy statistics 2014. Bulletin no. 128. Cat. no. AUS 190. Canberra: AIHW.

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Published by the Australian Institute of Health and Welfare

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